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Estimates

Ministry of Health

1st Session
44th Parliament

Tuesday 28 October 2025

Chair: Brian Riddell
Clerk: Vanessa Kattar

Journal des débats (Hansard)

SP-3

Comité permanent de la politique sociale

Budget des dépenses

Ministère de la Santé

1re session
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Mardi 28 octobre 2025

Président : Brian Riddell
Greffière : Vanessa Kattar

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CONTENTS

Tuesday 28 October 2025

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Tuesday 28 October 2025

Mardi 28 octobre 2025

The committee met at 1459 in committee room 2.

ESTIMATES

MINISTRY OF HEALTH

The Chair (Mr. Brian Riddell): Good afternoon, everyone. The Standing Committee on Social Policy will now come to order.

We are meeting to consider the 2025-26 estimates of the Ministry of Health for a total of three hours.

As this is the first ministry before the committee, I would like to provide some comments on the estimates process. In the past, members have been allowed to ask a wide range of questions pertaining to estimates before the committee. However, it must be noted that the onus is on the members asking the questions to make sure the question is relevant to the estimates under consideration.

The ministry is required to monitor the proceedings for any questions or issues that the ministry undertakes to address. If you wish, you may, at the end of your appearance, verify the questions and issues being tracked with the research officer. Are there any questions from members before we start?

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

Minister, the floor is yours.

Hon. Sylvia Jones: Well, thank you, Chair. I feel very blessed to be the first ministry appearing.

The Chair (Mr. Brian Riddell): You're the first one on the barbecue.

Hon. Sylvia Jones: Thank you, Chair Riddell, and all members of the committee for this opportunity to discuss the important work of the Ministry of Health and for the ongoing efforts to build a more connected, convenient and patient-focused health care system.

Under the leadership of Premier Ford, our government continues to make record investments and take bold and innovative actions to make it easier for patients and their families to have access to high-quality care close to home. We are making tremendous progress through our primary care action plan, supported by our government's historic investment of more than $2.1 billion, which is transforming front-line care in our communities and will connect everyone in Ontario to a publicly funded family doctor, nurse practitioner or primary care team by 2029.

Earlier this fall, the province launched a call for proposals to create and expand approximately 75 primary care teams that will connect a half a million more people to a primary care provider. We expect to confirm these successful primary care teams by spring of 2026. These new and expanded teams will prioritize attaching people without regular access to primary care, including those who are on the Health Care Connect wait-list, which, as of January 2025, has been reduced by half, with the province on track to hit its initial commitment by next spring.

Other key developments to expand primary care include this past June, when our government provided support to more than 130 new and expanded primary care teams to connect 300,000 people to primary care, with some of these teams already accepting new patients. Last year, nearly 400,000 more people were connected to primary care through the province's investments.

We are also investing up to $300 million to build up to 17 new and expanded community-based primary care teaching clinics in communities with high rates of unattachment to primary care. The clinic combines direct patient care with hands-on learning for primary care learners, enabling approximately 300,000 additional Ontarians to be connected to primary care.

Our government recognizes and appreciates everything our health care and community partners are doing to support the primary care action plan and provide Ontarians with the health services that they need and deserve. Our government will continue to work with our partners to build on this momentum and deliver on our commitment to ensure everyone in Ontario has access to primary care.

Along with the rapid expansion of primary care, our government continues to support and build up the province's world-class health care workforce. Since 2018, our government has registered a record-breaking number of new health care professionals, adding over 100,000 additional nurses and nearly 20,000 physicians, including an over 14% increase in family doctors and a 50% increase in the number of nurse practitioners.

We are continuing to prepare for the future by undertaking the largest medical school expansion in the province's history. This includes opening two new medical schools, including the TMU School of Medicine in Brampton that welcomed their first students this year and York University's new medical school in Vaughan, which will be the first in Canada focused on training family physicians. At Carleton University in Ottawa, we established

the first new university nursing program in 20 years, helping to maintain and expand the province's nursing workforce.

We're also making key investments to enable nurses to access more specialized training, upskill in their jobs, expand their scope of practice, and reduce barriers for internationally educated nurses. We have made it easier for people to get timely care closer to home by allowing pharmacists to assess and prescribe drugs for 19 minor ailments. As of September 2025, pharmacists have provided patients over two million assessments, with nearly 100% of community pharmacies participating in this program.

Our government is also continuing to expand and modernize our hospitals and local health care facilities to ensure they have the tools and resources to support high-quality patient care, investing nearly $60 billion in major health infrastructure projects over the next 10 years—part of our plan to get shovels in the ground on more than 50 major hospital developments across Ontario, which will deliver approximately 3,000 new hospital beds on top of the 3,500 we have already added since 2020.

Earlier in October, I was pleased to announce that our government is renovating and expanding the Timmins and District Hospital emergency department, which will expand the emergency department up to four times its current size. And in July of this year, I was in Waterloo region to announce that our government has invested an additional $10 million to support the planning and construction of the new Waterloo Regional Health Network hospital. I was also pleased to visit Brantford–Brant earlier this summer, where our government announced an additional investment of $12.5 million for the new Brant Community Healthcare System hospital, connecting more patients and families in Brant county, Six Nations of the Grand River and surrounding communities to more convenient, high-quality care close to home. Additionally, we are providing the hospital sector with a record almost $1-billion increase in funding for a third consecutive year.

Our government is also taking further action to reduce wait times and make it easier and faster for people to connect to publicly funded surgeries and procedures by investing in new community surgical and diagnostic centres. With investments in community surgical and diagnostic centres, our government is enabling more patients to access publicly funded MRI and CT scans, GI endoscopies and cataract surgeries faster while also continuing to support hospitals' surgical and diagnostic capacity. These are the types of investments that are helping to build on our progress, which includes achieving the shortest wait times of any province in 2024 for key surgical procedures.

We also continue to tackle emergency department wait times and find innovative ways to make it easier for Ontarians to access timely emergency care. With investments of nearly $1 billion in land ambulance grant funding, Dedicated Offload Nurses Programs and fostering innovative collaboration between hospitals and emergency medical services, we have seen tangible progress being made, including, as of August 2025, a decline in provincial ambulance off-load times by 66% since its peak in October 2022, and reducing emergency room closures by 82% since July 2022. And we're doing more to help cover the medically related costs of northern Ontario residents when they occur travelling to access OHIP-insured health care services, by expanding the Northern Health Travel Grant Program.

Our investments are also supporting people impacted by different medical conditions and diseases. We are connecting more women to life-saving services by expanding the Ontario Breast Screening Program so that women over the age of 40 can now self-refer to publicly funded mammograms. We've also made important developments in treating prostate cancer, with Ontario being the first jurisdiction in Canada to publicly fund and administer Pluvicto, a new treatment for advanced stage prostate cancer.

The Ministry of Health has also successfully negotiated funding under the federal government's National Strategy for Drugs for Rare Diseases to improve access to drugs and diagnostics for people living with rare diseases. And we're expanding the Ontario Fertility Program to support more couples and individuals in their journey to start or grow their family.

1510

Home care is another vital part of Ontario's health care system, and through our government's increased investments, we've seen an 18% increase in home care provided over the last two years, helping Ontarians get the right care in the right place, where they want to be: in their homes and communities. This is also freeing up hospital beds, relieving pressures on emergency departments and leading to the lowest level of alternative-level-of-care volumes in a decade. We continue to improve and expand the delivery of palliative and end-of-life options, including through expanded primary care, home care and hospice services, providing people near the end of their lives with comfort and dignity.

On the topic of mental health, our government continues to make progress with implementing the Roadmap to Wellness, our plan to build a world-class mental health and addictions system of care. Through our Roadmap to Wellness, we are investing $3.8 billion over 10 years to expand programs, fill gaps in mental health and addictions care and create new services. Since 2019-20, over $800 million in new base funding has flowed into services and supports through our road map. This includes new base funding for community mental services such as investments in the Ontario Structured Psychotherapy program, non-police mobile crisis services, mobile mental health and addictions services, early psychosis intervention and peer support.

We've increased investments specifically for the child and youth mental health sector to improve access to specialized mental health treatment; reduce wait times and wait-lists; expand existing programs; and create new programs to help manage stress, depression and anxiety. We've invested in addictions treatment services and pro-

grams and supports to address eating disorders, including the creation of eating disorder prevention networks across Ontario and a new specialized early intervention program.

We are providing more base funding for supportive housing, including funding to ensure continued supportive housing for individuals with mental health and addictions challenges that are at risk of homelessness.

We have established the Mental Health and Addictions Centre of Excellence within Ontario Health, which is a central point of accountability and oversight for mental health and addictions care. The centre of excellence is responsible for implementing Roadmap to Wellness, managing the mental health and addictions care system, supporting quality improvement and establishing service expectations to ensure that mental health and addictions services are delivered consistently across the province, integrated with the broader health care system, easily accessible and responsive to the diverse needs of people and their families.

Our government recognizes that children and youth can experience unique mental health and addictions challenges, and we understand the importance of supporting these in meaningful ways. One of the important services our government has expanded are youth wellness hubs, making it faster and easier for youth and people aged 12 through to 25 to connect to integrated mental health, substance use and primary care, as well as other services. I've had the pleasure of visiting some of these youth wellness hubs, most recently in Timmins. It is inspiring to see how these youth wellness hubs offer accessibility: integrated, tailored to the needs of young people, in a safe and youth-designed welcoming space.

Since 2023, our government has announced 10 new youth wellness hubs, which, once implemented, will bring the network to 32 locations across Ontario. We are already seeing results. For example, Sarnia's youth wellness hub has had 1,600 visits from April 2024 through March 2025. That's hundreds of children and youth getting the care they need. So far, the youth wellness hubs have connected nearly 73,000 young people and their families to high-quality mental health, substance use and wellness services, where and when they need it.

Our government is supporting young people's mental health through a number of other initiatives, including programs and supports. The ministry provides annualized funding to support One Stop Talk, an innovative, virtual walk-in mental health counselling service. This service provides low-barrier, virtual access to counselling services for children and youth to help address wait times and improve access to service across Ontario. We are investing in specialized youth mental health care in London, Owen Sound, Sudbury and Waterloo that is supporting the creation of a new step-down, live-in treatment program that supports youth in their transition home from in-patient hospital or secure treatment care to a less-intensive, community-based service.

Our investments are also supporting the development of the Ontario Intensive Treatment Pathway, a new community-based, intensive service model that will facilitate improved access to new and existing services for children and youth with complex mental health needs.

In addition to providing more services and supports for children and youth, there are many other ways we are addressing the different mental health issues that people experience. We've established three pilot mobile crisis response teams in Lambton county, Simcoe county and Thunder Bay. These innovative pilot programs are expanding access to specialized care in the community, avoiding unnecessary visits to emergency departments and police involvement, making it easier for people experiencing homelessness or mental health and addictions crises get the support they need.

In Guelph, investments in supportive housing will connect more than 100 additional people in the Guelph and Wellington area to supportive housing and high-quality mental health and addiction support services. Also in Guelph, I was proud to announce that construction is under way on the expansion of the emergency department at Guelph General Hospital, which will relocate the hospital's existing emergency mental health and addiction services unit from the emergency department to a new, dedicated space within the hospital.

This relocation will allow more patients and their families to access enhanced mental health and addiction support services, while freeing up over 12% more space in the emergency department to connect more patients to the right level of emergency care as quickly as possible.

We are making it easier for people in York region to connect to comprehensive mental health and addiction services by building a new mental health hub in Newmarket, which will bring together partners—including hospitals, primary care, community providers and first responders—to connect people to the care they need sooner.

Through the Ontario Structured Psychotherapy Program, more than 100,000 clients have enrolled and been provided care at no out-of-pocket cost since the program was launched.

In Thunder Bay, investments in Safe Sobering beds, operated by St. Joe's Care Group, are making it easier for people under the influence of substances to access a safe place to sleep and get the care they need.

Our government continues to take action to create a better system of care for people struggling with addictions and mental health issues, focused on prevention, treatment and recovery—a crucial step forward in our investment of almost $550 million to create 28 homelessness and addiction recovery treatment hubs, or HART hubs, across Ontario.

These HART hubs will connect people with complex service needs to a holistic approach to treatment services to help break the cycle of addiction. Services offered by HART hubs include mental health, primary care, substance use care, supportive housing and job retraining. These hubs will add close to 900 mental health and addiction supportive housing units, which is over 300 more than anticipated, helping thousands of people each year transition to more stable, long-term housing. HART

hubs are a vital way our government is continuing to address gaps in mental health—

The Chair (Mr. Brian Riddell): One minute remaining.

Hon. Sylvia Jones: —and addictions care, and the surge in demand for substance use services, helping to ensure vulnerable people connect to high-quality care. And we are already seeing results of the HART hubs seeing clients.

1520

Chair, I must say, all of this work happens because we have such a committed Ontario public service and partners working in the field making these changes possible, so I want to publicly acknowledge and thank them for their work.

The Chair (Mr. Brian Riddell): Minister, thank you for your presentation.

We will now begin with questions and answers in a rotation of 15 minutes for the official opposition members of the committee, 15 minutes for the third party members of the committee, five minutes for the independent members of the committee and 15 minutes for the government members of the committee for the remainder of the allotted time. As always, please remember to make your comments through the Chair.

For any staff appearing today, when you are called upon to speak, please give your name and your title so we may accurately record it.

I will now start with the official opposition. I recognize MPP Gélinas.

M^me^ France Gélinas: Thank you, Minister, for the presentation. I will start with the comments that you made about community surgical and diagnostic centres that you have invested in, specifically for MRI, CT, cataract, GI, surgery etc.

My first question to you is, what is the total funding through the Ministry of Health and Ontario Health combined for the private, for-profit provision of medically necessary health care? And I would like it broken down as to how much you've invested and how much in facility fees are being paid to those, and if we could go back a few years so I could see how much more money is going to those facilities.

Hon. Sylvia Jones: As you know, community and surgical diagnostic centres have been operating in the province of Ontario for literally decades. When I first became the Minister of Health in 2022, we did an expansion of existing cataract surgeries in London, Kitchener-Waterloo and Windsor, and we saw a substantial decrease in the numbers of individuals who have been waiting for cataract surgeries as a result of those expanded opportunities. I want to be very clear: All of the services that are occurring, whether it is cataract or other diagnostic surgeries, are of course covered by your OHIP card.

The work that we are doing expanding into MRIs: I will say again, since 2018, we've actually had 49 new MRI machines approved in the province of Ontario, and they are being distributed across our hospital partners. Some of those machines are literally the first ones that have been allowed to operate in some hospitals in Ontario. Midland and Collingwood come to mind—

M^me^ France Gélinas: Can I remind you of my question, Minister? My question is—we're in estimates; I'm interested in how much money.

Hon. Sylvia Jones: I'm getting there.

