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Tuesday 27 October 2015

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Mardi 27 octobre 2015

Standing Committee on Estimates

Ministry of Health and Long-Term Care

Comité permanent des budgets des dépenses

Ministère de la Santé et des Soins de longue durée

Chair: Cheri DiNovo
Clerk: Christopher Tyrell

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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON ESTIMATES

COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Tuesday 27 October 2015

Mardi 27 octobre 2015

The committee met at 0900 in room 151.

MINISTRY OF HEALTH AND LONG-TERM CARE

The Chair (Ms. Cheri DiNovo): Good morning, everyone. If members could take their seats, I believe we have a quorum.

The committee is about to begin consideration of the estimates of the Ministry of Health and Long-Term Care for a total of 7.5 hours. As we have some new members and a new minister and ministry before the committee, I would like 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 one hand, members of the committee take care to keep their questions relevant to the estimates of the ministry. 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 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 effectively. 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 the research officer.

Any questions before we start?

I'm now required to call vote 1401, which sets the review process in motion. All those in favour, please raise your hands.

Interjection.

The Chair (Ms. Cheri DiNovo): Apparently, I don't have to call a vote; we just get started. I assume you've all said yes.

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 up to 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, members of the committee and members of the public. Thank you for the opportunity to speak here today. I'll be sharing my time with the Honourable Dipika Damerla, Associate Minister of Health and Long-Term Care.

It's my pleasure to appear before this committee for the first time as Minister of Health, a role in which I have the privilege of working to improve the health of Ontarians and to safeguard and strengthen the province's treasured health care system. Health care is undeniably one of the most important issues facing our government and facing all of us as Ontarians. The stakes are high and have never been higher. Our population is aging and our financial resources are finite; these are the economic and demographic realities of our times. But these challenges we can manage, together with our partners, with determination, with courage and with new ways of doing things.

I'm proud to say that over the past five years, we've already made great progress. We've become a leader in improving quality, accountability and cost effectiveness right across the health care system. We've improved sustainability and quality in our acute care hospitals, our family health teams and elements of long-term care through performance management and activity-based funding. Thanks to the extraordinary efforts of our committed health system partners, our transformation work has been improving patient outcomes and delivering better value for investments; it has been enhancing the experience of Ontarians when they use the health care system; and it has been creating value and capacity in the health care system to make it more efficient in the long term.

Delivering quality services within approved funding envelopes will always be a challenge, but we can sustain the health care system by maintaining system growth at

about 2% and by reinvesting in key areas of focus. We've achieved a great deal already with the 2012 action plan for health care in moving from a provider-focused, fragmented system to one that puts patients and people first, and increases access to quality health services while achieving better value for our investments.

The action plan for health care really laid the foundation, and now we have to deepen and broaden the achievements of the past several years. Patients First, Ontario's renewed action plan for health care, builds on the progress we've made with our valued health system and our health system partners since 2012. It puts people and patients at the centre of the system by focusing on patients' needs first. The new action plan sets out four key objectives.

Faster access to the right care: We're working to expand access to more health services and more health care providers.

Connecting services: We're working to deliver better coordinated and integrated care in the community, closer to home. This pillar is key to transforming and sustaining our health care system, and I'll have more to say on this topic later.

Informing: This means supporting patients by providing them with the resources, information and transparency that they need to make the right decisions about their health.

Finally, protecting our cherished public health care system: Making those smart decisions to ensure that our health care system remains sustainable for generations to come.

I want to take this opportunity to outline our progress on all four pillars since I first announced the renewed action plan in early February this year.

First, faster access to the right care: In recent years, the burden of disease has been shifting from infectious disease and emergencies to more chronic conditions often associated with the demographic changes that I referred to earlier. We're learning that people with complex conditions can be cared for safely in their own homes, and that means the demand for home and community services will only continue to grow.

People have told us that they want to receive care at home or as close to home as possible. This is not only better for them, but for the health care system as well. To achieve this, they will need more flexible, reliable and affordable community and home care supports.

To achieve truly integrated and coordinated patient care that better serves people's needs, we're working hard to modernize the home and community sector. To help us reach that goal, I released Patients First: A Roadmap to Strengthen Home and Community Care in May, and it lays out a 10-point plan, 10 steps that our government is taking to strengthen the home and community care sector. But we're building on a solid foundation of success.

Today, 93% of eligible home care clients are receiving their first nursing visit within five days of being accepted, and 84% of home care clients with complex needs receive a visit from a personal support worker within the five-day target. More than 600,000 clients across this province receive services from community care access centres each year, including 6.5 million nursing visits every year and 27 million hours of personal support and homemaking services. Since 2003, we've more than doubled our funding for home care services.

Now beginning with our 2013 budget a couple of years ago, we announced that we would be increasing funding for home and community care by an average of 5% annually for three years going forward. Those increases were set to end in 2016, but I'm proud that in our most recent budget we have proposed to extend that funding increase for an additional three years, that is for fiscal years 2015-16 through to 2017-18, which represents an additional $750 million. That increase in funding is recognition of the importance of our home and community care sector.

Now to improve the care that we provide and to improve quality measurements to reduce the variation in services and to explore more innovative models of care, we established a group of health care experts led by Gail Donner. Our expert panel's mandate was to study how to improve the quality and the value of the care provided by the home and community care sector. In January, the expert group delivered its report, entitled Bringing Care Home. The road map that I released last May outlines the actions we're taking to implement all of the report's recommendations.

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The first phase of our 10-point plan is focused on expanding service and improving access, no matter where you live in the province.

The first of the 10 points is to develop a statement of home and community care values with our system partners, with our clients and with our caregivers to guide our transformation of home and community care, with the needs of clients and their caregivers at the very centre.

(2) Working closely with our partners, our clients and caregivers, we propose to create a levels of care framework to ensure services and assessments are consistent across the province.

(3) I mentioned this earlier: We're increasing home and community care by 5% each year over the next three years, investing an additional $750 million across the province.

(4) We've moved forward with what's known as bundled or integrated care, in which a group of providers use a single payment to cover all of the care needs of an individual patient. Building on strong local examples, such as the program developed at St. Joseph's Health System in Hamilton, we've already announced six sites and a plan to roll out this approach across the province.

(5) We will offer self-directed care. Over the next two years, we will begin to offer a self-directed care option in which clients and their caregivers are given the funds to hire their own provider or purchase services from a provider of their choice.

(6) We will expand caregiver supports. Caregivers, who may include family, friends and neighbours, are absolutely critical in the journey of individuals receiving care at home or in the community.

(7) Enhanced support for personal care workers: We intend to continue moving forward with our plan to enhance the wages of personal support workers and provide other supports to improve the stability of our PSW workforce.

(8) We will provide more nursing services. Our nurses play a critical role in home and community care to ensure that patients and clients have the supports and services that they need. Recent regulatory amendments increase the maximum amount and number of nursing visits and hours a patient may receive and allow our CCACs to exceed nursing service maximums in certain cases.

(9) We will support greater patient choice for palliative and end-of-life care. We will expand access and equity in our system, establish clear oversight and accountability, and introduce new support for caregivers.

(10) We will develop a rigorous capacity plan to ensure that high-quality, timely and appropriate home and community care is available, now and in the future.

Continuing on the subject of faster access to the right care in order to improve the capacity of the health care system: We're investing more than $11 billion in hospital capital grants over the next decade to build adequate infrastructure capacity in the health care sector. Across Ontario, more than 40 major hospital projects are under construction or in various stages of planning. In our 2014 budget, our government announced new funding of $300 million over 10 years to help shift care from hospitals to community settings and ensure adequate infrastructure capacity in the health care sector.

One of the greatest challenges facing our health care system when it comes to access concerns individuals in need of mental health and addictions services: not only acute care, but longer-term care and supports that revolve around the patient. That's why we are making targeted investments, like the $138 million over three years to shift more mental health services into the community—timely, effective and responsive ongoing care, and support that treats patients as people and breaks down the barriers that those struggling with mental illness and addictions too often face.

We've already made significant progress on mental health. For the first three years of our strategy, our strategy has focused on mental health supports for children and youth. Almost 800 additional mental health workers are now providing services for children and youth across the province, in our communities, in our schools and courts. Our tele-mental health service is providing nearly 3,000 psychiatric consults this year alone to benefit children and youth in rural, remote and underserved communities.

Now, to build on that success, we have asked Susan Pigott, a leader in the field, to chair the province's Mental Health and Addictions Leadership Advisory Council. The council has cross-sector representatives who will advise on strategy investments, promote collaboration across sectors and, importantly, report annually on the strategy's progress. I look forward to working with them to implement the next phase of this strategy.

Connecting services: By connecting patients to resources and those resources to one another, we're better able to support clients and patients. And, of course, if we want more of our system to perform as a unit, we have to change the way we pay for care. That means moving away from the current fee-for-service approach toward aligning incentives around the patient's journey, rather than the provider's activity.

I mentioned earlier our bundled care approach. It's an important part of the road map to strengthen home and community care, and is an innovative way to achieve better-integrated care. The bundled, or integrated, care model allows a team of health care providers to use a single payment to cover care for patients both in the hospital and at home, so as the patient moves throughout the system and back to their home, we know that the majority of their health care team in this model remains the same. Services are coordinated around the patient's needs, resulting, demonstrably, in fewer emergency department visits and less risk of being readmitted to hospital.

Patients in six communities already across the province now benefit from this approach that's helping them transition more smoothly out of hospital and back into their homes and their communities. We plan to support additional bundled care teams in the coming year, based on the results of these projects.

Informing Ontarians: Ontarians have a right to know how their system is performing. After all, they own it and are its most important stakeholder. That's why we continue to work in partnership with health care administrators, institutions and providers to drive accountability, transparency and quality throughout the system, while limiting expenditure growth. The road map to strengthen home and community care will play an important role in helping us improve accountability, transparency and quality in the home and community care sector.

As well, we welcome the Auditor General's insight and advice in her recent report on community care access centres.

The Chair (Ms. Cheri DiNovo): Minister, you have about five minutes left.

Hon. Eric Hoskins: Thank you. That's for my 20 minutes, is that correct?

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

Hon. Eric Hoskins: The 30 minutes. Okay, thanks. I apologize to my associate minister. I don't want to cut you short.

Mr. Michael Harris: Then we get 30, and then you get 30 back.

Hon. Eric Hoskins: At the end.

This report of the Auditor General—

The Chair (Ms. Cheri DiNovo): Sorry, 13 minutes left.

Hon. Eric Hoskins: Thank you.

This report is a catalyst to deepen our plan to improve home and community care. On September 10, I sent a letter to CCAC CEOs about transparency, accountability and my expectations for them to help us improve home and community care.

The budget for physician services has been limited to a reasonable increase of 1.25% for each of the next three years, and, through health system funding reform, we are continuing to create a sustainable and accountable system that provides coordinated care to people when and where they need it.

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Lastly, protecting the health care system: We've introduced the Health Information Protection Act that, if passed, would create stronger and more comprehensive protection of health information privacy, greater accountability and transparency in the health system about privacy breaches, a renewed provincial electronic health record privacy framework and improved patient care and safety. This is in keeping with recommendations of the Quality of Care Information Protection Act Review Committee that I convened.

Ontario's Information and Privacy Commissioner also supports legislative change to strengthen privacy protections.

The proposed bill would contribute to improving the quality of care and safety of all patients. It's one more way that our government is putting patients first.

As my final point under protecting: We have consulted with Ontarians on the key skills and experiences that Ontario's first patient ombudsman should have, and the results are in. Nearly 1,000 Ontarians have provided specific input on the qualifications they think are important for this role. This feedback has been incorporated into the current patient ombudsman selection process to guide recruitment for the new position. The top three skills that Ontarians identified included: being able to investigate facts and details to reveal the sources of a problem and enable its solutions, to be able to connect with decision-makers in the health care system, and to be able to develop clear recommendations based on large amounts of complex information.

The patient ombudsman will help patients and their caregivers who have not had their concerns resolved through existing processes at hospitals, at long-term-care homes or at community care access centres. The work of the patient ombudsman will also inform province-wide health care system quality improvement.

The patient ombudsman will play an important role in providing Ontarians with the information that they need to be active participants in their care in a health care system that is sustainable for generations to come.

Thank you again for the opportunity to speak to you. Now I'll turn it over to Associate Minister Damerla to make opening remarks.

The Acting Chair (Ms. Cheri DiNovo): Associate Minister.

Hon. Dipika Damerla: Thank you, Madam Chair. Thank you, Minister Hoskins.

Members of the committee and members of the public, thank you for the opportunity to speak here today. I'd like to begin by introducing Deputy Bell, who has the enviable task of supporting both Minister Hoskins and myself. We are very honoured to have him.

I'm also honoured to appear before this committee as Associate Minister of Health, a role in which I have the pleasure of working on long-term care and wellness. As part of my mandate, I want to strengthen accountability and transparency, especially of our long-term-care-homes inspection system.

Our government's priorities in the long-term-care sector include safety, security and peace of mind for our seniors, their families and their caregivers, both formal and informal. I'm pleased to report that we've made significant progress on these priorities.

Let me start with the quality of care provided in long-term-care homes. There are approximately 78,000 residents in more than 630 long-term-care homes across Ontario, and we're determined to ensure that residents' rights, safety and quality of care are safeguarded by inspecting complaints, concerns and critical incidents.

The ministry has transformed the inspection process to achieve a more accountable, consistent and transparent compliance inspection program that focuses on risk issues and resident care outcomes. I'm very pleased to say that since the Long-Term Care Homes Act was proclaimed, the ministry has completed comprehensive resident quality inspections for all long-term-care homes in Ontario. This is a first for the province.

Every home has undergone a comprehensive inspection that includes interviews with residents and their families, as well as staff; direct observations of how care is being delivered; and a thorough review of records, such as individual care plans and progress reports.

In addition, comprehensive resident quality inspections for 2015—this is year 2—have started and the ministry is on track to complete the inspections on an annualized basis.

The ministry performs unannounced inspections, applies enforcement measures and is transparent in these actions. For example, copies of inspection reports detailing the non-compliance findings are publicly posted in long-term-care homes and on the ministry's website. I believe this practice really puts Ontario as a leading jurisdiction in Canada when it comes to transparency in the long-term-care-home sector.

Work has also started on province-wide capacity planning in long-term care. This work is absolutely critical to ensuring we have the capacity we need now and in the future.

To further strengthen the quality of care in long-term-care homes, we're providing for up to 75 new attending nurse practitioners over three years, including 30 starting this fall. Working as part of a team of health professionals, these nurse practitioners will provide on-site primary care for patients and will address the complex care needs of residents.

Long-term-care-homes redevelopment: Our government has made important investments in home care so

that more seniors can live longer in their own homes, but once it's no longer possible to remain at home, Ontarians who reside in long-term-care homes deserve to live in a comfortable, safe and inviting environment. I'm proud to say that our government has already made terrific gains in this area during the last decade with the creation of more than 10,000 new long-term-care beds and the redevelopment of nearly 13,000 older long-term-care beds. But we are not stopping here. We continue to invest, and that is why we are moving forward with the latest phase of redeveloping another 30,000 beds.

As our population ages, long-term care will continue to play a vital role in our commitment to put people and patients first. And partly because of our increased supports for home care, we are seeing an increasingly acute population—

The Chair (Ms. Cheri DiNovo): Excuse me, Associate Minister. Now it is really five minutes that you have left.

Hon. Dipika Damerla: —in our long-term-care homes. That makes it even more important that we invest today to ensure the continued safety and quality of care for residents by helping to bring all long-term-care homes in the province up to the most modern design standards. We have set a deadline of 2025 for the operators of these homes to update their homes and to meet all provincial and local building codes, safety standards and revised design standards—all meant to enhance the quality of life and safety for residents.

Our Enhanced Long-Term Care Home Renewal Strategy was noted in the July 2014 provincial budget and I announced the strategy about a year ago, last October. Since then, significant progress has been made.

First, a dedicated project office to support the program within the ministry will facilitate a faster review of plans and will be a single point of contact for operators as they submit their plans through the process.

Second, we will increase construction funding subsidies by up to $4.73 per day.

Third, we have extended the maximum long-term-care-home licence term from 25 years to 30 years. The necessary amendments to the Ontario Long-Term Care Homes Act, 2007, have been passed to enable this, and came into force January 1 of this year.

Fourth, we established a committee to review individual requests for exemptions from the existing design standards. While we will not entertain variances that impact provincial or local health and safety regulations, operators have asked for other design flexibilities, and we will entertain those on a case-by-case basis.

Fifth, we will encourage the renewal of long-term-care-home beds to increase premiums for preferred accommodations.

Finally, we will work to schedule the redevelopment of homes.

We have consulted with the sector on these elements of our redevelopment plan and seek even further input on their implementation. It is important to note that the changes we are bringing forward are the result of significant consultations with key stakeholders in the sector and further consultation is intended to improve delivery and content, and will encourage a greater uptake in the redevelopment process. Working closely with the sector will be a big part of ensuring success. To this end, we will have a stakeholder advisory committee to continue the ongoing engagement with the sector.

I am very committed to addressing the disparities between older and newer long-term-care homes and to working with homes to help them reach the revised standards in the appropriate timelines. Redevelopment is essential to ensuring the privacy, safety, security and comfort of all long-term-care-home residents today and well into the future.

In conclusion, I'm absolutely determined to make sure that residents and their families feel more confident and comfortable about the quality of care and safety of long-term-care homes.

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We are taking concrete steps to accelerate the modernization of long-term-care homes to ensure continued safety and quality of care for residents by helping to bring all long-term-care homes in the province up to current design standards.

