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Ministry of Health

Ministry of Long-Term Care

1st Session
42nd Parliament

Tuesday 29 October 2019

Chair: Peter Tabuns
Clerk: Julia Douglas

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Président : Peter Tabuns
Greffière : Julia Douglas

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Hansard Reporting and Interpretation Services
Room 500, West Wing, Legislative Building
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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON ESTIMATES

COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Tuesday 29 October 2019

Mardi 29 octobre 2019

The committee met at 0900 in room 151.

APPOINTMENT OF SUBCOMMITTEE

The Chair (Mr. Peter Tabuns): Good morning, everyone. Estimates is back in session.

I gather, Ms. McKenna, you have a motion you would like to introduce.

Ms. Jane McKenna: Yes, thank you so much, Chair.

I move that Mr. Cho replaces Mr. Pettapiece on the subcommittee on committee business.

The Chair (Mr. Peter Tabuns): Any discussion?

Interjection.

The Chair (Mr. Peter Tabuns): You're just in support; I understand that.

Agreed? Agreed. Fine. Thank you.

MINISTRY OF HEALTH
MINISTRY OF LONG-TERM CARE

Mr. Peter Tabuns: As we have been away for some time, I'd like to welcome all of you back. We have new members. I'm going to take this opportunity to remind everyone that the purpose of the estimates committee is for members of the Legislature to determine if the government is spending money wisely and effectively in the delivery of the services intended.

I would also like to remind everyone that the estimates process has always worked well with a give-and-take approach. On one hand, members of the committee take care to keep their questions relevant to the ministry—I'm sure you will—and the ministry, for its part, demonstrates openness in providing information requested by the committee. As Chair, I tend to allow members to ask a wide range of questions pertaining to the estimates before the committee to ensure that they are confident the ministry will spend those dollars appropriately.

We are going to resume consideration of vote 1401 of the estimates of the Ministry of Health and Long-Term Care. There is a total of three hours and 15 minutes remaining.

Before we resume consideration of the estimates, if there are any follow-up materials that the minister would like to provide to the committee, perhaps the information can be distributed by the Clerk.

Do you have any material? Are there any items, Minister?

Hon. Christine Elliott: No.

Mr. Peter Tabuns: None. Okay.

When the committee last adjourned, the official opposition had nine minutes remaining in their rotation. Ms. Gélinas, it's all yours.

M^me^ France Gélinas: Thank you, Chair. My first question, I guess, would be to—I don't know who, so I'll put it out there. There are a number of outstanding questions from when we did estimates back in the spring, and I was wondering: Are there deadlines to answer those questions? When can we expect answers?

The Chair (Mr. Peter Tabuns): I'm not aware of any firm deadline. It is up to the ministry to provide answers, but there is no legislated rule in this matter, as far as I know.

M^me^ France Gélinas: Okay, so I guess I'll go to the ministry. I have a list that has been prepared—dated June 7, by the Clerk of the Committee—that has 14 questions, for which you were not able to provide answers that day and said that you would get us some answers. We haven't received them. Is there willingness to answer them?

Hon. Christine Elliott: Yes, absolutely. We are working to provide that material to you. I apologize for the fact that it hasn't been provided as yet, but we will get that to you as soon as we're able.

M^me^ France Gélinas: But you have received the document from the Clerk with the 14 questions?

Hon. Christine Elliott: Yes.

M^me^ France Gélinas: Okay. All right. I will use my few minutes wisely, starting with the Ontario health teams. The initial series of Ontario health teams have been identified. They had until the beginning of this month to submit. I know that some of them have decided—mine, the one in the northeast has decided—to submit a little bit later. Where in the estimates can I find—is there any money allocated to help the Ontario health teams get together?

Hon. Christine Elliott: I'll ask the deputy minister to reply to that.

Ms. Helen Angus: Yes, I can answer that.

Hon. Christine Elliott: Thank you.

Ms. Helen Angus: It's Helen Angus; I'm the Deputy Minister of Health. In last year's estimates, we didn't specifically allocate money to a vote or item that said "Ontario health teams." On the other hand, I think we've actually provided a lot of support to Ontario health teams, both through the self-assessment, the first part of the application process, as well as the second part for those

who were deemed to be ready to move on to a full application. Those supports will continue. We're just reviewing those applications now. I think that will give us a better picture of what supports Ontario health teams actually need to do the work on the ground.

I would say that from where we sit, we see an awful lot of effort and we see a lot of collaboration. People are rolling up their sleeves, as we had hoped, to come together and bring their capabilities, their leadership, their assets to actually do the job that we asked of them, which is to better connect care around patients. We have a platform called RISE and we're hosting webinars and how-tos and those kinds of things, but there isn't a specific financial item for Ontario health teams at this time.

M^me^ France Gélinas: All right. There has always been, on my part and on the part of many, a worry that the money that presently goes to community care would be at risk of being redirected towards hospital care when you put them all together. Is this a worry that you've taken into account and, if so, how did you do it?

Hon. Christine Elliott: Absolutely. That has been expressed to us by a number of people who thought that would be the case, that with the creation of the teams that they would be taken over, if I may say, by hospitals, but that's not happening. That's not our intention. The idea is to connect care around the patient throughout their health care journey. Hospital may be a part of that, but community care is also incredibly significant; home care is important; mental health and addictions care; long-term care as well. We want to make sure that it's centred around the patient, that there's no one organization over another that takes priority, because everyone has a role to play.

I think my colleague may have something to say with respect to the long-term-care aspect of it.

Hon. Merrilee Fullerton: I absolutely agree. I think it's becoming clearer to everyone in the health sector how important community care is in terms of ending hallway health care, in terms of creating additional capacity for care. I think that it's in everyone's best interest to consider the significance of community care.

M^me^ France Gélinas: In the north there are huge distances. They would like their electronic health systems to be able to communicate with one another so that as a patient journeys from hospital care to community care to maybe needing a little bit of mental health support or home support—would there ever be money available for them to update to a platform that would allow the different health systems to talk to one another? None of this can be done for free, and none of the players are in the business of developing electronic records.

Hon. Christine Elliott: Yes, absolutely. We know that our Digital First for Health Strategy is important to move forward with, along with the creation of the Ontario health teams, because it's going to be really important, if we are going to have integrated care for patients, that health providers are going to be able to speak to each other about it. We know, from previous work that has been done with eHealth and other aspects of care, that that hasn't necessarily happened and that there hasn't been that contact with the people who provide care on the front line. It's really important to us and for the success of the local Ontario health teams that we provide the digital tools that people are going to need, so our digital team is very involved in that.

I will ask the deputy minister to speak a little bit further about that.

Ms. Helen Angus: Yes. We actually published a digital playbook—it's kind of a digital language—which basically gave the Ontario health teams, amongst other things, a catalogue of all the things that have actually been bought with taxpayer dollars that they could leverage in their Ontario health teams. I would expect that obviously our digital investments over time will support Ontario health teams, but we've set up an expectation that Ontario health teams will allow patients to access their own information and be able to access care virtually more often. We're going to be pretty rigid about standards, so interoperability is really important. But we're going to allow some flexibility locally for Ontario health teams to adapt to their local circumstances. It is our great hope that with the investments in digital health we will see much more virtual care and connectivity across large geographies.

M^me^ France Gélinas: When you talk about the digital investment that you're making over time, can you quantify that?

Ms. Helen Angus: In the printed estimates it was $386.9 million, and we're obviously in the middle of our budget process this year to look at what digital investments we need to support given the uptake of Ontario health teams and I think the real opportunity we have to advance virtual care and put more information in the hands of patients wherever they may be.

The Chair (Mr. Peter Tabuns): Just a reminder: You have one minute left.

M^me^ France Gélinas: Okay. Of this $386.9 million, what does that support? Who will benefit from that money?

Ms. Helen Angus: At the end of the day, of course, patients will benefit from that money.

0910

M^me^ France Gélinas: But which agencies will be transfer payment agencies receiving part—

Ms. Helen Angus: Some of that goes to eHealth Ontario, which, as you know, will be transferred at a point in time into Ontario Health. But we have other digital partners across the health care system. There are some in LHINs, there is the Ontario Telemedicine Network, as you know, and OntarioMD and others. So we have a variety of digital assets across the province that will be helpful to the mission of Ontario health teams.

The Chair (Mr. Peter Tabuns): And with that, I'm sorry to say, you're out of time. We go to the government: Ms. Triantafilopoulos.

Ms. Effie J. Triantafilopoulos: Thank you, Chair, and thank you for pronouncing my name so well.

My question is for Minister Elliott. Thank you, Minister, for being here today. I know that you're very much a strong advocate for mental health and addiction supports.

It's estimated that 30% of Ontarians will experience a mental health issue at some point in their lives. It has been reported that one in 20 adults in Ontario can experience symptoms of major depression in a given year and that two million people each year consult their doctors for mental health and addiction-related reasons. And we all know a friend or relative who has experienced this in their past or even currently.

Our government has pledged to make substantial new investments in mental health and addiction services over the coming years. You've reported $174 million each year over the coming 10 years, and $28 million for youth programs to help them as well.

Given this mental health crisis that we have in our country, can you please tell us about the services available to Ontarians and how our government plans to strengthen supports for those experiencing mental health and addiction challenges? Also, given the crisis, are these investments sufficient to do the work that needs to be done going forward?

Hon. Christine Elliott: Thank you very much for the question. When I was here in June, I did have the opportunity to provide you with a bit of an overview of our government's investments in Ontario's mental health and addictions sector, an area of the health system that does require significant and focused attention. We are collectively aware that challenges persist for clients across this province seeking mental health and addictions care and services, including barriers to access, extensive wait times and inconsistent quality of services.

In addition, the mental health and addictions system is highly fragmented, and we lack the standardized data needed to inform better care and better system planning. As a result, more people are turning to emergency departments for their mental health and addictions needs, placing an unnecessary burden on hospitals and contributing, of course, to hallway health care. This was confirmed in the 19 province-wide consultations that Parliamentary Assistant Martin and I led earlier this year. We heard from mental health and addictions community organizations, front-line service providers, hospitals, advocates, people with lived experience and people with experience in Indigenous mental health and addictions that our government needs to invest in community mental health and addiction services. We need to do so now, because the community is the best place to realize success with regard to ending hallway health care.

We also learned that the sector and sector users are eager to see greater standardization, quality improvement and enhanced integration across community, primary and acute care settings. There has been extensive work and investments made to address these challenges and to work towards building a connected mental health and addictions system, one that will be client- and family-centred, comprehensive and focused on quality.

We recognize that solutions to address these challenges need to target the system at all levels: for clients and service providers as well as for system leaders. These solutions need to make the system easier for Ontarians to understand and navigate so that people know where to go to access the high-quality services that they need.

Solutions also need to focus on getting people help sooner by funding the front-line services we know are effective and needed. Solutions are needed to ensure the system remains accountable to Ontarians, including putting in place province-wide mechanisms to monitor and improve quality. We also recognize that in undertaking mental health and addictions system transformation, our government must pursue a multi-ministerial approach that brings much-needed supports to Ontarians by leveraging existing health, education, housing, justice and social-services-sector infrastructure.

I am pleased to have Associate Minister of Mental Health and Addictions Michael Tibollo here today to provide details about our government's efforts and to outline additional work that needs to be done to support Ontarians in need of mental health and addictions services.

Minister Tibollo, if you could please come forward?

Ms. Helen Angus: Why don't you come forward?

Hon. Michael A. Tibollo: Thank you, Minister Elliott, and thank you to the committee for allowing me to speak with all of you today.

As Minister Elliott indicated, our plan for mental health and addictions involves building the foundations of a sustainable, high-quality system while investing in the services that Ontarians need now.

Our government's historic investment of $3.8 billion over 10 years aims to build capacity in the mental health and addictions sector and seeks to provide evidence-based services that will help reduce pressure on hospitals and decrease wait times.

Since our government first took office, we have taken real action to address sector challenges by providing investments in areas identified as critical across the province.

On May 6, 2019, our government announced $174 million in new annualized investments for mental health and addiction services, with funding going to Ministry of Health programs as well as programs of partner ministries like the Ministries of Education, Children, Community and Social Services, and Municipal Affairs and Housing, just to name a few.

Investing in mental health and addiction services will contribute to building a strong continuum of care across an individual's lifespan. Our government recognizes that more work needs to be done, which is why we are taking a whole-of-government approach to making mental health and addictions a priority.

Investments for the fiscal year address six priority areas of the mental health and addictions system, in particular:

—reducing wait time for services;

—enhancing addiction services;

—expanding mental health beds in hospitals;

—creating additional supportive housing;

—building capacity in child and youth mental health services; and

—investing in services for Indigenous communities and priority populations, including francophones.

These services will benefit thousands of Ontarians, including children and youth, post-secondary students, individuals who are justice-involved, people experiencing homelessness, and Indigenous people, families and communities.

In terms of specific initiatives, our $174-million investment will be going to community addiction services, including support for people with opioid use disorder, such as our $6-million investment for community-based service providers to increase developmentally appropriate addiction services for youth, and our investment of $9.23 million for rapid- access addiction medicine clinics—which are a key component of our response to the opioid crisis—residential treatment, and withdrawal management.

These investments aim to increase access to addiction services, reduce wait times, and improve connections to other community-based health and social service supports, such as primary care. Some $174 million will also be going to mental health and justice initiatives for individuals with mental health and addiction issues who are in conflict with the law.

In total, these investments add up to $18.33 million and will help in assisting the police in de-escalating mental health and addiction crises in the community by providing mobile crisis teams and community treatment options to stabilize and connect individuals in crisis with needed services, diverting appropriate persons in crisis from hospital emergency rooms to safe bed programs for short-term crisis accommodation and transitional case management services, and stabilizing and preventing further involvement in the criminal justice system by increasing access to dedicated supportive housing units for this target population.

Supports include ongoing case management, psychosocial rehabilitation, medication management, life skills training, peer supports and, in addition, increasing capacity of mental health court support and diversion opportunities with access to longer-term community supports and resources.

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Our $174-million investment will also be going to child and youth mental health. As of fall 2018, the Ministry of Health and Long-Term Care, now the Ministry of Health, became responsible for child and youth community mental health services across the province, funding approximately 245 community-based agencies that deliver a set of defined child and youth mental health services. They do this province-wide, ranging from counselling and therapy to intensive specialized services. In 2018-19, the child and youth mental health sector received one-time funding of $10 million to improve access to core services. In 2019-20, child and youth mental health services received $406 million in base funding with an additional $28.6 million as new base funding.

Lastly, our $174-million investment will also see funding for supportive housing. Supportive housing provides community alternatives to institutional care for people with severe and complex needs. Our government recognizes the important role that supportive housing plays in decreasing pressures on hospitals and other sectors such as justice.

Creating additional supportive housing is a key component of the $174-million investment in additional funding for mental health and addiction programs and services in 2019-20. This investment includes $15.2 million for mental health in justice supportive housing. These are rent supplements in associated supportive services, supplemental investment in rent supplements to address agency pressures as a result of market rent increases and increases to utility costs, modernizing the Homes for Special Care Program and expanding the rent supplement program to minimize the loss of supportive housing due to the end of operating agreements.

As mentioned, we have made a number of significant investments in other sectors as part of an across-the-government approach to addressing the critical needs of the mental health and addictions system: $28.5 million is being provided to fund mental health supports in Ontario's education system, which will directly benefit schools, teachers, students and parents. This investment allows for the continuation of regulated mental health professionals with specialized training in student mental health in secondary schools, providing mental health promotion, prevention and intervention to students and their families.

Just over $5 million is being provided to the Ministry of Children, Community and Social Services to provide culturally appropriate mental health services and supports to Indigenous communities, including adults, families, children and youth. Some $7.53 million is flowing through the Ministry of Health to fund treatment centres and mental wellness programs, as well as mental health and addiction workers and coordinators for Ontario's Indigenous communities. There's $160,000 being provided to the Ministry of Education for culturally appropriate training and support for Indigenous front-line mental health workers in schools. This is a cumulative total of $12.77 million in new investments to directly support our Indigenous communities.

Lastly, $12 million is being provided to support approximately 50 new in-patient mental health beds. This is not only to help build hospital capacity but to ensure that all Ontarians have faster access to the care they need in our province's hospitals instead of waiting to receive care in settings not fit for their needs.

In addition to these investments, our government is continuing its commitment to support structured psychotherapy. A standardized, quality-based program that deploys an evidence-based stepped care pathway to treat depression and anxiety: The pilot is based on the world-leading UK program that is achieving excellent results for patients and can demonstrate, after 10 years of data, that treating depression and anxiety in the community pays for itself in the long run. Through this program, psychologists, psychotherapists, social workers, occupational therapists and nurses provide care for depression and anxiety in a variety of community settings. The program could lead to decreased emergency room visits and admissions.

At present, in the pilot phase, the program is serving approximately 40,000 people over three years. Over $30

million was invested in 2019-20 for the third and final year of the pilot to provide face-to-face psychotherapy.

