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Ministry of Energy

Ministry of Health and Long-Term Care

2nd Session
41st Parliament

Tuesday 24 October 2017

Chair: Cheri DiNovo
Clerk: Eric Rennie

Journal des débats (Hansard)

E-24

Comité permanent des budgets des dépenses

Ministère de l'Énergie

Ministère de la Santé et des Soins de longue durée

2e session
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Mardi 24 octobre 2017

Présidente : Cheri DiNovo
Greffier : Eric Rennie

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STANDING COMMITTEE ON ESTIMATES

Tuesday 24 October 2017

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Mardi 24 octobre 2017

The committee met at 0900 in room 151.

COMMITTEE BUSINESS

The Chair (Ms. Cheri DiNovo): Good morning, everyone. Our first order of business is a deferred motion by Mr. Tabuns regarding the production of documents. I'm just going to read it out. This is from October 18:

"Mr. Tabuns moved that, pursuant to standing order 110(b), the Standing Committee on Estimates directs the Ministry of Energy, the Independent Electricity System Operator, the Ontario Energy Board and Ontario Power Generation to produce, within 10 business days, all documents, including all electronic and digital correspondence, related to the government's fair hydro plan; and

"That the request for documents includes any and all related documents, including all electronic or digital correspondence, received or sent by the Minister of Energy and the minister's office; and

"That all documents be provided in searchable PDF format."

Is there any discussion on that motion?

Mr. Peter Tabuns: Yes.

The Chair (Ms. Cheri DiNovo): Mr. T—Mr. Tabuns.

Mr. Peter Tabuns: Thank you, Chair.

Interjection: Mr. T?

Mr. Peter Tabuns: Let the record not show.

Laughter.

Ms. Ann Hoggarth: I do not see a gold chain.

Mr. Peter Tabuns: Ann, your eyes are sharp. Your eyes are sharp.

The FAO's report, followed by the Auditor General's report, make it very clear that the people of Ontario are going to be saddled with an extra $4 billion in extra interest cost from the so-called fair hydro plan—$4 billion that even just meeting the government's own goals need not be spent.

I don't think I need to point out to you, Chair, but I want to note that the cost of the gas plants scandal was about $1 billion. This is four times bigger. Its consequence will be felt in Ontario for a long time. There's an awful lot that could be built with that $4 billion. There's an awful lot that could be saved on people's hydro bills if that $4 billion wasn't being thrown away.

The expenditure is born of the same motive as we saw with the cancellation of the gas plants. We have an election coming. A government wants their political stars to align. This is one that they hope can make them look good, effectively giving a free reduction in hydro prices without it showing up on the province's consolidated books.

Chair, that's indefensible. Frankly, Ontarians need to know what happened, just as they needed to know what happened with the gas plants scandal.

The minister was asked about this at some length. The deputy minister spoke to this as well. Neither of them gave a credible rebuttal to the facts presented by the Auditor General and by the Financial Accountability Officer. The argument made by the minister was that borrowing this money was similar to borrowing money to build a dam or other large hydro infrastructure: It was buying a tangible asset, and the $4 billion in extra interest cost shouldn't be something that's charged to taxpayers, but to ratepayers.

But in fact, the Auditor General was very good in laying out the argument that this is not a question of building some material infrastructure; this is resolving a political financial problem for the government, just as when Mike Harris set up the stranded debt to set the process in motion for the selling-off of Ontario's power generation assets in the 1990s. Borrowing was undertaken by the province and paid back by ratepayers on their bills. This is an entirely analogous situation, and it is entirely proper to have the full borrowing and all costs flow through the province's books so that people understand honestly, accurately, fully what's going on with the province's finances.

This committee has a responsibility to look at the expenditures of the Ministry of Energy. It has previously, in looking at the gas plants scandal, successfully requested and reviewed relevant documents and in that process, with regard to the gas plants, set out very clearly what was going on politically and what the people of Ontario were being charged for. They were being charged to save a number of Liberal seats.

In this case, the people of Ontario are being charged $4 billion to make the books look good in an attempt to increase the Liberal Party's performance in the next provincial election.

So, Chair, I move this motion, and I look forward to the debate on it. I believe the people of Ontario should have this information and there's no good reason for it to be withheld.

The Chair (Ms. Cheri DiNovo): Ms. Kiwala.

Ms. Sophie Kiwala: I think the Minister of Energy has been very clear and forthcoming about the documents that were released to the Auditor General, and has provided a lot of information this week and last week. He has said, every possible chance that he had, that our government remains absolutely committed to being open and transparent and that we will continue to co-operate with the Office of the Auditor General.

The Independent Electricity System Operator, so far, has provided 1,200 records to the Auditor General. Ontario Power Generation has provided hundreds of records. The Ontario Financing Authority has provided 3,242 records. Treasury Board has provided thousands of records. As of October 13, the ministry has provided 13,212 records to the Auditor General's office, and I understand that there are more to come.

In this process and throughout our everyday operations, the government is adhering to all document retention standards. The ministry is continuing to release additional information to the Auditor General as we speak.

I want to reiterate that the minister has been forthcoming and has continued to, and will continue to, co-operate and work with the Auditor General. The ministry has committed to providing all additional records to the Auditor General by November 1.

As the ministry has been regularly providing the Auditor General's office with additional responsive documents each week and has committed to providing all the relevant emails by November 1, we see no merit in this motion.

The Chair (Ms. Cheri DiNovo): Further discussion? Mr. Harris.

Mr. Michael Harris: The Ontario PCs will be supporting my colleague's motion. It's déjà vu all over again. I remember, back in 2012—was it 2012, Peter?

Mr. Peter Tabuns: Yes.

Mr. Michael Harris: Somewhere around there—us going through the same exercise here, actually, in this very committee. The one difference was that we outnumbered the government in that scenario and we were able to obtain the necessary papers, documents etc.

We're learning now—you can read it for yourself in the paper daily—about what's going on down the street with regard to the gas plants trial. I'm just reading here right now that folks in the Premier's office dismissed—when Peter Wallace was the top civil servant here in the province and advised McGuinty's chief of staff David Livingston about the fact that he had to come forward about retention of documents, he called it "political bullshit." That's what he said.

Some of the same players, in fact—

The Chair (Ms. Cheri DiNovo): Could we watch our language? We're still governed by parliamentary language in this committee.

Mr. Michael Harris: I'm just reading. I'm quoting—

Ms. Sophie Kiwala: You said it.

Mr. Michael Harris: Hey, it's what he said; not me. I'm just telling you—

Ms. Ann Hoggarth: No, you said it.

Mr. Michael Harris: Actually, yes—

The Chair (Ms. Cheri DiNovo): One at a time, please.

Mr. Harris, continue, please, without the expletives.

Mr. Michael Harris: You can read it for yourself in Kelly McParland's October 23 column from the National Post.

My point is, and it's sad to see: Kathleen Wynne came in after Dalton McGuinty's reign and said that she wanted to be more transparent and open, with open government—that was a throne speech that I listened to that seemed to only last for a day.

We are the oversight body of the Legislature. This committee, in fact, through estimates, has asked for—if you've said that the minister has been forthcoming, then he should be forthcoming with the committee, heed the call of the motion that my colleague has put forward to verify all of the documents that were supposedly handed over to the Auditor General to ensure that, in fact, we have all of the information.

0910

With regard to sensitive documents, the committee before had put measures in place to ensure that this committee, through its process, protects the confidentiality that may exist; they may be commercially sensitive.

It's just astonishing that the government talks a lot about openness and transparency, yet the very request that was agreed to back in the day—I remember the government saying, "Oh, the gas plants are only going to cost taxpayers about $40 million to relocate." Well, it's $1.2 billion, and now we're talking about a $4-billion expenditure on the backs of ratepayers and taxpayers.

I was at yesterday's chamber lunch in Kitchener, where the Premier talked about fairness. This is anything but fair to future generations, having to fork out $4 billion of unnecessary interest. I read an article about the fact—or I guess the auditor said it's like calculating your interest as an asset. Where do you guys come up with this stuff?

Look, perhaps my colleague will have an opportunity to jump back in with regard to his own motion and what the government has said, but it is a sad day when the government will not agree to this committee's request for documents pertaining to the fair hydro plan. Hopefully the voters will ultimately determine their distaste for this in June of next year.

We'll be supporting the motion from our NDP colleague, of course, and we'll see where it goes. Hopefully you'll rethink your decision on this.

The Chair (Ms. Cheri DiNovo): Further discussion? Mr. Tabuns.

Mr. Peter Tabuns: Yes, thank you. I won't go on at length, but I would just note: Ms. Kiwala, in your comments, you talked about providing the information to the Auditor General, which is a good thing, absolutely necessary, but my motion was to have that information presented here as well. I think that it's our duty as the estimates committee to review the material, determine

the reality, set aside interesting but irrelevant stories put forward by the minister and present to the people of Ontario what in fact is being purchased with their money. What's being purchased is an opportunity to look good in campaign ads next year.

Bring forward the documents. Let the committee review them. Let's make a decision and an assessment of what's really going on with this whole so-called fair hydro plan.

With that, I will just note that when we have a vote, I would like it to be a recorded vote.

The Chair (Ms. Cheri DiNovo): So noted. Ms. Kiwala.

Ms. Sophie Kiwala: Thank you to the member opposite for your comments.

It's very clear that families in the province were asking for real and immediate relief. It was all over the news. Everywhere we turned, we were hearing about the need for relief on hydro bills. That's what we delivered. We made a policy choice to ensure that we will continue to have a clean, reliable and affordable system for the ratepayers of today and tomorrow. The fair hydro plan keeps the cost of borrowing within the ratepayers' base, not the taxpayers' base, because it's the logical thing to do. Electricity financing should remain within the electricity system.

Our plan has been approved by the peers of the Auditor General at some of Canada's top accounting firms, including Ernst and Young, KPMG and Deloitte. In the development of the fair hydro plan, we also consulted with numerous third-party advisers in the application of accounting standards. IESO's management, IESO's audit committee, IESO's board of directors, IESO's external auditor and the Office of the Provincial Controller all support this accounting treatment.

Like you, I'm not going to go on at length. I think that we have said what needs to be said.

The Chair (Ms. Cheri DiNovo): Further discussion? Mr. Tabuns.

Mr. Peter Tabuns: Again, I don't want to spend a lot of time on this, but I do want to note that when the Auditor General spoke on this matter—and let's note that she is the custodian of accounting standards in this province. She is our Auditor General. She is independent, has no financial gain to be made from her position. We also had the former head of the Public Sector Accounting Board there at her press conference to affirm that what this government is doing is outside public sector accounting standards, notwithstanding whatever any consultant may say. The people who oversee public sector accounting note very clearly that the government is acting outside the bounds, is allowing itself to rewrite the rules so that it can say whatever it wants is reality. That isn't the way it works. Setting aside this immediate problem, which I think is very damaging to Ontario, ultimately it harms the credibility of Ontario and its ability to secure loans at a reasonable rate.

The Chair (Ms. Cheri DiNovo): Any further discussion? Is the committee ready for the vote? Okay, let's take it.

Ayes

Harris, Pettapiece, Tabuns.