Thank you again for the opportunity to speak to you today. Now I'd be happy to take your questions.

The Chair (Ms. Cheri DiNovo): You have a minute and a half left. Do you want to sing a song?

We're going to move to the official opposition, then. Mr. Yurek.

Mr. Jeff Yurek: Good morning, Minister, and Deputy Minister Bell. Thanks for coming in today. I guess you had no choice, but I'm glad you're here today.

Hon. Dipika Damerla: We're delighted to be here.

Mr. Jeff Yurek: I just want to start off—I've got numerous questions. Obviously, we'll be together for a while, but I wanted to take a look at doctor services and the cuts that have occurred over the last year. On October 1, you introduced a whole new round of cuts to doctor services, and we've totalled over $815 million alone to doctor services being cut from this government.

Minister, you've said over and over that there's no cap on the services that doctors can provide and they'll be paid for every service performed, but you've budgeted a certain amount, which is essentially a cap. So I just want to know what happens if the people of Ontario require health care services this year that surpass the physician services budget?

Hon. Eric Hoskins: That's a very important question you've asked. I'll begin by emphasizing that as a result of the 2012 negotiations that ended successfully with an agreement between the government and the OMA, it was very important to the Ontario Medical Association that we jointly agree on a framework for the subsequent set of negotiations, which are the ones I think that you're referring to, that have yet to end in agreement. In fact, the OMA brought forward their vision of what a negotiating framework might look like. We agreed in 2012, in writing, to pursue that model of negotiations and negotiated,

both sides, I'm confident in good faith for a year and a day over the entire course of last year, into January of this year. Regrettably, that process which we, on the government side—we followed the agreed, written, mutually agreed upon framework of negotiations to the letter, but we were unable to reach agreement.

During the course of the negotiations, both parties, as we had previously agreed, enlisted the help and support initially of a facilitator, Dr. David Naylor, and then subsequently a conciliator, an independent third party, retired justice Warren Winkler. And it was Warren Winkler's report, which was a public report—after having reviewed the positions of both parties, after having examined the government's offer that was on the table to the OMA, after extensive consultations collectively and individually with both parties, publicly, in his report, he determined and I would characterize requested the OMA to seriously consider—which, at that point in time, had been a rejection of our offer, and he asked the OMA to reconsider that rejection. He also asked the government not to resile from our position. After having looked up that word in the dictionary, it became clear that he was asking the government not to pull back from the offer that we had put on the table during that facilitation. Regrettably, the OMA decided not to take Justice Winkler's advice and not to accept the offer that we had put forward.

So as the process allowed for explicitly, in writing—that had been mutually agreed upon by both parties—we continued to follow that framework, and it allowed for, in the absence of agreement following that entire process, which, as I mentioned, took place over the course of more than a year—as we were enabled to do, but, regrettably, had to move forward with the approach that we've taken, quite frankly to ensure the sustainability of not only the physician services envelope itself, but also the health care system at a very challenging time, and to allow us to have the confidence to invest in other areas of priority such as the ones I referred to earlier.

I would argue against any characterization of what took place as "cuts." As I referenced in my opening remarks, the physician service budget, which is roughly between $11 billion and $12 billion annually—slightly more than 20% of my budget, almost roughly 10% of every dollar that this government spends in the province—that budget last year increased by 1.25%. We have allowed for a 1.25% increase in that budget this year and a 1.25% increase in the budget next year. We arrived at that level of increase, again, through substantial negotiations, through the advice that was provided to us either by Dr. Naylor or Warren Winkler, but also the evidence that shows that that would be a reasonable amount and an adequate amount to accommodate for the changing demographics in the province: an aging population and an increase in population. We continue, as we have done every year for the past decade, to increase the budget that is provided for physicians.

If I can perhaps end on a positive note—and if you've got additional questions or require clarification: Despite our great efforts to arrive at an agreement, including putting, I think, roughly 75 proposals in front of the OMA over the course of the year asking them to work with us to find ways that we could find savings, and to do it in a way which is fair and equitable—

Mr. Jeff Yurek: Sorry, Minister; I don't mean to cut in. I have a lot of respect for the position you're in and I have a lot of respect for you taking this role. It's a tough role.

This isn't question period, where I ask a question and you give a different answer. I asked: What's going to happen when the doctors' billings go beyond that 1.25%? Could you answer that question?

Hon. Eric Hoskins: Yes. As was, again, the basis for the discussions last year and, in fact, the offer that was endorsed by Judge Winkler, we are implementing Judge Winkler's—the independent third-party conciliator, the umpire, if you will, who endorsed our plan—we are implementing his recommendations. One aspect of that was a process known as reconciliation, where we would implement measures, as we have, to give us confidence that we can have a sustainable and predictable physician services envelope of the amount that I had suggested earlier.

The changes that you referenced at the beginning—some that came in, I think, on April 1 and others more recently: October 1—those changes have the impact of slowing the growth of the physician services budget so that it is maintained, hopefully and ideally, within that 1.25% that I described. So physicians will continue to be paid for every service that they provide and every procedure that they provide; that will not change. There's no cap on any physician; there's no cap on any procedure or service. What we've done is we've implemented changes, if you will, that slow that growth curve of the budget so it comes within the 1.25% increase annually for the three-year period.

I'm hopeful—I think I'd be more hopeful if the OMA was willing to return to negotiations—that those changes will have the necessary impact.

Mr. Jeff Yurek: Minister, we've seen that the growth of health care is more than 1.25%. It's naturally growing at over 2%, easily, per year. We know that you made these cuts. I know you hate to say "a cut," but cutting a service fee is a cut.

0940

We know the second round of cuts, October 1, was made because the growth of health care was beyond your 1.25%. And you won't let doctors know—which I think may be a good idea down the road—how close they are to reaching the cap that you have, or the budget limit, so that adjustments can be made.

After this year, do you have plans to institute more cuts to maintain your 1.25%? Because you are saying there are no more cuts this year, but you haven't said anything about the next two years going down the road. Are you planning to make more cuts if the growth in health care—which is naturally growing, considering the baby boomers have gradually started entering the health care system needing the increase in demand of services. Are you making more cuts next year and the year after?

Hon. Eric Hoskins: In answering that question, I need to remind you that we put roughly 75 proposals in front of the OMA over the course of the year of negotiations and did not receive feedback or advice from the OMA with regard to which of those roughly 75 proposals would best serve our need of a sustainable health care budget, but also would be as fair as possible to our physicians. We didn't receive that feedback. The basis of the changes that we made was in that context.

The OMA, through the course of negotiations, but also well in advance of any of the changes that we made, was made aware of the specific changes that we were proposing. They have been involved in that process. I would say that I'm reasonably confident that this process, as implemented, will lead to a sustainable budget of the nature that I describe with that 1.25% increase for that three-year period.

However, our ability to give confidence to physicians relies on the OMA returning to discussions and negotiations, and providing us with that valuable feedback with regard to existing changes that we've made and any future proposals that they might have for sustainability. I'm aggrieved by the fact that they have instead chosen a legal avenue rather than a more hopeful approach.

I want to acknowledge that they've agreed to partner with us on creating a task force for the future of physician services in this province in the context of a sustainable health care system. That is a medium-to-long-term process, but it's an extremely important one, and one of the recommendations from Warren Winkler as well.

I know that we are implementing what were the recommendations of the umpire—

Mr. Jeff Yurek: My question was: Are you planning on cutting services further to maintain your 1.25% increase over the next two years?

Hon. Eric Hoskins: I'll ask my deputy to step in.

Dr. Bob Bell: Thank you for these questions; they're fundamental. A couple of comments: First of all, we're not reducing services. For example, an orthopaedic surgeon faced with doing a total hip replacement that previously would have paid $810 would now receive about $26 less than that, based on the across-the-board changes that we've made to the fee schedule for a fee-for-service work done.

The other thing that we've implemented is a number of changes that are evidence based, so they're not just across—

Mr. Jeff Yurek: Sorry, Doctor, I don't mean to interrupt. My question was: Are you going to increase cuts 1.25% over the next two years?

Dr. Bob Bell: The anticipation is, with all these changes that we're instituting, both fee-for-service changes and contracts for rostered primary care physicians, as well as the evidence-based changes that really do not bring great value to Ontario patients, we're anticipating that a 1.25% budget increase year to year is feasible and achievable. Obviously, we're in the early stages of monitoring that in the second year of the agreement, but evidence to date suggests that those actuals are actually tracking close to what we hope them to be.

Mr. Jeff Yurek: So why won't you, Dr. Bell, let OMA know where they're at with regard to the 1.25% so that they're able to work with you as opposed to getting a shock come next April when you institute more cuts to make up for going over budget?

Dr. Bob Bell: Actually, the OMA has access to exactly the same information that we do on a monthly basis. There is a delay in billings that results from just the process of submitting bills that really keeps us about three months behind the actual time to bill to time of receiving funding. Of course, when we're talking about a budget increase, we're talking about actuals—cash out the door—as opposed to future payments. But we're providing the OMA with exactly the same information that the ministry has.

Mr. Jeff Yurek: Thank you.

Minister, back to you: You have said time and time again in question period and to the media that doctors have received a 61% raise since 2003. Is it really a raise for doctors or is the 61% raise actually to the doctor services budget?

Hon. Eric Hoskins: That is a figure that is based on data and research and analysis by ICES here in Ontario. Those are payments by government to physicians—so that's not the envelope. That is a change in the average payment to a full-time physician, and I think the period is either over the last decade or since 2003. It's based on the change of the average compensation by government to a physician at that time compared to today or their most recent data, which would likely be 2013-14. But it is physician-based as opposed to the envelope.

Mr. Jeff Yurek: So that $13-billion payment for services, that's strictly just for doctors. It's not for nurse practitioners, or does it go to the family health teams to distribute to pay for services in the family health team?

Dr. Bob Bell: The physician services budget element of the OHIP vote is about an $11.7-billion budget. There are other elements in that vote that relate to, as you've described, payments to non-physician health care workers who work within family health teams, some funding for independent health facilities. There are some other elements that make up that roughly $13-billion vote.

Hon. Eric Hoskins: If you'll allow me to add, I have the data before me—this is the ICES data that I mentioned. In 2003-04, on average, a physician was compensated by government at $220,000. In 2013-14, that estimate is $355,000, and that represents a 61% increase.

Mr. Jeff Yurek: So you're saying $11.5 billion—because you've been talking about the funding envelope to the media and to me in question period. So out of that $13 billion, $11.5 billion is the doctor services.

Now in your estimates book here on page 35 you mention that there are 5,648 new doctors in the system in the last decade. If you equate an average of a $350,000 payment to the doctor to provide his services, that's about $2 billion or 15% of the $13 billion, which would be more out of the $11 billion if you really looked at it.

Do you not think that it's disingenuous to be telling the media and question period that doctors got a 61% raise when actually there are other doctors in the system? It makes it sound like each doctor got a 61% raise when actually we've added more doctors into the system which kind of increases the pot as it grows?

Hon. Eric Hoskins: I appreciate the question, but the data from ICES is an average per physician. So it takes into account the expanding workforce. When we look at our family physicians, for example, on average compensation from the government to a family doctor in 2003-04 was $189,000. So a family doctor, on average, was compensated at that level, and in 2013-14 that had risen to $319,000. That's a 69% increase in the compensation from government for family doctors to the point where our physicians, generally speaking, are the best paid and highest paid in Canada. That analysis actually takes into account—because it's a per-physician average—any increase in the workforce.

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Dr. Bob Bell: It's also supported by a third-party report from the Canadian Institute for Health Information that reports that Ontario physicians receive, on average, $358,000—

Hon. Eric Hoskins: Sixty.

Dr. Bob Bell: —$368,000—thank you, Minister—and, of course, are the highest paid in the country.

Mr. Jeff Yurek: Now, wouldn't you at least concede the fact that that amount going to doctors would naturally increase due to higher demand and the number of seniors entering the population, the fact that we have 5,000 more doctors in the system taking up more patients, so more patients are utilizing our health care system? Would you not say that that's just because the doctors are providing more services and why the fee services have gone up?

Hon. Eric Hoskins: Again, we're looking at the compensation per physician. So the envelope as a whole has increased over that time frame as well, but also the average compensation per physician.

Mr. Jeff Yurek: Which is directly to my point: Each physician is providing more services.

Hon. Eric Hoskins: The evidence demonstrates that, notwithstanding that comment, that the increase per physician is substantial.

But let me say, and I think it's important to say, that I'm enormously proud of the fact that our government—particularly after a previous government had not provided a respectful level of compensation—that we've spent the past decade investing in our physicians to the point where they are the best paid in Canada. I'm actually enormously proud of that. I think that they should be well-compensated; they're among the best in the world. What I've stated publicly, is simply the fact that the level of compensation as provided by government to a physician in this province, on average, has increased by that amount as a percentage, to the point where they are the best remunerated in the country.

Also, I've stated regularly, I think without exception—perhaps I haven't always been quoted as such. When I discuss those figures, I make it clear that there are expenses and overhead costs that physicians incur on a day-to-day basis to run their practice. There's tremendous variability or variation in what that percentage might be, but I acknowledge that there are expenses that need to be paid by those physicians out of that remuneration.

Mr. Jeff Yurek: That would be out of the $300,000 that you're—

Hon. Eric Hoskins: The average, as CIHI has suggested, is $368,000.

Mr. Jeff Yurek: So they have to take overhead on that.

Hon. Eric Hoskins: But there's a tremendous variability. For example, if you're a physician in a hospital in an ER, you may have an overhead of 0%.

Mr. Jeff Yurek: So out of a National Physician Survey doc: Ontario has the second-highest number of doctors who pay 30% or more of their income towards overhead costs to operate their practice.

Hon. Eric Hoskins: I was going to say that we've also made other important changes—again, I'm proud of these changes—to benefit our physicians. We've allowed them to incorporate, where the estimated lifetime advantage to a physician of incorporation may be as high as $3 million.

Mr. Jeff Yurek: Yes, but 30% or more in overhead costs is not going to be balanced out by being incorporated.

Hon. Eric Hoskins: It's estimated as as much as a $3-million lifetime advantage, as well as income splitting—that physicians have other opportunities as well. We're talking about one aspect: the government funding—

Mr. Jeff Yurek: Do you have any data showing that with the higher overhead, that they're the second-highest paid in Ontario—and taking into account where they stand as your assertion that they're the highest paid? Have you taken into account the overhead costs to see where they range across the country?

Hon. Eric Hoskins: We look at a number of factors when viewing the level of compensation of our physicians, but I think, as I mentioned, there's tremendous variation. Any physician would tell you that there's tremendous variation from physician to physician; depending on the nature of the practice; depending on whether they're in, for example, a family health team or in private practice; depending on whether they have a group practice where they're able to share backroom costs, certain administrative and other costs; or, as I referenced, if you're working in a hospital environment, your overhead may be 0%.

I acknowledge that there is a significant cost to the practice of medicine, but as I mentioned, we've invested significantly in our physicians to the point where, over the last decade, roughly, our family doctors are earning—as they should—69% more than they were on average in 2003. I guess that is over a 10-year period, in fact to 2013-14. All physicians, on average, are at 61%. That's not our data; that's data that comes through an analysis from ICES.

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

Mr. Jeff Yurek: You state the doctors are earning some-odd $360,000 a year. However, they are businesses, and you can't look at a business owner and say their gross amount is what they're actually earning when it comes to costs to run their business, and doctors are small businesses. Do you not think it's not fair to take the doctors on the fact that you're saying they are making actually what their business is grossing?

Hon. Eric Hoskins: I've never said that. With regard to government compensation to physicians, the understanding is, as I've articulated this morning, that there are expenses to doing business. But over the course of the negotiations last year, we spent considerable and focused time with the OMA discussing this precise issue in terms of cost of practice.

Again, our hope would have been that we would have been able to reach an agreement with the OMA in terms of the nature of any changes that we would be making to make a sustainable physician services envelope. But I think, as well, what you're pointing to emphasizes the importance of one of Warren Winkler's recommendations, the creation of the task force for the future of physician services to look not only at compensation but sustainability as well, and the role of physicians within the broader health care system and how we can support them to do the best possible job.

Just over a week ago, I proposed again to the OMA—we have done this several times—that they participate with us on that task force, and I was gratified to see that they have finally agreed to participate.

Mr. Jeff Yurek: Will you stand by the statement that Ontario doctors' net income is the highest in the country?

Hon. Eric Hoskins: Look, I think you're trying to drive me down a road that I've never travelled. I've always been, and have expressed this, proud of the investments that this Liberal government has made over the last decade or so in our front-line health care workers, in this case, our physicians. We reversed a situation where physicians, quite frankly, were leaving this province in significant numbers, heading to the US and elsewhere, because of decisions that were made by a previous government. We made the decision early on to invest in our physicians, in which we have invested, and third parties have validated the extent of that investment.

I've never suggested or stated that there isn't overhead and other expenses associated with the cost of doing business. I know that as a physician myself. But the facts do demonstrate that, on average, our physicians have seen a 61% increase in their compensation from government. So I'm hopeful.

Certainly this process going forward would be much easier if the OMA would agree to resume negotiations with us and sit down and have these discussions with us. I think that there's one hopeful aspect, which is the OMA's agreement, finally, after considerable months, to agree to partner with us on the creation of a task force for the future of physician services, which will enable both parties, on behalf of Ontarians, the health care sector and our physicians themselves, to find those ways and look at other models that we can best support our physicians in the context of a sustainable health care system.

Mr. Jeff Yurek: How much time do I have?

The Chair (Ms. Cheri DiNovo): About a minute and a half.

