

Legislative  
Assembly  
of Ontario



Assemblée  
législative  
de l'Ontario

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**Official Report  
of Debates  
(Hansard)**

E-28

**Journal  
des débats  
(Hansard)**

E-28

**Standing Committee on  
Estimates**

Ministry of Health

1<sup>st</sup> Session  
42<sup>nd</sup> Parliament  
Tuesday 11 May 2021

**Comité permanent des  
budgets des dépenses**

Ministère de la Santé

1<sup>re</sup> session  
42<sup>e</sup> législature  
Mardi 11 mai 2021

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Chair: Peter Tabuns  
Clerk: Thushitha Kobikrishna

Président : Peter Tabuns  
Greffière : Thushitha Kobikrishna

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## LEGISLATIVE ASSEMBLY OF ONTARIO

## ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON  
ESTIMATESCOMITÉ PERMANENT DES  
BUDGETS DES DÉPENSES

Tuesday 11 May 2021

Mardi 11 mai 2021

*The committee met at 0900 in room 151 and by video conference.*

## MINISTRY OF HEALTH

**The Chair (Mr. Peter Tabuns):** Good morning, everyone. The committee is about to begin consideration of the estimates of the Ministry of Health for a total of 15 hours. As this is the first ministry before the committee, I'd like to take this opportunity to remind everyone that the purpose of the estimates committee is for members of the Legislature to determine if the government is spending money appropriately, wisely and effectively in the delivery of 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 that the ministry will spend those dollars appropriately. In the past, members have asked questions about the delivery of similar programs in previous fiscal years, about the policy framework that supports a ministry approach to a problem or a 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 the ministry can respond accordingly. If you wish, you may, at the end of your appearance, verify the questions and issues being tracked by the research officer.

I'll note before we begin that, other than myself, we have no members present physically in the committee room. The following members are participating remotely—

*Interjection.*

**The Chair (Mr. Peter Tabuns):** Ah. Before I go through the full list—no, I'll go through the list and I'll add another at the end. Currently, we have MPP Cuzzetto, MPP Monteith-Farrell, MPP Parsa, MPP Martin, MPP Anand and MPP Gélinas. And I note that MPP Barrett has joined us. MPP Barrett, I need you to confirm your identity and location in Ontario.

**Mr. Toby Barrett:** Yes, it's Toby Barrett, MPP, in Port Dover, Ontario.

**The Chair (Mr. Peter Tabuns):** Thank you so much. We're also joined by staff from legislative research, Hansard, interpretation and broadcast and recording.

To make sure that everyone can understand what is going on, it's important that all participants speak slowly and clearly. Please wait until I recognize you before starting to speak.

Are there any questions from members before we start? Seeing none, I'm now required to call vote 1401, which sets the review process in motion. We will begin with a statement of not more than 30 minutes from the Minister of Health, followed by a statement of up to 30 minutes by the official opposition. Then the minister will have a further 30 minutes for a reply. The remaining time will be apportioned equally among the parties.

Minister, the floor is yours. You have to unmute, I am told.

**Hon. Christine Elliott:** All right.

**The Chair (Mr. Peter Tabuns):** Excellent.

**Hon. Christine Elliott:** Wonderful. Thank you very much, Chair, and good morning to you and members of the committee.

**The Chair (Mr. Peter Tabuns):** Good morning.

**Hon. Christine Elliott:** Thank you for the opportunity to speak with you today. Over the last year, Ontario has faced the unprecedented challenges of the COVID-19 pandemic that has swept across our province, our country and around the world. The health and well-being of all Ontarians has been the government's top priority throughout this global pandemic, and we have taken swift and decisive action to ensure the province has been ready to respond to the COVID-19 pandemic. The Ministry of Health continues to work across government and with its health care system partners around the province to contain the spread of the virus and implement its vaccination rollout plan to safeguard—

*Failure of sound system.*

**The Chair (Mr. Peter Tabuns):** We've lost sound. Minister, you seem to have muted. I think it's a glitch, not you.

Okay, you're back.

**Hon. Christine Elliott:** Can you hear me now, Chair?

**The Chair (Mr. Peter Tabuns):** I can hear you now. Please proceed.

**Hon. Christine Elliott:** All right. Thank you.

Our response structure is in place to constantly review, strengthen and implement these plans.

The health coordination table, which reports to myself and Minister Fullerton via its co-chairs, Deputy Minister Angus, Dr. Williams and Mr. Matthew Anderson, serves as the central point for mobilizing the health system and accessing strategic advice to guide our response. A collaboration table of over 30 health care stakeholder organizations helps to inform the health system's response by identifying the challenges and concerns being experienced across the health system, and reflects the perspective and needs of different sectors.

A number of technical advisory tables have provided technical expertise, advice and data modelling to support our response throughout. Sector or issue-specific tables provide implementation advice and coordination on specific issues, such as long-term-care outbreak management, public health measures, mental health and addictions supports and more.

The ministry's emergency operations centre provides an overall coordination function among the components of the response structure. A bioethics table provides guidance to support decision-making throughout the response. The decision-making process has been guided by the government's key top priority: to protect the health and well-being of Ontarians. The government continues to make the necessary investments in our health care sector to keep Ontarians safe throughout the outbreak.

As we continue to use every resource at our disposal to protect Ontarians' health and safety during a pandemic, Ontario has made significant strides in its efforts to fight COVID-19. The province has expanded testing capacity, enhanced case and contact management efforts, supported front-line health care, developed a three-phase plan for the rollout of the COVID-19 vaccines, and created a framework to guide the implementation of public health measures. These actions have been based on the advice of the Chief Medical Officer of Health and public health experts and informed by evidence, the assessment of risks and local context.

Speaking of COVID-19 testing, in 2020-21, we have continued to significantly increase COVID-19 testing capacity, allowing health experts to identify cases of COVID-19 and support efforts to stop the spread of the virus in the community, long-term-care homes and other congregate settings. Our testing plan is helping protect Ontarians.

With over 13 million tests completed, Ontario has become the leading Canadian jurisdiction for testing. Our lab network can administer over 100,000 tests per day. The province continues to beat its turnaround target time, ensuring well above 80% of people tested receive their COVID-19 results within two days.

Testing was made available to any symptomatic individual or any individual with exposure to a confirmed COVID-19 case, 189 assessment centres have been established across the province, and a new user-friendly online portal was established to enable Ontarians to easily access their COVID-19 lab test results and ease pressure on public health units and front-line workers.

Eligibility for testing at assessment centres and participating specimen collection centres was further expanded

to include certain targeted high-risk groups, such as school and child care staff, farm workers or individuals who identify as Indigenous. High-risk populations were also eligible for asymptomatic testing at participating community pharmacies.

The province also implemented targeted testing campaigns to detect and contain cases by expanding asymptomatic surveillance testing through targeted mobile testing sites that focused primarily on vulnerable populations. Groups targeted for asymptomatic lab-based testing included: workers in long-term-care homes, retirement homes or other congregate settings; farm workers; cross-border workers; and certain school staff, as well as other vulnerable populations.

Targeting asymptomatic individuals through rapid antigen testing has also been made available to a wide variety of priority sectors and is an added measure of safety and screening in workplaces, including essential industries, congregate care settings and high-priority communities. Ontario has distributed over 6.4 million antigen point-of-care tests across the province.

#### **0910**

Another key component of the province's testing plan was to support outbreak management. Access to testing, both lab-based testing as well as point-of-care testing, has been implemented to ensure there is a rapid response capacity for outbreak management, including in specific neighbourhoods, regions, hospitals, institutions, workplaces, and First Nations and Indigenous communities.

To support rapid diagnosis and early outbreak management, the province ensured there was testing capacity in areas of the province such as rural, remote and Indigenous communities, where access to lab-based testing at assessment centres was limited.

Recognizing the increased risk that inbound international travellers may pose by potentially spreading new COVID-19 variants, we established a border testing program at Toronto Pearson International Airport for eligible international travellers arriving in the province from abroad and staying for at least 14 days. The voluntary pilot, established near the beginning of January 2021, was implemented to help quickly test, trace and isolate COVID-19 cases early in Ontario and help inform the development of future testing programs for broader implementation.

At the beginning of February of this year, the Chief Medical Officer of Health issued an order requiring every person, except those under the age of five, who entered Ontario on an international flight arriving at Pearson airport to take a mandatory PCR COVID-19 test, with limited exceptions. This order was revoked on February 22, and new federal regulations came into effect, including on-arrival and day-10 testing for international arrivals at Canadian airports.

COVID-19 variants have continued to enter the country and province through international travel. Our government continues to request that the federal government take immediate action at Canada's international borders to stop this significant threat to the health and well-being of Ontarians.

Ontario has also expanded data collection to help stop the spread of COVID-19, which responds to requests from public health experts and community leaders. We introduced a regulatory change to mandate the reporting of data on race, income, language and household size for individuals who have tested positive for COVID-19, which would provide the province with a more complete picture of the outbreak, who it is affecting and how communities are being impacted.

To further support neighbourhoods that were hardest hit by COVID-19, Ontario launched the High Priority Communities Strategy. Evidence has shown that racially diverse newcomer and low-income communities have been impacted more significantly by COVID-19 than others. These communities need specific supports as they face complex barriers to accessing services and enacting core prevention measures.

To support these communities, the strategy provided funding to lead local agencies in Durham, Peel, Ottawa, Toronto, Windsor and York region to provide tailored community outreach and engagement and increased access to testing and wraparound supports to connect individuals and families to services like food, income supports, health and social services and isolation centres.

These agencies have been working in partnership with Ontario Health, public health units, municipalities and other community partners to deliver these supports to these high-priority communities. Nearly 2,000 community ambassadors have been engaged by lead agencies to support the strategy. More than 100,000 PPE kits have been delivered, and wraparound supports have been provided to more than 9,600 people.

The Ministry of Health continues to adapt its testing plan, closely monitoring the situation as it evolves and updating the provincial testing guidance, eligibility and point-of-care testing initiatives to respond to development. The province's COVID-19 testing plan has provided Ontarians with more access to the full spectrum of testing options and has helped to quickly identify and manage outbreaks, track and monitor the virus, inform public health decisions, help control infection rates and ultimately save lives. The testing plan has also supported Ontario's economic recovery by administering and processing tests to keep workers and customers safe and help businesses operate responsibly.

Next, with respect to case and contact management, alongside Ontario's testing plan is the province's comprehensive Case and Contact Management Strategy, which has further supported the efforts to stop the spread of COVID-19 and protect Ontarians' health. The province has strengthened case and contact management to ensure that new COVID-19 cases and their contacts are identified early, contacted quickly and investigated thoroughly.

Ontario has supported public health units by hiring 1,000 additional case managers and contact tracers, as well as accessing 600 contact follow-up staff through a partnership with Statistics Canada. Along with staff who work in or have been redeployed within public health units, this support brings the total number of case and

contact tracers in the province to nearly 5,600 staff at peak capacity. These people are helping to isolate new cases of COVID-19 and stop the spread of the virus in communities across Ontario.

Investments in technology have also enhanced case and contact management. A new COVID-19 case and contact management system was implemented, replacing the legacy integrated Public Health Information System for COVID-19. Through a partnership with the federal government, the COVID Alert app was developed: a privacy-first exposure notification app to alert Ontarians when they may have been exposed to COVID-19, which has been downloaded across the country more than six million times.

Another key part of our government's response to COVID-19 has been to support our front-line workers, invest in our hospitals and build capacity in the health care system. Our first step to expand hospital capacity was an investment of \$341 million for a total of 1,500 beds, with 1,000 acute care beds and 500 critical care beds. Then, as part of the province's fall preparedness plan, Keeping Ontarians Safe: Preparing for Future Waves of COVID-19, additional funding was provided for 139 critical care beds and up to 1,349 hospital and alternate health facility beds. We continued to be responsive to how the pandemic unfolded and created up to 766 more beds at 32 hospitals and alternate health facilities across the province later in the fall.

In January 2021, the ministry immediately expanded critical care capacity in hospitals, with up to 519 critical care and high-intensity medicine beds being added to hospitals in areas with high rates of COVID-19 transmission. This investment also helped to relieve pressures on nearby hospitals due to rapid increases in hospitalization and ICU occupancy rates that have been experienced in the third wave of this pandemic, which has been driven by COVID-19 variants that are more transmissible and more likely to lead to serious illness and hospitalization.

To further address the financial pressures created and exacerbated by COVID-19, our government is also providing over \$1.2 billion in additional funding for Ontario's public hospitals. This includes funding to help cover historic working fund deficits for eligible public hospitals to ensure that they remain financially stable during this very critical time. The focus for this funding will be on small and medium hospitals, as well as specialty and rehabilitation hospitals that are facing significant strain due to their unique situation and the patient population that they serve.

Throughout the pandemic, all hospitals have been challenged by the loss of other forms of revenue, such as copayments for private rooms and the reduction of retail services, all of which contribute to patient care and support clinical services. This is why the government is investing up to \$572.3 million to reimburse hospitals for a portion of these losses.

Ontario has also invested an additional \$869 million in the hospital sector for supplies and equipment related to

addressing the surge in COVID-19 cases, including testing, swabs, saliva tubes and test kits. Overall, the total increase in funding to hospitals since 2019-20 is \$3.9 billion.

#### 0920

In recognition of the dedication, long hours and increased risk of working to contain the COVID-19 outbreak, the Ontario government has also provided front-line health care staff with a temporary pandemic payment. Those eligible to receive the payment included employees from across several sectors of government, including paramedics, those providing home and community care, and some staff in hospitals. Workers who deliver publicly funded personal support services were also provided with a temporary wage increase, including eligible workers in home and community care, long-term care, public hospitals, and children, community and social services who provide direct personal care supports for the activities of daily living.

Since the start of the pandemic, health care and other care workers have been on the front lines of Ontario's pandemic response. They have faced this deadly virus head-on. I know we are all extremely appreciative and thankful for their heroic efforts to provide the people of Ontario with the health care supports and services that they expect and deserve.

Ministry investments over the past year have helped to recruit, retain and support over 3,700 more front-line health care workers and caregivers. This is helping to ensure our health care system can meet a surge in demand while continuing to provide safe and high-quality care to patients and long-term-care residents.

The government provided over \$107 million in additional funding to support paramedic services and ambulance dispatch centres. This assisted with the provision of personal protective equipment, medical supplies and equipment, overtime for front-line workers, swabbing and testing, respirators, training, virtual care and special initiatives. Paramedics and ambulance communications officers in Ontario continue to play an instrumental role in responding to the COVID-19 pandemic.

Additional investments were made to support personal support workers and supportive care workers. This included funding to train, recruit and retain personal support workers in the home and community care and long-term-care sectors. Additional investments in nursing were also made to add nurses in areas of need across the province, such as long-term-care homes and acute care settings. All of these investments are helping to increase and stabilize Ontario's health care workforce.

Throughout the pandemic, the ministry further supported front-line health care by establishing a number of temporary initiatives to help stabilize physician services in support of the COVID-19 response. This included physician-focused funding for working in COVID-19 assessment centres, new virtual care OHIP codes, as well as additional funding related to ICU, ward and emergency department coverage, aerosol-generating medical procedures, life-threatening critical care, long-term-care homes and congregate care settings, and surgical backlogs.