M^me^ France Gélinas: If you have this at the top of your head, you will blow my socks off. I'm expecting one of the nice people behind you to come to the microphone and talk money, but I hope it happens fast.

Hon. Sylvia Jones: Thank you. So, as I said, the cataract surgery, we've already expanded; we're working now on the MRI and CT.

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

Ms. Deborah Richardson: Sure, and then, of course, you know I'll call up ADM Patrick Dicerni.

The Chair (Mr. Brian Riddell): Please say your name before you start.

Ms. Deborah Richardson: Deborah Richardson, deputy minister. Thank you for the reminder.

Ontario is making a significant investment: $155 million over the next two years to expand access to diagnostic services across the province. This funding will support the licensing of 57 new community surgical diagnostic centres, which, as the minister spoke to, will provide MRI and CT scans, as well as endoscopy procedures. This expansion will help 1.2 million people receive access quicker to publicly funded services, and it's a key part of the government's broader plan, Your Health—

M^me^ France Gélinas: When you say $155 million to expand, does that include the facility fees that are charged every time those private clinics do a procedure?

Ms. Deborah Richardson: I will turn it over to ADM Patrick Dicerni, who will introduce himself as well, so he can give the specifics.

Mr. Patrick Dicerni: Assistant Deputy Minister Patrick Dicerni; I'm the assistant deputy minister of the health programs and delivery division. Thank you for the question.

To answer your most recent question: Yes, the funding that the deputy minister referenced of $155 million over the next two years is part and parcel of the facility costs that will be paid to the new licensees within the ICHSC program for the provision of those services.

M^me^ France Gélinas: Do you put a limit as to how many procedures they can offer in a year or in a period of time?

Mr. Patrick Dicerni: Yes, we do. The relationships for the 57 new licensees that have been referenced are all a function of transfer payment agreements, with volumes that are set out in their transfer payment agreements.

M^me^ France Gélinas: Okay. So this is for the 57 new ones. We already had what used to be independent health facilities—the name changed. Is there any way to tell me how much money you used to spend? You can pick 2020, 2022, whichever dates you want, and show me the money that had been invested into what used to be independent

health facilities, which became community surgical and diagnostic centres, I think.

Mr. Patrick Dicerni: If you give me a moment—initial base funding: The increment is $155 million. With respect to the base funding of the previously known IHF program transitioning to the ICHSC program, I may need to take back that base funding amount for you.

Mme France Gélinas: Okay. If you find it quickly, let me know; otherwise, you can always send it to Ellen, who is really good at forwarding things to us.

When you talked about the community surgical and diagnostic centres, you talked about $155 million to expand. I would like to know how much money is in the existing—I mean, we had cataract surgery, we had independent health facilities before the name changed over. So I would like the total amount of money, including from the ministry, from Ontario Health, and including the facility fee going to those centres.

My next question has to do with staffing agencies. Minister, thank you for sharing how much you're investing in a new nursing school in Ottawa and the number of new nurses joining the province's workforce.

I would be interested in who keeps track of how much nursing staffing agencies cost our health care system over time and if it can be by sector—as in, how much in hospital versus long-term care. I know that in the House, you've mentioned a number of times that this number has come down. I would like to know what the number was and where it is at. Again, if we could go back a few years to see—basically, the mentions that you have made a number of times that those numbers are going down: what were they and what are they now, and by sector, if possible.

Hon. Sylvia Jones: The use of temporary staff for short term, for surges etc. is really an indication of individual hospital and long-term-care determinations. We have seen, anecdotally, a decrease, absolutely. We do track the numbers, as the individual hospitals track their numbers, to see how much they are wanting or deciding to use temporary health human resources. It's, of course, not necessarily limited to or exclusive to nursing, but we have seen a decrease.

I'm going to turn it over to Deputy Richardson for more specifics.

Ms. Deborah Richardson: Great, thank you. I will ask Dr. Karima Velji to come up, but I do have some quick statistics that I can give you.

As the minister spoke, it does vary from geographic region and nursing role, as you spoke to as well, MPP Gélinas. But hospitals decreased from 2.1% to 1.4%, which they've been doing—we've been out visiting them and hearing that they're spending a lot of time on retention and keep doing different things to keep their staff in place.

Mme France Gélinas: I called them nursing staffing agencies, but it's often more than nurses. The 2.1%: Is it specific to nurses or is it for all staff that come through a staffing agency?

Ms. Deborah Richardson: Dr. Karima Velji will speak to that.

Dr. Karima Velji: Dr. Karima Velji, chief of nursing and professional practice and ADM at the Ministry of Health. Thank you for the question.

1530

We are seeing a decrease in agency use in all our sectors, and it's because we are adding a net number of new staff to the system, with the education expansion that's under way, as well as the international nurses and interjurisdictional nurses that we are bringing into the system.

Just as the deputy said, for the hospital sector, from September last year to September this year, we've seen a reduction of worked hours provided by agency nurses from 2.8% to 1.4%. These are nurses—RNs, RPNs. We've also seen a similar reduction that MLTC can speak to, but we've also seen this in the long-term-care sector.

Mme France Gélinas: I'm interested in money. We're talking about estimates. You will see that all my questions will be about that. I'm happy you went from—you said 2.8% to 1.4%, but how much money are we talking about?

Dr. Karima Velji: We've just, as you know, tabled legislation, and the regulation is now posted for consultation about collecting information from agencies about their fee schemes, basically. So we will be starting to collect information about the money that people use for agencies. Having said that, as the hours of agencies decrease in the various facilities—and by the way, almost half of our hospitals don't use any agencies at all. As the hours decrease, the money that is being spent on agencies would also decrease.

Mme France Gélinas: Yes, I could do the link, but I'm interested in numbers. We don't know how much this 2.8% costs our hospital sector for RNs and RPNs. We just know 2.8% of nurses were agency, but we don't know how much it costs our hospitals. I have seen numbers before, so I would say check that.

Hon. Sylvia Jones: Chair, I know that MPP Gélinas knows this, but for clarity, it is obviously the hospitals that set those rates and remunerate. We are not the payer in that case. We can track the numbers, and we do track the numbers, and we are seeing, as has been raised, a dramatic decrease in the use of all agency, but we are not actually paying those amounts. Those are set and negotiated by the hospitals directly.

Mme France Gélinas: So the ministry doesn't keep track of—because the Ontario Hospital Association has put out numbers as to how much it costs the hospital system to buy agency nursing. But these numbers were never shared with you and you never checked it?

Hon. Sylvia Jones: We don't set the rates.

Mme France Gélinas: Yes, but do you ask the hospital association how much was spent on agency? You don't ask?

Hon. Sylvia Jones: What we do is, we give hospitals, as you know, an operating base amount and they make determinations about their local needs, ensuring that they have appropriate coverage. We do not set the rates for what they are paying their agency staff.

Mme France Gélinas: Okay. I'm not asking for the rate. I'm asking how much money did the hospitals spend on agency staff—how much money that you gave to the hospitals that the hospitals, in total, spent on agency staff.

The Ontario Hospital Association has put out a number. It doesn't share that with you, but it shares it with the world?

Hon. Sylvia Jones: I want to be very clear, Chair: We do not fund the hospitals to use agency staff. That is a local determination that they make based on their local needs. How they spend that base operating budget within parameters set by the Minister of Health is how they spend their dollars.

The Chair (Mr. Brian Riddell): I understand you've answered the question.

Mme France Gélinas: Okay. You've answered that.

My next question, then, has to do with primary care. I was happy that you started your presentation talking about primary care and the primary care action plan. I'm curious to see: What is the total cost of primary care services in Ontario over time? That would include coming from the Ministry of Health as well as coming from Ontario Health.

Hon. Sylvia Jones: Okay. I want to be very clear: The Ministry of Health and Ontario Health are the same, so there are not two separate funding lines. The funds that flow through Ontario Health are to implement the policies, the initiatives that the Ministry of Health set.

The Chair (Mr. Brian Riddell): One minute remaining.

Mme France Gélinas: Okay. So, how much money did we spend on community health centres, Aboriginal health access centres, family health teams, nurse practitioner-led clinics for primary care? And I would like those numbers for, let's say, the last five years.

Hon. Sylvia Jones: As the expansion continues, of course, we have made a commitment of $2.1 billion to ensure that all Ontarians who want a primary care practitioner have access to them. Those numbers are increasing as we bring on more primary care teams but also as we work with the Ontario—

Mme France Gélinas: But I'm curious to see what are those numbers that are increasing. I know they're increasing. I know that you are making announcements. What I'm interested in is, how much money have we spent? The number.

Hon. Sylvia Jones: OHIP billings?

Mme France Gélinas: No. How much money did you spend on community health centres, Aboriginal health access centres, family health teams, nurse practitioner-led clinics—

Hon. Sylvia Jones: So the total amount for primary care in the province of Ontario in 2024—

The Chair (Mr. Brian Riddell): Thank you.

We'll now move on to the third party. You will have 15 minutes. I recognize MPP Fairclough.

Ms. Lee Fairclough: Thank you all for coming to talk to us today about our spending in health care.

Just to comment on your remarks, Minister: I do appreciate some of the work that you've been doing in mental health. It's been nice to see the success of programs like OSP, where people can self-refer and get access to some services, as a good example.

I've got several questions that I'd like to try to get through in the 15 minutes. My first is really about the overall spending plan. I'm sure you've all seen the FAO report, as well, that did an examination of where that plan is going to take us. It's pretty stark, right? It says, basically, that with the current spending plan, we're probably short $3.2 billion for the 2025-26 year; we're short $6.48 billion for 2026-27 and $9 billion for 2027-28. That's just to maintain service. I say that in the context of Ontario being the most efficient in the country on so many measures, which they reiterated: the lowest per-capita beds in the country, the lowest cost per length of stay. We know that the FAO is saying, even with this plan, the number of nurses that we would be able to employ would decrease by 7,263 by 2027-28. That's jobs.

The conservative estimate from the FAO says that we need a minimum of a 4% increase to keep up with inflation and to keep up with the growth and need for service, just based on the population. This plan is a 0.7% increase. So I guess my question is, what is the scenario with a 0.7% increase where we won't be cutting services to live within this financial plan?

Hon. Sylvia Jones: What you see with the FAO report is a point in time where they are looking at the spending as of that time. I think that as you look at the investments that we have committed to, the investments that are ongoing—whether that is new HART hubs, whether that is additional nurses hired, physicians being trained and brought into the OHIP funding system—that you see an expansion that is appropriate for a growing and aging population.

I look at the FAO report as a, "This is as of today and it doesn't factor in the planning and the commitments that we have made as a government and as a ministry." For example, as you expand the number of medical seats in every single medical school, that is a funding commitment we have made that has not occurred yet, so that FAO wouldn't factor it in. So I look at the commitments that we have made and the onboarding, if you will, of new HART hubs, homelessness prevention hubs; of new medical seats in physicians, in nursing, in midwifery, in PSWs. Those are investments—and commitments, frankly—of a government that intends to have those individuals embedded and being compensated in our publicly funded health care system.

1540

Ms. Lee Fairclough: Then I guess my follow-up would be: You think that those things will be up and running sufficiently next year to achieve efficiencies of $3.2 billion. That is what the FAO is saying, right? That's what your response to me is: "We're going to adjust these things in our system and it's going to actually be the equivalent of $3.2 billion"—

Hon. Sylvia Jones: Respectfully, the FAO doesn't factor in—

The Chair (Mr. Brian Riddell): Let's not speak over each other, please.

Hon. Sylvia Jones: Apologies.

Ms. Lee Fairclough: Okay.

Hon. Sylvia Jones: Respectfully, the FAO doesn't factor in the funding commitments that we have made and put those into their report.

Deputy Richardson, I don't know if you wanted to add to that.

Ms. Deborah Richardson: I could maybe expand on that as well, because—

The Chair (Mr. Brian Riddell): State your name for Hansard, please.

Ms. Deborah Richardson: Deborah Richardson, deputy minister. You'll probably keep reminding me all along.

The minister is correct. The FAO—it is a point in time, so there are a lot of other things. Just to give you some examples about some of the projections around consolidated expansions that we have that the FAO wouldn't be exact on, there are the hospitals, including psychiatric hospitals, which is at $28 billion; OHIP, which is physicians and practitioners, at $21.2 billion—again, we are also including the physician services agreements and the other things that the FAO wouldn't have probably included; I don't know what his methodology is. The Ontario drug program is at $5.9 billion; community programs, at $6.8 billion; mental health and addictions programs, at $2.6 billion; and then other programs, including operating consolidations, at $20.6 billion; and then health capital, which also includes capital consolidations, at $2.5 billion.

There is a year-over-year growth rates and changes presented on the FAO website, but they're just not comparable to the estimates that I just wrote, so that's part of the challenge. When I was at Treasury Board, we always had challenges, because it is a point in time.

Ms. Lee Fairclough: Right. Fair enough. I guess, though, what I would say is that we're also hearing from hospitals that they're projecting a deficit of close to a billion dollars this year in hospital funding. Again, we know that for many, many years—probably eight to 10 years—we've been working in hospitals to make sure we stretched every dollar as far as we could. Certainly, labour agreements—often, we would have to find ways to pay for those agreements from within; 70% of those budgets are labour.

I look at the indicators that are in here. The hallway health care indicator is doubled from where it was. I can be more precise on that: It has gone from 709 to 1,435, since 2021 to now. To me, these are all the signs of places—and I know that people on the ground are delivering the care that they need to, to the best that they can, so I guess that's where I'm not feeling as confident as you, maybe, that we've got a spending plan here that's going to allow us to keep pace with the increasing demands for care that we need.

Maybe you could tell me what your thoughts are on how we're even going to be able to address that this year.

Hon. Sylvia Jones: Yes. Thank you for raising it. Specifically related to our hospital partners, for the last three years running, we have given almost a billion dollars in additional base funding to our hospital partners, which equates to approximately 4% per year for the last three years.

The work we are embarking on with our hospital sector now is to say, "What is your path to removing those deficits? What is your path to balance?" And I think it's incumbent on us as a ministry and a government to make sure we are directly working with hospital partners to make sure that patient care is protected, but that they are also looking at any opportunities that they have not previously considered, as they were receiving an additional almost-billion dollars annually for the last three years. That work just began. We asked for plans to be submitted in mid-September, and the work of assessing those to ensure, exactly to your point, that there is no impact to patient care is critical to the work we will do. And we will do that with our hospital partners, not impose upon.

Ms. Lee Fairclough: I would just go back to even your comments about what is or isn't the FAO report. This is a pretty stark difference between—you said 4% per year; 4% is what we actually need with a growing, aging population and more health care needs and inflation. In lots of areas of health care, inflation doesn't match what it actually is.

Even if there are some differences, this graph is pretty stark between the 0.7% to 4% increase. Again, I have to believe that organizations have been quite clear on driving to be as efficient as they can. We have the lowest number of beds per capita. We have the lowest spending per capita in the country. So, I don't think this is a matter of people not trying hard enough—and by a long ways too.