Nays

Colle, Fraser, Hoggarth, Kiwala, Rinaldi.

The Chair (Ms. Cheri DiNovo): I declare the motion defeated.

Honourable members, as you are aware, the parliamentary assistant to the Minister of Energy will be appearing on behalf of the minister this morning, at 9:30. We're going to take a 15-minute recess until then.

The committee recessed from 0915 to 0930.

MINISTRY OF ENERGY

The Chair (Ms. Cheri DiNovo): Welcome back. We are now going to resume consideration of vote 2901 of the estimates of the Ministry of Energy. There is a total of 12 minutes remaining.

Before we resume consideration of the estimates, if there are any inquiries from the previous meetings that the parliamentary assistant has responses to, perhaps the information can be distributed by the Clerk. Are there any items, Madame Des Rosiers?

M^me^ Nathalie Des Rosiers: No, there are not.

The Chair (Ms. Cheri DiNovo): Okay. When the committee last adjourned, the third party had five minutes remaining in the rotation.

Mr. Tabuns, the floor is yours.

Mr. Peter Tabuns: Good morning, Madame Des Rosiers, Deputy Minister, colleagues.

I want to start off with a recent report that came out of Niagara-on-the-Lake Hydro saying that customers of smaller utilities in Ontario that were swallowed up by Hydro One have paid nearly half a billion dollars more on their hydro bills than if these utilities had been bought by a smaller, municipally owned utility.

It seems that bigger is not that much better when it comes to Hydro One. In fact, customers in Haldimand and Norfolk, who were promised savings when their utilities were bought by the now-privatized Hydro One, are facing massive rate increases now that a temporary rate freeze is ending.

Why is it that your ministry continues to support the purchase of these publicly owned utilities by the privately controlled Hydro One?

M^me^ Nathalie Des Rosiers: I will let the deputy answer.

Mr. Serge Imbrogno: Mr. Tabuns, I'm not aware of that particular report.

I would just say that whenever there is a purchase of a hydro asset from one LDC to another—Hydro One

purchasing Haldimand—it has to go before the Ontario Energy Board. The Ontario Energy Board applies the "no harm" test. They have to convince the regulator that the sale is in the best interest of the ratepayers, so they apply that "no harm" test. It would have been applied in the case of the Haldimand purchase and any other purchase.

Mr. Peter Tabuns: And yet the ratepayers in those areas are seeing sharp increases in their bills five years after the honeymoon period has commenced.

I understand that this government says it's concerned about what ratepayers are paying. Why is it allowing the continued purchase of smaller local distribution companies by Hydro One when the track record is sharp increases in rates?

Mr. Serge Imbrogno: I can't verify the report. I would just repeat that the OEB is there to protect ratepayers, and they do apply that "no harm" test. They would ensure that, over time, ratepayers also benefit from any consolidation.

Mr. Peter Tabuns: To the deputy minister: Is your ministry assessing the impact of Hydro One's purchases on these LDCs?

Mr. Serge Imbrogno: We would rely on the OEB for that. That is the purpose of the OEB. The OEB would ensure that there is the benefit. We will track it. For example, on the Alectra consolidation, they committed to a $40 benefit, and that was part of the analysis that was provided to the OEB. So we are encouraging consolidation. We think there are savings. But again, it's on a voluntary basis, and it has to go before the OEB. So that process is in place.

Mr. Peter Tabuns: Is the OEB following up on five-year time scales to see if things have panned out and if, in fact, the initial benefit is maintained? Are you actually seeing that ratepayers are being protected over time?

Mr. Serge Imbrogno: Again, that would be part of the OEB process.

Mr. Peter Tabuns: Is the OEB doing that?

Mr. Serge Imbrogno: Each LDC, once they're consolidated, will have a period when they would return to the OEB. I'm not sure what that schedule is. It would vary across the LDCs. There's a different framework that LDCs could apply for. I'm not sure when Hydro One would have to track back in in that particular process.

Mr. Peter Tabuns: So your ministry is not following on an ongoing basis and checking with the OEB to see that these deals are actually good for the people of Ontario. You're leaving it with the OEB, and you're not checking with them to see that they're actually monitoring. Is that correct?

Mr. Serge Imbrogno: That is the job of the OEB. We monitor the distribution sector. We promote consolidation. Again, it's on a voluntary basis, and it goes through an OEB process to ensure that there's a "no harm" test applied.

Mr. Peter Tabuns: You don't monitor the OEB to see that it's doing its job. Is that correct?

The Chair (Ms. Cheri DiNovo): Mr. Tabuns, you have under a minute.

Mr. Serge Imbrogno: We have regular updates from the OEB. The OEB has put out scorecards where they're ranking LDCs. We are encouraging a more active OEB when it comes to looking at efficiencies in the sector. We'll have the long-term energy plan come out on Thursday. It will have more direction on how we want more efficiencies—

Mr. Peter Tabuns: What's the mergers and acquisition budget for Hydro One?

Mr. Serge Imbrogno: I don't know off the top of my head.

Mr. Peter Tabuns: Could you provide that to this committee?

Mr. Serge Imbrogno: I'm not sure if they do have a mergers and acquisition budget. We can look at what they've submitted to the OEB.

Mr. Peter Tabuns: If you could do that and report back to this committee, I would appreciate it.

Mr. Serge Imbrogno: If there is such a thing. I don't know, but we can look at their application to the OEB.

Mr. Peter Tabuns: Legislative research has that; that's good.

The Chair (Ms. Cheri DiNovo): I'm afraid your time is up, Mr. Tabuns.

We now move to the government side. Ms. Kiwala, you have seven minutes and 20 seconds.

Ms. Sophie Kiwala: Thank you very much for being here again, and congratulations to MPP Des Rosiers. It's a pleasure to see you there.

I want to talk today about the saveONenergy program. I just want to put on the record a wonderful announcement and celebration that we had in Kingston a couple of years ago with the then Kingston General Hospital. They took advantage of the saveONenergy program and had a grant—I think it was about $500,000—that was invested into some energy-saving programs, and the result of that investment has allowed them to save roughly $800,000 every year. The investments went towards lights, heating, cooling and water systems. So I'm really proud of this program and very excited that we continue to have this program.

In general, I just want to say that I have also heard that the ministry plans for Ontario's electricity needs and that conservation is the first resource that needs to be considered. You said before that for every single dollar that has been invested in conservation programs, Ontarians have avoided $2 in costs to the electricity system. Some of these initiatives are targeted to residential customers and businesses. Like the story of the now Kingston Health Sciences Centre, we have been able to take advantage of the conservation programs. I'm very glad. I don't want to lose this program. Thank you very much. We're on the right track with that.

I'm wondering if you can add a little bit, PA Des Rosiers, or the deputy minister, on what conservation programs are available to promote affordability and give customers choices on how to increase the energy efficiency of their homes and businesses.

M^me^ Nathalie Des Rosiers: I know that this is a very exciting area for the ministry. I was briefed on it yesterday, and I'm really looking forward to hearing more about it from the deputy.

Mr. Serge Imbrogno: I'm going to call up ADM Kaili Sermat-Harding. She's the ADM of the conservation and renewable energy division, and she will talk to all the good work on conservation.

Ms. Kaili Sermat-Harding: Thank you very much, Deputy. Good morning. My name is Kaili Sermat-Harding. I'm the assistant deputy minister of the conservation and renewable energy division at the Ministry of Energy. I'm very pleased to have an opportunity to chat this morning about the range of conservation programs that are available to Ontario energy consumers.

Ontario's conservation and energy efficiency programs are helping Ontarians manage their energy use and their utility bills. Between 2006 and 2015, electricity conservation programs and improvements in building codes and standards helped Ontarians save 13.5 terawatt hours of electricity in 2015. That represents enough electricity to power the cities of London, Kingston, Ottawa, Peterborough and Thunder Bay in 2015.

During the same time, the conservation programs delivered by Ontario's natural gas utilities saved over 1,700 million cubic metres of natural gas, equivalent to the natural gas used by about 800,000 homes in a year.

We know that conservation requires a sustained commitment to achieve ongoing savings over the long term. That's why on January 1, 2015, Ontario launched a six-year electricity Conservation First Framework, which is supporting the development of new and enhanced electricity conservation programs to meet local needs and to offer more choice to customers. The framework is expected to achieve seven terawatt hours of savings in 2020 and assist the province in achieving its long-term conservation target of 30 terawatt hours in 2032.

0940

In addition, on December 22, 2014, the Ontario Energy Board released the six-year natural gas demand-side management framework, doubling budgets and bringing Ontario's total spending on DSM in line with leading jurisdictions.

Both of these frameworks, the Conservation First Framework and the natural gas demand-side management framework, are aligned to enable greater collaboration of conservation efforts among electricity and natural gas utilities

Let me turn first to electricity conservation programs for residential consumers. Under the saveONenergy brand, and with support from the Independent Electricity System Operator, customers have access to the saveONenergy heating and cooling incentive, which recognizes that the heating and cooling system is one of the biggest investments a homeowner can make. The program provides up to $850 in incentives for the purchase and installation of eligible central heating or cooling equipment through a participating contractor. Electrically heated homes can receive up to $4,000 in rebates for high-efficiency heat pumps.

Once the installation of central heating or cooling equipment is complete, a customer can save up to $325 a year, on average, on their electricity costs. Electrically heated homes can save up to 50% on their heating costs by switching to high-efficiency heat pumps. In addition, contractors can help customers program their heating and cooling equipment for different times of the day, offering further opportunities to save.

The Chair (Ms. Cheri DiNovo): Ms. Kiwala, you have just about a minute left.

Ms. Kaili Sermat-Harding: From the customer's perspective, here's how the heating and cooling incentive program works. The first step is to find a participating contractor on the saveONenergy website, which has a contractor look-up based on postal code or by company name.

Step 2 is to install an eligible measure to make the home more comfortable and energy-efficient. This could be a qualified high-efficiency furnace, a qualified central air conditioner or, again, for electrically heated homes, a qualified heat pump. The contractor will then submit an application on the customer's behalf, and the contractor will also send the application to the customer, to confirm the application details and so that the customer can submit proof of purchase.

The last step is for the customer to receive a rebate, and a cheque will arrive in approximately four to eight weeks.

Another program available to residential customers is the saveONenergy instant discounts program, which became available starting October 7 of this year at participating retailers, for a wide variety of energy-saving measures such as LEDs, power bars and more. This program is taking the place of the saveONenergy coupon program, which ended September 30—

The Chair (Ms. Cheri DiNovo): I'm sorry; time is up.

This concludes the committee's consideration of the estimates of the Ministry of Energy. Standing order 66(b) requires that the Chair put, without further amendment or debate, every question necessary to dispose of the estimates. Are the members ready to vote?

Shall vote 2901, ministry administration, carry?

Mr. Peter Tabuns: Recorded.

Ayes

Colle, Fraser, Hoggarth, Kiwala, Rinaldi.

Nays

Harris, Pettapiece, Tabuns.

Mr. Peter Tabuns: And recorded for all the rest, please, Chair.

The Chair (Ms. Cheri DiNovo): I declare that the motion is carried.

Shall vote 2902, energy development and management, carry?