Digital health and information management have been an important part of the ministry's response to COVID-19. We have offered a better way to connect health information and digital solutions to provide the most up-to-date advice and health information, enable contactless delivery of health care services and use data to track and support the pandemic response. There has been an increased adoption of and improved access to virtual care throughout the pandemic. There have been more direct doctor-to-patient video appointments, including virtual care initiatives that allow patients to virtually access hospital services, provide support in transition to virtual pre- and post-surgery care and appointments, and remotely monitoring COVID-19 patients and other vulnerable populations. These important developments in digital health and virtual care are providing more options for services that meet the needs of patients.

The ministry is also using digital tools to support the COVID-19 response through the creation of the Ontario Health Data Platform, established in consultation with the Ontario Information and Privacy Commissioner. This new platform securely holds integrated health data that allows researchers to better support urgent health system planning and responsiveness, including the immediate need to analyze the current COVID-19 outbreak in such areas as increasing detection of the virus, risk factors for vulnerable populations, predicting where outbreaks may happen, identifying where to allocate resources and evaluating how vaccinations are working.

Now to move on to the vaccine rollout. A cornerstone of Ontario's fight against COVID-19 is the province's vaccine rollout plan. We developed a three-phase COVID-19 vaccine plan to administer vaccinations in accordance with an ethical framework for COVID-19 vaccine distribution, based on expert advice from the Ministers' COVID-19 Vaccine Distribution Task Force and aligned with the National Advisory Committee on Immunization.

Ontario's vaccine plan prioritizes vaccines for those at greatest risk of severe illness and those who care for them. Phase 1 focused on protecting the most vulnerable populations with the greatest risk of harm, which represents approximately 1.8 million people living in Ontario. This included residents, staff, essential caregivers and other employees in congregate living settings for seniors; health care workers; adults in First Nations, Métis and Inuit populations, including remote communities; adult recipients of chronic home health care; and adults aged 80 years and older. There was a clear benefit to focusing on vaccinating the province's most vulnerable during phase 1, as evidenced by the subsequent decrease in long-term-care home cases and COVID-19-related deaths.

Health care providers who could administer the vaccine were expanded to include nurse practitioners, registered nurses and registered practical nurses, along with pharmacists, pharmacy student interns and pharmacy technicians.

Distribution of vaccinations during phase 1 was conducted through hospital site clinics, mobile teams, site-specific clinics and mass vaccination clinics. As vaccine supply increased, Ontario expanded the delivery channels



available to administer COVID-19 vaccines to include pharmacies and primary care settings, as well as pop-up and workplace clinics.

The Ministry of Health and Ornge collaborated with the Ministries of Indigenous Affairs, the Solicitor General and Natural Resources and Forestry and the federal government's First Nations and Inuit health branch to co-develop a plan with Nishnawbe Aski Nation and the individual communities to offer vaccinations to 31 fly-in First Nations communities in northern Ontario and Moosonee. Known as Operation Remote Immunity, this initiative was led by Ornge and was successfully completed at the end of April. A total of over 25,000 first and second doses were administered under Operation Remote Immunity.

As vaccine supply increased, Ontario launched an on-line booking system and a provincial call centre to answer questions and support appointment bookings at mass immunization clinics. In alignment with phase 1 priorities, the provincial system initially supported booking of appointments of individuals 80 years of age and older, and then expanded its capacity to many more eligible groups.

While work continues with public health units to offer vaccines to remaining phase 1 priority populations, we have moved into phase 2 of the vaccine rollout plan. Phase 2 is focused on vaccination by age and risk, including targeting those who live and work in congregate living settings and some primary caregivers; those who live in hot spot communities where there are high rates of death, hospitalization and transmission of the virus; and certain workers who cannot work from home. Ontario will enter phase 3 when vaccines are available for every Ontarian who wants to be immunized.

Individuals who receive the COVID-19 vaccine are also being asked to voluntarily share sociodemographic information such as race, ethnicity, childhood language, official language most comfortable with, total household income and household size. Such data will only be collected with the consent of the person being vaccinated. Collecting this data will help the province have a more complete picture of who is being vaccinated, help ensure access to the vaccines for communities that are at risk and disproportionately impacted by the pandemic, and ensure that everyone who wants to be vaccinated is being reached. Every safeguard will be in place to protect the privacy of the information collected.

**0930**

In response to an expected increase in vaccine supply from the federal government, we have been accelerating the vaccination rollout to reach all Ontarians as quickly as possible. With additional supply, our government increased access to the COVID-19 vaccines in the communities hardest hit by COVID-19 to a targeted, time-limited increased allocation of COVID-19 vaccines to hot spot communities. During the weeks of May 3 and May 10, 50% of vaccine supply was allocated to the hot spot communities across 13 public health units. Targeting these communities will slow the spread of the virus and protect communities with the highest rates of transmission.

Starting in Peel and Toronto, the province is providing support for pop-up clinics to administer vaccines at faith-

based locations in hot spot neighbourhoods. These are in addition to existing mobile and pop-up clinics that are in place to administer vaccines in high-risk congregate settings and residential buildings in these communities.

The province has also launched mobile vaccine units for small to medium-sized businesses in hot spot communities. These mobile units are offering vaccinations in Toronto, York and Peel at select businesses that have a history of risk or outbreaks.

More predictable supply has allowed us to continue to expand COVID-19 vaccine booking eligibility over the past several weeks, as well as develop a schedule to further expand eligibility throughout May, with individuals aged 18 or older expected to be able to book through the provincial booking system as early as the week of May 24. We are continuing to make significant progress, with over six million doses administered; and we're on track to have administered first doses to 65% of Ontarians age 18 and over by the end of May.

In consultation with the Chief Medical Officer of Health and other health experts, the government developed the COVID-19 Response Framework: Keeping Ontario Safe and Open, in fall 2020. This framework implemented public health and workplace safety measures in a targeted, incremental and responsive manner to help limit the spread of COVID-19—

**The Chair (Mr. Peter Tabuns):** You have two minutes left, Minister.

**Hon. Christine Elliott:** Thank you—while focusing efforts on keeping schools and businesses open, maintaining health system capacity and protecting vulnerable people, including those in long-term care.

Public health unit regions were categorized into five levels, with specific public health and workplace safety measures and targeted measures for specific sectors, institutions and other settings. A public health unit region was placed in the level based on indicators and thresholds related to epidemiology, health system capacity and public health system capacity.

With the recent declaration of emergency implementation of the province-wide emergency brake and a stay-at-home order in effect, the framework is currently paused during this time. These tools are in place as part of the government's comprehensive approach to responding to the third wave of this pandemic. The government will continue to remain vigilant, because nothing is more important than the health and well-being of the people of this province.

As the COVID-19 pandemic has evolved in Ontario and other jurisdictions around the world, Ontario has continued to adapt to this evolving situation in order to ensure the safety of all Ontarians and the ability of the health system to provide care for patients. This approach has helped guide the province over the last year and will continue to do so in the foreseeable future.

I would like to again thank you for the opportunity to speak with you today about significant actions the government has taken over the last year to fight the COVID-19 pandemic, and I look forward to your questions. Thank you, Chair.

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

I will now go to the official opposition. MPP Gélinas, you have 30 minutes.

**M<sup>me</sup> France Gélinas:** Thank you, Minister, for this really informative overview of the pandemic response from your ministry and from the government. I always appreciate hearing from you.

I will give what I call “the 10,000-foot view” as to our questions through the estimates. We will be focusing on spending and making sure that the spending for the programs went as intended.

Not surprisingly, quite a few questions about hospitals—our hospitals make up \$26 billion of the health care budget—and questions about how will we address the overcrowding that was there before the pandemic, that will be there again. Compound this with the surgical and procedure backlog that has happened through the first wave and is happening now that hospitals received a directive to cancel non-emergency surgeries—a bit also about hospital redevelopment in certain areas of our province.

The other big area of expenses, of course, is OHIP, at \$17 billion. I also saw that there’s a \$1.3-billion increase, an 8.4% increase in that line, so I’m curious to see how the OMA negotiations are coming. I’m curious to see other professionals who get paid through this. I know the optometrists have been quite vocal, and a number of other health professionals who get paid through that envelope.

Then questions about our public drug plan, at \$5.4 billion, I think. I also saw that there’s a \$367-million increase to the drug benefits, so questions about rare diseases, some medications that are exceptional access in Ontario but not in other places, and questions surrounding that.

Tons of questions on community programs or home and community care sectors: I get complaints against our home and community care sector—not a day goes by that I don’t have somebody reaching out to me about this, so there will be quite a few questions. They come from different parts of the province, but they really focus on basically the transformation in the home and community care sector, as well as the services not meeting people’s expectations and not meeting patients’ needs.

Then in mental health and addictions, some questions about kids and about schools and about what a lot of people call the “second pandemic,” where we’ve seen a lot of people having a tough time through the pandemic that has had an impact on their mental health and well-being, and what is the government’s plan to try to help people certainly make it through the pandemic but also through to the other side.

There are a whole bunch of odds and ends in there that I will call “other programs” that go from the Assistive Devices Program to MEAO, the myalgic encephalomyelitis association, that has their annual day at Queen’s Park on Wednesday; some questions regarding midwives, nurses, that kind of stuff.

Then long-term care: It is within the health estimates, the \$5.6 billion spent on long-term care. I was not exactly sure if the questions about long-term care are going to be

answered during this estimate, given we don’t have the Minister of Long-Term Care, but when I looked at the estimates books, the long-term-care expenses are in there, so I figured that was all good.

And then a little bit about all of the capital expansions going on, some here again throughout the province—some questions about that.

**0940**

I don’t have the intention of using [*inaudible*] 30 minutes dealing with much more than that, just to say that I will use part of my first 30 minutes to go into those questions, but really to set the tone that the pandemic has put stress on our already stressed health care system like none of us has ever seen before. I have daily contact with health care workers who are telling me, “I have never worked this hard in my life, France. I’ve worked so hard in the last year,” and then it goes on to they are exhausted and they simply want hope. Add to this Bill 124, which limits nursing to a 1% wage increase, and it goes from, “I’m exhausted; I can’t take it anymore” to “I’m angry at the government,” and nothing good comes when health care workers get too angry at anyone.

I would say, talking about not-too-nice feelings, I heard the same angry feelings from families of residents in long-term care. The report from the Auditor General, the report from the commission and the testimony coming from the Armed Forces all lead people to anger, to saying, “How could this be that, in Ontario—like, people in Ontario are good people. They are people who care. How could it be that people died of thirst, died of malnutrition and died of basic, basic care that was not provided?”

As I say, I will be curious to see how we rebuild the confidence of the people in, certainly, long-term care, but it has an impact on all of the areas of care, whether we talk about health promotion, disease prevention, primary care, home and community care, palliative care, long-term care—the whole spectrum. People have to have trust, and trust is starting to be eroded in many parts of our health care system. What is the government’s plan to rebuild this and make sure that it’s there? You’ve heard me many times: Health care happens between two people. If the trust is gone, it is impossible to provide quality care. It has to be there. So this is my 10,000-foot level as to what we intend to go into.

Of course, both Judith and I are from northern Ontario, so you can expect to have the northern flavour often in some of our questions. I know that Judith has quite a few questions about the Northern Health Travel Grant. You will see my colleague Sol Mamakwa will be joining us this afternoon, again, focusing on some issues with providing health care to First Nations. The First Nations in his area are often fly-in, isolated First Nations, but First Nations people throughout the province. There will be a bit of a focus on this, given that both Judith and I represent people in northern Ontario, but there will be questions that relate from Ottawa to Windsor to Toronto and Hamilton and everything else in between.

Judith, did you want to do a little bit of a 10,000 feet of your questions, or do you want me to go start into my questions?

**Ms. Judith Monteith-Farrell:** France, you can go ahead. It will be generally on the state of the Northern Health Travel Grant Program and the issues that we're having here in northern Ontario.

**M<sup>me</sup> France Gélinas:** Okay. All right. In no particular order, I will start with something that is really problematic in my community right now. You will have heard that Laurentian University has cancelled their midwifery program. The midwifery program at Laurentian University was the only bilingual program in all of Canada. They take in about 12 to 15 francophone student midwives every year. They also had a tri-cultural mandate, a specific mandate to help train First Nations and Aboriginal midwives as well as English-speaking midwives. If you look in northern Ontario, almost 100% of the francophone midwives come from Laurentian University, the program that has been cancelled.

My first question has to do with midwives, and it has two parts to it. The first one is: I know that it is the Ministry of Health who funds the midwifery program in northern Ontario; right now the midwife students are being redirected to Ryerson in Toronto and to Hamilton. For many of them, that does not work. There are no French capabilities in any of those universities, and there's certainly no knowledge of what it means to be a midwife in a First Nations or Aboriginal community in those two universities either. So how is the Ministry of Health dealing with the fact that northern Ontario needs a school for midwives that will graduate midwives who can speak French, who come from First Nations and Aboriginal communities, and who know the north and want to come back to the north? That would be my first question.

*Interjection.*

**M<sup>me</sup> France Gélinas:** You're muted.

**The Chair (Mr. Peter Tabuns):** Minister, the floor is yours.

**Hon. Christine Elliott:** Thank you very much, Ms. Gélinas, for your outlook and your outline of the issues that you want to talk about from 10,000 feet, and now we're getting into the specifics. Certainly, we are quite aware of the importance of the midwifery program at Laurentian, and we are working closely with the Ministry of Colleges and Universities to make sure that these students can be redirected. We know how important it is for midwives who can speak French that can be supporting people in your community, and that there are some issues there; the transfer to Ryerson and McMaster is maybe not answering all of their needs. But we are looking to make sure that there is a transition and a transfer so that they can complete their courses, so that they can receive the qualifications that they need, and we're working through all of those issues to make sure that they will come back to the north to work.

I believe the deputy minister has some more specifics on that particular issue that she might wish to comment on at this time.

**Ms. Helen Angus:** Thank you. I'm Helen Angus. I'm the Deputy Minister of Health. Nice to see you again.

What I'm going to do frequently in the course of the day, since we're talking about set-up—there's a whole

team at the Ministry of Health who are responsible for a variety of different program areas, and so this would be an example where I would obviously provide some general awareness and direction, like the minister did, and then pass it along to, in this case, probably David Lamb, who is the director responsible for the program and who has been working actively to resolve the issue, in order to give you the best information and answer to your questions. I hope that meets with the committee's agreement, but there is a whole team on the phone and on video this morning. If David is available, he might want to talk a little bit in more detail about what kinds of accommodations and programs we're putting into place in order to deal with what is a very unfortunate situation related to Laurentian University.

**0950**

**M<sup>me</sup> France Gélinas:** Thank you, Deputy. Sure, I'd be happy to hear from David Lamb. I'm guessing somebody will make that happen?

**The Chair (Mr. Peter Tabuns):** Yes. Is there a problem unmuting him?

*Interjection.*

**The Chair (Mr. Peter Tabuns):** Okay. I gather that you should be able to be heard.

**Mr. Michael Hillmer:** Hi. It's Michael Hillmer here, Deputy Angus. I'll be fronting the health human resource question. David is not on the line.

**Ms. Helen Angus:** All right. Well, go ahead, Michael. Michael Hillmer is the ADM responsible for health human resources and capacity planning.