Mr. Jeff Yurek: A minute and a half—I guess I'll leave the rest for you this afternoon when I get a chance, but just a quick question. Laboratory funding: Has there been a cut in the budget from last year to this year?

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

Dr. Bob Bell: Thank you. Yes, there's been a reduction in the community laboratory budget by about $46 million anticipated for this year. That's based on evidence as to the decreased cost of testing that has resulted from industrialization of lab testing. It used to be that in order to get a serum sodium result you would have to sit in front of a test tube with a flame in front of you. Now, of course, a small sample of blood is put into a robotic machine and results for about 100 different tests are achieved. The fee schedule that has previously been in place for community laboratories has really not kept up with the times, not kept up with technology. We've attempted this year to actually rationalize that.

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We've done a lot of work on the community laboratory schedule of benefits, looking at the true costs of not only the test itself, the analytic cost, but the so-called pre-analytic costs of what it takes to actually gather a specimen in a blood-drawing centre, to transport that, to fractionate the blood so that you can put it into the robotic equipment, and then report the test back to the provider. We think that there is opportunity for savings there. The methodology with which we achieve those savings—

The Chair (Ms. Cheri DiNovo): Thank you. I'm afraid the time is up for the official opposition. Now we move to the third party. Madame Gélinas?

M^me^ France Gélinas: Given that this is my first time to talk about the estimates, I will start at the 40,000-feet level and basically look at how in 2013-14 we had a 2.6% increase in the overall health budget, followed by a 1.2% increase this year in the overall health budget, or $600 million.

What was the rationale to say that our health care system was only going to grow 1.2%? What changed between 2014 and 2015 that would support the decision to go from a 2.6% increase to a 1.2% increase?

Hon. Eric Hoskins: I'm going to answer that, but I think there's a useful clarification that I'll just ask the deputy to provide first, if that's okay.

M^me^ France Gélinas: Sure.

Dr. Bob Bell: In terms of the increase, the increase is actually 1.4%, based on the comparison from the actual results of the system for 2014-15 compared to the budget for 2015-16. The 1.2% was an estimate provided in the Q3 estimates; when we actually saw the final results, it's actually a 1.4% increase.

M^me^ France Gélinas: Okay.

Hon. Eric Hoskins: I would begin by stating that these year-over-year increases are in the context of roughly a decade of substantial investments in our health care system, not just on the operating side, but on the capital side as well. We just opened the Humber River Hospital, for example; the Oakville hospital will be opening soon. So there are significant investments in infrastructure, as well as significant increases in our hospital budgets, for example, of 50% on average over the past decade. This discussion, I think, needs to be situated in the context of a government that spent the better part of a decade making those very significant investments to ensure that we had a health care system that was well functioning for the population.

In recent years—we would probably, I hope, all agree—we have been making some fairly fundamental transformations within the health care system, most notably in the hospital environment, to the credit of our health service providers in the hospital environment and the leadership that they have demonstrated over the past few years, where we have moved dramatically in the direction of where we are funding hospitals based on the quality of the services that they provide, as well as the outcomes that we desire, the best possible outcomes for all Ontarians. That transformation has been coupled with finding new, innovative, efficient ways of delivering health care. We've been successful at doing that, and ensuring that the services that are provided are delivering the results that Ontarians would expect.

As a result of that and other efficiencies in the system, we're confident that the level of funding increase—and there has been an increase in funding in the health budget every year since this government came into office in 2003. There has always been an increase, but we're confident that with the transformational activities we're undertaking, and finding and implementing innovations in health care, working in close partnership with our health care providers, we are able to maintain and indeed improve the quality of care in the context of the levels that you indicated.

M^me^ France Gélinas: Okay. You did mention it, but because I'm just starting, I want to put the numbers on the table and make sure we all agree.

I'm in the estimates book, page 291, if anybody is following closely. Basically, it says infrastructure expenditures for 2014-15 were $3,575,000,000. If we look for this year, it's $2,668,000,000. There's a billion-dollar drop here, almost—I'll let you count. How do we explain this?

Dr. Bob Bell: What page was that?

M^me^ France Gélinas: Page 291. I'm in the budget—sorry.

Hon. Eric Hoskins: As you can appreciate, the two hospitals that I referenced—Humber River and Oakville—are large capital investments. I think in the case of Humber, it's approximately $3 billion.

Given how investments and builds take place, there is an ebb and flow, depending on the length of the planning stage and actually doing the build itself. So it's not uncommon, particularly when we're talking about huge capital investments, to see variations from year to year. If you look at it on average over, for example, a 10-year period, it's easier to see the extent of the investment that takes place.

Also, as I mentioned, we've made the commitment in previous and recent budgets as well, in terms of roughly a $10-billion spend over a 10-year period into those capital investments and in health care. Again, it's in the context of the substantial investments, in the order of 6% or 7% per annum, that took place over the past decade.

The year-over-year increases that we're seeing in this fiscal environment are consistent with what other jurisdictions across Canada and elsewhere are implementing, as well, to restrain, but to restrain in the context of having confidence through innovation and finding efficiencies, that you can find new models and transformational models of delivering care—the bundled care that I referenced, for example—that will improve the quality of care that Ontarians receive but that don't necessarily have to cost additional money.

In a sense, we've been very successful, not only through our capital investments but increasing our operating budgets, as well. I mentioned hospitals as one example.

Across the province right now, we have roughly 20 hospital builds in some phase, some stage of that planning—

Dr. Bob Bell: Thirty-five.

Hon. Eric Hoskins: Is it 35? Thirty-five hospitals that are either being built or in the planning phase of that process.

Our commitment to infrastructure is evident, I think, with the activity that's taking place across the province.

But I would caution anyone to look too deeply into—in terms of the analysis of a single figure, it's more important, I think, to look at the trend.

Dr. Bob Bell: If I can come down to that, also on page 198, you'll see an expenditure change from the 2014-15 estimates of $350 million in the capital lines. That's largely related to major hospital projects, which are $291 million less than expected. That's due to the time of substantial completion, which is when the project is booked, and small delays that take it out of the year-end.

M^me^ France Gélinas: Okay. If you don't mind, you referenced that there are 35 hospitals in different stages of infrastructure expenditure. Do you have this list with you?

Interjection: Yes.

M^me^ France Gélinas: If you could share that. You don't necessarily have to read it into the record, but sharing it with the committee would be very useful.

Hon. Eric Hoskins: Yes, I guess I've just been given it, so I'm assuming I was given it to enable me to give it to you.

M^me^ France Gélinas: Are you? Very good. Thank you. Those were my questions at the 40,000-foot level.

Because I only have five minutes left before this committee rises, and my colleague has spent quite a bit of

time talking about the OMA negotiations, I want to finish using my time with this: We have close to 28,000 very unhappy physicians right now. I know that when you speak, the words that come out of your mouth are that they are the highest-paid physicians, and you're proud that they are. But communication is a two-way stream. When you say things like "They are the highest-paid physicians" and "The negotiation is all about money," what do you figure that people in Ontario hear when you say that?

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Hon. Eric Hoskins: Certainly, the many individuals, the health care practitioners, including physicians, but other health care practitioners like personal support workers and nurses and nurse practitioners and others, and Ontarians who are not in the health sector, those that I've spoken to agree that physicians should be well compensated, and they have confidence that the government has made efforts to do just that.

But I think it speaks to the bigger challenge, which is that I believed it was possible, over the course of the year of negotiations, to reach agreement with the OMA. There was a public report from an independent third party that implored the OMA to accept the government's reasonable offer. I was disappointed that the OMA leadership decided to reject it, because had they accepted it—I think that it was fair, at the present time particularly. Being a member of the profession, but through discussion as well—and I think Ontarians generally accept this—given the financial constraints that we have, I believe physicians do understand that there are a number of priorities in the health care system, including the recent investment we made in our PSWs—

M^me^ France Gélinas: They do understand that there are priorities within our health care system, but you can't help but admit that they're very unhappy. They filled the gallery here last week, to come and talk to us. They are very active, reaching out to all of us as to—they are not happy.

They understand everything you say, but we have a group of people who feel really disrespected right now. When you say things like they are the highest paid and you're happy about it, the average Ontarian hears that they are the 1%, greedy, rich people who put money ahead of care. When the Minister of Health stands up and keeps saying, "They are the highest paid, and I'm proud of it," the average Ontarian hears something completely different. That's what makes them angry. That you haven't realized you are the one fueling the fire that makes them angry is disheartening.

I agree with what you have said. Physicians agree that there are priorities, but they want the discourse to be respectful, and right now, it is not. Nothing good comes when 28,000 physicians are not happy. They are an important part of our health care system, and if they cannot function at 100%, nothing good comes of this.

What is the strategy to bring peace with physicians?

Hon. Eric Hoskins: I know my deputy shares this—we're both members of the medical profession—I have the greatest respect for my colleagues, and I've articulated that at every chance that I get. They are the backbone of our health care system, along with our other health care professionals. We need to remember that there are other health care professionals as well. I have not made any effort to isolate or disrespect our physicians. I certainly haven't done anything intentionally.

We have always been willing to discuss and negotiate with the OMA—always. The OMA has decided to pursue a legal avenue. I would say that they've mischaracterized our intentions repeatedly with their membership. We have limited means of communicating with physicians. I asked the OMA to allow me to send a letter to the 28,000 doctors, for them to facilitate the delivery of that letter through their electronic system, and they refused. My ability to communicate directly with my colleagues—in this case, with the physicians who so aptly represent their sector and our health care system—has been limited, and—

The Chair (Ms. Cheri DiNovo): Thank you, Minister. I'm so sorry.

Thank you, everyone. This committee now stands recessed until 3:45 this afternoon. Thank you.

The committee recessed from 1015 to 1545.

The Chair (Ms. Cheri DiNovo): Good afternoon. Before we get started, the official opposition has made a request that we ask for Hansard to put a rush on the draft Hansard for estimates going forward. Is there agreement from the committee to do this?

M^me^ France Gélinas: Sure.

Mr. Bas Balkissoon: Put a rush on what?

The Chair (Ms. Cheri DiNovo): To put a rush on the draft Hansard for estimates; in other words, get it to us quickly.

Mr. Bas Balkissoon: Is there a particular reason why? Just asking for a request without telling us why makes it difficult—

The Chair (Ms. Cheri DiNovo): The official opposition not being here, I'm not going to answer for them.

Mr. Bas Balkissoon: Well, then, I can't agree—

The Chair (Ms. Cheri DiNovo): Madame Gélinas?

M^me^ France Gélinas: Well, I can tell you that usually it takes a really long time to get. Because of some of the questions that have been asked and some of the questions that will be asked—they come from constituents who are not able to connect.

In my riding, I can tell you that the legislative channel isn't carried because we don't have cable where I live, and it's only available on cable. With dial-up Internet, forget about connecting to here, but those people would like to have access. You will see that we will go into questions that have to do with people who are interested in what's going on in here, and the only way for them to get this is to read it in Hansard. Asking Hansard to come out in a timely manner—there is sometimes up to a month delay before they get to it.

We have done that in the past where we ask Hansard to get the—there are two levels. There's the draft, and then there's the final. They get the draft out so that people

can read it. It's as simple as that. His request comes from people living in rural Ontario, but it applies to people living in northern Ontario just as well. The only way we have access to what's going on in here in part of my riding is Hansard.

The Chair (Ms. Cheri DiNovo): Thoughts?

Mr. Bas Balkissoon: Can the Clerk's office shed any light on this?

The Clerk of the Committee (Mr. Christopher Tyrell): All I can say is that there was a request made by the official opposition—

Mr. Bas Balkissoon: No, I mean, they're complaining about a delay and that it affects them doing their work. Estimates has been meeting for years. I've never heard this to be a problem, and this is my second term sitting on this committee.

The Clerk of the Committee (Mr. Christopher Tyrell): I'm not in a position to comment on whether it affects their ability to do their job or not. I will say that in years past, estimates was given priority, or Hansard did give estimates priority for transcription just so that when we met in the morning and the afternoon, by the afternoon, the morning transcript would be available to members.

The Chair (Ms. Cheri DiNovo): So, Mr. Balkissoon, basically right now I've just asked if there is agreement. Do we have—

Mr. Bas Balkissoon: Can we take a five-minute break so I can just—

The Chair (Ms. Cheri DiNovo): Sure, absolutely. We will come back at—

M^me^ France Gélinas: In five minutes.

The Chair (Ms. Cheri DiNovo): Yes, five minutes.

The committee recessed from 1547 to 1552.

The Chair (Ms. Cheri DiNovo): Okay, we are back. I'm going to repeat this again: The official opposition has made a request that we ask for Hansard to put a rush on the draft Hansard for estimates, going forward. Is there agreement from the committee to do this, yes or no? Mr. Balkissoon.

Mr. Bas Balkissoon: Madam Chair, I'm not familiar with this request being made in the past, but there's so much going on with this committee, and the committee has been meeting on an annual basis after the budget. I think if we want to have this as an adopted procedure, we should work with the Clerk and do it at a future date. But today, I can't agree.

The Chair (Ms. Cheri DiNovo): So you're saying no. The official opposition has the option to move a formal motion, which would then go to a vote. Do you want to do that?

Mr. Bill Walker: We'll table that for now and we'll bring it back at an appropriate time.

The Chair (Ms. Cheri DiNovo): Thank you.

We will now resume consideration of vote 14071 of the 2015-16 estimates of the Ministry of Health and Long-Term Care. When we recessed this morning, the third party had 15 minutes and 37 seconds left in their rotation. Madame Gélinas, please proceed.

M^me^ France Gélinas: Really? We keep 37 seconds? I'm impressed.

The Chair (Ms. Cheri DiNovo): And you just blew them.

Laughter.

M^me^ France Gélinas: All right. Well, I didn't think I had it.

I ended up talking about physicians. Now I would like to talk about nurse practitioners a little bit. The first thing that comes to mind when we talk about nurse practitioners are the multitudes of letters that I am copied on. Most of them are addressed to you. Some of them are addressed to you, as well as the deputy ministers, but they all say the same thing.

I have this letter from Jennifer Clement, who is the clinic director of the Sudbury District Nurse Practitioner Clinics, which is the very first nurse practitioner-led clinic that happens to have sites in my riding, that says: "Our budget has remained unchanged over the last six years, yet costs around us continue to rise due to the cost-of-living increases," and they're having a tough time recruiting nurse practitioners. She wrote that this summer. This spring, she wrote to you, again saying, "The looming disparity in compensation between primary health care nurse practitioners, as well as other members of the interprofessional health providers and administrative support staff in the acute care sector, has been yet again dropped from any actual agenda."

You also had the letter from seven physicians from the Caroline Family Health Team who wrote to you, basically saying, "Nurse practitioners are leaving primary care to find better compensation. In fact, those who work as nurse practitioners in hospitals, in long-term care, in CCACs are earning $20,000 to $30,000 more than community sector nurse practitioners." And they ask you: "We feel that attention needs to be taken immediately to bridge the increasing wage gap as outlined above for all primary health care teams in Ontario."

We have Brigitte Gravelle from the City of Lakes Family Health Team, who feels frustrated: "I am in underpayment and unfair treatment of health professionals in primary care"—I'm sure you know what I'm talking about. Is there any place in the budget where there is money set aside to address the wage gap between nurse practitioners practising in primary care versus other settings?

Hon. Eric Hoskins: Thank you for this question. It's a very important one. Certainly this is an issue that I'm aware of. I've had discussions with nurses, including nurse practitioners, as well as those who represent them, including—I think this falls, at least in part, in the category of the issue that has been raised with me on a number of occasions of recruitment and retention of nurses, and nurse practitioners in particular. So it's an issue that I know the ministry is working very diligently on with our partners in the nursing profession and those who represent them.

I think it's important for the public to also understand, notwithstanding your comments, that it's within a

broader context where there are literally tens of thousands more nurses employed in this province than were employed when we came into government in 2003, including considerably more nurse practitioners.

We were the government that initiated the development and implementation of nurse practitioner-led clinics, which I know you're very familiar with and supportive of. We now have 25 nurse practitioner-led clinics in the province, serving almost 50,000 patients, including a number of those nurse practitioner-led clinics in the northern part of the province, which I'm very supportive of because they provide the highest quality of care.

We continue to work in terms of scope of practice as well to make sure our nurse practitioners are able to practise to the maximum scope, and we're in ongoing discussions with them on how we continue to expand their scope of practice so they're able to provide the quality care that they do.

Perhaps the deputy may have something to add, but certainly the ministry, under my direction and instruction, has been working with our partners to look at and hopefully appropriately address the issue that you've brought forward, which is the issue, as I mentioned, that I would refer to as the challenges in recruitment and retention which are found in a variety of circumstances around the province.

M^me^ France Gélinas: The question was: Will I find any money in the budget that is set aside to increase the pay of nurse practitioners working in primary care settings?

Hon. Eric Hoskins: Mike, do you want to address—or the deputy?

Dr. Bob Bell: In terms of increasing the number of nurse practitioners, you're aware of the 75 nurse practitioner full-time equivalents who will be coming into the long-term-care sector—30 this year and subsequently a further 45.

As you know, there are now 25 nurse practitioner-led clinics with 97 nurse practitioners working there and relatively few vacancies. There's also a grow-your-own-nurse-practitioner initiative that has been successful that is being subscribed to. The issue in terms of the difference in pay between primary care nurse practitioners, mainly in family health teams and hospital-based nurse practitioners: There are some differences in expectations, the kinds of roles they undertake and the kinds of supervision they have.

We do recognize that there is an inequity and we'd like to move to address that. There's nothing in the 2015-16 budget to address that, but we are looking at the potential for 2016-17.

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M^me^ France Gélinas: All right. So I can take from what you've said, Deputy, that you do recognize that there is an inequity and we will all hold our breath till the next budget comes around, with fingers crossed?