The government is also taking action to respond to the recommendations from the 2010 all-party Select Committee on Mental Health and Addictions. At the time, the committee called for the creation of a central body accountable to the province to manage and coordinate Ontario's mental health and addictions services system. Following the 2019 budget, Minister Elliott tabled legislation to create a Mental Health and Addictions Centre of Excellence within Ontario Health, the new agency that has been created to oversee the health care system as a whole. If passed, the Centre of Excellence will support a provincial system-level approach to a mental health and addictions transformation, enabling the government to maximize the impact and value of the $3.8 billion committed to mental health and addictions services and supports.

The Centre of Excellence would serve as the implementation arm of the ministry's mental health and addictions strategy, while the minister would maintain overall policy direction for the mental health and addictions system. This will be a significant opportunity to leverage and amplify the best practices of provincial agencies that are being transitioned to Ontario Health, including Cancer Care Ontario, eHealth Ontario and the Trillium Gift of Life Network. As a central engine for the province-wide mental health and addictions system, the proposed centre of excellence would provide the focused leadership that many in the sector have been calling for for years.

While new funding is a critical component to addressing challenges with accessing care and long wait times, the ministry recognizes that much more is needed. That's why the 2019 budget committed to developing a core services framework embedded in a stepped care model, in addition to a robust data and performance measurement framework.

The ministry's upcoming mental health and addictions strategy will build out these foundational aspects of a comprehensive and connected mental health and addictions system. It will also enable the government to set out evidence-based core services, triage clients to the most appropriate level of care to meet their needs, support and monitor quality improvement, collect standardized data, and measure and report on system performance. This modern system infrastructure will ultimately build the capacity needed for community mental health and addictions providers, including child and youth organizations, to eventually integrate into Ontario health teams.

We're proud to continue to make mental health and addictions a priority and look forward to collaborating with our partners across government to create an Ontario where everyone is fully supported in their journey toward mental wellness.

The Chair (Mr. Peter Tabuns): Thank you, Minister. Mrs. Triantafilopoulos.

Ms. Effie J. Triantafilopoulos: Thank you, Minister Tibollo. A lot of work has obviously been done as we move forward into the mental health centre of excellence. I wanted to ask you if you, Minister Elliott or Minister Tibollo, could also focus in on how the mental health centre of excellence would integrate with our new Ontario health teams.

Hon. Michael A. Tibollo: Ontario Health would basically be charged with the responsibility of establishing the level of care, evidence-based strategies that would be utilized when it comes to mental health and addictions. What would happen from there is that they would provide the strategy to the Ontario health teams, which in turn would do the implementation and would perform, based on the established criteria that are evidence-based and that support the strategies or the therapies that would be utilized.

Ms. Effie J. Triantafilopoulos: Specifically, how would the supports necessary be addressed in northern communities and in rural communities, where we know there's a lot of fractured care today?

Hon. Michael A. Tibollo: What we have been doing so far, thanks to Minister Elliott, MPP Robin Martin and the team—

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

Hon. Michael A. Tibollo: We've travelled around the province and tried to identify where the gaps exist. You're correct: In the north there are numerous gaps. But as we go out and create the Ontario health teams, or as they're brought forward, we're able to identify the strengths and the weaknesses, and our work will be in helping support finding the ways that we can build connections and bridges between the various groups that are providing services. Where there are no services, we're going to work with the communities to help them build the evidence-based models that will support the work that they need to do.

0930

Ms. Effie J. Triantafilopoulos: I'm certainly very intrigued about the pilot project you discussed that has been launched in the UK. Can you elaborate a little bit more on that for us?

Hon. Michael A. Tibollo: Yes. Structured psychotherapy is actually very useful—

The Chair (Mr. Peter Tabuns): I'm very sorry to interrupt because I'm interested in your answer, but you're out of time.

Madame Gélinas.

M^me^ France Gélinas: And I am going completely opposite, but it was very interesting listening to you. Thank you for sharing that.

I would like to concentrate my questions more around public health and emergency services and the changes coming. The first is that, on page 115 of the estimates, we see about a $100-million cut to public health funding. This is close to 10% of the public health budget. I'm curious to see: How did you come to that number?

Hon. Christine Elliott: Just to start off with one of the things that was noted by the Auditor General in previous reports, she felt that there was a lot of overlap, that there were a lot of public health units that were doing the same kinds of research, that they weren't well coordinated in the

work they were doing. There was an indication that it was difficult to get the people with the experience that you needed in each of the public health units, and she recommended a reduction. There was a team that studied it and came up with a reduction from 35 down to something a little bit more than 10. I can't remember the exact number, but in any event it was a reduction in the number—

M^me^ France Gélinas: It was 14, lined up with the LHIN boundaries.

Hon. Christine Elliott: Fourteen with the LHINs; thank you. But it was recommended that there be more coordination. When we took a look at it, we realized there were some elements that could be dealt with provincially, not necessarily by each public health unit. The low-income seniors' dental benefits was one of those things that we considered could be something that could be rolled out provincially, which we are in the process of doing for 100,000 low-income seniors at a cost of $90 million.

There are some things that can be done at a provincial level and some things by more of a local level. With that, I'm going to ask the deputy minister if she could speak more specifically to the numbers.

Ms. Helen Angus: Absolutely. It actually was one of the first things, when I became Deputy Minister of Health, was to come to public accounts and talk about the spending in public health. I had a chance to really understand some of the recommendations of the Auditor General. So it really was on that basis that we looked at a reduction. I'm going to remind the committee that the Auditor General found, in her 2017 report, significant inefficiencies across the public health system, limited formal systems to coordinate the work, and duplication of effort. Particularly, I think when I was here in this room, chronic disease prevention and management programs was where that duplication was probably most obvious.

The government at the time decided that a consolidation was recommended, and that was the course that we pursued since the time of estimates. Minister, you may want to talk a little bit more about this. I think we heard very clearly—and the minister and I were at the AMO conference in August. We heard from our municipal partners that the scale and pace of change that we were proposing was probably too quick and that we couldn't and shouldn't apply any changes retroactively, given that they're on a different fiscal year than we are. They generally start on January 1.

It needed to consult more broadly, and that's exactly what we've done. Minister, you may want to talk about Jim Pine and some of the consultations that were undertaken.

Hon. Christine Elliott: Sure.

M^me^ France Gélinas: Just before you go, Deputy, I was there when you came to public accounts. The health units themselves had an opportunity to come and explain what was going on with their chronic disease management. I can assure you that nowhere in public accounts or in the work of the Auditor General will you identify $100 million worth of duplications of work. The part of the money that the health unit uses for their chronic disease management is a fraction of the $100 million you have identified. I'd like you to focus on the number—we're in estimates after all—where does the $100 million come from?

Ms. Helen Angus: I think we looked at efficiencies across the whole portfolio of public health units. Since the time of printed estimates, though, the government has looked at the whole implementation of public health modernization. We've been consulting. We've slowed the implementation in order to be able to consult with municipalities, and therefore we will not be seeking to achieve those savings this year.

M^me^ France Gélinas: But there is still $100 million worth of savings for next year, so you've recognized that you could not do it retroactively, but it's still there. How did you come to that number? I'm no further ahead than I was.

Ms. Helen Angus: Honestly, I would have to look at the detailed notes that we looked at, but I think it was basically looking across the public health units, looking at other reports beyond the Auditor General that had recommended a consolidation of public health units and thinking about not only the people side, but the physical footprint and other things. It was felt that as a percentage of savings, I believe it's roughly 10%, that that was not unreasonable for an effort that looked at making sure that we were doing the right things provincially, that we were doing the right things locally, that we were able to look at the duplication and we were able to build out a more robust public health system in the places where that didn't exist.

M^me^ France Gélinas: Some of the reports that you based your response on didn't talk about 10. It talked about 14. At the time, it was to line up the boundaries of the public health system with the boundaries of the LHINs. How did we go from 14 to 10?

As well, the report had also talked about inequities, that some health units are funded way more per capita than other health units. I happen to be in one that's at the losing end of that formula. How do we address this at the same time as you're asking each of them—remember, it doesn't matter if you are one of the ones that was better funded; there was this program put into place where some health units were getting increases while the others didn't so that we brought equity. What happened to all of that?

Ms. Helen Angus: I think there was an effort to look across the portfolio in acknowledgement that public health units are funded at different levels, so it wasn't going to be consistent across public health units. There was some customization to both the size and the depth of funding that already existed in public health units.

With that, we are actively going back out and consulting with municipalities and others to determine both the right number of public health units, but I think more importantly, it's the function and what needs to be done provincially. That would include—you remember when Peter Donnelly was here—what is done provincially by the ministry or at Public Health Ontario, what work needs to be done locally and what relationships are important in the delivery of public health. We certainly heard that at AMO, right? With how they're so embedded in some of

the municipal delivery of other social services that contribute to population health.

So I think under Jim Pine's leadership, we are going back out and having thoughtful discussions with municipalities with the aim of coming up with the right number and the right functions and listening to our municipal partners. But, Minister, you may want to talk a little bit more about our path forward.

Hon. Christine Elliott: Sure.

Mme France Gélinas: Just before we go forward, I'm still interested in looking back. So we had a report that recommended 14. You came out and recommended 10. Where does that come from? Where does the 10 come from? What was the work that was done to come up with 10?

Ms. Helen Angus: I may have to ask David Williams, Chief Medical Officer of Health, who also runs our public health division, to talk specifically about the thinking around 10. I think that we obviously looked at population thresholds and other things that would contribute to an optimal number, an optimal size, knowing at the time that we were also looking at the role of LHINs. David, you may want to just answer that specific question going back in time.

0940

Dr. David Williams: It's Dr. David Williams, Chief Medical Officer of Health, province of Ontario. Thank you for the question.

The questions that you're asking about—one was that in the expert panel we did a review, as you said, and we looked at the number 14, trying to understand what the best way is to look at some ramping up of regional entities that would give better delivery across the board and enhance the ones that are smaller health units. When we were asked for a new direction, looking at the changes also with a wider Ministry of Health: How could we map into that to make a number that was workable as a starting point? We looked at 10 at that time. Now we've had the discussion and the consultation process, so we haven't really fixed a number at this stage. We're going to go out and hear what the municipalities have to say and have some further discussions about how best to organize our health units.

As you've noted, there is a wide spectrum across. Some are more able and more equipped than others, and sometimes there needs to be more assistance than that. How can we bring those together in some functional way to give much more local enhancement, due to resources available more in geographical areas around the province? We're continuing that dialogue.

As you've heard with Mr. Jim Pine being added to it, and having municipal consultation as well—the public health sector have their technical tables. We're interested to hear their suggestions because certainly they are aware of these issues. These are not new ones; this has been going on for a long time. What's the best way to organize ourselves in Ontario to make sure we maintain front-line public health services, and at the same time give more resources and access to expertise that they would need to undertake, assess, review and then enhance their local services—because we're a big province, as you know, and wide and varied, and we have to make sure they're as close as they can to the front-line service providers.

Mme France Gélinas: Shouldn't we have done all of this before you came out with the number 10?

Dr. David Williams: I think part of that is in the discussion with the sector undertaking that process to understand: As a starting point, what does that mean? The concept of having less than 34 at the moment: What does that mean? Where is the right number? Back 20 years ago, we looked at a different number. It was around 20 or so.

There are various ways to look at what a core deliverable is, with population size, that would give you enough staff size—enough back-office staff to give you those added values of doing areas such as program evaluation, epidemiological analysis and things that you would like to ascertain, and have available for a local front line to align their programs and services better to meet the local population, especially the vulnerable populations, as per our new Ontario Pubic Health Standards, which were released in 2018. The first year of rollout was in 2019.

Mme France Gélinas: The health units were bracing for the cuts. You've postponed it until after you talk to them and come out with the right number and the right work.

In the meantime, there are many health units that have really curled back on their immunizations, especially around the flu shots, because they're trying to save money. Was this an anticipated outcome?

Dr. David Williams: We haven't heard any direct communication that they have cut back on their programs and services in that way. In fact, we're continuing to encourage them to keep pushing—especially in flu season—to get people out. We had one of our best years last year. We hope to emulate that and do that again this year, and have Ontarians turn out and get prepared for the winter season and flu season. We haven't seen that.

I think the changes that you've noted on page 115—there are a variety of different things. A lot of them are not related to chronic disease. There are other issues, with bits and pieces there that—I don't know which ones you want to address in particular, but those changes have been adjusted. We're continuing to look at that as we review the process and look at what is best for a modernized public health sector in Ontario.

Mme France Gélinas: Is it the aim of the government that health units will continue to have a role in health promotion?

Dr. David Williams: That is correct. Certainly, with our new Ontario Public Health Standards, one of the key changes we made in there is that instead of prescribing exactly what they have to do in health promotion—because the populations they deal with are quite wide and varied—we asked them to look a lot more at their health status data. That means more data requirements, more expertise at the local areas to determine that.

Then we're saying—we call it standardized flexibility. Instead of dictating that you have to do this and this and this and this exactly like it is in health protection, which is

important, we ask you to take a look at your data, and in your annual plans, you decide which ones you want to use, supported by your health status data, and then reallocate your staff and resources in your health promotion area—chronic disease prevention—to address those issues that are largest in your area.

That's a big change, and this is our first year ramping that up. That means even more pressure on the health units to do that local analysis, to do that local reallocation of staff and resources, because it doesn't make sense that areas in one part of the province have one, two and three and others have five, six and seven. They would emulate and do the same things, so we want that local diversity to address both.

M^me^ France Gélinas: So how did we come up with the $16.4-million cut in health promotion?

Dr. David Williams: That was a compilation of a number of different aspects. One was the Healthy Kids challenge that wrapped up that year. It was planned to close in 2018, so that was a reduction. There were other ones related to some other campaigns with health resource centres. So it's not exactly a reduction to the health unit programs. These are other initiatives that had been undertaken, and one had completed its process in 2018, so that's why the estimates showed a reduction accordingly.

M^me^ France Gélinas: And what was your position when the government decided to allow promotion of vaping and now decided that we're not going to allow the promotion of vaping products in corner stores and gas stations, but not until January? Why not today?

Dr. David Williams: Did you want me to answer that question, Minister, or did you want to answer that question?

Hon. Christine Elliott: It's probably more of a question for me.

That is something that, when we made the decision at the time, based on the information that we had—but of course, in the last year, the information has changed dramatically and we've seen a huge uptake in vaping among our young people. It has increased by 74% between 2017 and 2018, and is still increasing.

Since I made the ministerial order a month or so ago requiring public hospitals to report to us any indications of vaping-related pulmonary illnesses, I have heard from many people that it hasn't really reached hospitals yet, but there are still a number of young people out there who are not well as a result of vaping, and so we made the determination that it was necessary to do something right away. The consultations that I've held thus far have indicated unanimous consent about banning the promotion of vaping and vaping ads in convenience stores and gas bars.

M^me^ France Gélinas: And why not online and on billboards and on TV and everywhere else they advertise, where kids can still see them?

Hon. Christine Elliott: Some areas are part of provincial responsibility and some are areas of federal responsibility. Some of the ads that I've heard are at places like Union Station and so on—TV ads and those sorts of ads—they're a responsibility of the federal government, not of our government, so we're doing what we can provincially. But I can tell you that I look forward to having this discussion with the new federal Minister of Health whenever he or she is sworn in, because it is a matter of significant public interest and concern, and something that we hope to be able to work collaboratively with the federal government on.

M^me^ France Gélinas: Does that mean that you agree with a ban on all advertising outside of specialty stores: a ban on advertising online, on television, in media, on billboards etc.?

Hon. Christine Elliott: Yes, that would be something that has been recommended to us. That's not something that is within provincial powers, of course, but it's something that I do intend to discuss seriously with the new federal minister.

M^me^ France Gélinas: I'm a little bit surprised to hear that we cannot limit billboards in Ontario from the Ontario government. Those are in our territory. But anyway, I will leave it for—Dr. Williams, you're smiling. Did you have something to add to this?

Dr. David Williams: These are all areas that we're trying to investigate. We're working with the Council of Chief Medical Officers of Health at the federal/provincial/territorial committees. The timing, of course, during the federal election didn't allow us to proceed further, so we hope to be able to address that assertively, mostly with advertising that's targeted towards youth. We're trying to look at limitations on a pan-Canadian basis: how we do it locally, provincially, federally—

The Chair (Mr. Peter Tabuns): You've got one minute left.

M^me^ France Gélinas: Is there any intention of funding the health units to help with the vaping crisis in some of our communities?

0950

Hon. Christine Elliott: It may be something that we will need to do. We're looking at all options right now and all considerations because this is a significant concern to members of the public and we want to make sure that our young people's health is protected.

M^me^ France Gélinas: And when you look at vaping, would you also look at limiting the amount of nicotine that is in some of those products?

Hon. Christine Elliott: That's also a concern that has been indicated to us. As you probably are aware, there is enough nicotine in a cartridge of a vaping product that's it's equal to smoking a pack of cigarettes. I know that the European Union has limited—

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

We go to the government. Mr. Cho.

Mr. Stan Cho: It's really great to see you here, Minister Fullerton. I know that in my riding of Willowdale long-term care is an issue that comes up a lot, not just at the door but in my constituency office and constantly, and I'm sure that's the case for all members here today. Of course, that's understandable, given that we have an aging

population—an aging population, of course, that will put further strains on our health care system, and it requires some serious work to be done today to prepare for that.