**Mr. Michael Hillmer:** Right. Thank you for those questions, MPP Gélinas. For the record, Michael Hillmer, assistant deputy minister of capacity planning and analytics.

Just to double-check, everybody can hear me okay?

**M<sup>me</sup> France Gélinas:** Yes. No problem.

**Mr. Michael Hillmer:** Okay. Wonderful.

As the minister and Deputy Angus have pointed out, midwives are an important part of the health care system. They deliver nearly 20% of all the babies in the province. Laurentian was one of the three universities to train the midwives. And as you mentioned, MPP Gélinas, the francophone training capability was a very important component of that training program.

The unfortunate proceedings at Laurentian have forced us to very quickly create a process where we can try to provide as seamless a training experience for the existing students as possible, knowing that nobody expected this to happen at Laurentian. I think we're now needing to work with our partners in the various educational institutions in the north and those who are able to provide francophone training to ensure that both knowledge of how to provide care in the north and the francophone training experience continue. This will take some time to discuss with all our partners, but in the meantime, our priority was to provide that continuous educational experience so their training was not disrupted, and these important providers could get into the system and start helping Ontarians deliver babies in that midwifery model of care.

I'll stop there. Thank you.

**M<sup>me</sup> France Gélinas:** Thank you, ADM Hillmer. We used to take 30 midwife students every year in northern Ontario, and they go through the four-year process. Do I take from what you've said that the money will continue to be there to fund training in the north once things settle?

**Mr. Michael Hillmer:** Well, I think that our long-term goal is to be able to have that northern component. At the moment, we're just going through the discussions and planning to figure out how to make that happen now that the Laurentian educational footprint for midwives is no longer an option. I think this came as a surprise to everybody, in terms of what happened at Laurentian more broadly; and for us in the health education provider field, it meant that we needed to do some very quick planning to ensure the continuous nature of the education.

But I would say that absolutely, we want to be able to look at the short term, not disrupt these students' experiences any more than has happened already; and then, longer term, how do we ensure that northern educational experience and francophone training continues on? But at this point, it's still early and at a discussion and planning phase.

**M<sup>me</sup> France Gélinas:** Are you able to tell me that basically, the dollars—I think it's \$10 million a year that the Ministry of Health invests in midwifery in northern Ontario—that this money is safe, that it will still be available to whatever form the midwifery program in the north—francophone, Aboriginal—takes in the future? Or is there a chance that this money would no longer be available from your ministry?

**Mr. Michael Hillmer:** We need to make sure that there are midwives who are trained in the north. We know that where you train is an extremely important determinant of where you set up your practice, and it is our plan to ensure that that money is available to continue on training midwives in the north.

**M<sup>me</sup> France Gélinas:** Okay, thank you. Still with midwives: Would you agree with me that the wait-list to be taken on as a midwife has grown? Certainly, in my part of the province but in most of Ontario, through the pandemic, a lot of women and families didn't want to go to the hospital. They wanted a home birth. A home birth usually means you need to get on with a midwife. Most of the midwifery practices turn away women every month, because they don't have enough capacity.

What is the government's plan to make sure that the midwifery practices that exist are able to take on new midwives so that they deal with basically the wait-list, the backlog? As well, are there any plans to open up new midwifery practices in communities that still don't have them but would love to have them?

**Mr. Michael Hillmer:** Thank you for that question, MPP Gélinas. We work closely with the Ministry of Colleges and Universities with workforce planning to be able to determine factors like the number of seats and how the training curriculum and then the transition to practice happen. We're very much committed to workforce planning, and as you say, midwives are a key part of that. Every year, new midwives graduate and join existing

practices, and I think we're always looking at new gaps that might emerge, as you've mentioned. And when they arise, we go through our planning process to understand what communities might need midwife practices or which practices might need additional midwives to meet the demand. This is an ongoing and ever-constant process for us in collaboration with the Ministry of Colleges and Universities.

**M<sup>me</sup> France Gélinas:** Besides the training, they also need to be paid once they join the practice, and I tried really hard to go to the estimates book to see if there's money in this year's budget to pay for expanded practices and open up new midwife practices so that we can better serve the need.

**Mr. Michael Hillmer:** That's a great question. I would say that, in general, we want to make sure Ontarians have a range of options and locations and providers to be able to have their birthing services.

In terms of the funding question specifically, I might ask my colleague Patrick Dicerni, who has responsibility for some of those funding lines, to be able to comment on that. I might ask, MPP Gélinas, if you have other questions related to midwives in the supply and educational realm, you can continue to ask me since we're talking, and if not, I might pass it to my colleague.

**M<sup>me</sup> France Gélinas:** No, my next series of questions all have to do with money.

**Mr. Michael Hillmer:** Okay. Oh, maybe back to the deputy; I apologize.

**The Chair (Mr. Peter Tabuns):** Yes, the deputy has indicated that she wants to speak to this. Deputy, please proceed.

**Ms. Helen Angus:** Thank you. I guess I'm learning how this works. I'll put my hand up occasionally if I want to jump in.

My notes here from the estimates suggest that our 2020 interim actuals were just over \$190 million, and our estimates for midwifery are \$203.52 million, which is about a 10% increase, which actually is reflective of the fact that there are about 90 new midwife graduates each year. That's on a base of, I think, 900 or almost a thousand registered midwives, but about 830 midwives in practice, so it is a program that is growing at about 10% per year, both in terms of numbers of people as well as, it looks like, in the budget.

**1000**

For more details, I'm happy to have Patrick answer any questions, but I think that might help give you a sense that there is regular program growth in midwifery.

**M<sup>me</sup> France Gélinas:** Okay, so this almost \$13 million more is not going to go for the pay equity that they won through the court?

**Ms. Helen Angus:** I can talk to the pay equity. I think we have modest compensation increases. We have received a signed court order confirming the timetable. That was on March 9, so that would have been probably after the numbers were locked in the budget. For implementing the Human Rights Tribunal orders and appointing a third-party administrator to carry out the work with the

retroactive compensation and the calculations and everything else, I believe we're still in process, and we are working to get that work done.

**M<sup>me</sup> France Gélinas:** So what happened on March 9?

**Ms. Helen Angus:** March 9 would have been the date that we would have received the signed court order confirming the timetable for implementing the Human Rights Tribunal of Ontario's orders.

**M<sup>me</sup> France Gélinas:** Okay. So you will be implementing the court order? You're not going to continue with the court proceedings to challenge the court decision?

**The Chair (Mr. Peter Tabuns):** You have two minutes left.

**M<sup>me</sup> France Gélinas:** Really? How fast.

Sorry. Please continue.

**Ms. Helen Angus:** We are continuing—there is a third-party administrator who has been appointed to carry out the work around doing the compensation adjustment. So we are proceeding to work through the issues of the court order with a third party to assist us.

**M<sup>me</sup> France Gélinas:** Coming back to the \$13-million increase in the budget for midwifery, this will have a slight compensation increase for all of the practising midwives, as well as a component of this to create employment for the 90 graduating midwives? Am I reading that right?

**Ms. Helen Angus:** I might want to just check with Patrick, but that's my understanding.

**M<sup>me</sup> France Gélinas:** ADM Dicerni, are you online?

**Mr. Patrick Dicerni:** I am, Madame Gélinas. Thank you very much. I'm Patrick Dicerni. I'm the assistant deputy minister in our OHIP division and our drugs and devices division at the Ministry of Health.

Thanks to the deputy for the accurate and good lead-in. By my rough math, that's about a 16% increase, the \$190 million to the \$203.5 million in the estimates, and you are correct, Madame Gélinas: The increase does take into account the three-year negotiated agreement that was reached with the midwives in Ontario, and that does equate to a 1% compensation increase over and above the HRTO settlement that the deputy touched on.

**M<sup>me</sup> France Gélinas:** So the \$13 million will cover the HRTO, the 1% increase and the 90 new midwives?

**Mr. Patrick Dicerni:** Correct. The only thing I would like to—

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

It's now back to the minister. She has 30 minutes. Minister?

**Hon. Christine Elliott:** Thank you, Chair. In my opening remarks, I spoke about the important actions the government has taken in response to the COVID-19 outbreak in our province. The COVID-19 pandemic has reinforced the importance of the Ministry of Health's work to transform the public health care system and has highlighted the benefits of a better-integrated and connected system. Health transformation initiatives have helped support the health system in responding to COVID-19.

The government remains committed to our overall goal of building a modern, sustainable and integrated health

care system that is focused on the needs of patients and that will end hallway health care. We are continuing to work and inform the health care system in order to improve the patient experience and strengthen local services. The government has a comprehensive plan to end hallway health care and make a patient-centred health care system. The ministry has continued to focus on making investments and advancing new initiatives across four key pillars to support this objective.

The first pillar is prevention and health promotion. The focus is on keeping patients as healthy as possible in their communities and out of hospital.

The second pillar is providing the right care in the right place. When patients need care, we need to ensure that they receive it in the most appropriate setting, which is not always in a hospital.

The third pillar is about integration and improving patient flow. By better integrating care providers, we can ensure patients spend less time waiting in hospitals when they are ready to be discharged. Ontario Health and Ontario health teams are playing critical roles in this integration, connecting care providers and providing health system oversight, all of which will help contribute to ending hallway health care.

The fourth pillar is about building capacity in the province's health care system by investing in new hospitals and long-term-care beds while increasing community-based services across Ontario.

The government strongly believes in a publicly funded health care system and is committed to strengthening public health care so that it works for all the people of Ontario.

This is a plan that is vitally important to the future of our health care system, and I would like to highlight some of the key developments that have occurred over the past year.

First, our province has world-class health care services provided by some of the best health care workers. However, over time, the province's health system has become fractured and disconnected. Many challenges that have faced our health system arise from dissimilar ways in which different health services are planned, managed and delivered at the local, regional and provincial levels, with, for example, siloed local care delivery, fragmented oversight and duplicative administration.

In many jurisdictions, governments face similar challenges. In response, many have introduced new models for funding and oversight of health care delivery. The new health care models share some similar features. Organizations share financial and clinical accountability for quality of care, experience and total cost of care for the patients. Their services are integrated and are focused on and driven by primary and community care. They use a flexible approach that allows for innovation.

In Ontario, the integrated model of care that was created is Ontario health teams. At their mature state, an Ontario health team will improve performance across a range of outcomes, including better patient and population health outcomes; better patient, family and caregiver experience;

better provider experience; and better value. Ontario health teams will measure and publicly report against the standardized performance framework and will also be funded by a single budget tied to this network and framework. They will share savings back to the health care system and reinvest among partners in the model to drive further improvements in patient care. Ontario health teams will provide a coordinated continuum of care for a defined population and function through a single point of accountability.

Through an Ontario health team, patients will experience easier transitions from one provider to another, including, for example, between hospitals, home care providers or long-term-care homes, with one patient story, one patient record and one care plan. As Ontario health teams mature, patients and families will also have access to 24/7 navigation and care coordination services. Ontario health teams will help maintain hospital capacity by coordinating programs that link hospitals, primary care, home and community care services, long-term-care homes, congregate settings and other services, as well as supporting virtual care, online appointment booking and patients' digital access to their own health information. Patients, families and caregivers will also be a key part of Ontario health team planning and decision-making.

#### 1010

In 2020-21, 18 additional Ontario health teams were established, which means there is now a total of 42 teams across the province. At maturity, these 42 Ontario health teams will cover over 86% of the province's population. Under an Ontario health team, Ontarians can continue to contact their existing health care providers, as they always have, to access the health care that they need. Patients who are supported by providers who are participating in a new Ontario health team would not need to sign up or undertake any administrative processes. Over time, patients served by an Ontario health team will experience greater access to care and support from a broader network of other physicians and interprofessional providers working together as a team to help support the patient's care.

The Ontario government will continue working with its health care partners until Ontario health teams are fully established across the province and everyone is supported by a team. Ontario health teams continue to be supported by the ministry through an expanding central program of resources and expertise.

The strong partnerships and integrated care established by Ontario health teams, as well as by Ontario Health, have helped better position the province to respond quickly and effectively to COVID-19. This included supporting long-term-care homes, simplifying the purchase of personal protective equipment, helping establish assessment centres, launching virtual urgent care initiatives and expanding remote patient monitoring programs to support COVID-19 patients and other vulnerable populations.

The Ontario health team model has already proven how a collaborative team can support each other in times of need, such as when there's a significant outbreak at a long-term-care home. Ontario health team partners were able to

come together and quickly respond to addressing staffing shortages, implement infection prevention and control measures, and support keeping residents and staff safe during COVID-19.

In another example, in Toronto, Ontario health teams are the backbone of mobile and pop-up vaccination efforts, reaching the hardest-hit, most vulnerable populations, including homebound seniors and high-priority communities. Ontario health team-led mobile and pop-up clinics are administering thousands of doses a day and are among some of the highest-volume clinics in the city. Already, these stronger partnerships between hospitals, primary care, home and community care and long-term-care homes are helping to create a better-connected health care system focused on the needs of patients and supporting our brave front-line care workers.

The province continues to work closely with the Ontario health teams to identify and leverage key learnings of COVID-19 to support our health care system's ability to deliver care that is centred truly on the needs of patients.

Ontario Health is the single agency the government has created to provide a central point of accountability and oversight of the health care system. The agency has brought together the expertise of over 20 existing and former health organizations and programs, creating an integrated public health care system, improving clinical guidance and support for health care service providers and, most importantly, enabling better quality of care for patients.

In 2020-21, the government announced the transfer of the Trillium Gift of Life Network and the health system planning and funding for non-patient-care functions from the local health integration networks to Ontario Health. This builds on the previous transfers of Cancer Care Ontario, Health Quality Ontario, eHealth Ontario, Health Shared Services Ontario and the HealthForceOntario Marketing and Recruitment Agency that took place in 2019.

**The Chair (Mr. Peter Tabuns):** Minister, I'm sorry to say that we're out of time for this morning. We will recess, and we will return at 3:30 this afternoon.

Thank you all for your participation.

*The committee recessed from 1015 to 1530.*

**The Chair (Mr. Peter Tabuns):** Good afternoon, everyone. We're back in session. We're going to resume consideration of vote 1401 for the estimates of the Ministry of Health. There is now a total of 13 hours and 48 minutes remaining for the review of these estimates. When the committee recessed this morning, the ministry had 18 minutes and 20 seconds remaining.

But before we go to the ministry, we have two more MPPs who have joined us, and I'd like them to confirm their identities and their locations. MPP Skelly?

**Ms. Donna Skelly:** Good afternoon, Mr. Chair. It is lovely to see you.

**The Chair (Mr. Peter Tabuns):** Likewise.

**Ms. Donna Skelly:** It is MPP Skelly, and I am at Queen's Park.

**The Chair (Mr. Peter Tabuns):** Thank you so much. MPP McDonnell?

**Mr. Jim McDonell:** Hi. It's Jim McDonell. I'm calling in from Williamstown, Ontario.

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

And I see MPP Mamakwa has joined us. If you could confirm your identity and location, please.

**Mr. Sol Mamakwa:** Hi. Good afternoon, Chair. Good afternoon, everyone. I'm Sol Mamakwa. I'm in Queen's Park.

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

We have no others? All right. And do we have the minister? We are summoning up the minister electronically. Committee, please bear with us. We are trying to contact the minister to have her come in. Thank you.

