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Ministry of Health and Long-Term Care

1st Session
42nd Parliament

Tuesday 4 June 2019

Chair: Peter Tabuns
Clerk: Timothy Bryan

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Comité permanent des budgets des dépenses

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Greffier : Timothy Bryan

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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON ESTIMATES

COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Tuesday 4 June 2019

Mardi 4 juin 2019

The committee met at 0901 in room 151.

MINISTRY OF HEALTH AND LONG-TERM CARE

The Chair (Mr. Peter Tabuns): Good morning, everyone. The committee is about to begin consideration of the estimates of the Ministry of Health and Long-Term Care for a total of seven hours and 30 minutes.

As this is the first ministry before the committee, I would like to take the opportunity to remind everyone that the purpose of the estimates committee is for members of the Legislature to determine if the government is spending money appropriately, wisely and effectively in the delivery of services intended.

As Chair, I tend to allow members to ask a wide range of questions pertaining to the estimates before the committee to ensure they're 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 efficiently. However, it must be noted that the onus is on the members asking the questions 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. Thank you, Deputy Minister. If you wish, you may, at the end of your appearance, verify the questions and issues being tracked by the research officer.

Are there any questions by members before we start? Good.

I'm now required to call vote 1401, which sets the review process in motion.

I understand that the Minister of Health and Long-Term Care would like to open with a statement. We'll begin with a statement by the minister of not more than 30 minutes, followed by a statement or questions by the official opposition for up to 30 minutes. Then the minister will have a further 30 minutes for reply. The remaining time will be apportioned equally among the parties in 20-minute rotations.

Minister, the floor is all yours.

Hon. Christine Elliott: Thank you, Chair. Good morning to you and members of the committee. Thank you for the opportunity to appear before you this morning.

Our health care system is facing capacity pressures today. A visit to the emergency department during the busiest time of flu season will give ample insight into how our system could and should be better, when we have people receiving care in hallways because we just don't spaces available.

Only 33% of patients were admitted to a hospital inpatient bed from the emergency department within the provincial eight-hour target. In fact, close to 12,000 people every day in Ontario receive health care administered in hallways. The fact that "hallway health care" has become a term we use regularly in the sector is a reflection that our system is failing to meet the challenges before it.

The system has been grasping for reactive solutions in the absence of a real plan. Failing to act is not an option. The consequences of preserving the status quo are too severe.

Right now, Ontario's health care spending represents 42% of total government spending. However, our health care system costs are projected to rise more closely with aging demographics than inflation. Our current system is not structured in a way that can withstand future challenges. The system simply does not have the right mix of services, beds or digital tools to be ready for a growing and rapidly aging population with more complex care needs. There are over 34,000 Ontarians waiting to get into a long-term-care home, and wait times for mental health and addiction services can be up to a year or longer.

Care is fragmented, particularly at transition points from hospital to home care. We are sending people home to recover with no clear understanding of when or where care is going to arrive, if it ever does at all. Too much time and attention is spent on maintaining a siloed and fragmented system. Different care providers are not incented to work together as a team, and information-sharing and communication between providers and their patients is inconsistent. As a result, patients experience fragmented care and challenges sharing information as they transition from one provider to the next.

Far too many people believe that it is the patient's or the family's job to navigate this complicated system during what is already one of the most traumatic and stress-filled periods in their lives. System fragmentation and heavy and sometimes duplicative oversight make care

navigation confusing and frustrating for both patients and providers. Ontarians expect to be able to manage their own health, and yet they don't have an easy way to access their own medical records or to access virtual choices in care.

One of the most frustrating aspects of all is the fact that Ontario is home to some of the world's best doctors, nurses and health care teams, but we have left them to do their job with a patchwork system simply not built to help them do their jobs to the best possible capacity. Day in and day out, we hear from health care providers that they are ready for a system that encourages collaboration and partnership and finally frees them from a system slowed by the bureaucracy constructed within it.

At the same time, spending in the health care sector is growing at an unsustainable rate. If we are to protect our health care system for the future, we must be prepared to make the tough decisions. Our government is protecting what matters most. Our priority continues to be to focus our health care investments where they will have the most impact: on front-line care. We are reducing duplicated and bloated administration and reinvesting those savings back into front-line care, where it belongs.

The Ontario government has made a commitment to the people of Ontario to end hallway health care. We have to take meaningful action to ensure that the health care system is sustainable and that high-quality care is there for Ontarians when they or their loved ones need it most.

Our government is committed to the fundamental right of Ontarians to universal access to a publicly funded health care system. To me, it's part of what it is to be a Canadian and to be a proud Ontarian. But while universal access to publicly funded health care is not up for debate, the structure and effectiveness of our system is.

One of our key priorities as a government is to deliver local, community-based care unencumbered by bureaucracy. In February, our government introduced The People's Health Care Act, 2019, to enable and support this system transformation. Our vision for patient-centred community care starts with the creation of local Ontario health teams. Ontario health teams are being introduced to provide a new way of organizing and delivering health care services in communities.

These teams would be made up of your local health care providers and would be organized in a way that would enable them to work as a coordinated group. They will be built to guide patients between providers and shepherd families through difficult transitions. They would share responsibility for care plans, service provision and outcomes, and, most importantly, they would take the guesswork out of navigating the health care system.

Through Ontario health teams, patients would finally have a say in their health care journey. With safeguards in place to protect information, patients would have an option to securely access digital health services such as making online appointments, talking to a specialist virtually, or having access to your own electronic medical health records. And a great part of Ontario health teams is that they will rely on leadership that already exists in the community rather than creating another level of bureaucracy and management.

When our government first announced The People's Health Care Act, I shared an example of how similar models are already working, and working well, in different parts of the province. Southlake hospital, which is in my riding of Newmarket–Aurora, approached me late last year with a proactive proposal for integrated community care, specifically around the hospital and home care relationship. It was called the Southlake@Home program, and through collaboration, we enabled the hospital to partner directly with home care providers in an effort to transition patients more effectively from hospital and tackle Southlake's escalating alternate-level-of-care rate, one of the key drivers of hallway health care.

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Early indicators show that this program has been a huge success. Patients enrolled in the program have been able to get all of their home care and community support services lined up while still in hospital. The result has been zero alternate-level-of-care delays for these patients—yes, zero. Compare that to the LHIN baseline of 14.2 days. Across Ontario, 15% of patients needlessly remain in hospital because of ALC delays. Against these statistics, Southlake@Home's results are certainly something worth celebrating. This is just one example of how community providers are already seeking out opportunities to join forces without interference by a heavy-handed government that thinks they know better than the front line.

It is these opportunities and relationships that we are seeking to empower through the creation of Ontario health teams, which will finally put the patient at the centre of the provider network. We envision a community-based health care delivery model that connects care and includes primary care and hospitals, home care and long-term care, and mental health and addiction supports, just to name a few.

Ontario health teams will not be a one-size-fits-all model by any means. Emerging health teams will work with their local communities to determine how best to organize themselves to meet their circumstances. This includes creating opportunities to improve care for Indigenous populations, francophones and other population groups in Ontario that may have distinct health service needs.

We live in a province larger than some European countries, and the needs of each community are going to be different. The solutions that are going to work in northwestern Ontario are not going to be the solutions for downtown Toronto. Governance and delivery models have to be customized to the characteristics of the population and the geography we are trying to serve. The size of each local Ontario health team will also vary, depending on local geography.

This is an opportunity for providers to take the lead on what they are doing and to organize in a way that best achieves desired outcomes. Ontario health teams will be both clinically and fiscally accountable for delivering a full and coordinated continuum of care for their patients. It is expected that over time, providers will find savings through enhanced coordination and efficiency in care, and

that these savings will be reinvested into front-line care. The intention is for Ontario health teams and teams in development to be prioritized for future investments and receive incentives based on performance.

I also want to stress that patients will retain full choice in who they see for their care. Even if a patient receives care from an Ontario health team, they may still choose to receive care from providers outside that group.

Although physician participation is voluntary, physicians—in particular, primary care physicians—are a key element in achieving full success in this type of an integrated care model. Physicians who currently work closely with non-physician providers across the continuum of care have seen the benefits of integrated care models for both patient care and their own practice. There is significant interest amongst physicians and patients in making these models of care more widely available. In fact, we are already seeing a great deal of interest in Ontario health teams from across the sector.

On April 3, the ministry launched an open call for self-assessments for interested groups and organizations to assess their readiness and begin working to meet key readiness criteria for implementation. The first call for self-assessments was due May 15, and the response was extremely positive. We have already received over 150 applications to become an Ontario health team from every region of the province.

It is important to know, however, that this is not a one-time occurrence. Applications to become an Ontario health team will continue to be accepted and assessed, and groups will be supported along this process. We expect the first cohort of Ontario health teams to be selected this fall. As these teams reach maturity, we expect they will improve performance across a range of outcomes. We expect to see better patient and population health outcomes; better patient, family and caregiver experience; better provider experience; and better value.

At maturity, Ontario health teams will be measured and will publicly report against a standardized performance framework. They will be funded by a single budget tied to this framework. They will also provide every patient with 24/7 access to a system navigation service and to a patient portal to their health information. This will make it easier for patients to access their health care system and their personal health information, if they should choose to use it.

Ontario health teams are also being asked to take a digital-first approach. This includes the provision of digital choices for patients to access care and health information, and the use of digital tools to communicate and share information among providers, all of which will be in alignment with provincial digital health policies and standards.

Our government's efforts to transform our health care system are focused on improving patient experience and strengthening local services. Patients and families will have better and faster access to more connected services. They will not have to stay in beds or hospital hallways, or be left to navigate between providers on their own. By relentlessly focusing on patient experience and on better-connected care, the government aims to reduce wait times and end hallway health care. Ontarians can be confident that there will be a sustainable health care system for them when and where they need it.

But Ontario health teams are only one of the ways we are modernizing our health care system through The People's Health Care Act. Our plan would also enable the phased reorganization of many government agencies under the single roof of Ontario Health. Over time, Ontario has continued to add, but not integrate nor co-ordinate, new agencies and health care programs. Ontario currently has a large network of provincial and regional agencies, clinical oversight bodies and 1,800 health service provider organizations. This creates confusion for both patients and providers trying to navigate the health care system. And as you can imagine, each of these agencies has its own administrative and back office support.

Another drawback as it relates to system planning is that having all of these different agencies has led to all of these organizations working towards separate visions, following their own distinct work plans and embracing, at times, divergent views on how to deliver the best possible care to patients. These agencies also often focus on specific patient populations or disease states, while the reality is that people are whole individuals who span multiple groups or areas of focus. The fact is that world-class programs are being developed and delivered through our various agencies. But once again, we have locked away the value of our system in silos.

We have a genuine opportunity to amplify the strength of what's working by bringing our resources together and comparing what ideas and successes can be translated to improve other programs. The people of Ontario want to know that their government is using their resources wisely. Under a single agency, we will reduce overlap, eliminate duplicated administration and reinvest these savings into front-line care. Instead of multiple agencies providing different oversight and direction in our health care system, a single agency—Ontario Health—would oversee health care delivery, improve clinical guidance and provide support for providers to ensure better-quality care for patients.

For example, under a single agency we can build on Cancer Care Ontario's world-class model and expertise for application to other chronic diseases and conditions, such as diabetes and mental health and addictions, to get people healthier. Steps are also being taken now to integrate multiple existing provincial agencies into a single health agency, Ontario Health.