That's where I just want to push back a little to say that things are getting worse for people who are trying to get care, trying to get care in crowded emergency rooms. It's going to take some time. I'm pleased that we're moving on primary care. It's going to take some time for that to give some relief to our hospitals, so how can we be so certain with this projection, even if it's not the whole story from the government's perspective?

Hon. Sylvia Jones: I'm pleased to have this conversation with you, because I literally just arrived back last week from Calgary, where health ministers from across Canada came together. I can tell you, the bed-per-patient population is something that other Canadian jurisdictions see as a real advantage that is happening in Ontario because we have so many other opportunities and pathways for treatment.

The acute-care hospital system is absolutely critical to the health and welfare of Ontario, but so are all of the other initiatives that we are doing: having supportive housing in the province, having multi-year expansions of community care so that home and community care continues to expand and allows people who don't, frankly, need to be in a hospital bed—because they are finished their acute care part of their treatment pathway and are now continuing their recovery in home. I think that those are things that, while they may skew the numbers on per-bed hospital, actually tell a very positive story about how there is an

entire system that is there to protect and look after people through their treatment pathway.

We will continue to invest in those to ensure that not only our hospital acute-care bed capacity is available and ready, but also home and community and long-term care, all of the other pieces—supportive housing—that play an important role.

Ms. Lee Fairclough: Maybe then I'll transition to primary care, because I do agree with you that we need to build these things up in our system. The attachment to primary care literally fell off from where we were in 2018 to where we are today, and now we're putting some investments into it.

I know my colleague asked some questions about the size of the investment that's being made into some of the team-based models for this year, so my questions are: I'd be interested to know more specifics about how much will be invested in incremental new primary care service through those teams and, again, the proportion of the high-need postal codes that you think will actually have new attachments within this year as well.

Hon. Sylvia Jones: A couple of things—I'm going to try not to be political, Chair, but the member raised how it changed in 2018. Yes, it did. Previously, we had governments that were actually cutting medical seats in the province of Ontario, which has, frankly, led to some of the pressures that we are experiencing. Notwithstanding that, a commitment of $2.1 billion in expanding primary care access in the province of Ontario: Our initial rollout in February 2024 ensured that 78 new or expanded primary care teams—in some cases, nurse-practitioner-led teams; in many cases, multidisciplinary teams—78 in the first rollout—

Ms. Lee Fairclough: Sorry—78. And what was the cost with those? How much of the funding was associated with the first 78? Sorry to interrupt. I just wanted to make sure I got the numbers before my time runs out.

Hon. Sylvia Jones: The first round, in February 2024, was $110 million. Those 78 teams are now operationalized, hired, taking on new staff. The second round that you referenced was, actually, a little more specific to not just all of Ontario, but the Ontario regions that had the highest needs. We did a little bit of postal code. We also did some tweaking to make sure that in northern Ontario—because a postal code would, frankly, eliminate much of northern Ontario, so we tweaked a bit of the second round.

1550

The Chair (Mr. Brian Riddell): One minute remaining.

Hon. Sylvia Jones: We continue to see how those current investments are rolling out, and I have to say, we've seen primary care teams that committed to taking on 10,000 patients actually taking on more because they have that multidisciplinary approach.

Ms. Lee Fairclough: Just really quickly: I didn't see that measure in the material. I'm sorry if I missed it. Now that it's in legislation, will we be tracking that from now on with this?

Hon. Sylvia Jones: Yes, absolutely. The second round was 305 additional teams to attach approximately two million people, including more than $235 million in 2025-26 to establish and expand, again, approximately 130 additional primary care teams across the province, which will equate to 300,000 more patients. So, we are absolutely doing the—

The Chair (Mr. Brian Riddell): Thank you.

We will now move on to the independent member for five minutes. I recognize MPP Clancy.

Ms. Aislinn Clancy: I do appreciate that the ministry is making big investments in primary care. I know we've seen it in my riding. It has done a lot to address the wait times on Health Care Connect. We know there are a lot of folks who aren't on that list, so I look forward to more of that.

Also, our hospital investment in the Waterloo region is really needed. I appreciate seeing the expansion. We have an overcapacity hospital. I think our hospital is at between 110% and 120% capacity, and that really is felt by the people who try to use our hospital system.

The diversion is key. Hopefully, there will be more expansion to diversion, especially when it comes to people facing psychosis. We have a lot of great stuff for children and youth, but it would be nice to see folks who are facing these complex addiction and mental health issues have a diversion away from our emergency rooms.

You talked a lot about the staffing issues and your efforts to address them by having more doctors and nurses trained in the province. I have a family medicine satellite program in my riding, and I met with the students. They shared that because of the many hours unpaid for administrative work, 50% of the students in that program—just from my surveys of the first-year and second-year students—actually aren't going into family medicine. I know there are a lot of nurses that are leaving the practice or leaving the registration, to the tune of around 10,000 last year.

So, I'm just curious how you can improve the working conditions, maybe first for family doctors, especially when it comes to paperwork, investments in a centralized wait-list and movement to use better data management. I just called my doctor today, and I had on the answering machine, "Please send faxes."

I know that's a very long-winded question, but I know we can do better with our time, and we can do better to retain staff. I'm just hoping to hear you respond to investments in those areas.

Hon. Sylvia Jones: Thank you. Actually, it's a really exciting piece about how to make sure—back to recruitment and retention: what drives people to Ontario, what makes people want to stay.

Specifically, as it relates to the paperwork piece for our primary care providers, we embarked on a pilot project with the Ontario Medical Association and the Ministry of Health called AI scribe. It is essentially a program that allows that primary care clinician to be able to be present while there is the AI scribe happening and engage with their patient. At the end of the interaction, the AI scribe

spits out an assessment of the issues that were discussed. The initial feedback has been, frankly, phenomenal.

Not only are the patients embracing the fact that there is a program that allows the physician, the primary care practitioner, to be able to be engaged directly with the patient and not having to be typing over on the side, but the physicians have seen huge benefits in terms of literally hours shaved off their day because of the accuracy of the AI scribe program. I will give credit to the Ontario Medical Association for being willing to have that pilot project start, and I am very hopeful that we will continue to roll that out province-wide.

The Chair (Mr. Brian Riddell): One minute remaining.

Hon. Sylvia Jones: The investment in multidisciplinary teams is, frankly, part of that ability and assurance to make sure that—the example I always give is, Mrs. Jones just got diagnosed for diabetes. The physician, the primary care clinician, does not have 30 minutes or an hour to then spend and talk about the changes in lifestyle that that involves. Having a multidisciplinary team with our primary care teams means that there is a dietitian on the team who can literally walk that patient through the next steps. The same with mental health providers—

Ms. Aislinn Clancy: Can you speak of the wait-list? A centralized wait-list?

Hon. Sylvia Jones: Centralized wait-lists, specifically as it relates to primary care providers or—

Ms. Aislinn Clancy: Referrals to specialists—people are spitballing and wait-lists use up a lot of time trying to find somebody who is available, and we could do it better—

The Chair (Mr. Brian Riddell): Thank you.

We'll now move on to the government side for 15 minutes. I recognize MPP Dixon.

Ms. Jess Dixon: Thank you, Minister. In a past life, I was a federal prosecutor, and I worked in Guelph's Drug Treatment Court for quite some time. I can tell you that back then, having something like the HART hubs would have been incredibly helpful. We would screen people for entry and one of the things I would always look at was their housing and so on, because it's very difficult to pursue hope and sobriety when you don't have the supports.

As to the HART hubs, I wonder if you can speak a little bit more about a status update on their current status: where they are, where they are in the next few months. Also, what types of programs are they actually delivering to Ontarians?

Hon. Sylvia Jones: First of all, the 10 consumption sites that submitted and were prepared to transition into HART hubs were operationalized as of April 1. We also announced expansions, so depending on the community, we have different HART hubs in different forms of providing services.

I will give an example: In Barrie, we have now a HART hub that is mobile, used in a mobile system, that will ultimately be housed in bricks and mortar. But what we are seeing is, similar to multidisciplinary teams, when you provide all of the services in a centrally located location, what you end up seeing is that the individual coming in looking for help gets help, whatever they are needing at that moment in time. Today, it might be primary care; tomorrow, it might be support for addictions or mental health services. In some cases, it may be supportive housing, because to your point, when people aren't safely housed, it is really challenging to provide them any ongoing treatment and services. Ultimately, we see the HART hub model as being able to be used for employment support and services as well.

I think, for me, leveraging existing partners in a community who were already providing mental health supports, who were perhaps already providing social housing supports—bringing them all together in that HART hub model has been truly a game-changer for individuals who are being served. You're not simply giving them a phone number or telling them to go down the street for some other part of their treatment pathway; it's there to assist them.

As I said, the various HART hubs are in different pathways of readiness because some already have the supportive housing piece, some already had the addictions treatment piece, and some needed to build that up and have their partners build it up.

Ms. Jess Dixon: Thank you so much, Minister.

The Chair (Mr. Brian Riddell): I recognize MPP Pierre.

Ms. Natalie Pierre: Thank you, Minister, and to the team from the Ministry of Health for your remarks earlier today.

1600

Minister, earlier this afternoon, you spoke about the progress the government is making through the primary care action plan, transforming front-line care in our communities—including in my riding of Burlington, with funding that went to the Burlington Family Health Team, where those government investments helped connect thousands of people in my community to a primary health care provider; in this case, it was a primary health care team.

I'm just wondering if you could go back and tell us what the government is doing to make sure that all Ontarians, regardless of where they live, have access to primary care; what investments are being made to strengthen the system; and maybe touch on a little bit about the progress that you're seeing to date.

Hon. Sylvia Jones: There are many parts of the primary care expansion that I'm excited about. Obviously, a $2.1-billion investment really speaks to our commitment to make sure that every Ontario resident who wants one is going to have access to a primary care clinician. The initial round—and we talked about it previously—was Ontario-wide, and as you can imagine, because we have not had a call for expansion for primary care teams in many, many years, there was a lot of generated excitement and a lot of submissions to go through.

For the second round, as we narrowed it down a little to more targeted communities that we saw had a higher need

for attachment to primary care, again, we saw those applications and were able to review them very quickly, from making an announcement in June—and, as I said, those teams are now being operationalized, hiring and bringing on new patients.

One of the pieces that we did work on was Health Care Connect. I know there was a comment made about how Health Care Connect does not capture everyone who is actively looking for a primary care clinician, but I will say it does connect and find the individuals who are seeing the immediate need and wanting a connection to a primary care clinician.

So having and driving a change that says we're going to focus on Health Care Connect and make sure that people who have submitted their names—the work that was done over the spring and the summer connecting with every individual who is on that Health Care Connect list, making sure they were still actively looking for a primary care clinician, has led to a 50% increase from the number we started with in January to today.

Also, a side benefit is that because we are now talking about Health Care Connect more, we actually have more people signing up, so it has allowed us to very quickly match an individual who is looking for a primary care clinician in their community with a new or expanded primary care multidisciplinary team. So I think there has been an added side benefit of talking about how not only are we going to eliminate the Health Care Connect wait-list we started with in January, but more people are starting to understand what Health Care Connect can do and how they can assist them, and we get that matching with a clinician and a patient sooner.

The Chair (Mr. Brian Riddell): I recognize MPP Leardi.

Mr. Anthony Leardi: I have a question about pediatric care. I know that the government has added about $330 million annually to pediatric care services, and I know that has made a difference in my area, so I have a double or dual question for the minister. The $330 million that the government added annually to pediatric care: My first question is, what difference has that made and can we get some tangible examples of tangible results for children and families?

Hon. Sylvia Jones: Absolutely. I can tell you that from speaking to pediatric hospital leaders, the one comment that was made directly to me was that if we had not made that investment of $330 million in pediatric care specifically, the challenges that they would have experienced two winter seasons ago with RSV and flu would have overwhelmed their system. Because that enhancement and investment had been made, they were able to seamlessly deal with not only surgeries, but also ICU capacity.

Deputy Richardson, did you have some other examples you wanted to share?

Ms. Deborah Richardson: I could ask ADM Danielle Jane to come up, and she will speak.

I just wanted to expand, while Danielle is coming up, around—I set up a cadence, a meeting, with all the CEOs of the pediatric hospitals. They created a system—I think, before, there wasn't a system for peds, and then all of a sudden, they just were able to create that system. Danielle will maybe expand on that.

Ms. Danielle Jane: Thank you for your question—Danielle Jane, the assistant deputy minister for hospitals and capital.

As noted, the government has made historic investments of $330 million in pediatric health care. This began in 2023-24 and was annualized in 2024-25.

Echoing the previous comments made, my own personal site tours have really shown the results of this investment, particularly in the spring, when I went to the Children's Hospital of Eastern Ontario. This investment has not only supported the health sector, but it's also supported the Ministry of Children, Community and Social Services' programs for children and youth. Out of the $330 million referenced, $285 million was for the Ministry of Health and $45 million was for the Ministry of Children, Community and Social Services.

In terms of the specifics of the investment, it supported over 100 high-priority initiatives to ensure children and youth in every corner of the province continue to connect to emergency care, surgeries, ambulatory services, diagnostic imaging and mental health services, and we've already begun to see the results of that very rapid implementation. This also included $45 million per year to connect children and youth to mental health services across the province so they have the access to care when they need it and where they need it in their communities.

To get into some of the specific results, really focusing on 2024-25, I'm going to break it down into three main categories, the first of which is pediatric surgery. Ontario Health has reported that from June 2023 to December 2024, the investment allowed for over 22,000 additional surgeries to be completed. That same period, this allowed for over 71 additional surgical blocks that were opened and 119 staff that were hired with the pediatric recovery funding.

As of April 2025, the pediatric surgical wait-list was approximately 39% lower than the projections prior to the investment. The pediatric recovery investment has also supported initiatives that are really focused on reducing surgical wait times, focusing on areas where there are patients waiting for longer-than-recommended wait times. This is now projected to be 29% lower today than prior to the investment.

I would also like to highlight how our pediatric recovery investment is supporting surgical partnerships between specialty and community hospitals to enhance the expertise and capacity in community hospitals and to increase the number of surgeries that can be performed.

Through the Toronto regional pediatric community partnership model—partnerships between the Hospital for Sick Children and community hospitals, including the Scarborough Health Network, North York General Hospital, Unity Health, the St. Joe's Health Centre site, Trillium Health Partners and Michael Garron—collectively, we have created a system-wide approach to reducing the wait times for surgery and endoscopy, ensuring that children

can receive rapid access to the care they need in the most appropriate setting. Cases include urology; ophthalmology; orthopedic; plastics; dentistry; ear, nose and throat; and endoscopy.

Under this model, the team at SickKids has been supporting partner sites with education and training. Within this model, it has allowed for over 700 surgeries to be completed in these community hospitals in 2024-25.