While we're waiting for the minister to appear, I see we are joined by MPP Pettapiece. MPP Pettapiece, if you could identify yourself and tell us where you're located.

MPP Pettapiece? It's still connecting. Okay. Ah, and I can see the minister, and a hand.

MPP Pettapiece, good afternoon. If you could identify yourself and tell us where you are.

**Mr. Randy Pettapiece:** Yes, sorry, Chair. I was having some issues. Anyways, it's Randy Pettapiece. I'm in Ontario.

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

Minister, welcome back. You have 18 minutes and 20 seconds remaining before we go to the next round, and the floor is yours.

**Hon. Christine Elliott:** Thank you very much, Chair. Prior to the break I was speaking about Ontario Health, so I'll just carry on from where I left off.

Ontario Health is a critical part of our effort to better coordinate and connect our health care system from top to bottom, make the system more efficient and improve the delivery of patient-centred care. The government has worked with Ontario Health to develop careful transition plans to transfer provincial agencies and organizations into Ontario Health, to ensure that there are no impacts to patient care.

Since its creation, Ontario Health has demonstrated its effectiveness. Throughout the COVID-19 pandemic, Ontario Health and its regional leadership have been essential partners in the planning, development and implementation of actions to increase health system capacity, allocate critical supplies and equipment and respond to outbreaks in long-term-care and retirement homes. The creation of Ontario Health and the bringing together of the various agencies, and working together with the 14 LHINs through five regional leads, has significantly enhanced the health system's ability to quickly and effectively respond as the COVID-19 outbreak evolved in Ontario.

Ontario Health has played a key role in Ontario's COVID-19 testing strategy and in rapidly increasing Ontario's laboratory and testing capacity. It has played a critical role in Ontario's pandemic supply chain, supporting the pandemic stockpiles and allocating critical supplies to health service providers in need.

The agency has helped with pandemic organization and planning through participation on the province's command table. The Mental Health and Addictions COVID-

19 Response Table is chaired by the Mental Health and Addictions Centre of Excellence at Ontario Health. Members of this response table represent organizations from across the mental health and addictions sector and are focused on ensuring that available supports are maintained during the COVID-19 pandemic, and any issues impacting the province's mental health and addictions system are quickly resolved.

The value of Ontario Health to our health care system has been demonstrated throughout the COVID-19 outbreak. It has helped strengthen public health so that it works for the people of Ontario.

Moving on now to home and community care: Ontario's health care system does a number of things really well. However, there are opportunities to improve the system and how it is structured to enable the types of connected care that better meet the needs of patients and families. It is increasingly evident, particularly throughout the COVID-19 pandemic, how important it is for health care providers, including hospitals, home and community care, and primary care, to work together as one coordinated team to provide this connected care for patients.

Over the last year, the work of home and community care workers has been critical. They have helped to reduce the burdens on our hospitals and hallway health care, and helped to ensure that patients continue to get the care they need in the community or in their own homes. The ministry has supported their efforts by providing more than \$115 million to support service needs during COVID-19 in the home and community care sector. This has supported more than 2,000 patients across the province with high, complex care needs to access services at home or transition back from a hospital to their home and community setting, which has added hospital capacity to the system. As the province continues to move forward with transforming health care to be more collaborative and patient-focused, home and community care will be a vital part of an integrated health care system and not a stand-alone service.

As I mentioned, some transition has taken place regarding the LHINs and Ontario Health. The LHIN corporations are being maintained to function as interim home care delivery organizations pending the eventual assumption of home and community health delivery functions by Ontario health teams. The LHINs now go by the name of Home and Community Care Support Services. Patients and caregivers can continue to access the home and community care and long-term-care-home placement services they need in the same way as was done prior to this transition, while work continues to create new ways to enhance the patient and provider experience.

The Connecting People to Home and Community Care Act, which was passed in the last year, lays the groundwork for integrating home and community care into Ontario health teams. This is a long-term transition process that will happen over the coming years. It is an important step in breaking down long-standing barriers that have separated home care from primary care. With a growing and aging population, creating a better-integrated approach to home and community care will support our goal

to end hallway health care and support more patient-centred care in both the home and community.

Moving now to mental health: Over the past year, the government also strengthened our health care system by making critical investments in mental health and addiction services. Mental health and addictions is a key priority for the government. Mental health and addictions is clearly one of the most serious health issues in our province. More than one million Ontarians experience a mental health or addictions challenge each year, which can have a significant impact on a person's quality of life, including their ability to go to school or make a living.

Ontarians have faced unprecedented challenges during the COVID-19 pandemic, and this has also had an impact on mental health. The government quickly responded to these impacts, investing an additional \$194 million in 2020-21 to immediately expand access to provincial mental health and addictions services. This investment included adding more staff; virtual supports; supports specifically for Ontario's front-line workers; housing, with embedded mental health and addictions support and short-term accommodation; and other supports to continue providing safe in-person services where appropriate. To date, more than 71,000 Ontarians have accessed provincial virtual mental health supports alone.

#### 1540

In addition to Ontario's commitment to expand access for critical mental health and addictions supports during COVID-19, the government invested \$176 million in base funding in 2020-21 to help address urgent gaps in care, enhance access to mental health and addictions services, create new supports, and expand programs in several priority areas. This included investing in: community-based services, including for children and youth; mental health and justice services; supportive housing; community addictions treatment and care; increased culturally safe supports for Indigenous peoples, families and communities; and more hospital in-patient beds for mental health and addictions patients.

This funding supports the implementation of Roadmap to Wellness, the government's plan to build a connected, comprehensive mental health and addictions system that works for all Ontarians, which was launched in March 2020, just before the COVID-19 pandemic began. To develop this plan, the government undertook extensive engagement with experts, grassroots organizations, health care providers on the front lines and first responders, as well as people with lived experience, families and caregivers. We listened and heard about the key challenges facing Ontario's mental health and addictions system: Wait times were too long, people did not know where to get help, and patients found it hard to understand and navigate the system. We heard about how our world-class service providers were inhibited by inadequate system-level coordination and that there is a need for better data to support effective accountability and oversight.

In my own experience of listening to families over the past two decades, these have been long-standing concerns despite the best efforts of dedicated professionals working

on the front lines of care. Volunteering on the board of directors at Durham Mental Health Services, I saw first-hand the gaps in care that forced patients to languish on wait-lists.

When I co-chaired an all-party Select Committee on Mental Health and Addictions in 2009, we listened to testimony from over 230 people and received more than 300 submissions. This, of course, included MPP Gélinas as well. This led to 23 recommendations, including the creation of a central engine to design, manage and co-ordinate the system.

Later, as the province's first Patient Ombudsman, Ontarians shared with me their experience of feeling lost in a system defined by its complexity. Thinking that there was nowhere else could go, they turned to overcrowded hospital emergency departments for help only after reaching a crisis point.

Indeed, while they span decades, each of these experiences and the stories shared along the way make clear that Ontarians' struggles with our mental health and addictions system still exist.

With Roadmap to Wellness, Ontario has an action-oriented plan that is built on four pillars: enhancing the quality of services, expanding services and making strategic investments to reduce wait times in priority service areas, implementing innovative solutions to fill gaps in care, and improving access to services by making navigating the system easier for patients and family.

Underpinning these pillars is the new Mental Health and Addictions Centre of Excellence within Ontario Health. The centre of excellence will serve as the foundation on which Roadmap to Wellness is built and will be responsible for its successful implementation. It will establish a single point of accountability and oversight while also doing the hard work of standardizing and monitoring the quality and delivery of evidence-based services. It will, for the first time in Ontario's history, drive the broad and systemic transformation we need to see in order to fully understand these gaps in care and, in turn, finally develop a comprehensive and connected system of high-quality services.

To do so, the centre will work with people with lived experience, service providers, clinicians and researchers to finally formalize a core services framework, defining the core services that will, over time, be made available to all Ontarians.

Leveraging the great work done on child and youth mental health core services, which was supported by the child and youth mental health sector, Ontario's new core services framework will guide future funding decisions rooted in evidence for years to come. The result will be that in the future, every Ontarian, regardless of where they live, will have access to high-quality mental health and addiction services. As the centre of excellence does its work, it will also provide support and services to Ontario health teams as they better connect patients to the different types of care that they need. While critically important, this work will take some time.

As I have mentioned, the government is continuing to move forward with making key investments to expand



existing services while also filling urgent gaps in care. One way the government is addressing an urgent need is through Ontario's new structured psychotherapy program, which provides access to evidence-based publicly funded treatment offerings, such as cognitive behavioural therapy. This program uses a stepped care model for people living with depression, anxiety and anxiety-related conditions, the most common mental health issues to impact Ontarians. This new program is being implemented by the centre of excellence within Ontario Health and is currently offered through four regions: the Centre for Addiction and Mental Health, Royal Ottawa Mental Health Centre, Ontario Shores Centre for Mental Health Sciences and Waypoint Centre for Mental Health Care, with the launch of six new networks being recently announced. The ministry is working closely with our partners at the centre of excellence to provide access across the province and to tailor support to access points for populations that may face barriers to mental health and addiction supports.

Hospitals, the next topic: Another fundamental priority in the government's plan to modernize the health care system is to invest in an efficient, stable and modern hospital system that provides all Ontarians with timely access to high-quality care. Ontario continues to make necessary investments in our hospitals and build critical system capacity. This government has committed to invest approximately \$20 billion over the next 10 years in health care infrastructure projects, targeting communities with high-growth needs based on robust data on where the demand for new services will occur.

Over the past year, there were a number of key results in the hospital sector: The new Groves Memorial Community Hospital opened its doors in Fergus; the ministry invested in the redevelopment of a culturally appropriate health campus for the Weeneebayko Area Health Authority that will include a new hospital and a lodge providing long-term-care services for local elders in Moosonee.

Ontario also supported the redevelopment of the Lake-ridge Health hospital site in Bowmanville, the planning and design of the new Quinte Health Care Prince Edward County Memorial Hospital in Picton, and the construction of the new Grey Bruce Health Services Markdale hospital. These new facilities will feature numerous modern and upgraded facilities and support the government's efforts to provide equitable access to high-quality services and end hallway health care.

To further support Ontario hospitals and their efforts to meet the demands of care and reduce hallway health care, the government has also invested in developing five new reactivation care centres in Hamilton, Kingston, Newmarket, Sudbury and Toronto. These centres will provide up to 234 hospital-based transitional beds for patients who no longer need acute care services but may be living with dementia or are in need of personal supports and other restorative care while they are waiting for an alternate care facility such as a long-term-care home.

**The Chair (Mr. Peter Tabuns):** You have two minutes left.

**Hon. Christine Elliott:** Thank you.

One hundred and twenty-nine hospitals across the province were also provided additional funding through the Health Infrastructure Renewal Fund to address critical upgrades, repairs and maintenance to their facilities.

The ministry also invested in a new emergency department ambulance off-load facility at the Ottawa Civic Hospital and provided funding support for dedicated off-load nurses to receive ambulance patients at hospitals across the province.

**1550**

In closing, I would like to acknowledge that it is an honour to serve the people of Ontario as the Minister of Health. This is an important responsibility that I do take very, very seriously. These investments and decisions the government has made over the last year regarding Ontario's health system have been made first and foremost to protect the health and well-being of all Ontarians. They're also contributing to building a more connected, integrated and sustainable health system for the people of Ontario, a health system that is centred on the needs of its patients.

I would like to close again by expressing my deepest gratitude for our front-line health care providers for their courage and commitment throughout the pandemic, and to the people of Ontario for their resiliency and support for one another during this unprecedented time.

Thank you, Chair, and I look forward to the rest of our discussion this afternoon.

**The Chair (Mr. Peter Tabuns):** Thank you very much, Minister. We now go to the official opposition. They have 20 minutes. When they are done their 20 minutes, we'll go back to the government. Who will be speaking? MPP Mamakwa, the floor is yours.

**Mr. Sol Mamakwa:** Meegwetch, Chair, and also kitchi meegwetch to Minister Elliott on the presentation. Thank you for inviting me to this committee, France. I'm not part of this committee, but certainly, I think you talked about a number of things—Ontario Health, home and community care, mental health and hospitals—for this portion, anyway, that I heard.

As you know, Minister, there's a lot of jurisdictional ambiguity that exists when we talk about First Nations on-reserve. I know one of the examples is when a person flies up into, say, Sioux Lookout, which is our main hub in northwestern Ontario, where it services 30 First Nations. An example is if somebody needed IV antibiotics. We don't have home and community care in the community, in the fly-in communities, so what happens is that if they have to be on antibiotics for six weeks, they have to come out and live in a hostel and be there for six weeks, away from their families. That's the reality of it.

I think it's imperative that we start looking at bringing services closer to home. It's so important. That's why we requested, as First Nations, to start looking at a health care system where we bring services closer to home, whereby that could mean transforming the health care system, using the provincial and the federal dollars together, to create our own system.

But one of the things I want to bring up is, I want to bring to your attention the stability of surgical services in

the northwest, in northwestern Ontario. That includes the riding of Kenora and also Kiiwetinoong. We have small towns there, small municipalities that provide surgical services. I think there's a team of 10 that provide those surgical services in that big riding—by “big riding,” I mean geographically: Kenora, Red Lake, Dryden, Sioux Lookout. It's so important that we have that.

One of the things that's been happening is the contract that's with all the surgeons that provide that service is outdated. The terms have not been examined since 2004. It's so difficult to keep these surgeons in that area to provide that service, and it's costing a lot of resources to bring in locums to provide those surgical services.

I know there's this group called the Northwestern Ontario Regional Surgical Network, which is the 10 hospitals, the 10 municipalities and the 10 surgeons that work together to try to address that. I'm wondering if you can speak about what work has been done. I know they have written letters to your office numerous times over the last number of years. I'm wondering if there's anything that we can do to bring surgical services closer to home for people. Can you speak about that a bit?

**The Chair (Mr. Peter Tabuns):** Minister.

**Hon. Christine Elliott:** Certainly, yes. Thank you very much, MPP Mamakwa. You're raising some very, very important issues.

I know that with the services being provided by both the federal and provincial governments there are often situations where things can fall between the cracks, and that is not serving Indigenous peoples, First Nations peoples, Métis and Inuit.

First, I'd like to share with you our commitment to working with First Nations, Inuit and Métis people to develop health care solutions that meet your communities' needs. That means working directly with you and also with the federal government. I'm just checking the date: It was just in March I did sign a letter committing to work as partners in a trilateral process with First Nations, with the federal government and the provincial government to work on solutions that are going to make sense for your communities.

I will ask the deputy minister to speak more directly on the northwest regional surgical network, but I would like to also just comment on a few of the things that we have worked on together recently that have been very successful. One would be Operation Remote Immunity, which was worked on by Ornge and with First Nations leaders in order to bring the first dose of vaccines to 31 fly-in communities as well as Moosonee. Because of the support of many leaders in the First Nations community, that was a very, very successful effort, and I think it shows how well things can be done if the planning is done in advance and we all work together.

I know we've also worked with some leaders—I'm going to just refer to some specific information. Mental health and addictions investments have also been done recently. There was an investment of \$12.8 million on March 4 of this year to immediately expand and enhance culturally appropriate mental health and addictions services for Indigenous peoples, families and communities

across the province. This funding is part of the \$176 million in annual funding that's being invested through the government's mental health and addictions plan, Roadmap to Wellness. There have been additional investments for mental health and addictions, and we look forward to continuing to work with First Nations leaders to enhance these supports across the province and especially across the north, because we know that's an area where we are lacking in supports and services.