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This is about coordinating and connecting the system from top to bottom to make it more efficient. We are focusing on patient-centred care and on improving direct care delivery. Some of the provincial agencies which will transition to Ontario Health include Cancer Care Ontario, Health Quality Ontario, eHealth Ontario, Trillium Gift of Life Network, Health Shared Services Ontario, HealthForceOntario Marketing and Recruitment Agency, and the 14 local health integration networks.

We are going to transition the agencies in phases. We anticipate it will take a few years for Ontario Health to reach a mature state. However, our ministry has already begun the necessary planning to implement this transition.

On March 8 of this year, I announced the members of the board of directors for the new agency, which is chaired by Mr. Bill Hatanaka. And we are fortunate to have Susan Fitzpatrick, who brings with her decades of experience in health care and the public sector, as interim CEO as we build Ontario Health's capacity.

Susan brings with her a wealth of experience and will play an important role in the initial phase of setting up Ontario Health. She most recently held the position of CEO at the Toronto Central Local Health Integration Network and was previously an associate deputy minister at the Ministry of Health and Long-Term Care. We anticipate she will be able to draw upon her considerable background to help ensure a seamless patient experience.

When Ontario Health is working at full capacity, the agency will operate an integrated, efficient and seamless organization, accountable for the delivery of core programs of the health care sector; help us redirect funding from administration to front-line services; and help reduce the overlap and duplication that exists in our health care system today. It is going to strengthen our efforts to create a health care system centred on the patient.

Another important part of our government's efforts to modernize our health care system is creating a leading patient-focused health sector supply chain in Ontario. Today, health service providers in Ontario procure goods and services through an inefficient mix of in-house and third-party services. Providers pay vast price differences for the same products, and vendors struggle to participate in procurement processes weighed down by unnecessary red tape. Ultimately, it's Ontario's patients who are suffering from poor value for products and a lack of consistency across the province. Our government knows we can do better, and the people of Ontario expect nothing less.

According to Ernst and Young, the health sector alone accounts for over $12 billion in addressable spend that fails to leverage provincial purchasing power or take advantage of modern supply-chain practices found in high-performing health systems around the world.

We have seen health sector supply chain transformation in other jurisdictions result in savings through integration, better spend management, price harmonization, modern business processes, and advanced data analytics. For instance, the British Columbia Provincial Health Services Authority has projected $465 million in savings on $2 billion in procurement spending, and Alberta Health Services realized $300 million in savings over seven years after transitioning to a modern, data-driven supply chain model.

Supply chain modernization crosses many ministries, and we're working together in parallel to ensure that the public sector supply chain best serves the people of Ontario.

For the health sector, we are working with patients, providers and the sector to create an integrated, patient-focused supply chain for health care products and services, one that delivers greater value for Ontarians and enables the highest-quality patient care. We know that Ontario's health system is complex and diverse, and our supply chain needs to accommodate a vast array of unique needs of patients and providers across the province. From large hospitals to small community agencies, Ontario's health service providers have varying needs, capacities, barriers, opportunities, starting points and end points.

Modernizing public sector procurement is an example of how we can break down silos and create a more streamlined and collaborative health system. It is another important way we can restore trust and accountability to the province's public finances. By modernizing our supply chain model, we will leverage the province's purchasing power to enable health care providers to deliver the best possible care to their patients. With the creation of an integrated supply chain, Ontario is paving the way for value-based procurement, making the most of every dollar the health system spends on products and services.

This approach considers the entire patient journey in purchasing decisions, moving away from initial cost being the deciding factor. This transformation will reduce red tape for Ontario's health innovation companies, bringing innovative technologies and processes into the health system faster to improve patient care. Our procurement system will build on current successful models aligned under the oversight of a single authority: Ontario Health.

We are committed to working with our provincial agency partners and to engaging broader public sector organizations, providers and the vendor community to design a supply-chain approach that harnesses innovation and addresses the diverse needs of Ontarians. An efficient, integrated supply chain results in better value for health care products and services, ultimately protecting the services that matter most to Ontarians.

Now, because I expect it will be a topic of discussion today, let me briefly address our government's plan to strengthen Ontario's public health system. As this committee will know, our government made the decision to maintain the in-year cost-sharing adjustments for land ambulance and public health as well as child care services. We are a government that listens. We heard from our municipal partners on the need for more time. We are taking this approach with the understanding that our municipal partners will use this additional time to work with us to find savings. Let me be clear. While the way in which we are implementing our plan to strengthen public health has changed, here's what hasn't: the need to do so.

In 2017, Ontario's independent Auditor General reported that public health units are poorly coordinated and duplicating work while not delivering consistent service. Also, in 2017, an expert panel on public health commissioned under the previous Liberal government recommended that the province establish 14 regional public health entities, making a clear case for consolidation. While we disagree slightly on the optimal number of units, we agree on the need to streamline the system. This should not be controversial. Streamlining the 35 existing

public health units into 10 regional public health entities will maximize the benefits of consolidation—namely, more efficient service delivery, better alignment with the health care system and more effective staff recruitment and retention, while still preserving the ability of the new units to respond to the needs of local communities.

Modernizing and streamlining the role of public health units across the province will better coordinate access to health promotion and disease prevention programs at the local level, ensuring that Ontario's families stay safe and healthy.

Through technical working groups, we will work with our municipal partners to design governance and delivery models that protect and preserve the voice of all municipalities. In doing so, we will ensure that public health investments better meet the needs of local communities. While this modernization unfolds, the government is committed to continuing to work with public health units to ensure that public health programs and services continue to be effectively delivered to Ontarians.

Mr. Chair and members of the committee, Ontario needs a connected and sustainable public health care system that will see patients get the high-quality care they need and deserve, not just right now but well into the future. Real, meaningful change is never easy, but the pressures our health care system is facing are only going to continue as our population ages. The kind of change our government is undertaking is absolutely necessary. The future of the health care system we rely on is at stake, and we have an obligation to enhance and protect that system.

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This government is committed to building a coordinated health care system here in Ontario centred around patients. Modernizing our health care system is a reflection of our commitment to protect what matters most to Ontarians.

With that, I would like to thank you once again for the opportunity to speak with you today and to share our government's vision for our health care system. I look forward to your questions as the day progresses.

The Chair (Mr. Peter Tabuns): Thank you, Minister. To the official opposition: Ms. Gélinas.

M^me^ France Gélinas: I'd like to start by thanking the minister for sharing the vision of her government for our health care system. It is much appreciated and has, I would say, clarified a lot of questions that had been circulating out there. So I thank you for putting that on the record for all of us to know.

I would like to start with high-level questions regarding the estimates. Some of the high-level questions have to do with the savings that are specifically identified in the budget. In the budget, we see that there will be annualized savings of at least $350 million by restructuring our health care system along the path that you just told us, with Ontario Health and Ontario health teams. I am interested in you sharing with us the details of those calculations. How did you come to $350 million rather than $250 million or $450 million? How did this number come up?

Hon. Christine Elliott: Well, I can say that, generally speaking, with the consolidation of the agencies and the LHINs into Ontario Health, there will be some back office savings with administration—not affecting front-line services but in terms of some of the back office administrative functions. We have made the detailed calculation on that basis, and we do have some additional information available. I will turn things over to the deputy minister in a moment, but just to give you some further information: The savings from consolidating the agencies and reducing the duplicated administration are equivalent to annual funding for 500 to 700 hospital beds, 5,000 to 7,000 long-term-care beds, or 3,100 to 4,300 full-time, front-line nurses. So we can agree, I believe, that that's a far better use of health care dollars than simply spending money on back office administration, and—

M^me^ France Gélinas: Minister, I can do the calculation of 500 to 700 hospital beds in my head, but do you have this number, just to save me the calculation?

Hon. Christine Elliott: Yes. I'll actually turn that over to the deputy minister for that specific figure.

Ms. Helen Angus: Yes, for sure. Your first question was really about how we came up with the larger savings target—

The Chair (Mr. Peter Tabuns): Sorry, Deputy Minister. Could you just introduce yourself for the record?

Ms. Helen Angus: Of course; absolutely. My name is Helen Angus. I'm Deputy Minister of Health and Long-Term Care.

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

Ms. Helen Angus: We actually know those agencies well. We've had oversight of them for, in some cases, a decade or two, if not more. Some of us actually worked in those agencies.

We looked at what we understood to be back office functions. The target was customized to each agency. The things we looked at and then we asked the agencies in turn to look at were things like back office consolidation; we know we have multiple payroll systems, for example. We looked at questions about contracted services and consulting that was going on inside the agencies. We looked at what percentage of the staff were front-line versus providing more administrative functions.

We looked at leases and real estate. For example, there are 158 leases in the portfolio of the agencies that are rolling into Ontario Health, so we looked at our footprint and thought about what kind of consolidation and efficiencies we might get there. We looked at things like non-essential travel. Finally, we thought quite a bit about how we would want to apply the expertise of Cancer Care Ontario, in the way that they had done it for cancer and then for renal care, and we would apply the methods, the data collection and the clinical leadership that they have for areas that the minister mentioned in her speech, like mental health and diabetes. So we did a pretty careful review, and I would say that the new board of Ontario Health is continuing to do that work. I can say, even in these early days, that they're very much on track.

M^me^ France Gélinas: Can somebody tell me the amount of money associated with the payroll, the consultants, the admin staff, the lease, the non-essential travel? How did we come up with $350 million?

Ms. Helen Angus: I think, again, we had a rough estimate of 20% and we went up or down, depending on the particular circumstances and size of the agency and the estimate of back office functions. We did have the organizational charts of the agencies, and we calibrated it from there. Now that the board of Ontario Health is in place, they're doing a deeper dive into the agencies, not only looking at where there are opportunities within the existing agencies but looking across—in what we would call the horizontal—where there are consolidation opportunities. We actually—

M^me^ France Gélinas: Sorry, Deputy. What I'm looking for is things like, "from the back office, we expect $100 million of the $350 million; from the payroll and consultants, we expect $25 million; from the decrease in admin staff, we expect $10 million." That's kind of the—

Ms. Helen Angus: So you wanted that kind of breakdown.

M^me^ France Gélinas: Yes.

Ms. Melanie Fraser: This is Melanie Fraser. I'm the associate deputy minister for health services. As the deputy was mentioning, we started first with a high-level approach to a planning figure for savings. The first thing that we did was, we looked across all of these impacted agencies and we removed anything that was patient-facing. Anything that provided or supported direct services to patients, we removed from the denominator in our calculations. What remains, then, is really an administrative budget that would be constituted by the things that you just referenced, whether that's payroll for administrative supports, the leasing costs, and what we call ODOE, or other direct operating expenditures—contracting for services, travel and that sort of thing.

We made some assumptions, based on their spending patterns historically and their mandates and how they've grown, that in the first year we could reduce the budget by 15%—that administrative spend—growing up to 20% to 25%, depending on the agency and how much administration they had.

As the deputy mentioned, we calibrated up and down again, depending on which agency. We've also left a lot of room for the new board of Ontario Health to do the detailed review of all of the assets within those organizations. They will come back to us with a fine-tuned calculation on where those savings will come from. I will say that we've had lots of great meetings with them to date. I think the board has met seven times, and they are making great progress on finding those savings and in fact have already been able to identify savings that could go to enhance services and supporting more patient volumes, which was the reason for this whole endeavour to begin with.