I'm wondering if you can share with us some of the work that you have been doing as well as what our government plans to do to support the long-term-care sector moving forward.

Hon. Merrilee Fullerton: Thank you for the question. In June of this year, Premier Ford named me the Minister of Long-Term Care and entrusted me to create a stand-alone ministry dedicated to long-term care. This is a job that I take very, very seriously, and so does our government.

Before I was elected, I was a family doctor for almost 30 years—28—practising medicine as a family physician. I witnessed the challenges in our health care system and our long-term-care system. Then I experienced it from a personal perspective with my grandmother and my father, with my mother, who was the primary caregiver. My brother and sister—we're all doctors. Do you think we could manage to keep all those balls in the air? No. We're not alone and I know there were people all across Ontario facing the same challenges, so it's close to my heart. It's a very significant move to make a long-term-care ministry, and I think it's going to be very helpful.

Seniors and their families expect that when they move into a long-term-care home they will receive the kind of care that is respectful of their needs and in a loving and comfortable environment. We all have someone we know, whether it's a relative or a neighbour or a loved one, a friend, who has needed long-term care, and one day we may need it ourselves. We will all be touched by it in some way.

I want to start by saying that a vital element of Ontario's long-term-care sector is the care providers. Their hard work, their dedication and their professionalism is a real strength of our long-term-care system. It is those care providers who work day in, day out. They deserve all the credit in the world for what they do and what they contribute to the quality of life of our residents in long-term care.

But despite the great work that's taking place in our long-term care sector, we've got 36,000 people or more by this time on wait-lists and we have a 99% occupancy—98%, 99%, depending on what day you measure it. The unmet demand has created tremendous pressure in hospitals; it has contributed to what we're calling hallway health care, as you know; and it has left many Ontarians feeling unsupported, just like my family did.

As of August 2019, the wait for a placement in a long-term-care home was 138 days on average. That fluctuates. We hear anywhere from 144 to 154, so that's fluctuating. That's almost half a year that a family—an individual, a real human being—is waiting for a safe place to call home. I often say that long-term care is not a place you go to stay; it's a place you go to be cared for. Some 97% of long-term-care residents are long-stay residents. Only 7% are under the age of 65, but I just heard the other day that there's a growing number in some areas of younger populations in long-term-care homes for a number of reasons. Approximately 65% of residents have been diagnosed with Alzheimer's and other forms of dementia. I know, professionally and personally, what a toll that takes on families. So the numbers are jarring, and we know that improvements need to be made.

Our most vulnerable people deserve a sense of dignity, to have a place to call home and to receive high-quality care. The current model leaves people waiting in hospitals for spaces to open in a long-term-care home. I can tell you, I've done my share of waiting with my relatives. It's not the most appropriate space for their needs. It leaves them open to other risks. We need to open up beds in hospitals and find the most appropriate care for people needing long-term care and the services surrounding long-term care, and we need to allow others who need acute care to get into the hospitals and get the care they need when they need it as well. We are focused on delivering care that considers the preferences, the needs and the values of the residents and their families.

We're investing $1.75 billion to create 15,000 new long-term-care beds and redevelop another 15,000 to modern design standards over five years. In just over a year, we have already allocated half of those beds, and on October 1 we announced a new call for applications for potential operators and current operators to be able to apply and get those beds moving, get shovels in the ground and redevelop beds. It will bring us another step further. This is a process; it's not something that will happen instantly. We are looking at how we can streamline processes and make it easier for our sector to contribute to addressing capacity issues.

Just in the last year, we have invested $72 million more than the previous year—money to support more beds, nursing and more personal support care. I hear about personal support workers all around the province; it's very important. To help seniors remain at home as long as they can while receiving a high level of care and the supports that they need, reducing strain on hospitals, our government has also invested $155 million in additional home and community care. We've talked about that and how important that is. Previous governments pushed that off and pushed that off. Our government is addressing that. Our work has only just begun.

As Minister of Long-Term Care, I am working to build a system that is focused on residents and is a place where our most vulnerable people can call home. We are committed to building a 21st-century long-term-care system that ensures that residents are treated with respect and dignity—and I don't think that can be repeated enough. A 21st-century long-term-care system is one that ensures that there is space in a long-term care when that individual needs it or, as a matter of fact, when the caregiver can no longer manage. To achieve this, we need to work together to change the way that long-term care works in Ontario.

Our government recognizes that sometimes we experience a build-up of red tape that interferes with our ability to deliver high-quality care for residents. We are working to reduce these regulatory burdens and administrative

barriers and to facilitate the development of new long-term-care beds as well as the redevelopment of older beds to ensure that residents can get the best possible care. We continue to actively engage with our sector to modernize long-term care by reducing red tape, integrating greater flexibility, and encouraging innovation in the development and delivery of long-term care. That will also include virtual mechanisms, which is so exciting and so crucial.

We will continue to work with all of our partners to ensure that proposed projects serve the needs of their communities. We heard loud and clear that there are regional differences, and what one group might be struggling with in a rural area may be a different issue in an urban or suburban area. So a key element for our government for long-term care involves building capacity, creating flexibility, and ensuring that Ontarians have access to the care they need when they need it. We are determined to provide residents and caregivers with the care and support that they need when they need it. We need to ensure that all residents and their caregivers have confidence that when they choose, in this life-altering way—it's often a crisis that drives families to long-term care—it's there when they need it and that they are making the right decisions and they can trust the system.

1000

We're hard at work on modernizing our long-term-care system. We are redirecting money to front-line services, where it belongs, to provide better, faster and more connected public health care. As I said, our government is taking swift action. We hit the ground running as soon as the ministry was created, and our Ministry of Health and Long-Term Care did very good work getting it started.

We are working on rolling out high-acuity priority-access beds in long-term-care homes in Ontario for people who are medically complex. That's something that we're hearing across the province, that the complexity of long-term-care residents is increasing. We need to be addressing that, and that's what we are doing. For a family with a loved one of complex care, this means faster admission into a long-term-care home where they can get support for their complex needs.

We're investing approximately $13 million to enable what we call HPAB, or high-priority-access beds—there are so many acronyms. These high-acuity beds will address several barriers to long-term-care placement. They're going to help to ease the pressures off hospitals. They'll increase much-needed beds so that applicants don't have to wait in hallways for days, and allow our long-term-care and allied health professions to work more efficiently and provide better and faster care for all of us. I was recently to a community paramedic program using technology, and I know about the nursing rapid response teams. These are really important innovations that we can use to help.

These beds and our innovation are part of our larger strategy to end hallway health care and create capacity in hospitals, and to address the long-term care that's been neglected for years, so ensuring that when people are ready to leave hospital or people are ready to move to long-term care, there's a place for them, freeing up our hospitals and our nurses and doctors to work more effectively and efficiently within hospitals. This will support access for those who need it not only in long-term care but also hospitals, and for families who need that support and our caregivers.

We're proud to be giving more seniors, families and caregivers access to the quality care they deserve. We've committed to updating the funding structure of the long-term-care system to reflect the needs of the 21st century. Demographics have changed, families have changed, and we need to adapt to that.

We have unique challenges, staffing and funding challenges, but our government has listened and will continue to listen to our sector, get feedback, and work collaboratively with them to find the solutions that we need.

After consulting with our stakeholders, government is extending the high wage transition fund, as you know, and the structural compliance fund while we work on developing programs to address the concerns that have been raised by our sector partners. We heard from them loud and clear that a minor capital funding program is needed to maintain long-term-care homes. Some things just don't work anymore. Costs of land have changed, and many different things across the province.

To address this, the government will be extending the structural compliance premium to March 31, 2020, while we consult on what that program might look like. As well, our government is extending the high wage transition fund to December 31, 2020, as we redevelop a long-term-care staffing strategy, and that is absolutely heard loudly and clearly, that we need that. The extension of these funding streams will ensure that gaps in long-term-care staffing and funding can be addressed while providing and preserving the highest quality of care for our long-term-care residents, and make sure that that's uninterrupted.

I mentioned that we'll be working on a comprehensive staffing strategy, which dovetails into how I started my remarks, about the vital importance of our caregivers. We need to support them just as much as we support our seniors. There's a real shortage of staff in our long-term-care homes, whether it's porters, personal support workers, registered nurses, licensed nurses or registered nurse practitioners, and there are probably others that I've missed. They have been ignored for a long time, so we need to make sure that they feel as valued and supported and cared for as residents do.

Training and education support is something that we need to consider, so taking a personal support worker and offering them training and education to enable them to grow professionally. There are wonderful programs going on across our province that are involving "living classrooms" training and research, and moving that into the realm of personal support workers as well.

1005

Ensuring nurses are getting the appropriate training and education to upgrade credentials is something that should be looked at. How do we provide a more efficient career ladder?

We also know that the needs of long-term-care residents are getting more complex; I mentioned that earlier. It means that our long-term-care system needs to have the ability to support these complex needs. One of the consequences of increased complexity of need is that long-term-care residents need to be on multiple medications and manage multiple medical conditions. We're committed to ensuring that the systems in long-term-care homes are equipped to provide safe and effective management of medications. We heard this in Justice Gillese's report as well.

On July 31, 2019, I made a commitment, in response to the public inquiry of Commissioner Gillese's final report—I haven't checked the pronunciation of that name; I believe it's Justice Gillese—that our government is committed to addressing the recommendations of the report. I intend to honour that commitment and work to ensure that Ontario has the safest and most secure medication management system in the world. We have initiated a steering committee to provide a platform for collaboration between ministries and a coordinated response to address the recommendations, and we will report back on their progress in July 2020. We've talked about a government-wide, multi-ministry, across-ministry approach, and this is what will be needed.

There are examples of how the government is responding to the long-term-care sector's needs and fulfilling our commitment to build a 21st-century long-term-care system that supports Ontario's most vulnerable people. We will not be satisfied until we fulfill that commitment to the people of Ontario.

Another real challenge we are seeing is that the demand for homes and beds outpaces the supply. I've been travelling across the province and have been apprised of this issue across Ontario. In urban centres, land can be scarce and very expensive. Competing interests often buy up land because they can afford to pay large sums of money for the land. In rural areas, land is available but I'm seeing moratoriums placed on large-scale development because of the local infrastructure—perhaps their water system or whatever; there are issues surrounding that in smaller areas. The size of the construction: How do we adapt with the skills and the support that we will need to build? Then you add in zoning and you see the number of barriers, and that's just to mention a few.

My team and I meet with partners and stakeholders regularly to discuss those solutions. In the interest of getting the homes built faster, I'm working to see what we can do through government to mitigate these barriers and streamline the processes.

My vision for long-term care is a system where couples who have spent their entire lives together, like my parents, can stay together while receiving the right care they need. I see retirement homes and long-term-care homes partnering to be more integrated, allowing for better transitions and coordinated care for residents across the province. I see long-term-care homes as a vibrant, integral part of the community with expanded day programs that help residents live fully and that provide support for their caregivers.

It also means expediting processes to get shovels in the ground faster and residents into homes when they need it. I've heard from many long-term-care operators from many regions in Ontario about the challenges that they are facing when it comes to building new homes and new capacity across the province. Our government is going to continue to work with our partners in long-term care to look for innovative ways to provide the service that is so much needed and to build the infrastructure that we need to support Ontario's growing population of seniors—and it's growing.

We are going to work together to make sure that any proposed projects meet the unique needs of the communities they serve. The challenges facing the long-term-care sector are complicated and multifaceted. They connect to many other sectors, and we need a government-wide approach with many ministries involved. I thank the Ministry of Health and Minister Elliott for doing great work. Thank you.

As you may know, our government recently committed $11 million to home care and community care, in addition to the $144 million already announced as part of this year's budget. Home and community care are vital pillars of the health care system, especially the long-term-care sector—

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

Hon. Merrilee Fullerton: —and it will only become more so. Home and community care can help keep people in their homes longer and out of the long-term-care system.

1010

We've all heard countless stories of the elderly person or couple doing everything that they can to stay in their home. Our aim is to help them do just that. Whether it means a couple staying in their home, or an individual who has lost their spouse being able to access long-term care, we're looking to achieve that.

Last year, more than 60,000 people lived in retirement homes, and that sector has grown. There are ample opportunities for co-operation between retirement homes and long-term-care homes. I envision an integrated system that would be able to provide people with the transitions throughout the phases of care that they need.

Also, the swift application of applied research—I touched on this earlier—will allow for us to be more flexible in our processes.

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

Hon. Merrilee Fullerton: Thank you.

The Chair (Mr. Peter Tabuns): Thank you, Minister.

Madame Gélinas.

M^me^ France Gélinas: Thank you for this. Just a few quick questions, because I know I only have four minutes. I've been forewarned.

The government has, in the estimates, shown $72 million in new program spending. Could you tell me how much of that $72 million is to meet the inflationary

pressure—to meet inflation in the running of a long-term-care home—versus supporting program spending?

Hon. Merrilee Fullerton: We went around Ontario and met with a number of groups at AMO, and we heard from our sector that we really need to be addressing the funding. There are a number of different areas; it's beyond the scope of our discussion today. But we heard from them loud and clear. That's why we're spending that $72 million more this year—I want to make sure it's clearly heard that that is more this year—and the $1.75 billion towards our long-term-care-home redevelopment and new beds.

I'm going to call on my ADM. Where are you, Brian? If you wouldn't mind making a few comments about what is in that $72 million, that would be great. Thank you.

Mr. Brian Pollard: Sure. Good morning, Chair. Brian Pollard, assistant deputy minister for the long-term-care operations division.

The Chair (Mr. Peter Tabuns): Thank you.

Mr. Brian Pollard: As the minister said, there is $72 million more in the budget this year. That included a 1% per diem increase to all of the envelopes.

I should probably just say that the majority of long-term care is structured on an envelope basis. There's a nurse and personal care envelope, a program support services envelope, a raw food envelope and an other accommodation envelope. We gave a 1% increase across all those envelopes.

We also gave additional dollars for, as the minister said in her speech, high-acuity priority-access beds for behavioural support units. We also supported small homes. There are a number of investments that are part of that $72 million.

In addition to that, there is also a significant amount of flexibility that we've built into funding this year to allow homes to maximize their dollars. One of the things that we had observed was that, in a number of years, homes had actually been returning dollars to us that they were unable to spend, for any number of reasons.

When you put it all together, it was really a strategy to support homes in maintaining staffing levels, and even, in some cases, an increase in staffing levels. As the minister said, subsequent to when we were here in May, we've also extended the high wage transition fund and the structural compliance premium fund.

Those are all of the elements that make up the $72 million.

M^me^ France Gélinas: Thank you. Are you able to break that down for us, maybe in writing, or if you know it off the top of your head? How much went to—the 1% that went to personal support, the 1% that went to raw food—in my mind, this is like inflation. The cost of staff has gone up—

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

M^me^ France Gélinas: Then how much of the $72 million was left?

Mr. Brian Pollard: What we actually did this year—again, within the theme of flexibility—was to give homes flexibility in how they allocated dollars across those envelopes. What we gave was something called a global per diem of $1.77 per resident per day across those four envelopes, and then you were able, as an individual operator, to allocate those across envelopes as the need in your home dictated.

However, one constraint on that is that no more than 32% of that $1.77 could be allocated to the other accommodation envelope. I wouldn't be able to give you an exact number for each envelope because it would vary by home.

M^me^ France Gélinas: Okay. I'm happy with the $1.77. What's the final number? Do I just multiply 78,000 times $1.77 times 365?

Mr. Brian Pollard: Yes.

M^me^ France Gélinas: Okay. And the rest of it—

The Chair (Mr. Peter Tabuns): I apologize. I thought I'd catch your attention. We've run out of time.

Interjections.

The Chair (Mr. Peter Tabuns): It was very effective. We are recessed until 3:45. Hold that thought.

The committee recessed from 1015 to 1546.

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 two hours and two minutes remaining for review of these estimates, and we should then have enough time to do that.

When the committee adjourned, the official opposition had 15 minutes and 48 seconds remaining in their rotation. Ms. Armstrong, if you would like to proceed.

Ms. Teresa J. Armstrong: Thank you, Chair. Also, good afternoon to the ministers and deputy ministers here today.

The government has said that it has increased sector spending by $72 million. Earlier today, the assistant deputy minister went through the explanation where the $72-million increase can be found. This is with regard to long-term care. Can the assistant deputy minister continue to explain how to find the $72 million in spending, how much is attributed to inflation and how much is in additional program spending? If there is an increase in program spending, which programs have been selected?

Mr. Brian Pollard: Brian Pollard, assistant deputy minister for the long-term-care operations division.

The Chair (Mr. Peter Tabuns): I apologize, sir, but could you please bring the microphone closer? Thank you.

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

A number of investment decisions were made for the budget this year, but maybe the best way of explaining how we structured the investments is to identify for you how we structure the spending. Long-term care, at its base, is a per diem funding protocol. There is funding for four envelopes: nursing and personal care, program and support services, raw food and OA. In addition to that, we have a number of supplemental funding streams that are usually targeted to specialized services, and you heard examples of those earlier today with the high-acuity priority-access beds. Another example of that would be

behavioural support units, or BSUs, which are for people with chronic behavioural problems.