With respect to First Nations health transformation, in February 2019 I wrote to First Nations leaders to share our health transformation plans and to confirm that we wanted to continue to work with First Nations communities through dedicated trilateral processes. I have had several meetings with Nishnawbe Aski Nation to reaffirm our commitment to the Charter of Relationship Principles with NAN and the federal government, and our commitment to supporting First Nations-led health transformation initiatives. That is something that is going to be ongoing. We understand that what works in the south is not going to work in the north and probably won't work in many Indigenous communities, because there are other principles that need to be applied that are culturally appropriate. We are committed to continuing to work together.

As far as the aspect of surgical supports is concerned, I will turn it over to the deputy minister to provide you with the information that you've asked for.

**Ms. Helen Angus:** Thank you for your question.

I'm going to ask Patrick Dicerni, who you'll probably hear a lot from at this committee because he has both the drug file and the OHIP file. He's the general manager of OHIP, and I know he's familiar with the situation of the surgeons coming up to northwestern Ontario.

Patrick?

**Mr. Patrick Dicerni:** Thank you very much, Deputy.

Thank you for the question, MPP Mamakwa. It's nice to see you again.

**Mr. Sol Mamakwa:** It's good to see you.

**Mr. Patrick Dicerni:** Dr. Touzin, who I think you would know to be the chair of the regional surgical network up in the northwest, has been in correspondence with—

**The Chair (Mr. Peter Tabuns):** Mr. Dicerni, could you just restate your name and title for Hansard? Thank you.

**Mr. Patrick Dicerni:** My apologies, MPP Tabuns. I'm Patrick Dicerni, I'm the assistant deputy minister in the OHIP division and the drugs and devices division at the Ministry of Health.

**The Chair (Mr. Peter Tabuns):** Thank you. Sorry to have interrupted. Please go on.

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**Mr. Patrick Dicerni:** As I was saying, Dr. Touzin, who is the chair of the regional surgical network, has been in touch with my office and, as I understand, spoke with our team as recently as yesterday. I want to acknowledge the challenging situation of retaining and identifying surgeons to provide those necessary services in the northwestern area of the province—your point around locums.

We are in active discussion with the Ontario Medical Association on this matter and recognize the Ontario Medical Association as the bargaining partner for the government, as it relates to physician services and physician compensation. But the matter of what I understand to be one, if not two, surgeons—more in fact—recently suggesting maybe tendering their resignations is something that the ministry is seized with, and I assure you we are working with the appropriate bargaining partner in this respect.

**Mr. Sol Mamakwa:** Okay. Thank you, Patrick. Thank you for those answers.

Also, one of the things that's happening during this pandemic too is—when we talk about health services and fly-in communities, one of the things that happens is—there's 12 programs that federal nurses provide. When we talk about well-being clinics, well woman clinics, well child clinics, one of those programs is public health. Public health is the last thing they do. There's no public health system within the north because they work on emergent and primary care.

I want to go back to Sioux Lookout First Nations Health Authority. When this pandemic hit last year, there was no system in place. I think back in early April, I know that Sioux Lookout First Nations Health Authority, which organized themselves to be—what's the word—their own public health system, which kind of approaches to community well-being, which means they would have—and it's all part of the two jurisdictions, the Northwestern Health Unit and the Thunder Bay District Health Unit within their jurisdiction.

One of the things they asked about was, they wanted their own system to be their own public health position, to have the same powers as provided within the HPPA. That goes back to the same question resulting in—when we talk about health transformation, it's about jurisdiction.

There are three things that happen when we talk about health transformation. It's about bringing back the authority. It's about bringing back the accountability, responsibility and resource allocation. Those three things are very important when we do that, when we talk about health transformation—not just good words, but actual resources into the system.

So, what dialogue is happening when we talk about Sioux Lookout First Nations Health Authority having their own medical officer of health, having their own designate?

**Hon. Christine Elliott:** Thank you again for this question, MPP Mamakwa. First, I would say that we understand. We've very clearly seen throughout this pandemic how important public health is across Ontario generally and the huge role that our public health units have played during this time.

I think maybe some of the issues that you were speaking about earlier relate to the trilateral nature of the discussion that we need to have. I understand that there are some situations where the federal government provides certain supports, the provincial government provide certain supports, but they don't always integrate together very well. So that is where it's very key that we all sit down

together, have those trilateral discussions and understand what the services are that the First Nations communities want.

I know that you have very experienced health professionals there who can very clearly advocate for services, some of which may be similar to what is in southern Ontario, some of which are very different for culture reasons and other reasons, maybe related even to geography, sometimes, because they're fly-in communities. But I think we need to continue to work at that together, to try and integrate the system that is going to meet Indigenous people's health needs, and that we also need to look at what First Nations health transformation looks like, because we've started in that process. It isn't just a discussion. It's meant to be: What is needed? And how do we get there? We are firmly committed to continuing to engage in that process, because we know that the health system that we have now is not meeting all of the needs of First Nations peoples and that we need to do better.

I'll turn it over to the deputy minister in just a moment, but I think we're closer now to getting to an understanding, because I think we all recognize that transformation is needed across our entire health care system, and so it's no surprise that we need First Nations health transformation as well. We are committed to working towards that with First Nations leaders.

With that, I will turn it over to the deputy minister for some further comments.

**Ms. Helen Angus:** I think that's exactly right, that the role of public health is part of the larger conversation—

**The Chair (Mr. Peter Tabuns):** Deputy Minister, would you introduce yourself again, please?

**Ms. Helen Angus:** Of course. It's Helen Angus. I'm the Deputy Minister of Health.

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

**Ms. Helen Angus:** My pleasure.

I think it's a broad mandate to look at the organization and governance of health services in the north, and the minister has talked about the process we've engaged in. In the meantime, we continue to provide funding to Indigenous-governed public health programs like SLFNHA and WAHA, the Sioux Lookout First Nations Health Authority and the Weeneebayko Area Health Authority in the James Bay and Hudson Bay community. Certainly, those programs, I think, have been incredibly successful in allowing public health data to be gathered and analyzed for the Sioux Lookout First Nations Health Authority and the WAHA First Nations community.

I do know there is an associate medical officer of health position dedicated to Indigenous communities in the Thunder Bay area, but the larger discussion of governance will happen within the context of health transformation.

I know Dr. Williams has had to step away briefly from the estimates; he will be back shortly. In the meantime, I don't know whether Liz Walker, who may have joined the meeting from the Office of the Chief Medical Officer of Health, may want to add a little bit more detail. I don't know that she's on. We can get you more information.

**Ms. Liz Walker:** Hello. Thank you—

**Ms. Helen Angus:** Oh, there she is.

**Ms. Liz Walker:** I'm here.

**Ms. Helen Angus:** You need to introduce yourself. There she is. Hi, Liz.

**Ms. Liz Walker:** I will. Hi. Thank you, Deputy. My name is Liz Walker. I'm the director of accountability and liaison in the Office of the Chief Medical Officer of Health here in the ministry.

Good afternoon, MPP Mamakwa. Thank you so much for your question. Yes, we have been working very closely with our partner communities, with Indigenous affairs Ontario and with the federal government over the last number of months, with respect to supporting communities in their response to the pandemic.

There's a number of tables that we join at a senior leadership level with your political leadership and technical leadership in the First Nations communities and organizations, including the Sioux Lookout First Nations Health Authority. The collaboration between the northern health units and SLFNHA, the communities, the tribal councils and the federal government has been quite significant over the last few months. It's been wonderful to see that.

We also recognize, as the deputy and the minister have said, that there is work left to do, certainly in relation to the jurisdictional aspect of public health in the communities and streamlining that access.

**The Chair (Mr. Peter Tabuns):** You have two minutes left.

**Ms. Liz Walker:** Thank you.

One of the things that we were working on fairly recently has been the additional funding that was provided to a number of the tribal councils, Nishnawbe Aski and Sioux Lookout First Nations Health Authority, for additional public health nursing positions in the communities themselves, as well as in the organizations that were there to help support the administration of rapid COVID-19 testing within the communities, and in the instruments and platforms that were provided to be able to do diagnostics more locally in the communities, support case and contact management, and school supports. Over \$9 million was committed through last fiscal and this to support that.

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So we look forward to continuing to work with partners around blending those services and those supports—as the minister referenced earlier, those supports on the ground with respect to the administration of vaccines through Operation Remote Immunity initially and through the partnership between the health units known as SLFNHA and WAHA.

There is an additional \$50 million that the government has committed across all First Nation communities in the province and our urban Indigenous partners to support the administration of the vaccine rollout in a way that is culturally safe and culturally appropriate for the communities.

We certainly look forward to working in more of those partnerships over the next little while.

**Mr. Sol Mamakwa:** How much time have I got, Chair?

**The Chair (Mr. Peter Tabuns):** You have 10 seconds, MPP Mamakwa.

**Mr. Sol Mamakwa:** Maybe just a statement—maybe put resources and the health transformation dollars to start that process of health transformation within NAN territory. Meegwetch.

**The Chair (Mr. Peter Tabuns):** We now go to the government. MPP Parsa.

**Mr. Michael Parsa:** Before I get to my question, Chair, I just want to thank Minister Elliott, Deputy Minister Angus and everyone at the Ministry of Health, who I know have been working non-stop these last 14 months or so. On behalf of my constituents of Aurora–Oak Ridges–Richmond Hill, I want to thank you. We honestly couldn't be more grateful.

Minister, our government's rollout of the vaccines to Ontarians across the province has been a massive undertaking. And now that we see a more stable supply of vaccines coming into Ontario from the federal government, we've seen even greater success, with over six million vaccine doses administered. As you know, vaccines are an important tool to help to stop the spread of the virus, to build immunity in Ontario, and to allow us to safely resume normal life. It's that light at the end of the tunnel, Minister, that just keeps getting brighter and brighter as we vaccinate more people.

On Sunday, Minister, my wife, Valerie, and I were actually among the tens of thousands of Ontarians who received their first dose of vaccine. I have to tell you, it was so nice to see the joy on everyone's faces, the smiles from ear to ear. I know they were wearing a mask, but trust me, they were smiling ear to ear.

I was wondering if you could tell us a little bit about the province's COVID-19 vaccination plan and provide an update on the rollout.

**Hon. Christine Elliott:** Thank you very much for your comments and your question, MPP Parsa. Congratulations to you and your wife on receiving your first shots. I hope it was a pleasant experience for you.

Since the beginning, this government has been ready to distribute COVID-19 vaccines to Ontarians as soon as they are received, starting with vulnerable populations and those who care for them. Ontario began administering the vaccines on December 14, 2020. Despite challenges regarding the stability of supply, the province has made great progress in the vaccine rollout and has proven that we adjust to circumstances and refocus our efforts to protect the most vulnerable.

For example, in February, Ontario focused on its goal of completing the administration of first doses of COVID-19 vaccines to residents in long-term care, high-risk retirement homes and First Nations elder care homes by February 10. As we speak, more than 95% of long-term-care residents have been fully vaccinated, and 99% of retirement home residents have received at least a first dose.

With an expected increase in vaccine supply this month, the Ontario government will continue to expand booking eligibility until eventually all Ontarians who want a vaccine will have the opportunity to get one through several vaccine channels.

I will now pass it over to Deputy Minister Angus to provide more details on the update.

**Ms. Helen Angus:** I think, sometime while we're meeting during this meeting today, we will cross—if we haven't already—the 50% mark for all adults over the age of 18 receiving their first dose of vaccine. That's an important milestone. We will also cross six million doses administered, again, sometime today, given how we're tracking. I can tell you, if I'm looking at my phone, it's because we're tracking vaccine doses by the hour as well as booking. It's quite an enterprise, and I'm very thankful to my colleagues at the Ministry of the Solicitor General and Dr. Homer Tien for their leadership on the vaccine task force.

I'll go back to the beginning, because I think it's a story of execution and many hands making a successful vaccine program. Back in December, we developed an ethical framework for a three-phase vaccine distribution program. That was based on the expert advice of the COVID-19 distribution task force, which was formerly chaired by General Hillier. This work was done in alignment with the advice and guidance from the National Advisory Committee on Immunization, which you will know as NACI.

The first phase of the vaccine rollout focused on vulnerable populations at greatest risk of contracting and spreading the virus, such as residents of long-term care, high-risk retirement homes, First Nations elder homes and health care workers; First Nations, Métis and Inuit communities; and adults 80 years of age and older as well as adults who are recipients of chronic home care. That was the first phase.

The second phase is focusing on vaccinating based on age and at-risk. That includes individuals with specific health conditions and some primary caregivers; individuals who live and work in congregate settings and, again, some of their primary caregivers; individuals over 18 who live in hot spot communities, and there are 114 of those that have been identified; certain workers who cannot work from home; and then going through the age groups, descending as the supply permits.

And then, as the minister said, phase 3 is when vaccines are available, and they are coming in larger and larger supply. They will be available to every Ontarian who wishes to be immunized.

Throughout this pandemic, Associate Deputy Minister Blair—she will introduce herself, but she is the associate deputy minister of pandemic response and recovery. She will give you a through briefing on the vaccine effort to date. There are many aspects to it that she will cover.

Alison?

**Ms. Alison Blair:** Thank you very much, Deputy. Good afternoon, everyone. I'm Alison Blair, and I'm the associate deputy minister for pandemic response and recovery. I'm happy to give you a bit more detail about our three-phase vaccination implementation plan and the ethical framework.

As the minister and deputy mentioned, in December of last year, the Ontario government released an ethical framework for the COVID vaccine distribution, which was developed in partnership with the COVID-19 vaccine

distribution task force, to guide the vaccine prioritization and distribution across the province.

The ethical framework serves as the foundation for the plan and includes the following principles to guide the vaccine distribution:

- first, to minimize harm and maximize benefits;
- second, to reduce illness and death related to COVID-19;
- third, to ensure equity in the distribution of vaccine without bias or discrimination;
- fourth, to ensure fairness such that every individual within equally prioritized groups has the same opportunity to be vaccinated;
- fifth, to communicate to the public transparently, ensuring that the principles, decision-making processes and plans for COVID-19 prioritization are clear and understandable and also to ensure legitimacy, making decisions based on the best available scientific evidence, shared values and input from affected stakeholders; and
- finally, to earn and sustain the public trust.

Guided by this framework, in December, Ontario released a three-phase vaccine distribution plan that prioritizes populations to be vaccinated, based on the expert advice of the Ministers' COVID-19 Vaccine Distribution Task Force and, as the deputy and minister had talked about, in alignment with the National Advisory Committee on Immunization.

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The three objectives of the vaccine plan are to reduce death; to reduce hospitalizations, intensive care occupancy and long-term effects from the illness; and then, thirdly, to prevent transmission of COVID-19.

The deputy outlined phase 1, which is focused on the vulnerable populations at higher risk of contracting and spreading the virus, and that included residents, staff, essential caregivers and other employees of congregate living settings that provide care for seniors. That included long-term-care homes, high-risk retirement homes, First Nation elder care homes and assisted living facilities. It also included health care workers, including hospital employees, staff who work or study in hospitals and other health care personnel; adults in First Nation, Métis and Inuit communities, including remote communities; adult recipients of chronic home care; and adults 80 years of age and older.