M^me^ France Gélinas: Could you share with me—let's say you looked at Cancer Care Ontario. Some 90% of what they offer is patient-facing; 10% is not. Of that 10%, were they targeted for a 15% or a 25% decrease? Same thing with Trillium Gift of Life; same thing with—

Ms. Melanie Fraser: Yes. I can actually go through the estimates and tell you how they were reduced—each of the agencies—if you like.

M^me^ France Gélinas: Please.

Ms. Melanie Fraser: At that level of detail, we had in vote item 1402-1 a $3-million reduction. I believe that's related to HealthForce Ontario. In the eHealth vote, 1403-1, there was a $65-million decrease. In the eHealth and information management vote item, 1403-2, there was a $10.4-million-level—I'm rounding—reduction.

0940

Again, in the LHIN vote, for instance, there was a $61.5-million reduction; that's vote 1411-1-1.

In LHIN vote 1411-1-2, there was another $6 million.

Again, in the provincial programs vote, for instance, 1412-1—that's where you would find Cancer Care Ontario and other related programs—there was an $86.5-million reduction.

In vote item 1412-2, there was about another $4-million reduction.

All of these I think, if I've gathered them up, equal $256.7 million in 2019-20 and, as the budget reflected, we anticipate that that will grow to approximately $350 million in the following fiscal year.

Those represent decreases, again, as I said, against their administrative budgets. For instance, Cancer Care Ontario, their services budget, that direct-facing line, actually increases in 2019-20 in the estimates by—I would have to get the number from my CAO here, but it goes up. So there are some puts and takes here, but the administrative budgets decreased and the services budgets increased.

M^me^ France Gélinas: Thank you. Yes, that's what I was looking for.

My second question is also about the budget, right at the beginning when you say that you will find $250 million in savings from changes to OHIP+. Again, I'm interested in finding out: How did you come to $250 million rather than $200 million and where is the savings coming from in OHIP+?

Ms. Melanie Fraser: I'll just get our notes here.

Hon. Christine Elliott: First of all, we are focusing the OHIP+ benefits on the people that need them the most. As of April 1, as you'll know, children and youth 24 years of age and under who are OHIP-insured and do not have a private plan will continue to receive coverage for eligible prescriptions through OHIP at no cost. But there is also an important contribution to be made by private insurers, so if people already have coverage through an insurer, that would be the primary payer, and OHIP will only cover those people who do not have coverage.

M^me^ France Gélinas: While you search for the numbers—you use "primary payer" as if the government was the secondary payer, but the government is not the secondary payer; it's the primary payer for people who don't have a plan and it's the zero payer for everybody else that has a plan, no matter if the plan is adequate or not.

Ms. Helen Angus: It's Helen again. I think the plan actually would have—those who don't have coverage would actually then be then eligible for the Trillium Drug Program. There's a deductible that is calculated on the basis of income, and that becomes sort of the safety net program for all Ontarians—

M^me^ France Gélinas: But it's not OHIP+?

Ms. Helen Angus: Right. Yes.

M^me^ France Gélinas: Okay. And the $250 million come from—

Ms. Helen Angus: I don't have the precise calculations here, but we do have the executive officer in another room who can come here. But it would be some combination of the population, our estimates of what percentage of children would be in families where there is drug coverage and what the profile of drug utilization would be amongst that group. I believe those are the three things that would determine the savings amount.

M^me^ France Gélinas: I'm curious to see if you had done the calculations to have OHIP+ as the secondary payer, as in, if the parents' drug plans don't cover the drug or if the parents' drug plan is maxed out, those children would have OHIP+ as a secondary payer. Did you ever look at the difference in savings if you had done that?

Ms. Helen Angus: I think, obviously, the coordination of benefits is something that governments would like to do. I think actually, from an implementation perspective, that connection and that ordering of payers has proven to be quite challenging. It certainly is work that could be done, but it wasn't done last year for this program. I think it was a policy decision to contract the program to be the first payer for only those who don't have drug coverage.

Hon. Christine Elliott: But we also recognize that there might be some need for some people who, if they had a private insurer that didn't cover for the full amount, there was still the Trillium program that they could apply to for assistance if it was outside of their family income.

M^me^ France Gélinas: But that's Trillium; that's not OHIP+.

Hon. Christine Elliott: That's correct.

Ms. Melanie Fraser: Excuse me. She's here.

M^me^ France Gélinas: Okay. Do you have the numbers to show how we got to $250 million?

Ms. Melanie Fraser: I was just mentioning that our executive officer for the drug program is now in the room in case someone needed some additional detail.

M^me^ France Gélinas: I would like that, if he or she can come forward.

Ms. Helen Angus: Suzanne, why don't you come up and introduce yourself?

Ms. Suzanne McGurn: Good morning to the committee. I'm Suzanne McGurn. I'm the assistant deputy minister for the drugs and devices program, as well as the executive officer for the Ontario Public Drug Programs.

I hope I have heard the dialogue as I've been walking here.

M^me^ France Gélinas: I can repeat the question. The budget says that the changes to OHIP+ will bring a savings of $250 million. How did you calculate $250 million? Why is it not $150 million or $350 million?

Ms. Suzanne McGurn: Thank you for the question. Just as a reminder that OHIP+ was introduced in January 2018, we have had one year of experience with the program. We did have to make a number of assumptions in determining what the potential savings would be. Some of those assumptions included what the percentage of the prevalence of private insurers is. We were able to gather some of that information based on the transition of children to the OHIP+ program when it was launched. We were able to look at what would be the average prescription cost in the early part of the program implementation and be able to extrapolate those over the experience we had had in the first year.

Again, recognizing that there was only one year of experience, we did have to make those assumptions, and we are continuing to monitor and track towards those numbers. Based on the information that we have at this point in time, we think that that was a reasonable estimate, and we remain on track for those savings at this point in time.

M^me^ France Gélinas: What was the average prescription cost?

Ms. Suzanne McGurn: I apologize; I don't have that number with me.

M^me^ France Gélinas: Is this a number that you would be able to track down and share with the committee later?

Ms. Suzanne McGurn: We can get back to you and look into that matter.

M^me^ France Gélinas: Okay, I would appreciate it.

I know that the minister and I had a number of conversations about the high-protein formula for babies and high-caloric formulas for babies that used to be covered, that went into OHIP+. Now, nobody covers them. How much will it cost to bring this program back?

Ms. Suzanne McGurn: May I continue?

Interjection.

Ms. Suzanne McGurn: I am aware of the media coverage on this particular issue, and I think the first important piece of information is that there's actually been no change to what was covered prior to OHIP+ to post-implementation of OHIP+. There are a number of nutritional products that are covered in certain clinical circumstances, where for the individual it's their sole source and they meet specific clinical criteria. The nutritional supports are identical from prior to OHIP+ till now. The only difference in the intervening one year is that those individuals who would have been eligible through OHIP+ would have had those services provided at no deductible and no co-payment.

For those individuals after the changes on April 1, similar to the question that was being asked earlier, they remain eligible for support for high-cost drugs through the Trillium program, but there has been no fundamental change to the nutrition supports pre- and post-OHIP+.

M^me^ France Gélinas: All right. There's something that derailed on the way to heaven here because in Sudbury and Nickel Belt, for all of the preemie babies that were on nutritional supplements, the families always got monetary support for the special formula and now they don't. So is this something that derailed in February?

Ms. Suzanne McGurn: Yes, we would be happy to look into that. But prior to January 1, 2018, to now, there is no change. So I would be happy to look into that for any of your constituents.

0950

M^me^ France Gélinas: Okay. The minister opened the door to public health. Yes, we will have many questions on public health, but my first series of questions is high-level. How did we get to $200 million for restructuring public health? How come it was not $180 million? Why was it not $250 million? Why $200 million? How did you get to that number?

Hon. Christine Elliott: First, we recognized that we needed to do the change. It was recommended by the previous government that we reduce the size and go from 35—they had recommended 14 public health units. We recommended that we reduce to 10 for a variety of reasons: to be more effective and to be better able to recruit the people we needed in order to do those jobs. In some circumstances, it's difficult to find people for some of the smaller public health units. We wanted to make sure that we could get the best people available, and then to have them available in specific geographic areas where they could respond to the needs of their local areas.

We also recognize, though, that there's a responsibility on the part of the provincial government to take over some of the work as we were making these changes. That's one of the reasons why we brought in, for example, the $90-million-a-year program for low-income seniors for dental benefits. Some of those services were being provided by public health units, but we're taking it up to the provincial level because we know that many people in the province aren't able to get the services that they need. They will be able to receive them in many cases in public health units, in community health centres, other community agencies and in dental buses in situations where there aren't any local units immediately available.

In terms of the idea behind it, it's to make sure that they can be more nimble, more efficient and provide better service and deal with local geographic concerns. As far as the specific numbers are concerned, I will ask the Deputy Minister for her comments on that issue.

Ms. Helen Angus: Yes. I'm happy to answer your question. If you go back in time, you'll know that the provincial/municipal cost-sharing on public health has varied quite considerably over time. The basis of the calculation is really on the basis of the provincial/municipal share and the idea that that would change over time, and specifically that there would be some additional funding in a different funding formula for smaller public health units, just like we have for capital programs at the Ministry of Health and Long-Term Care. The ability to raise funds off of the municipal tax base was deemed to be less in smaller communities.

I might get Dr. Williams—or, do you want to get into this, Peter, in terms of the percentages? But again, it was designed to go 60%/40% for provincial/municipal, and also for the city of Toronto, and then 70%/30% for all other regional public health entities in the province. There wasn't a change to the basic spend; it was really the cost-sharing there.

M^me^ France Gélinas: So the $200 million in savings will come from the share of the province going down by $200 million?

Ms. Helen Angus: Yes, over time.

M^me^ France Gélinas: Over time? Okay.

Minister, you mentioned the $90 million in dental benefits. Is part of that $90-million money presently in the system, in public health, for dental? I'm curious to see how much of the $90 million is new money and how much is money already in the dental system.

Hon. Christine Elliott: It's all new money.

M^me^ France Gélinas: It's all new money? So it's on top of what was already there?

Hon. Christine Elliott: Yes.

M^me^ France Gélinas: Okay. I just wanted to make sure.

You spent the first half-hour of estimates laying out the new vision for the restructuring of the health care system. How much money will this restructuring cost? When you talked about digital access, when you talked about people being linked, where is the money for the restructuring, and how come I haven't found it?

Hon. Christine Elliott: It is going to cost some money to procure these services, but we don't really have a choice. We really need to make sure, in order to have the best possible services available for providers to provide to patients, that they're connected. If they're not connected, there's no point of the exercise, but also to allow people to be able to have access to their own electronic medical records. That will help them when they're travelling, for example, to be able to access their records—

M^me^ France Gélinas: I'm all for that, but every hospital wants this. There's a pent-up demand in Ontarians who want to have access to this. The hold-back in my hospital and the dozens of other hospitals that I've talked to is always money. They haven't got the money to upgrade their computer systems to be able to have this functionality, so how much money is available to them to do that and everything else that's required to make your vision a reality?

Hon. Christine Elliott: The good news is that there are many organizations and groups across Ontario that are already providing these services; they've been able to put together these systems without a huge cost. As far as specific amounts, I'm going to defer to the ministry. Mr. Kaftarian or Deputy?

Ms. Helen Angus: I'll start, and maybe my colleagues can chip in as well. I would say that one of the most heartening things about the work on Ontario health teams is the fact that people have signed up to do this because they know that connecting care is the best thing for patients. We actually didn't have to put any money on the table. They've come together voluntarily to work in a more collaborative way around patients and to be accountable for patients.