Hon. Eric Hoskins: In my remarks a short while ago I acknowledged that that challenge does exist and it's one that I'm aware of personally and the ministry is aware of. I've publicly spoken to it and identified it as a priority as well.

To be sure, we're talking about individuals beyond strictly nurse practitioners as well in certain environments—for example, family health teams. There have been representations made to me and to the ministry to more fully help us understand the nature of the challenges that they're facing. Many of the organizations that are funded through the ministry do have some modest flexibility within their budgets to reallocate resources, including increases in base salaries, as long as it's done within a net-zero framework. So there are a variety of mechanisms that potentially are available. As I mentioned, it is an issue which—when I had some of those initial conversations, I asked the ministry to see how we could address it in a way which is fair to the profession.

Dr. Bob Bell: The other issue, of course, you're aware of is the issue of benefits: that in the hospitals the nurse practitioners are receiving HOOPP, a 22% relative benefit. That's something we're looking at as well: trying to equalize on the benefits side as well as starting to move on the compensation side.

M^me^ France Gélinas: All right. That is encouraging. I think, Minister, you've addressed it. The nurse practitioners are the ones where the gap between primary care-based nurse practitioners and any other—whether they work for the CCAC, they work in long-term care or they work in hospitals, they all make substantially more.

The second profession I would say where the gap is the biggest is dietitians/nutritionists. Are they also on the radar to be looked at? Because it's really difficult to recruit in primary care when hospitals pay $20,000 more for the same professional.

Hon. Eric Hoskins: Those were the types of individuals that I was referencing a moment ago when I indicated that that challenge on recruitment and retention and the salary challenge extend beyond specifically or uniquely nurse practitioners. In that context, I've asked the ministry to look at those categories of individuals to see how we can help address that gap.

M^me^ France Gélinas: Okay.

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

M^me^ France Gélinas: Thank you.

When you talk about professionals—social workers, nurses, health promoters, nutritionists/dietitians—everybody who works in an interdisciplinary primary care model will be looked at, salary-wise as well as benefit-wise?

Dr. Bob Bell: Yes. We're aware that some of the discrepancies are greater than others in the health professional roles. For example, in physiotherapy the differential is not as great as it is; for kinesiologists and recreational therapists, it's not as great as it is. The roles that you've mentioned, in particular advanced practice nurse and dietitians, are probably recognized as having the biggest gap.

At the same time, there aren't a lot of vacancies, I understand. So we are able to recruit, but the trouble is

that folks tend to move on to other roles in the hospital when they become open. That has been the big concern. We are filling the roles, but there is a higher turnover in primary care; you're absolutely right.

M^me^ France Gélinas: Okay. I can tell you that the clinic in Sudbury has a maternity leave right now and they are not able to recruit. The same thing with the nurse practitioner-led clinic in Alban: They have a vacancy and they are not able to recruit. I have three nurse practitioner-led clinics in my riding, and all of them have vacancies. Am I out of the norm, that nobody wants to work in Nickel Belt, or what?

Hon. Eric Hoskins: I'm sure that's not the case.

M^me^ France Gélinas: Good.

Hon. Eric Hoskins: Hopefully through my response and the deputy's response as well, we've acknowledged that there is a disparity that exists. As a matter of priority, I've directed the ministry to look at that disparity with regard to nurse practitioners and, as the deputy mentioned, certain other categories where the disparity is pronounced, to see the potential—looking at a variety of possible measures to see how we might be able to effectively address that.

Our nurse practitioners, our dietitians, a whole host of individuals who are part of a comprehensive health team or are those front-line health care workers are invaluable to the delivery of health services.

M^me^ France Gélinas: I just want to make sure that the engagement, what you have shared with me, will apply not only to nurse practitioner-led clinics, but community health centres, aboriginal health access centres and community-governed family health teams, that all of the interdisciplinary primary care models will be reviewed with a view of having equity for the professionals who work there.

You have to speak because—

Hon. Eric Hoskins: Understood. Moving towards a situation of equity is what we're anticipating, yes.

M^me^ France Gélinas: For all of the interdisciplinary primary care models?

Hon. Eric Hoskins: The interdisciplinary primary care models we would all move in the same way.

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

Do I have a minute left?

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

M^me^ France Gélinas: Okay. In my two and a half I want to keep on primary care.

Twenty-five nurse practitioner-led clinics—now I want to talk about family health teams. How did you come to the conclusion that we were only going to add so many new physicians and family health teams every month?

Hon. Eric Hoskins: Well, the conclusion that we reached was that there are certain parts of the province where they are underserved by the family health team model. We felt that it was incumbent upon us as a government to take what has been and is a very successful model of delivering primary care, that multidisciplinary team model, and work diligently through incentives, in part to address the fact that there are certain areas, certain regions within the province that would benefit from the presence of family health teams.

We made the decision, and it was a decision, a proposal that was proposed well in advance to the OMA, where we asked for their consideration, discussion and reflection. The decision was made to focus new family health teams in those underserviced areas. We reached out to the LHINs and they, through consultation, determined, based on demographic and other features, where they believed those underserviced areas might be.

M^me^ France Gélinas: I followed the process to identify the areas that would and would not. The part I don't understand is why the monthly limit?

Dr. Bob Bell: In the past we have taken about 40 primary care physicians a month and put them into what's called the family health organization model, which, from a physician's perspective, is the funding model that qualifies you as a family health team. Currently we've got—

The Chair (Ms. Cheri DiNovo): I'm afraid that will have to wait. I'm afraid that your time is up. Thank you, Madame Gélinas.

We will now move to the government side.

Interjection.

The Chair (Ms. Cheri DiNovo): Minister, we will move to you for 30 minutes.

Hon. Eric Hoskins: Thank you, Madam Chair. Thank you, members of the committee as well and members of the public. Thank you for the opportunity to provide further remarks. Once again, I'll be sharing my time with Associate Minister Damerla.

In my opening remarks I focused on our transformational progress over the past year. Now I would like to discuss our plans for coming months and years ahead.

Some of you will know that my background is as a public health specialist—as a physician, but as a public health specialist—and so the work that my ministry is doing to protect and promote the health of Ontarians is particularly close to my heart. Everyone in this room understands the importance of vaccines, for example, to overall good health, and you understand, no doubt, that vaccines prevent diseases, save lives and, at the same time, they reduce health care costs.

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Fortunately, the current generation of Ontarians has been spared the devastating effects of diseases like polio or diphtheria. That's because Ontario has had, for many years now, a strong and effective publicly funded immunization system. Thanks to our vaccines, infectious diseases that were the leading cause of death worldwide, a hundred years ago, are now the cause of less than 5% of all deaths in Canada.

Our system provides access to programs and information that support the people of Ontario in making informed immunization choices. I'm proud to say that Ontario's strong immunization system provides excellent value in protecting Ontarians from vaccine-preventable diseases.

The Universal Influenza Immunization Program is one of our immunization programs that is particularly important right now. I just launched our fall vaccination program yesterday morning. It's important as we enter this year's annual flu season.

As part of the Universal Influenza Immunization Program, the province is providing a new type of free vaccine for children this flu season. It's a quadrivalent vaccine that's made to protect against not three, but four different strains of the flu virus: two which are influenza A, and two influenza B viruses. This added protection comes against an additional B strain of the flu virus, which affects children and youth more frequently than it does affect adults.

With the presence, this year for the first time, of the new quadrivalent vaccine, parents now have more choice in helping to protect their children against the flu. They have an even greater choice because this year, for the first time, we've introduced a free nasal spray flu vaccine called FluMist.

I can tell you, speaking as a public health specialist—in fact, I did my PhD at Oxford University, back in the 1980s, in measles and measles vaccination. It took me nine years to get my PhD. It was a rather prolonged period of time, but at the end of the day, they were either extremely generous or I deserved it, but nonetheless. It took so long partly because the fieldwork for the vaccination that I did was in Sudan. I lived and worked and conducted the fieldwork for my PhD for three years in Sudan.

Speaking as a public health specialist, I can tell you that both the injectable and the nasal spray forms of the flu vaccine are safe and well-tolerated for children and youth, with no contraindications. In Canada, of course, we have rigorous testing of all vaccines. So getting your flu shot is the best way to protect yourself, your family and, importantly, the community around you against the flu.

I'd like to change the subject, I suppose you could say, entirely and move from protecting the health of our children and youth to how we plan to improve palliative and end-of-life care. As we all know, death isn't an easy subject to talk about, but that's changing. Today, attitudes towards end-of-life care are remarkably different than even just a few years ago.

At any given time, up to 100,000 Ontarians are in their last year of life. Now, polls tell us that the vast majority, upwards of 80%, want to spend these last years at home and out of the hospital. But today, that's not the reality. While our hospitals do an excellent job and deliver first-rate and compassionate palliative care, it's challenging to provide the home-like setting that's so important to people and so respectful to people in their final days.

That's why, as part of a broader strategy, my parliamentary assistant, John Fraser, and I will be working together to oversee the expansion of hospice care in Ontario, to include up to 20 new hospices across the province. This will provide palliative patients the opportunity to spend their final days close to home in a home-like setting.

At the same time, I've asked John to work at the national level to engage in the dialogue on dying with dignity in Canada. We're taking this step because of our shared belief that we have a responsibility as people, as a society, to think and talk about how best to make the end of life both peaceful and dignified. We have a responsibility to focus on the quality of dying as much as we focus on the quality of living.

MPP Fraser has been holding round table discussions across Ontario to support the development of a comprehensive strategy on palliative care. That work is ongoing, but let me tell you some of what we've heard already.

Number one, we've heard that we need to be doing more to connect end-of-life care with the very people who would benefit from it. The reality is that palliative care can happen anywhere that health care happens: in people's homes, in residential hospices, in long-term-care homes and in hospitals. But too often, patients and their families don't know the treatment and support options that are available to them. That has to change.

Another message we've heard loud and clear is that we need to take a more personalized approach to how we deliver end-of-life care, tailored to the specific needs of the individual patient and the patient's family. We're taking steps on that front, too. Our Patients First: A Roadmap to Strengthen Home and Community Care will help to address some of the concerns around consistency in the quality of care that we're delivering across Ontario. The road map includes plans for greater patient choice for palliative and end-of-life care, for expanded access and equity, clear oversight and accountability and, importantly, new supports for caregivers.

As well, there is enhanced public education on the issue of advanced care planning so that families are aware of the wishes of their loved ones when it comes to palliative and end-of-life care. We're improving how palliative and end-of-life care is provided by listening to patients and caregivers. Ontario's new approach will improve quality of life and result in an improved and dignified quality of death. We're also prioritizing services and resources for caregivers and volunteers to acknowledge the important role that they play in palliative care, and to keep them healthy as well. This comprehensive approach will improve access to palliative and end-of-life care. It is part of our government's plan to improve home and community care, helping patients have better access to health care faster and closer to home.

I also want to note that, in collaboration with 10 other provinces and territories, Ontario has taken the lead in establishing an expert advisory group on physician-assisted dying, focusing on the needs of patients and their families.

Dementia and Alzheimer's are terrible diseases that impact many of us and can bring turmoil and anguish to all those involved. These diseases not only affect those who are diagnosed, but also the people closest to them. It will take a coordinated, collaborative effort from all of us to help understand and treat these diseases. I've tasked my other parliamentary assistant, MPP Indira Naidoo-

Harris, with the responsibility of working to develop a comprehensive strategy to care for patients with dementia and Alzheimer's disease.

Right now in Ontario, there are more than 200,000 people—that's one out of every 10 over the age of 65—with a form of dementia. And that number, as we all know, is expected to grow. It's estimated to grow to 300,000 by 2017. Now, these figures, as compelling as they are, tell only a small part of the story. They don't reflect the immeasurable toll that the disease takes on individuals and families. As we all know, the real cost of dementia goes far beyond the numbers: It's the real emotional impact on families and friends that can be, in many cases, the most devastating. And there is an enormous cost to the health care system of the province as well.

According to the Alzheimer Society of Ontario, the direct and indirect annual cost of dementia in Ontario is more than $5 billion. That is expected to increase by $770 million per year through to 2020.

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To respond to this very serious issue, Ontario has a plan to support those who live with Alzheimer's and other dementias, and their families and loved ones. Since people, including those with Alzheimer's and related dementias, prefer to stay in their homes and communities for as long as possible, we're committed to providing the support that they need so they can stay healthy and at home. But we also know that there may come that time when home care is not enough, and so our government has made substantial investments to improve the lives of Ontarians with Alzheimer's and related dementias and support their caregivers. Now, as part of her mandate, Indira will be working across government to identify ways to expand supports to these invaluable informal caregivers.

The plan that we're working on will ensure that all Ontarians with dementia and Alzheimer's disease, along with their families and care partners, are first, and perhaps most importantly, treated with respect; second, that they have access to information that allows them to make the best possible choices regarding their health and well-being; and third, that they are living well with dementia, helped by appropriate services and supports where and when they need them.

It's a plan built upon a patient-centered model of care which respects the preferences and the rights of individuals with dementia. It's a plan that will raise awareness to reduce the stigma associated with dementia and will educate patients, care partners and providers on prevention and treatment options and innovations. There will be a focus on accessibility and equity of care across the system to ensure that it is responsive to both current and emerging needs. Of course, we're going to engage the full spectrum of services and sectors to make it easier to deliver comprehensive and coordinated care for people with dementia. We're going to ensure that there is appropriate system capacity across that full continuum of care. We're going to achieve this goal through evidence-based long-term planning, policy, infrastructure and investment decisions. Last, but certainly not least, we are going to ensure that our system is accountable and sustainable. We will do this through an ongoing evaluation of the quality of our services and our achievements.

As Ontario's health minister, I'm fortunate to witness, every day, the life-saving and life-improving treatments that are already making such an enormous difference in patients' lives. Ontario's medicine and medical devices are already sought after globally. Ontario is the third-largest hub for biotech and the fourth-largest biomedical research centre in all of North America. Its life sciences companies bring in over $14 billion in annual revenues. Ontario is also one of North America's leading biomedical research locations, with universities and teaching hospitals investing almost $2 billion per year.

Yet, the Ontario Health Innovation Council identified significant barriers to the development and commercialization of health technologies in Ontario. That has to change if we are to remain competitive and provide tangible benefits to patients. So we're determined to do things differently, to benefit Ontario's people and patients.

We need to build pathways to connect to the key players and resources involved in Ontario's health innovation sector. That's where the Office of the Chief Health Innovation Strategist will come into play. This office will provide the leadership necessary to make Ontario a major centre for health technology innovation. It will form part of government and will serve as a central authority to align strategy and resources right across the system. It will integrate, coordinate and marshal existing resources in the innovation environment. It will reduce barriers and accelerate the development, assessment, adoption and, ultimately, the spread of health technology innovations.

We're very fortunate, as a province, to have Mr. William Charnetski as Ontario's first Chief Health Innovation Strategist. Mr. Charnetski is an accomplished national and global executive who has worked in the highest levels of business, as well as law and government. He has a track record of leading transformational change, in developing organizations, in leading people to realize their potential, to fostering internal and external partnerships and collaboration, and, importantly, delivering results. The technologies that his office will help to foster and bring to life will allow Ontarians and people across this country and around the world to live healthier, more engaged, more prosperous lives.

Advances in medical technology hold tremendous potential as perhaps the best enabler of transformation. By embracing innovation, we can spend our health care dollars more efficiently, but also more effectively, helping to improve outcomes for patients.

Let me conclude by reiterating that, working with our valued health system partners, Patients First, our action plan for health care, provides the opportunity to revolutionize health care in this province, in ways that will better serve Ontarians in the months and years ahead.

Madam Chair, committee members, it's been my pleasure to appear before you. I'm not going anywhere.

Thank you again for the opportunity, and now Minister Damerla will take the floor.

Hon. Dipika Damerla: Madam Chair, how much time do I have?

The Chair (Ms. Cheri DiNovo): You have about 13 minutes.

Hon. Dipika Damerla: Madam Chair, members of the committee, members of the public, thank you once again for the opportunity to provide remarks. I'm pleased to be back for the afternoon edition. I was pleased to focus earlier this morning, as you know, on long-term-care homes in my opening remarks. Now I'd like to return to our work in the wellness area.

Health and wellness initiatives: My two key priorities, as associate minister for wellness, are to reduce smoking and childhood obesity. Our efforts towards achieving the lowest smoking rates in Canada got a boost with the passing of the Making Healthier Choices Act, 2015. Many of you are very familiar with that. The act will play an important role in empowering Ontarians to make the decisions that help them lead healthier lives and move us ever closer to a truly smoke-free Ontario.

Between 2000 and 2014, Ontario's smoking rate dropped from 24.5% to 17.4%, which equals approximately 408,257 fewer smokers in Ontario. Since 2005, Ontario has become an international leader in tobacco control because of our Smoke-Free Ontario Act. On January 1 of this year, new regulations took effect that make it more difficult for young people to purchase tobacco by prohibiting sales on post-secondary education campuses. The new regulations also prohibit smoking on almost all bar and restaurant outdoor patios and prohibit smoking on playgrounds, publicly owned sporting areas, spectator areas adjacent to sporting areas, and the 20 metres surrounding these areas.

Our government continues to take active steps to protect young people from the health risks and impacts of smoking. Electronic cigarette, or e-cigarette, use is an emerging trend in Ontario. Many concerns have been raised about the possible health effects of e-cigarette use by media and the medical community. Until now, there has been no regulation to control their use, and we know that they're appealing to young people. They're also seen as less harmful, but there is insufficient evidence yet to back this claim. So keeping up with technology, the legislation makes Ontario one of the first Canadian jurisdictions to regulate electronic cigarettes. Under the new Electronic Cigarettes Act, 2015, it will be illegal to sell e-cigarettes to minors and use e-cigarettes in enclosed public spaces and enclosed workplaces. The ministry is proposing that these prohibitions come into force on January 1, 2016.