I should note here that the 80-plus population was moved from phase 2 into phase 1 after there was clinical assessment of the vulnerability and because supply of vaccines permitted. We continue to be responsive to evidence related to vaccine effectiveness in certain populations as it emerges.

On December 14, shortly after the approval of the Pfizer-BioNTech vaccine by Health Canada, Ontario began administering the vaccine. Currently, 95% of Ontario long-term-care residents are fully immunized; 85% of long-term-care staff, 99% of retirement home residents and 70% of retirement home staff have received at least one dose.

While continuing to offer vaccines to the remaining phase 1 populations, on April 6 of this year, Ontario

entered into phase 2 of the vaccine implementation plan, and it continues to focus on vaccinating Ontarians based on age and risk. That includes individuals with specific health conditions and some primary caregivers, individuals who live and work in congregate living settings and some primary caregivers, individuals 18 and over who live in hot spot communities, certain workers who cannot work from home, and age groups descending through the ages, as supplies permit. Ontario will enter phase 3 when vaccines are available for every Ontarian who wishes to be immunized.

The timeline for this rollout has depended almost entirely on the supply of vaccines, which we receive from the federal government. Ontario currently has the capacity to administer about 150,000 doses per day at this time, if supply were to allow. Until recently, the province faced an unstable supply of vaccines from the federal government, so we've had to adjust accordingly throughout the implementation process.

On December 9, the Pfizer vaccine was approved for use by Health Canada, and with our first shipment, we began the vaccine rollout in two hospital sites, one in Toronto and one in Ottawa, on December 14. We increased that to 17 additional sites the following week.

On December 23, the Moderna vaccine was approved for use by Health Canada, and with our first shipment on December 31, we began administering vaccines to residents at long-term-care homes and high-risk retirement homes in Toronto, York, Peel and Windsor-Essex.

Then, on January 15, Pfizer announced that they had slowed production, impacting the amount of vaccine that would be supplied to Canada for the following month. As a result, Ontario faced a substantial reduction of Pfizer vaccine shipments between January 25 and February 15, which had a significant impact on the level of vaccine distribution.

Under the guidance of Ontario's health experts and officials, the government moved to focus on quickly delivering first doses to the most vulnerable populations. First, vaccination to long-term-care, high-risk retirement and First Nation elder care home residents was accelerated, with the goal of offering vaccines within each of these settings in the province by February 10, 2021.

Concurrently, on February 1, 2021, Ontario launched Operation Remote Immunity, which the minister referred to earlier, working with Ornge, our federal government partners, as well as the Nishnawbe Aski Nation to offer vaccinations to community members 18 years of age or older in 31 fly-in First Nation communities and Moosonee in northern Ontario.

Recognizing the critical importance of engaging the Indigenous leadership in how vaccines are offered to their communities, the plan was co-developed in partnership with NAN. By mid-April, the first- and second-dose clinics were completed in all 31 fly-in First Nation communities and Moosonee.

In addition, the intervals between the doses were extended by a safe margin as needed to support vaccination of the most vulnerable populations. For Pfizer-BioNTech,

the dose interval for residents for long-term-care, elder care homes and high-risk retirement homes was maintained at 21 to 27 days per resident, and for all other recipients it was extended to 35 days or no later than 42 days. The 28-day interval for Moderna was maintained.

Subsequently, based on evidence about the robust protection offered by the first dose of the COVID-19 vaccines currently authorized in Canada, the National Advisory Committee on Immunization strongly recommends that in the context of the current limited supply, jurisdictions should maximize the number of individuals benefiting from the protection provided by these vaccines by extending the timeline for the second dose of vaccine up to four months after the first dose.

The province accepted and started following NACI's recommendations on March 10, with some limited exceptions. Extending the interval between doses for up to four months has allowed Ontario to rapidly accelerate its vaccine rollout and maximize the number of people receiving a first dose.

Exceptions to the dose interval change included residents of long-term-care homes, retirement homes, elder care lodges and assisted living facilities, who are at the greatest risk of both exposure to COVID-19 and serious illness and death, and also remote and isolated First Nations communities. The exceptions also included immunocompromised people, such as transplant recipients and individuals with malignant hematological disorders and non-hematologic malignant solid tumours receiving active treatment.

In the last month or so, since moving into phase 2, Ontario's vaccine rollout has expanded considerably. During the week of April 12, select education workers, starting with those who provide direct support to students with complex special education needs across the province, and educators who work in hot spot postal codes in Toronto and Peel, became eligible to receive a vaccine.

On April 13, Ontario announced it was rolling out vaccines to hot spots which were identified based on historic and ongoing high rates of COVID-19 deaths, hospitalization and transmission, including 114 highly impacted neighbourhoods in 13 public health units easier to be reached through mass immunization clinics, mobile teams and pop-up clinics.

By mid-April, the first- and second-dose clinics were completed in all of the 31 fly-in First Nation communities and Moosonee. Then, during the week of April 19, individuals aged 40 and over became eligible for the AstraZeneca vaccine at pharmacies and primary care settings across the province, and 20 pharmacy locations began offering 24/7 vaccinations, with the majority located in hot spot communities. Then, on April 27, individuals aged 45 and over in hot spot communities became eligible for vaccination.

So most recently, in response to an expected increase in the vaccine supply from the federal government over the coming weeks, we accelerated the vaccine rollout and developed an anticipated schedule to expand the COVID-19 vaccine booking eligibility throughout May. On May 3,

individuals aged 18 and over in hot spot communities became eligible for vaccinations.

On May 6, the following groups became available to book through the provincial online booking system or directly with public health units that have their own system: those individuals turning 50 and over in 2021; individuals with high-risk health conditions; people who cannot work from home who fall under group 1, which includes elementary and secondary school workers; and First Nations, Inuit and Métis individuals could book online in addition to the other channels previously available to them.

This week, the week of May 10, the following groups are eligible: individuals with at-risk health conditions, people who cannot work from home in the group 2, and those two groups were eligible as of this morning at 8 a.m.; and then on Thursday, individuals turning 40 and over in 2021 will be eligible to book a vaccine.

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This week, we also announced that the dose interval for Moderna and Pfizer vaccines for high-risk health care workers will be reduced to the monograph-indicated interval—

**The Chair (Mr. Peter Tabuns):** You have two minutes left.

**Ms. Alison Blair:** Thank you very much—and that these health care workers will be eligible to book their new vaccine appointment by the end of this week.

As we look forward to the weeks ahead, on the week of May 17, individuals turning 30 and over in 2021 will be able to book, and finally, as early as the week of May 24, all individuals aged 18 and over will be eligible to book their vaccine appointment.

I'll just touch now on the vaccine access and locations. We're very pleased with the progress being made getting vaccines into arms as quickly as we receive them, and this is the result of the hard work of the public health units and their local community partners, who play a critical role in the vaccine rollout. After the province receives the vaccines from the federal government, they're delivered to all 34 public health units across Ontario. As part of that provincial plan, public health units are leading local vaccination programs, working with partners from the health and municipal sectors to develop and implement efficient and localized solutions, and conducting prioritization in accordance with the provincial guidance and direction.

The implementation and the specific mix of vaccination sites vary across the 34 public health units, reflecting the unique local needs and populations. Vaccines are being delivered through a variety of channels, including hospital clinics, mass immunization clinics, pharmacies, primary care, mobile teams, pop-up and workplace clinics.

As you know, on March 13, primary care providers began administering the AstraZeneca/Covishield vaccines, and as of April 21, over 1,400 pharmacies were offering the AstraZeneca/Covishield vaccine to eligible Ontarians aged 40 and over. The province's—

**The Chair (Mr. Peter Tabuns):** Thank you. With that, you're out of time.

**Ms. Alison Blair:** Thank you very much, Chair.

**The Chair (Mr. Peter Tabuns):** We'll go to the official opposition. Thank you so much. MPP Monteith-Farrell, it's yours.

**Ms. Judith Monteith-Farrell:** Thank you, Chair, and thank you for the information provided by the ministry. I've been very interested in what I was listening to. I think I'd be remiss if I didn't state that special thanks go out to everyone who has been working in health, and the tax dollars that are paying for all those salaries of all those front-line workers—we owe a lot of people a debt of gratitude in Ontario.

In our discussions, even today, we were talking about public health. Before the pandemic, there was the planned rollout of the amalgamation of public health units, and the northern Ontario big-city mayors, our city council in Thunder Bay and other municipal groups are sounding the alarm on that. I think the pandemic really laid bare the great work that that unique situation—the work that public health units do. As Ms. Blair was saying, that ability to address the local situation is so critical.

And so I have a question: Is the ministry considering now retracting that amalgamation plan because of the example that we see? And if this amalgamation plan is going forward, what are the savings and what are the detriments? What is the cost-benefit analysis that was done?

**Hon. Christine Elliott:** Thank you very much for your question, MPP Monteith-Farrell—a very important point. We have seen throughout this pandemic how important public health is. They've been there with respect to the testing, the case and contact management, and now, with the vaccinations, they are being distributed to the 34 public health units and going into hot spot areas and being distributed across their geographic area.

Prior to COVID-19 coming along, we were looking at modernizing our public health care system to be focused on the public health issues that are important across the province. This was something that had been commented on by the Auditor General in the past, and so we were looking at doing that, but we also knew that there were some concerns expressed by many municipalities, including in the north, and that's why we asked Mr. Jim Pine to help us engage in those consultations to understand the best way in order to do that. You don't want to throw out the baby with the bathwater, as they say; you want to make sure you keep the best and just make changes where you absolutely need to.

Mr. Pine had not finished his consultations at the time that COVID-19 struck us, and at that point public health units obviously became very involved in protecting the health and well-being of their residents. What we would propose to do when the time is right is to go back to those consultations so that Mr. Pine can finish his work and make some recommendations to us, which we will then consider.

So it's not really a question of costs so much as it's a question of organization in such a way that the health and well-being of the people of Ontario is going to be at the centre of it all, because we want to make sure that

whatever changes we make are going to prepare us for other problems in our health care system.

I don't want to think about another pandemic in my lifetime, and I'm sure you don't want to think about one in yours either, but we need to learn from this and be prepared and make the adjustments that we need to make so that if something like this should strike us again, we will be ready to respond immediately to it and to deal with it.

That's where we are with public health. But I think that the deputy minister would have more to add to that.

**Ms. Helen Angus:** Yes, I think you're right, Minister. There's obviously a lot to learn from the pandemic experience as well, and I think a little pause for reflection as we think about what went well. It certainly has been trial by fire. I think that the public health units have stepped up both in the COVID response and when I think about the IPAC deployment into long-term care and beyond, the work on vaccine rollout, and the work that they're going to have to do to catch up on vaccines in children and young people and schools and everything else. There's a lot of work to be done, and I think there's a moment of reflection.

Obviously, Mr. Pine will, at the request of the government, continue his work, but I do think that as we've gone along in this pandemic, we've had a very tight relationship with the council of medical officers of health and the public health unit leads in the vaccine rollout—we meet with them I think several times a week. I think there are some things that have been facilitated by the structures and the leadership that we have and some things have been more challenging. We're not through it yet, and I certainly would like to have some time to kind of process what we've been through and understand how the needs of the population would be best served by a strong public health system.

**Ms. Judith Monteith-Farrell:** So at this point, it's still in the process, and I guess we can report that it is not decided yet. And hopefully we have learned the lessons, because the public health units have worked tirelessly and their work has been critical to keeping our populations informed and supported. Up north here, they work very closely with Indigenous communities. So I'm encouraged that there is going to be some reflection around that decision around public health.

I'd like to ask now about something near and dear to my heart. The Canada Health Act guarantees equitable access to health care in this province, and that's not the case for people in northern Ontario. People are still suffering in the sense that they cannot access health care if they have to travel for health care. Of course, that was stopped for a while during the pandemic, but it still carried on. I was disturbed to hear that the appeals process for Northern Health Travel Grant reconsideration was actually paused during the pandemic—and we only find that out through the liaison. So that was very disturbing. We have people that are waiting for answers—a year, 15 months later, there isn't any clear indication.

The other thing that is still happening, and what I was really hoping wasn't going to happen, is that we did get

the direct deposit option—that's a big improvement, so good on that—but people are still falling through the cracks, with conditions that aren't meeting the criteria. This really needs to be looked at and examined.

One case that just came to mind: A doctor reached out to me who is in Atikokan. She's a family physician. They have maternity cases. Atikokan is 200 kilometres and a bit from Thunder Bay, and those women can't birth in Atikokan. There isn't that kind of facility, so if they have any kind of issue, they have to go to Thunder Bay in the last two weeks of their gestation and pay for it themselves because the Northern Health Travel Grant doesn't pay for any of that.

**1640**

What happens is women can't afford to do that: They can't afford to leave their families or they just can't afford to do that, so they stay in the community and then have to be maybe air-ambulanced out, or an ambulance has to come the 200 kilometres, which is a dangerous situation for these mothers. So, it needs to be fixed. I think what I really would like to hear is, is there any hope that the Northern Health Travel Grant money and program will be expanded to really, truly meet the needs of northern Ontario?

**Hon. Christine Elliott:** Thank you very much for the question. We certainly know that residents in northern Ontario are disadvantaged in many respects in their health care needs, because they're often very far away. Even with the northern Ontario travel grant, in some situations, people have to travel during the winter on icy roads, several hours' drive, and that is not in their best interests. It's dangerous and perilous to make that drive.

We do want to help, though, with the northern Ontario travel grant, to help, I guess, equalize the opportunity for people to receive the care that they need. We've got the funding based on the kilometric rate and provide the accommodation allowance. But you've mentioned several situations where there isn't anything provided, and certainly as part of our health system transformation we want to make sure that people can receive the health care that they need, both physical care and mental health and addictions care, across the province. That is something that we are continuing to work on.

I think one of the ways that we can deal with that—not in the example that you just provided where someone would need to be provided with hospital care—is through virtual care; that's one way that people can connect with specialists in their home riding where they don't have to travel long distances, they don't have to be away from their families. They can receive that virtual care. But that's not for everybody; I recognize that. That can help with certain things but not for all of their health care needs. But this is something that is being addressed.

I will turn it over to the deputy minister to speak more particularly about what is provided and what perhaps can be provided.

**Ms. Helen Angus:** Yes, I think last year was an unusual year—

**The Chair (Mr. Peter Tabuns):** Deputy Minister, before you go further, I've had a request from Hansard. I



do need everyone to identify themselves who is not an MPP.

**Ms. Helen Angus:** Fair enough.

**The Chair (Mr. Peter Tabuns):** You're doing good work, but I do need you to identify yourself. Thank you.

**Ms. Helen Angus:** I'm just enthusiastic on answering the questions.

**The Chair (Mr. Peter Tabuns):** Yes, I know the focus.

**Ms. Helen Angus:** There we go: Helen Angus, deputy minister. My apologies, I will write that down—"introduce self"—and I'll stick it on the book so I remember to do that. Thank you for the reminder.

With that, I'll probably actually pass it on to Patrick Dicerni, because you've asked some questions about the operations of the program, and so he would be able to explain both the policy but also the mechanics of the reimbursement, the volumes and the particular programmatic rules.