Within the emergency department, in 2024-25, funding for the emergency department diversion clinics provided alternative care for children with minor illnesses and injuries. The emergency department diversion clinics contributed to a reduction in emergency department volumes in 2024-25 compared to the previous years, which improved both the efficiency and quality of care for children and families.

1610

There are six hospitals that received funding for this emergency department diversion activity through the pediatric recovery initiative. Within these hospitals, they experienced a 30% reduction in emergency department visits from lower-acuity pediatric patients in the first quarter of 2025-26, compared to the same period prior to the investment.

The Chair (Mr. Brian Riddell): One minute remaining.

Ms. Danielle Jane: This suggests that the diversion clinics are caring for a higher volume of lower-acuity patients, thereby alleviating the burden on emergency departments, allowing them to care for higher-acuity patients.

In terms of beds—the final point—the pediatric funding supported at least 26 additional beds, focused on pediatrics for continuing care, day programs and in-patient beds.

Thank you very much for your question.

Mr. Anthony Leardi: Thank you.

The Chair (Mr. Brian Riddell): Thirty-seven seconds left.

Mr. Anthony Leardi: I'll let it go.

The Chair (Mr. Brian Riddell): We'll now move on to the official opposition for 15 minutes. I recognize MPP Lennox.

MPP Robin Lennox: Minister, my question relates to public drug spending. We're one of the provinces that has yet to sign on to an agreement with the federal government for their Pharmacare Act. Can you recall for me how much public drug spending we have spent in the past year on diabetes medications and contraception?

Hon. Sylvia Jones: I don't have the numbers off the top of my head. I can tell you that Ontario leads Canada in terms of putting new pharmaceuticals on the Ontario drug plan once they have gone through Health Canada and pan-Canadian pharmaceutical.

MPP Robin Lennox: Thank you. Okay. We can shift gears, then—

M^me^ France Gélinas: Ask again who can give you the answer.

MPP Robin Lennox: Oh, yes. Sorry. Can you just let me know who does have the answer to that?

Hon. Sylvia Jones: I'm happy to pass it over to Deputy Richardson for more specifics. There are two other programs that we just recently announced, which will ensure faster access to oncology and cancer drugs, in particular. But Deputy Richardson, did you—

MPP Robin Lennox: These are fairly generic medications that have been on the formulary for some time. I'm not looking for new diabetes or contraceptive medications but just wondering how much we stand to save by entering into the agreement with the federal government.

Hon. Sylvia Jones: Well, respectfully, we would have to have a willing partner. Since Prime Minister Carney has come on as Prime Minister, there has been no outreach from the federal government to continue those conversations.

There has been some public musing from the Prime Minister to suggest that he would ensure the many provinces and territories who have yet to sign will be made whole, but as recently as last week, speaking with the federal health minister, there has been no restart of those conversations.

So, it's not because Ontario is not a willing partner; it is because there has been silence from the federal government.

MPP Robin Lennox: So sad that we missed out on that opportunity earlier. Thank you. I'll move on to another topic.

M^me^ France Gélinas: Do you want to ask how much money?

MPP Robin Lennox: Pardon?

M^me^ France Gélinas: How much money did we spend on contraceptive and diabetes medication?

MPP Robin Lennox: Do you know? We can circle back while you're looking for—

Ms. Deborah Richardson: I think ADM Dicerni has that information for you. We're just pulling it up for you.

MPP Robin Lennox: I'll ask my next question in the meantime—

Hon. Sylvia Jones: Of course, Chair, as we know, there has been no decrease in the amount, even though the federal government signed with some provincial territories and not others.

MPP Robin Lennox: Thank you. I'll move on to my next question while we're waiting for that information.

We spoke a little bit earlier about the funding for the HART hubs. My curiosity would be—I know how much has been committed, but I would like to know how much has actually been transferred to the agencies thus far to support the HART hub programming.

Hon. Sylvia Jones: As the HART hub lead organizations submitted their annualized budget, we are and have been working diligently over the summer to make sure that there was a consistency in approach in how much was being spent on supportive housing, how much was being spent on addictions treatment and mental health supports. That work happened all over the summer and—

MPP Robin Lennox: How much funding has actually been transferred now?

Hon. Sylvia Jones: Six point three—

Ms. Deborah Richardson: And divided by the 12.

Hon. Sylvia Jones: Yes, by the signed agreements, so there's 6.3 that has flowed.

MPP Robin Lennox: That's $6.3 million?

Ms. Deborah Richardson: Actually, I'll turn it over to Associate Deputy Minister Alison Blair, who has more specifics for you.

Ms. Alison Blair: Alison Blair, the associate deputy minister for health integration and partnerships.

The funding for the HART hubs has been transferred over to Ontario Health, who provides the amount, and will be given out to the hubs on a regularized payment basis.

MPP Robin Lennox: But my question is, how much has actually gone to the agencies now?

Ms. Alison Blair: Based on the funding agreements, it would depend on when they had operationalized services, and so the nine that opened soonest would have, since April, the regularized payments—

The Chair (Mr. Brian Riddell): Could you please speak closer to the microphone?

Ms. Alison Blair: Sorry about that.

The Chair (Mr. Brian Riddell): That's okay.

Ms. Alison Blair: The nine that opened on April 1 would have months of payments and the ones that are opening up—

MPP Robin Lennox: And how much is that, in terms of actual dollars?

Ms. Alison Blair: I don't have the numbers at my fingertips.

MPP Robin Lennox: Okay. But what was the $6.3 million?

Hon. Sylvia Jones: Once per year.

MPP Robin Lennox: Of course. But in keeping track of the monthly payments, you mentioned a $6.3-million figure. What was that referring to?

Ms. Deborah Richardson: That's how much each HART hub, once they're fully operational, will be approved. What the minister was referring to is, it's basically $6.3 million divided by 12, as soon as they're up and running. We did provide wind-down and start-up funding. That was provided. I don't have that number right at my fingertips to provide that, because it was really in terms of this fiscal year. We're talking about the estimates from last fiscal year.

MPP Robin Lennox: Gotcha. Okay. Do we have any sense about how much money has actually been allocated or spent in net new supportive housing beds through the HART hub model?

Hon. Sylvia Jones: So, breaking down the $6.3 million per HART hub organization into supportive housing, what piece—

MPP Robin Lennox: Yes, what is the net new supportive housing—not supporting operations of existing supportive housing for those agencies that were already offering it, but net new supportive housing beds?

Hon. Sylvia Jones: Well, the difference between the consumption sites and the HART hubs is literally a quantum of almost a six-times increase. It is because we are providing not only access to mental health and addictions treatments but also all of the other pieces that include supportive housing.

As we review each of those funding agreements, then the impacted agencies will come to us and say, "We planned to have X number of hours of mental health supports. We have X number of dollars set aside for primary care. We have X number of dollars set aside for supportive housing." Then the organizations will work with their local communities to see how quickly those—in the case of your specific question about supportive housing and the supports that come with it—are up and running. Do they have to be built? Do they have to be brought online? Does hiring have to happen? It literally would depend on each individual agency.

Please correct me if I'm wrong, ADM Blair.

Ms. Alison Blair: Just to be correct: Right now, we don't have any actual net new supportive housing beds funded currently.

Ms. Deborah Richardson: ADM Kyle MacIntyre has those specifics.

Mr. Kyle MacIntyre: Do I need to be affirmed? No? Kyle MacIntyre, ADM, mental health and addictions division.

Just to parse out your questions: What is the allocation for supportive housing related to the HART hubs? It's $1.31 million per hub, so 28 hubs—they get an allocation of $36 million-some-odd.

And then, what is the net new supportive housing units that are being brought on because of the investments related to the supportive housing side of the HART hubs? It's close to 900 units. I think that the tally is 895, so close to 900 new units.

Hon. Sylvia Jones: Which, Chair, is actually more than what was originally suggested when we announced the 28 heart hubs.

1620

MPP Robin Lennox: Those are projections, right? Because we actually haven't seen those net new supportive housing beds materialize yet. That's what you're hoping for.

Mr. Kyle MacIntyre: What the minister had said is that they're in different stages of rolling out, and that's absolutely right. We've had 185 clients using the supportive housing units right now. So they're up and running. They're rolling out.

The 900 units is based off of engagements with each of the hubs. We have to be able, as the minister said, to determine what the budgets are for them. They are in different localities. Some hubs have rental supplements; some don't. Each of those have to be negotiated and understood so we can finalize the budget with each of the hubs. The 900 number, or the 895 number, is based off of those discussions with each of those hubs about what they say can be brought online with the funding that's available, the $1.31 million.

MPP Robin Lennox: Gotcha. Okay.

I'm going to shift a little bit. Could you tell me how much has gone to Shoppers Drug Mart specifically for the MedsCheck Program last year?

Ms. Deborah Richardson: ADM Patrick Dicerni will speak to us on that.

Mr. Patrick Dicerni: I'm happy to address an earlier question that was asked that—well, my keyboard fell off my laptop while I was attempting to answer your question.

I believe the question was related to how much money does the Ontario public drug programs currently spend on diabetic supplies, medications and contraceptives. That figure—and apologies; this is not exactly how we parse our numbers in the drug program, but that number is between $1.5 billion and $1.6 billion annually.

MPP Robin Lennox: Okay.

Mr. Patrick Dicerni: An important nuance to your question, though, is that the drugs that were represented on the federal list, if you will, do not nearly encompass the totality of the drugs that the Ontario public drug program spends in both of those therapeutic areas.

MPP Robin Lennox: What would the difference be in terms of dollar—

Hon. Sylvia Jones: Chair, if I may, if we had signed off on the original proposal, we would have actually been providing less pharmaceutical and drugs to the people of Ontario.

MPP Robin Lennox: If I may clarify, though, you would have actually net been providing more, because there are lots of people who aren't accessing ODB formulary right now for those medications, because they don't qualify and can't afford it, right?

Do you have a sense, then, of what the net difference would be just for those who are fortunate enough to have coverage through ODB right now—what the difference would have been had those that were covered under the federal pharmacare plan been covered?

Hon. Sylvia Jones: No, because we have programs in the province of Ontario that actually allow individuals to have coverage that would not have been covered if we had signed off on the original program that the federal government was providing. Through the OHIP+, the Trillium Drug Program, ODSP, we have coverage for far more individuals than would have been able to be covered if we had signed off on the federal agreement.

Look, I'm happy to take Ontario tax dollars through a federal transfer program, but I want to make sure that it doesn't compromise in any way our existing offerings that we have for the people of Ontario.

MPP Robin Lennox: Just so I'm correct, a 30-year-old woman right now who wanted to access contraception and doesn't qualify for Trillium: Would she have gotten access to the program had you signed on to the federal Pharmacare Act?

Hon. Sylvia Jones: It's speculative.

Mr. Patrick Dicerni: Minister, I'm happy to respond. Our engagements with the federal government related to their expression of national pharmacare never progressed to the degree that we would be able to answer some of those detailed questions that you're asking.

To the minister's point, the nuances and contributions that are contemplated through programs like the Trillium Drug Program, for those who do qualify, are on a sliding scale. I appreciate the question; the precision of the answer was not something that we progressed beyond prior to the federal election.

MPP Robin Lennox: Gotcha. Okay. On to another topic—

M^me^ France Gélinas: Shoppers Drug Mart.

MPP Robin Lennox: Oh, sorry—the Shoppers Drug Mart figure you were going to get me.

Mr. Patrick Dicerni: I don't have at my disposal the exact amount of money distributed to Shoppers Drug Mart as a result of the MedsCheck Program. Over the past number of years, the MedsCheck Program has moved between an approximately $40-million expenditure to a $60-million expenditure. For reasons of access during the pandemic, where virtual meds checks were afforded to make sure that we were providing access to those who either couldn't, or couldn't safely, come into a pharmacy environment, we saw that expenditure increase to approximately $90 million.

The Chair (Mr. Brian Riddell): One minute.

MPP Robin Lennox: It's at $90 million now?

Mr. Patrick Dicerni: During the pandemic, we did.

MPP Robin Lennox: During the pandemic, okay. And sorry, what was it in the most recent year?

Mr. Patrick Dicerni: Approximately $55 million, but I don't want to give you an inaccurate number. If that is not precisely it, I will correct.

MPP Robin Lennox: Thank you.

My next question is, do you know how much in physician billings was declined due to the lack of a valid OHIP card, so a failure code of EH2?

Hon. Sylvia Jones: What we have been tracking is that 0.58% of submissions have been reviewed and some of those reviews take longer. I think the number at this point is less than 1% are not resolved within 30 days.

ADM Dicerni?

Mr. Patrick Dicerni: With respect to your question—

The Chair (Mr. Brian Riddell): Thank you.

We will now move on to the third party, and I recognize MPP Fairclough.

Ms. Lee Fairclough: For my next set of questions, I wanted to just come back to some of the hospital work for a second. Working capital for many of the hospitals, as you know, is completely decimated, which is often required to help fund some of the digital enhancements or other innovations that we need. I've heard, certainly, that enabling care digitally is also pretty important, but I also actually saw a reduction in the digital data and analytics program lines.

Considering this, considering the state of working capital in hospitals, considering some of the reductions reflected here, what is your plan to actually be able to continue to transform the way we deliver care digitally?

Hon. Sylvia Jones: We have been working a lot in the digital space, ensuring that not only primary care practitioners, our diagnostic partners as well as hospitals have that access more cleanly—we have done some pilots, in particular, in Niagara, if memory serves me correctly.

I'm going to turn it over to Deputy Richardson for more specifics.

Ms. Deborah Richardson: If I could just start with your question around the reduction in digital: Just for clarification, it's because it shows up in two separate places. It's not a reduction overall; it's just in 1403, and then 1416 is an increase.

Ms. Lee Fairclough: Okay, so it was just to pass through from one program to another.

Ms. Deborah Richardson: Yes. That's right.

Ms. Lee Fairclough: Okay. What is that going to be funding in this next year, more specifically?

Ms. Deborah Richardson: In the plan, we've got secure log-on for patient access, remote care management, Health811 and electronic health records. Those are all in those items.

Ms. Lee Fairclough: And will any of those things be used to help hospitals be able to continue to evolve digitally? Some of the other programs that we talked about recently at public accounts, like child and youth mental health—we desperately need to improve things digitally there, so we can also track data differently. Are you feeling that these investments are going to actually make a difference around that level of care?

Hon. Sylvia Jones: Absolutely. Our goal is to make sure that a patient has access to their own records, but also the ability to transfer between, as I said, a diagnostic to a hospital to a primary care clinician. The ability for us to do this type of innovation and, ultimately, hopefully move to central referral for specialists—all of that work is really tied in together to make sure that we have the ability to easily and smoothly, with patient support, transfer those records.

I don't know if Deputy Richardson wanted to add to the work that we're doing in the digital space.