We also know, in the digital health world, that we have spent a lot of money buying different systems for different parts of the province and that we really haven't maximized or scaled up the things that we've bought already. So, really, the whole digital health strategy I think is going to be much more consumer-focused. We can get Greg Hein here to come up and talk about it, but we think that there are things that we have already purchased that can be

repurposed and scaled up across the province that will give us a provincial capability that we haven't had before.

We're still spending a considerable amount of money on digital health in the budget, but I think that there is real opportunity here to look at some of the digital health redundancies, some of the systems that were built—whether it's eConsult or eReferral—and make those more universally available and to be able to do those at lower cost. So there's a big opportunity there.

Did you want to add to that?

Ms. Melanie Fraser: It's Melanie Fraser again. With respect to the overall transition costs associated with the broader restructuring, I think it's fair to say that it wouldn't appear in the estimates as a particular line item under a vote, but, for instance, as we restructure and migrate 20 agencies into Ontario Health, we know that the transition costs associated with ending a lease—we have factored that into our ability to achieve the savings.

As I mentioned earlier, in our initial planning our assumptions are proving out, and there are sufficient costs through the restructuring not only to achieve the savings targets but also to cover some of the transition costs associated with that, whether that's some additional supports in terms of asset valuation and asset reviews or termination clauses associated with leases or particular service contracts.

M^me^ France Gélinas: Okay. I want to be clear that the cancer screening program did not receive a $22-million cut. That's what the minister said yesterday, that the $22 million that was removed from cancer screening programs is being redirected to—okay, fill in the blank.

Ms. Helen Angus: Actually, the cancer screening volumes—the money for volumes has actually increased this year overall for screening. There are some opportunities to streamline some of the back office functions of a screening program and how patients are either tracked or invited to participate, but the money for screening volumes is actually increasing in the budget.

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M^me^ France Gélinas: How can I follow that?

Ms. Helen Angus: That would be within the Cancer Care Ontario vote, if I can find it.

Hon. Christine Elliott: We're just looking for the exact figures on it.

Ms. Helen Angus: We'll find you the number, but it's in there.

M^me^ France Gélinas: Okay. So from cancer screening to Cancer Care Ontario, Cancer Care Ontario is seeing an $86.5-million target reduction. How do I reconcile the two?

Ms. Melanie Fraser: I'm happy to jump in here—Melanie Fraser, again. When we looked at the reduction, the reduction was related to their administrative budget, so like any large—

The Chair (Mr. Peter Tabuns): Ms. Fraser? I'm sorry to say, you're out of time. With that—thank you, opposition—we go back to the minister. You have 30 minutes.

Hon. Christine Elliott: Thank you for your questions so far. Thank you for the opportunity to deliver some rebuttal remarks.

In my opening remarks, I spoke at length about the important changes our government is making to modernize our health care system. It's a plan our government believes is vitally important to the future of our health care system, a future that preserves and enhances access to critical services. As part of our efforts to strengthen our public health care system, we are making a number of critical investments to improve care for patients.

Take, for example, our investments in mental health and addictions services. Mental health and addictions issues have emerged as one of the most serious health and social challenges facing families, children and youth. It's estimated that 30% of Ontarians will experience a mental health issue at some point in their lives, and roughly two million people per year go to their doctors for mental health and addiction-related reasons.

No one should have to wait long periods of time to get the mental health and addictions services they need when they need them. Despite this, we know it continues to be a challenge here in Ontario. The mental health and addictions system in Ontario has been challenged for too long by extensive wait times, barriers to access, inconsistent quality, a lack of standardized data, and widespread fragmentation. This was confirmed during the government's extensive province-wide consultations with experts, providers and people with lived experience.

We know many families are waiting for access to care, and once they finally get it, they find it to be disconnected from the rest of the care they are receiving. We know the system is failing patients and parents when they hear it will be a year before their child gets treatment for an eating disorder, a serious and life-threatening mental health challenge. People should not have to be in crisis to find timely access to mental health care, and yet it is a continuous cycle experienced by many vulnerable Ontarians. It's a complicated issue, one that we cannot solve overnight and one that affects our entire health care system.

Our government understands the system needs to be better. We know there are low-barrier solutions to intervene early in cases of mild to moderate depression and anxiety. We know we can set up a system that makes clear where people can get help when and where they need it.

The need to act now has never been greater. Our government is committed to invest $3.8 billion over 10 years to develop and implement a comprehensive and connected mental health and addictions strategy, but there are immediate needs and solutions we can invest in today. That's why our government is investing $174 million this year to help address our fractured mental health and addictions system. To ensure mental health and addictions service providers have stable, long-term funding, the government will be making this additional funding available every year.

These investments are going directly into providing front-line services for patients and families in need of help,

and is part of our plan to build a comprehensive and connected mental health strategy. With this funding, children and youth are going to receive earlier, faster mental health and addictions help at schools and in the community. We are going to help people facing the dual challenge of homelessness and mental health and addictions get more housing supports.

Our government will also be investing in new mobile crisis teams that will help police officers and other first responders manage sensitive situations when assisting people in crisis with severe mental health illness and addiction issues, and we are going to provide faster access to addictions treatment for youth and adults.

New or improved services will also target priority populations, including Indigenous peoples and francophones. We are taking a cross-government approach to solving Ontario's mental health system challenges because we know mental health impacts so many different facets of our lives and the lives of our loved ones. That's why we're investing in mental health services and supports in our communities, schools, colleges, universities, retirement homes and correctional facilities.

Another important aspect of our investment in mental health services are the key investments we are making to address the ongoing opioid crisis. Our government takes this situation very seriously. Late last year, our government engaged in an evidence-based review of supervised consumption services and overdose prevention sites to determine if they were effective. I reviewed findings from peer-reviewed literature on drug consumption services and effective addictions treatment services, and site data, as well as recent opioid morbidity and mortality data in Ontario. I also met with people from across the spectrum: health professionals and associations, community leaders, local business representatives, police, municipal leaders, site operators, researchers and people with lived experiences, all who have been in some way involved with services for people who use drugs. And I visited supervised consumption services and overdose prevention sites in the neighbourhoods where they operate.

After careful consideration of all of the evidence from our review and consultations, the Premier and I came to the conclusion that we need to do more if we are to put a stop to the opioid crisis here in Ontario. While critical, simply preventing overdoses is not enough. We need longer-term solutions to the problem. That's why our government introduced the consumption and treatment services funding program. It is a program that focused uncompromisingly on connecting people to treatment and providing more and better support to those living with drug addiction. This integrated model is not only equipped to prevent overdose deaths, but it also offers clients a greater chance of recovery by connecting people who use drugs to primary care treatment and rehabilitation services, and other health and social services. It also echoes what we heard from health professionals, police, local business representatives and community members about the need for better, more comprehensive supports for those living with addiction.

So far, we have approved 15 consumption and treatment services sites in communities with high needs. These first 15 CTSs are located in communities across the province, including Toronto, Ottawa, Guelph, Hamilton, Kingston, London, St. Catharines and Thunder Bay. Overall, availability and access, the number of consumption booths, hours of operation and capacity for site visits will be increased under the CTS program when compared to the same supervised consumption services and overdose prevention site models the province has been using in the past. It is anticipated that the ministry will fund up to 21 CTSs located in communities across Ontario, and we continue to accept applications from interested organizations across the province.

These important investments are helping our mental health and addiction workers provide high-quality care for Ontarians, but this is just one of the many parts of our system in which we are continuing to make important investments. A larger and well-functioning long-term-care sector is a crucial part of the government's priority to end hallway health care. The challenge is to provide high-quality care to a growing aging population, while at the same time building additional capacity.

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Currently, the system is operating at 98% occupancy. The wait-list is simply too long, and growing. In fact, there has been a 32% increase in the number of individuals on the wait-list for long-term-care-home placement since 2016. This unmet demand is creating pressures in the hospital sector. Too many patients are kept in hospital while waiting for space in a long-term-care home. Practically the day we were sworn in as government, we got straight to work on the long-term-care file because it is unacceptable for over 34,000 Ontarians to be left waiting for a safe place to live and to be cared for.

Our government will create 15,000 new long-term-care beds over the next five years. These new beds will help address hallway health care and move patients to a more comfortable care setting. This capacity would be in addition to the over 78,600 existing beds in the system.

Furthermore, the government is committed to upgrading an additional 15,000 older long-term-care beds to modern design standards, which will allow the long-term-care sector to provide more appropriate care to those with complex health conditions.

To support this commitment to new long-term-care beds, in addition to the over 6,000 new beds previously allocated, the government is moving forward immediately with the allocation of an additional 1,157 new long-term-care beds through 16 projects across the province. We are proud that our government has fulfilled almost half of our commitment toward these new long-term-care spaces in just under a year.

As well, the government will be making it easier to find property for new long-term-care-home developments. The government's efforts to reduce red tape and streamline processes to sell buildings and properties mean that these properties will be more easily evaluated prior to sale to determine if they can be used for long-term-care spaces.

The future of health care in Ontario will include modern long-term-care homes in which residents can expect to receive the care they deserve, and live in dignified, home-like environments.

Last fall, our government made it easier for our long-term-care homes to ensure the safety and security of their residents in an emergency without unnecessary government interference. We reduced the administrative barriers so long-term-care homes can focus on taking care of their residents by making it easier for homes to secure emergency licences where long-term-care beds are needed to help those affected by a temporary emergency, and by expanding the scope of temporary emergency licences.

Government should not be an impediment to the safety and security of residents living in long-term-care homes. This was an important change to support families and home operators in a time of emergency.

Now, hospitals: Ontarians need to know that the services they require are going to be there for them in the event of an emergency. That is why our government is committed to an efficient and stable hospital system that lets patient voices be heard.

Our government understands the importance of our hospitals to our health care system. In fall 2018, we took immediate steps to deliver on our promise to end hallway health care by investing $90 million for 1,100 beds and spaces in hospitals and in the community, including more than 640 new beds and spaces in communities across the province. This urgent action helped communities prepare for last winter's flu season and reduced the strain on the health care system by creating new capacity and enhancing existing capacity in high-priority areas in both hospitals and in the community, particularly in communities struggling with patient volumes.

Our government is also moving forward quickly to address challenges facing the health care system by developing a long-term health care strategy that focuses resources on patients' needs to end hallway health care.

The Chair (Mr. Peter Tabuns): Minister, I'm sorry to say your time is up. Well, you have more time, but you'll have to come back in the afternoon.

Hon. Christine Elliott: Thank you, Chair.

The Chair (Mr. Peter Tabuns): Members of the committee, we'll be recessing until 3:45 p.m.

The committee recessed from 1015 to 1630.

The Chair (Mr. Peter Tabuns): Good afternoon, everyone. We're going to resume consideration of vote 1401 of the estimates of the Ministry of Health and Long-Term Care. There's a total of six hours and 18 minutes remaining. When the committee adjourned, the minister had 16 minutes and 30 seconds remaining in her reply—not to put too fine a point on it.

I will now give the floor to the minister to complete her remarks.

Hon. Christine Elliott: Thank you very much, Chair. Just before the break, I was speaking about the important role that hospitals will play as part of the Ontario health teams in our province, so I'll continue with that.