When we think about the funding, what I said this morning was that we made a 1% increase to the per diem, so that was across all of the envelopes. That's a $1.77 per resident per day, and that was applied across the NPC, the PSS, the raw food and the OA envelopes. What we had additionally said was that you couldn't put any more than 32% into the OA envelope, one of those envelopes, but operators had flexibility in how much they allocated to each envelope.

As we came to August 1 of this year, the per diem that homes were receiving was $182 and change as a per resident, per day amount. In addition to that investment, we also made a $13-million investment in high-acuity priority-access beds. That is a new service that we are introducing to the system, as the minister said, to support medically complex residents gaining faster access to long-term care because, in our assessment, one of the things that was causing the system not to be able to flow as effectively as possible was the lack of medically complex residents being able to transfer into long-term care from hospital. So that is a new service, a new investment.

In addition to that, we also have in the budget $4 million which is to expand behavioural support units. We have had behavioural support units in the system, but this money is really being targeted to expand the number of those units and those beds because, as you can appreciate, we have a growing dementia population, many with responsive behaviours.

In addition to those investments, we've also supported small homes—those are homes with 64 beds or less—to make sure they have a fixed amount of funding in addition to that per diem that I mentioned earlier. That fixed amount of funding is $180,000 per home. Again, that's for homes that are 64 beds or less. The reason we've invested in small homes is because we know that a per diem approach leads to diseconomies of scale, so we wanted to make sure that they were supported and had an appropriate staffing model.

We've also invested to make sure that staffing that was put in place the year before was able to be continued. We had put in a certain amount the previous year that started in July. We wanted to make sure, as we had a full year now with staffing, that homes were able to maintain that staffing amount.

Finally, in addition to all of those changes, we also made a number of policy changes that allowed homes to use their money in a more flexible manner. A simple example of this would be, again, for smaller homes. They were usually subject to having to hit 97% occupancy if they were going to get full funding. We basically said that if you are a small home, you will not have that occupancy lever anymore.

There are a number of changes that were made in the system this year, all designed to have more flexible funding so that homes can certainly use that funding in any manner that is necessary to achieve the outcomes that they want.

Ms. Teresa J. Armstrong: Okay. My next question is, the government has allocated $1.75 billion over five years for new and redeveloped long-term-care beds. The funding is only provided to long-term-care facilities once the beds are built. This may disadvantage long-term-care facilities that aren't able to acquire the capital to finance new beds, which is often the case for non-profit and municipally operated long-term-care facilities.

Can the government explain how they plan to allocate beds and the long-term-care funding so that non-profit and municipal homes aren't squeezed out by the for-profit facilities because of unfair funding policies?

Hon. Merrilee Fullerton: Thank you for that question. It is very important, and we heard this from across the province. We heard from multiple long-term-care homes about the regional differences and the size of the homes, these all being issues. Our commitment is to that 15,000 new beds in five years and a redevelopment of another 15,000. We've been collaborating with the stakeholders to understand their precise needs, because there are really unique challenges depending on where the homes are, and the size. We've been working with them to understand fully and encouraging them to communicate with us.

When we brought in the changes in the extension for the high wage transition fund and the structural compliance premium and extended those, we anticipated that many of the issues would be improved for a number of homes, but even then, we're still finding that there are some homes that are not going to be in an improved situation because of that. We're saying, "We want to work with you. We want to understand what your concerns are and the challenges, and if it's zoning, let's address zoning. If it's cost of the land, let's work and find out how we can accommodate and how we can improve that for you." If it is staffing costs, then we're looking at ways to improve and make sure that we have proper staffing for our homes.

This is something where we've been absolutely clear with our sector and our operators about how we can address their needs. We know that the population is aging. We know that we have a current wait-list that is 36,000. That's a lot of people, but with more seniors in the community—growing, I think it is, about 4.3% every year—we know that those numbers will continue to increase. That's why we are really making sure that we're listening to our sector.

Brian, do you have anything you want to—

Mr. Brian Pollard: I would just say that in addition to what the minister has said, it's important to underscore here that it's the same funding approach for all homes, and certainly from our programmatic perspective, we see equal enthusiasm between not-for-profit and for-profit operators. But to the extent that there is an equity issue, you may not know, but in our funding model we actually provide a planning grant to not-for-profits once they have signed a DA, a development agreement, to continue, obviously, developing and building a home, and that is unique just to not-for-profits. That is one way the ministry tries to maintain balance in the system.

Ms. Teresa J. Armstrong: The minister mentioned the two funds that they originally were going to cut, and now

you're extending those two funds, the $34 million. Can you explain why you're going ahead cutting the $34 million from long-term care while wait-lists have increased?

Hon. Merrilee Fullerton: Are you referring to the high wage transition fund and the structural compliance fund?

Ms. Teresa J. Armstrong: Yes.

Hon. Merrilee Fullerton: Just for clarity, they were never cut. They go back to the 1990s—1996 and 1998, I think, respectively, or vice versa. They were designed for a time when there were issues at that time as well; they carried on. Many of the homes really became quite dependent on them, even though they weren't using those funds for the services that they were expected to be funded for. So, those got transitioned. We were going to transition those, then we realized we have wait times; we have serious issues. We need to address these, and we extended them. One is being extended to December 2020 and the other one is being extended to March 2020. Just to be clear, those were not cut. They have been extended a couple of times but not cut.

We want to address the funding gaps in the system and understand from our sector where their issues are because, as I said, some were affected by those two funds and others had other issues. So just to be clear that those are continuing, and we really, fully respect the challenges that we have with the long-term-care waits. That's something that we take very, very seriously.

Ms. Teresa J. Armstrong: Okay. Thank you. Can the government confirm the number of beds it has operationalized since 2018?

Hon. Merrilee Fullerton: Since 2018? Well, I know in the last year there have been 1,814 new beds and almost 8,000 allocated, but 1,814 of those are new in the past year.

The deputy has also reminded me about the minor capital fund. In my remarks to MPP Cho's question this morning, I did mention the minor capital fund. That's to help address the gaps in the funding. We know it's exceedingly important for us to have continuity. We must make sure that our most vulnerable people are able to receive the care they need on an ongoing basis.

Ms. Teresa J. Armstrong: Thank you, Minister. I also want to ask a question about the monthly long-term-care home system report. It was produced by the Ontario government and it shows that in July 2018 there were 78,766 beds available. One year later, in August 2019, there are 78,787 beds available. That's a difference of 21 long-term-care beds in the year since the government was elected. We know that reducing the long-term-care wait-lists will help address hallway medicine. Can your government explain why it's going ahead with a $34-million cut to the long-term-care sector when it has failed to operationalize beds to meet the increased demands?

Hon. Merrilee Fullerton: To be clear, those two funds are continuing and they were extended. They have never been cut. I think we need to clarify that and make sure—

Ms. Teresa J. Armstrong: So, on that point, they're extended till when?

Hon. Merrilee Fullerton: The high wage transition fund is extended until December 2020 and the structural compliance premium is extended to March 2020.

Ms. Teresa J. Armstrong: And it'll continue? Like, it won't stop on those dates that have been extended?

Hon. Merrilee Fullerton: Well, what we're doing in the time frame—one will address staffing; the other will address wages. So we're looking at addressing the gaps. We will have a staffing strategy that's in the works for one, and in the other case, in terms of the structural compliance premium, it's transitioned into the construction subsidy fund.

Interjection.

Hon. Merrilee Fullerton: The construction funding subsidy, yes. So the funding is actually fairly complicated, but in terms of the 78,000 beds that we have, looking back over the last 15 years, there were some that were built but not to meet the demand. The focus was very much, previously, about not building capacity in long-term-care homes. It was more about providing community care.

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It's very clear with the demographics of dementia that our most vulnerable people are going to need a long-term-care home. Many people can be maintained in the community, and we're looking at innovative ways to provide that capacity as well. But it takes 36 months to create a bed, and I think we've lost runway. The previous government had 15 years to do that. We've hit the ground running. We have a lot of things to fix and we're addressing that now.

In terms of the Ministry of Health, they're also focused on the home care areas and how we can provide people with more supports in their homes, which is often where people want to be. But when they need to make the choice about going to long-term care, we're committed to the 15,000 new beds and 15,000 to be redeveloped over five years.

We put the money behind that: $1.75 billion has been committed for that and we've spent $72 million more this year over last, as we've talked about. The commitment on the part of the government is there, but we know that we are challenged with a growing and aging population. That's not going to be a simple task. It's going to take all of us in a cross-government, multi-ministry approach to get the care and the capacity and the access that we need and to create flexibility—

Ms. Teresa J. Armstrong: Thank you, Minister. I think you answered that well. One last point. I just want to ask the government: You've decided to raise the—

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

Ms. Teresa J. Armstrong: You've decided to raise the copayment fees in the long-term-care-sector funding. Can I ask you why you would do that when people are having trouble with the copayments now?

Hon. Merrilee Fullerton: First of all, the copayments are fairly independent. They go up with the Canadian inflation index, so they go up automatically. It's not something that the government chooses to do or not to do. They are tied to the Canadian inflation index. So, if you understand the funding, the system is partly funded by the

ministry, partly by residents, and through those accommodation copayments, for anyone who is not familiar with that. But it's tied to the Canadian inflation index. It's not something that government decides.

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

Hon. Merrilee Fullerton: Thank you.

The Chair (Mr. Peter Tabuns): Now to the government. Ms. Khanjin?

Ms. Andrea Khanjin: Thank you, Chair. My question is for the Minister of Health. I wanted to thank you again for coming to Barrie to tour Royal Victoria hospital in my riding. As you know, my riding, in addition to many across the province, is obviously experiencing much growth, and with much growth comes extra hospital development, building new hospitals, of course.

What I wanted to ask you about is, in terms of hospital infrastructure, what are we doing to build up hospital capacity in this province? I know in my riding of Barrie we'll be expanding to the south campus in a 10-year period of time. Right now, we're just looking at the location—certainly not ready to get shovels in the ground. But there are many places across Ontario that are ready to get shovels in the ground, and I was wondering if you can talk about the importance of hospital infrastructure across our province.

Hon. Christine Elliott: Sure. Thank you very much for the question. This is an issue that I know is very important to many MPPs as well as many communities across the province. Investing in hospital infrastructure meets several critical areas of need related to growth in demand for services, critical infrastructure deficiencies and bringing care closer to home for patients.

As you know, our government plans to invest $27 billion over the next 10 years in hospital infrastructure projects, of which $17.6 billion are in capital grants. Given the fiscal realities, however, facing the province of Ontario, investments that are made are fiscally responsible and efficiently address the most critical areas of need in the province.

The government of Ontario has identified a strategic priority for the ministry to end hallway health care. This strategic priority requires a multi-year approach and includes the development of a long-term, comprehensive health system capacity plan, with advice and leadership from Dr. Devlin and the Premier's council on hallway medicine.

Investments made throughout the portfolio of approved capital projects over the next 10 years will result in capacity for approximately 3,000 new hospital beds, and several of the larger projects in the plan will address key areas of demand growth across the province.

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

At this point, I'm going to ask the deputy minister if she could provide further detail on our investments in hospital infrastructure.

Ms. Helen Angus: Thank you, Minister.

As the minister indicated, the government's intention is to support the investment of $27 billion over the next 10 years to build and strengthen hospital infrastructure. I think that about $17.6 billion of this will be put towards capital grants.

Our focus in the ministry is really to expand and ensure that we've got the right mix of beds and service types within the system, whether that's urgent care, ambulatory services, mental health beds or primary care. Having the right mix enables local health service providers to develop local health solutions to their health challenges. This is entirely consistent with our approach around Ontario health teams.

While we're working to, and planning to, build new hospitals, we also know that our existing hospitals are aging. We actually have looked at the quality of the facilities. We're always under pressure to maintain the capital stock that we have in the system. So we're continuing to work with our health care partners to make needed investments, both now and in the future, as we look at the capital stock and we look at the capacity plan that the minister just spoke about.

We're working with hospitals to make sure that the projects that are actually included in the plan have the right scope of work in order to ensure value for money and meet the capacity needs that have been identified.

I will ask Mike Heenan, who is the ADM of hospitals—he has both hospital operating and capital in his portfolio. He can talk a little bit more about the health system challenges and how we're responding using our capital program to support the infrastructure that the health care system needs.

Mike, come up and introduce yourself.

Mr. Mike Heenan: Good afternoon, Mr. Chair. My name is Mike Heenan. I'm the assistant deputy minister for hospitals and capital branch inside the Ministry of Health.

The Chair (Mr. Peter Tabuns): Welcome.

Mr. Mike Heenan: Thanks for taking some time to allow me to speak and to expand on the minister's remarks this afternoon. As the deputy mentioned, I'll start off by talking a little bit about the system challenges, highlight some of the cross-sector strategies that the minister is leading us with, and then link that back to hospital infrastructure.

As the minister noted, the government is developing a strategy to end hallway health care. That's built on the work of Dr. Devlin and the Premier's council on ending hallway health care.

In addition to the many strategies related to digital health, expansion of long-term care through Minister Fullerton, and Ontario health teams, as Deputy Angus mentioned, we really need to think about the right mix of services and programs to help patients and families across this great province. Part of that is actually improvement in hospital infrastructure. While it's only one plank, it is an important plank in order to deliver high-quality, safe care for patients and families.

What does this mean? It means that hospitals need to be operating efficiently and working with community partners across the province to reduce alternate-level-of-care rates, otherwise known as ALC. We need better partnerships to enable discharge of hospital patients to home care, as the minister highlighted in her visit to Newmarket recently, with the successful Southlake@home program. We need new congregate home care models and supportive housing. And we need new innovative short-term transitional care models, such as the successful Sunnybrook Health Sciences Pine Villa facility, in which they're partnering with community programs like SPRINT and LOFT, with a greater emphasis on transitioning patients out of acute care to home care.

Finally, many of you may know about the successful work of the Humber River Hospital and its Reactivation Care Centre, partnering with hospitals across the GTA, in which patients can receive the physiotherapy and related treatments they need to be discharged home to a less-acute-care setting, opening up acute-care capacity on acute-care sites across the GTA.

By making these investments in the right mix of services to best address the individual needs of patients, we really are ending hallway health care. We're on our way towards that and opening up acute-care capacity across the province.

In addition to that, recently the minister announced a new investment of $45 million for targeted, innovative integrated care models in high-need communities to support the delivery of up to 29 transitional care projects aimed at reducing ALC, alternative level of care, and hallway health care rates in the short term. These projects are a great demonstration of the partnerships that are happening across the province between acute care, community care and long-term care. We see over 300 hospital spaces opening up as a result, serving up to 10,000 patients in this year alone.

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The 29 projects fall into one of three types of models or delivery systems:

—the emergency department diversion or post-acute transitional care models;

—the retirement home to long-term-care placement model; and

—the congregate care or reactivation centre model, which I just described.

Not all of these projects involve capital, which the members asked about, but many of them do. Demand for hospital infrastructure investment remains high. As our population starts to age and grow, so do our facilities begin to age and also deteriorate. There is a need for capital investment for both new facilities and repair to our existing facilities.

As the minister noted, we are also well aware of the fiscal realities of the province, so we are working together across the government to do this in a fiscally responsible manner that allows us to grow capacity while doing it in a financially responsible manner.

As the minister and deputy highlighted, we are investing up to $27 billion over the next 10 years in hospital infrastructure projects, of which $17.6 billion will be disbursed in capital grants. The intent here is to balance growth—that is, new capital infrastructure to deal with increasing demand—as well as renewal, maintaining existing facilities in good repair so it allows us to meet the needs of our communities.

This does require a multi-year approach and includes the development of a long-term comprehensive capacity plan, which is under way. Effective capacity planning will address immediate system needs while always looking out for the long-term health of this province. Investments made in the approved capital projects over the next 10 years will result in approximately 3,000 new beds. Included in this figure are a number of projects to support some of the fastest-growing areas of the province. I'll take a few minutes to highlight a few for our members today.

In Mississauga and Etobicoke, the Trillium Health Partners' broader redevelopment involves multiple capital projects across the hospital's two sites, in Mississauga and Queensway. It will help that growing community. The proposed project's scope includes a new patient tower at the Mississauga hospital site, and renovations to space and a new patient tower at the Queensway site to serve rehabilitation and complex continuing care patients.

In the great city of Ottawa, we will be redeveloping the Ottawa Civic campus. This project involves the construction of a greenfield redevelopment for the Civic to meet its growing demand and consolidate services so that clinical service can be done in an efficient, effective and patient-safe way. This new state-of-the-art facility will be patient-focused and designed with patients in mind through their patient and family advisory council.

The Mackenzie Health new Vaughan site, just north of us here, is also supporting the need for more services in our growing community known as York region. The new hospital will accommodate emergency services, surgical services, operating rooms, acute in-patient, mental health, intensive care and all of the support services like diagnostic imaging, lab and pharmacy. Once the new hospital is open, Mackenzie Health will become a two-site hospital system, with hospital services distributed between the Vaughan hospital and the Richmond Hill hospital to ensure great care across York region in an efficient way.