Ms. Deborah Richardson: There are a couple of other pieces that I think are pretty important. We did speak at SCOPA last Monday around the work that the centre of excellence is doing around the data digital initiative for children and youth. There's that piece of work going on.

I think the other interesting piece of work that's happening is—we did refer to this around central intake and e-referral. There's quite a good uptake, actually, so far as we're starting to get family docs and—I think I had a statistic here a little bit earlier that was pretty impressive, actually, around the uptake from specialists and family docs. Now we're really focusing in on adoption and making sure that—because you can have a system, but if people aren't using it, it's useless, right?

1630

Ms. Lee Fairclough: If I can interrupt for a second, this is where I'm worried on the hospital side, because I think we've often relied on them as partners that find ways to be able to participate. But if working capital is in such rough shape, are we going to be able to rely on them to participate in the same ways?

Ms. Deborah Richardson: That's part of the work. I will turn it over to Associate Deputy Minister Catherine Wang to speak a little bit about the work that she's been doing at the hospitals.

Ms. Catherine Wang: Thank you—Catherine Wang, associate deputy minister for clinical care and delivery.

I do think we're starting to have hospitals organize themselves a little bit differently now on digital, knowing that they have some pressure on working capital. Ontario Health is now really creating more regional perspectives around how hospitals participate in digital initiatives. We're still expecting to see the themes that come through from hospitals on this, as well as the provincial priorities that the deputy and minister have already laid out.

Ms. Lee Fairclough: Okay. I hope they will be able to do it.

I'm going to move on to my questioning. I did want to ask about the surgeries that are funded in an ambulatory environment versus in a hospital. Initial requests for information show that the rates could be close to three times more than what a hospital would be paid to do the same surgery. Certainly it's been emphasized this is all OHIP dollars, so that's good, but as a taxpayer I don't really like paying three times more for the same care. I'm buying this pen and I pay either $3 or $1; I'd rather pay $1.

So I'd like to know a little bit more information on what is the difference, the extra that we're paying to those providers in those community environments versus hospitals. And again, how are you planning to make up for the fact that hospitals ultimately, then, will still need to care for some more complex patients in hospitals? This is a priorities choice for me about why we would choose to spend so much more for the same care.

Hon. Sylvia Jones: I think it's a longer conversation that really talks about, do we have existing capacity or can we add capacity by enhancing what we already have in community, which is the surgical and diagnostic centrepiece? As we allow and expand in community, we give that patient, frankly, some flexibility in terms of perhaps having the surgery faster—

Ms. Lee Fairclough: I don't argue with any of that, Minister. I'm sorry to interrupt. I don't argue with any of that. I feel if we can care for somebody outside of a hospital setting and it's better for them, I'm there.

I am very confused why we pay three times more for something with taxpayers' money. That's where I completely disagree with you on this issue. Why not create a level playing field for both, see if we can do it for the same price?

Hon. Sylvia Jones: The difference is that hospitals are not funded by the procedure or the patient that walks through their door—

Ms. Lee Fairclough: Oh, we get procedure funding for surgeries, I believe—sorry to interrupt.

The Chair (Mr. Brian Riddell): Let her answer the question, please.

Hon. Sylvia Jones: —whereas a surgical or diagnostic centre in community actually, as ADM Dicerni mentioned earlier, has a set number of procedures that they are allowed to perform in any given fiscal year, and we fund them accordingly.

We do not do that for hospitals because, frankly, a small northern hospital would never be able to have the same kind of formula to ensure, as a patient walks in, that they get funding. They need to be operationalized and serving their community 24/7. So we fund them as a block fund to ensure all of the services that they provide at any given time are available to them. It's not done per procedure.

Ms. Lee Fairclough: No, no—for some of the procedures we're talking about, I think in these clinics they are quality-based procedures; they're funded on a volume basis. There's a rate, so—

Hon. Sylvia Jones: QBPs are not the same as—

Ms. Lee Fairclough: For cataracts etc., it's all volume funded. That's why I am pushing a little on this, because I think it's a really important point. I just want to know what's the incremental cost more to doing it in those environments than what we would be expected to do in a publicly funded hospital.

Hon. Sylvia Jones: I'll turn it over to ADM Dicerni.

Mr. Patrick Dicerni: Thanks, MPP Fairclough. Apologies—I'm not sure exactly where the three-times-the-cost figure is coming from. I don't have that at my disposal. But what I can tell you is that—and this is in the public domain in terms of how we have administered or are moving through the administration of the calls for application for ICHSC licences. And this does touch on an earlier question that was asked by MPP Lennox, I believe. For a unilateral hip, we will be compensating the facility costs at $6,530, and for a unilateral knee replacement at $5,797.

Ms. Lee Fairclough: How different is that than what you would be compensating hospitals for the same work?

Mr. Patrick Dicerni: I would want to defer to my colleague ADM Danielle Jane with respect to the comparability. But what I can tell you is the group of experts that we convened to work through both what is appropriate clinical procedures to go on in these facilities as well as the pricing was entirely informed by current QBP rates.

Ms. Lee Fairclough: And things like cataracts—you would have no difference in what you'd be paying for cataracts today either? Maybe you can comment on that too.

Ms. Danielle Jane: Thank you for your question.

To drive a bit more into specifics on the hip and knee example, we were very deliberate in actually aligning the pricing in the ICHSCs with what a hospital would receive. We also took it another layer deeper in terms of actually adjusting the price. Right now, a hospital is a combined inpatient and day surgery price. For the ICHSC, we just do the day surgery case costing to leverage the price. We did our best to keep it aligned but also reflect the nuance of the population that will be less complex in that environment.

Ms. Lee Fairclough: And every provider of these services is getting the exact same rate and there's no additional funds that they're getting for facilities or anything beyond this?

Mr. Patrick Dicerni: Correct.

Ms. Lee Fairclough: Okay, great. Thank you. And then maybe you can come back on the cataracts—

Mr. Patrick Dicerni: I should reference that, in both the hospital environment and the community surgical environment, the professional fees paid to the physicians will be billed directly to OHIP, as is a matter of course in the hospital world. So that's a wash.

Ms. Lee Fairclough: Yes. That's the same, but it's good to know these numbers. I'd be interested to know if there's been any difference in cataract negotiated rates as well, if we can come back to that.

Can I move to another question? I think I still have some time.

The Chair (Mr. Brian Riddell): You have three minutes and 46 seconds.

Ms. Lee Fairclough: Maybe I will ask it quickly. I am interested to know, in these numbers, what's the total that's through a federal transfer that would be accounted for in here at a high level? I know we talked about it in detail yesterday on mental health. Also, which are the key performance measures that are tied to that federal transfer portion?

Hon. Sylvia Jones: It's very timely because we were discussing this at the Calgary first health ministers. Ontario's Ministry of Health, not including long-term care, is $87 billion, and the health transfer back to Ontario is $21.332 billion.

Ms. Lee Fairclough: Great. What metrics is that tied to and are they in this book?

Hon. Sylvia Jones: Well, that's a great question. I would like it to be 40% because Ontario is 40% of the population.

Ms. Lee Fairclough: No, no. Sorry. What are the actual outcome metrics? They are giving us $21.3 billion, so what's our commitment back through the mental health plan, home care etc.? What are we required to deliver for that money?

Hon. Sylvia Jones: We must maintain all of the services as stipulated through the Canada Health Act, and if there is any diversion, then the federal government has the right to claw back a percentage.

I'm proud to say—and Deputy Richardson is going to correct me if I'm wrong—to date, Ontario has never had a clawback.

Ms. Lee Fairclough: Great. Can you just remind us, Deputy, about the proportion of the mental health funding that's coming through the federal transfer program? That includes some of the HART hubs, I believe.

Ms. Deborah Richardson: That was $1.9 billion and that does expire March 31, 2026. Maybe I could just speak about some of the priorities under the federal health transfer:

—improving access to primary health care;

—improving the supply of health care workers and reducing wait times for surgeries;

—improving access to mental health and substance use services;

—modernizing health care information systems; and

—helping people in Canada age with dignity, close to home, with access to home care or a home in a safe long-term-care facility.

CIHI monitors this in terms of how the provinces and territories are doing in this space.

Ms. Lee Fairclough: How they're doing in meeting their requirements—that's good to know.

The Chair (Mr. Brian Riddell): One minute remaining.

Hon. Sylvia Jones: And I think it's really important to highlight that that commitment of mental health dollars was a 10-year commitment; Ontario matched it, which was the $3.8 billion in total. But that 10-year is coming to a close—sunsetting—and there, again, has been no signal, as recently as last week, that they're moving forward on extending that program.

Ms. Lee Fairclough: Hopefully they will, given the need for mental health services—there's no question.

My last question really is about the HART hubs. Chair, have I still got some time?

The Chair (Mr. Brian Riddell): Twenty-four seconds.

Ms. Lee Fairclough: Twenty-four seconds? I'll leave it there. Thanks very much.

The Chair (Mr. Brian Riddell): I'm going to call a 10-minute break. It's 4:41. We'll return at 4:51.

The committee recessed from 1641 to 1650.

The Chair (Mr. Brian Riddell): If everyone would take their seats, please. We're back in session. We'll go to the independent member. I recognize MPP Clancy.

Ms. Aislinn Clancy: Hi, there. I do appreciate the investment in our addiction services. I know we're trying to do more in outpatient care. I have seen two of the four youth addiction centres closed. I know the centres were hoping to divert money into outpatient and keep that funding locally. The not-for-profit in my area had a closure and lost all the funding for the youth addictions; meanwhile, we see a rise.

I have a statistic that in-patient treatment wait times to get help have expanded from 44 days in 2021 to 253 days. When I talk to folks who are working on the front lines, for lack of a better term, in the opioid crisis that we're facing—and we're hopefully going to get a strategy there—trying to get folks timely referrals and admissions into in-patient treatment is essential.

Can you speak to what we can do to address these ballooning wait times to get into in-patient addiction treatment?

Hon. Sylvia Jones: It's a really important issue to raise. In terms of access to in-patient care, obviously, the work that we're doing on the youth wellness hubs is to try to get some preventative pieces and some prevention there. The 38 youth wellness hubs that we have started across Ontario—we're seeing really good results to make sure that people, before they get heavily addicted and need that more intensive in-patient treatment, can get that access.

I'm going to turn it over to Deputy Richardson to speak to more specifics on the in-treatment expansions that we're working on.

Ms. Deborah Richardson: Sure. I'll invite ADM Kyle MacIntyre to come up. But there has been an announcement through Roadmap to Wellness and some of the other initiatives around an increase of 500 new beds into the system, so that will start to address wait-lists.

I will invite ADM McIntyre to potentially expand on that.

Hon. Sylvia Jones: Including, if I may, in northern Ontario, some very specific land-based treatment options that we have been able to operationalize that did not exist previously. That was working very directly with First Nations partners—working with them on the proposals of how they would like to see addiction in-treatment in community.

Mr. Kyle MacIntyre: In terms of the comment about the strategy, overall, the Roadmap to Wellness is the government's strategy for mental health and addictions. One of the key areas of it is around building a full-care continuum that will address some of the bed-based issues that I think you're talking about.

The government has made a number of investments through different programming. Annually, it spends about $370 million on addictions. The minister has already spoken to some of the aspects of the youth wellness hubs, which is targeting transitional-age youth from ages 15 to 25, with a number of youth who have already been served so far through that. As part of the youth wellness hub model, it offers access to primary care, which includes opioid agonist therapy, so helping folks who might have an addiction issue or substance use disorder, that they can access those types of services through the youth wellness hubs.

There are also other investments that the government has made, both through the Roadmap to Wellness funding, but you also might be aware of the addictions recovery fund, which is an initial investment of $90 million over three years that was announced in February 2022. That was renewed in 2024 for an additional $124 million over three years. Through the investments to that, there have been over 500 bed-based addictions services added for that. Now, the Ministry of Health funds over 2,100 addiction services beds across the province at an annual cost of over $137 million each year, and 230 of the new addiction beds have been added in northern Ontario, as the minister had mentioned. Those beds go towards different service types like withdrawal management beds, other types of supportive-related beds and things like that.

So, there has been a series of investments associated with more of the bed-based care that you've been talking about.

Ms. Aislinn Clancy: I'm hoping you could also speak to specialized hubs of care—the folks in my community whose children have Down's syndrome, for example. I know, with women's health, having somebody who specializes in these areas—will we see any teams added to specialize in things like Down's syndrome and women's health?

Hon. Sylvia Jones: I think you're probably more appropriately directed to MCCSS.

Ms. Aislinn Clancy: No, like—for example, with women's health, we have very limited access to menopause care. It takes a long time to get to the services, and they're not spread consistently across the province. For my middle-aged-women cohort of friends, a lot of folks are

feeling the impact of menopause, and access to menopausal care—just as one example of women's health issues that are not fully addressed in our current system.

Hon. Sylvia Jones: Because we are so seized with enhancing and access to primary care, we don't have a specialist particularly for many individual illnesses. We want to make sure that the primary care clinician piece is there to support through whatever journey we happen to be on.

We've had some conversations with the CPSO to make sure that primary care clinicians are appropriately trained to be able to see whatever illnesses come forward. But the ability to have that primary care clinician be part of the entire treatment pathway is really important and why we focus that expansion specifically on that.

Deputy Richardson, am I missing anything—

The Chair (Mr. Brian Riddell): Thank you for your time and comments.

We'll now move to the government side. I recognize MPP Jordan.

Mr. John Jordan: Minister, as you know, it's very important that when people need a physician, they have access to a physician. I know this government is doing more than ever to increase access to physicians. It is a success story that is truly made in Ontario, the strategy.

Can you please shed a little light on how this government is expanding medical education in Ontario and how the expansion is progressing?

Hon. Sylvia Jones: Absolutely. Thank you. Every single medical school in Ontario has had access and additional funding to expand the number of medical seats available to them. But we've gone beyond that. Of course, TMU in Brampton—a brand new medical school—accepted its first 96 students in the fall, but there are also programs that we have started that, frankly, perhaps haven't had as much fanfare. I would point to a partnership between Queen's University and Lakeridge Health, where 20 students who know from the get-go of their medical education that they want to practise in family medicine—I think this is the third year running—are training specifically with a partnership to have their specialty in family medicine. That program has now been in place for three years. I can proudly tell you that the interest and uptake and applications have exceeded expectations. That program is another example.

The Practice Ready Ontario Program: again, a relatively new program for Ontario. Last year, we had our first 100 participants. The Practice Ready Ontario program allows individuals who trained in international countries to be able to come to Canada and Ontario and more quickly integrate into the Ontario health care system in exchange for a shorter time period for their assessments, which involves a lower cost. In exchange for doing that, they agree to practise in underserved communities.

1700

This comes back to a conversation we had earlier about how we make sure that as we train and as we welcome new practitioners to the province of Ontario, we're actually making sure they are going to communities that are in high need. As I said, it's a relatively new program, and I'm sure Dr. Karima would like to speak to it more. They are literally welcoming physicians and primary care physicians into communities that haven't seen an increase in their primary care practitioner load in, in many cases, decades.