Ayes

Colle, Fraser, Hoggarth, Kiwala, Rinaldi.

Nays

Harris, Pettapiece, Tabuns.

The Chair (Ms. Cheri DiNovo): I declare that vote 2902 is carried.

Shall vote 2905, electricity price mitigation, carry?

Ayes

Colle, Fraser, Hoggarth, Kiwala, Rinaldi.

Nays

Harris, Pettapiece, Tabuns.

The Chair (Ms. Cheri DiNovo): I declare that vote 2905 is carried.

Shall vote 2906, strategic asset management, carry?

Ayes

Colle, Fraser, Hoggarth, Kiwala, Rinaldi.

Nays

Harris, Pettapiece, Tabuns.

The Chair (Ms. Cheri DiNovo): I declare vote 2906 carried.

Shall the 2017-18 estimates of the Ministry of Energy carry?

Ayes

Colle, Fraser, Hoggarth, Kiwala, Rinaldi.

Nays

Harris, Pettapiece, Tabuns.

The Chair (Ms. Cheri DiNovo): I declare that the 2017-18 estimates of the Ministry of Energy have been carried.

Shall the Chair report the 2017-18 estimates of the Ministry of Energy to the House?

Ayes

Colle, Fraser, Hoggarth, Kiwala, Rinaldi.

Nays

Harris, Pettapiece, Tabuns.

The Chair (Ms. Cheri DiNovo): I declare that the Chair will report the 2017-18 estimates of the Ministry of Energy to the House and that this has been carried.

We stand recessed until 3:45.

The committee recessed from 0945 to 1605.

MINISTRY OF HEALTH AND LONG-TERM CARE

The Chair (Ms. Cheri DiNovo): The committee is about to begin consideration of the estimates of the Ministry of Health and Long-Term Care for a total of 15 hours. We welcome everyone.

As there is a new ministry before us, I would like to take this opportunity to remind everyone that the purpose of the estimates committee is for members of the Legislature to determine if the government is spending money appropriately, wisely and effectively in the delivery of the services intended. I would also like to remind everyone that the estimates process has always worked well with a give-and-take approach. On the one hand, members of the committee take care to keep their questions relevant to the estimates of the ministry, and the ministry, for its part, demonstrates openness in providing information requested by the committee.

As Chair, I tend to allow members to ask a wide range of questions pertaining to the estimates before the committee to ensure they are confident that the ministry will spend those dollars appropriately. In the past, members have asked questions about the delivery of similar programs in previous fiscal years, about the policy framework that supports a ministry approach to a problem or to service delivery, or about the competence of a ministry to spend the money wisely and efficiently. However, it must be noted that the onus is on the member asking the question to make the questioning 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. I trust that the deputy minister has made arrangements to have the hearings closely monitored with respect to questions raised so that the ministry can respond accordingly. If you wish, you may, at the end of your appearance, verify the questions and issues being tracked by our research officer.

Are there any questions before we start?

I am now required to call vote 1401 of the estimates, which sets the review process in motion. We will begin with a statement of not more than 30 minutes by the minister, followed by statements of up to 30 minutes by the official opposition and 30 minutes by the third party. Then, the minister will have 30 minutes for a reply. The remaining time will be apportioned equally amongst the three parties.

Minister, the floor is yours.

Hon. Eric Hoskins: Thank you, Madam Chair and members of the committee. Thank you for the opportunity to speak with you today.

When we last spoke in the fall, I had much to share about the progress that we had made. That progress created momentum that has continued well into this year, and it has me, quite frankly, excited. Hopefully, I can keep you excited and enthusiastic for the next 29 and a half minutes—and the seven people who may be watching this at some point in time.

As both Ontario's Minister of Health and a doctor, I am driven by a genuine passion for improving health care for all patients and all Ontarians, no matter who they are or where they live. It has always been imperative for me to ensure that all Ontarians continue to enjoy a health care system that delivers the highest quality of care possible—not just today, but for generations to come. Our government has a plan to do exactly that.

It has been nearly six years since Ontario first unveiled its action plan for health care. In that time, we have strived to provide better quality, better accountability and cost-effectiveness right across the health care system. We have strived to improve its sustainability and its quality through performance management and activity-based funding. Perhaps most importantly, in 2015 we entered the second phase of health care transformation with our Patients First: Action Plan for Health Care. That plan is a commitment to the people of Ontario. It is a commitment to focus our government's efforts on transforming our health care system into one that truly puts patients' needs first.

But why put patients first? In my time as a doctor, I have worked with many health care workers—doctors, nurses, specialists of all different varieties—and there's one thing that motivates them all: caring. They care for their patients and they care what happens to their patients. They want to help them so that they can enjoy the best possible health and the best possible patient outcomes.

Caring is also an important part of who we are and what we stand for as a society that values human life—a society, quite frankly, that believes in dignity and respect for all; a society that believes that all people have the right to health and to health care. If that is indeed what we all believe, and I firmly believe this to be the case, then we should always ask ourselves: How do we ensure universality? How do we ensure improved access? And how can we deliver the highest quality of care?

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Of course there will always be challenges before us. Yes, with the baby boomers entering their later years, we have an aging population. And yes, we have to be mindful of the trust that taxpayers have placed in us to spend their money wisely. But these challenges are not so great that we can't overcome them. It's really a matter of the choices we make, and it's about making smart choices. We need to be innovative and we need to find better ways of delivering care. So we focus on the patient, because delivering better care means understanding and predicting their needs, and supporting the models that best help them.

We have to ask ourselves: What do patients want and what do patients need from their health care system? We know that patients want a health care system that is easy to access. They don't want to have to travel far from home to access these services. They also want a system that's going to provide them with the information that they need to make the right decisions about their health. And perhaps, most important of all, they want to know that their health care system is going to be there for them when they need it—not next week, but when they need it. They want to know that it's going to be there when they need it and it is going to be there not just right now, not just next week, but next year, and the year after that and the year after that. They want to know that their health care system is going to be there for their families, long after they might be gone themselves.

What does that mean? That means faster access to the right care, better-coordinated and integrated care closer to home, having that information that they need to make the right decisions, and protecting our health care system for generations to come. These four key objectives have served as the guiding principles in the government's efforts to transform our health care system into one that focuses on patients. They are the four pillars of the Patients First action plan, and they have guided not only our decision-making but that of all of our valued health system partners since our plan was first introduced.

Together, we've made significant strides, including over the last year, to realize that vision. One of the biggest strides we have made in the last several months is in how we go about delivering better-integrated and coordinated care, again, as close to home as possible.

In December, our government passed the Patients First Act. Our motivation for this legislation was to help patients and their families get better access to a more integrated health care system. It's about improving the patient's experience and delivering higher-quality care.

Patients will still make an appointment to see their doctor or nurse practitioner when they need to talk to someone about their health, whether it be for treatment or because they have a concern. But we're going to make it easier for health care providers by ensuring that they are better positioned to help patients take that next important step in terms of their care, so that they can realize a better outcome.

As a doctor, I know one of the greatest struggles is ensuring that the patient gets the care they need after they leave your office. If I had a patient who needed to be referred to a specialist, often I would simply have to write down that specialist's number on a Post-it Note. I'd give that Post-it Note to the patient, and then I would have to hope that they would make that call to follow up. That's not a good example of well-coordinated care.

As a doctor, I would often worry that the patient wouldn't make that call or access that care that they needed, that I had referred them to. Of course, it would be equally frustrating to the patient who has to go home

after an unsuccessful effort to obtain the care that they need, and then follow up again to seek that same care.

With the Patients First Act, that is all changing. Now, for example, if I'm the doctor, I may no longer have to hand them that note, or hand them the phone number of the home care services or the CCAC. Now I might be able to direct them down the hall to someone within the same facility who will help to connect that patient to the services they need.

Our aim is, once that patient leaves their doctor's office or their nurse practitioner's office, that everything has been arranged for them. From the doctor's or the nurse practitioner's perspective, that's a lot more fulfilling, because instead of having to wait and hope, now you know that the patient is getting the care they need.

This is what we mean by "better-coordinated care," and it's just one of the benefits of the Patients First Act.

For instance, if you were a patient right now and you were looking for a new family doctor or a nurse practitioner, most people would not know where to even begin. So we're going to make it easier than ever by providing patients with a single number to call to connect them with a new family doctor or a nurse practitioner in their community.

The Patients First Act is going to mean that more of the important health care decisions that affect patients are going to be made in their own community. It only makes sense. Health care delivery is not a one-size-fits-all. What works in Toronto may not be ideal for Moose Factory.

There are a number of different factors that impact how we can deliver the best possible care. Are there large distances to be crossed? Is there a language barrier? Is the care culturally appropriate? These and others are all things that have a great impact on how we deliver care. But with the right planning—planning that addresses local needs—we can ensure that the elderly grandmother with a chronic illness who can only speak French can get the care that she needs, or the young person struggling with mental health challenges in a remote community can access the right services for them.

Local health care planning does more than just improve care. It also helps to strengthen the voice of patients and families and health care providers in their own health care planning.

Now, if you'll indulge me for a moment—I guess you have no choice in that matter, but thank you for indulging me—I'd like to further explore that last example of the young person struggling with mental health challenges, because it speaks to why it is so important that patients have a voice.

For too long, historically, mental health challenges were treated as if they were something to be ashamed of. It was something families didn't talk about. People struggling with their mental health were stigmatized and treated differently. They were treated as if they weren't ill in the same way as someone with a broken bone or a cancerous tumour.

Fortunately for those living with mental illness, times have changed. Today, we are shining a spotlight on mental health. We are now bringing the challenges around mental health and substance use disorder into our ongoing health care conversation.

Our government wants to expand effective mental health and addictions services, so that people living with mental illness and substance use disorder will be able to equitably access services in their community even earlier.

We need to address these challenges before they become a crisis. That's why, earlier this year, we made a commitment to invest an additional $140 million in mental health initiatives over the next three years, and more than $50 million of new dollars every year after that.

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This funding will be used to expand access to mental health and addictions services, from Kingston to Kenora and everywhere in between. Part of this funding is being used to create a new province-wide structured psychotherapy program that will provide thousands of Ontarians with access to treatments like cognitive behavioural therapy.

We want to help people living with anxiety and depression to learn strategies to improve their health and be more successful in their daily lives. We also want to identify mental health issues as early as possible, knowing that 70% of mental illness arises during childhood and early youth. By identifying it as early as possible, we will be able to get patients the help they need before more serious issues arise. To do that, we're investing in up to nine new integrated youth service hubs across the province.

In many cases, people with mental illness and substance abuse disorder struggle with finding proper housing. This, as we all know, can create added pressures and place a lot of added stress on both their mental and physical health. It creates a difficult and negative spiral. So we're taking steps to address the issue of housing by investing in new supportive housing units across Ontario.

These new units will provide residents with more than just a roof over their head; the units will also offer access to services such as counselling, case management and treatment services. We're bringing the services to clients and patients rather than the other way around.

It's all part of our plan to transform the services we deliver to those struggling with mental health and substance abuse disorder, so that they have access to equitable, high-performing, recovery-oriented services. Our overarching goal is to deliver effective and responsive mental health care to our patients and clients where and when they need it, regardless of where they live.