Just east of us here, in east Toronto, the Michael Garron Hospital new patient tower is also another great example of where the province is partnering with hospitals to expand and invest in great care. Construction of a multi-storey building will provide a new in-patient and out-patient space to address child and adult mental health, cardiac care, diagnostic imaging, surgery, rehabilitation and maternity, along with children's ambulatory care. The project will also renovate an existing building to allow administrative and support services that surround the process of care.

We tend to think only in terms of beds and bed counts, but just as important a consideration is ensuring that our growing and aging population has access to urgent care, ambulatory care and primary care.

Across the province, we have many projects, in planning or under way, that will expand or redevelop emergency departments. Impacted communities that will gain from this investment include Geraldton, Carleton Place, Mount Forest and Scarborough.

But it's not just about hospitals. Our community health program is expanding access to primary care and other services for some of the most vulnerable and at-risk populations in our province. Examples of community health projects that this minister and ministry are investing in include the Canadian Mental Health Association's office in Parry Sound, the Dave Smith Youth Treatment Centre in Ottawa and the Gateway Community Health Centre in Tweed.

In the past few months, the ministry also announced the following community health projects that have reached substantial completion and are now open. These include the Centretown Community Health Centre in Ottawa, the Central King seniors' centre here in Etobicoke, the Etobicoke Services for Seniors' Humbervale Place, and Unison Health and Community Services here in Toronto.

In addition to expanding capacity, we also need to ensure that we improve hospital facility conditions across the province and provide health care in a safe and secure environment. If a hospital is unable to continue operating because it has not been maintained properly, it can lead to disruptions in access to services and issues of patient safety that put patients, physicians, staff and volunteers at risk.

To aid hospitals in improving the infrastructure, the province invests $175 million annually in the hospital repair and renewal fund, otherwise known as the Health Infrastructure Renewal Fund—for those of us who like acronyms, HIRF—which provides funding to 128 hospitals across the province to support over 1,000 renewal projects annually. It may seem small, but these important projects, like replacing boilers and HVACs or repairing leaky roofs, are important to ensure patients can receive care in safe environments that are secure for patient safety reasons. In fact, many hospitals across this province have used these funds to ensure patients are protected from falling, to assist with our infection control practices or to start to build space for surge capacity in the flu season.

Similarly, we don't forget about the community through the Ministry of Health either. The province invests $7.5 million annually through the Community Infrastructure Renewal Fund, or CIRF, which supports over 60 community health services and over 120 repair and renewal projects.

Despite these investments, sometimes a hospital's share of these annual program allocations is insufficient and we need to look at how we move forward in these hospital locations. Accordingly, we have several large projects under way that are intended to update outdated hospital facilities to ensure that all Ontarians, no matter where they live, continue to receive health care in a safe, modern and patient-safe facility. Three such projects include:

—the West Lincoln Memorial Hospital, which is an investment that replaces an existing hospital that is aging and in need of upgrades. Our investments will ensure that emergency, obstetrics and surgery programs continue to operate in Grimsby and the surrounding areas;

—the Weeneebayko Area Health Authority project, which will replace the general hospital on Moose Factory Island with a new hospital to be in Moosonee and the development of an ambulatory health facility on Moose Factory Island, helping not just the north but our Indigenous communities; and

—the Groves Memorial Community Hospital in Fergus, which is a greenfield site that also now opens up acute care facilities in that area.

Balancing these needs of growing the health system and maintaining access is not an easy task, so planning is a vital component of what this ministry and government do. The ministry uses a prioritization framework to make these decisions and prioritize infrastructure investments. The ministry's prioritization framework has been developed to ensure that these investments support government priorities such as ending hallway health care and delivering better mental health services, and considers factors like patient safety when it comes to facility repair and population growth.

Within the framework, benefit and threat calculations are made for all project proposals that lead to calculating a numerical or quantitative number for prioritization purposes. Once we get that number, we don't rely on numbers only. A qualitative review of project prioritization is also undertaken so that we can consider regional considerations across this province, and to respond to emerging risks of service interruptions and other priorities that may not be captured by the math. To make sure the best use of infrastructure investments in the health system continues to occur, the ministry will continue to work with its health system partners on this qualitative and quantitative assessment.

As you may know, building a hospital is not an easy task, and it's a lengthy process. For that, we partner with Infrastructure Ontario to design and procure hospitals across Ontario. As many of you know, Infrastructure Ontario is a crown agency that's known around the world for developing public-private partnerships that deliver complex infrastructure projects for the people of Ontario, including hospitals. For large, complex hospital-based projects, Infrastructure Ontario leads the procurement, development and implementation process, together with the sponsoring hospital and its local governance. Their staff bring a wealth of experience in building construction and operations when advising the ministry and the government of the day and sponsoring hospitals on the planning and procurement of projects.

In terms of value for money, Infrastructure Ontario drives high-quality design innovation through the use of performance-based output specifications. They also maintain performance-based contracts to ensure that the government receives full value of the asset before contractors are compensated.

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With that in mind, in conclusion, planning and procuring health infrastructure is a complex process, but the

Ministry of Health and the minister are committed to making capital investments based on a thorough analysis, like the framework I've described, using data, sound fiscal planning and community engagement as our basis.

I appreciate the time to explain this to you today, Mr. Chair.

The Chair (Mr. Peter Tabuns): Thank you. Ms. Khanjin?

Ms. Andrea Khanjin: I just wanted to ask the minister a follow-up question. I spent a lot of time at Southlake hospital with my grandmother, so I firsthand did see some of the help the hospital does need. I was wondering if you could tell us more about the Southlake@home program and the announcement you did.

Hon. Christine Elliott: Certainly. It's a wonderful program to help move alternate-level-of-care patients out of hospital and get them back home, which is where they want to be. The hospital has partnered with two home care agencies. They meet in advance with the person—the alternate-level-of-care patient—talk to them about what their needs will be when they go home, and then they supply those programs and services to them so that they don't end up with complications and come back into hospital emergency departments.

It has been really significant in lowering their numbers for alternate-level-of-care patients in the hospital, which of course improves patient flow and helps end hallway health care. But it's high in terms of patient satisfaction because the people are able to go back to their own homes. In some cases, they end up going to retirement homes or other places, but they still have the home supports that they need. What we're finding is that a lot of these patients were considered to need placement in long-term-care homes originally, but with the Southlake@home program, they've been able to be successfully maintained at home.

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

Hon. Christine Elliott: This program has been so successful in reducing the number of alternate-level-of-care patients that there are a number of hospitals across Ontario that are coming to Southlake to find out more about this specific project, and local Ontario health teams, as they're formed, are looking at this as the basis for getting patients back into their own homes. So we're very, very encouraged by the success of this particular program.

Ms. Andrea Khanjin: Thank you, Minister.

The Chair (Mr. Peter Tabuns): Ms. Martin?

Mrs. Robin Martin: I would just like to ask, as well, about Pine Villa, which I think Mr. Heenan mentioned as another example of this kind of integrated care—or the minister, if you wanted to comment about that and how it differs, maybe, from Southlake.

Hon. Christine Elliott: We're looking at a number of different models, of course, to help get people from hospital back into their own home. When the Minister of Long-Term Care was speaking about creating the 15,000—

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

Hon. Christine Elliott: Okay, thank you.

The Chair (Mr. Peter Tabuns): Madame Gélinas?

M^me^ France Gélinas: If you could stay there one minute—before I go into my next series of questions, I just wanted to ask you for an update on Cambridge hospital infrastructure. This is a P3 that is two years late. The last update was in April. Bondfield, BMO and Zurich are now fighting it in court. Are we ever going to see a build in Cambridge?

Mr. Mike Heenan: The government is committed to absolutely building and opening up the facility in Cambridge, and we continue to work with the partners that you've just described on finding a solution.

M^me^ France Gélinas: Do you have an estimated time of getting moving again and being terminated on this project?

Mr. Mike Heenan: I don't have it with me, Mr. Chair, but I'm sure we can follow up and get additional information for the member. I don't have the exact details with me on the timeline. As you've noted, there are three partners that are involved in that, and so I'm happy to get back to the member, Mr. Chair, with some detailed information, but I don't have it ready today.

M^me^ France Gélinas: Thank you.

The Chair (Mr. Peter Tabuns): Madame Gélinas.

M^me^ France Gélinas: All right. I'm back with Ontario Health. This morning we talked about Ontario health teams. I'd like to focus on Ontario Health for a little bit. Do you keep track as to how much it costs in consultants, in meetings to set up Ontario Health?

Hon. Christine Elliott: Yes, we do.

Ms. Helen Angus: Yes, we do.

Hon. Christine Elliott: Deputy Minister, if I may ask you to comment specifically on the tracking?

Ms. Helen Angus: Yes, absolutely. I would say that Ontario Health has actually incurred, I think, fairly modest expenses. There are some per diems for the board members that are entirely consistent with Treasury Board guidelines. I believe—and I'm just going to look at my notes so I don't make up a number here—but I think that, overall, in expenses, we're expecting to come in around $6 million this year.

M^me^ France Gélinas: Okay. Same thing: How much have you spent so far to set up Ontario health teams? I have participated in a number of seminars that you have put forward—those are consultants who do this. How much have you paid so far for the resources that are available online, for all of the training that took place, all of it so far?

Ms. Helen Angus: I would say, again, given the size of the effort, the expenses have been pretty modest. We fund RISE, which is the platform and the supports for the knowledge exchange.

Most of the webinars—the minister and I have both participated—have been done with existing resources, whether that's ministry staff—we've obviously engaged with Health Quality Ontario, with some of their assets, as well as other partners. So we haven't hired consultants at

the ministry to help us with the set-up of Ontario health teams.

Mme France Gélinas: For all of the consultations, the support and all of this, it has all been done in-house? There haven't been any expenses?

Ms. Helen Angus: Pretty much, actually. My team has just been out doing site visits in the last few days. They expect to have the site visits done for the first 31 by the end of next week. Again, it's ministry staff working with some staff who will be transitioned into Ontario Health doing that work.

Mme France Gélinas: All of the review of the applications—same; it's all done in-house?

Ms. Helen Angus: Yes.

Mme France Gélinas: When the government first identified that $350 million was going to be saved with the decision to restructure the health care system, where did this number come from? And can you assure us that it's not going to have an impact on the number of health care jobs or patient care?

Hon. Christine Elliott: Initially, it was—$250 million this year, $350 million next year. There was a specific set of criteria that was looked at.

Deputy Minister, would you like to comment on that?

Ms. Helen Angus: Absolutely. We were looking at the opportunities to streamline the agencies. I can confirm that one of the criterion that we worked with Ontario Health on was that there would be no impact on direct services, front-line services that affected patients. Most of the savings resulted from the reorganizations of agencies, such as LHINs, duplicative administrative positions, whether that's communications, planning, analytics, financial services. There were a number of vacancies, obviously, created over time, and so those gave the agency an opportunity to make sure that they were able to achieve the savings target without affecting individuals as directly. I think that was an important aspect to the plan.

Mme France Gélinas: So the $250 million came mainly from jobs being redundant because they were now together. Those people losing their jobs, you don't have to pay them anymore—$250 million for that?

Ms. Helen Angus: Correct.

Mme France Gélinas: Do we know how many jobs were included in that $250 million?

Ms. Helen Angus: I believe, from memory, there were about 400 positions eliminated in the summer from the legacy agencies, which we call them, that will comprise Ontario Health. There were a number of vacant positions that were also eliminated at that time.

Mme France Gélinas: So the $250 million this year, you will meet this target—and you feel confident that the $350 million next year, you will meet that target also?

Ms. Helen Angus: Yes. Our conversations with the board of Ontario Health have been very productive. They are still setting up their organization and looking at what we would call the horizontals across the various functional areas.

We've made sure that the clinical leadership and the efforts that they have placed—as you know, I spent 10 years at Cancer Care Ontario—that those programs will continue how to leverage the experience of Cancer Care Ontario for the proposed new centre of excellence in mental health, looking at how they might streamline their regional expression, regional operations. So they're still working through all of that, but I know we have confidence that that savings target seems quite reasonable. We're looking forward to, through our multi-year plan, putting those dollars back into front-line care and having an agency that's really able to drive improvement in a number of areas using the model that was developed for cancer by Cancer Care Ontario.

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Mme France Gélinas: So do you see a structure where Ontario Health would have regional offices where you would find what used to be Trillium, Cancer Care Ontario, all of this, in regions?

Ms. Helen Angus: I don't want to speak for the board of Ontario Health. They've been given a mission and performance measures—and I think very capable people. It's their organization to design and come back to us for the necessary approvals, but I would expect that they would have strong clinical verticals like in cancer, mental health, renal, which I worked in at the Ontario Renal Network, and other program areas where we think that the combination of clinical leadership, performance measurement, performance management and structure implementation is going to have results for patients.

At the same time, I've been in the health care system long enough to know that it's important that we have some eyes and ears across the province that tell us how well the system is working. I think Ontario Health has indicated that they need to have that line of sight in order to be able to work with communities, identify issues and solve problems, so I would expect that they will want the same.

Some of us have lived through 42 district health councils, 26 district health councils, 14 LHINs, six regional offices of the Ministry of Health, so I think every effort to organize the health care system does require some regional presence.

Mme France Gélinas: So if I look at the administrative costs of the 20 what you call "legacy" agencies and I add those costs, I will be able to see 350—how come I'm not able to find this in estimates?

Ms. Helen Angus: I think you can find the initial savings—I think there's a detailed chart in the far back. Maybe one of my staff can identify what the profile is for the agencies. Some of the monies may still be in the lines of the legacy agencies. There's a people aspect of this, but of course there's also real estate, payroll systems and all kinds of things that comprise costs for agencies where we think there's a real opportunity, again, for savings and consolidation.

Mme France Gélinas: Okay. But at the end you're confident that the—will we see a $350-million reinvestment in front-line care in the next budget?

Ms. Helen Angus: I don't think that's my job, to forecast the budget. Nice try.

Hon. Christine Elliott: We know we will meet the $350-million target.

M^me^ France Gélinas: All right. I'm going to go back to the public health kind of thing. What's happening with the dental care for low-income and the $85 million that was supposed to be spent this year, and how come I haven't seen a penny of it come my way? But it starts with this: How are we doing with the low-income seniors' dental care and the budget amount of $85 million that's supposed to be spent this year?

Hon. Christine Elliott: Well, that is rolling out. That has been in the planning stages. We expect to be able to make an announcement about that imminently.

M^me^ France Gélinas: Has a senior received dental care so far?

Hon. Christine Elliott: There are currently some programs that are already existing, but under this program, getting this program initiated will start very soon.

M^me^ France Gélinas: And who are the partners that you are working with?

Hon. Christine Elliott: A lot of them are community health centres. Some of them are going to involve mobile buses as well in rural/remote areas, northern areas. It's a combination of factors in aboriginal health access centres as well. There's a number of partners, which is perhaps one of the reasons why we haven't been able to roll it out sooner, but it is very close to being initiated.

M^me^ France Gélinas: Are you confident that the $85 million targeted for this year will be spent this year?

Ms. Helen Angus: I think there may be some underspending this year, given the likely start date. I know there are also some capital costs associated with buying dental equipment, whether it's a bus or whether it's dental suites in the locations that the minister referenced.

Our first effort is really trying to leverage where we have capacity, particularly those that may serve the Healthy Smiles program for kids so that we would be able to use that equipment and everything else, but it's pretty clear that we need to buy new equipment. Where we end up in terms of capital and uptake, I would say we're looking at a pretty big deployment across the province.

M^me^ France Gélinas: When do you expect that low-income seniors who have sore mouths will be able to see someone even if they can't afford it?

Ms. Helen Angus: Very soon.

Hon. Christine Elliott: Very soon—imminently, is all I can say.

M^me^ France Gélinas: Imminently; that's good news. How did you come out with 100,000 seniors when there are way more than 100,000 seniors?

Ms. Helen Angus: If you want to get into a lot of detail I can ask the public health team to come up, but the team did do some modelling about the number of low-income seniors, the number of seniors who would avail themselves of a program such as this. We have quite a bit of experience looking at start-up programs. It takes a while for them to be understood in the community, for people to take advantage of and make themselves available for it. I think all of those factors came into what we expect that the uptake would be, as well as the program costs.

M^me^ France Gélinas: When you speak about 100,000 low-income seniors, are those the seniors you think will avail themselves, or are those the numbers that will qualify to gain access to the program?

Ms. Helen Angus: I believe that actually those numbers—if you look at the number of low-income seniors, it's larger than 100,000, so this is really those low-income seniors who are likely to come to a clinic and receive dental care. I think this is a good number. We're hoping that the program will achieve that target and that people will make use of it, because we've got other information that suggests, if I look at my notes, there are about 60,000 emergency visits a year that go to hospitals because of issues with dental care, and a good portion of those would be seniors. So I think it's in all of our interests to have this program working.

Hon. Christine Elliott: Yes, we don't want people to get into an emergency situation where they have to go to an emergency department of a hospital to receive care. We want them to be able to receive care in a more timely manner in their community.

M^me^ France Gélinas: The 60,000 number that you quoted who go to the emergency: Are those low-income seniors or everybody in Ontario? Because some of them would be 45, not seniors.