So, Patrick—and then, Patrick, introduce yourself.

**Mr. Patrick Dicerni:** Thank you, Deputy. Patrick Dicerni, assistant deputy minister in our OHIP and our drugs and devices division in the Ministry of Health. I also put a sticky note on my computer.

Thank you very much for the question, MPP Monteith-Farrell. As you noted in your opening, I believe it was further to a town hall that you had had in the Atikokan area that you wrote to Minister Elliott and made some suggestions for program improvements. And, as you noted, I'm happy to say that we've moved forward with the electronic communication/direct deposit, should it be available, and there have already been some positive responses to that added piece of functionality within the program.

A couple of the other issues that you raised—I'm happy to respond to them as best I can. With respect to your reference to some of the challenges in providing, I'd say, limited, or addressing the limited nature of obstetrical services in some of the either rural or remote areas of the province, that's certainly something the ministry is always seized with and engaged on. With respect to the intersection of the Northern Health Travel Grant Program and midwifery specifically, I believe, is the one you raised, that would be a case where midwifery, not being a specialty, would fall outside of the criteria within the program. But I don't want to discount or minimize, as has been mentioned, some of the challenges in accessing care in rural or remote areas.

With respect to some of the mechanics of administering the program, you're right: The pandemic has caused some degree of challenges. The MAC, the Medical Appeals Committee that we do have set up for those cases of appeals being made after a claim has been turned back internally or denied—which is for the reasons of program criteria not being met, in many cases. In the main, those are for reasons of no medical justification being provided, or if the services sought out were a non-insured service.

With respect to some of the reimbursements, as you may know, if you are required to travel anything in excess of 100 kilometres to the appointment, mileage is eligible and would be provided. And if that travel is 200 kilometres or more, overnight stays are considered.

We will resolve to continue to look at and respond to individual needs within the program, including some of the ones I've noted around program improvements, such as direct deposit.

**Ms. Judith Monteith-Farrell:** So am I correct in that the appeals process has been reinstated and will start to roll out so that people can expect some answers?

**Mr. Patrick Dicerni:** You are indeed. We did have the need to staff our MAC with medical advisers, and that process has been undertaken. As I understand it, we are back adjudicating the appeals that have come in against the program.

**Ms. Judith Monteith-Farrell:** The Thunder Bay regional hospital is something I've brought up many times because it often was at a case of being at capacity before the pandemic. I know that they received some funding through the program that you mentioned, Minister, but I'm worried that after the pandemic, we'll go back to that time where we're overcrowded and people are unable to safely access the hospital.

Also, connected with that is that there is a program running right now that—there's a big community push for cardiac care at home, to try to institute a cardiac and surgical unit in Thunder Bay so people don't have to travel to Hamilton or Ottawa or sometimes Winnipeg for cardiac surgery. Tragically, many people have lost people, right? They're flown out, and then they never see their loved one again. So there is a lot of fundraising going on in our community, and I would be remiss if I didn't ask: Will there be some kind of commitment for that cardiovascular surgical unit here in Thunder Bay?

**Hon. Christine Elliott:** Thank you very much for your question. I guess there are two parts to it.

First is the situation with hallway health care, and will we go back to that even though our hospitals are very full right now. Your question is, will that continue? We've worked very hard to ensure that we are going to continue to have spaces for people. We've expanded our health care facilities by over 3,100 beds since the beginning of the pandemic and expanded our intensive care facilities by 14%.

We know that we need more intensive care beds after this pandemic. We're studying exactly how many that will be right now. They need to be geographically fairly divided to make sure that there are facilities in northern Ontario, because especially in Thunder Bay—Thunder Bay receives patients from all over the north, and it needs to have space to make sure that people don't have to be significantly far away from their family members—although I recognize that they're coming from fly-in communities; that, unfortunately, will happen.

**1650**

We are working very hard to make sure that we have facilities to expand our mental health and addictions services, for example, so that people don't need to use—

**The Chair (Mr. Peter Tabuns):** You have two minutes left.

**Hon. Christine Elliott:** Thank you—so that people don't use the emergency department of the hospital as their

last resort, because they're in a crisis and they don't know where else to go.

We want to make sure that we can handle other situations, where people can do their pre- and post-surgical consultations virtually, and that people can receive home care through virtual care. That's being done in many communities across Ontario.

To answer your specific question on the question of cardiac care at home—I will turn that over to the deputy minister to respond to that.

**Ms. Helen Angus:** I'm not as familiar with that particular program—it's Helen Angus, Deputy Minister of Health. But I would say that during the course of the pandemic, we have seen some remarkable delivery of health care to people in their homes that otherwise wouldn't have been—and I think our commitment to virtual care is strengthened as a result of that experience.

Obviously, we've got the COVID at-home program, which is able to help maintain people with COVID-19 at home, with remote monitoring and oxygen measurement devices provided to them.

Obviously, this cardiac program really helps people by not having to travel.

So I think this is going to be, at the end of this pandemic, a regular feature of the health care system. We've seen great patient satisfaction from the delivery of virtual care, as well as that it works well for providers.

I think one of our challenges—they're happy challenges—will be to look at all those programs that have delivered value and quality services to patients—

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

We have to go back to the government. MPP Cuzzetto, the floor is yours, sir.

**Mr. Rudy Cuzzetto:** I would like to thank Minister Elliott, PA Martin, the deputy minister and all your staff during these difficult times. Thank you for everything you've been doing.

As well, I'd like to thank the minister and everyone there for the investment in the new Trillium Health Partners hospital that will be built in my riding of Mississauga-Lakeshore. It means more than just the hospital to me—my mother worked there, as a first-generation immigrant, in the kitchen. As well, I was born there, and it was called South Peel at the time. So thank you very much for all that you're doing for Mississauga, for the whole community.

Minister, I'd like to ask you about the impact that COVID-19 has had on our hospitals. We know that COVID-19 has really strained our hospitals. Can you please tell us what the government is doing to assist the hospitals in managing the challenges they are facing during COVID-19?

**Hon. Christine Elliott:** Thank you very much for your question, MPP Cuzzetto, and for sharing your personal story.

In response to the outbreak of COVID-19, the Ministry of Health took deliberate action to ensure that Ontario public hospitals had the necessary policies in place to

protect the health and safety of the people of Ontario. Measures to support hospitals were put into place. They were done immediately, in the spring of 2020, when the severity of the situation we were facing became clear.

I'd now like to turn it over to Deputy Minister Helen Angus, who will further outline the actions our government has taken to support hospitals in responding to COVID-19.

**Ms. Helen Angus:** It was really through the quick and thoughtful action of the government, working with the health sector and our partners at Ontario Health, that we were able to ready the health system to respond to the COVID-19 pandemic. That support has remained in place from the first wave to today, to make sure that there is high-quality patient care throughout the last 14 or 15 months.

Since March 2020, we've made investments in the hospital sector and have protected the health of Ontarians. I'll give you some highlights, and then I'll pass it over to Mel Fraser, whose area of responsibility includes the hospital sector. The government has invested \$760 million in funding for over 3,100 new beds. That's really the equivalent of opening up six new large community hospitals, which is kind of a remarkable feat if you think about both the speed and size of the response. The beds will continue to provide COVID-19, as well as non-COVID-19, patient care and they will be in place to help clear the surgical backlog over the coming months.

We continue to increase hospital capacity through the implementation of mobile health units to allow our sickest patients to receive care within hospitals. With the additional capacity, we've also made investments and continue to support the outstanding health and human resources we have in Ontario. I'd add my personal thanks during Nursing Week to the front-line health care workers who have stepped up again and again to care for patients.

In October 2020, the government began to implement a health human resources strategy that was really customized to the COVID response. This will ensure that the talented health and human resources continue to grow, but not only for COVID-19. I think again to some of the comments I just made to the previous questions: These are things that will be there for us in the years to come. We've built infrastructure and put into place programs and supports that really will help us deliver excellent health care to Ontarians in the years ahead.

We made significant investments of \$572 million to ensure that the health care sector is able to access personal protective equipment needed. As well, we've supported assessment centres to test for COVID-19, and the lab capacity needed to support timely screening, testing and diagnosis. Those are part of our efforts to decrease the transmission of COVID-19.

I'll ask Mel to speak more about the health system challenges and how we've responded to the pandemic and, specifically, to answer your question around how we've been supporting hospitals in the care that they provide. So, Mel, over to you, and don't forget to introduce yourself.

**Ms. Melanie Fraser:** Hello, everyone. I'm Melanie, or Mel, Fraser. I'm the associate deputy minister for health

services at the Ministry of Health. There's a mouthful, if I have to say that every time.

Thank you for that, Deputy Minister. I'm very happy to tell you about the supports that we've provided to the hospitals and the hospital sector since the very early days of the pandemic, and even before it was a pandemic. Those supports are both financial as well as operational and, as the deputy minister said, working closely with our partners at Ontario Health to deliver those supports.

What I'd like to do is talk to you a little bit about the added capacity that we've built in the system, not only in terms of bed capacity for patients, but also for assessment in terms of the testing and diagnosis of COVID-19. In last fiscal year 2021, the government invested over \$3.4 billion into the hospital sector to address those particular needs. Really, those investments were made not only to ensure that we could respond to COVID but to also ensure that we could make certain that we had appropriate care for non-COVID patients and that they could continue to access high-quality care in the health care system throughout the pandemic.

Maybe as I talk a little bit about capacity, I'll try to unpack it a bit. One of my former colleagues used to always say, "A bed is not a bed is not a bed." I think it's really important to recognize that there were many different types of capacity that were required to respond, both to the pandemic but also to maintain capacity for the rest of the population throughout. So we'll talk about different types of capacity that were created, but also, I think, especially around the critical care capacity. These are the highly specialized assets in the hospital system: the ICU beds and the highly specialized health human resources that go along with those. I think, as folks have seen over the course of the pandemic, critical care capacity has really been a requirement to serve the COVID population. As I said, it's not just a bed; it requires a selection of equipment. That would include things like ventilators, IV pumps. We have special ECMO units, monitors. There are specialized beds and mattresses, even, for COVID patients.

#### 1700

As we create capacity for these patients in critical care, there's also supporting infrastructure that's needed, so medical gases, laboratory systems, diagnostic imaging and pharmacy, and then, of course, probably the most important thing is specialized HHR, health human resources: specialized nursing positions, critical care physicians, respiratory therapists, perfusionists. There are a range of professionals who are trained and designed to provide this very specialized care—and then even things like transportation. As we talked about building this capacity—and I think the minister referenced building 3,100 additional beds in the health care system, plus some additional critical care capacity. It's all of these things combined and probably most importantly, the staff that go along with them.

Just to reflect on the funding a little bit: Back on March 25, 2020, we invested \$341 million for an additional 1,500 hospital beds. That was part of the wave 1 response. That

included 1,000 acute care beds—those are medicine beds, stepdown beds out of the ICU etc.—and then 500 critical care beds on top of that. In addition to that, we stood up numerous assessment centres for testing and diagnosing COVID attached to the hospitals. Those investments at the time assisted hospitals and their response to the first wave of COVID, but we didn't stop there. Actually, I don't think we've stopped at all over the past 16 months.

As we were coming through first wave and over the course of the summer, we began working with our colleagues at Ontario Health to then develop a plan to support the hospitals through what could potentially be a wave 2 at that time, which resulted in the release of the fall preparedness plan. We released that plan publicly in September 2020. That included an additional investment of \$213 million to support another 139 critical care beds, plus another 1,349 hospital beds. In addition to that, we also had some subacute care beds. Those were beds in what we call alternative health facilities, outside of hospitals, to build some buffer in the system and to help manage patients who don't necessarily need to be in a hospital but may not have somewhere else to go.

In addition to that, we worked with the Ottawa Hospital. We created a special emergency department ambulance off-load and medical transition unit. That was a structure that was built there to allow patients to be safely off-loaded by paramedics while they're waiting to be triaged, allowing the paramedics to return quickly to the community. Again, as we're talking about all of these things, there's a natural flow that happens in the health care system. Through our planning—it wasn't only planning for the capacity within the hospital; we had to manage the flow, the transportation, and investments were made in that to ensure that we had that full-system view.

Then later on in September, we made an additional investment of \$116.5 million. That was to add another 766 more beds at 32 hospitals and alternative health facilities as we saw the COVID cases trending above 400. You will recall, at that time, we hadn't seen numbers that high, and it was hard to imagine where we would be. In total, those investments represented, as we've mentioned before, over 3,100 new beds added to the system—the equivalent of building six hospitals in less than a year—to surge up to meet the requirement of this once-in-a-generation pandemic.

Just this past January, when the modelling showed that there was a very real possibility that our critical care capacity could become overwhelmed, the ministry then invested another \$125 million to add another 519 critical care beds to the hospital system. This additional capacity has been absolutely critical in us being able to manage the patient volumes that we've experienced during this third wave.

The ministry has, as maybe has been mentioned, committed to running these beds for the entirety of this fiscal year. We've secured \$760 million in the 2021 budget and an additional \$363 million since then in April 2021 to maintain those beds and to maintain that commitment. I believe, as the minister mentioned, these will become

valuable resources, not only in responding to wave 3 of the pandemic, but also to helping us make gains against any backlogs and surgeries and procedures that may require access to those acute care beds. So when they're not being used for COVID and as the pandemic winds down, that additional capacity will be leveraged to address the backlog.

In summary, in recognition of those system-wide pressures, we've added many different types of beds throughout the pandemic, as I said, including critical care beds, acute care beds, long-term vent beds, rehab and complex care beds and traditional care beds. Really, what we've done is to ensure that patients continue to receive the most appropriate care, based on their needs, and ensure that we have appropriate patient flow within the hospitals and that patients are in the right level of acuity bed, have the right equipment and the right staff around them.

In addition to that, we also provided hospitals with some other tools, including that we made some approvals under subsection 4(2) of the Public Hospitals Act. What it did was allow hospitals to also operate or use institutions, buildings or other premises outside of a hospital. Those are what we refer to as alternative health facilities. You may have heard them referred to as AHFs. This also helped the hospital sector deal with patient volumes during the pandemic. An alternative health facility is usually occupied by a patient who is not requiring acute care but who doesn't have a place to be safely discharged to. It's really a demonstration of creative problem-solving and hospitals being able to pivot very quickly to continue to provide the best care possible.

What happens in the case of an AHF is that a hospital will retrofit a non-traditional space to operate like a hospital setting. This means they provide everything there, from patient spaces that respect patient privacy—there are telecommunications, there's cleaning, there are meal services, there's the equipment and supplies needed and the infection control and prevention practices. These become another place to allow patients to flow through the system. An example might be a hospital taking over a vacant ward in a retirement home facility—we saw some of this through the pandemic—so that they could move alternate-level-of care patients into that facility, continue to care for them appropriately, but then, as I said, use the space back in the hospital attached to medical gases and the laboratory etc. for higher acuity patients. We continue to work with our sector, our hospitals and Ontario Health to ensure that we have the access to the capacity that's needed, based on patient needs.