I've often said that there can be no health without mental health, and I've often described mental health as being one side of a coin, one side being physical health, but the other side being mental health; two sides of the same coin, both equally vital and equally important. Our commitment needs to be equal to both.

We're fortunate, as I referenced early on, as a society to have evolved significantly. There is still great stigma

against those who suffer from mental illness, don't get me wrong, but we have progressed a lot, where the conversation is now much more out in the open and there is an understanding and respect that we have an obligation as a society to normalize mental illness, acknowledge the importance of pursuing and achieving mental health, and providing the requisite services that are required. That's what we're trying to do here. We're trying to play a role not just in the provision of services, but understanding that government has an important role to play in reducing and eventually eliminating the stigma associated with mental health. And increasing our investments. There is, quite frankly, a long way to go. But that's our overarching goal: to deliver effective and responsive mental health care to our patients and clients where and when they need it, and regardless of where they live.

With that in mind, I can't stress enough the need to address—and I know my colleagues, all of you, agree—opioid use disorder in this province. Right now in this province, and frankly across this country, we're all struggling with the magnitude of the opioid crisis that is in our midst. Across this country and in Ontario, families are losing loved ones as a result of opioid overdoses—865 individuals last calendar year alone. Each one of those deaths, each one of those overdoses, is its own tragedy. This national crisis is built upon literally thousands of them.

Across this country, the true heroes of our health care system, the front-line workers, are working under incredibly difficult and emotionally challenging circumstances to attempt to meet this crisis, and meet it head-on.

Sadly, these lives that are being lost are entirely preventable, so our government has a responsibility to respond to this crisis and respond effectively. We have a responsibility to ensure that all Ontarians have access to quality health care, and as a society that believes that everyone is to be treated with dignity and with respect, we've got work to do. The lives of people who use drugs and people living with substance use disorder matter. They are valued and they are important, and they deserve high-quality care, care that is dignified and compassionate.

So we have taken action. We have made naloxone available at over 1,500 local pharmacies, through public health units and eligible community organizations, for free, so that people who are at risk of opioid overdose and their friends and loved ones can get access to this life-saving drug.

We have improved access to quality data, so that we can get a better idea of what's happening on the ground, and the data that we receive will help us to share information about the impact of opioids and help to strengthen our response.

We've committed to funding for four supervised injection service sites, including three right here in Toronto, and we're sending reinforcements to the front lines by providing every single local board of health with funding to hire more workers to expand their local opioid response capacity.

We're also funding new harm reduction outreach workers, who will connect vulnerable individuals accessing harm reduction with other health and social services, and we are providing specific community agencies working with populations at risk with funding to hire more workers.

It's our goal to increase access to harm reduction services and treatment for opioid use disorder in every region and every part of this province. We want to ensure that the people who are fighting opioid use disorder have access to the resources they need, when they need them. We cannot allow this public health crisis to continue any further. Too many lives have already been lost.

That is why our government is investing close to a quarter of a billion dollars in the fight against the opioid crisis, and to improve services for those with opioid use disorder. This will ensure that the individuals who are most at risk can get the help that they need in their communities as quickly as possible.

We continue to invest in new harm reduction programs; culturally appropriate care for indigenous people, families and communities; and developmentally appropriate addiction treatment to meet the unique needs of youth. We're going to help people get the care that they need, so that families don't have to go through the pain of losing the ones they love.

As I have said at the outset, if we are looking to truly provide universal care, that means we need to ensure that all Ontarians have access to quality health care. For too long, indigenous people have suffered from the legacy of colonialism, which has resulted in poorer health outcomes and inequitable access to services. Of course, this is especially true of the north, where there are significant gaps in health services. So we have been working closely with indigenous partners to ensure that they have access to culturally appropriate and safe care, and the improved health outcomes that come from that.

I was pleased to announce an investment of nearly $222 million over three years, the biggest investment of new funds for indigenous health services in this province's history, this past May, which is being used to improve health services.

This investment will go into programs like the remote First Nations family medicine residency program at the Northern Ontario School of Medicine, which will address primary health care, public health and health promotion needs in remote First Nations communities. It also includes increasing physician services by more than 2,500 more days each year for 28 First Nations communities across the Sioux Lookout region. And it includes delivering cultural competency training for front-line and administrative health care workers who work with First Nations communities. We have already trained thousands of front-line health care workers in that cultural competency.

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These are just a few examples of the investments that we're making. These investments are being implemented and evaluated in close partnership with indigenous partners as we collaboratively work to deliver the care they need.

While we're transforming our health care system to provide patients with the care they need closer to home—in some cases, right in their homes—there's one thing that this transformation will not change: the need for our hospitals. No matter the reason, patients expect that our hospitals are going to be there for them when they need them, that they are going to provide them with the best possible care for today and for tomorrow.

For this reason, our government has been investing in a number of hospital infrastructure projects as part of the 2017 budget. This $9-billion investment, combined with our previous commitments, means that Ontario will see over $20 billion invested in hospital infrastructure over the next 10 years. That means up-to-date facilities to deliver life-saving heart surgeries, kidney dialysis and many, many other services that Ontarians rely on.

We're committed to several new-priority major hospital projects that will give patients access to the right care in the right place at the right time. It will also serve to sustain our hospitals for years to come because, you see, our hospitals can only be reliable and deliver that top-quality care when they are maintained. They need to be kept in working condition. We need to update them to make them suitable for the latest advances in technology and innovation. That's why this investment of $20 billion over the next decade is so important.

We also know that just as important as the infrastructure is, we also need to keep the lights on. We need to ensure that doctors, nurses and the staff that people rely on are there when patients need them. So, as part of the budget, we increased the operating funding for every one of Ontario's public hospitals by a minimum of 2%. Keeping our hospitals vital and thriving for the future is a critical part of our plan to put patients first.

We want to build a health care system that is even more responsive to the needs of patients, but to do that we need to understand better the needs of patients. Earlier, I mentioned that we would ensure that patients have an opportunity to have a say in the delivery of their health care, and we're taking a number of steps to see that happen. I've established the minister's Patient and Family Advisory Council for Ontario to advise our government on health policy priorities that have an impact on patient care and patient experience. By involving patients and families, their caregivers and advocates in the policy development process, we will be helping to ensure that their needs and concerns are fully understood. This council will help to make our health care system even more responsive, even more transparent and even more accountable to the people it serves.

In addition, every single local health integration network will, by October 31 this year, establish one or more of their own patient and family advisory committees to help ensure that the voices of patients and their families are part of health care policy decision-making at the local and regional levels.

We know that this system is not, nor will it ever be, perfect. There will always be challenges, but we want all patients to have an opportunity to be heard even when their concerns cannot be resolved through the processes in place for home and community care, hospitals and our long-term-care homes. That's why we recruited Ontario's first Patient Ombudsman. Now the Office of the Patient Ombudsman is up and running and helping to address the concerns of patients across the province.

Putting patients first, I know, is an ambitious goal, but it's an achievable one. As you can see from the investments that I've outlined today, we're making great strides in our efforts to provide patients with care that is focused on their needs. We're going to continue to be guided by our commitment to patient-centred care in all of our decision-making.

I want to thank you once more, Madam Chair, members of the committee, the drafters of this 30-minute piece—which is remarkably well-timed, because I only have seconds left and I'm on the last paragraph. Chair, how much time do I have left?

The Chair (Ms. Cheri DiNovo): You actually have just over a minute.

Hon. Eric Hoskins: So thank you for the opportunity to speak to you today. But it does give me a number of seconds—almost a minute—to thank my parliamentary assistant, John Fraser, who has done remarkable, admirable work over the last number of years in support of this goal of providing the highest-quality health care in the province. I want to commend him on all fronts for the time and effort that he has invested, which comes from a place, I know, in his heart where he is so deeply committed to providing that high-quality care and ensuring that the patient, the caregiver, the family and the health care worker's voice is exceptionally well heard. I thank him for that work. I know he is not done and has a lot of work yet to be done still. Thank you, John.

The Chair (Ms. Cheri DiNovo): Thank you, Minister. We now move to the official opposition: Mr. Yurek.

Mr. Jeff Yurek: Good afternoon, Minister and Dr. Bell. I'd say "thanks for being here," but you really had no choice. I will make the best of the next time we're together—

Hon. Eric Hoskins: Delighted to be here.

Mr. Jeff Yurek: I too appreciate John Fraser's role in the Legislature. I think he does a wonderful job, and I would say he should be a minister somewhere in the cabinet. Anyway, I'm going to go right to some questions and use my time. My questions are straightforward, and I look forward to some straightforward answers.

First, I want to dive into the Canada Health Transfer. Could you let me know how much of the Canada Health Transfer for 2017-18 is earmarked for mental health?

Hon. Eric Hoskins: I will be able to in a moment. I have a recollection, but I want to make—

Interjections.

Hon. Eric Hoskins: I apologize—unless my deputy has that number at his fingertips. I know we'll have that momentarily.

Interjection.

Hon. Eric Hoskins: Oh, I see. Okay. My apologies. I was imagining that you were referencing the recent bilateral agreement between the federal government and ourselves, which does have additional targeted funds for both mental health and home care services. But when it comes to the Canada Health Transfer, am I correct, Deputy, that there is not an amount earmarked specifically for mental health services that's in the transfer itself?

Dr. Bob Bell: Yes, that's correct, Minister. There's $39 million—

The Chair (Ms. Cheri DiNovo): Oh, excuse me: Could you introduce yourself?

Dr. Bob Bell: Oh, of course. Sorry, Chair. Bob Bell, Deputy Minister of Health and Long-Term Care.

Minister, there's $39 million for mental health services in our bilateral agreement outside of the Canada Health Transfer.

Mr. Jeff Yurek: So $39 million per year, from the—

Hon. Eric Hoskins: That is for year one. It does vary from year to year.

Mr. Jeff Yurek: And we have that? We've received that money for this coming year?

Hon. Eric Hoskins: We have received the funds, the $39 million, for mental health for this year. Yes.

Mr. Jeff Yurek: But for the Canada Health Transfer you don't specifically earmark any of that? That just goes into general revenues—the Canada Health Transfer. Is that—

Hon. Eric Hoskins: The federal government does not specifically earmark within the transfer itself.

Mr. Jeff Yurek: So you're saying that $39 million has been allocated for this year. How much new provincial funding is allocated for the 2017-18 year? You've mentioned $140 million over three years, but how much of that is for this year?

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Hon. Eric Hoskins: I'm hesitating because I know that—the answer has arrived.

Dr. Bob Bell: Yes. The total expenditure on mental health services, including hospitals and communities, is about $3.4 billion.

Mr. Jeff Yurek: And that's for direct mental health services?

Dr. Bob Bell: I don't believe that includes OHIP services.

Interjection: It does.

Dr. Bob Bell: It does. It does include OHIP services and physician billings.

Mr. Jeff Yurek: Do you have that broken down away from physician billings? Do you have it separated?

Dr. Bob Bell: Yes. Just a second and we'll get you the full distribution.

Hon. Eric Hoskins: Feel free, by the way—in the future, if you'd like a more prompt response, you're welcome to submit your questions in advance.