Ms. Helen Angus: I don't know, from what I have in front of me, what the age breakdown would be, but I would think that in the working-age population many people do have dental plans. They may go to their dentist rather than to the emergency department. It feels like the emergency department in this situation, as it is in others, is kind of like the health care provider of last resort.

M^me^ France Gélinas: In this imminent announcement you will make, will we know how many sites? Are all of the sites going to open at the same time? Is there going to be one in the northeast?

Hon. Christine Elliott: There will be a number across the province. However, I anticipate that some of the buses may not be travelling as quickly as some of the centres. Some of the centres already have the dental equipment there, so they will be able to open straightaway, but there may be others that may open in a more phased approach.

M^me^ France Gélinas: Okay. So this will come imminently and the announcement will be made. And as soon as you make the announcement, those services will actually become available to people, and the full $85 million may not be spent this year because of the delay. Did I get this right?

Hon. Christine Elliott: Yes. As the deputy minister indicated, the full amount may not be spent this year. However, we are going to do our best to try and make sure that many services across the province can be made available to our low-income seniors.

M^me^ France Gélinas: Are the dental suites that exist in public health units going to be made available for that program?

Hon. Christine Elliott: Yes.

Ms. Helen Angus: Yes.

Mme France Gélinas: As well as the one that exists everywhere else?

Ms. Helen Angus: Yes.

Mme France Gélinas: Okay. Just an aside, because I see that there's $5.7 billion in community programs: I used to be able to break that down to see home care, the coordination that the LHINs did and how much money was spent by the LHINs to actually provide home care. I'm not able to find that anymore. Do any of you know how much of the $5.7 billion that was spent in community programs was spent on home care, the contracts for home care versus anything else?

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Ms. Helen Angus: Yes, we can certainly look into that. I would believe that the ministry should be able to produce a summary of the direct service—you're looking for the direct service provided to people in their homes versus what's provided to care coordination?

Mme France Gélinas: Correct.

Ms. Helen Angus: Okay. We can look into that. I know that there are roughly 5,000—and that may vary a little bit in time—but roughly 5,000 care coordinators across the existing local health integration networks.

Mme France Gélinas: Do we know what will happen to the work of the care coordinators?

Ms. Helen Angus: Well, I think there are lots of views on care coordinators.

Hon. Christine Elliott: Well, we certainly know that they're going to be integral to the success of the new Ontario health teams as they are moved into that function. Will they look exactly the same as they look now? They may be more directly involved into direct care planning, but we will still, of course, need them.

Mme France Gélinas: Who will be their employer?

Hon. Christine Elliott: The local Ontario health teams.

Mme France Gélinas: The Ontario health teams.

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

Hon. Christine Elliott: Yes.

Mme France Gélinas: Okay, the Ontario health teams. So, let's say a hospital is the lead for the money. Would they automatically become their employers, or will a separate corporation named "Ontario health team 27" be formed?

Hon. Christine Elliott: We are leaving it up to the local Ontario health teams to develop the means of governance that they choose. So they may decide to incorporate. They may have a partnership agreement. They may have a governance agreement of another kind. However, of all of the agencies, groups that are part of the local Ontario health teams will have a say in the expenditure of funds. It won't be up to any one particular group. I know there is a concern about hospitals. That is not the intention that hospitals will take this over, at all. We recognize that every community agency has a role.

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

To the government side: Ms. McKenna?

Ms. Jane McKenna: Yes. Thank you so much, Chair. I first want to start off by saying, Minister Elliott, it's so refreshing to sit in the House and listen to all of the things that you have to say. Because when things are at a band-aid and you're always just fixing things as a band-aid, people left out respect and honour all the things that your ministry is doing to make sure that we don't just do band-aids back and forth that they've been doing for the last 15 years. We want to make sure that we get it right, and it's not easy to make those changes overnight. So I want to thank you so much for all your hard work, your team's and everybody else's there.

I understand that the government of Ontario's long-term plan to fix the public health care system includes a patient-centred focus that will improve access to services and patient experience. Electronic medical records and telemedecine consultations seem to be more and more popular with clinicians, and like a lot of technology, it really helps them work more effectively and efficiently.

So I just wanted to start off by saying, along with MPP Khanjin, it was great because you've gone to so many—I'm sure—a lot of MPPs' hospitals. You have been out to mine a couple of times. I'm very appreciative of that. I know the CEO, Eric Vandewall, who formerly held positions as director, health reform implementation team—HRIT—and also was a director of the health promotion branch and then the director of the integrated health system and comprehensive health organization, and also with the MOHLTC 11 years prior to that.

I know he asked you this question and I just wanted to know if you could elaborate here for the committee. Can you share with the committee an overview of the key work our government is supporting on this file and perhaps elaborate on how electronic and digital initiatives will deliver on the ministry's commitment to improve health care and end hallway medicine?

Hon. Christine Elliott: Absolutely. Thank you very much for the question. Our Digital Health Strategy is central to the ministry's efforts to deliver on its priorities, including, in particular, the ministry's commitment to end hallway health care.

The health care system cannot be integrated and information cannot flow seamlessly without strong digital capabilities. By taking a digital-first approach, the ministry is putting people first and fundamentally changing Ontarians' experience of health care, giving them more convenience as well as more choice. The Digital First for Health Strategy will realize these outcomes in five key areas, including virtual care; online appointment booking; greater data access and portability; system integration and digital tools; and finally, data integration and predictive analytics.

A key component to improving the public health care system is Ontario health teams, or OHTs, as we've been talking about today. The ministry is working closely with Ontario Health and with OHTs as they come online to ensure digital health adoption from day one, giving them the tools and information they need to provide quality care to patients. In August 2019, the ministry released the

Digital Health Playbook, a resource that guides OHTs in developing their own digital health plans. The playbook includes a provincial catalogue of digital services that are available and should be considered for use, and a policy guidance document that instructs OHTs in how to streamline the delivery of health care services using digital tools; for example, the digital health information exchange policy.

If I may, I would like to ask the deputy minister to please provide a bit more information with respect to these initiatives.

Ms. Helen Angus: Thank you very much, Minister. I think this is one of the most exciting areas of health care. I will ask Greg Hein in a few minutes to step up, but when I think about how digital technology has changed our lives and think about how easy it has been for most of us to do routine tasks, certainly in my case, whether it's ordering a seat in a restaurant, getting food delivered to my house, talking to my family members using instant messaging or video calls—I certainly haven't been in a bank in some time—it makes our lives simpler, easier and more convenient.

We know, just to be clear, that other jurisdictions are able to do this in health care a whole lot more than what we've been able to achieve to this point in time. Right now, I think I wouldn't be alone in observing that our health care system has been developed in a way that's very siloed. Patients have been very much left on the outside looking in. As a daughter and as someone who accesses the health care system only occasionally, I have experienced the disconnected nature of the health care system, which doesn't support a patient journey.

The vision here, really, is to create an integrated system built around patients, which means that in a practical sense, the patients don't have to carry around paper files, handwritten medication lists or, God forbid, CDs as they move through the health care system. A hallmark of the system we're trying to build is the ability of information to flow across all these settings.

Digital First for Health is kind of how we talk about building this modern health care system, where all the providers are connected seamlessly to one another. It really is there to allow patients, providers, but also innovators and the whole health care system to reap the benefits of technology by making health care simpler and easier, and more convenient to interact with.

Some people think about digital health as technology. It really is how we deliver health care. So it's the delivery of health care supported by technology. For Ontarians, it really means that they'll have choices about how we receive health care, how we access our own personal health information and how we hopefully do not have to retell our story over and over again to different providers.

For health care providers, it will mean having the necessary information to provide excellent care at their fingertips, to focus on the patient rather than on technology. Innovators—and we're just as concerned about the ecosystem that supports innovation and brings these great products and services to patients. So, really, they'll have more opportunities to engage with the local health system and to sell to a domestic market instead of moving internationally. We've heard over and over again about companies that have great products and services and have a hard time getting traction in Ontario with those ideas. I think the whole health care system will benefit from a unified approach to digital health delivery.

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We have plans to update some of our privacy laws so that it will make it easier for Ontarians to access their health information and we'll be able to use Ontario's data to give us the necessary insight with, again, appropriate privacy protections to make sure the health care system is actually tracking to the results that we're working so hard to achieve.

We've talked already today about Ontario health teams. They are our key delivery partner in streamlining how patients navigate the system. The minister has already talked in some detail about the Digital Health Playbook. It really is guidance for Ontario health teams and how they are going to develop their digital plans, how they're going to offer the kinds of services that we've talked about, such as virtual care. The bedrock of this is very strong guidance on standards, again, to support interoperability and the connectivity between the parts of the system that we're talking about, but allowing freedom for innovation because we want the system to keep moving, to keep growing, to keep being responsive to the needs of patients, and supporting local innovation is probably one of the best ways to do that.

Perhaps I will ask Greg Hein, who has spent his lifetime thinking about digital health and how we can modernize this aspect of health delivery, to come up and dig into this a little bit further and give you some answers to the questions.

Mr. Greg Hein: Good afternoon. I'm Greg Hein, ADM on digital health in the ministry.

Perhaps I'll add to the minister's and deputy's remarks by giving you some before-and-after shots of what we have now in Ontario and what we'll get through this Digital First for Health Strategy.

Right now, your access to your own personal health information in the province depends on where you live. If you're fortunate enough to live around Sunnybrook's catchment area, or UHN's, you have pretty darn good access to your PHI through the hospital portals that they have. But really, there's not good, consistent access to that PHI, and so one of the fundamental goals of the Digital First for Health Strategy is to ensure that no matter where you live in the province, you can access your own PHI. You've heard the word "choice" a few times. You'll be able to do it based on whether you want to access your PHI through an application—through an app—that, for example, helps you with a chronic disease that you may have, or you can go to a hospital portal. These various channels to access your PHI will all be within a standards-based framework to allow for that comparable experience. So that's one before and after that's pretty substantial.

You've heard about virtual care, conventionally known as telemedicine. That's something extensively used certainly in the north but also in other parts of the province. It's mostly videoconferencing right now. There was a fascinating study done in Ontario based on a pilot project showing, maybe not surprisingly, that most Ontarians want to use secure messaging—quick, easy secure messaging—to interact with their providers, and they want to do it at home, or at work even, on their own time. There are some legacy rules that make that very difficult to do, and we've been having excellent discussions with the Ontario Medical Association to ensure that all providers across the continuum of care, regardless of the funding model they're in, will be able to provide care virtually to patients. There are some stunning statistics in other jurisdictions: 35% to 40% of primary care can be done virtually.

It's at this point that I'd emphasize that we're never going to stop someone from seeing their provider face to face. If someone likes that human interaction, they can absolutely do so. This is based on choice and convenience.

We talk a lot about the pressures that hospitals face; Mike did in his address. Hospitals are coming to us more and more saying that we can help patients post-discharge through remote patient monitoring, and most patients love it. Imagine having gone through a surgical procedure. The last thing you want to do, especially if you live in the north, is travel to a hospital to get that post-discharge assessment. That's something that in the acute setting can be done virtually as well.

Shifting to providers now: A lot of solutions developed up to this point have been done by technologists, engineers and computer scientists, and they've given short shrift to clinical interests and clinical requirements. We think that has to change. We also think that the systems that support clinical care have to be embedded with stronger clinical practices so that when your specialist or primary care provider is treating you, they'll have the best data, the best evidence at their fingertips at that point of care. That's something that we really have to improve upon. We have pretty good penetration use of technology in Ontario, but it's in a middling sort of way, it's not the most sophisticated kind of use, so we want to improve that.

The other point, which I think is pretty graphic, and from a before-and-after perspective, is, we have too many front-line IT systems right now. If you think about every hospital and every primary care office, never mind home and community care, we have thousands and thousands of them. They all have their own IT staff. They all have their own cyber security threats. This is something that the Digital First for Health Strategy will really shore up—and offer greater security protection to Ontarians, and also absolutely achieve savings by virtue of that efficiency of infrastructure, but those savings can be channelled back into front-line care.

Another interesting idea that one of my colleagues had that's really influencing the strategy is getting doctors out of the practice of IT operations. Doctors and other providers should be caring for Ontarians, not worrying about the operation of an IT system. There are lots of ways that you can shift the operation of IT systems to vendors who are happy to take that risk for an operating cost, and we're exploring that because we think that, again, we could achieve savings.

The deputy and the minister also mentioned some far-reaching changes that will affect every part of the health sector. One is called the Digital Health Information Exchange Policy. Ontario has never had rules of the game, so to speak, to ensure the free flow of information across providers and to patients. We have allowed information blockers to stop that free flow of information, mostly because we've had, previously, permissive rules—rules that will allow little islands of data to be held back and not shared. We think—and the Digital First for Health Strategy will accomplish this—it's time for that to be passed and to figure out exactly how to do that. That's another important part of the strategy.

The other really interesting area—and the deputy mentioned this—is, if you think about Ontario and the Toronto-Waterloo tech corridor, all of the—

Hon. Merrilee Fullerton: And the Ottawa—

Interjections.

Mr. Greg Hein: —and the Ottawa tech corridor, all of the ingredients we have to be an innovative market, and couple with that how much money we spend on health care, a lot of these changes in opening up the flow of data will make it easier for Ontario start-up companies in Waterloo and Ottawa to be able to have a business model where they can grow into the United States. A lot of innovative companies tell us, "The only way for us to develop is to first go to Europe or the United States and then come back and sell our products to Ontario." We certainly have to correct that.

I'll close just by talking about the amazing opportunity that Ontario health teams have provided people who think about digital health. It's an amazing model, to think about how to strengthen the integration of health service delivery through opening up the flowing of information, and it's something that we're working, literally, if not night and day on, then evenings and days—figuring out how to support OHTs. We've received their plans, including their digital health plans, and they're pretty impressive. We're going to be working with them over the next little while to ensure that they can meet all of their objectives.

1700

The last point I'll make is how compelling it is to have all of the functions under Ontario Health that previously were disparate. When I referred previously to embedding clinical standards into digital health solutions—we had to go talk to Health Quality Ontario and eHealth Ontario and Cancer Care Ontario. Now that's all under one governance roof, so to speak, and we think it has lots of potential to advance the strategy.

The Chair (Mr. Peter Tabuns): Ms. McKenna.

Ms. Jane McKenna: Mr. Hein, you very much pointed out that everybody is in their silos and we need to get away from that. I'm just curious: Will this be a unified plan? You've mentioned that the OHTs are going to do their own thing. So how is that going to work?

Mr. Greg Hein: Even in the Digital Health Playbook, it strikes a balance between leaving some room for innovation but having a very standards-based approach, as I said, to ensure that all Ontarians have a comparable experience. You do see on Twitter and in other discussion groups this idea that OHTs will perhaps fragment the way that Ontarians receive care. From a digital perspective and otherwise, that's absolutely not the case. The way that the digital plans are being developed—the overarching policies, like the information exchange and the PHIPA modernization—will absolutely ensure a coherent provincial approach. There will just be that tailoring in individual OHTs, which we think makes sense. It strikes a balance.

The Chair (Mr. Peter Tabuns): Mr. Cho, you have one minute.

Mr. Stan Cho: Oh, lots of time—

Interjections.

Mr. Stan Cho: Yes, I appreciate that.

There's a lot I'd like to chat about. It's encouraging to see that you're talking not just about the dollars that are being spent, but the outcomes for patients.

When you talk about technology, can you talk about any measures, very quickly, that you may be taking to future-proof these ideas—we know technology moves fast—maybe learning from the mistakes of the past?

Mr. Greg Hein: That's a great point. We're landing on metrics to be able to track progress. One of our key assets is the Centre for Digital Health Evaluation out of Women's College Hospital. It's a big partnership with lots of folks across the province, so that we can give them solutions, whether they're big provincial solutions or smaller apps, to evaluate, and they can give us third-party advice on which ones are working better, which ones deserve more investment and which ones should be potentially decommissioned after a while.

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

Members of the committee, we have 46 minutes of questioning left. I know you there will be very happy to hear that. I suggest we divide it: 23 minutes each side. We'll go with Madame Gélinas. You have 23 minutes. Then we'll go to the government: 23 minutes.

M^me^ France Gélinas: Before Mr. Hein leaves—we all know that there is pent-up demand within the Ontario population: They want to have access to their personal health information. I'm always a little bit leery, when there is pent-up demand—don't go away; I'll ask a question to the minister, but then it will come to you. Is there a commitment from the government that there won't be a charge to Ontarians to access their personal health information? Right now, what we have at women's health and at the University Health Network—you get into the portal for free. It's very exciting. Is there a commitment from this government that they will never charge the patients to gain access to their PHI?

Hon. Christine Elliott: There's no indication right now that we plan to do that.

M^me^ France Gélinas: And a commitment to the future also?

Hon. Christine Elliott: Yes, unless something changes dramatically. We want people to be able to have access to this information. It is their health information. They should be able to have access to it.