As this important work continues, Ontario will invest $27 billion over the next 10 years to modernize and increase capacity at hospitals and to address things in urgent need of repair. Health capital investment is a critical component of the government's strategy to end hallway health care. Investing in new facilities to expand services and ensuring existing facilities are maintained in a state of good repair will ensure that the people of Ontario have access to care when and where they need it.

Right now, in communities across Ontario, there are approximately 60 major hospital projects currently under construction or in various stages of planning, and our government is committed to working with hospitals to implement these projects to meet local health system needs.

The government will also invest an additional $384 million in hospital operations as part of our efforts to end hallway health care by ensuring our hospitals have the spaces they need in critical situations, increasing access to highly specialized and innovative treatments, and supporting volume growth.

Moving now to home and community care: Home care supports Ontarians of all ages to stay in their homes or be cared for in the community longer, which is where many people would prefer to be. Across Ontario, our home and community care workforce is providing nursing, personal support and homemaking, therapies and other professional services at home, at school or in other community settings.

Home care helps to support a smooth transition for people who need support after returning from a stay in hospital, rehabilitation or another health care setting; and home care provides ongoing care to people who need support dressing or bathing, or to people living with complex medical conditions.

When we look at the health system overall, home care service providers can provide palliative services at home or in a hospice. Home care services help to reduce the use of more costly health care services, such as hospitals and emergency rooms; provide respite to caregivers; and reduce admission into long-term-care homes.

To further support ending hallway health care and provide those living at home with additional supports and services, the government is investing $144 million in additional funding for home and community care services. This will include investments focused on increasing front-line care delivery, such as personal support services, nursing, therapy and other professional services at home and in the community. Investments will also provide community supports such as meals and transportation, assisted living services in supportive housing, services for people with an acquired brain injury, and services for Indigenous peoples and francophones.

Increasing access to support in the community is expected to enable more people to get care when and where they need it. As Ontario health teams begin to take shape across the province, Ontarians are going to experience more timely access and a better patient experience accessing the home and community care they need.

As the population grows and ages, expanded home and community care is also expected to reduce wait-lists for

long-term care and decrease pressures on hospitals, thereby alleviating hallway health care.

Scope of practice, another area: Again, home and community care is just one more way we are working to bring an end to hallway health care. Another is by responsibly expanding the scope of practice for certain regulated health professionals, such as pharmacists, nurse practitioners, dental specialists and optometrists.

Scope of practice can be defined as the services and activities a person of a certain profession is authorized to perform. Many of our health care professionals have extensive education and training and possess in-depth knowledge and strong clinical skills, yet they are currently underutilized and can be capitalized upon within the health care system.

I want to stress that our government is committed to ensuring that patients receive quality health care services from qualified and competent individuals, but our government also sees an opportunity to provide patients with greater access to care by enabling regulated health professionals to use their education and training more effectively by expanding their scope of practice. This is a basic change that can save time and money and get Ontarians healthier quicker.

These changes will improve convenience for patients by reducing the time spent travelling between providers for multiple visits for diagnostic tests and routine care and treatment, and help doctors, nurses and other health care professionals provide better, faster health care for patients and their families. By reducing regulatory barriers to accessing up-to-date drug therapies, for example, health care providers will have more treatment options for their patients, thereby alleviating the need to make referrals to other providers, who can then focus their time and attention on patients with more serious and/or complex conditions. Enhancing professional scopes of practice is key to easing pressures on hospitals and helping doctors, nurses and other health care providers deliver better, faster health care for patients and their families.

My ministry has developed an evidence-informed analytical framework called the Model for the Evaluation of Scopes of Practice in Ontario to evaluate proposals for changes to professional scopes of practice. This model emphasizes that changes to a profession's scope of practice must meet patient and health system needs, while allowing health professionals to fully utilize their skills and knowledge in their practice. The framework takes a patient- and system-centred approach, considering factors such as patient and health system needs provider competencies, patient safety, funding, integration with the health care system, and alignment with ministry priorities.

Ontario has so many people in our health care sector who play an important role in helping Ontarians get healthy and, of course, stay healthy. They are caring, compassionate and dedicated to providing the best-quality care to patients. Scope of practice represents another way we can improve care while ensuring it remains centred on the needs of the patient.

Now, dealing with dental care for low-income seniors: Our government also recognizes the importance of good dental health for a patient. We also know that at least two thirds of low-income seniors do not have access to dental insurance. As a result, untreated oral issues such as infection, pain and abscesses can lead to chronic disease and a lower quality of life.

The numbers tell us that the rates of dental decay, gum disease and oral cancer are higher among seniors, and that the longer oral health care is delayed, the more costly and painful treatment will become.

Untreated oral health issues represent a significant burden on the health care system and contribute to hospital overcrowding. In 2015, there were almost 61,000 hospital emergency visits for dental problems, at a cost to Ontario's health care system of approximately $31 million.

More importantly, no senior in Ontario should go without access to high-quality dental care because they don't have the money to pay for it. That is why the government is moving forward with its commitment to introduce a new dental program for low-income Ontario seniors with an annual investment of approximately $90 million when fully implemented. By late summer 2019, single seniors aged 65 and older with incomes of $19,300 or less, or senior couples with combined incomes of less than $32,300, who don't have existing dental benefits will be able to begin receiving dental services through public health units, community health centres and Aboriginal health access centres located throughout the province.

By this coming winter, this program will be expanded. We are going to invest in new dental services in underserviced areas, including through mobile dental buses and an increased number of dental suites in public health units. This new publicly funded dental care program for low-income seniors will help reduce unnecessary trips to the hospital, prevent chronic disease and increase quality of life for Ontario's seniors. At the same time, we are going to further help reduce the pressures on our hospitals that contribute to hallway health care.

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In conclusion, our government is taking a comprehensive, pragmatic approach to addressing the needs of our public health care system. We are determined to build a connected and sustainable health care system centred on patients, and we are committed to protecting our public health care system for the benefit of all Ontarians.

We know the health care budget is growing, not shrinking, and we know our population is also aging. That is why we are committed to making the tough decisions and to ensuring that health care dollars are going where patients expect: to front-line care.

From the moment we took office, our government has been focused on putting an end to hallway health care. We recognize that our health care system is facing significant capacity challenges and unsustainable hospital occupancy levels contributing to hallway health care. People should not have to receive health care in hospital hallways or storage rooms. It is no way to treat a patient in need of care. Our doctors and nurses don't want to operate that way either.

Our government has always acknowledged that we are faced with an enormous challenge. At the same time, we refuse to rely on band-aid fixes and ad hoc solutions. We refuse to accept the status quo.

We have known all along that this is a multi-faceted problem, one that will require complex and innovative solutions. I have always been convinced that the solution lies in system transformation, in building a health care system for the future. That is why we are modernizing our health care system, to break down the silos that act as an impediment to providing high-quality care and to better connect and integrate our health care system.

From our decision to create Ontario health teams to our commitment to make the largest investment in mental health care in the history of this province, all of our efforts have been focused on how we can provide the best possible care for patients; how we can get them out of beds in the hallways of our hospitals and into the right care setting for them, of course when and where they need it; and how we can do it in a way that ensures our health care system is sustainable for the future.

I thank the committee for the opportunity to address you today. It is an honour to serve as Ontario's Minister of Health and Long-Term Care. I look forward to your further questions.

The Chair (Mr. Peter Tabuns): Thank you, Minister. With that, we go to the official opposition. Ms. Gélinas?

M^me^ France Gélinas: Thank you so much. I will continue with a very high-level question and then start to drill down. The first one is: When can we expect Bill 74 to be proclaimed?

Hon. Christine Elliott: Very shortly. Deputy Minister, perhaps you would like to expand on that a bit more.

Ms. Helen Angus: I'm not going to scoop the minister on an announcement of the proclamation, but I think we're working very closely with the board of Ontario Health for them to become the full capability of the agency that is in the mandate of Bill 74. As we think about the phased stand-up of that agency, the proclamation is obviously on that critical path. They've got some serious work to do, and heavy lifting, but I think proclamation will help them get to the place that they need to, so stay tuned.

M^me^ France Gélinas: Don't share any secrets with me, but let's say, before September?

Hon. Christine Elliott: I would anticipate so.

M^me^ France Gélinas: Good enough. Okay.

How much of the health care budget will the new Ontario Health manage? Hospitals, long-term care, home care, palliative care, mental health and addictions, and some primary care—how much?

Ms. Helen Angus: I think when we did a rough back-of-the-envelope, it was more than half of the health care budget. Obviously drugs and doctors, the OHIP budget and the Ontario public drug programs are the purview of the Ministry of Health and Long-Term Care. I would say we're still working through some of the details of the oversight of Ontario Health. We don't want to transfer accountability to them until they're full and ready.

I think what's important is that Cancer Care Ontario, for example, has always had the money for buying more volumes of cancer services, renal services and also for PET scanners. As we look at the LHIN role and how that rolls into Ontario Health, I think we'll have some conversations with them about how and how fast their oversight responsibilities—how quickly they'll move into those spaces.

I'm acutely aware, as a former deputy of Treasury Board, that our colleagues at Treasury Board will be watching this process very carefully to make sure that the accountability for results and for making improvements is clear, and that we have good, solid expectations for the performance of Ontario Health.

M^me^ France Gélinas: Will this accountability, those performance indicators, be known publicly, and will you report publicly on them?

Hon. Christine Elliott: There will be reports, yes. The most important issue here is patient safety. We want to make sure that the transition doesn't happen until the local Ontario health teams are absolutely ready to take on their responsibilities. They are working with Ontario Health. They are working through the 150 applications that we received to truly assess their actual readiness to take on these roles, and that's why we anticipate that it will take several years before the entire scheme is entirely rolled out, because patient safety and accountability is the critical factor that we need to take a look at.

M^me^ France Gélinas: From your answer I take it that Ontario Health will have a big role to play in identifying Ontario health teams. What is the role of the ministry in identifying which Ontario health teams will be designated first, second and third?

Ms. Helen Angus: I'll ask Mel to jump in as well. The ministry has really taken a lead in the early days of establishing—

The Chair (Mr. Peter Tabuns): Deputy Minister, if you'd just introduce yourself again.

Ms. Helen Angus: Yes, of course, sorry—Helen Angus, Deputy Minister of Health and Long-Term Care.

M^me^ France Gélinas: Only Hansard doesn't know you.

Ms. Helen Angus: The Ministry of Health has taken the lead in putting in place the process to select the early-adopter group of Ontario health teams. I'm not sure we expected 150 applications, but we got them.

As we start to think about supporting the ongoing implementation, clearly there are capabilities at Ontario Health that will be useful to that process, whether it's the clinical leadership inside Cancer Care Ontario, the measurement capabilities that Ontario Health will have, the digital capabilities that come with eHealth Ontario—all of that will be made available and designed to support Ontario health teams.

I would characterize the relationship between Ontario Health and the Ministry of Health as kind of interdigitated. We're working very closely with them to make sure that the capabilities of the ministry and those that exist within Ontario Health are brought to Ontario health teams so that they have the maximum chance of being successful in

achieving the connected care that the minister described earlier.

M^me^ France Gélinas: Was there any cost saving identified directly with the creation of Ontario health teams?

Ms. Helen Angus: The short answer is no. I think we're really looking at Ontario health teams as the ground game for transformation, the opportunity to really make improvements in connecting care for patients. We know from other jurisdictions, whether it's in the US or the UK, in accountable care organizations, that they have produced savings opportunities, but we haven't banked those in the fiscal plan by any means. We think that there are real opportunities for them to make improvements in care for patients.