Mr. Jeff Yurek: Yes.

Dr. Bob Bell: The total funding for adult mental health services is $3.39 billion, of which $2 billion is funded through the 14 LHINs and $1.39 billion is funded through $692 million of OHIP physician billings and $561 million of mental health public drug funding.

In the services that support provincial assets such as ConnexOntario and PSSP, which is a provincial organization focused at CAMH: $27.5 million. Supportive housing, rent supplements, dedicated portfolios, homes for special care: $108.1 million.

In the LHIN investments of $2 billion, there is $1.05 billion of community mental health services and supports and $953 million of hospital care for mental health patients, including funding for mental health beds in 75 general hospitals and four speciality psychiatric hospitals, totalling about 4,684 mental health dedicated beds.

Hon. Eric Hoskins: If I can just add, although it's outside my purview, there are also funds provided through the Ministry of Children and Youth Services for that particular demographic.

Mr. Jeff Yurek: So you don't transfer any funds from the Ministry of Health to the Ministry of Children and Youth Services for those programs?

Dr. Bob Bell: No, we don't. Those are directly funded. We don't fund any services that come directly under the Ministry of Children and Youth Services.

Mr. Jeff Yurek: With the Canada Health Transfer, just moving over to home care, how much did you receive as that extra, outside amount this year for home care?

Hon. Eric Hoskins: That would be outside of the Canada Health Transfer, right, so the bilateral agreement that was signed earlier this year where we referenced the $39 million for mental health. You're correct: There was a targeted amount for home care. We're just getting what this year's amount is.

Mr. Jeff Yurek: And again, out of the Canada Health Transfer, none of that money is earmarked for home care.

Hon. Eric Hoskins: The federal government does not provide that targeted earmarking within the transfer.

Dr. Bob Bell: In-year is $73 million for home care, Mr. Yurek.

Mr. Jeff Yurek: How many, sorry?

Dr. Bob Bell: It's $73 million.

Mr. Jeff Yurek: So $73 million.

Hon. Eric Hoskins: Again, that will change from year to year.

Mr. Jeff Yurek: How much was budgeted in the home care sector for this year?

Dr. Bob Bell: Just give me a second for that. We've got it here. It is:

—$2.786 billion through the former CCACs, with community support services funded for $589 million;

—the brain injury programs in the community funded for $80.1 million;

—mental health services, $960 million;

—community mental health I've already mentioned;

—addictions services, $217 million;

—community health centres, which are funded through our community vote, $397 million;

—assisted living services and supportive housing, $325 million.

Mr. Jeff Yurek: With regard to the LHIN, the CEO of the South West LHIN was let go last Friday. Do you have any details of his payout for cutting him loose from the organization?

Hon. Eric Hoskins: I do not have any details. I think you appreciate that this is a human resource matter internal to the LHIN. I certainly am not privy to that information at this point in time.

Mr. Jeff Yurek: Are you able to access that and share it with the committee?

Hon. Eric Hoskins: I'm happy to look into it.

Mr. Jeff Yurek: The Ontario Mental Health Foundation, if Bill 160 is passed, will be wound down. Where would the funding for the mental health foundation be reallocated?

Hon. Eric Hoskins: It was important to us that the level of funding that was being provided to the foundation would remain within the mental health envelope of the Ministry of Health. It remains and will be allocated within that context.

Interjection.

Hon. Eric Hoskins: In fact, I can add to that that we're doing—which was my recollection, and I appreciate the deputy clarifying—a special call for research utilizing those funds, consistent with the mandate, essentially, of what the foundation was.

Mr. Jeff Yurek: Okay. With regard to your opioid announcement in August, the $222 million over three years, can you give us a breakdown of what you've spent or promised to spend up to today of that $222 million—how much has gone to where?

Hon. Eric Hoskins: So you want a breakdown of that $222 million in terms of how it's being allocated?

I can start. I know that there are—which is one of the most important components—$21 million that goes specifically to harm reductions efforts to those agencies already established that are providing harm reduction services—

Mr. Jeff Yurek: That would be CHCs in public health or—

Hon. Eric Hoskins: Yes, CHCs and other community agencies that have peer support and other harm reduction workers and professionals who interact directly with those who are suffering from substance use disorder. And $9 million will—I'm sorry, the $222 million that was announced was, I believe, the third funding announcement that I had made at the time, so some of it is augmenting activities that were already under way. An example of that is:

—approximately $20 million added to expand further the supply of naloxone, providing naloxone to emergency departments and providing it more broadly to community agencies, similar to the ones that I just referenced, and also exploring opportunities to make, under the correct circumstances, nasal spray naloxone available;

—$70 million is specifically to respond to the community-level need for addictions treatment, including—and there are many already established; we will be establishing new ones, as well as augmenting the existing ones—rapid access addiction medicine, or RAAM, clinics, the example being somebody comes in with substance use disorder or an overdose, for example, into emergency and they're able to refer them directly, often within the same facility, for them to get that medium- and longer-term support that they require;

—$23 million is to provide additional support for existing harm reduction programs, including, for example, needle exchange, and additional funding to expand supervised injection sites;

—$12 million specific for appropriate care and pathways to treatment for indigenous communities;

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—$8 million to develop specialized addiction treatment and services targeted to the unique needs of youth;

—CAMH will be receiving just under $8 million as well to work providing mentorship and education to primary care physicians and nurse practitioners working together with the Ontario College of Family Physicians;

—$15 million to support health care providers on appropriate pain management and opioid prescribing; and

—just over $1 million for data collection and monitoring.

I'm not sure what that adds up to or if there are additions to that.

Dr. Bob Bell: There you go: 2017-18, 2018-19 and 2019-20.

Hon. Eric Hoskins: I have a chart here which has fewer lines to it but segments it into how the funds—so in the first year of 2017-18, for example, a total of $42 million will be disbursed. The majority of that is going to harm reduction and the sorts of things that I spoke to. Treatment will be $15.5 million. Appropriate pain management will be $3.75 million, and surveillance and reporting: $2 million. That gives you an idea, at least for 2017-18, of that total of $42 million broken down that way. And it's similar—but increased amounts: $90 million, for example in 2018-19 and $88 million in 2019-20.

Mr. Jeff Yurek: The large numbers you've given: That's for over three years, then.

Hon. Eric Hoskins: It's $22 million, I believe, roughly over a two-and-a-half-year period.

Mr. Jeff Yurek: So you've spent roughly $50 million in this—

Hon. Eric Hoskins: Between now and the end of the fiscal year, yes.

Mr. Jeff Yurek: Okay. The Public Health Ontario opioid morbidity and mortality reporting tool displays data up until only March of this year. Do you have plans to make that current, and when?

Hon. Eric Hoskins: I would say that the ministry, and particularly the Chief Coroner, have done exemplary work over the course of the past year to, on the part of the coroner, modify the approach of the Office of the Chief Coroner to investigate and determine a cause for overdoses that are suspected as being due to opioids. With information previously, we would see a lag time of more than a year before a suspected case would actually be determined or not determined to be related. Through changes made within the Office of the Chief Coroner now, that overdose data shortly—I think in a matter of weeks—will now have a roughly three-month lag period from the time that it is reported to the office of the coroner to the time that that determination is made.

Similarly, we introduced new data collection measures this past spring where we are now collecting, on a weekly basis from emergency departments throughout the province, data on overdoses that present themselves to emergency departments. That has resulted in information that previously lagged by a quarter or even two quarters; we're now receiving that information on a much more expeditious basis, which allows us to make it available not just to public health units but to the public at large.

Mr. Jeff Yurek: When do you think that will be updated? We're sitting at March.

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

Dr. Bob Bell: Yes. We expect that the public site will be at least a quarter behind. We have information on a more timely basis within the ministry for surveillance, but posting to that public site requires an extra step of data cleaning etc. that keeps us about a quarter behind, we expect.

Mr. Jeff Yurek: Okay. Why doesn't the data regarding opioid-related morbidity and mortality published by Public Health Ontario distinguish between incidents involving prescriptions versus incidents involving street or counterfeit drugs? Or do you collect that data?

Dr. Bob Bell: We do. I'll start off by simply saying that the cause of death is, of course, a coroner's decision, and the determination of what drugs have been used by the deceased, I would imagine, is sometimes difficult to determine. Whether we actually—

Hon. Eric Hoskins: Deputy, can I make the suggestion that—and this is your time, but we have not only our Chief Medical Officer of Health but he's also the provincial overdose coordinator, who I think is probably best placed to answer this question.

The Chair (Ms. Cheri DiNovo): Could you introduce yourself, please?

Dr. David Williams: Yes. Dr. David Williams, Chief Medical Officer of Health and provincial overdose coordinator.

If you're asking about the morbidity data, when the coroner undertakes the investigation he is trying to put out right now, as the minister has alluded to, a "probable" case in a new database—that will be for the first three months; it will be out shortly, in November. That's for April, May and June. In the final one, completing the whole, full investigation which is required by the Coroners Act, he will then do a toxicological screening which they can now do for 30 to 35 synthetic opioid agents. He will try to determine if the main agent is one of the regularly prescribed opioids that are available or if it's one of the illicit ones, and he can denote that in the cause of death if it seems to be the major contributing cause.

Many of these have multiple drugs involved, especially some of the ones on the illicit side. Sometimes you can't actually attribute it to one specific drug. If he can, he will try to determine that.

Mr. Jeff Yurek: Okay. Just further with the data you're collecting, I've spoken with local police departments, and they would find it very helpful if the hospitals would be able to share the type of drug that is occurring in the overdoses they're finding. If they have that data, they find it would be very easy to target their resources better.

Dr. David Williams: One of the things we're trying to look at is that the hospitals, up until most of this year, do not have that type of capacity to look at all those synthetic forms that are coming out. They will mostly determine it by the response to Narcan or naloxone, and that's mostly their task, to try to do the resuscitation.

The determination of whether they're dealing with which specific agent doesn't really affect their response. But if you're dealing with—what we're trying to put forward in an early warning system—if there seems to be, in the impression of EMS, police, public health, harm reduction staff and/or ED departments, a cluster of unusual presentations, we are trying to set up a system now where we can expeditiously have them taken to one of our four labs that do the sophisticated mass spectrum chromatography on that and can give an analysis back in four hours. That would help to determine if they have a new agent in their midst that has been brought in through some means, and they might have a cluster that they could take action on. But that is not available at the moment, so the need for the ED doctors to know, combined with the police, would be if they're trying to ascertain if there's something new and highly toxic within their midst, especially if it's presenting with multiple cases, and they need to do a different type of response on a very short-term basis.

Mr. Jeff Yurek: Okay. Just back in general, I asked this question the other day and didn't get a response. I didn't want to do a—whatever you call those—a late show. Funding for naloxone for police services: Is there not a way for the amount of money that's been targeted for the opioid crisis to be sent towards the police services in this province to ensure that our officers have naloxone on them, as opposed to downloading the cost to the municipality to find?