Other prohibitions in the act, such as the ban on selling e-cigarettes in certain places, such as pharmacies, and a ban on displaying and promoting e-cigarettes, will be considered. As well, we are prohibiting the sale of flavoured tobacco products, including menthol, and increasing the maximum fines for those who sell tobacco to youth, making Ontario's maximum fines among the highest in Canada. We believe that prevention is a key part of staying healthy, and we can help ensure Ontarians, especially the youngest among us, have the information they need to make better choices about staying healthy.

Childhood obesity: Evidence shows that 28% of Ontario children and youth are overweight or obese. In some communities, that number is even higher. Children and adolescents who are obese are at greater risk for bone and joint problems, sleep apnea and social and psychological problems, such as stigmatization and low self-esteem. Unfortunately, a large proportion of obese youth grow up to become obese adults. It is well documented that adult obesity can lead to increased risks for chronic diseases and conditions, like certain cancers and type 2 diabetes.

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On the other hand, healthy behaviours bring many benefits to our children, their families and communities. For example, just 60 minutes of daily physical activity helps children and youth to develop healthy bones, muscles and joints, healthy hearts and lungs and better coordination, not to mention a healthy body weight.

We know that Canadians are eating out more, particularly at chain restaurants, and buying more prepared foods from grocery and convenience stores. Currently, there is a lack of nutritional information for prepared foods served in these locations.

The Healthy Menu Choices Act, 2015, which is part of the Making Healthier Choices Act, requires calories for standard food and beverage items, including alcohol, to be posted on menus and menu boards in restaurants, convenience stores, grocery stores and other foodservice premises with 20 or more locations in Ontario. It also requires regulated foodservice premises to post contextual information that would help to educate patrons about their daily caloric requirements and authorizes inspectors to enforce the menu-labelling requirements.

By January 1, 2017, we will have fully delivered on our commitments, under the Healthy Menu Choices Act, 2015, to post calories on menus in restaurant chains and other foodservice premises with 20 or more locations in Ontario.

I was also very pleased to see the amazing response to our Healthy Kids Community Challenge. I've been visiting communities across Ontario to help them launch their own challenge, which can serve as the catalyst for a lifetime of healthy eating and living. There are 45 communities participating around the province, including six aboriginal communities. I look forward to hearing about their progress to engage partners throughout the community to encourage physical activity and healthy eating among children.

I can tell this committee that I've had the pleasure of actually visiting many of the communities that are going to receive this money, and the excitement there is really something that has to be experienced first-hand. I was in Sudbury, in Peterborough, in Windsor and in Hamilton, and every single place I went—you know, what's really

powerful about this particular program is that it gets all of the stakeholders. It gets the YMCA, it gets the schools, it gets the municipalities, all of them, coming together. In fact, the most successful applicants were the ones where all of the stakeholders came together and where a number of municipalities worked together. So we are very excited about this particular program and what it's going to mean in terms of reducing obesity for our children. It's a big part of our Healthy Kids Strategy to improve children's health by focusing on a healthy start, healthy food and healthy active communities.

We've come a long way and have done some terrific work, but there's more work to be done. In addition to strengthening smoking-related legislation, we know we must also focus on cessation to reduce smoking rates. To that end, the ministry is working on a revamped cessation strategy to be launched in 2016. Again, this is something that the ministry has been working very hard on, and I'm really looking forward to seeing what we come out with with the revamped cessation strategy.

The Chair (Ms. Cheri DiNovo): Associate Minister, you have about five minutes left.

Hon. Dipika Damerla: We have revived the ministers' working group, which I co-chair with Minister MacCharles, through which we are developing the next set of initiatives for the Healthy Kids Strategy while continuing to implement existing initiatives, such as the Healthy Kids Community Challenge in 45 communities across Ontario.

Before I conclude, I do want to speak to another initiative which I know is also close to many of you here, including Madame Gélinas, which is the Healthy Menu Choices Act, which is about posting those calories. I want to talk about why I think it is so powerful. The reason I think this is such a powerful initiative is from a personal experience of mine. The first time I ran for an election back in 2011, I was a little nervous. It was my first election. I recall a friend of mine telling me, "You know, Dipika, win or lose, one thing is for certain: You're going to lose weight in the campaign." So the election came by, I won and I was very excited, but a funny thing happened, and that was that I gained weight. I remember that very clearly, because I remembered that conversation. And then when I came to Queen's Park and we were trading war stories, there was MPP Crack telling me about losing 10 pounds in his—

Mr. Grant Crack: Eleven.

Hon. Dipika Damerla: Eleven, I'm sorry. Meanwhile, I'd gained some weight. And the penny didn't—what's the word—fall into place until a few months later when I accidently found out, just by surfing on the Internet, that a medium-sized Iced Capp can pack 700 to 800 calories. It was a summer election, as many of us will remember, and I have this practice of canvassing three times, and after every canvass, because volunteers are so precious, I would take them out for a round of coffee at the local Tim Hortons. They might have ordered a coffee, but I was gulping Iced Capps. They might have had one a day, because they come and do one canvass; I was doing three canvasses. So I was taking in about three Iced Capps a day. That's 2,100 calories. Contextual information: Probably 1,800 calories a day for me. No wonder I gained weight. This is the power of this information, because had I known that it was 700 calories, I'm sure I wouldn't have had three, perhaps just one. So we are really, really excited about this initiative.

Finally, in conclusion, I just want to say that I look forward to continuing to carry out the priorities entrusted to me as we work toward delivering sustainable, long-term care to Ontarians, and strengthening a culture of health and wellness across the province. I think the health and wellness piece sometimes doesn't get the focus it deserves, but it goes back to that old saying: An ounce of prevention is worth a pound of cure. At the ministry, I am determined to really, really put that old saying into practice and focus on prevention, as I've said. A primary focus is on obesity as well as smoking cessation, and the reason for that is, as we know, almost 30% of kids in Ontario are obese and that is something that we definitely want to tackle—I'm sorry?

Mr. Bill Walker: Too many Iced Capps.

Hon. Dipika Damerla: Too many Iced Capps—and that's why we need the calorie board up there.

Ontario is already the second-lowest smoking jurisdiction in Canada. We don't want to stop there. We really want to get to first place, and we look forward to working with all of you in making sure that this happens.

Once again, thank you so much for the opportunity to speak to you. I'm ready to welcome any questions that the committee might have.

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

Mr. Bill Walker: Thank you very much, Madam Chair, and Minister, Associate Minister and Deputy Minister.

I just want to start off my comments by thanking the minister for his recommitment to the Markdale hospital funding, and I hope that's continuing on in its regular process. You recently gave some money to the Southampton emergency facility—not in my riding but very close next door and is part of Grey Bruce Health Services—and I hope you'll continue your commitment to the RCU, which we've brought to your attention significantly.

I'm going to focus most of my remarks on long-term care. Minister and Associate Minister, I hope you'll enjoy that. I'm always pleased to come and try to help you with your job, to be able to take it back to cabinet and make sure you're putting your priorities in the right place for Ontarians. I'm going to put it in the context of—as you're well aware and everyone in the room probably is well aware—the number of people age 65 and older has been increasing at a rate of roughly 4% to 5% per year. Our senior population is expected to double to over 4.5 million, or 25.5% of the population, by 2041.

I want to start off with the thought that there are over 20,000 people on a waiting list for long-term care. I want

to talk about it a little bit, because we know the demand is only going to increase for this population demographic. Your government promised to build more long-term-care beds to accommodate our growing senior population, so my first question is: What was the target that you set for yourself?

Hon. Dipika Damerla: Sorry, could you clarify: target for what?

Mr. Bill Walker: A target for long-term-care beds. When you came to government—your government—what was the target that you set for long-term-care beds that you would build in the province?

Hon. Dipika Damerla: Since coming to office, we have brought online 10,000 new beds. As a matter of fact, I was in Windsor very recently for the opening of Schlegel Villages, and I believe that was close to 250 new beds. That's new beds, so this was not a redevelopment. I'm looking forward to going to Sudbury soon where there's another redevelopment, but there's going to be an additional close to 40 new beds. I'm also going this Friday to London where a brand new long-term-care home—again, about another 196 new beds. So the new beds are consistently being built.

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The other thing that I can say, as you probably know, we have launched comprehensive capacity planning across the health care system. It's probably the first robust one that we're doing in some time, and the entire purpose of this capacity planning is to determine the need for long-term-care beds not only today but going forward.

I think it's really important to keep in mind that long-term-care beds is the continuum of care. So if we can invest more in community care—for instance, we are investing $750 million additionally over the next three years—and help seniors stay at home, that has an impact on the number of beds we are going to need. So it's a holistic system. Increasing investments on one side can have an impact on demand, for instance, for long-term-care homes.

Given that investments in one sector could increase or decrease demand for long-term care, we are very mindful that it's a very dynamic system. We know that Ontarians have told us that their preference is to stay at home for as long as they can, so you will see us continue to invest in community care, but we also know that long-term care is an important pillar.

Mr. Bill Walker: Respecting all of that, Minister, but the question was: How many beds did you target and say you would commit to building in your term of government? So what's the number?

Hon. Dipika Damerla: That's what the capacity planning—

Mr. Bill Walker: I don't want the capacity; I want a number.

Hon. Dipika Damerla: Well, you can't have a number in the absence of an evidence-based process, and that evidence—

Mr. Bill Walker: You've had 12 years. You made commitments that you would build beds. How many beds did you plan to build?

Hon. Dipika Damerla: We've already brought online 10,000 new beds since—

Mr. Bill Walker: And what was your target?

Hon. Dipika Damerla: —coming into office, and we've done it based on the need. So the target—

Mr. Bill Walker: Ten thousand as a total of how many?

Hon. Dipika Damerla: Sorry. What do you mean? Ten thousand new beds—

Mr. Bill Walker: Ten thousand as a total of how many beds?

Hon. Dipika Damerla: So the total capacity—

Mr. Bill Walker: Ten thousand of how many—

Hon. Dipika Damerla: No, no. He's talking 10,000 beds. So every new licence that was planned has been built now. If that's your point—

Mr. Bill Walker: So what's that number?

Hon. Dipika Damerla: We have brought 10,000 online since coming into office in 2003. We've added 10,000 new beds.

Mr. Bill Walker: And what was your target?

Hon. Dipika Damerla: That was our target, and unless the minister wants to add—

Mr. Bill Walker: May I ask the deputy minister to clarify? I think he had a different number.

Dr. Bob Bell: No. The total number of long-term-care licences and beds is 78,000 in the province.

Mr. Bill Walker: Is currently?

Dr. Bob Bell: Is currently. That's correct.

Mr. Bill Walker: And when you took over, how many was it?

Dr. Bob Bell: It was 10,000 less, 10,000 fewer—I'm looking for the answer. Since October 2003, 10,286 new beds have been developed.

Mr. Bill Walker: So my understanding is, there were 70,100 long-term-care beds in Ontario when you came to power. How many are currently in place?

Hon. Dipika Damerla: About 78,000.

Dr. Bob Bell: Yes.

Mr. Bill Walker: Seventy-eight thousand, so not 10,000. That's about 8,000 beds. So can you clarify those two numbers, your 8,000 and your 10,000?

Hon. Dipika Damerla: I'm sure we can get back with the clarification, yes.

Dr. Bob Bell: I think we'll have to take that number away and bring it back to you.

Mr. Bill Walker: So are you again telling me that there is no target? You've planned, you've studied—I hear it all the time in the House. You've done comprehensive consultation. You're studying, but you don't have a number of how many beds you are actually needing in the province? Knowing that our population is increasing the way it is, you don't have a target that you're working towards?

Hon. Dipika Damerla: That's why we have the capacity planning exercise under way—exactly to respond to your issue—and that exercise will inform us through an evidence-based—

Mr. Bill Walker: So when will your capacity planning end? When are you going to put some defining numbers in place so that the people of Ontario—particularly those seniors who are looking at needing a facility or their family is looking at what's going to be needed—have a comfort level, that you're actually moving towards a target?

Hon. Dipika Damerla: So I think it's really important to recognize the fact that since coming to office, wait-times for long-term-care homes have declined by 45%.

Mr. Bill Walker: Okay.

Hon. Dipika Damerla: That has happened because of the investments we have made. That's happened because we've built new beds, but it's also happened because we've invested more in community care. So it's really important to understand that it's a continuum of care that we need to invest in. So to focus on just long-term care or just community care doesn't do justice to the whole idea that it's a continuum of care and that we provide the right care at the right time. Sometimes the right care is going to be in the community, sometimes it's going to be in the long-term-care home, and sometimes it might be just continuing care. So it's a continuum of care that we are looking at. We've added a lot of beds, and we continue to add, as you can see the evidence—I've just given you examples of three instances of new beds, so that's adding to the footprint of Ontario's long-term-care beds. And we are concurrently going to be redeveloping 30,000 new beds. That's really important to keep in mind.

The reason redevelopment is important is that sometimes, when a home is not up to modern standards, people don't put that as their first preference, so that has an impact on wait times. As we modernize these beds, we know that modernizing the existing beds will also reduce wait times. Investing in community care, as we plan to, will also reduce wait times.

Concurrently, we are also doing a capacity planning exercise; hopefully in summer or fall of next year we should have good evidence that will point us in the direction of how many more beds we need to build.

Mr. Bill Walker: Minister, you've brought up a good point: that you've made promises and commitments. My numbers are slightly different: You're saying you committed to 30,000 beds; my understanding was that the number when you campaigned on it was actually 35,000 beds. That's just 5,000, so we can work on that.

At the end of the day, what I really wanted to know is—and your Seniors Strategy expert, Dr. Samir Sinha, said that this needed to be done—how many of those beds have actually been renewed to date?

Hon. Dipika Damerla: The 30,000 number refers to the new phase of redevelopment. We've already redeveloped 13,000 beds, and now another phase of redevelopment has started; the target for that is about 30,000 beds.

Mr. Bill Walker: So you're suggesting that the total number will be 43,000 beds that you're actually committing to?

Hon. Dipika Damerla: Yes, because we have 13,000 that have already been redeveloped since coming to office.

Mr. Bill Walker: And can you just give me and define and clarify what you mean by "renew," so that we are all on the same page as to what you mean by those terms?

Hon. Dipika Damerla: Which terms?

Mr. Bill Walker: Renew a bed. Redevelop, renew a bed.

Hon. Dipika Damerla: Redeveloping a bed means that you don't increase the footprint. So if you had 50 beds, you'll still have 50 beds, but what you've done is rebuilt the facility to modern standards. When I talk about net new beds, what it means is that these beds never existed and so now there has been an actual increase in the capacity.

Mr. Bill Walker: Okay, so then just let me clarify: The 13,000 number that you've just given me, are those renewed beds or new beds?

Hon. Dipika Damerla: Redeveloped. Those were existing beds that were modernized.

Mr. Bill Walker: Those were redone.

Hon. Dipika Damerla: Yes.

Mr. Bill Walker: So our need has jumped, by stats I'm provided with, by 85% between 2005 and 2012. Where is that change going to happen? Because what I'm understanding is that you've only actually increased the number of beds by 3% in that time. Redeveloping is a wonderful thing; I get that sometimes they need modernization, but that's not helping with the demographic wave that's coming at us.

Hon. Dipika Damerla: We've added 10,000 new beds, plus redeveloped 13,000 beds.

Mr. Bill Walker: Correct, but I still don't think you're keeping pace with what the need is. That's my concern.

Hon. Dipika Damerla: I think we have, because the evidence points to the fact that wait times have been reduced by 45% since we came to office. Since your government left and our government took over, there has been a 45% decline in wait times. That tells me we are addressing the need. That doesn't mean we stop; we continue to invest. That's why we have embarked on a capacity planning exercise to look at what else we need to do. But let's not just build randomly; let's do this in a scientific, evidence-based way. If that means we take six to nine months to do a proper plan, that's how we want to do it.

Mr. Bill Walker: I fully appreciate the strategic intent that you're following, but at the end of the day, there are almost 25,000 people waiting for a bed. I've asked you a couple of times where your plan is. You've been in power for 12 years, so saying that you need nine to 12 months—where have the first 11 years of that been when you've known about—seniors aren't just a new thing.

Hon. Dipika Damerla: I'm going to answer that. I know the deputy wants to weigh in.

In the last 11 years, with all due respect, we added 10,000 new beds. In fact, the number is 10,200—

Mr. Bill Walker: You committed to 30,000, though.

Hon. Dipika Damerla: We didn't commit to anything. Those were the beds—

Mr. Bill Walker: You campaigned on it; that's a commitment, is it not?

Hon. Dipika Damerla: That was redevelopment. Those are two very different issues. We campaigned on redeveloping 30,000 beds, which we intend to follow through on; the process has already started. We also added 10,286 new beds. I gave you three examples—I'm going to reiterate them: I was in Windsor—close to 200 beds; Thunder Bay—close to 40 beds; London I'm going to on Friday—close to another 200 beds. These beds have been coming online regularly over the past 12 years that we've been in office, and that accounts, to some extent, for the 45% decline in wait times. But I want to reiterate that some of that decline is also because we are investing in community care. We are investing in helping people to stay in their homes longer. It's an effort that is twin-track, if I may.

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I want you to recognize that, as we continue to focus on reducing wait times—we are going to build new long-term-care homes, absolutely; we await the results of the capacity planning—in the meantime, we are aggressively investing in community care: $750 million over the next three years. That's going to make a huge dent, as well.