Deputy Richardson or doctor?

Ms. Deborah Richardson: Maybe I'll start just to build on some of the things that the minister shared.

We're already seeing the impact of this historic expansion, with the first 60 expansion positions filled in July of 2023, 76 in 2024, followed by 140 more in 2025. In 2025, there are a total of 1,464 ministry-funded postgraduate entry positions, and we're forecasting that a further 102 positions will be added in 2026, which will bring us to a total of 1,566. This represents a total increase of 378 positions over three years towards the 551. That's the position target, meaning close to 70% of the new positions will be implemented by 2026.

Ontario's physician supply and specialty mix are critical elements within, obviously, the broader health human resource strategy aimed at growing and enhancing our health workforce in the shorter and longer term.

I now will turn it over to Dr. Karima Velji, who is our chief of nursing and professional practice division and assistant deputy minister. She will talk to you a little bit more about our medical expansion within the context of our broader HHR strategy.

Dr. Karima Velji: Thank you so much, Deputy. I'm Karima Velji, chief of nursing and professional practice and assistant deputy minister responsible for the HHR files at the ministry.

As you've heard, our efforts to grow the physician workforce through the expansion of medical education are part of Ontario's HHR strategy that tries to foster growth and increase HHR capacity across the health system in meaningful ways. We have a very robust HHR strategy. We are not leaving any stone unturned to create the capacity that we need to serve the population today but also the population in the future.

Our strategy has four pillars in it. It's comprehensive.

Pillar 1 is education expansion and clinical supports. It is where our medical school expansion component is found. There is an equal expansion under way on the nursing side, and we have a big allied health expansion as well. This is intending to create the domestic workforce that we need for the future.

Pillar 2 is expanding the scope of practice to allow Ontario's highly trained health workforce to work to the full extent of their expertise. You may have heard of the pharmacy minor ailment program, the RN prescribing program, the nurse practitioner scope of expansion. All of those scope of expansion components fall under this pillar. As you know, we are now consulting on a big scope expansion that actually involves allied heath care practitioners.

Pillar 3 aims to expedite pathways for internationally and interprovincially educated practitioners by unlocking opportunities for health care professionals from within

Canada and internationally who want to work in Ontario's health care system.

I wanted to acknowledge here that we are at the forefront of the country in the work that we are doing around expediting pathways. The Practice Ready Ontario initiative that the minister cited is one such initiative. But Ontario is the first province that has implemented the as-of-right legislation for interjurisdictional practitioners and is now moving to automatic recognition of licensure for physicians and nurses.

Finally, pillar 4 supports the retention and distribution of health care professionals to areas that are in most need.

Collectively, through this strategy, we are taking bold and innovative action to connect more people to care by growing Ontario's health care workforce. Medical education expansion, first announced on March 15, 2022, is moving forward alongside the growth of other health care professionals. I mention them as any expansion of the physician workforce can only be successful as part of the expansion of the entire health workforce. We have a team-based care orientation to growing our health workforce.

That's why we are working with colleagues at the Ministry of Colleges, Universities, Research Excellence and Security, MCURES, to expand other areas of the workforce. It is why we've added, as many of you know, 3,000 nursing seats to the health system. This will build on over 100,000 nurses we've added to the system since 2018. We have doubled the number of provincially funded physician training seats, as well as physician assistant training seats, to 104 between 2023-24 and 2024-25.

Also, the allied health expansions, as I said, are under way with 700 net additional seats in the system. As these providers graduate from the system, they will be critical to adding capacity to deliver health care services in a number of key sectors across the system, including hospitals, primary care and community care sectors. As you've heard from the deputy, we are about halfway through the implementation of the post-graduate medical school seats, and we've birthed a new school, the Toronto Metropolitan University medical school.

Perhaps we should take a step back and be clear on what it takes to be trained to be a physician in Canada. After high school and a four-year baccalaureate degree, individuals wishing to train to be a physician will need to undertake a four-year undergraduate Doctor of Medicine degree, and a post-graduate degree that can vary between two years, for example for family physicians, and eight years for something like pediatric surgery where actual subspecialty training is required.

One of the principal areas of funding relates to post-graduate medical training spots offered every year in Ontario's medical schools. Prior to the expansion in 2022, Ontario funded 1,188 postgraduate spots every year. Once all the expansion seats have been added to the system, by 2028, there will be 1,739 seats offered in Ontario. This represents the addition of 551 seats, or an increase of around 46%. These are postgraduate seats. As you know, MCURES, the Ministry of Colleges and Universities, looks after the undergraduate seat component of this expansion.

In terms of the progress made to date, as the deputy has remarked, we are forecasting a total of 1,566 seats for the 2026 CaRMS match. This is the residency match that has now started where medical students and residents will be selected for the 2026 academic year. This represents an increase of 31% of our 2022 total.

It's also important to note that the key area of focus for this medical education expansion is the training of family physicians in support of increasing primary care capacity in the province. As such, 340 of the 551 seats, or just over 60% of the seats, will be dedicated to family medicine, with the other 211 seats to other specialties, such as emergency medicine, pediatrics and other specialties. We are working to ensure that postgraduate medical school seats are distributed across all medical schools to support workforce growth across the province and do what is needed.

1710

These postgraduate learners or residents not only make a significant contribution to the provision of health care services while they are learning, it's also hoped that, by learning in a given area, they are more likely to remain practising in that area once they have been licensed by the College of Physicians and Surgeons of Ontario. As such, the distribution of our expanded medical seats includes all of the existing medical schools and TMU.

I wanted to just share with you the breakdown of seats for our medical schools: 50 positions will go towards McMaster University; 50 positions at the University of Ottawa; 52 at Queen's University; 63 positions at NOSM, the Northern Ontario School of Medicine University; 50 positions at Western; and 67 positions for the University of Toronto. It will also include 117 positions for the TMU School of Medicine, which, as the Minister said—

The Chair (Mr. Brian Riddell): One minute remaining.

Dr. Karima Velji: —recently opened in July 2025, as well as the planned 102 seats for the new school at York, which is devoted to training residents in family medicine and primary care practices.

When operating at full capacity, the new TMU School of Medicine in Brampton will have 94 undergraduate seats and 117 postgraduate entry positions. It will expand Ontario's pipeline of highly skilled physicians and help protect the province's health system for generations to come. Expansion will also support existing efforts to expand interprofessional primary care teams being pursued through the Ontario primary care action plan.

As part of the 2025 Ontario budget, the government is also—

The Chair (Mr. Brian Riddell): Thank you very much.

We'll now go to the official opposition. I recognize MPP Lennox.

MPP Robin Lennox: I'd like to ask about the goal to end hallway health care. In the briefing materials, we saw that our baseline number of patients receiving care in a hallway went up from just over 700 in March 2021 to over 1,400 in March 2024. You had a target of zero patients in

hallways as of March 2025, and I'm sure you know that that target wasn't met. I can certainly attest, having worked on hospital wards recently, that there are plenty of patients in hallways.

If we weren't able to achieve that target with the 4% annual budget increase that hospitals were receiving prior to this, how do you see us able to achieve a target of zero patients in hallways if we're only going to squeeze 0.7% for hospitals, which will likely result in their service restrictions, as they've said?

Hon. Sylvia Jones: I think there are a couple of pieces that very actively speak to ensuring that we end hallway health care. One, of course, is the almost $60 billion in capital infrastructure, whether that is new hospitals—expanded, renovated hospitals—across the province of Ontario; almost 50 projects in total. But I would also point to our work that we're doing with alternative level of care within our hospital partners, working very directly with the Ministry of Long-Term Care, ensuring that individuals who are in a hospital but not in need of an acute-care bed can continue their transition to either a long-term-care-home facility or, through investments that we've made, most recently this week—Minister Bethlenfalvy and I announced an additional enhancement to home and community care of almost $1 billion. We've already seen numbers of individuals who are waiting for home and community care decrease, as well as, of course, the access to it.

I would also point to programs that we've put in place called the Dedicated Offload Nurses Program, working directly with our paramedics in community paramedicine—again, making sure that individuals who are at higher risk in community are getting those touch points from paramedics so that they don't end up having to come to an emergency department and ultimately get readmitted. Those types of programs are very much something that we have been working on directly with hospitals, municipalities and paramedics. Many of them, frankly, are directly as a result of them supporting and coming forward with ideas.

The last one I would speak to very quickly is a hospital-to-home program. That, again, with this week's announcement and the imminent fall economic statement, will see an enhancement for additional hospitals to be able to offer that service. I'm particularly pleased with it because not only does it speak to having individuals being able to leave the hospital but, equally important, making sure that in those critical next 30 days, they're not having to be re-admitted through emergency departments.

MPP Robin Lennox: I think you raise a lot of important points about how we would reduce hallway health care—certainly, addressing the number of ALC patients, increasing the number of long-term-care beds, right-sizing our hospitals to actually meet the in-patient capacity. I just don't see any of that accounted for in the budget.

When we look at the long-term-care beds, you've only created 1,800 new long-term-care beds since you've been in government. The goal was 30,000 over 10 years. We're not going to meet that whatsoever. As a result, for every 1,000 Ontarians over the age of 75, we're only going to have 56 long-term-care beds in 2027-28, compared to 60 per 1,000 currently. That's certainly not going to relieve the pressure on our ALC folks in hospitals. Similarly, with these budget restrictions, we're going to see, likely, a decrease from 220 funded hospital beds per 100,000 Ontarians to 203 funded hospital beds per 100,000 Ontarians.

I think we're just at a point where, unless we're investing to actually right-size our hospital in-patient units or actually creating those long-term-care spaces, we're not going to be able to realize this vision no matter how good the proposed models are if they're not actually materializing. The people that we care for are still going to be sitting in hallways.

Hon. Sylvia Jones: I will turn to Deputy Richardson to speak to the investments we've already made in home and community care. We have seen not only a decrease in the amount of time it takes to access the home and community care, but also an increase in the number of individuals who are accessing those services.

Again, it comes back to this: We are not just looking at hospital beds; we are not just looking at long-term care beds. I think this is the third billion-dollar investment in long-term home and community care. We are making sure that people who can safely and want to continue the recovery at home can do that.

Deputy Richardson, can you add—

MPP Robin Lennox: I appreciate that answer. Just on the access to home care services, just to provide a small clarification: The wait time from community to first home care service after a discharge in March 2019 was six days. It then went up to seven days under your government, and now we're back to six as of March 2025, or at least that was the target. So we're sort of aiming for where we started, in many ways.

How would we consider that to be an improvement in access to home care when, for example, in those six days, if we're seeing a patient with dementia discharged after a stay in hospital, there are extremely high rates of readmission to hospital in that first week if they're not getting access to home care. What would be a target value that you're aiming for in this coming year to actually improve those results?

Hon. Sylvia Jones: All of the programs together are really about ensuring that access and ensuring that fast turnaround. But deputy Richardson, can I ask you to get into more specifics?

Ms. Deborah Richardson: Certainly. Hospital to home actually has quite a different model as well, but I will ask ADM Rhonda McMichael to come up and give you specifics on your home care questions.

1720

While she's coming up, I did want to give you some facts around some of the expenditure changes that we've made around increases. The hospital sector investments: We provided an additional $1.678 billion. Alternative level of care and patient flow investment—as you were speaking about, that's the biggest piece—was $133,500,000.

Then women's health investments, as well—I just wanted to add that line item.

Rhonda, maybe over to you, if you could introduce yourself and then speak to some of the statistics and data that the MPP was asking for.

Ms. Rhonda McMichael: Yes, absolutely. Rhonda McMichael, assistant deputy minister of strategic partnerships at the Ministry of Health.

Just to answer specifically your question around wait times: The reason that we have wait times for home care, the reason that we're introducing new programs like hospital-to-home is to address exactly things like that. Now we have hospital-to-home at 47 sites across the province, and with the expansion that was announced yesterday, that will increase the sites across the province quite significantly.

We already have really good data from the hospital-to-home program, which used a dementia patient as an example. That would be one of the patients who would be transitioned home with supports, and the supports are within zero to three days, so sometimes it's same-day. That's exactly one of the purposes of the care that we're looking to provide and the targets that we're hoping to reach.

There are lots of efforts around the modernization of home care, to look at how we can bundle care for specific patients, so that it's very much more tailored to their needs and that we can address things like wait times.

MPP Robin Lennox: Fantastic. Thank you.

One of the other things I know is important in the community is, we're just coming off the largest measles outbreak we've seen in modern memory in Ontario. Our public health units haven't seen a significant base increase in funding in many years. One of the strategies that was used to increase vaccine uptake during the COVID-19 pandemic was the vaccine ambassador program. That funding ended in December 2023.

Do you foresee any increase in our public health budgets moving forward for specific programs like vaccine ambassador programs to try to increase uptake of early childhood vaccines, which are currently about 20% below target when we're thinking measles specifically?

Hon. Sylvia Jones: As you know, the Chief Medical Officer of Health, Dr. Moore, has declared that the measles outbreak has finished in the province of Ontario.

We have committed and publicly shared with our 28 public health units that they can expect an increase in their funding every year. We have also embarked on some work through the Chief Medical Officer of Health that I personally think is very important, and that is working directly with the public health units to make sure that provincial priorities are the focus of public health units, precisely because of the issue you raise.

As we see emerging issues nationally or internationally, we want to make sure our public health units are focused on the health of their communities but also on provincial priorities, because we saw, frankly, through the pandemic that when public health units worked very specifically on provincial priorities, we had very good outcomes.

I think that as assessments have been made, Canada fared very well. I think it was second only to Japan in terms of protecting their populations. That speaks a lot, frankly, to our public health units making sure they focus in on provincial priorities and getting that work done.

Deputy Richardson, I will turn it over to you if you have any further details.

MPP Robin Lennox: I'll just use my remaining time to speak about a different topic, if possible. One of the things we talked about was this investment in supportive housing through the HART hub model, up to 900 units. We currently have about 80,000 people across the province who are currently unhoused, a significant portion of which would benefit from supportive housing. The 900 number would obviously just be very specific to a small, small subset.

What is the commitment to net new supportive housing units across the province over the next year from the Ministry of Health?

Hon. Sylvia Jones: Thank you—

MPP Robin Lennox: Outside of those 900.

Hon. Sylvia Jones: Correct. We are not dealing with this in silos; we have very much had a government-wide approach to housing and homelessness prevention. I point to the Ministry of Municipal Affairs and Housing. In my own community, we had a Homelessness Prevention Program that is funnelled directly to the upper tier, so county governments or regional governments, that, in my specific example, was a five-fold increase. Half a million dollars went into the county of Dufferin for homelessness prevention programs.