Hon. Eric Hoskins: For some time, directly between ministers, myself and the Minister of Community Safety and Correctional Services have been discussing what might be the most appropriate way to provide police services and address their concerns, both their ability to be life-savers, if they come across or see an individual

who appears to have overdosed due to opioids, that they can intervene and, quite frankly, have the potential to save a life, but also police services' and individual police officers' concerns with regard to their own personal safety. We have been having those discussions—of course, involving police services themselves—and are confident that we will reach a conclusion that will address the concerns that have been raised.

Mr. Jeff Yurek: Can you comment on if there has been a cut in funding to peer services for psychiatric patients? We have a psychiatric survivors network in Elgin. Our LHIN is shutting them down as of the end of the year, which is drastically reducing peer services for mental health clients in our community. They are 24/7. They will be gone as of December 31, and our LHIN has not set up a system that will maintain that.

1700

Has it been a cut to mental health funding which is causing our LHIN to cut peer services?

Hon. Eric Hoskins: Certainly not that I'm aware of.

Mr. Jeff Yurek: So that would be totally a LHIN decision with regard to the delisted services?

Hon. Eric Hoskins: The LHIN that you're referencing is—

Mr. Jeff Yurek: South West LHIN.

Hon. Eric Hoskins: Yes. My understanding is that there has been work for some time by the LHIN to reorganize peer support for those with mental illness. But I'm not aware of any decisions to cut funding, certainly not at the level of the ministry.

Mr. Jeff Yurek: Speaking to Michael Barrett last week—he was the CEO of the LHIN—he commented that his intention was not to reduce services with regard to peer services. However, he was not aware that the PSNE was going to be shut down, and seemed to be taken aback by that.

Would we be able to get your support to the ministry to ensure that our South West LHIN ensures that peer services are available in Elgin county?

Hon. Eric Hoskins: Now that you've made me aware of the specifics and the concern, I'll discuss it further with the ministry.

Mr. Jeff Yurek: Okay. Can you let us know the mandate of the Canadian Association of Provincial Cancer Agencies' Cancer Drug Implementation Advisory Committee, CDIAC?

Hon. Eric Hoskins: Thank you.

Dr. Bob Bell: The executive officer for the publicly funded drug program, Suzanne McGurn.

Mr. Jeff Yurek: Hello, Ms. McGurn.

Ms. Suzanne McGurn: Hi. I don't have their mandate printed in front of me, but in a general sense, I can provide you with some information.

The CDIAC is a group that has been established under the CAPCA, which is the Canadian Association of Provincial Cancer Agencies, in response to escalating costs in regard to cancer care and particularly related to drugs.

What was happening previously was that—as you're quite aware, the decision to fund a drug goes through a process that includes Health Canada's regulatory approval followed by an assessment through CADTH, the pCODR, about the individual drug, and then subsequently a determination by the individual jurisdictions participating in the pan-Canadian Pharmaceutical Alliance as to whether they will participate in a negotiation for those products. As part of that work, individual jurisdictions were seeking the best advice from their cancer agencies to inform that work.

Since the pCPA's objective is to improve the consistency of coverage across the country, it was identified that there was an opportunity for the cancer agencies who have the expertise to coordinate across their own agencies. CAPCA has taken on looking at additional advice to the jurisdictions, in a collective way, to inform the pCPA negotiation.

Their mandate is available on the website. I simply do not have it verbatim with me.

Mr. Jeff Yurek: Who do they report to?

Ms. Suzanne McGurn: The CDIAC reports to the board of CAPCA, which is representatives of all of the cancer agencies across the country. As well, they do have participating members—representatives—from the pan-Canadian Pharmaceutical Alliance. Their advice is provided to the pCPA.

The Chair (Ms. Cheri DiNovo): Mr. Yurek, you have under three minutes.

Mr. Jeff Yurek: Three minutes? Thank you.

Are there any timelines for CDIAC that they must adhere to on their recommendations?

Ms. Suzanne McGurn: To the best of my knowledge, no. The CDIAC is a relatively new process, and so it is still in its maturing phase, similar to pCPA a few years ago. I can get back to you on that. I can look into that further.

Mr. Jeff Yurek: I've heard concerns about a lack of transparency with the CDIAC process. Do you have plans to address those concerns?

Ms. Suzanne McGurn: The CDIAC provides their advice to the pCPA at this point. I am unaware of any plans for the information to be made public, but certainly that issue has been flagged for us for consideration going forward.

Mr. Jeff Yurek: Okay. Thank you. How much time?

The Chair (Ms. Cheri DiNovo): Just under two minutes.

Mr. Jeff Yurek: Under two? Well, we've got time for this: Does the ministry plan to implement the report on the minister's expert panel on public health which recommends reorganizing the province's 36 health units and replacing them with 14?

Hon. Eric Hoskins: I obviously appreciate the work that the expert panel has done to prepare the report with recommendations. Apart from general terms of reference, it was a panel that did its work, I would say, completely independent of certainly my office and the ministry, apart from those original terms.

It was important to me to put the report out with its recommendations in a way which was agnostic and to solicit feedback and input based on their recommendations. That's the phase we're in: to hear from stakeholders, within the public health community and also more broadly, their views on the recommendations of the expert panel. Certainly no decision one way or the other has been made by the government or by my ministry in terms of how we would respond.

Mr. Jeff Yurek: Do you have the timeline on how long you're going to hear consultations?

Hon. Eric Hoskins: Yes. I presented, the same day or perhaps the day after the report was made public, to the Association of Municipalities of Ontario table, to brief them and solicit their feedback. As well, we've made it available more broadly to the public health community, as I referenced, and we opened up the consultations, which we anticipate will run until the end of this month.

The Chair (Ms. Cheri DiNovo): And that is time up.

We now move to the third party. Madame Gélinas?

M^me^ France Gélinas: Thank you for your opening comments. As you probably all know by now, I and the NDP have been filing a ton of freedom of access to information requests regarding overcrowding and overcapacity in our hospitals. I want to take you back to May 2016. We had filed such a request to your ministry, and the answer really puzzled me. It says, "The Ministry of Health has no guidelines or standards on what hospital occupancy should be."

Basically you responded to a freedom of information request by saying, "Please be advised that the ministry does not have standards, guidelines, policies or best practices with respect to hospital bed occupancy as it is related to hospital operations." I'm just curious to find out: That was in 2016; since then, has the ministry created any standard or guideline for hospital occupancy levels?

Dr. Bob Bell: Thanks, Ms. Gélinas. We look at the performance and activity of hospitals based on weighted cases as opposed to beds in service at any one time. However, we have paid a lot of attention over the past year to accurate measurement of hospital occupancy.

We think now that we have a much better way of achieving that data, in that we're getting data daily from each hospital based on the midnight census: How many beds are actually occupied at midnight? As you know from being around hospitals, if that measure is taken during the daytime, there are frequently more patients present than there are beds, simply because a patient may be in the operating room, going to a bed that is going to be currently having a patient in it. That patient is going to be discharged, and the patient will subsequently arrive there.

So we have much better data now in terms of occupancy on a daily basis at midnight. We also have data on how many patients are admitted in the emergency department, and that data is collected daily.

M^me^ France Gélinas: So is there going to be any kind of a standard put out for occupancy? We now know the number of patients, but the World Health Organization does put out a standard that says anything over 85% capacity—I have no problem with measuring at midnight, but are we going to have a standard? I'll leave it to you.

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Hon. Eric Hoskins: We currently rely on and expect our hospitals to follow best practices and guidelines, but we respect as well the independence of our hospitals to be able to make decisions that will result in the highest quality of care that they can deliver. So we currently have no immediate plans.

Dr. Bob Bell: We do have a number of ways of measuring safety and performance in hospitals. As you know, hospitals standardize mortality ratios, nurse-sensitive indicators related to patient falls, decubitus ulcers, urinary tract infections, C. diff. infections, and we follow these closely. The trend for most of these indicators of hospital safety has been generally improving over the past few years.

M^me^ France Gélinas: Okay. So although the World Health Organization puts out a standard that says a hospital acute care ward occupied at over 85% has an increased risk of transmission of infectious diseases, we don't follow that in Ontario?

Hon. Eric Hoskins: I think it's most important to us that we provide the tools and resources so that our hospitals and the health care workers, professionals who are working within are able to not only follow best practice, but also to achieve the outcomes that the deputy just referenced. That, for example, is the basis of the investment that I announced yesterday for 1,200 new acute hospital beds to be implemented over the course of this calendar year. So that is currently the approach that we're taking.

M^me^ France Gélinas: Okay. In your work as the overseer of the health care system, I respect the fact that hospitals are independent corporations and they make their own decisions. I respect that. But in your role as Minister of Health, who oversees the system as a whole, we don't have any guidelines or standards that say, "If all of our hospitals are at 95%, that would trigger something within the ministry to look at overcrowding or overcapacity"? It sounds weird to me.

Dr. Bob Bell: I think if we look at the issue of safety in hospitals generally, the issue of occupancy is one issue that determines safety and outcomes. However, there are many issues. For example, you mentioned the issue of infections. The proportion of staff who are taking advantage of the three moments for handwashing while looking after their patients—that's a very important indicator, as you know, that determines risk of infection. Ontario hospitals have improved dramatically with respect to compliance with best practices in handwashing over the past few years.

If we look at issues related to surgical infections, compliance with use of antibiotics in operating rooms, compliance with methods for skin preparation, these are all very important. They're measured in the NSQIP re-

porting that's going on across Ontario hospitals with a high proportion of surgical care.

Certainly, occupancy is one factor that determines safety and outcome. We tend to measure the outcomes more than the processes that go into creating the outcomes, but many of the other elements that contribute to a safe hospital environment are present in Ontario. If we look at things like C. diff rates, if we look at issues related to return visits to the operating room, readmission after discharge—these are all elements that we measure—they're generally moving in the right direction.

M^me^ France Gélinas: I agree with this. I was just wondering if you make any correlations to occupancy, but it seems like Ontario doesn't have a standard, and we have our own indicators of hospital performance that are independent of the system as a whole, occupancy overcrowding.

Hon. Eric Hoskins: I think what the deputy is saying is that may be over-simplistic to look at just one measurement. I'm not aware of any province or territory that does have a specific target with regard to bed occupancy. As the deputy referenced, we now have very accurate and timely measurements of bed occupancy across the system, but we also—I would imagine we measure and make publicly available wait time data as well as the outcomes that the deputy referenced that are part of our decision-making process when we work in partnership, in collaboration, with an individual hospital. We look at all of these reference points to ensure, most importantly—I think most people would agree that the outcomes are what are most important. But we have a wealth of data, much of it publicly available, that allows us to ascertain if an individual hospital is achieving the goals we would want to see.

Dr. Bob Bell: For example, when we were determining the distribution of incremental beds that are going to be used in a surge-capacity fashion by the LHINs over the next few months that the minister announced yesterday, there were several factors that went into the determination of the distribution of those beds. Certainly occupancy was one of those. Another one was the number of patients admitted in the emergency department at 8 o'clock in the morning. Another one was the increase in weighted cases that had been experienced by a hospital over a period of time. Another one was cancellation of elective surgery that had gone on because of bed unavailability. There was a fifth factor that I—

Interjection.

Dr. Bob Bell: ALC; thank you. ALC was the fifth factor.