Mr. Bill Walker: So when you're saying $750 million, do you have a plan of how many beds and where they're going to be located and built and what time frame?

Hon. Dipika Damerla: The $750 million is investing in community care, to keep seniors in their homes so that they don't need the long-term care right away.

Mr. Bill Walker: How much have you budgeted for the actual building of new beds that you've committed to?

Hon. Dipika Damerla: The way we build beds is the operator builds them up front. Once that facility is ready to have seniors move in and it hits all of the codes and we inspect it and it's up to code, it's only then that we defray the capital cost over a 30-year period. It's a very efficient model, where the initial risk of building, getting capital, is borne by the operator. The ministry has to start paying that expense—it's like paying a mortgage. It's over 30 years. It's a very good use of taxpayer dollars.

Mr. Bill Walker: I appreciate that, but you obviously know the numbers that are needed for people to be in beds. You would then have, I would expect, a corresponding number of beds that are going to be built per year in a location. What I'm trying to get down to is, please provide me with that. What is the time frame, how many beds and where, to get those 20,000 people off the waiting list? I commend you. If you drop the waiting list by 45%, that's wonderful. But for the 55% who are still on the waiting list, that's not wonderful.

Hon. Dipika Damerla: That math is wrong.

Mr. Bill Walker: What I want to know is, when you budget—you're using terminology like "a mortgage." When I go out and build a house, I know how much I'm going to spend and when I'm going to spend it and when I expect that house to be built. I would like you to share with the committee what you believe to be the plan—

Hon. Dipika Damerla: The deputy wants—

Mr. Bill Walker: Or the deputy. That's fine.

Dr. Bob Bell: Over the last 10 years, $1.344 billion has been expended on new beds and on beds that have been redeveloped, to this point.

I think, perhaps, the discrepancy in the conversation relates to the best practices around care for the elderly. Our geriatricians—some of the leading geriatricians in the world are here in Ontario—point to the fact that utilization of long-term-care beds on a historic basis has probably not been best practice in the province. There are jurisdictions in the world—the Scandinavian countries, for example—where longevity is even longer than it is in Ontario, where there are virtually no long-term-care beds. There are assisted living residences, and we have increased the number of assisted living opportunities as part of the home and community living investments that the minister has responded to.

I think part of the discussion that we're having is around let's not blindly build long-term-care beds. We don't know the right number based on the changing desires of the population. Let's look at what we can accomplish through assisted living supportive housing. Let's look at what we can accomplish through enhancement of home and community programs, and there has been a tremendous focus on that—

The Chair (Ms. Cheri DiNovo): Excuse me. Mr. Walker, you have just under five minutes left.

Mr. Bill Walker: Thank you.

Dr. Bob Bell: The summary, Mr. Walker, is: Do we know the number of long-term-care beds that population will need? No. Do we follow closely the waiting times to see if we do see evidence of a peak building up? We do follow those very closely, not only on a provincial basis, but, of course, on the basis of our LHINs. We're really, really hoping that the $250-million-a-year investments in home and community care, not just for care in the home, but also community care that brings neighbours to shovel off walks and also brings supports to people in their own housing, as well as supportive housing, are going to reduce some of the traditional demand that's been there for a long time.

Mr. Bill Walker: I certainly applaud those and I'm a supporter of all those. We need to look at doing things differently. But I think you have to be pragmatic, in fact. When I'm out in long-term-care facilities, what I hear from the front-line staff and the administrators is that we're having an increase in acuity for the people who need those beds. That's not going away. I don't care what model you want to use; that's a reality.

Dr. Bob Bell: That's entirely appropriate.

Mr. Bill Walker: We need to know what those beds are going to be. We need to be projecting how many we're going to build.

A quick stat here: The Ontario Health Quality Council reported in 2010 that the wait time for a long-term-care

bed has tripled since 2005. Can we get, from your ministry, a list of wait times for the last 10 years?

Hon. Dipika Damerla: I'm sure we can look into getting you that information, but a lot of that information is publicly available, as well, on the Health Quality Ontario website, which actually points to the 45% decline since 2002-03.

But just coming back to your question, and to reiterate what the deputy said, it really is about the balance, and the balance is between investing in community care and in that continuum of care that helps seniors stay at home longer. That means that when they do come into a long-term-care home, yes, the acuity is higher, because we've managed to keep them in the home for longer. But it's also worth bearing in mind that the average stay in a long-term-care home today is 18 months. If you went back six or seven years ago, it could have been as long as four years. So the acuity is—

Mr. Bill Walker: I fully appreciate that, but you even said 30,000 beds, so all I want to see is a schedule. If you identified there was a need for 30,000 beds, what is your time frame to build those? If you haven't met that timetable, give me a rationale of why you've had to change it, why you've had to move it. There has to be a game plan going forward.

I'm going to use the Markdale hospital. There's a facility that, 12 years ago, was identified as a need. People there continually ask me on a daily basis, which I have to come and ask you folks on a daily basis, "Why isn't it built?" You saw the need; you knew it was there; the community stepped up.

I get the same type of questioning, if you can appreciate, from constituents in my riding. I live in a riding that has above the provincial average of seniors. They're saying to me, "Bill, my mom and dad are 82 years old. They're going to need a facility." They're packed to the rafters now, so how are we addressing that? That's the question I'm asking you.

I want to see a plan to give them comfort, so that they actually have a plan in place. When you say 30,000 and they're not there, then tell me the time frame when they will be there.

Hon. Dipika Damerla: The 30,000 number—I think there's some confusion. The 30,000 that we committed to is redeveloping the beds. I'd be happy to talk to you about the progress we are making on that redevelopment. In fact, if you will give me a minute, I do want to talk about it, because I think it's a really, really important part of what we are doing.

The redevelopment process, the new phase for the 30,000 beds, has started. We have increased the funding subsidy by up to $4.73, compared to the previous phase of redevelopment, to make it more attractive for our operators to redevelop. We've also increased the licence time from 25 years to 30 years. We have created a dedicated office at the ministry, with a dedicated person to stickhandle the entire redevelopment process.

The first batch of long-term-care operators who are interested in redeveloping has been identified; they have been admitted into the program. But the admission doesn't mean they are going to get the funding. There are still some more hoops for them to jump, in terms of financial liability, making sure that they can secure the financing, at which point we hope there will be shovels in the ground and we'll be ready to go public. I'll be delighted to share that with you—

The Chair (Ms. Cheri DiNovo): Thank you. I'm afraid I'm going to have to cut you off there. Mr. Walker, your time is up.

We now move to the third party: Madame Gélinas.

M^me^ France Gélinas: All right. I just wanted to finish the sentence that you were halfway through.

I was asking you about FHO, which is how family physicians get paid if they are within an FHT, a family health team. You were telling me that there are currently 4,000 physicians on this particular payment model, and then my esteemed colleague called it off. What were you going to say after that?

Dr. Bob Bell: Thanks for that question. In the family health organization model, there are 4,500 general practitioners—total number, 4,591—who are practising in family health organizations. They're paid on average about $431,000 per year. In family health teams, there are 2,792 practising, earning about the same as the family health organizations. The difference between the two models is that in the family health team, we have other professionals providing care as well as the primary care physicians, whereas that's not entirely true in the family health organizations.

Your question was why we have gone from a monthly average of about 40 graduates—new doctors—entering into these managed entry-to-care models, leading to this kind of a rostered model of care.

The significance of these two models is that, rather than getting paid on a fee-for-service basis, physicians are compensated based on the number of patients that they look after.

The reason is that, as you've heard, at $431,000 a year, these are lucrative models. They are higher than the average family doctor receives in fee-for-service care. We think with this substantial number, over 7,000 doctors working in this of the roughly 12,000 primary care physicians, that we probably have enough that we don't want to keep rapidly increasing these numbers. Rather, we want to focus on the problem that you're very sensitive to: redistribution of physicians across areas which have a lower doctor-to-citizen population. That's why we've reduced the number of people entering these models to 20 a month from 40 a month, but we've worked with our LHINs to define areas of the province which are high-need areas. These areas are the ones that we want to incent doctors to move to. This is one of the incentives that we have put in place to move doctors to these underserviced areas.

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Because of the desire of new graduates to move in to roster care models, the minister has already announced over the last week or so another managed entry to care model—managed entry to practice model—which is—

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

Dr. Bob Bell: Please, Minister, over to you.

Hon. Eric Hoskins: Are you interested in hearing more?

M^me^ France Gélinas: Sure.

Hon. Eric Hoskins: As I mentioned and the deputy mentioned, our efforts have been focused on encouraging physicians to utilize the family health team model in the underserviced areas of the province. Those underserviced areas that are co-designated—or at least we get the good advice of the LHINs and the partners that they work with to identify the underserviced or high-needs areas—are reviewed on a quarterly basis as well. So we welcome input from our health care providers and partners to ensure that we in fact correctly—in a dynamic way, as well, as changes are made and deployment occurs—make sure that that categorization is current and accurate.

This was important to me, I think it's fair to say, personally as well as professionally as the minister: I recognize that there are graduates, including new graduates, who receive their training in this comprehensive care model, the family health team model, and they may have received that training or are perhaps a resident in an environment in Ontario which isn't designated high-needs. As the deputy alluded to, we have been working over the past months—this is a proposal that was shared with the OMA, in-depth and well in advance, quite some time ago, before the summer, to get their feedback and comments—to provide that opportunity for family medicine graduates who perhaps were trained in that environment, who want to remain in that environment but aren't prepared for a variety of reasons, or maybe for personal reasons don't have opportunity to be deployed or to work in an underserviced area.

We're calling that, I think, the new grad entry model—

Dr. Bob Bell: New grad entry program.

Hon. Eric Hoskins: —new grad entry program. That will provide opportunity, as well, for an additional stream, if you will. I'm not sure if we—have we established a target number, or are we approaching that on a case-by-case basis?

Dr. Bob Bell: Probably on a case-by-case basis, yes. Probably we expect that there won't be as much demand to fill the remaining 20 spots a month, but we are hopeful that we will get some interest in this model.

Hon. Eric Hoskins: I can't remember the number in the north, for example, but I really feel compelled to this as a great model of delivery of health care services, due to the comprehensive nature of it. I think it's good for everybody involved. It's particularly good for the patient—we've measured their confidence in this particular form of delivering health care—but it's good for the broad-based health professionals, including our doctors who are working within it. I feel compelled as minister that I have a responsibility to ensure that that model, when it's made available, is made available in an equitable fashion.

This new model that we have brought forth, the new grad entry model, is an effort, I think, to reach that balance, to recognize and respect the personal choice that needs to and should exist for a physician in this province, but it also allows us to target our predominant efforts for reaching out to those high-needs areas, to ensure that they have the physicians and, particularly, have the opportunity in this model of the family health team to be able to deliver health services.

M^me^ France Gélinas: I'm also curious—this is a question I ask every time there are estimates: We're now at 2,792 physicians that work within the family health team models. How many other practitioners are funded through the family health team model?

Dr. Bob Bell: How many?

M^me^ France Gélinas: Yes, and if I could have a breakdown by profession that would be perfect.

Hon. Eric Hoskins: You may have that shortly. We could certainly—

Dr. Bob Bell: We will get you that information.

Hon. Eric Hoskins: Yes.

M^me^ France Gélinas: I know that there won't be more than 20 physicians a month added to that 2,792. Do we also have a target as to how many other professionals are being added to the family health team models?

Dr. Bob Bell: At the present time, we are focusing on physicians moving into practice utilizing the same interprofessional teams and expanding the family health organization model. We don't have a plan at present to expand the number of interprofessional care providers in family health teams.

M^me^ France Gélinas: Are there plans to open up new family health teams?

Hon. Eric Hoskins: Well, this is the intent of us maintaining and providing incentives and opportunities for family health teams to emerge in the high-needs areas. But as I mentioned as well, we've now introduced a further program. For example, if a group of physicians in Nickel Belt wanted to establish a new family health team, they could approach the ministry and, assuming it's a high-needs area, we would work with them. So in a sense it can come from both directions. It can be an initiative by a number of physicians—and other health care professionals, for that matter—who express an interest, but it is coincident with the efforts that we're making to provide access to this model of care. It's one of many. We haven't made any changes to, say, family health groups or fee-for-service types of practices. Those other opportunities exist for our physicians, but if we're talking specifically about family health teams, that's—

M^me^ France Gélinas: Okay, that's the part I don't understand. Twenty new physicians will get to be on a roster payment program called FHO to work within a family health team, but if you create new family health teams, there doesn't seem to be any money to fund the rest of the team. This is what the deputy just said. So how do you open up a new family health team without having a team? All you're doing is opening up alternate payment plans called FHO.

Dr. Bob Bell: Going back to one of the earlier questions you asked, Ms. Gélinas, there are 2,102 inter-

disciplinary health professionals serving with 2,792 physicians. We think there is opportunity to recruit some more physicians to that family health team model. Within that, we think that probably there could be more physicians working within that model.

Currently we're equally focused, if not slightly more focused, on recruiting people to family health organizations where they would work in a rostered model, providing comprehensive care without necessarily introducing interprofessional team members with them.

What we recognize is an equity-of-care issue in the introduction of family health teams. I think it has to be recognized that Ontario has really led the world in terms of introducing these kinds of publicly funded interprofessional teams. We have to recognize that by colocalizing these interprofessional providers with physician models, we don't necessarily focus the care of those interprofessional teams on the citizens that need them most. What we're doing is looking at the model of community health centres as well as family health teams and saying, "How can we ensure that these models are going to be equitably distributed and serving the needs of the patients, as opposed to simply serving the model of the care provider?"

We're doing some work on this now to look not only at how patients who are rostered to the doctors in family health teams get access to care from interprofessional care providers or in community health centres, but rather how any patients in the region who need care from interprofessional teams can access it, even if their physicians aren't members of these family health teams. We're looking for equitable distribution to these interprofessional resources. That's been part of our Health Links process, that you're aware of: trying to focus interprofessional, comprehensive care, especially on the needs of high-needs patients.

M^me^ France Gélinas: So we're at 2,102 interdisciplinary team members that work within the family health team model, and this is it? This is where it's going to stay for the foreseeable future?

Hon. Eric Hoskins: I guess I would point to at least a couple of important developments. This speaks to the earlier conversation this morning about our partnership with our doctors as well. I'm optimistic and gratified that the OMA agreed to work with us and to partner with us on the creation of the task force that I had referenced earlier, the task force on the future of physician services.

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I view this as probably the most important recommendation of Judge Winkler, who was involved in the negotiations process as the conciliator. He felt it is critically important not just for the fiscal sustainability of the health care budget and the health care system, but, equally as important, in a medium- and long-term process, to garner the expertise not simply in Ontario but from around the world, to bring together experts in true partnership with our doctors and the government, to determine how best to support our physicians and those who work with them, our primary care providers, and to do that in the context of a sustainable health care system.

This gives us for the first time—and perhaps ever, but certainly in a long time—the opportunity to work hand in hand with the OMA to address the precise issues you're describing. And then the other—

M^me^ France Gélinas: While those discussions will take place, the idea that new family health teams could be created out of those 20 new physicians who will be there—none of this will happen?

Dr. Bob Bell: I think the way that we look at family health team service expanding is twofold: first of all, by new physicians moving into existing family health teams where the ratio—

M^me^ France Gélinas: Those are not the ones. We're finally able to recruit in northeastern Ontario where we never had physicians before, so some of those 20 are now setting up shop. Three or four of them got their FHO. They're setting up shop in a community that never had access to primary care before. But what I'm asking you is, will they ever be able to have an interdisciplinary team attached to them?

Dr. Bob Bell: There are a couple of issues. Will they actually have an interdisciplinary team that works around them, or will their patients be able to get access to interdisciplinary resources according to their health needs? Certainly, the second will be true.

M^me^ France Gélinas: Okay.

Dr. Bob Bell: It's hard to anticipate exactly where those interprofessional resources will be sited. But what we know now is, some of the interprofessional team members within family health teams may not be providing care that is directed towards the maximum health care opportunities that they can provide for patients. They're not necessarily serving the needs of high-needs patients. A model based on access to interprofessional care, depending on what kind of model your doctor works in, is not what we want. We want to have these resources distributed according to patient need.

Hon. Eric Hoskins: If you'll allow me just very, very briefly—the other example I was going to give is the Price report on primary care reform that they delivered to me earlier this year and that we have made public. That speaks to some of the issues that Bob has been referencing.

I think we've got tremendous opportunity at this point in time. Again, we're focusing our efforts on the high-needs areas. I take your point in terms of the importance of the comprehensive nature and the other health care professionals who are very valuable to that team-based approach. Correct me if I'm wrong, but I believe it already is the case that those resources can be made available through physicians who may not be part of that family health team with the consent of the family health team itself.

Dr. Bob Bell: Correct.

M^me^ France Gélinas: Yes, correct.

Hon. Eric Hoskins: So that opportunity already exists. But I think we're at a moment in time—and again,

I'm optimistic and gratified that the OMA has accepted my invitation to form this task force, that it gives us the opportunity, in the context of the Price report and other work that has been done—considerable work over the past few years of working with our stakeholders to establish precisely what methodologies are working the best, how we can support our physicians and other primary care workers to deliver that quality of care and address the issue of equity as well as access across the province. These are important issues that you're pointing out.

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

M^me^ France Gélinas: Okay. Next are going to be money questions. You are shifting resources to the community sector. In 2014-15, there was $270 million. That's a 6% increase that was committed to the community health sector. Where can I get a breakdown as to where that $270 million actually went?

Dr. Bob Bell: We will have that for you momentarily.