Hon. Christine Elliott: And if I may say, that's what we're seeing with some of the organizations that have already started to provide integrated care, notwithstanding some of the impediments that the ministry has put forward. We want to remove those silos so that those local health care providers can work together to provide that integrated care for patients. That's really why we're doing this: because people are feeling disconnected from care and feeling that once they are discharged from hospital, for example, they often don't know who is providing home care, when, what home care will be provided, and so on. We want to make sure that people feel connected to their health care system throughout their entire health care journey.

1650

M^me^ France Gélinas: So the contract, for lack of a better word, will be between Ontario Health and Ontario health teams for the entire team? Right now there are accountability agreements with many of the transfer payment agencies that I'm assuming will be on those teams. How is this going to work?

Ms. Helen Angus: I don't know, Mel, if you want to answer that. I don't want to give the impression that Ontario Health is actually going to hold accountability for the physician portion at this time. Why don't you talk about how that relationship is going to work? It will evolve over time, I think, as well.

Ms. Melanie Fraser: Melanie Fraser, associate deputy minister.

Maybe I'll just back up for a quick second to say that Ontario health teams are self-organized groups that come together and identify a single fund-holder as part of coming together. As we move forward—I think the minister said that this is a maturity game—we know that we'll be funding them as a whole for a risk-adjusted patient population. The idea is that through funding them as a whole, as opposed to the way the sector is funded today in silos through multiple funding agreements, we can ensure that the dollars more closely follow the patient journey, and we can also ensure that we're creating the space for innovative models of care to emerge, scale and be funded.

I think a really good example of that is probably our recent work on bundled payments for hip and knee surgery, for instance, where, as opposed to funding a hospital for a surgery, home care for delivering care before or after the surgery and different parts of the system, we provide a bundle of funding and quality outcomes and patient experience outcomes that that funding is then used to achieve. What has happened is that we've not only seen an improvement in outcomes; we've seen less time spent in hospital, better care provided at home and better patient experiences.

The idea of the Ontario health team is really to take that concept of integration and bundling and scale it up. Initially, we'll start, I would say, small. We're going to walk before we run, thinking about the core sectors—hospital, home care, primary care, long-term care—but eventually you could see that expanding out to cover much broader components that maybe deal with the pre-determinants of health, such as social housing, Meals on Wheels—things that we know contribute to the health and outcomes of a patient, and may actually cost a lot less than a trip to the doctor's office.

M^me^ France Gélinas: Okay, so there will be a single fund-holder. The one that I have seen in my part of the province most of the time is the hospital; they are the biggest show in town. So the hospital, let's say, becomes the single fund-holder, but how do the funds flow to the long-term-care home, to the community health centres, to the other partners? It flows through the fund-holder, whoever that is?

Ms. Melanie Fraser: Yes, and I would say that for the early period, things aren't going to change that much. We understand, as I said before, that this is a long-term game, so for the time being, we'll continue to provide funding through the existing accountability agreements and let those organizations come together, form the relationships and decide how they're going to govern themselves.

We don't see this as being a hospital-led initiative per se; we're actually going to let the OHTs determine what governance works for them in their communities with their resources. In some cases it could be a hospital. In some cases it could be another health services provider.

Eventually, as we learn and grow from this, we'll move towards more bulk funding of the health care services going to those teams. So yes, you would have a sort of group—maybe "consortium" is the wrong word, but I'm trying to think. The governance that they decide on, they would identify who would hold and administer the funds, and as a collaborative, they would then disburse those funds to achieve patient outcomes, financial outcomes and clinical outcomes.

Ms. Helen Angus: It's Helen again. We already see hospitals doing this in small examples. I think the minister talked about Southlake earlier. It seemed to be advantageous that actually money would go to a community crisis centre for mental health rather than stay in the hospital.

It feels like we've locked value into the silos that we fund health care systems in, and I think there's a real opportunity to capitalize on the local knowledge and the willingness of providers to actually move the money to where the patients are, and when they see themselves as being responsible for an episode of care or a continuous

journey, I think that will be a game-changer. So, as much as it's also about the money, it's about how people see their jobs and how they work together to produce better outcomes, and there's room for improvement.

We have some stops and starts between home care and the hospital or between hospital discharge and primary care that are really less than ideal. If you look at the Commonwealth Fund Report that looks at health care systems every year, we are not at the top of the list in terms of those outcomes and the continuity of the patient journey. I think this takes the best of the solutions internationally that have shown to be kind of effective at breaking down the silos, but making them work in the Ontario context.

M^me^ France Gélinas: How many of those teams you figure will be operating—or announced, started or recognized or whatever term you want to use—before the end of this year?

Ms. Helen Angus: We're trying to set a fairly high bar because we want them to be really impactful. Again, we're still sorting through the 150 applications and we've got a set of criteria that we're looking towards. If you'd asked me probably six weeks ago, I would have said somewhere between five and 10. You know, organizations have put a lot of effort into this.

The other thing that I think is incredibly important is that even the process of working together to develop the application has started to cement some of the relationships between providers that are necessary and foundational to delivering more integrated care. The intention—and Mel can talk about this—is to keep people on the path of connecting around a patient population. We're starting to see some benefits already, and particularly in primary care we've got some that are being led by community health centres. It's really encouraging to see how the system has responded to this idea and how giving them a little bit of control in how they can organize themselves around a problem that everybody acknowledges has been as impactful as it has.

Hon. Christine Elliott: And that trusting relationship is really important. That's the key to success, and in those areas where they are already providing integrated care, they are working together to identify where the gaps are and then who can provide the solution. They're really looking at the individual patient in a holistic way, not just as a disease, state or physical condition. They're looking at all of the issues that need to be taken into consideration to help that person be well.

M^me^ France Gélinas: Minister, you are on record. At the beginning, you were talking about 30 Ontario health teams, then you changed to 50 Ontario health teams. Are we looking at way more than this now, given what has happened as in, you got 150 that came forward?

Hon. Christine Elliott: We did say originally 30 to 50 health teams, depending on the geographic area that they intend to cover and whether there are some that are looking to cover more provincial areas. If you take a look at children with complex medical needs, for example, I don't even know if there's a group that has applied, but there may be a group that has applied to look at that across the entire province, because that happens in every area. So there may be some of those groups; the others will be based on geography. It really depends on, once the analysis has been completed, what size of groups we're looking at.

We did originally indicate that 300,000 was the maximum number of people we would like to see included in one Ontario health team, but of course it may go down from that size in areas of perhaps northern or more rural Ontario, to maybe more like 100,000. We really have to do that level of analysis before we can actually say what number of actual teams we'll have.

1700

M^me^ France Gélinas: Do I get from this that you would be open to having 60 rather than a maximum of 50 if it made sense on the ground?

Hon. Christine Elliott: Yes, absolutely.

M^me^ France Gélinas: Okay.

Ms. Helen Angus: You may find us also being a bit of a matchmaker. If we've got some that are geographic in nature that overlap and they haven't talked to each other, we may try to facilitate some conversations between two different proponents if it makes sense from a geographic basis. But, obviously, it would be up to them how they would want to pursue that.

M^me^ France Gélinas: Okay. So right now, you're looking at willing partners only?

Ms. Helen Angus: Yes.

Hon. Christine Elliott: Yes.

M^me^ France Gélinas: My next question has to do—so, I had started with indicators and how you track success. You've talked about quality outcomes and patient experience outcomes. If we look at the Premier's Council on Improving Healthcare and Ending Hallway Medicine, do they have the same thing? Do they have indicators of success? If they do, are those public, and how are they doing?

Hon. Christine Elliott: Well, we do meet with Dr. Devlin and his council on a regular basis and confer with them. I believe they have another report that will be coming forward at some point. But we do confer with them on issues. We did speak with them about the Ontario health teams. They are in agreement with the paths that we're on with respect to that. They also give us, from time to time, more specific information as well.

Ms. Helen Angus: I would say that their next report—I've just seen the draft—does address the area of indicators. I think it's pretty well understood in the health sector that quadruple aim seems to be a pretty good framework that both Ontario uses and others use as well.

M^me^ France Gélinas: Sorry, could you repeat—

Ms. Helen Angus: It's called quadruple aim, so looking at four distinct areas of measurement. Health Quality Ontario uses that as a framework.

Interjection.

Ms. Helen Angus: Have you got it in front of you?

Ms. Melanie Fraser: It's right there.

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

Ms. Helen Angus: Basically, we're really looking patient and caregiver experience, patient and population health outcomes, increased value and efficiency and provider experience. So those are the four elements. As I say, it was originally triple aim. It was developed by the Institute for Healthcare Improvement. It's kind of the international standard for how one thinks about health system performance and improvement.

Those four buckets, I think, will guide our measurement efforts going forward. We've been out in the sector talking about quadruple aim and how it is helpful for us, thinking about that.

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

We go to the government side: Ms. Martin.

Mrs. Robin Martin: Minister, our government has introduced a new model—we've talked a bit about the Ontario health teams—to provide a new way of organizing health care and delivering health care services in local communities. I think we all have an understanding that health care providers such as hospitals, doctors, home and community care providers will be working together as part of a coordinated team.

Can you please describe for the committee a bit more about how these teams will work and how the new model is expected to benefit the health of all Ontarians?

Hon. Christine Elliott: Certainly. Thank you very much for the question. Ontario does have world-class health services provided by some of the best health care workers. I congratulate them for the great work that they do.

However, many patients experience care that is disconnected. Access issues such as being able to get same-day and next-day appointments contribute to challenges in other parts of the system, and we know that transitions and hand-offs between providers could be improved as patients move along the care journey. These challenges across the system have resulted in a rise in hallway health care in hospitals throughout the province, and that is why we announced the launch of Ontario health teams.

Ontario health teams are groups of providers and organizations that are clinically and fiscally accountable for delivering a full and coordinated continuum of care to a defined geographic population. Ontario health teams will be made up of local health care providers, which will be organized to work as a coordinated group. These teams will be built to guide patients and their families through transitions in health care. The Ontario health teams will share responsibility for care plans, service provision and outcomes. Most importantly, they will take the guesswork out of navigating the health care system for patients and their families.

Through Ontario health teams, patients will finally have a say in their health care journey. With safeguards in place to protect information, patients will have an option to securely access digital health services, such as making online appointments, talking to a specialist virtually, or having access to your own electronic medical records.

Deputy, would you mind perhaps elaborating on how Ontario health teams will play a key role in modernizing the Ontario health care system?

Ms. Helen Angus: Thank you, Minister. I think everybody knows that it has actually been a pretty short period of time since we've done this. It's taken the health sector by storm in some ways, because it was only on April 3, 2019, that we actually launched the process for the early adopters to apply to provide an expression of interest on their Ontario health team application. We really outlined the process and held a number of webinars with the sector to elaborate on the idea. I think we got 5,000 in your first webinar, Minister.

It really builds off a model—and I've talked a little bit about it in the questions. Other jurisdictions, whether it's the UK, Germany, the United States, New Zealand and other Canadian provinces, have really tried to integrate care. I think we're trying to build on the experiences of those jurisdictions, as well as scale up some of the pockets of integration, Southlake being a leading example, but there are others across the province that are doing this well for specific populations but not as a regular course for all patients in the province.