M^me^ France Gélinas: Okay. I know that you have started collecting information from hospitals on usage of unconventional beds. Can you tell me: Are those collected from all of our hospitals and are those collected on a daily basis or weekly?

Dr. Bob Bell: We don't collect information on that specifically with respect to numbers. As mentioned, we look at midnight census data. We look at patients admitted in the emergency department. We are doing that on a daily basis, so we do get a trend over time of increased bed utilization. The minister's investment announced yesterday certainly is designed to try to address some of the issues that we've been concerned about with overcrowding that you were mentioning.

M^me^ France Gélinas: So we don't keep track of how many unconventional beds are being used in Ontario hospitals?

Hon. Eric Hoskins: I think, de facto, by having an accurate measurement of hospital bed occupancy rates, that gives us a clear impression in terms of the patient load that is residing within that hospital at that particular moment in time.

Dr. Bob Bell: We do have information from the Ontario Hospital Association related to the use of unconventional spaces that might occur during the day. For example, while the patient is waiting for someone to be discharged from a bed, they may be spending a period of time in the hallway outside that room before they get admitted. We have not tried to validate that experience.

What we're doing is getting a very accurate measure on a daily basis of how many patients are admitted. We know the number of beds in utilization every day; that gives us a sense of patients who may be looked after in spaces other than patient rooms.

M^me^ France Gélinas: Do you take it for granted that if, at midnight, a hospital has 300 beds but reports to you that they have 320 patients, the other 20 are in an unconventional space?

Dr. Bob Bell: Generally speaking, those patients are going to be admitted in the emergency department. That's the usual, most common unconventional space. That, of course, is a safe environment as long as staffing is appropriate for those patients and, generally speaking, staffing responds to those admitted patients.

M^me^ France Gélinas: If the ER is full, what are the other unconventional spaces used by hospitals to care for them?

Dr. Bob Bell: There are a number of different options for hospitals if they're experiencing a remarkable surge. For example, post-anesthetic care units can be used; they're well equipped with monitoring equipment. Those are usually 20 to 30 beds within any hospital. Especially in the evening time, that might be a space that could be utilized.

M^me^ France Gélinas: Am I the only one here who has gone into a hospital and seen that the TV room is no longer a TV room—it's a patient's room; that the waiting room is no longer a waiting room—it is a patient's room; and the sunroom is no longer a sunroom—it has become a patient's room? Am I the only one here who has ever seen that?

Hon. Eric Hoskins: You may be, at least among your colleagues, the only one. Given that, I would imagine that you would support the investment that I announced yesterday with regard to the 1,200 new acute care beds across this province, including 16 new acute beds at the Sudbury hospital.

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Again, we're using the formula and the strategy that the deputy referenced earlier. We are allocating investments to those hospitals where we believe they have challenges or where we can assist in them meeting their outcomes. That investment not only of the acute beds but also the transitional care of roughly 600 beds and the 200 affordable housing units for seniors as well—that more than 2,000 speaks to the concern that you've raised—

M^me^ France Gélinas: Not really, but I want to come back to my question. I will ask you, Minister: Have you gone into a hospital and seen patients admitted into a TV room, a patient lounge or a hallway?

Hon. Eric Hoskins: I've made many visits to hospitals under different circumstances. They vary greatly, not only in terms of any particular challenges that they might face with regard to patient care. But I'm confident that the investment that we announced yesterday, and the $500-million investment—

M^me^ France Gélinas: Yes, but my question was: Have you ever spoken to a patient who is admitted into a hallway or a TV lounge?

Hon. Eric Hoskins: Again I'll speak to the fact that there are parts of the province where the population growth is such that we are intent on making investments to address that growth. But I refer again to the investment that we're making, as well as the $1 billion invested over the course of the last two budgets in the operating costs.

M^me^ France Gélinas: Deputy, can I ask you the same question? You come from the hospital sector. I know that you go back into our hospitals regularly. Did you ever talk to a patient who has been admitted into a hallway or into a TV lounge?

Dr. Bob Bell: I'm reminded by my colleagues that we've visited a lot of hospitals, our entire team behind us. Probably three quarters of that team has spent at least five to six visits over the last two to three months in hospitals. I think it's fair to say that we've seen a variety of unconventional spaces. For example, recently visiting Lakeridge hospital, we saw that a former emergency department had been taken out of commission and is being proposed as surge space for admitted patients who have been admitted through the emergency department and don't yet have a bed available.

Those spaces have monitors. They have equipment available. They're close in proximity to the nursing stations for the emergency department. That would be classified as an unconventional space.

M^me^ France Gélinas: Can you give me another example in another hospital where you saw unconventional beds being used?

Dr. Bob Bell: One of the things that's often termed an unconventional space is part of the hospital where beds have been closed on a unit. Sometimes hospitals will open new areas, renovated areas, and will close other areas. As surge occurs, they may open that area again that has facilities—oxygen in the walls—appropriate for patients who require admission, and at that time—

M^me^ France Gélinas: Wouldn't those be called unfunded beds, not unconventional beds?

Dr. Bob Bell: They might be called unconventional spaces based on the hospital's perception of what's funded, but of course, we don't truly fund the number of beds; we fund activity within the hospitals. As the minister mentioned, we rely on hospitals—their management teams, their clinical teams—to make good use of the funds to produce the kinds of weighted cases they've agreed to in their hospital accountability agreements. That's the basis on which we look at activity within hospitals.

You're absolutely right that we have been concerned, as you have been, about overcrowding in hospitals. We think we now have data that allows us to make rational investments. How hospital beds and how hospital patients are counted is an area that's often in flux during the day.

Could you see a patient waiting for a period of time in a hallway? That does happen; I agree with you. Those patients are waiting for a bed that will become available, that will be counted at midnight, but during that course of time that they're waiting for that bed to be cleaned and the room to be emptied and the patient discharged, they might be in a space where—we consider a hallway to be an unconventional space.

M^me^ France Gélinas: When you do your daily data—at midnight, you do your counting. Do you count acute care units versus mental health versus pediatric versus etc. or is it hospital-wide you get one big number?

Dr. Bob Bell: For our general hospitals, we get one number. In the so-called ADT feeds, the admission-discharge-transfer feeds, we get from hospitals, we can break it down into specified critical care beds, stepdown beds, emergency beds. I'm not sure whether we actually classify for mental health.

Interjection.

Dr. Bob Bell: We do. We classify for general hospital mental health beds, so we can get that information. We generally don't look at that in our daily census; we usually have one figure for the hospital which represents the number of beds occupied that day.

M^me^ France Gélinas: Okay.

Hon. Eric Hoskins: I just need to reiterate as well, the vast majority of our hospitals across this province operate below capacity and that—

M^me^ France Gélinas: What do you define as capacity? When you say they operate below capacity, tell me what you mean by capacity. Is it 85%, 90%, 100%?

Hon. Eric Hoskins: That they're able to provide the services, including in-patient services, to the patients who require them and within conventional spaces; also being cognizant and recognizing the pressures that certain hospitals are facing for a variety of reasons. That is the basis for the very specific and targeted investment that was announced yesterday of the 1,200 new acute care beds that will be opening this calendar year. Again, the deputy gave the criteria that allow us to establish where those areas of need are. Certainly, the midnight census

does help us provide that data. Again, the foundation of all of this is to ensure that we're providing the necessary resources to the hospitals so that they can meet the outcomes that are expected of them.

M^me^ France Gélinas: So at midnight tonight, will you be able to say how many hospitals are at 85% capacity, how many hospitals are at 100% capacity, how many hospitals are over 100% capacity?

Dr. Bob Bell: If I may, Minister? For example, when we did a recent survey to see how many hospital beds within standard units could be opened, we found that there were almost 2,000 beds that could be opened with appropriate funding. If a hospital says, "We're currently running 240 beds; we've got another 20 beds that are out of service and today we have 243 patients," would they appear to be at 102% capacity or would they appear to be at 96%, based on those unopened beds?

We think that's an important metric to monitor, so that we understand when, indeed, surge is occurring. That's our goal in measuring midnight census, not so much to get a capacity measurement, because most hospitals in Ontario have other beds they could open. They are, indeed, not at 100% capacity; they're at 100% capacity for the staff that are employed and present in the hospital at that time, but with further operating funds, as the minister announced yesterday, it's possible to open further beds and that's what we're doing—the equivalent of roughly eight medium-sized community hospitals' worth.

M^me^ France Gélinas: Do you see overcrowding and overcapacity as an issue in our hospitals right now?

Hon. Eric Hoskins: The census that was conducted together with the Ontario Hospital Association demonstrated that there were upwards of 2,000 conventional spaces available within our hospitals. To answer the question: Generally, if there are—they're conventional but unfunded.

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It demonstrates, I think, the scale of availability within many of our hospitals, if they do face particular or unique capacity challenges, that it's within those 2,000 beds that are currently available but unfunded—conventional spaces—that those patients would go.

Your characterization of the unconventional spaces, I think, needs to be seen in the context of—to get back to the deputy's characterization, there is often space available in a conventional way which is wholly suitable for the admission and care of a patient.

That being said—

M^me^ France Gélinas: Let me quote something for you. I'm quoting from a letter written by the Ontario Hospital Association to you, dated September 11, 2017—a month and a week or so ago.

The OHA goes on to say: "This summer, wait times for patients admitted through emergency departments hit the highest monthly level recorded since the province started measuring wait times nine years ago. Many of the province's largest hospitals reported occupancy levels exceeding 100%."

When "many of the province's largest hospitals reported occupancy levels exceeding 100%," are you saying that the way that they measure occupancy and the way that you measure occupancy were not saying the same thing?

Hon. Eric Hoskins: I think, historically, that often was the case, that there were different measurements that were undertaken by individual hospitals. That's why, over the course of this year, we refined and agreed upon a specific way of measuring—at midnight—to get a precise census that all parties could agree on.

There's a variety of reasons. For example, in Mississauga or in Brampton, the reason why there may be pressures faced by specific hospitals is partly due, if not largely due, to the fact that there is a rapidly growing population in that area, notwithstanding the fact that the demographic is shifting to a more senior population.

There are specific instances which we're responding to through this investment that was announced yesterday, that addresses what are often unique situations.

Do you want to add, Deputy?

Dr. Bob Bell: If I could just add a bit, Minister.

Ms. Gélinas, we look at a number of indicators that determine adequacy of capacity. We look at the alternate-level-of-care patient proportion, and, yes, we have seen that going up. We have almost daily calls with the Ontario Hospital Association, to not only have the metrics but also to have the contextual information that we can get from them.

We did become concerned this summer that ALC rates, which usually come down in the summertime, failed to do that. We became concerned about the number of patients admitted in emergency departments at 8 o'clock in the morning. We became concerned about the time taken for admitted patients to achieve an in-patient bed. These were all indicators that suggested that Ontario hospitals were reaching a point where concerns could be experienced.

Our strategy not only includes increasing surge capacity within hospitals. It also serves to pull patients who are in the hospital, waiting for community resources or long-term care, into alternative settings in the community—restoration or transitional spaces. We're hopeful that with increased rehabilitation in the community, patients who are on long-term-care waiting lists within ALC categories can actually potentially get home, as has been experienced by hospitals that have started these transitional care programs.