Hon. Eric Hoskins: I was going to say, the deputy seems to have a lot more charts and diagrams and spreadsheets than I do, so it's likely that he has the answer—or these folks.

Dr. Bob Bell: Thank you. The answer is, in the 2015-16 estimates, community care access centres will see a 7.8% increase in funding; community support services, 8.8%; assisted living services and supportive housing, 1.6%; folks living in supportive housing for acquired brain injuries, 6.9%; community health centres, 5.4%; community addictions programs and community mental health programs, 5.7%, for an overall increase to the community sector of 5.8% or $283 million.

M^me^ France Gélinas: Okay. You're talking about fiscal year—

Hon. Eric Hoskins: That's current fiscal.

Dr. Bob Bell: That's current, 2015-16.

M^me^ France Gélinas: It's 2015-16?

Dr. Bob Bell: Yes.

M^me^ France Gélinas: All right. Can I have the same breakdown for 2014-15, for last year?

Hon. Eric Hoskins: Yes. He represented the year-over-year increase. The percentages he was describing would be the year-over-year, but we certainly have the actuals; don't we?

Dr. Bob Bell: We have the actuals; we also, for the increase for 2014-15, based on the interim accounts—just quickly: CCACs, 7.3%; community support services, 4.8%; assisted living and supportive housing, 10.6%; community health centres, 3.6%; community mental health and addictions, just under 6%.

M^me^ France Gélinas: Okay. And those are available on what page of the whatever?

Dr. Bob Bell: Can anybody tell me where they are in the estimates?

Mr. Mike Weir: That's a customized breakdown.

M^me^ France Gélinas: Can I have a copy?

Dr. Bob Bell: We'll provide it to you, absolutely.

M^me^ France Gélinas: Because I'm not going to get the Hansard of this and as fast as I am at taking notes down, I cannot do that.

Dr. Bob Bell: We will provide this to you.

M^me^ France Gélinas: Okay, sounds good.

My next question has to do with Healthy Smiles. I know that CINOT and Healthy Smiles Ontario are going to be rolled into the new Healthy Smiles program. I'm curious about how much funding was allocated to CINOT in 2014-15, how much was spent and how many kids were seen, as well as how much is being allocated to CINOT this year, for 2015-16.

Same questions for Healthy Smiles Ontario: How much was allocated in 2014-15, how much was actually spent in 2014-15, how many kids were seen and how much have we got allocated for 2015-16?

Dr. Bob Bell: So, CINOT—

Hon. Eric Hoskins: Too bad it's in different categories; right?

Dr. Bob Bell: Yes. As you know, all these programs are being brought together—

M^me^ France Gélinas: I'm fully aware.

Dr. Bob Bell: —with an incremental allocation of $22 million in 2015-16 and $24 million allocated for 2016-17. If we look at CINOT, the funding in 2014-15 that you asked for was $15.8 million.

Hon. Eric Hoskins: That's the treatment, that component, yes.

Dr. Bob Bell: Yes, this is for the Children in Need of Treatment. That included the expansion funding within the public health units. The number of children treated, I'm not sure I can provide you with right now, but we have that data. If you're looking at the expenditure for CINOT, $15.8 million has continued forward—

The Chair (Ms. Cheri DiNovo): I'm sorry, I'm afraid your time is up. Thank you very much, Madame Gélinas. Now we move to the government side. Ms. Naidoo-Harris.

Ms. Indira Naidoo-Harris: Chair, my question is for Minister Damerla. Minister Damerla, as you said earlier, an ounce of prevention is worth a pound of cure. Certainly there's no area where this statement is more true than when it comes to the costs associated with keeping Ontarians healthy. As health costs continue to rise and a rapidly aging population continues to squeeze the available resources from the health sector, it is becoming increasingly important to encourage Ontario's residents to live healthier lives.

Creating an environment of wellness and prevention is an important part of keeping Ontarians healthy. Tell me, what are the main initiatives that your ministry has been rolling out to reduce the prevalence of chronic diseases and encourage people to lead healthier lives?

Hon. Dipika Damerla: Thank you, MPP Harris. That's an excellent question.

Mr. Bill Walker: You didn't say that to me.

Hon. Dipika Damerla: You have to ask excellent questions.

Currently, as you know, the ministry invests more than $370 million annually on health promotion programs and initiatives to address the common risk factors associated with chronic disease and longer-term health outcomes.

These initiatives include healthy eating, physical activity, tobacco and alcohol use, problem-gambling prevention and maternal/pre-natal help.

Our government is building on investments to date with a focus on keeping Ontarians healthy. And I'm proud to say that we've made some great progress as of late. As I mentioned earlier in my opening remarks, our government passed the Making Healthier Choices Act, 2015, and I want to thank both parliamentary assistants, Parliamentary Assistant Fraser and Parliamentary Assistant Harris, as well as the MPP from Kingston, Sophie Kiwala, for all of your help with the Making Healthier Choices Act, 2015.

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This really is landmark legislation. It puts Ontario out in front as a jurisdiction on many fronts. On smoking, we become the first jurisdiction in Canada to move forward with regulating electronic cigarettes. We also become the first jurisdiction in Canada to move forward with mandating chain stores that sell prepared foods to post calories on menus and menu boards. The act also, it's worth noting, includes amendments to the Smoke-Free Ontario Act. For example, we've increased fines for retailers who sell or try to sell cigarettes to youth under the age of 18—doubled the fines, making our fines now the highest across Canada.

So our government feels that initiatives like these are really important, that people are more likely to reach their full potential when they lead healthy and active lives. That is why Ontario is committed to promoting healthy behaviours and preventing disease in Ontarians. You started with one old saying about how an ounce of prevention is worth a pound of cure, and I think the one that I like best is, "Health is wealth." We all recognize that, and it's the basis of our social prosperity, so I'm really pleased with the focus that we are putting on health promotion. Thank you.

Ms. Indira Naidoo-Harris: Thank you so much, Minister Damerla, and I want to commend you on these initiatives, actually.

I would like to find out a little bit more about some of the things that you're rolling out, but I'm particularly interested right now in just what kind of reception you're getting from people out there. How are some of the initiatives you're moving forward with being received by people, and what's your sense—this suggests to me that there's a shift in thinking in health care.

Hon. Dipika Damerla: Two examples that I want to use—there are so many people I meet who ask me, "So when am I going to see those calories on the menu board?" I feel that in government we do many things, but there are some things that really resonate with the public, and certainly the whole idea of posting calories on menu boards is one that is really resonating with Ontarians. I've lost track of the number of times friends and family and my constituents have either tweeted to me or sent me pictures from New York, saying, "Here, it's already in New York. When is it coming to Ontario?" In fact, Minister Coteau was in, I think, California recently and he also sent me a picture. So really huge excitement on this particular initiative, and it's something that tells us that we are moving in the right direction.

The other one that's really resonating is the Healthy Kids Community Challenge. Again, I alluded to that earlier. I was in Oshawa, and it was fascinating because I went to make this Healthy Kids announcement and they had about 20 or 30 children waiting for me there. You know, the level of questions that they asked me—they knew that Oshawa was getting $1.2 million. They wanted to know exactly how much $1.2 million was. They knew it was for children and they were so excited by the idea that this was money for them. So, again, that's another example of an initiative of ours that is really, I think, resonating with Ontarians.

And of course, you know the excitement that the youth had, and I want to share the credit with Madame Gélinas, when we banned flavoured tobacco. I mean, they were so excited. They hosted a tug-of-war with, I guess, the tobacco side losing, and then they came and gave both you and me a plaque, and it was their leadership, their involvement. They showed ownership and they really felt that the government came through for youth.

So I really believe that health promotion is something that Ontarians deeply care about. I think these three examples give you a flavour of how they are resonating, and we're really excited and we look forward to continuing to move the needle.

Ms. Indira Naidoo-Harris: Thank you so much for that. I want to tell you that just in my own household I've seen that this has had an incredible impact on our family. My daughter, who is 16, is now reading every label that comes along and is very concerned about what she's eating. She has become a vegetarian and now a vegan, so that labelling is even more important.

But, you know, with busy families, we find that there are endless options sometimes for unhealthy fast food that are out there, and frozen or processed foods. These things save time and we all find ourselves at times being moved towards perhaps taking one of these options. How can the government, do you think, make a difference and encourage people to make healthier food choices?

Hon. Dipika Damerla: Thank you. That's an excellent question, because I think that's something that we all struggle with at some level. We all lead very, very busy lives. We live on the run. It's very tempting to, I guess, grab the closest snack that there is. So we in government have been working and we've come up with some really, really innovative things that we are working on.

I know I've talked at length about the fact around getting restaurants to post those calories. I really think that's going to be a game changer. Two things are going to happen. One is that people are going to make those healthier choices. Somebody like me is still going to order the Iced Capp; I'm just not going to have it three times a day. I think you're going to see that with people going to Starbucks or whatever it is, they will still order what they want, but maybe a small size.

But the second thing that I think will happen—and in jurisdictions where this has been legislated, it has already

happened—is that the formulations that the restaurants have of their food will become healthier. Nobody wants to post 1,000 calories next to their muffin, so really, the idea of the healthier choices is going to come through.

But I don't want to leave the impression that this is the only thing the government is doing, so if you'll indulge me, I'm going to also just remind everybody of some of the other initiatives that this government is working on.

The first one is the Northern Fruit and Vegetable Program. We can only imagine, as hard as it is for us to live and eat healthy food living in southern Ontario, where you have access to food from, I guess, South America, so that you get fresh fruit, fresh tomatoes year-round. But it wasn't so long ago that we didn't have access to fresh food year-round. In the north that continues to be an issue.

That's why the government has the Northern Fruit and Vegetable Program, which increases awareness of and consumption of fruit and vegetables for elementary and intermediate school-age children in three northern regions. It does so by providing no-cost fresh fruit and vegetables in combination with healthy eating and physical activity education. Expansion in 2014 doubled its reach to more than 36,500 students in 194 schools, including 6,600 aboriginal students. I hope that MPP Walker is making note of these numbers, because I know he likes them all to add up.

The healthy eating and active living initiatives offered by aboriginal health access centres and the Ontario Federation of Indigenous Friendship Centres provide culturally tailored, culturally appropriate health promotion and chronic disease prevention programming, with an emphasis on increased opportunities for physical activity and healthy eating, which leverages traditional aboriginal practices and teaching approaches. In 2014-15, over 4,200 people participated in healthy eating and active living programming proposed by the aboriginal health access centres.

The public health units deliver public health programs and services, which include promoting healthy eating, healthy weight, physical activity, tobacco-free living, and healthy growth and development. Diabetes prevention initiatives delivered by our public health units and our aboriginal health access centres and community health centres provide programs and supports to address modifiable risk factors associated with type 2 diabetes such as physical inactivity and unhealthy eating. They also drive behaviour change among individuals who are at higher risk for developing type 2 diabetes, in order to prevent or delay the onset of this disease.

EatRight Ontario, which is operated by Dietitians of Canada, offers email and toll-free telephone access to registered dietitians. In 2014-15, they responded to 18,200 calls and emails, and there were two million visits to their website.

Healthy Eating in Secondary Schools Grants was a one-time funding program which provided in January 2014 for innovative projects that changed the food culture in schools and complied with the Ontario school food and beverage policy.

The Fresh from the Farm: Healthy Fundraising for Ontario Schools pilot, which represents collaboration with the Ministry of Education, OMAFRA, Dietitians of Canada and the Ontario Fruit and Vegetable Growers' Association, is a new approach to fundraising in schools by selling Ontario-grown fruits and vegetables.

I hope that gives you a flavour of just some of the programs our ministry is delivering.

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Ms. Indira Naidoo-Harris: Absolutely. In fact, in my riding there is a program under way right now where we have—I can't remember the name of the program. We have young children after school—it's an after-school program where they go in, and it's not just eating locally and vegetables produced locally, but learning how to prepare them. The great thing about the program is that they're not just learning how to prepare foods in a certain way, they're learning about all kinds of different types of food and preparation, so different country preps and so on, and learning to rediscover food, really, and rediscover healthy food. So thank you so much for that.

I'd like to get back to your comments about the menu-labelling legislation and how important that is. Can you tell me a little bit about what some of the key elements of that legislation are?

Hon. Dipika Damerla: Yes. That's an excellent question, again, because I think the devil's in the details. The ministry has worked really, really hard with our stakeholders to work through the nitty-gritty of exactly what is going to be labelled and what our expectations are. I'm happy to give you a sense of the direction that we're going.

Our government has heard loud and clear from Ontario parents; they want information and support to help keep their children healthy. That's why our government passed the Making Healthier Choices Act, because we want to help Ontarians make healthier food choices by giving families the right information at the right place and the right time.

I'm proud to tell this committee that this legislation makes Ontario the first province in Canada to require chain restaurants to post calories on menus as part of the Making Healthier Choices Act. Our legislation was developed following consultations with the food industry, health sector and parents.

Specifically, it will require calories for food and beverages, including alcohol, to be posted on menus and menu boards in restaurants, convenience stores, grocery stores and other foodservice premises with 20 or more locations in Ontario. It will require foodservice premises to post a contextual statement regarding daily calorie requirements.

I think that contextual statement is really, really important. It goes back to the idea that three Iced Capps a day are 2,100 calories. If the contextual statement says that your daily recommended intake is 2,000 calories, I think that gives people pause to say, "Wait a minute, this would be my entire day's calories."

It will authorize public health inspectors to enforce menu-labelling requirements and prohibits municipalities

from creating bylaws to require additional nutritional information to be posted on menus and menu boards. This avoids a patchwork of different menu-labelling requirements in different municipalities by levelling the playing field for businesses operating in multiple municipalities across Ontario. By implementing legislation to require the posting of calories on menus and menu boards, Ontario will raise public awareness about the calorie content of foods eaten outside the home, and I think that's really, really important—raising public awareness.

I know Madame Gélinas did an excellent job in the Legislature during one of our discussions when she read off a whole list of different food items and the calories. I can't remember whether it was a Subway sandwich that can pack 1,200 calories to 2,000 calories. Just having that awareness—

The Chair (Ms. Cheri DiNovo): Ms. Naidoo-Harris, you have about five minutes left.

Hon. Dipika Damerla: For me, I think my—

M^me^ France Gélinas: The tuna melt.

Hon. Dipika Damerla: Sorry?

M^me^ France Gélinas: It's the tuna melt at Subway that has 1,800 calories.

Hon. Dipika Damerla: Thank you, 1,800 calories. We think that it's a healthy—and some salads hide a number of calories as well. Personally, for me, the one that shocked me was when I learned that a small Cinnabon is 1,000 calories. That's every bite—I mean, how many bites is a Cinnabon? Four? So every bite is 250 calories. I think that kind of awareness is really, really important—

Interjection: The minister knows her calories.

Hon. Dipika Damerla: It's just going to make it easier for people to make healthier choices when dining out. It will encourage industry to offer healthier items and reformulate high-calorie menu items. This will create a more supportive food environment that will make it easier for Ontario families to choose healthy foods.

I'd also like to note that this legislation does give the government the authority to add additional nutrients, including sodium, to menu posting requirements in the future through regulation, and we remain open to reviewing additional information.

Ms. Indira Naidoo-Harris: Thank you for that. I just want to add that the notion of having these calories and labelling posted is helpful for everyone, but I know it works towards reducing child obesity also.

We went into a lot of the details, but if you don't mind, just going back to outlining for me—this is really an initiative that's about changing the way we look at health care and improving the overall health of Ontarians. These initiatives are really about not just crisis care and care in facilities and when people wind up in hospitals, but it's about looking at how we can perhaps slow down the process when people arrive in hospitals and wind up needing crisis care. Just finally, your thoughts on that?

Hon. Dipika Damerla: I couldn't agree with you more. I think the beauty of this particular legislation is that it's not about telling people what to do. We all know we need to eat right. We've gotten that message, I think—most of us have. I think this is about empowering Ontarians. This is really giving people that ability to make the choice, to make healthy choices.

I think it's a real shift from just saying, "You have to eat healthy; you have to exercise," to making it easier for people to eat healthy. It is about changing the environment so that it becomes easier for people to eat healthy or to exercise. I think where you'll see the government moving in terms of some of our initiatives is, what can we do to make it easier for Ontarians to be healthy?

My favourite example—I know, Deputy, you will indulge me, because you've heard me share this story before. I read in the Toronto Star—I believe it's Ryerson, or is it George Brown? I can't remember. At Ryerson—I think it was Ryerson—they built a new campus. When they built the atrium, they put a staircase in the middle of the building and put the library on the first floor. By doing that, what they found was that because it was a nice, large, airy atrium, and because the stairs were dead centre in the middle, a grand staircase, and because the elevators were tucked away to a side, there was changed behaviour and people were now taking the stairs to go to the library. If the stairs were not there—if it was more like Hepburn Block, where I work, where the stairs are hidden, you'd take the elevator to the first floor.

So it really is about changing the environment, about all of the things that we can do to make it easier for people to be healthy. I think the healthy choices act is a phenomenal, fantastic example of that, and we're very proud of it.

Ms. Indira Naidoo-Harris: Thank you so much, Minister Damerla. I want to thank you for these initiatives, because it really is changing the way that we all look at our health. I think it will ultimately, in the end, impact on our health care system.

While we're seeing some changes now, I think the real changes are going to come years from now, when the young people that we're talking to in the schools become older. I think it will really slow down the process and slow down the needs in terms of chronic disease care. Thank you.

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

Mr. Jeff Yurek: I'm just going to ask a few questions, and then I'm going to turn it over to Mr. Walker.