At maturity—I think Mel talked about it earlier. It's going to take us a little while to get to a fully mature system, but think about what they're trying to achieve:

Improving performance across a range of outcomes: We've talked about the quadruple aim, so that will be the framework. We expect improvements in all four areas, as I've mentioned: health outcomes, experience for the family and caregiver, experience for the provider, and better value. We want to make sure that they're able to be measured, and reported against a standardized performance framework. That performance framework will be understood as the Ontario health teams start their work.

Be funded by a single budget: We've just had a conversation about that. I think we've got some work to do to develop population-based funding models. That work is well under way.

Provide a continuum of care for a defined geographic population.

Function as a single point of accountability: I think the "accountability" word is an important one as it relates to the Ontario health team concept. And then the features of the accountable care organization are really sharing back to the health care system any savings and having those reinvested amongst the partners to drive further improvements in patient care.

The additional features—because we want this to be experienced by patients as something different and better than what they've received before. So, 24/7 access to a system of navigation and to a patient portal for their health care system: I would say that we have a number of patient portals, but I think they provide valuable information to patients who can use them to become better partners in their own health. That online access to that information I think is critical for that.

Taking a digital-first approach: We can talk a lot about digital standards, digital choices for patients, modernizing the system in a way that allows patients to do things, like the minister said: communicate and share information between providers and between providers and patients.

We've really thought about all the partners who need to be part of the continuum of care. We've talked about primary care, hospital care, rehabilitation services, home and community care, residential long-term care and, most notably, mental health and addictions. They're really encouraged to come together and self-organize about how they're going to best meet the needs of their local population and how they're going to provide that full continuum of care for patients.

For Ontario health teams, we know that they've done that. They've been seeking out partnerships already. I think that's resulting already in some redesign of some of the relationships and the care pathways that are so important to patients, that they're continuous, and using data and local intelligence in an active way to understand the patient population and the characteristics of the people they're serving. We're trying to get them to think imaginatively about how they might actually deliver services to patients.

1710

A big part of the value proposition here as well is us thinking about doing some rule-busting, whether it's waivers or whether it's looking at how we've boxed in some value into the silos. We will work alongside with the Ontario health teams to make sure that they're innovative ideas, that the rules and regulations that we've put into place don't get in the way along that journey.

Maybe with that, Mel, I might ask you to give a little bit more detail about some of the features of Ontario health teams.

Ms. Melanie Fraser: Sure. Thank you, Deputy.

Again: Melanie Fraser, associate deputy minister.

I'm really excited to talk about this. I think the passion and the enthusiasm that we saw from the sector in terms of their response to this is really shared by all of us here. We could probably talk to you about Ontario health teams all day, but I will try to keep it to our 20 minutes.

I think some of this comes from personal experience. The minister mentioned about the transitions in care being fragmented, and siloed delivery of care. I think all of us have probably had that experience, either with ourselves or with our parents—really challenging transitions from, for instance, the hospital to palliative care or from primary care into mental health services. We see these as real challenges that we want to devote ourselves to solving. The Ontario health teams do become our—I think you called it our ground game, but it really is a means of transforming the delivery system for health care and integrating care around patients.

Coming into this ministry a short while ago, I thought it was very interesting that we've taken this sector and almost completely repositioned it to centre around patients. Instead of looking at patients through the sectors and the silos that have existed for a long time, we're starting with the patients and working back from there. Much of our work is centred in the patient experience and the patient expectations—from their words, what they expect from their health care system; not only patients, but caregivers and families—for health care in 2020 and health care for the future. This guides everything that we've done in terms of our planning around these.

As the minister mentioned in her opening remarks this morning, a survey a couple of years ago showed that only 44% of Ontarians were able to get an appointment within the same or next day with their primary care provider when they were sick or needed medical attention, and 41% of Ontarians ended up going to their emergency department for a condition that could have been treated by their primary care provider. When you look at those statistics and you couple that with how the population is growing and becoming more complex, certainly, this is a burning platform for us to solve. These Ontario health teams are really a new way of organizing and delivering care centred around patients.

We want to empower the health care teams, as the deputy mentioned, to really connect and work around the patients as a team, to look at taking on the work of easing transitions between different care settings and being responsible for understanding a patient's medical history and their needs and directly connecting that patient to the care they need. It is a high bar, but I think, from the response that we've seen, it's certainly one that the sector is interested in achieving.

In the end, this will mean that patients and families and caregivers will have better access to care, more connected services, and hopefully wait less; they won't be staying in beds in hospital hallways and won't be left to navigate for themselves the services that they need for their families—children, moms. I think we've all had that experience.

As we said, this is really an idea that has come from the sector. I think the 150 applications show that we're all on the same page. We're really bringing to life the innovation and the ideas from our partners across the sectors and from patients. Of course, the focus will be on providing support for patients to be able to navigate the system on a 24/7 basis. I think that that's a really important point as well. There are examples of this across the province today, some really great examples, where patients received amazing care across their care journey, but it certainly isn't uniform. We certainly don't see digital tools deployed everywhere, and it is something that we want to scale and spread.

I'll just maybe talk to you a little about how we get there from where we are now. As we talked about earlier, this is going to be an ongoing process. This wasn't a one-time call for applications. We're in a cycle of continually receiving applications and assessments from the field. As Helen mentioned, we had several webinars with the field and several technical sessions to help explain to them the journey that we're on and the process in becoming an Ontario health team. As a result of that, we did receive these 150 self-assessments. That's really the first phase. So what that phase did was allowed interested groups of

providers to organize themselves to reach out to their networks, to broaden their networks and look at their geography, to look at patient referral patterns in their ecosystem and identify for themselves how ready they were to meet the bar of being an Ontario health team. So this was really an opportunity, I think, as Helen said, to really build more cohesion than already existed. That's the phase that we're in now.

As we have these 150 assessments, we've been working through with experts in integrated care delivery from across the province, and actually international experts as well, to inform how we evaluate these self-assessments. Really, there are no winners or losers here. All of these applications and all of these assessments are fantastic for us. There will be assessments that, when evaluated, will be seen to be more mature. In those cases, we will be inviting those groups to participate in the exercise of filling out a full application to be an Ontario health team.

I think the more interesting piece for us is all of those who are just below that level. We're very interested in those groups, which I think we will consider "in development," and look at what supports we can provide to get them as close to the leaders in this space as we can through the same time course, so that we're constantly in this process of accepting assessments, reviewing applications, providing supports and learning from experts whom we'll embed with the teams, so that we have active learning cycles and active evaluation so that we can continue to scale and spread as we go.

Ultimately, all of these candidates for becoming an Ontario health team, whether very mature or still in development, will be on the path to becoming a designated Ontario health team. We certainly expect that we may have some of these ready for the fall. As we said, the self-assessment process closed on May 15. It's been just such a tremendous experience, from the time we started having these conversations with the sector until today. The submissions, I'm not sure if we mentioned, cover the entire province, from every corner of the north to the east and west of the province. So we have some fantastic teams to look at and to learn from and to build from.

I'm not sure if there's more that I should say about that, but I guess what I can say is that, in the end, we're all learning as we go. As Helen mentioned, through this rapid learning process, we'll be actively inviting input from the providers. I think we're already learning, as we read through some of their assessment forms, about some of the barriers that exist in the system. I think some of them are policy barriers, in terms of legislative and regulatory changes that we may need to make to break down some of the silos that exist and some of the rules, as you put it, that get in the way of actually integrating and centring care around patients. Some of them are just the ministry probably taking a lighter touch in terms of dictating how health service providers provide care to their patients along the care journey and focusing more on the what: on the outcomes and the experience and accountability for that work. There's still a lot of work to be done, but I think we're exactly where we want to be in the process, and we've completed this first step together.

Maybe one of the greatest successes that I would comment on that we've had to date has been, as the teams begin their work together, focusing on how to improve care for the patients, the trust in the relationships that has been developed through that process has been such a huge benefit to the system. We continue to be very encouraged by the level of enthusiasm from the providers and the health teams, and we look forward to continuing to support this work as we move forward.

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

Mrs. Robin Martin: Mr. Cho, I think, has the next question.

The Chair (Mr. Peter Tabuns): You have under two minutes, Mr. Cho.

Mr. Stan Cho: Oh, I have under two minutes? Oh, jeez. Okay.

The Chair (Mr. Peter Tabuns): Use it well.

Mr. Stan Cho: That's a lot of pressure.

I wanted to chat a little bit about supply chain management reforms. It's hugely important because—well, you've touched on a lot of important points here: that we have a fragmented system, that we are siloed, indeed, across all ministries, but health being 42% of the spend, it's particularly important.

Looking at supply chain management reform is not just about cost savings, necessarily; it's about value-based procurement, looking at life cycle costs. Of course, I always point to the example that if you're hurt right now in Orillia, and Orillia EMS shows up and you need an IV and you need to be flown to Toronto General, well, when Ornge air ambulance shows up, they need to change the IV because Ornge buys from a different supplier, and when you get to Toronto General, they have to change the IV a third time because, of course, Toronto General buys from a different supplier. That's the sort of examples we have with our disjointed system.

I'm wondering if you can comment on why supply chain initiatives are so important and on some of the work that you've accomplished so far in your ministry, and what sort of measures you've been taking to improve our supply chain management so far.

Hon. Christine Elliott: Yes. Thank you very much for the question. The government of Ontario's new long-term plan to fix and strengthen the health care system will focus directly on patients and families. One of the ways we are doing this is by working with patients, providers and the sector to create an integrated supply chain for health care products and services. As you've pointed out, they're not always in alignment.

Supply chain is a critical component of a high-performing health care system. Ontario's current health supply chain model—

The Chair (Mr. Peter Tabuns): Minister, I am sorry to interrupt you. The committee is in recess until after the vote. We will resume when we come back.

The committee recessed from 1723 to 1743.

The Chair (Mr. Peter Tabuns): The committee resumes. The opposition has the floor. Madame Gélinas.

M^me^ France Gélinas: Thank you. My next series of questions are all over the map, because I thought I would have two 20 minutes, but now I have one. So I'm sorry if I rush you along.

The first one has to do with the dental program, the $90 million. The first question I have is kind of an odd one. Whenever the Premier talks about it, he refers to 100,000 people who would qualify for the program, yet when I look at what you, Minister, have mentioned—the $19,300; the $33,000 for a couple—that's the same thing for the Ontario Drug Benefit. There are 354,000 seniors who quality for the Ontario Drug Benefit, yet only 100,000 with the same salaries for the dental. What's the difference between the two?

Hon. Christine Elliott: Well, people will have to apply to become enrolled in the program. They'll have to qualify according to the criteria. We're not anticipating that everyone will come forward straight away. The 100,000, I think, is more the expected number of people who will come forward in the first year.

Deputy, did you have something to add to that?

Ms. Helen Angus: Yes, I think that's exactly the case: that these programs take a while to get some traction and ramp up.

I don't know if you know much about me, but I set up the Trillium Drug Program years ago and, in the first year, it took a long time for people to understand what the benefits are that they could receive and how to access them, despite best efforts to actually really market the program. So we want to make sure that we've got an allocation that fits what we think is an orderly implementation.

M^me^ France Gélinas: Right now, there are some dental suites in community health centres that are not fully utilized due to lack of funds. I know you've started to talk to public health units about setting them up, but nobody in the community health centres has received a call yet. Are they next on the list, or what's up?

Hon. Christine Elliott: Yes, they will be notified. There are some that have fully operational dental suites and others that don't have any. We want to make sure that they will receive the services and the funds they need to set up. Of course, there are also going to be some mobile dental buses as well for more northern or rural areas where the location may not be convenient for seniors to get to.