I think that we need—and we have worked very diligently as a government—to make sure that this is not exclusively the purview of one particular ministry. The truth is, when people are housed, they can get treatment; when people have jobs, they can get housing. All of the pieces together really speak to a government-wide approach to make sure that as our economy is stable and grows, our population is also being housed appropriately and getting the appropriate social services that they need.

I think that looking specifically at what only the Ministry of Health does—clearly, we provide funds for supportive housing and assistance at a staff level. But it is a government-wide approach that includes not only the Ministry of Housing, but many other ministries within the government.

MPP Robin Lennox: I totally appreciate that. In having had conversations with Minister Flack about the need for supportive housing in Hamilton, he actually directed me to your ministry to ask about the operating costs for supportive housing. So my question is, specifically from your ministry, in terms of the operating costs for supportive housing, what have you committed to supportive housing for the province for the next year, outside of those 900 units that are allocated?

The Chair (Mr. Brian Riddell): One minute remaining.

Hon. Sylvia Jones: So $150 million in new funding over three years is supporting a suite of supportive housing

initiatives designed to bolster support for vulnerable populations: an 11.75% increase in rent supplements for up to 10,679 supportive housing units to mitigate the impact of increasing rent costs; maintaining 1,137 dedicated supportive housing units that have operating agreements that are about to expire, ensuring that continuation with mental health supports; partners like Indwell Community Homes and funding for rent supplements and mental health and addictions support for maintaining supportive housing for over 640 individuals. Those—

The Chair (Mr. Brian Riddell): Thank you, Minister.

We'll now go to the third party. I recognize MPP Fairclough.

Ms. Lee Fairclough: I was going to ask about a few topics. I'm going to ask about home care, I'm going to ask about the HART hubs, and then I may have a colleague that comes in to sub in for me in a few minutes.

First of all, I just want to talk about home care. I apologize if I missed some of this; I know your colleague was up here before. This is certainly, I would say, an area that I hear a lot about from constituents, just being unable—particularly, initially getting set up for their home care service.

I was interested in the metric you've got around timely access to home care services that's in here, tied to the funds, that says that from community to time of service is six days. Do you have a good sense of what that time is, from when they're being referred from hospital to initially receiving their home care?

Hon. Sylvia Jones: I think this is a really important topic to cover because it really speaks to some of the hospital bed capacity that we're also trying to protect—

Ms. Lee Fairclough: Yes. That was my next question, around ALC.

Hon. Sylvia Jones: So protecting that. The work that we're doing with, for example, the program initiated by some hospital leaders called Hospital to Home—where, essentially, that patient continues to be monitored at both the hospital and in the community. What we have seen—and ADM McMichael will speak to it in more detail—is that in the important 30 days post-leaving a hospital, we're not seeing the readmission, which I think speaks to that monitoring that is happening in the community. I know that there needs to be—

Ms. Lee Fairclough: But outside of that—sorry to interrupt you, because I know we're short for time. I do know the program. It's got good promise. But for most patients who may not be in that pathway now, what do we know?

1730

Hon. Sylvia Jones: There are 46 hospitals that currently have it, and with this week's announcement and the successful passage of the fall economic statement, we will have an additional 10—

Ms. Rhonda McMichael: Eighteen new ones.

Hon. Sylvia Jones: There you go.

Ms. Rhonda McMichael: So it will be about 65 sites across the province that will have hospital to home.

I appreciate—I can keep going, if you like?

Ms. Lee Fairclough: Yes. Sorry to interrupt you.

Ms. Rhonda McMichael: I appreciate that this is one program, but there is broader work being done, as I mentioned before, to bundle care. That's designed to bring down the transition to care. Also, there's a lot of focus on missed visits and things like that, even though the number has gone down significantly. There's lots of work with providers on that as well.

Overall, with the announcement that was made yesterday, home care delivery will have increased 24% over the last three years.

Ms. Lee Fairclough: Okay. When you say delivery, you mean just the—

Ms. Rhonda McMichael: So, the number of hours—

Ms. Lee Fairclough: The number of hours—

The Chair (Mr. Brian Riddell): You're talking over each other. One at a time, please.

Ms. Lee Fairclough: I'm sorry. I'm asking for clarification.

Ms. Rhonda McMichael: Yes, so that's the 8% increase in the number of hours. Some patients are more complex, so it doesn't break down into—because, obviously, each patient requires different levels of service. We have the number of increased patients, but it doesn't necessarily equate to the same number of patients due to the level of service that's required.

Ms. Lee Fairclough: Great. Thank you.

My next questions are really around the HART hubs again. I apologize if I may have missed some of that content. Yesterday, we certainly had a discussion at the open public accounts meeting about the progress on HART hubs and some of the Auditor General's findings around what we're doing around the opioid strategy.

From a funding perspective, I wanted to just be sure—it was confirmed that the policy decision of the government was to move ahead with a pathway of care that does not include an evidence-based component of that, that's offering CTS.

I want to double-check that the money that was originally invested in all of those sites has, in fact, been reinvested into the HART hubs. Yes, we've closed service; yes, we've pulled funding for that purpose. But that money is still part of the funding that's going into HART hubs. What was the total of that amount of money?

Hon. Sylvia Jones: Not only is it being reinvested into HART hubs, but the HART hub model actually has a fivefold increase in their operating pathway because we want to make sure that there are additional supports. I'm going to read very quickly from an individual who used to work in the addictions treatment—

Ms. Lee Fairclough: Does it relate to—

Hon. Sylvia Jones: It does.

Ms. Lee Fairclough: I'd love to hear it. I can hear it after, maybe, but is it about the money?

Hon. Sylvia Jones: It says: "Honestly, I was so burnt-out from responding to overdoses and watching people die that I had become really traumatized."

To me, that speaks to exactly why we have to move away from consumption and use of illicit drugs, deadly

drugs, to a model where we give people assistance where they're at. As I said, it could be for primary care today; it could be for supportive housing tomorrow. But we need to make sure that those services are all together and operated cohesively in one location so that people have a pathway out. I don't—

Ms. Lee Fairclough: I said yesterday, publicly, I do agree around the different levels of services that we need. We need to be expanding access to those services. I think this was always seen as part of that service pathway, and the choice has been to not do that.

That's your choice to do that. I just wanted to make sure that the dollars have been fully allocated and are part of the HART hub model as we go.

Hon. Sylvia Jones: And then some: $15 million for the nine sites that transitioned from consumption to HART hubs.

Ms. Lee Fairclough: That's great. Again, just coming back, because this is always a combination of performance metrics as well: What are the key performance metrics for the investment in those HART hubs that you're seeing, especially around—I know we've talked about housing etc. But for me it's all about incremental service, not more using the existing capacity—incremental service. So how are you going to be sure that we're going to get that with this investment?

Hon. Sylvia Jones: Like every transfer partner agency in the province of Ontario, whether it's a hospital, whether it's a community health centre, accountability agreements have been inked and signed with the individual lead organizations. So the metrics will be, are you maintaining and have you provided the services that you agreed to in your accountability agreements?

Deputy Richardson, am I missing anything?

Ms. Deborah Richardson: No, but ADM MacIntyre can speak about the specifics if you want to hear about the performance measurements.

Ms. Lee Fairclough: Yes. I heard about some of it yesterday. I think what I heard was that we wouldn't necessarily have the full evaluation approach until the end of March 2026. Is that right?

Mr. Kyle MacIntyre: As the minister was saying, there are a number of metrics that are already included in the accountability agreements between Ontario Health and each of the hubs. Those are related around individuals served by unique clients, the type of service that they're delivering. We've got additional measures around referrals, who is seeking bed-based care, that type of stuff. That information is typically provided through quarterly reports. We've also instituted a bi-weekly monitoring system, so we're getting updates every couple of weeks as well.

Then there is an additional piece of work that is going to support the evaluation of the hubs after the three-year investment is done. A part of that is the development of a logic model and an evaluation framework, which—we're finalizing the draft right now. It's pretty close to being ready to go. What will follow with that is just a touch-base with hubs and others in order to finalize that, to get their feedback into what that model is, and then the data will start to be required once that is finalized.

Ms. Lee Fairclough: Right. So we won't know what we're doing now and how it feeds into that, but—

Mr. Kyle MacIntyre: Yes. We're collecting the data, which I was saying, now, and then prior to March—it will be before March 2026 with the full evaluation framework in place.

Ms. Lee Fairclough: I'm going to switch gears in my final minutes here.

The Chair (Mr. Brian Riddell): You have five minutes and 46 seconds.

Ms. Lee Fairclough: Thank you very much, Chair.

My next question is really on the team versus the solo practitioners as part of the primary care strategy. Again, I'm a bit focused on the metrics now in this part of my questions; we've heard a lot about the investments going into primary care. Will you be tracking those metrics separately? Because I know the goals of the program and the investment in the program around access to teams—the legislation didn't really commit to access to teams. But will we know whether the money is resulting in people actually not only being attached but getting access to team-based care?

Hon. Sylvia Jones: Yes, for sure. As you know, as the applications come in, are assessed and ultimately approved, there is a piece that says, "What is your multidisciplinary team going to look like?" So, what is it made up of? Is it primary care? Is it nurse practitioners? Is it mental health workers, dietitians etc.? But also, the application says how many they will attach, so how many patients are connected. Through the monitoring of OHIP billing numbers, we can not only see how many patients are attached to those specific multidisciplinary teams, but we can then see through the use of OHIP activity how many are actually going to that team for the multidisciplinary approach. I think—

Ms. Lee Fairclough: Can I just ask a quick question, a clarification, then? Will you not fund any primary care through this program that isn't in a team-based model? So if a family physician is still primarily working in their office on their own with somebody supporting scheduling, they wouldn't be eligible for this program? Is that fair to say? We wouldn't be bringing any physicians in on that?

Hon. Sylvia Jones: The primary care expansion and the work that the primary care action team is doing is, yes, very specifically focused on multidisciplinary teams. I will put a caveat on it, because we have expanded some nurse-practitioner-led clinics and some community health centres. So, it's not all exclusively multidisciplinary teams, but, absolutely, it is the bulk. And why we did that is, obviously that's what patients want, but it's also what we're seeing new practitioners want. They want to work in that team-based care.

1740

Ms. Lee Fairclough: We will still end up, at the end of the four years, though, with some patients being supported through teams in the province and some that will still be

looked after outside of a team-based model. I just want to be clear on that.

Hon. Sylvia Jones: We're not shutting down fee-for-service clinicians.

I will tell you, again, that it was quite helpful to go to Calgary and talk to other health ministers last week. Ontario is approximately 80% team-based care and 20% fee-for-service, and in many Canadian jurisdictions, it's actually the flip. So what you see happening in Ontario is new grads, new clinicians wanting to work and seeking out those opportunities in community health centres and multidisciplinary teams. We're seeing less and less interest in that individual fee-for-service, on their own, no moral or peer support.

Ms. Lee Fairclough: Great. I think I'll leave it there. I will look forward to next year's book, where we actually will have the primary care metric as part of it. Thank you very much.

The Chair (Mr. Brian Riddell): You have two minutes left. Do you want to give that up?

Ms. Lee Fairclough: Yes.

The Chair (Mr. Brian Riddell): We'll go to the independent. I recognize MPP Clancy.

Ms. Aislinn Clancy: I do have some concerns about for-profit care, especially when it comes to LTC investments. I know our not-for-profit sector doesn't have a big budget to buy the land and get the planning, and so I'm worried about over-subsidization of a for-profit model, especially because a lot of the big companies did very poorly during the COVID pandemic in terms of outcomes of patients.

Could someone speak to the percentage of investment in for-profit LTC beds as opposed to not-for-profit LTC beds, knowing that not-for-profit LTC beds generally have better outcomes and they're more efficient when it comes to operating dollars once they're up and running?

Hon. Sylvia Jones: We, actually, in the province of Ontario, have three models of care for our long-term-care facilities. One, of course, is municipally run. One is a not-for-profit model that, quite often, is focused on a particular segment or population—I think in terms of organizations that tailor to a particular language—and, of course, the model for for-profit.

I want to be very clear, though: All of the standards, all of the expectations, all of the accountability agreements, if you may, are equivalent across those three different models. There is absolutely an expectation of government and of the Ministry of Health and the Ministry of Long-Term Care that, regardless of where you receive that long-term-care bed, you are getting the equivalent expectation of services. There is no difference in what is expected and what is compensated for those three different models.

Ms. Aislinn Clancy: Would somebody be able to get me that breakdown of for-profit and not-for-profit?

Hon. Sylvia Jones: That's probably, respectfully, a question better asked to the Minister of Long-Term Care.

Ms. Aislinn Clancy: Okay.

I just want to push back, just because of COVID—the outcomes were very different. I appreciate the expectations are still equivalent, and maybe under these circumstances right now, I think we need to keep monitoring performance and maybe investing in ones who perform better in future.

Hon. Sylvia Jones: If I may, and I realize again that this might be more appropriate for long-term care, I'm going to give some very specific examples.

In my community, absolutely, there were long-term-care homes that needed help. Our hospital partners stepped up and assisted with infection protection and understanding how this could be prevented or held back.

I have worked very hard as the Minister of Health to make sure that those connections between our long-term-care facilities and our hospital partners continue. I describe it as a string that formed during the pandemic, and I want to build a bridge, because I know that part of the way we are going to deal with alternate-level-of-care patients in hospitals is to make sure that we have a robust, functioning long-term-care system.

That's why Premier Ford made such a commitment to make investments in our long-term-care facilities, whether it was for ensuring they all had air conditioning, whether it was ensuring infection prevention and control, and, of course, now expansions across Ontario. There's no doubt that we fell behind in the province—

The Chair (Mr. Brian Riddell): One minute.

Hon. Sylvia Jones: —of Ontario and we needed to catch up, and I think we're doing that now since 2018.

Ms. Aislinn Clancy: I have a question about pay parity, especially when it comes to nurses. You know my community health team has a real big struggle in maintaining their health care staff, just because of the gap between what people get paid in a hospital and what they get paid in community, especially for our nurse practitioners. I just wonder if we can get a bit of stats or if there's a plan on trying to bring everybody up to the same level of pay. I think that would help us avoid some of the agency nurse issues if we can retain staff, and it would improve the outcomes for patients, I would argue.

Hon. Sylvia Jones: I'm sure Dr. Velji is getting ready to back me up, but we have obviously made some very substantial investments in PSW wage enhancement. Initially, it was a temporary measure that we've now made permanent—$3 an hour increase—

The Chair (Mr. Brian Riddell): Thank you, Minister.

We'll now go to the government side. I recognize MPP Pang.

Mr. Billy Pang: Chair, through you to the minister: It's a long day; thank you for your hard work.

The government is investing nearly $60 billion to get shovels in the ground for over 50 hospital developments, building 3,000 new hospital beds across the province over the next 10 years. Minister, can you tell us more about what the Ministry of Health is doing to ensure Ontario has modern, safe and efficient health care infrastructure that can meet the needs of Ontario's growing population?