To the associate minister: Just questioning your statement on long-term-care home wait times—I have a chart here, and it's provided from the Ministry of Health and Long-Term Care. It spans the time frame from 2003 to 2012-13. To me, wait times from hospital have gone from an average of 24 days in 2003-04 to an average of 65 days. The average wait time from home has gone from 86 days to 111 days.

You're claiming you've cut those wait times by 45%. Are you able to share your information? I know sometimes you can pick and choose data to suit your argument. This data is from your ministry. It looks like it skyrocketed by 2008-09, and it's starting to come back

down, but it's still higher than it was 10 years ago, and the wait times for hospital seems to be trending in the wrong direction. They seem to be increasing over the last few years.

Do you have an explanation on what the difference is? Will you share all your data, and how you achieved your numbers for the past 10 years, with this committee?

Hon. Dipika Damerla: I'm delighted to share that. Before I go ahead and share the numbers—in fact, these numbers are from Health Quality Ontario. These are not ministry numbers. You don't have to take our word for it. This is—

Mr. Jeff Yurek: This report is from Health Quality Ontario, too.

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Hon. Dipika Damerla: Yes. The thing that I do stand corrected on is that I should have been comparing it from 2008-09 when, in the community, wait times were 190 days and now they're down to 116 days.

Mr. Jeff Yurek: Right. So your earlier statement—you want to correct your record that it wasn't—

Hon. Dipika Damerla: Yes. I corrected—

Mr. Jeff Yurek: —from our last government. I think your quote was, "Your last government, your wait times were outrageous."

Hon. Dipika Damerla: Let me correct that.

Mr. Jeff Yurek: Okay.

Hon. Dipika Damerla: The last government did not—

Interjection.

Hon. Dipika Damerla: No, no. The last government did not collect wait time information. So we have no idea—

Mr. Jeff Yurek: But that wasn't the question.

Hon. Dipika Damerla: Let me finish.

Mr. Jeff Yurek: No, let me finish. The time was actually 66 days, spiked to 190 and now down to 111. So, really, wait times under your government have worsened for long-term care.

Hon. Dipika Damerla: I do correct my record, but I think it's important to say that it's impossible to compare our record to yours because the previous government—

Mr. Jeff Yurek: I'm comparing it to wait times for people waiting to get into a long-term-care home—

Hon. Dipika Damerla: Let me finish.

Mr. Jeff Yurek: —over the last decade.

Hon. Dipika Damerla: Okay.

Mr. Jeff Yurek: Because we're not government anymore. We haven't been government for over a decade. We can't fix our previous record, but you guys are still accountable for each and every year of the last decade and two years, and the trends are going the wrong way.

Hon. Dipika Damerla: Right. I'm going to finish my thought if you will allow me. It's impossible for us to compare our record on wait times with the previous government because the previous government did not record or measure wait times. It is true that wait times did increase, but since 2008-09, we've made a concerted effort in reducing wait times and you can see that it's declined from 190 days to 116 days.

Mr. Jeff Yurek: Except in hospitals it has increased. Hospitals have gone from 49 to 65. So you're looking at almost a 30% increase, plus—

Hon. Dipika Damerla: When you combine them both together, you would see an overall decline in our wait times.

Mr. Jeff Yurek: You should look at them separately. Wouldn't you agree that people waiting in the hospital have a higher cost to our health care system? That's a little more of something to be targeting, whereas people waiting at home you can help out with cheaper care through community care access. It's 10 times cheaper to provide services at home than at the hospital. Wouldn't you think that you would want to keep those two separate and try to work on the more expensive cost to the system to be declining instead of heading in the wrong direction?

Hon. Dipika Damerla: So the way the CCACs determine eligibility and prioritize—

Mr. Jeff Yurek: No, my question wasn't about eligibility of CCACs. It's a straight question. Wouldn't you want to focus on the higher cost of our health care system where people in the hospitals are waiting for long-term-care beds?

Hon. Dipika Damerla: I'm going to answer your question. The CCAC determines the priority list and includes people who are in hospitals and people who are in the community, and it's up to the CCAC, on a very evidence-based basis, to decide who gets that highest priority to go into a long-term-care home—

Mr. Jeff Yurek: So you just give CCACs a blank cheque, and if they screw up, they screw up?

Hon. Dipika Damerla: We don't give them a blank cheque. They have protocols, and if you will bear with me, I would actually like to go through that protocol because I think it's really important to understand—

Mr. Jeff Yurek: No. We know the protocol. We don't need—

Hon. Dipika Damerla: I think it's really important, Jeff—

Mr. Jeff Yurek: We're dealing with estimates and numbers and not the protocol.

Hon. Dipika Damerla: Let me answer the question.

Mr. Jeff Yurek: So back to my next question, and maybe you could enlighten me on this. I was visiting some long-term-care homes in London, where I'm glad you're going to open new residences. There was a regulation change that if a patient is in a long-term-care home and has to go to the hospital for medical treatments—and patients in long-term-care homes are more complex nowadays—if that exceeds 30 days, then they lose their bed. It used to be 60 days, I believe, and your government has cut it back to 30 days.

So with the higher increase in complex care, patients are returning back to the home as quickly as possible so they don't lose their bed because the wait times, which you've just mentioned, are going in the wrong direction. Why did your government cut back on that time period to

be away from the bed when we know that beds are in short demand and complex care has increased?

Hon. Dipika Damerla: I'm going to ask the deputy to respond to that.

Dr. Bob Bell: That's to ensure that the beds are being utilized at their—you know, they don't like to see an empty bed. We don't like to see an empty bed. The other issue is, there is some flexibility in that.

As a practitioner, if I had contacted the long-term-care home of a patient who had come into hospital with a fractured hip and said that this patient will be able to return to their bed, maybe not exactly in 30 days but in 45 days, the operator would often be able to accommodate that and would plan in advance. So it's not such a tight regulation that at 31 days the bed is given up.

The other thing is, there's a turnover of beds within long-term care. The increased acuity of residents living in long-term care has resulted in shorter length of stay. People are being admitted to long-term care at a more appropriate point.

Some of the reasons why we've asked long-term-care operators to not hold beds vacant is because of this increased turnover: There is more availability when patients are ready to return from hospital.

Mr. Jeff Yurek: Can you confirm with me that there's that flexibility? Can you give us the policy that allows for that flexibility? Because I'm hearing reports that there is no flexibility in that, and it's quite concerning.

Dr. Bob Bell: My experience is that there is flexibility. Just speaking as a practitioner, I've seen that happen.

Mr. Jeff Yurek: You've seen it, but there's no policy that allows for that flexibility. I've seen administrators within the LHINs and CCACs be pretty strict on what the government sets out as policy. Can you send me a confirmation that that is indeed happening?

Hon. Dipika Damerla: If I can just say something, though: At the end of that hospital stay, if the person is deemed to be a priority, they are on priority placement. It's not like they go to the bottom of the list. If they are deemed to be in crisis or they are deemed to be a priority placement requiring the highest-priority placement in a long-term-care home, then they are on that priority list. It really is needs-based.

Mr. Jeff Yurek: However, they lose their bed in that home, and they might not go back to that home, right?

Dr. Bob Bell: They go on a readmission list, and they are placed at the top of the waiting list for admission to that home.

Mr. Jeff Yurek: But they still may be stuck in hospital, so there's that. But if you can send me the policy that allows that flexibility, I can assure the residents in my long-term-care homes that that is flexible policy and not stringent. I think that what you think is happening, from your experience, isn't happening throughout Ontario.

Bill?

Mr. Bill Walker: Thank you. I'm going to go back a little bit to what we were talking about earlier. I'm just going to ask, very simply, if you can provide a breakdown of the redeveloped beds—you've made a commitment to a number of beds—and how they will be built and when. I'm not holding you to account that every bed has to be on that day, and opening that day. But you either have a plan and you know how you're going to get to that 30,000 you committed to, or you don't have a plan, and that makes me very concerned. But if you can share both the redeveloped beds and timelines and the new beds and timelines, that will give me and the people of Ontario a sense of comfort—or not—that you know what you're doing.

I want to turn my attention to 2008. The government's Sharkey report identified the need to increase the level of care in long-term-care facilities from current levels to four hours per person per day. The Ontario Association of Non-Profit Homes and Services for Seniors has been telling you for years that long-term-care facilities are facing a crisis in meeting the growing needs of seniors, and called on you to fulfill your promise of increasing the level of care in long-term-care facilities. Can you tell me what was the amount budgeted for those improvements?

Hon. Dipika Damerla: Sorry, the amount budgeted for which improvements?

Mr. Bill Walker: For improvements to the non-profit homes and services for seniors.

Dr. Bob Bell: I can fill in for a moment, Minister.

The Sharkey report, as you know, came at a time when we were providing about 3.1 hours of care per day on average. The recommendation was to increase that to as high as four hours. It's currently at about 3.5 hours of care a day, when we look at all the various elements of care that are provided under the NPC budget line, the PSS budget line and under extra services provided by Behavioural Services Ontario.

Nancy will confirm: I think we're up to 3.5 hours a day on average.

Ms. Nancy Naylor: Yes.

Mr. Bill Walker: So if you're at 3.5, but the recommendation was four—again, from a logistical—when will we get to four, and why isn't it at four?

Hon. Dipika Damerla: I want to clarify that the recommendation was not four. In fact, the Sharkey report did not endorse implementing a minimum staffing standard for long-term-care homes.

I'm going to quote directly from the report: "We are not persuaded that simply establishing a minimum staffing standard will fully address quality of care of residents."

I further quote: "We are convinced that the complexity of determining staffing requirements related to residents' quality of care and quality of life requires a comprehensive approach beyond setting staffing ratios and staffing standards."

I think it would be fair to say, MPP Walker, that all of us want to ensure that the residents in long-term-care homes get the care they deserve. The government's approach is to have a tailored approach. The way we fund the long-term-care homes is based on the unique acuity of each resident. What some other people are suggesting

is one-size-fits-all, so everybody gets four hours, regardless of whether you need four hours or not—

Mr. Bill Walker: Do you feel that you're meeting that need currently?

Hon. Dipika Damerla: Yes.

Mr. Bill Walker: Fully meeting the needs of the seniors?

Hon. Dipika Damerla: Absolutely, because the long—

Mr. Bill Walker: Thank you.

Hon. Dipika Damerla: Let me—okay.

Mr. Bill Walker: No, that's good. If you feel you're meeting it, that's all I want to know.

Hon. Dipika Damerla: Okay.

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Mr. Bill Walker: The Ontario Association of Non-Profit Homes and Services for Seniors approached you on this issue in the last year in regard to missing some targets and some of the challenges. They told you $385 million was needed to get some of the needed work done. Your budget did not include that money at all. Can you tell us again why you would ignore that when they've actually done the study, they're working in partnership with you and they provided you something very black and white, and you did not include any portion of that $385 million?

Hon. Dipika Damerla: I cannot speak to their calculations. What I can speak to is the fact that every single year, we have increased funding for the nursing component and the personal needs component of long-term-care funding. This year, we increased it by 2.5%. So we have been increasing funding.

But again, I come back to that fundamental principle of a tailored approach. I think that's what Ontarians want. Ontarians want for their loved ones to get the tailored care they require. If that's six hours of care, so be it. If it's seven hours of care, so be it.

The long-term-care act very clearly says that every resident should have a care plan. That care plan is to be written in such a way that it adheres to the minimum requirements of the long-term-care act. Based on that, the homes are expected to provide the levels of care. So it's a very tailored approach based on the unique needs of every single resident, as opposed to a one-size-fits-all approach.

We didn't do this without expert advice. We did consult with the Sharkey report, and I'm happy to quote again from the Sharkey report, "We are not persuaded that simply establishing a minimum staffing standard will fully address quality of care of residents." In this context, it's really important to note some of the significant investments we have made. Since coming to office, we have increased by almost 95% the operating funding of long-term-care homes. That's a huge increase—

Mr. Bill Walker: So it's a good point. However, Minister, as we know, with most of these types of operations, the bulk of those increases go to wages and to benefits and to retirement programs, not to getting more people through the system, not to getting more care through the system. I'm pleased to hear that you gave that 2.5%. What I'm not pleased with and what I hear from my constituents in my riding and across the province is that they still have wait lists. They're still not getting the care that they believe they're entitled to.

I'm going to switch gears a little bit. After promising but failing to fix the squeeze in long-term-care and hospital beds, your government made another promise to defuse the situation. It promised to help seniors get care right in their home and in their community. Again, I'm going to ask very directly: What targets have you set for delivering restorative and rehabilitative services, and what are your actual numbers?

Hon. Dipika Damerla: I believe that question might be better answered by Minister Hoskins, so I'll turn that over to him because it falls in his bailiwick.

Hon. Eric Hoskins: Yes. I'm going to kindly ask you to repeat that. I heard it, but—

Mr. Jeff Yurek: You thought you were done.

Hon. Eric Hoskins: I thought I was off the hook? No, not at all. I was listening intently.

Mr. Bill Walker: I was kind of hoping, Minister, that you would say, "That's a good question, Bill." What are your targets you have set for delivering restorative and rehabilitative services, and what are your actual numbers?

Hon. Eric Hoskins: I know that you've got a particular interest in this because of the Chesley restorative care unit. We're currently reviewing that along with others in the region.

The Chair (Ms. Cheri DiNovo): Just a reminder: You have about five minutes left, Mr. Walker.

Mr. Bill Walker: Thank you.

Hon. Eric Hoskins: So, in fact, part of what we're doing—

Interruption.

Hon. Eric Hoskins: Is that something that I can use? Okay, sure.

Mr. Bill Walker: Whew. Just-in-time delivery.

Hon. Eric Hoskins: What this is telling me if I'm reading it correctly—I'm trying to read the handwriting—is $11 million per year for three years that we've budgeted to assess and restore, and that begins in the 2014-15 fiscal year. We've also budgeted an additional $1.5 million for fall prevention. In terms of the number of beneficiaries that that would reflect, I'd be happy to talk to my ministry to see if we could dig up some specific figures on that, as well.

Mr. Bill Walker: Great.

Hon. Eric Hoskins: But you raise an important question, because to be honest on this—to be fair, is probably a better word—the work that's currently being done with regard to Chesley, and the other similar units in the geographic catchment area, partly came about through a recognition and an understanding that some of the work that is currently being done by those short-stay units, which is entirely appropriate, has significant impact on the individuals and their families that we're talking about to prepare them for that transition back

home. We have learned that, in many parts around the province, that support is in fact—because of innovations and changes in technology and the ability to support more complex patients in the community, much of that care in much of the province is in fact being carried out through our CCACs and not in independent—or facilities that may be within or associated with the hospital.

In the case of Chesley—and in fact we were alerted to this in part when we were looking at Chesley, which, as you know, was slated for closure—I asked our LHIN and the hospital to pause on any decision so we could do a proper assessment and review, not just of Chesley but of the surrounding ones, as I referenced.

Mr. Bill Walker: No, it should be across—I mean, I share with you that I think it should be a model for the actual province, because I think it is delivering what you wanted it to deliver.

Hon. Eric Hoskins: And this review gives us the opportunity to actually make such an assessment.

Mr. Bill Walker: Great, and I think I'm going to almost be out of time so I'm just going to ask a real quick one here.

One of the targets you set in your Ontario's Action Plan for Seniors, launched in 2013, was to provide home care for 90,000 more seniors. Did you hit this target? What was the financial target to achieve this target?

Hon. Eric Hoskins: You're asking great questions. I think my job is probably to anticipate that a number is approaching from behind me, but—

Interruption.

Hon. Eric Hoskins: There it is. That's pretty quick. Look at that.

Mr. Bill Walker: Ask and you shall receive.

Hon. Eric Hoskins: So I'm not exactly sure what I'm looking at here.

Dr. Bob Bell: This is the increase in the home care funding.

Hon. Eric Hoskins: Yes. So, I mean, I can talk about the increase in the home care funding, but I know that you're specifically interested in the target for an increased—

Mr. Bill Walker: Yes. You said as a government, in your plan, that you would provide home care for 90,000 more seniors, so, again, I'm trying to follow a trend here that if you're saying these things, you should have an actual plan of how you're going to get there. Where are you on it? How much did you budget and how close to that budget are you?

Hon. Eric Hoskins: On the budgeting side of it, our budget for home and community care: I think it's actually, and this is surprisingly lower than I had imagined when I saw, not the budget, but in terms of the demographic breakdown, about 60% of those who receive home and community care who are in fact seniors. So it's important to recognize that. But what I'm talking about is the global budget for home and community care over the years, and that—

Mr. Bill Walker: Minister, if I could, though, it's very specific. You said 90,000 more seniors. I just want to know where you are. Did you get to that 90,000? You set a number—

Hon. Eric Hoskins: While we can certainly get you that data, I suspect we are now somewhere between—I mean, the ministry will be able to provide the actual figure. Certainly in excess of 600,000 Ontarians are receiving home care in the province as of this fiscal year. If you make the extrapolation that roughly 60% of those are seniors, that gives you an idea of—

Mr. Bill Walker: But you said 90,000. I'm expecting you, when you make a number like that up, when you promise Ontarians—how many of those 90,000 actually got the care that you promised them? That 90,000 is not my number; it's your number.

Hon. Eric Hoskins: I know. But I've also committed to getting you that number. I think you need to be fair as well.

Mr. Bill Walker: Okay, fair enough.

The Chair (Ms. Cheri DiNovo): And we are going to have stop it there. Thank you all. This committee stands adjourned until tomorrow at 3:45.

The committee adjourned at 1758.

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Also taking part / Autres participants et participantes
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Mr. Jeff Yurek (Elgin–Middlesex–London PC)

Clerk / Greffier
Mr. Christopher Tyrell

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