M^me^ France Gélinas: Can you share with the committee the work that has been done to see what is needed where? Because the dental suites that exist in public health units in all of this are not distributed based on needs; they're distributed on whoever was able to put those suites together, as opposed to needs. Is there a needs analysis that exists for the entire province and then a plan to say, "Well, here's where the needs are. Here's what we're going to set up where"?

Hon. Christine Elliott: Yes, there will be that level of analysis done. I understand that Dr. Williams is here, the ADM, who is working specifically on this project. So perhaps Dr. Williams can come forward and give you more specific information about what is actually being done.

M^me^ France Gélinas: Okay.

Ms. Helen Angus: He's also the chief medical officer of health for the province, as you probably well know.

The Chair (Mr. Peter Tabuns): Yes.

Ms. Helen Angus: I would say that this year there's money for capital for making improvements to dental suites as well as the operating dollars. But, David, you might want to talk a little bit about how we're approaching the ramp-up across Ontario.

M^me^ France Gélinas: Deputy, just within the $90 million: Some of the $90 million could be used this year to buy dental suites?

Ms. Helen Angus: There is some money for improvements to facilities.

M^me^ France Gélinas: Or is this outside of the $90 million?

Ms. Helen Angus: I will have to look at that. I believe it's—have you got the numbers here, David?

Dr. David Williams: Yes. Good afternoon, Chairman. It's Dr. David Williams, chief medical officer of health.

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

Dr. David Williams: Thank you for the question, Madame Gélinas.

In the $90 million, there is money set aside for capital. We have gone to each of the health units to ask the status of that. They've done some needs assessment because some of them have had suites before, but they have been sometimes let go after the changes. But some have new suites needed. We have an estimate of the different capital needs for the various ones. We're prepared to move out when we have permission to send the funding for them to assist and to get their suites up to function so that when we start to roll out the program by late summer they'll be ready to go. That's one of the processes, and that's included in the $90 million.

M^me^ France Gélinas: And it's included in the $90 million? Have we got a plan as to where the needs are and where those suites will be located?

Dr. David Williams: Yes, we've been asking each of the health units to look at their locations within their facilities and then look at their community health centres as well as the Aboriginal health access centres.

M^me^ France Gélinas: So it's led by the health units?

Dr. David Williams: That's correct.

M^me^ France Gélinas: Okay. And nurse practitioner-led clinics won't be getting any? It's CHCs, AHACs and public health?

Dr. David Williams: Yes, just the latter, not the nurse practitioner-led clinics.

M^me^ France Gélinas: Okay. While I have you there, was there any—how should I say it?—risk assessment that was done that would come with the changes that are coming to the health units? With the $200 million less, is there any risk assessment that has been done on the health of the population with those changes?

Dr. David Williams: With the $200 million, the change in the provincial contribution to the grants system, where it maintained all of the Ontario public health standard programs and services—so the health units are

required, as well as the boards of health, to deliver all of the standards and programs as before. As a result, we were to look at the overall cost-sharing arrangement between the province and municipalities. But there's no intent to cut the services and programs of the health units on that line there and to maintain the status there. As far as their programs and services, they had submitted their budgets for 2019 to maintain and carry out all of the programs and services as they saw fit.

M^me^ France Gélinas: While you're there, again, there was a cut of $17 million in the outbreak-of-disease budget line in the estimates that had a lot of people worried because a few measles cases have been identified throughout our province. How do you explain the cut of $17 million in the outbreak-of-disease budget line?

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Dr. David Williams: That's just because of where it's held in the vote. It actually relates to the high-dose flu vaccine. We had a $17-million one-time funding last year. We have a new submission to cover the program for this year. But for the accuracy of the budget, it was put in that way. So it doesn't relate to any reduction in "Outbreaks of Diseases" per se; it's more related to the universal influenza flu campaign.

M^me^ France Gélinas: So if the high-dose vaccine is available again next year, where will that money come from?

Dr. David Williams: We will be seeking the funding for that in due process. We're in the process now.

M^me^ France Gélinas: In the budget line and in the estimate line, where does that money sit?

Dr. David Williams: In the budget line there, it would be sitting in the overall vote. We would have to go and acquire that—because we had to order new vaccines and new purchases with procurement processes. That has to be carried through in the proper process as we're obtaining because sometimes—the vaccines change each season, so some ones are available or not available. We have to put through a new comprehensive proposal for the UIIP. It still is in "Outbreaks of Diseases"—same line.

M^me^ France Gélinas: So it stays in "Outbreaks of Diseases," but this line has gone down $17 million.

Dr. David Williams: Because the amount that was there last year was a one-time fund. Therefore, now we have to put in a new one to cover the current needs and future needs in that, so we have a new submission in the process.

M^me^ France Gélinas: So could we see a $17-million increase in that budget line?

Ms. Melanie Fraser: I think we're going to ask our CAO to answer the financial questions. The estimates are a bit detailed.

M^me^ France Gélinas: Sounds good.

Ms. Melanie Fraser: Peter, maybe you could jump in here.

The Chair (Mr. Peter Tabuns): And if you could introduce yourself for Hansard.

Mr. Peter Kaftarian: Hi. I'm Peter Kaftarian, chief administrative officer at the Ministry of Health. As I was walking back and forth, can you just please repeat your question, Ms. Gélinas?

M^me^ France Gélinas: Yes. There is $17 million less in the "Outbreaks of Diseases" budget line. The chief medical officer just told us it was because of the high-dose flu vaccine one-time funding from last year. My question is that if we are going to fund the high-dose flu vaccine again this year, where will the money come from?

Mr. Peter Kaftarian: The plan would be somewhere within this vote. We will be covering the cost associated with the flu vaccine. There is an annual process each year whereby the quantity of vaccines that are required to be ordered is followed. There is a process to work with the federal government to place the orders, and then to ensure that we get the necessary vaccine in through Dr. Williams's team and the distribution through a unit in my shop.

When it comes to being able to have the necessary vaccine to provide, whether it's high-dose or regular flu vaccine, the funding line that covers various vaccines is this line here. Sometimes there is additional funding required for some vaccines versus others. Last year, there was an additional amount. But if we need to figure out a way within this allocation to pay for that additional cost, that's what we'll be doing.

M^me^ France Gélinas: As well as communicable diseases and everything else that falls within that line?

Mr. Peter Kaftarian: Yes. There are 17 different components within this line where various things are ordered on an annual or every couple of years—

M^me^ France Gélinas: So am I right in thinking that, God forbid, if we have a measles outbreak, the money to deal with that would could from that same line?

Mr. Peter Kaftarian: Measles, specifically, I'm not sure, but if that is one of the 17, then the answer would be yes.

M^me^ France Gélinas: Yes, it is one of the 17, so the answer is yes. Okay. All right.

I'm jumping all over the place. The next one is something that's specific to northern Ontario. After the closure of the HealthForceOntario Marketing and Recruitment Agency—this is a program that is used in northern Ontario lots. We use it, basically, as funding for local programs, to fill gaps, to ensure continuity of services in northern, remote and rural communities. We also use it to cover the costs of travel, communication and accommodations to manage and deliver health services in northern Ontario. What's going to happen now that HealthForceOntario Marketing and Recruitment Agency is no longer there?

Ms. Helen Angus: I would just say that—it's Helen Angus again—the functions of HealthForceOntario are being moved inside Ontario Health. There still will be a function there that deals with exactly what you talked about: the recruitment, retention and deployment of health human resources in northern Ontario.

Having been involved in some of those, I would say that HealthForceOntario is an important partner, as is the northern Ontario medical school, as you well know, and

Queen's University, in particular, in northeastern Ontario. So we have many actors who try to make sure that we've got the human resources that we need across Ontario. Ontario Health has that object within its mandate.

M^me^ France Gélinas: Will the funding allocated for Ontario's First Nations Health Action Plan continue?

Ms. Helen Angus: I will have to check. I believe so, but—for the Indigenous—

M^me^ France Gélinas: It's called Ontario's First Nations Health Action Plan.

Ms. Melanie Fraser: We are being advised, yes, it will continue.

M^me^ France Gélinas: Yes, it will continue?

Ms. Helen Angus: Yes.

M^me^ France Gélinas: You're on the record. I'm going to hold you to that.

Ms. Helen Angus: Yes.

M^me^ France Gélinas: Okay. Very good.

Ms. Melanie Fraser: And I'm going to hold my colleague to that.

M^me^ France Gélinas: All right. It's a chain reaction. Okay.

Again, jumping all over the place: In the estimates around Smoke-Free Ontario, under the population and public health division, the estimate is identical to last year, but I'm curious to see what programs will be funded for tobacco prevention and cessation, given the change coming to public health.

Hon. Christine Elliott: The Smoke-Free Ontario Act and its regulation came into force on October 17, 2018. It prohibits the smoking of tobacco, the smoking of cannabis, the use of electronic cigarettes or, to vape any substance in enclosed workplaces, enclosed public places and other specified places.

Smoke-Free Ontario is a comprehensive strategy that combines programs, policies, social marketing and legislation to reduce tobacco use and lower health risks to non-smokers in Ontario. Through SFO, the government is focused on protecting Ontarians by putting smoking and vaping laws in place to protect Ontarians from second-hand smoke—

M^me^ France Gélinas: I'm not interested in the policy as much as I'm interested in the money; as in, what tobacco prevention and cessation programs can we expect to be funded?

The Chair (Mr. Peter Tabuns): Minister, can you bring the microphone closer to you?

Hon. Christine Elliott: Yes, certainly. Deputy, do you have—or should we ask—

Ms. Helen Angus: I actually don't have the breakdown by organization. I don't know whether our colleagues in public health that fund that—or we can certainly look into that, because the funding for last year and the funding for this year are in fact the same. So there is a continuity in funding. I would say that there are monies there for counselling and supports. There's money for no-cost nicotine replacement therapies and other things within the budget.

I don't know if you've got any more detail.

M^me^ France Gélinas: So are we expecting no changes? Given that the money stays the same, will the programs that are funded also stay the same?

Ms. Helen Angus: I think that—

Ms. Melanie Fraser: We need to take that back or ask Dr. Williams to come and speak to this one.

Ms. Helen Angus: Yes, because I think there are some changes to the programs. Obviously some of them have been—

M^me^ France Gélinas: I think so, too.

Ms. Helen Angus: I think so, too. Yes. I'm not going to tell you they're not, but there are some complicated manoeuvres around transferring some of the programs so we get better value out of the programs that we have. I know there was interest in moving some of the phone service to our telehealth line and other things that would actually make sure that we're capitalizing on the resources that we already have to help with smoking cessation. Some of these programs were designed probably 20 or more years ago. For example, for young people we do know that they're looking for apps and digital approaches to make sure that we're giving them the supports that they need to quit smoking.

Hon. Christine Elliott: Perhaps Dr. Williams could come forward and give us more specific information with respect to the funding issues.

M^me^ France Gélinas: He's flipping through his binder nervously back there.

Dr. David Williams: Again, Dr. Williams, Chief Medical Officer of Health. As you've asked which I think are the questions under the Smoke-Free Ontario Act—

The Chair (Mr. Peter Tabuns): With that, I'm very sorry to say that we've run out of time.

With that, members of the committee, we adjourn until tomorrow at 3:45 p.m.

The committee adjourned at 1800.

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