M^me^ France Gélinas: I would say that there's great support out there for what you've just laid out in the last few minutes. But I can't help but bring this back to—Health Sciences North in Sudbury has this outdated IT system that they have been wanting to change for a long time, but they've never had the resources. They don't have the money to update their IT system. They know that it's old. They've had breaches to it. They've had to shut it down. They still don't have the money to migrate to anything else. Where will the money come from to do this? And this is just one hospital. There are 154 of them.

Mr. Greg Hein: We're keenly aware of the pressures that hospitals and other health service provider organizations face. That's why we're trying to figure out a way to consolidate all of that expensive infrastructure. There's already a provision where you can seek an exemption to the BPS procurement directive to join an existing contract hospital information system if yours needs upgrading, because of that expense. So there are ways to help hospitals.

Up to this point in time, hospitals have made their own financial decisions about the acquisition of those big pieces of technology. But this idea of shifting those pieces of infrastructure to manage services that can be more cost-effective—we're being driven by that pressure. So we understand it, and it's reflected in the strategy.

M^me^ France Gélinas: Is there money someplace to move on with that strategy, to make those changes happen, that I haven't seen yet? If there is, let me know where it is.

Mr. Greg Hein: Up to this point, the strategy for front-line clinical systems, including hospital systems, has been based on figuring out ways for them to save money by joining other hospital information systems.

I won't address the question of the financial one right now.

M^me^ France Gélinas: Except that we're in estimates. That's what we talk about in estimates.

Mr. Greg Hein: We're talking about existing funding, so it's always open to thinking about where future dollars could go. Certainly, the hospital sector—if you talk to a lot of them, they would like to retain that independence of making their decisions about what are the best IT systems to use. We're continuing to engage them on the best way for them to renew their systems and to optimize them, and the strategy will help with that.

M^me^ France Gélinas: So the province would decide as to what the infrastructure would look like for an IT system that is robust, that has the flexibility that we want for people to get access to their PHI etc. And the money to do that will come from where, again?

Mr. Greg Hein: Again, there are large investments that go to hospitals for all sorts of purposes, and digital health has a fairly sizable budget too. I think that there will continue to be discussions with the hospital sector—as you keep raising that one—about the best way to allocate those

funds to ensure that technology is used for the right health outcomes.

M^me^ France Gélinas: Do we have an amount of money that will be available to do that?

Hon. Christine Elliott: We are having conversations right now with the teams that are presently going through the full application process. As Mr. Hein has indicated, there are some parts of Ontario that have very robust procedures and policies in place and systems in place; other areas do not. So we will be listening to the local Ontario health teams that tell us what they need, what additional infrastructure they're going to require. We know setting up these teams initially is going to cost some money and it's going to be different for each Ontario health team. You will be able to expect that the money will come from the Ontario health funds, written large.

M^me^ France Gélinas: I'm glad that you agree that it will take money to establish those teams. We're at estimates; do we have any idea as to how much money the government is willing to put to establish those teams?

Ms. Helen Angus: I'll jump in here. We're looking at the first 31 applications as an opportunity for us to learn about what are the policy changes, what are the infrastructure requirements—what supports for the relationships that are emerging that we need to put into play. So we see this first cohort of Ontario health teams as a chance for us to learn from the early-adopter group. That's the intention of the very careful review that we're doing of the completed full applications as well as the site visits. I think you'll see us being responsive to those needs in future iterations.

1710

We're in a funny place here right now because we're in estimates for this year, but we're also in the middle of multi-year planning for next year, and we're learning very much from the early work on Ontario health teams. I think some of them are asking for a variety of supports. Some of them are asking for us to bend some rules where we've locked value in silos. I think Greg has identified one of those, which would be that we require everybody to go through their own procurement process, so maybe there's a way for us to make that work a whole lot more smoothly and lower the cost of implementation. So those are the kinds of things that we're looking at and that we're learning from the initial groups, who have done an incredible amount of work across the province.

M^me^ France Gélinas: So is it reasonable to expect that in the next budget, we will see a certain amount of money allocated to those 30 first health teams? Thirty-one?

Ms. Helen Angus: Again, I would go back and say that that's the purview of the Minister of Finance. I think we'll be bringing forward ideas, as all ministries do, in our multi-year planning process.

Hon. Christine Elliott: Suffice to say, we expect that there will be costs associated with that that we will be bringing forward, but the deputy minister is right: It would be the Minister of Finance that will bring that forward. But we know that this is not going to happen without some costs to them.

M^me^ France Gélinas: Okay. And when you were speaking about virtual care and telemedicine—I come from the north; we use it a lot—the idea of secure messaging to your primary health provider or other provider is all great. Does that mean that we have a deal with the OMA for them to agree to do this work?

Mr. Greg Hein: We've been having productive discussions with them and, I'll be frank, they're multi-staged ones, so there are a couple of different components involving video conferencing; non-video, like secure messaging; use of technology beyond the Ontario Telemedicine Network; and the standards to ensure that privacy and security are met. That work is ongoing, and so far, it's been really excellent.

When it comes to secure messaging, there's a fairly sizable proof-of-concept pilot project that's been ongoing in a couple of different parts of the province, called Enhanced Access to Primary Care. That embeds all of the different ways that you can communicate with patients—video conferencing, secure messaging, storing and sending images—and that's the sort of integrated approach that will be used when the strategy is finally launched.

M^me^ France Gélinas: Okay. I don't want to use too much of my time with this because I have other questions, but I can tell you, from the north, a lot of specialists are really reluctant to do telemedicine because you have to book your time. You'll see your patient at 2:30, but at 2:30, if you happen to be in the middle of something else that you have to drop to go and sit in front of the—all of these logistics are all real where I come from, not to mention that we do have a follow-up with discharge through telemedicine. But I can tell you, where I live, I have cell service at the end of the dock in the summer. My dock is not in the water anymore, so I don't have cell service anymore, and my Internet comes through a phone line, which means that if there is a picture, I cannot get Internet.

I'm not the only northerner. Cell service and Internet service—how can I say it—sucks in northern Ontario, which means that in the areas where we need it the most and where people are open to this technology, it is not available to us. I listen to you and I dream of what you said coming true, but I'm too much of a realist to say that if there's no money attached to it, if there are no changes, then it is just a dream that is never going to come true for the people that I represent.

Mr. Greg Hein: I can tell you that one of the heartening parts of the discussions with the OMA is the shared concern over continuity of care and the shared concern for ensuring access in rural and remote areas. There are lots of mitigations that are being put in place to ensure that's the case. There was no arguing with them about that. That was fantastic.

M^me^ France Gélinas: Okay. There's a sentence that you said: There are little islands of information that won't flow, that's holding on amazing opportunity. What were you referring to?

Mr. Greg Hein: I won't cite any examples, but there are hospitals and there are primary care practices, there are groups of providers in the province who, when eHealth

Ontario in the past has gone to them to say, "We want you to share your information with us and we'll share it back through our provincial viewer," they basically say, "No." This digital health information exchange, as in the United States, as in Denmark, as in other jurisdictions, will stop them from saying no, because they're the recipients of public funds, so in the public interest you will have to share information. That's the idea behind this strategy.

M^me^ France Gélinas: Coming back to the—we have 31 health teams that are developing. How much of the health budget do you figure will go through Ontario Health for now? We know hospitals, long-term care, mental health, primary care, palliative and community. How much of your ministry's budget will end up going to Ontario Health?

Ms. Helen Angus: I'm just going to look at the percentage. I think it would be the same as probably was flowed through the LHINs under the previous organization of health care services. Cancer Care Ontario has cancer volumes, renal volumes; they pay for dialysis services, for example. The LHINs would have hospitals; they would have held the contracts and the accountability agreements for home and community care. The ministry directly funds physicians, drugs, labs. Physicians aren't health service providers in the formal sense of the word, so those are funded directly from the ministry, probably with the exception of some of the community health centres and Aboriginal health centres as well.

I think I will just look quickly at my notes, but we're estimating somewhere around $30 billion would be under the accountability of Ontario Health. How the money actually flows, I think we're still in discussions. We certainly want to present in estimates real clarity for this committee, as well as to the public, clarity on the money that goes to hospitals, that goes to the various transfer payment agencies.

M^me^ France Gélinas: The LHINs used to receive about $28 billion.

Ms. Helen Angus: Yes.

M^me^ France Gélinas: So it will be very similar. You say "$30 billion," so very similar to what used to happen through the LHINs will now happen through Ontario Health.

Ms. Helen Angus: Correct.

M^me^ France Gélinas: And then Ontario Health will distribute this to the Ontario health teams.

Ms. Helen Angus: Correct. Yes, that's the intent, with the addition of roughly $2 billion that Cancer Care Ontario holds for the volumes that they access. As a practical matter, I think the way that it worked with the LHINs is that the LHINs and Ontario Health will make recommendations to the ministry, and we actually flowed the money from the ministry out to the health service providers on the direction of the LHINs and on the direction of Ontario Health.

M^me^ France Gélinas: Okay. So of the $28 billion that used to flow through the LHINs, we had about $22 billion that was for hospitals, and we have $5 billion or so—$5.8 billion, by memory—that went through home and community care. If I follow the money, the money will go to Ontario Health, so hospitals and stuff won't be transfer payment agencies of the Ministry of Health anymore. They will be—

Ms. Helen Angus: The accountability agreement would be held by Ontario Health—between Ontario Health and the hospitals. This is all sort of an evolution at the moment, so things like that—you just heard a fair bit on the capital program. The intent is for the ministry to continue to hold the capital program. It's got to be a very careful process of working together, because things like capital—I think Mike walked through some of the larger projects. Of course, those have operating costs, so we need to have an integrated view of capital and operating.

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You can think about what it's going to look like eventually when we have Ontario health teams. The idea there would be that we would have an integrated budget for a population. We're probably a couple of years away from doing that and understanding the movement of money according to the priorities of Ontario health teams and allowing them to more flexibly address their population, but with that as the intent, it would make sense that Ontario Health would direct and hold the accountability for those Ontario health teams at maturity.

You've got to remember where we are with that agency. It's pretty early days. We haven't issued the transfer order. There's a lot of planning work behind the scenes. But we will be working very closely with Ontario Health to make sure that the money and the accountabilities and everything line up to achieve the outcomes that we're trying to get for the health care system.

M^me^ France Gélinas: So about a $30-billion pie goes through. What happens in the transition where we have 31 teams—that means lots of hospitals. Who will hold their accountability agreement if the LHINs are gone and they're not part of a team yet? What happens to them?

Ms. Helen Angus: Ontario Health will hold the accountability agreements with the health care providers. I think that the health care providers who form an Ontario health team—there are different models that are emerging through the 31 early adopters—have agreements to work together. Many of them are basically coming with the monies that they hold in their budgets, and we're trying to give them some flexibility to bring innovative solutions to the population of patients that they've signed up to work with.

It may be that some of them want to invest in some parts of their delivery system and move money between hospitals and providers, and I think that as long as it's aimed towards the outcomes we're trying to achieve—the whole premise of Ontario health teams is to build local solutions and have them work in a more flexible environment so that they can actually offer the integrated and coordinated care that we're trying to achieve, particularly in those transition points that have proven to be so problematic.

M^me^ France Gélinas: You used the term "the population that they signed up to work with." How can they define the population?

Ms. Helen Angus: Many of them actually got workbooks. I can ask the team to come up and describe the workbooks, if that would be helpful. They talk about the geography of the patients that they wanted to work with and the providers that they're working with that serve that geography. They were given population and health information about that in order to facilitate their planning. Some of them may be starting with particular populations within that geography where the transition points are particularly challenging, whether that's frail elderly or whether that's people with chronic mental health problems. We're pretty supportive of that. We think they've got to kind of walk before they run, and so some of those populations really require a bigger team.

We know from some of our analysis that 5% of patients use about two thirds of health care resources, that many of them access many different parts of the health care system. When I look at some of the patterns of care, I would say that nobody would design a system that would have you going to 16 different physicians and in some cases going to the emergency department week in and week out. Those are symptoms of a system that's not working, and so if an Ontario health team decides to put those patients as their initial focus, we think that they will have a tremendous benefit, both for the patients as well as for the system of care. They will develop those capabilities over time.

Of course, you've just heard from Greg around virtual care. Again, we want Ontario health teams to offer patient portals and be a locus of improving access to services, and improving access to services virtually. We're going on a journey with those Ontario health teams. The things that work—I think we will try and knit them together so that they learn from each other and that we build up some capabilities across the province to do that.

M^me^ France Gélinas: I see my time is running. Just very quickly on long-term-care beds: You've made the announcement. Have we got a timeline as to when those new beds will open? If you could share that—or do you know?

Hon. Merrilee Fullerton: As you know, the 15,000 beds is a commitment—and the redevelopment. Looking at the timeline, there are estimates—

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

Hon. Merrilee Fullerton: —as to when it would transpire, but looking ahead, we can either do it two ways: We can count back from, say, 1,500, and say, "How many do we have in the queue?" Which is easy enough to do. The other way to do it is, "What is our maximum capacity? Can we even go beyond that?" So it depends on which way we work, but we do have a—

M^me^ France Gélinas: But I'm looking for deadlines for when those projects that have been approved for funding will actually open and welcome residents.

Hon. Merrilee Fullerton: Well, the reality is, it takes about 36 months, but we are looking at streamlining processes and making sure we can get shovels in the ground sooner, and we're actively working on that.

M^me^ France Gélinas: So some announcements were made a year and a half ago, so in a year and a half from now, they will open?

Hon. Merrilee Fullerton: Some of them may open in a year and a half. It depends on how quickly we can streamline some processes. We were at one announcement just recently—

M^me^ France Gélinas: So you haven't got dates as to when they're scheduled to open to share with the committee?

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

We go to the government side. Mr. Pettapiece.

Mr. Randy Pettapiece: I'm sure this is the question you've all waiting for, because this is the last one of the day. So I'm very pleased to be giving you this question.

Minister Elliott, you open a newspaper and sometimes you see stories about the latest and greatest drugs that look very promising for a lot of conditions that Ontarians are struggling with. They need access to a certain drug that isn't covered; sometimes it's experimental or sometimes it seems it's just recently approved. I can imagine, with so many pharmaceutical companies in the market, there must be piles and piles of studies, clinical trials and evidence to carefully review.

Can you please tell me and my fellow committee members about how new drugs get covered for eligible Ontarians?

Hon. Christine Elliott: Yes, certainly. Thank you very much for this important last question of this session.

As Deputy Premier and as Minister of Health, I can say with confidence that I am very proud of what this government has achieved on this critical file. Despite a challenging economic climate, we have continued to make investments, as you know, in Ontario's health care system.

From the beginning of our government's mandate, we recognized the complexity of the challenges facing the province's health system and appreciated the difficulties surrounding this system's future viability. As the government, it's our responsibility to make sure that we're doing everything we can to keep as many drugs as possible as affordable as possible for as many patients as possible.

In the face of rising drug costs, provinces and territories have a responsibility, of course, to thoroughly review the drug funding requests and to consider clinical effectiveness, safety, cost-effectiveness and affordability, as well as the impact on other health care services.

It is critical that our funding decisions be informed by solid scientific and clinical evidence to ensure that we are spending our health care dollars wisely. This diligence is necessary to continue to provide adequate care while sustaining a publicly funded drug system for generations to come.

Deputy Minister Angus, I'd be pleased if you could provide some further details.

Ms. Helen Angus: Thank you, Minister. I concur with the minister on the need for balance and making sure that we've got medications available to the people who need them.

On a personal note, early in my career I actually was able to work on and set up the Trillium Drug Program. It's a program that's designed to support individuals who have

high drug costs relative to income. I would say that one of the proudest days of my career was actually calling some of the first applicants who needed to get medications and were previously unable to afford them.

So I've kind of watched the drug file over a period of years with great interest. I know from watching it up close that the drug approval and funding decision is multi-faceted. It involves many stakeholders. Obviously, the pharmaceutical industry is an important one, but it also involves patients—what they receive and their preferences—clinicians, and my provincial, territorial and federal counterparts.

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The level of rigour that we apply to the drug file is necessary not only because we want to serve inter-access to clinically effective drugs, but it's also important to note that the publicly funded drug program in Ontario is the fourth-largest area of expenditure. It represents roughly 10% of all provincial health expenditures. It's a growing program, and we want to make sure that we get the best value for the people of Ontario.

We've worked together with our provincial, territorial and federal partners to make sure that we're aligned on drug funding decisions through national drug review, led by Canadian Agency for Drugs and Technologies in Health—some of you may know that as CADTH—to achieve the best possible value for the drug system.

We've also taken steps to streamline the drug review and funding process to align with national processes and reduce duplication of effort and making sure that our drug funding decisions are, in fact, evidence-based.

So we try to balance access to medications and achieving better value for taxpayers' money by fostering innovation in the life sciences sector and directing benefits to those who need it most. We want to make sure that Ontarians have access to the right medication at the right time, and it's an important part to ending hallway health care. It's an important part of keeping people healthy.

I might ask Patrick Dicerni, another ADM at the Ministry of Health—he's actually the assistant deputy minister of the drugs and devices division. We have a unique responsibility in Ontario. He's also the executive officer of the Ontario public drug program. He can talk to you a little more about how drugs are listed and the processes that we use to make sure that we achieve the balance that I just talked about.