It has been a multi-modal investment in capacity.

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

M^me^ France Gélinas: If we look at the $100-million announcement you've made to create additional beds, is this a base budget increase for those hospitals, as in they can count on this money from now on?

Hon. Eric Hoskins: We've made the investment of $100 million, this in-year investment, so that is the amount that we're investing this fiscal year in addition to

the $40 million for home care—also in-year for this fiscal year, as is normal.

We have already begun the pre-budget process within the ministry and with Treasury Board and finance to put forward what the ministry believes is a responsible ministry budget for the out years, particularly for 2018-19—

M^me^ France Gélinas: So a hospital that accepts this money right now has no guarantee, come April 1, that this money will become part—they could be opening up eight new beds, and everybody will be very happy, but they don't know if they're going to have the money come April 1.

Hon. Eric Hoskins: I don't think it's unique to the allocation of funding for hospital beds or the allocation within the ministry generally, or allocations from any ministry—this being my fourth ministry, as well. The basis of the budgetary process and the pre-budgetary process that the ministry engages in is to make responsible decisions with regard to funding on a go-forward basis, and that allocation would be reflected in the spring budget for future years.

That being said, we obviously will be working closely with our hospitals and our LHINs, evaluating this investment closely, and making the responsible and appropriate decision. But we've already begun that budgetary process, which, again, is not at all atypical from our ministry's perspective or, indeed, across government.

Dr. Bob Bell: The other thing we're trying to look at is to smooth the functions of the various ways that we utilize hospitals. We all know that the flu season, the last quarter of any fiscal year, is the time when more patients get admitted through the emergency department. It's also the time, traditionally, when hospitals are trying to achieve completion of their wait-times funding for surgery. So we tend to get a tremendous amount of activity focused on the last quarter of the fiscal year. We think that it would be much wiser to look at smoothing activity throughout the year, especially with respect to scheduled surgery—hips, knees—that can be done at a variety of times. We're working with the Ontario Hospital Association, with a couple of health services researchers, with a couple of hospitals leading this focus, to see how we can better smooth the utilization of hospitals, especially with respect to scheduled surgery, so that we're not trying to do everything in the last quarter of the fiscal year.

The Chair (Ms. Cheri DiNovo): I'm afraid time is up. We now move back to the minister.

Minister.

Hon. Eric Hoskins: For how long, Chair?

The Chair (Ms. Cheri DiNovo): For 30 minutes.

Hon. Eric Hoskins: Okay—

Mr. Jeff Yurek: We can ask more questions.

Hon. Eric Hoskins: And no doubt you will ask more questions—but I appreciate the questions. We've certainly tried to do our best to answer them directly and in a fulsome manner. I want to thank each of you who have asked questions thus far.

Madam Chair, as well as members of the committee, appearing here before you today provides me with an opportunity to update the people of Ontario on the significant progress that we are making. We spend a lot of time here at committee going over the nuts and bolts of our health care system, and we get called to account—as we should—for how the money is being spent. I really believe it's an important exercise for accountability purposes. It's a reflection of a strong democracy, and I believe strongly in the value of this committee.

We all want what is best for the patient. We want all Ontarians to enjoy the best health possible, and we want them to know that the services are going to be there for them when they need them. We all want to see our health care system remain strong and vital for our children, our grandchildren and our great-grandchildren.

That speaks to how deeply universal health care has been ingrained in all of us as part of our identity as Canadians. Of course, we can and we will debate the fine details of how that money is being spent or whether some initiative is as effective as it should or could be. But at the end of the day, we all believe that health care is a right for all.

Ontarians cherish their universal public health care because of the caring hands, kind faces, warm voices and big hearts of extremely talented professionals throughout the system. Ontarians feel relief when a clinician tells them their mom has made it through surgery just fine or when their doctor tells them that the strange symptoms their baby is experiencing are nothing to worry about at all, and they feel understood when a care provider hears and listens to their story. That's not just a system; that's people caring for people, and it's the pure motive at the heart of health care in our province. It's what we do.

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We all value our universal health care system. We all believe that whether you're in the 1% or in the 99%, you're just as entitled to 100% from Ontario's health care system. It's the one thing we can all agree on, no matter which side of the political spectrum you come from: We're all entitled to health care, each and every one of us, without payment, without judgment, without exception. Our health is everything. That's why the concept of universal health care resonates so deeply within us. It's also why we strive to ensure that universal health care reaches everyone everywhere.

There are now close to 14 million people in this province, and we have a population that's as diverse as any in the world. We welcome those who want to come and share it with us. Our province is as diverse in its geography as it is in its people. We live in beautiful small towns, vibrant urban centres and remote regions.

We have an aging population who have built the society we treasure, and to whom we owe so much. Our children and our young people are faced with pressures so much different today than when many of us grew up. All of these factors put a strain on our health care system.

Despite everything we've accomplished, despite the fact that we all believe that universal health care is the

right thing to do, we haven't got everything right. What we have accomplished together is pretty incredible, but there's still clearly much more work to be done. We work very hard to ensure that everyone has access to care when they need it. Knowing that we're entitled to health care makes it easy for us to be complacent. In fact, many of us have come to simply expect that it will be there for us when we need it.

But there is an inherent obligation that comes with universality. We must resist complacency. We need to continue the hard work of previous generations. We need to build a bridge across that gap between entitlement and access, and we need to ensure that everyone is benefiting from the access to which they are all entitled. We can't ever accept that a model or a practice can't change because that's the system.

That's why Ontario introduced the Patients First Act, which I spoke of in my opening remarks. We want to make our health care system easy to navigate. We want patients to always feel like their needs are the top priority. Getting the health care you need should not be a process, nor should we or can we let it stagnate. We must invest in improvement. We must strive for better.

For that reason, our government has been making critical investments in our health care system, many of which can be found in our most recent budget. Of those investments, there is one that I think really speaks to the value that we place on universal health care, and one, in fact, that is truly historic. As part of the 2017 budget, Ontario took a significant step towards greater fairness in universal health care with the introduction of Ontario's children and youth pharmacare program. We're calling it OHIP+, and it's the first program of its kind in Canada.

This new program is going to fully cover the costs of prescription drugs for everyone aged 24 and under, regardless of family income. Starting January 1, four million children and young adults will have access to universal drug coverage. OHIP+ will pay for any and all drugs found on Ontario's drug formulary. That's over 4,400 different medications. It will cover asthma inhalers, insulin, seizure medications, cancer drugs and drugs for rare diseases.

In keeping with our vision of making services easy for patients to access, this program is incredibly straightforward: You or your parents go with your OHIP number to your local pharmacy to pick up your prescription. All you need is your OHIP number, which is likely already on file, and hand over your doctor's or nurse practitioner's prescription, for free—no copayments, no annual deductible, no upfront costs and no reimbursements. It doesn't get any easier than that. You don't have to apply; it's automatic.

Now, some people may question if this is really necessary: "They have access to doctors when they need it and they can purchase their prescriptions just fine." From their perspective, universal health care is doing exactly what it's supposed to be doing. But that's not true for everyone.

As a doctor, I've spent most of my clinical time with refugees, new immigrants and poor working families. Each time I wrote them a prescription, I could see in their eyes that they were making a calculation, sitting right there with their child. They're considering their options. They were wondering if they can buy enough food, maybe even pay the rent, and still fill their child's prescription in the same week. We know that at least one in 10 families cannot afford that prescription, and that it or another pressing family need often goes unfilled.

Our universal system gave that same family access to a doctor, but our universal system isn't with them anymore when they get to the pharmacy. As a doctor, you go to that cabinet or that drawer with the samples, and if you're lucky, you might be able to provide the child with access to the drug that they need in that way—or maybe not the drug that you would prescribe, but something close enough to do the job. While you may be able to help that patient on that particular day, this is by no means a reliable way to ensure that people get the prescriptions they need.

To deliver truly universal health care, we need to do better. We need to build on the legacy of Tommy Douglas, the father of universal health care, Lester Pearson and Allan MacEachen, the Minister of Health of the day who took that provincial legacy and made it national. It wasn't easy. All of the same conversations that we're having now about national pharmacare we had about medicare: "It wasn't affordable. Was it necessary?"

Introducing universal health care in Canada was not easy; it wasn't even guaranteed. Many provinces, including ours, were not convinced it would work. Alberta was the last province that reluctantly came on board.

But it's time to finish the job. For all our love of universal health care, Canada is the only industrialized country with universal health insurance, but no national pharmacare strategy. We know it's going to take leadership to get this done, but we have an opportunity to lead the way here in Ontario. We have an opportunity to demonstrate that pharmacare is affordable, is workable, is worthwhile and it certainly is necessary.

That's one of the reasons that I'm so proud of the work that we're doing on this file. OHIP+ is the continuation of the legacy of universal health care. It's that unfinished business that was already and always spoken of when we introduced medicare 51 years ago to this country. There was always a phase 2, and that was pharmacare.

We here in Canada, as I've mentioned already, have become very comfortable—indeed, enthusiastic—with this idea of universal health care. It's something we're immensely proud of. It's a part of our national identity. But we need to strive for improvement and innovation to make our system stronger, to ensure that it meets the needs of everyone.

Our world has changed so much that sometimes we overlook the fact that our universal health care system was created in the era of rotary phones. Doctors had answering services. They kind of still do.

Dr. Bob Bell: We do.

Hon. Eric Hoskins: It's an interesting comment, but I'm sticking with it.

Dr. Bob Bell: We use faxes.

Hon. Eric Hoskins: We do use faxes. Ask anybody under 20 what a fax machine is.

Your health information was stored in a filing cabinet. But we live in a new era. By today's standards, even email is starting to look archaic. We use smartphones and tablets. We can transmit information around the world in a matter of seconds. We've made tremendous technological advances, many of them originating right here in Ontario. We're working hard to see that technology make an impression on how we deliver patient-centred care.

You can liken it to holiday shopping, I suppose. Today a person can get all of your Christmas or holiday shopping done on a November morning while you're sipping coffee in front of a laptop in a Starbucks. This is what we're striving to achieve in our health care system: access that's easier than ever before. Not delivering a latte with your health care, if you're wondering that, but the kind of access that patients have already come to expect in almost every other aspect of their lives.

At the very basic level, putting the patient first means keeping up with the patient's life. It's not just about making life more convenient for patients. The advances in technology present us with opportunities to make life-changing change for people living with complex or chronic conditions. It can provide them with the opportunity to enjoy life in the comfort of their own home instead of finding themselves living out their lives in institutions. And it speaks to another element of universality that often gets overlooked: A universal system helps every patient live their best possible life. It makes life easier for those who are struggling with their health.

One of the ways we can enable patients to live better lives is through the opportunities that digital health provides and presents. Digital health is an important enabler for the patient. It's one that can truly help patients live that best life.

For as long as most of us can remember, patients needed to be in the hospital so that they could be monitored by trained health care professionals.

Interruption.

Hon. Eric Hoskins: And on that note—

The Chair (Ms. Cheri DiNovo): There being a division in the House, and we are almost at time, I declare that this committee stands adjourned until tomorrow at 3:45. Thank you, everyone.

The committee adjourned at 1752.

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