Hon. Sylvia Jones: Absolutely, and thank you for this. A lot of our conversation today was very rightfully focused on the health human resources piece and how we are

expanding that in a growing and aging population, but I think it's equally important to say that we need to make sure our infrastructure is also there. For me, infrastructure is primarily a $60-billion commitment and investment in hospital capital—over 50 different projects across Ontario.

Of course, we often talk about Trillium Health Partners in Mississauga, but I could equally point to Windsor and the enhancement of a desperately needed emergency department expansion in Timmins that we were able to recently announce. If I move over to Ottawa, we have another, basically, sorely overdue expansion for the Ottawa hospital. In the next couple of weeks, we will be able to celebrate the opening of the West Lincoln Memorial Hospital, down in Niagara, and, for those of us who are watching Niagara, seeing the South Niagara Hospital literally being built on schedule and on time.

I think those point to an understanding and appreciation that, as we bring on additional clinicians and health human resources, we also need to make sure that they are working in safe, up-to-date facilities that are there to serve them and the public.

Deputy Richardson, over to you.

Ms. Deborah Richardson: Just maybe to touch on the three key priorities from our capital plan investment strategy: obviously, growing demand in health care services as our population ages and our communities expand, which we heard about today; infrastructure renewal that the minister just spoke about, essential repair and renewal needs can be met; and also, I think most importantly, bringing care closer to home by supporting community-based care, outpatient services and modern health hubs so that patients don't always have to travel far for skilled care.

1750

I would like to turn it over to Associate Deputy Minister Catherine Wang, who is just going to get into some more of the details of the investments that we're making.

Ms. Catherine Wang: Thank you, Deputy.

As the minister and deputy alluded to, we have a very robust long-term capital plan that will invest over $43 billion in health infrastructure grants over the next 10 years, contributing to nearly $56 billion in total health infrastructure investments across the province. The plan will expand and modernize Ontario's health infrastructure, ensuring we have new and modern health facilities that allow for the expansion of services across the continuum of care. This includes crisis in critical care, emergency and urgent care, general and specialty acute care, ambulatory services, mental health and addictions care and primary and community care.

By investing in the right mix of services to best address the unique needs of local communities, the ministry is strengthening access to care and advancing its commitment to end hallway health care, ensuring that the appropriate mix of services are available to Ontarians where they need it.

In partnership with health system operators, we are making strategic investments for the short, medium and long term. While major hospital redevelopment projects are planned over a multi-year horizon, we're also delivering smaller, targeted investments to renovate, modernize and add capacity to existing buildings and ensure communities benefit from improvements in the short and medium term.

At the same time, we are investing in renewal and repair projects to address maintenance and repair needed for aging buildings, keeping them functional and safe for patients, families and health care providers. Together these investments are building for the foundation of a stronger, more connected and sustainable health care system that puts people first.

I would like to give a little bit of an overview of the overall capital plan. Effective capacity planning ensures Ontario's health care system can meet both immediate and future needs. It supports long-term sustainability through health system transformation and ensures that care is available when and where people need it most. As noted, the Ministry of Health has a comprehensive and forward-looking capital infrastructure plan that will not only add approximately 3,000 hospital beds over the next decade but will also strengthen the full spectrum of health care services in the right place.

Demand for major health capital investments remains at an all-time high. As Ontario's population continues to grow and age and our health care facilities continue to age, there's a clear and pressing need for continued capital investments. These investments support both new infrastructure projects that expand system capacity and access, and renewal projects that maintain and repair existing assets.

There are two main types of capital projects under the ministry's plan: (1) renewal projects to maintain, modernize and extend the life of existing facilities and (2) expansion projects to create new infrastructure that increases capacity and supports the delivery of new or expanded services.

Renewal projects are undertaken to restore, rehabilitate or replace an existing asset to its original capacity or performance level. These projects are fundamentally carried out to extend the useful life of building assets. They go beyond addressing facility maintenance as they modernize spaces, improve clinical workflows and enhance patient and provider experiences. By improving functionality, renewal projects ensure our existing facilities remain safe, efficient and fit for modern care delivery.

In 2025-26, the Ministry of Health is investing approximately $257 million in its renewal funding programs to support critical upgrades and repairs at 126 hospitals and 66 community health care facilities across the province. Hospitals received $242 million through the Health Infrastructure Renewal Fund, and over $14.9 million was provided to community health services providers through the Community Infrastructure Renewal Fund.

These funds allow health care system providers to address urgent infrastructure renewal needs such as upgrades or replacements of roofs, windows, electrical, HVAC, security systems, fire alarms and backup generators. These

are essential improvements that will, in return, deliver excellent care to patients on the front line in a safe and comfortable environment.

I'd like to give a couple of examples of these infrastructure upgrades supported through the HIRF, or Health Infrastructure Renewal Fund. For example, Riverside Health Care Facilities received over $3.7 million towards infrastructure renewal projects, including over $3.1 million for pharmacy modifications, allowing for critical treatments to be delivered on site.

An example of infrastructure upgrades supported through CIRF, our Community Infrastructure Renewal Fund, includes Community Care Durham, who received $406,364 for infrastructure renewal, including replacement of their fire alarm system, as well as upgrades to their hot water system, emergency lighting and electrical that would improve energy efficiency and address building health and safety.

By contrast, expansion projects are designed to increase an organization's ability to deliver service by increasing their capacity of an existing asset. The Ministry of Health is planning on expanding hospital capacity by approximately 3,000 beds over the next 10 years. I can share a couple of examples of these, as well. In 2025, the Ontario budget announced improvements and approvals for Trillium and district hospital emergency department expansion and renovation project. This will include renovations and an addition of over 27,000 square feet to the existing emergency department, expanding the new emergency department up to four times its current size. On average, more than 43,000 patients visit the ED at Timmins and District Hospital every year, with local demand only expected to increase. This new ED will address aging infrastructure and support future growth.

Another example: The 2025 Ontario budget also announced $50 million to support planning for the new Lake of the Woods District Hospital. This hospital will have expanded medical services, including increased access to core programs and services, including a modernized ED and a mental health unit and a transitional care unit, Indigenous health spaces and ambulatory care spaces.

I'd like to spend a bit of time now to provide an overview of the health capital policy framework. The Ministry of Health provides guidance and support to health service providers across the province to build and renovate health care facilities. The Hospital Capital Planning and Policy Manual establishes the overarching policy framework for hospital capital projects and processes. The manual sets out the policies governing these projects, including approved capital funding. It documents the submission requirements for hospitals proposing to undertake a capital project and the subsequent review and approval processes carried out by Ontario Health and the ministry. More specifically, the hospital capital planning manual communicates the ministry's capital planning and approval processes, policies and guidelines to stakeholders; outlines the requirements to be compliant with ministry and government policies to maintain legislative and fiscal accountability; provides direction on how to effectively navigate the capital submission and review processes; and finally, it facilitates the development of capital submissions that will foster the delivery of high-quality care through patient-centred design.

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

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

The ministry is committed to making capital investments based on sound fiscal planning and ensuring that these investments are carried out efficiently. The ministry also works with health service providers to appropriately plan projects within their approved budgets through the provision of planning grants to enable planning to a target bed or cost level and progressively increasing standardization approaches.

As with all sectors, the Ministry of Health is facing significant cost pressures and challenging construction market capacity in its portfolio of large capital projects. Limited labour and bidder availability, input, price fluctuations, supply chain disruptions and rising inflation and interest rates have all required new approaches to procurement and project planning. In response, the ministry continues to develop approaches to mitigate these challenges by making adaptations to project scope, staging and procurement processes.

Increasing standardization for hospital infrastructure projects is a key component of the ministry's comprehensive plan to address current construction market conditions. The ministry has progressively increased standardization of hospitals over time through the employment of Canadian Standards Association, otherwise known as CSA Z8000, in the review and approval of capital projects and the development of hospital department space benchmarks and functional program tables to support hospital capital planning projects.

1800

The ministry is working with the sector, Ontario Health and Infrastructure Ontario to expand current hospital capital standardization policies and practices to further streamline the planning, design and approval process for public hospital capital projects and support government efforts to accelerate the construction of health infrastructure. Standardization will be achieved through policy levers such as the provincial vendor of record for functional planning and enforcing of benchmarks, templated design and updates to existing capital policy and process.

In the future state, the ministry will provide hospitals with more and better tools and templates at the outset of design so that hospitals produce functional programs that are more closely aligned with government standards, benchmarks and health system needs.

The Chair (Mr. Brian Riddell): One minute.

Ms. Catherine Wang: The Ministry of Health also maintains a Community Health Capital Programs Policy that provides a unified approach for the review, approval and funding of community health care infrastructure projects in Ontario. The community policy outlines eligibility criteria for community sector health service providers, including a process for expanding eligibility to additional community providers and operational models of service for co-located and integrated proposals, capital cost share and space standards and, finally, a unified project management and funding framework. The Community Health Capital Programs Policy provides the framework for capital funding to both single provider-led projects and co-located and integrated facilities projects.

The government continues to be committed—

The Chair (Mr. Brian Riddell): Thank you very much.

We will now go to the official opposition for six minutes and 24 seconds.

M^me^ France Gélinas: I will use my time wisely.

The first question I have is about IVF. I was really happy that more IVF cycles are being allocated out. I saw that Pollin has received 500 IVF cycles, while Mount Sinai has received zero.

Do you look at things like ownership of the clinics when you do your assignment? You will know that the private equity-funded clinic, Pollin, with good connections to your government, received 170% more IVF cycles—500 cycles; Mount Sinai received zero. Do you also look at how much those clinics charge patients for services that are not covered by OHIP? I can tell you that this particular clinic charges three times what the independent physician-owned clinics charge. Does it make any difference if it's a venture capitalist from the States who owns a clinic because they want to make money versus a physician from Ontario who owns a clinic and wants to help people when you make your allocation decisions?

Hon. Sylvia Jones: In terms of the IVF expansion, we have been able to not only ensure that the existing IVF clinics in communities have had an additional allotment for additional patient access in cycles, but also an expansion to ensure that communities that had less access, particularly in northern Ontario, were getting that.

I'm going to turn it over to ADM Patrick Dicerni—

M^me^ France Gélinas: So you don't look at whether they are US equity that owns the clinic? It's a US conglomerate that owns a clinic versus a not-for-profit hospital. It makes no difference? You just give them the cycle?

Hon. Sylvia Jones: As I said, we were able to not only expand for existing clinics to offer more cycles, but also new players in the field to ensure that some of the areas in the province of Ontario that had less access had that opportunity—

M^me^ France Gélinas: But that player is in downtown Toronto, where there is the most access to—

Hon. Sylvia Jones: All IVF clinics were able to get additional capacity.

M^me^ France Gélinas: I can assure you that Mount Sinai did not get 500 more IVF cycles.

Hon. Sylvia Jones: All IVF community clinics were given additional access.

M^me^ France Gélinas: Community clinics. Okay.

My next question has to do with the Ottawa Hospital Civic Campus redevelopment. Was it true that there was only one bidder for this project at about $6 billion? That seems like a lot of money. I know that for the Trillium Mississauga hospital, there was only one bidder for a $13.9-billion price tag that the taxpayers will have to pay. Is that the same path that you're going down for the Ottawa Civic Campus redevelopment?

Hon. Sylvia Jones: The Ottawa Civic Campus hasn't gone out for bid yet, and I hope you're not suggesting with the direction of your questioning that we should stop building based on who is coming forward to provide these necessary services and expansions.

M^me^ France Gélinas: It is absolutely a necessary service, but the P3 projects that you put forward mean that EllisDon and PCL are the only ones bidding on this, and that a hospital—$13.9 billion is maybe—it's absolutely needed; is this the best price we could get? I don't know. Ottawa Civic seems to be going down the same path with one bidder, the same bidder that has got the contract for $13.9 billion.

Hon. Sylvia Jones: As Associate Deputy Minister Wang referenced in her most recent remarks, we've actually been making some updates and improvements on the process, to ensure that we are getting the most appropriate use of our taxpayer dollars.

I can tell you—I can give you very specific examples. Bird Construction was able to, during the pandemic, build their first hospital in the province of Ontario on schedule, on time, so we have additional players who are interested. There was a very recent bid given last year, where four bids came in for one hospital project, and a local builder was the successful build.

M^me^ France Gélinas: I hope Ottawa gets four bids also, but it doesn't look good.

I only have a few minutes—

The Chair (Mr. Brian Riddell): You have one minute left.

M^me^ France Gélinas: I want to talk about midwifery. We saw a 0.1% increase in the number of midwives. I have underemployed and unemployed midwives in northern Ontario who would love nothing more—if only there was money allocated to the midwifery centre to hire them. If only there was money allocated to the midwifery clinic to be able to make ends meet, but there isn't.

You see a decrease in access to delivery services in northern Ontario, when we have unemployed midwives because you haven't funded any midwifery positions in the existing clinics and you haven't kept up with the cost

of living for those clinics. How can you explain this to the people of northern Ontario?

Hon. Sylvia Jones: In fact, specifically as it relates to midwifery services, we've been able to partner with some First Nations—

The Chair (Mr. Brian Riddell): Thank you very much.

I would like to thank the minister and her staff for their comments and insight today. Thank you very much. This concludes the committee's consideration of estimates of the Ministry of Health.

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

Yes?

M^me^ France Gélinas: There were some questions that were not answered—where they said that they would get back to us, but that were not answered. I was wondering if we could make a little list of them and send them a reminder that they have told us that they would give us some—

Interjection.

The Chair (Mr. Brian Riddell): Yes, go ahead.

The Clerk of the Committee (Ms. Vanessa Kattar): Any questions that the ministry has undertaken or confirmed that they will get back to you on, the research officer will put it together in a memo and our office will circulate it to the ministry.

M^me^ France Gélinas: When will we see that list?

The Clerk of the Committee (Ms. Vanessa Kattar): Probably within the next week or two, I would think.

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

The Chair (Mr. Brian Riddell): All right. Shall vote 1401, ministry administration program, carry? All those in favour? All those opposed? The motion is carried.

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

Shall vote 1403, digital, data and analytics program, carry? All those in favour? All those opposed? Carried.

Shall vote 1405, Ontario health insurance program, carry? All those in favour? All those opposed? The motion is carried.

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

Shall vote 1412, provincial programs and stewardship, carry? All those in favour? All those opposed? The motion is carried.

Shall vote 1416, health services and programs, carry? All those in favour? All those opposed? The motion is carried.

Shall vote 1407, health capital program, carry? All those in favour? All those opposed? The motion is carried.

Shall the 2025-26 estimates of the Ministry of Health carry? All those in favour? All those opposed? Carried.

Shall the Chair report the 2025-26 estimates of the Ministry of Health to the House? All those in favour? All those opposed? Carried.

That concludes the committee's business for today. The committee now stands adjourned until Monday, November 3, 2025.

The committee adjourned at 1811.

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