The Chair (Mr. Peter Tabuns): If you would introduce yourself, please.

Mr. Patrick Dicerni: Hello, my name is Patrick Dicerni. I'm the assistant deputy minister in the drugs and devices division, and the executive officer of the Ontario public drug program.

Mr. Chair and members of the committee, thank you very much for allowing me some time today to come and talk in a little bit more detail to what we've already heard from the minister and the deputy with respect to the Ontario public drug program. With the goal of improving the efficiency of our publicly funded drug programs, Ontario has established an evidence-based approach for making decisions which considers the clinical effectiveness of the drug, its safety, patient experience, and the affordability and effects on the health system in Ontario.

The drug approval process relies on the review of recommendations of expert committees that provide an objective evaluation of clinical, economic and patient experience of a new drug or indication. Informed by the recommendations of expert committees, the drug is considered for pricing negotiations after that. These negotiations are conducted with the manufacturers of the drugs to achieve greater value for publicly funded drug programs and patients.

Ontario has six well-established publicly funded drug programs under the banner of the Ontario Public Drug Programs that provide access to cost-effective drugs to support the health of all Ontarians, the largest of which is the Ontario public drug program. Under the Ontario Drug Benefit Program, drug coverage is available to eligible individuals including social assistance recipients enrolled in Ontario Works and the Ontario Disability Support Program, and individuals who are OHIP-insured and belong to one of the following groups: seniors aged 65 and older; children and youth aged 24 who do not have access to private insurance; people residing in homes for special care, community homes for opportunity and long-term-care homes; people receiving professional home care services; and individuals, as the deputy mentioned, who are enrolled in the Trillium Drug Program. These are individuals and families who have high out-of-pocket expenses for drugs.

Over five million Ontarians are currently directly benefiting from the Ontario drug benefit program. This represents about 36% of all Ontarians. Of these, over 2.2 million seniors benefited from the ODB program in the year 2018-19.

Each year, pharmacies in Ontario submit over 180 million drug claims for all ODB recipients under the Ontario drug benefit program. Including the first full year of impact from the OHIP+ program, total government expenditures for 2018-19 were $6.4 billion. That's an increase of 8.5% over the previous year.

I should point out that that figure I just quoted was under the previous design of the OHIP+ program, and that also does include all the drugs that are provided through the Ministry of Community Safety and Correctional Services.

For Ontario Drug Benefit Program recipients, publicly funded drug coverage is provided for medications listed on the formulary, which is a comprehensive list that has grown to include more than 4,400 drug products, such as drugs for heart disease, high cholesterol, high blood pressure, insulin for diabetes, hepatitis C drugs and antibiotics for infections, as well as over 1,000 additional drug products that may be eligible for coverage with a case-by-case review through the Exceptional Access Program. The Exceptional Access Program facilitates patients' access to drugs not funded on the formulary or where no listed alternative is available for people who are eligible to receive Ontario drug benefits.

Examples of drugs considered through the Exceptional Access Program include oral cancer medications, drugs to treat more common illnesses, such as multiple sclerosis and rheumatoid arthritis, as well as a growing list of drugs for rare diseases.

I would now like to provide a detailed overview of the process for approving new drugs for funding under the Ontario drug programs. The drug review process begins with manufacturers applying to Health Canada to have their product authorized for sale in Canada. Health Canada reviews and assesses the safety and efficacy of drugs compared to a placebo effect, as well as the quality of the drug.

Health Canada also regulates the manufacturing of the drug, and if at the completion of this review the conclusion is that the benefits outweigh the risks and that the risks can be mitigated, the drug is approved for sale in Canada. After the drug is approved for sale in Canada, it is up to each province and territory to determine whether or not the drug will be funded under their respective drug programs. It is important to note that Health Canada does not assess the cost or cost-effectiveness of a new drug.

The health technology assessments are where drugs are evaluated for clinical effectiveness and/or cost-effectiveness and may include legal, ethical and societal implications of the drug on patient health and the health care system at large.

I would now like to talk about the health technology assessment evidence review process in a little bit more detail.

A new drug can only be funded under the Ontario Drug Benefit Program if it has been authorized by Health Canada for sale, and simultaneously or subsequently is being reviewed by bodies for clinical effectiveness, safety, cost-effectiveness and patient experience with that drug. The provincial drug product review process is typically initiated by a drug manufacturer who makes a submission to have its products funded under the Ontario Drug Benefit Program. The submission requirements for manufacturers are set out in regulations made under the Ontario Drug Benefit Act and the Drug Interchangeability and Dispensing Fee Act. It is important to note here that Ontario has implemented several changes to streamline drug review processes, as well as our continued commitment to making efforts to reduce the administrative burden on stakeholders in the pharmaceutical industry.

The Canadian Agency for Drugs and Technologies in Health, as the deputy mentioned, more commonly referred to as CADTH, is the national organization responsible for the review of non-cancer and cancer drugs. This is where we're going to get into some degree of heavy acronyms, so I'll do my best.

For non-cancer drugs, the Canadian Drug Expert Committee, or CDEC, is the pan-Canadian expert advisory body to CADTH. This committee provides drug funding recommendations and evidence to publicly funded drug plans of jurisdictions that participate in the CADTH Common Drug Review process, which Ontario is involved with.

For cancer drugs, the pan-Canadian Expert Review Committee, or pERC, and the pan-Canadian Oncology Drug Review, or pCODR, as it's known, perform the same functions as I've described a little bit earlier for non-cancer drugs.

In Ontario, for drugs that are not reviewed by CADTH, non-cancer drugs are evaluated by the Committee to Evaluate Drugs, while cancer drugs are evaluated by the Ontario Steering Committee for Cancer Drugs. One might ask why CADTH doesn't review all the drugs in this space. CADTH really reserves its bandwidth and time for truly new drugs or significantly new indications for those drugs. If there's a line extension to a drug that's done, whether that be a different dose, a different strength or perhaps a different manner in which the molecule has been put together, those are referred to our provincial drug approval structures. Again, we've made efforts over the last few years to align the efforts of CADTH and our provincial bodies.

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The Committee to Evaluate Drugs is Ontario's provincial drug review body. The primary function is to evaluate the therapeutic value and cost-effectiveness of drugs based on best available scientific, clinical and economic evidence, and to make recommendations as to which drug should be listed as benefits on the formulary or have funding changed—for example, expanded, reduced or removed from the Ontario Drug Benefit Program.

Now let's move to the next step in this process, which is moving into the negotiations with manufacturers that I described earlier. Following a funding recommendation from a national review body, Ontario participates in the pan-Canadian Pharmaceutical Alliance, also known as the pCPA, which negotiates with drug manufacturers on behalf of all participating Canadian provinces, territories and some of the federal drug programs to drive better value, harnessing the collective volumes of the participating plans, including better pricing and limits on utilization. The objectives of the pCPA are to increase access to clinically and cost-effective drug treatment options, improve consistency of decision-making among participating jurisdictions, achieve consistent and lower drug costs for participating jurisdictions, and reduce duplication of efforts to improve use of resources.

It is estimated that the collective efforts of the public drug plans through the pCPA on brand and generic initiatives have resulted in $2.2 billion of annualized combined savings, which equates to about $1.5 billion from brand initiatives and about $750 million from generic initiatives as of March 31, 2019.

Furthermore, of the most recent generic initiatives, which were implemented in April 2018, it is estimated that we have saved an additional $385 million in the first year and up to $3 billion over the next five years through a combination of price reductions and the launch of new generics.

Public funding requests for all new brand drugs are considered by the pCPA negotiations with the manufacturer. The pCPA also coordinates provincial and territorial

discussions for generic drug products to Canada to achieve greater value for publicly funded drug programs and patients in alignment with the five guiding principles governing the Ontario Drug Benefit Program, which are:

—The public drug system aims to meet the needs of Ontarians as patients, consumers and taxpayers.

—The public drug system aims to involve consumers and patients in a meaningful way.

—The public drug system aims to operate transparently to the greatest extent possible for all persons with an interest in the system, including, but without being limited to, patients, health care practitioners, consumers, manufacturers, wholesalers and pharmacies.

—The public drug system aims to consistently achieve value for money to ensure the best use of resources at every level of the system.

—Lastly, funding decisions for drugs are to be made on the best clinical and economic evidence available and will be openly communicated in as timely a manner as possible.

The decisions to fund drug products covered under the Ontario drug program are therefore based on recommendations of expert reviews with respect to clinical evidence, the cost-effectiveness of drug products, outcomes of pricing negotiations, and public interest. Since April 2018, under the process I have just described for approving new drugs for funding, Ontario has provided access for funding to eight new drugs or indications in 2018-19, and so far in 2019, six drugs or indications for rare diseases such as Vimizim for mucopolysaccharidosis and Orfadin for hereditary tyrosinemia—these are relatively new terms for me; 36 new cancer drugs and expanded indications such as Rituxan for lymphoma and Darzalex for multiple myeloma; and 44 brand drugs and indications such as Synjardy for diabetes and Lancora for heart failure. In addition, 32 brand drugs or indications have also accessed increased use, such as Taltz for psoriatic arthritis, CellCept for organ transplants and 103 generics, of which 21 are first-line generic drugs.

Harnessing the collective volumes of public plans across Canada to strengthen negotiating positions with pharmaceutical industries achieves far greater value for publicly funded drug programs, including the Ontario public drug program. We will continue to advocate on behalf of our publicly funded drug programs.

In conclusion, I wanted to point out some of the challenges on the horizon that are facing all public drug programs in the country. A decade ago, there were about 1,500 drugs in the development pipeline. As these new drugs come to market they are increasingly complex and far more expensive. For example, in 2017, 51 new medicines received approval through the USFDA, the European Medicines Agency and/or Health Canada. Nearly half were for use in the treatment of rare diseases. Many were biologics and/or oncology medicines. Over three quarters of these drugs have treatment costs that exceed $10,000 per year.

For 2019, there are over 30 drugs in Health Canada's pipeline for cancer drugs, and the pipeline for drugs for rare diseases continues to increase as biochemical research shifts to focus on these new agents, such as biologics or gene therapy.

It is expected that public spending on drugs for rare diseases will continue to grow and be a significant cost driver in the future. In fiscal 2018-19, Ontario funded 23 drugs for rare diseases for about 1,700 patients, with a total expenditure of approximately $130 million. That's a greater than 13-fold increase over the previous year.

In spite of the anticipated increases in drug costs associated with pipeline drugs and drugs for rare diseases, Ontario is well positioned to take advantage of the opportunity innovative medicines present because Ontario public drug programs are designed to provide access to clinically effective prescription drugs to eligible Ontarians in accordance with the best evidence available. This includes understanding the cost-effectiveness of medicines and the opportunity costs and benefits to the system as part of the decisions to fund a particular medicine.

We need to make sure that we continue to provide Ontarians now and in the future with access to prescription medicines that will keep them healthy, reduce the impact of chronic disease and provide life-sustaining and, in some cases, curative outcomes.

Ontario is committed to making decisions that are centred around providing access to the right medications at the right time at the right value, which is foundational to protecting our universal public health care system.

Once again, I would like to thank the Chair and members of the committee for the ability to speak to you today.

The Chair (Mr. Peter Tabuns): Thank you. Mr. Pettapiece.

Mr. Randy Pettapiece: That was quite informative. I wonder, if we have some more time, if you could give us the full acronym instead of—so we could understand—

Interjections.

Mr. Randy Pettapiece: —what they are. And those last two drugs you described were interesting. I'm glad you could say that. It was about as interesting as pronouncing my colleague's name here.

Mr. Patrick Dicerni: They phonetically do them for me.

Mr. Randy Pettapiece: If the United States passes a drug—they do all the testing on a drug and they say it's safe for their citizens and whatever else—and then it comes up to Canada, do we go through all the same procedures again as what the United States does?

Mr. Patrick Dicerni: To answer your question, yes, we go through a similar set of procedures, and that is the responsibility of Health Canada. That would be the equivalent, as I mentioned, to the United States FDA. But for the purposes of ensuring that that drug is safe, that the drug does what it says it's going to do and that the manufacturing processes behind that drug are of good quality, Health Canada does conduct its own rigorous assessment.

Mr. Randy Pettapiece: I'm thinking of money. It's going to cost money to do that, and if the United States—we don't always agree with the United States, but I think

these types of things probably are tested very rigorously in the United States first before they get to Canada—

Mr. Patrick Dicerni: True.

Mr. Randy Pettapiece: —or most of them are. So I wonder—and I guess it's not up to us—if there could be a cost-saving measure if we agreed with the United States' assessment of the drugs.

Mr. Patrick Dicerni: Thank you for the question, MPP Pettapiece. I think one of the larger issues that you're getting at is time to market for drugs and the costs that are associated with all of that.

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

Mr. Patrick Dicerni: I'm happy to say that there have been efforts both at the national and, in particular, provincial level to make the application process for having a new drug or a new biologic access the Ontario market or the Canadian market. There have been steps taken to streamline that process as much as possible. I think there's always more that can be done, but through bodies like CADTH and some of the pCPA collaborations, we've been able to streamline some of the—I think 10 years ago—what you would have seen as duplicative steps in that approval process.

Mr. Randy Pettapiece: That's good to hear. I know we hear not only in this industry but in the agriculture industry, which I know a lot more about, that when we get into pesticides, it goes through a rigorous process in the United States a lot of the time, because that's a big market down there, and then it comes up here and we do the same things all over again and get the same results. But it costs money to do these things, and you just described—

The Chair (Mr. Peter Tabuns): With that, I'm sorry to say, Mr. Pettapiece, in mid-sentence, you're out of time.

Colleagues, this concludes the committee's consideration of the estimates of the Ministry of Health and Long-Term Care. Standing order 66(b) requires that the Chair—myself—put, without further amendment or debate, every question necessary to dispose of the estimates.

Madame Gélinas?

M^me^ France Gélinas: There were a couple of questions where they promised an answer later. I just wanted to make sure that they have been captured. To the first set of questions, five months later, we've got no answers. Is there anything we can do to expedite the answering of questions so I don't die of old age before I get an answer?

The Chair (Mr. Peter Tabuns): I understand your concern. I understand from research that when commitments were made to answer questions, that information was captured.

M^me^ France Gélinas: Jason captured them all?

The Chair (Mr. Peter Tabuns): Yes.

M^me^ France Gélinas: Thanks, Jason.

The Chair (Mr. Peter Tabuns): So, are members ready to vote? You are?

Shall vote 1401, ministry administration program, carry? All those in favour? Opposed? Carried.

Shall vote 1402, health policy and research program, carry? All those in favour? Opposed? Carried.

Shall vote 1403, eHealth and information management program, carry? All those in favour? Carried.

Shall vote 1405, Ontario Health Insurance Program, carry? All those in favour? Carried.

Shall vote 1406, population and public health program, carry? All those in favour? Carried.

Shall vote 1411, local health integration networks and related health service providers, carry? All those in favour? Carried.

Shall vote 1412, provincial programs and stewardship, carry? All those in favour? Opposed? Carried.

M^me^ France Gélinas: So I have this really dumb question: Am I a member of this committee? Am I allowed to vote?

The Chair (Mr. Peter Tabuns): You're subbed in.

M^me^ France Gélinas: I am? Okay.

The Chair (Mr. Peter Tabuns): Any time.

Shall vote 1413, information systems, carry? All those in favour? Opposed? Carried.

Shall vote 1407, health capital program, carry? All those in favour? Carried.

Shall the 2019-20 estimates of the Ministry of Health and Long-Term Care carry? All those in favour? Carried.

Shall the Chair report the 2019-20 estimates of the Ministry of Health and Long-Term Care to the House? All those in favour? Carried.

Okay, the committee is now adjourned until 3:45 p.m. tomorrow, when we will meet to consider the estimates of the Ministry of Education.

Interjection.

The Chair (Mr. Peter Tabuns): Are you trying to get my attention?

M^me^ France Gélinas: I am. Aren't you supposed to ask us if we want this thing to be translated?

The Chair (Mr. Peter Tabuns): I don't believe so. I think it's automatically translated.

M^me^ France Gélinas: They used to ask us.

Interjection.

The Chair (Mr. Peter Tabuns): I'm assured that it's a different type of report and your concerns will be addressed.

Before I bring down the gavel, thank you, everyone who has participated in this. Very much appreciate your commitment and time.

The committee adjourned at 1753.

STANDING COMMITTEE ON ESTIMATES

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Mr. Peter Tabuns (Toronto–Danforth ND)

Vice-Chair / Vice-Président
Mr. Wayne Gates (Niagara Falls ND)

Mr. Stan Cho (Willowdale PC)
Mr. Stephen Crawford (Oakville PC)
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Ms. Effie J. Triantafilopoulos (Oakville North–Burlington / Oakville-Nord–Burlington PC)

Substitutions / Membres remplaçants
M^{me} France Gélinas (Nickel Belt ND)
Mrs. Robin Martin (Eglinton–Lawrence PC)

Also taking part / Autres participants et participantes
Ms. Teresa J. Armstrong (London–Fanshawe ND)

Clerk / Greffière
Ms. Julia Douglas

Staff / Personnel
Mr. Jason Apostolopoulos, research officer,
Research Services