In addition, you would probably have seen in the news that we've created two mobile health units. In January of this year we issued a request for assistance to the federal government to request the creation of two mobile health units. This, again, was to create added capacity so that we could manage more complex patients in the hospitals, proper hospitals, while having mobile hospitals on-site. The first unit opened at Sunnybrook hospital last month, in April, and we have another one located at Hamilton Health Sciences that will open within a couple of weeks if

it's needed. Again, these have the capacity to provide hospital care for up to 160 patients, if needed. Despite looking like tents on the outside, they're actually quite sophisticated units. They come with everything that you might expect in a hospital, including bathrooms, boardrooms, showers. There are surgical suites, although we won't be doing surgeries in them. Again, it's added capacity to ensure that we have room to manage patients of all needs within the system.

**1710**

**The Chair (Mr. Peter Tabuns):** You have two minutes left.

**Ms. Melanie Fraser:** Okay. I will just wrap up by saying that in addition to the added capacity in the system, we have also supported the hospitals with both their lost revenue and their working funds. Maybe we can talk about this a little bit later in more detail. I think folks will know that, as a result of the pandemic, not only did the hospitals experience net new costs because of COVID-19, but they lost funding related to out-of-province patients, co-payments from private rooms, parking, retail services. So the government announced that it would be setting aside \$572 million to help hospitals manage that lost funding. In addition, we know a number of our hospitals are struggling with their working capital position, and so the government is also investing over \$696 million to provide that financial stability and relief by eliminating significant portions of the historic working funds deficits for eligible hospitals. Those are largely our small and medium hospitals, as well as some of our specialty and rehab hospitals that experienced financial strain due to their unique situation.

With that, I'll try to wrap up and say we can probably spend another section talking about the health human resource supports that have been provided to the hospitals.

I think we've had a very effective working relationship. We are certainly grateful to our hospital partners for the tremendous role that they played in responding to this pandemic, particularly the third wave, and for the care that they've been able to provide, not only to COVID-19 patients but to all those patients requiring urgent and emergent care across the province.

**The Chair (Mr. Peter Tabuns):** That ends the time. We now go to the official opposition. MPP Gélinas.

**M<sup>me</sup> France Gélinas:** I will start with a couple of cleanup questions.

Assistant Deputy Minister Dicerni, you were telling me if there was any money left to pay for the pay equity of midwives when our very talented Chair put the hammer down, and I did not hear your answer. So if I could go back to you, Assistant Deputy Minister Dicerni?

**Mr. Patrick Dicerni:** Thank you very much for the follow-up question, MPP Gélinas.

Further to what I was starting to say when time elapsed—I believe we were talking about the increased expenditures we helped plan in the midwifery area. I'm happy to unpack that for you.

The 2021-22 estimates represent an ongoing base of \$182 million, plus \$21.5 million that was required for the 20% compensation increase, as a result of the HRT0

remedy order. That has been included in all of the funding agreements in the various practice models for midwives across the province.

With respect to total midwifery investments of \$8.3 additional million in 2021-22, that represents a 1% compensation increase. That was per the negotiated three-year agreement that runs between 2020 and 2023 with the AOM. That's going to allow for additional expanded general registrant midwives and caseloads there within to be expanded, to expand access to midwifery services in the province.

I would be happy to break those down for you across the various midwifery practice models. It might just take me a moment. But it is the full slate of, whether that be transfer payment relationships with midwives, the Indigenous midwifery program, and—there is one other that if you give me a moment, I'm sure I will recall.

**M<sup>me</sup> France Gélinas:** Well, you piqued my attention, but I have a load of questions, so could I request that you send me the practice-by-practice information in writing so that I could go on with my big list of questions and not tap your memories too much, either?

**Mr. Patrick Dicerni:** I would have to say that I don't have this broken down at the riding level, but I would be happy to take it back and see what we can provide at the practice group level.

**M<sup>me</sup> France Gélinas:** No, not riding—practice level.

When you answered about the Northern Health Travel Grant, from your answer, is it that northern women having to travel to see a midwife will continue to not qualify for the Northern Travel Health Grant because midwifery is not a medical specialty? There's no hope there?

**Mr. Patrick Dicerni:** Thank you for your question, MPP Gélinas. I wouldn't want to comment on what is in the realm of hope or not, but that is not an element of the program as it's currently constructed. But I'm happy to take that back. As per my earlier comments, we're always looking at how to ensure equitable access to obstetric services for those living in any area of Ontario.

**M<sup>me</sup> France Gélinas:** Thank you. When MPP Mamakwa was talking to you about—oh, I'm not sure if it was to you or to Liz. Anyway, you can tell me if I'm at the wrong person. You talked about health transformation and collaborations with NAN. Is there any money in the budget or in the estimates that is targeted to health transformations for NAN territory?

**Mr. Patrick Dicerni:** Thank you for the question. That would not be within my purview, but I'm happy to pass to my colleague Sean Court, who I've just seen turn his camera on.

Thank you very much, ADM Court.

**M<sup>me</sup> France Gélinas:** Okay.

**Mr. Sean Court:** Hi. Thank you, MPP Gélinas. Sean Court. I'm the ADM of strategic policy, planning and French language services in the Ministry of Health.

MPP, there's not a specific line that is identified into the estimates associated with First Nations health transformation. There are a variety of pockets of funding that go to support the provision of Indigenous health services

across the ministry, but there is no specific line that is associated with First Nations health transformation.

**M<sup>me</sup> France Gélinas:** Okay. Again, when my colleague MPP Monteith-Farrell talked about public health units, the deputy minister made it clear that you'll hit pause, you'll finish the consultation, but there was \$100 million that had been taken out of public health. Is the idea to also pause the cuts to their operating fund, or is the \$100 million that has been taken out, with the changes to the way health units are funded with municipalities picking up 50% of the cost etc. for different levels of service, still going on?

I guess I'm going to the deputy minister, because she has all the answers.

**Ms. Helen Angus:** Thank you very much. Helen Angus, Deputy Minister of Health. I will ask—now, Liz is probably in the best position to answer the question about the funding for public health units, but certainly the funding for public health units has continued to grow in the time of COVID. I will ask Liz, maybe, to come on the screen and answer the question specifically about the year-over-year funding for public health units.

**Ms. Liz Walker:** Thank you very much, Deputy.

**Ms. Helen Angus:** Yes, go ahead. I just would note that some of the funding for public health units this year, as it was last year, is kind of based on an invoice basis as well, and the costs that are being incurred in the whole COVID response. So it is a little hard to predict exactly where we're going to land on some of the COVID expense areas.

Liz, over to you.

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**Ms. Liz Walker:** Thank you. It's Liz Walker. I'm the director of accountability and liaison in the office of the Chief Medical Officer of Health.

Thank you for your question, Madame Gélinas. With respect to the funding changes that were announced with respect to public health modernization, the change in cost-sharing between the provincial and municipal governments was made in January 2020. However, given the situation that we have been in over the last number of months and until the end of this year, the government had made a commitment to fully offset any additional costs to municipalities that were as a result of that cost-sharing change. That was provided both last year and this calendar year. Any of the additional savings that were anticipated as a result of changes through public health modernization, as the deputy and minister referenced earlier, in the pause in that, have been paused as well.

In addition, as the deputy has just referenced, there were additional extraordinary costs provided to public health units last year—and we anticipate it will be the same again this year—to enable them to respond to this pandemic and the very taxing situation they all find themselves in with respect to things like case and contact management and additional costs and expertise that they require.

**M<sup>me</sup> France Gélinas:** Thank you. That was the wrap-up of the little questions where I still had questions.

Moving on, my next series of questions will have to do more with the surgical backlog and the procedures backlog. I know that in your budget you have identified, going by memory, \$655 million to address the backlog. Our Financial Accountability Officer has made projections, because hospitals received a directive from your ministry once again to only focus on emergent surgery. The FAO puts the backlog at 419,196, to be exact, for surgeries, and at 2.9 million for procedures. He puts the estimates to deal with this backlog at over \$1 billion for surgery and \$1.3 billion for procedures.

I'm strong in math. That's way more than what has been put into this budget. How are we going to handle this? I guess to the DM. You've been very good.

**Hon. Christine Elliott:** I'll start off with it, if you don't mind, MPP Gélinas.

Certainly, it's been unfortunate that we've had to delay a number of surgeries and procedures, which happened between the first and second wave, and now it's happening again in the third wave. This is very concerning. I know too many people who have been waiting a long time for their surgery. However, I would note that there is a process by which someone can be evaluated, I would say especially for cancer or cardiac surgery, so that if it is life-threatening, if it really needs to be done right away, that is assessed by a team of medical experts and they determine whether the surgery has to be performed immediately or whether it can be postponed somewhat.

We—the Ministry of Health, our hospitals—have performed over 420,000 surgeries since the pandemic began. So it hasn't stopped completely. It has been slowed down; there's no question.

But we do have a plan. We did have the plan that we've brought forward with our fall preparedness plan, anticipating any further waves of COVID—and that has been increased. We now have over \$500 million in extra funds put in to allow our hospitals to perform additional surgeries, either more during the day or during the evenings, weekends and so on. So we will be able to get back to doing surgeries when our intensive care levels subside somewhat and our level of new COVID patients coming into hospitals also subsides.

We're also using our entire health care system as almost one unit, and I would say that collaboration amongst our hospitals now is unprecedented. They really are working as one team. We are also taking a look at regional wait-lists to ensure that if there is surgical availability in one hospital for orthopedic procedures, for example, that surgeons can then move to that hospital to do their surgeries there, and the same for cardiac procedures. We have some that are regional cardiac centres, and they can accept patients as well. We're also using surgical smoothing to help deal with that.

Of course, we also have the Cortellucci Vaughan Hospital, which has been opened to deal as a sort of load-balancer, I guess I would say, in terms of COVID patients across the entire province. They will ultimately go back to being a regular hospital, I guess, doing normal operations, and they have surgical capacities there as well.

So we are moving forward. We do look at the levels of patients every day. The surgeries and the diagnostic procedures that are still waiting to be performed are top of mind for us, because we know that they're so important to the people of Ontario and we want to get back to it as soon as possible.

At this point, I will turn it over to the very knowledgeable deputy minister for further information.

**Ms. Helen Angus:** It's Helen Angus, Deputy Minister of Health. Yes, knowledgeable and old, maybe.

I might just comment a little bit on the FAO report and then maybe Mel wants to jump in and provide some details. I think it's important to know that the estimate of the backlog is a modelled estimate; it's not a true count of patients who are actively waiting for surgical care. When we look at the patients who are waiting for care, which is top of mind, I think, for us, it's about 263,000 procedures. That's the current estimate, but that's not the actual number of people waiting on a surgical wait-list. You've got different numbers here. We estimate that the numbers who are on a wait-list for surgery—it's still a significant number—is 173,000.

And just for a bit of context, surgical wait-lists are kind of a fluid concept. Certainly in pre-pandemic times, generally around 200,000 would be at some point waiting for a procedure, and some of those waits, obviously, would have been quite short. The number of 263,000 are people who may present for surgery, but a good chunk of them may not have yet sought out health care services. So it's been difficult to determine how many patients would actually present to the surgical system and when, and whether the pandemic has altered the demand for surgery over the last 14 months. That's the challenge we face.

We're certainly working closely with Ontario Health and with hospitals for maximizing the province's surgical resources, and the minister has just described how we're going to do that. But once hospitals are able to ramp up surgeries again—and with the numbers that we're seeing in the last few days, we're optimistic that will be soon—Ontario will have a sustained progressive reduction in the surgical backlog, and it will take some time to do that.

I think the issue around the shortfall for funding, which was also raised by the FAO, doesn't take into account that recovery from the pandemic, as I think he's rightly described it, is a multi-year journey and that funds will be available in the out years once the system returns to normal. Certainly, his estimate that this will cost the province \$1.3 billion to deal with the surgical and diagnostic imaging backlog—we haven't been able to verify those numbers, again, depending on how many patients actually present, what the true size of the backlog is. But note that we've allocated \$610 million to address the surgery and diagnostic procedures backlog. I think some of that relates to the timing of the writing of the 2020-21 budget. It occurred obviously before the directive on April 21 to halt elective surgeries and non-emergent diagnostic procedures. Dealing with this pandemic is nothing if not fluid; we've learned that. We've learned to be nimble. We've learned to be flexible. I think when Mel described the

investments in hospitals, obviously, it was done sequentially over periods of time.

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**The Chair (Mr. Peter Tabuns):** You have two minutes left.

**Ms. Helen Angus:** We've been back to Treasury Board many, many times as the situation has unfolded in front of us. I expect, perhaps much to our colleagues at Treasury Board's chagrin, that that will continue and that as the path forward becomes clearer and we come out of the pandemic, hopefully, for this last wave, that the financial requirements and the capacity needs will be clearer, and we're constantly paying attention to that.

**M<sup>me</sup> France Gélinas:** Just quickly, Deputy: The \$650 million you had budgeted was for how many surgeries? Was this for the 173,000 that you talked about? You came up with \$610 million to address the backlog. In your mind, that was a backlog of how many—and if you could separate surgeries from procedures.

**Ms. Helen Angus:** I'll have to ask Mel Fraser to answer that in specific detail, about how far out we were able to forecast the number of surgeries. We do know the composition of some of the surgeries. Obviously, we've kept up pretty well in many surgeries, but the areas where we need to do the catch-up is largely but not exclusively in orthopedics and cataracts. Those, of course, have different price points and different capabilities to get through the backlog.

I might ask my very capable team to answer the specific questions about how that was broken down in order to provide an estimate for the budget. I just don't recall that right here in front of me right now.

**Ms. Melanie Fraser:** I think we're going to run out of time, but—

**The Chair (Mr. Peter Tabuns):** Unfortunately, you have run out of time—a good predictor.

We now go to the government: MPP Martin—oh, no. MPP McDonell, sorry.

**Mr. Jim McDonell:** Okay. I'm unmuted.

Thank you, Minister. I know you've had to utilize every tool at our disposal to fight COVID-19. One of those tools that I'm quite interested in knowing more about is the Ontario Health Data Platform. Could you please tell us about what the platform is and how this digital tool is supporting our response to COVID-19?

**Hon. Christine Elliott:** Thank you very much for your question, MPP McDonell. At the onset of the COVID-19 pandemic, there was an increasingly apparent need for fast, easy and secure access to accurate health information to enable the government to deal with this emergent public health crisis. The government rapidly deployed the Ontario Health Data Platform—called OHDP—an authoritative, secure and privacy-protected big data platform that gives researchers and public health the data they need to generate timely, actionable insights to inform the government's response to the COVID-19 pandemic.

I will now pass it on to Helen Angus, deputy minister, and her team to provide you with additional details regarding the platform.

**Ms. Helen Angus:** Perfect. Thank you very much. I'm Helen Angus. I'm the Deputy Minister of Health. To add to the minister's comments, the Ontario Health Data Platform was designed to fuel innovation to help strengthen the province's ongoing response to COVID-19. It's well on its way to becoming one of the largest sources of comprehensive health data available for machine learning and artificial intelligence in Canada. I would note that Ontario's data is particularly significant for research and analytics because of the diversity of our population. It's very rare to find the 14.7 million lives covered that are as diverse as the population of Ontario. People come to Ontario to do this kind of health services research because of the strength of our data, and we certainly want that to continue.

Behind the Ontario Health Data Platform is a lot of mechanics that actually make it work, and I'll talk a little bit about that. It has a robust data governance and stewardship model that helps ensure that the data about Ontarians actually serves to benefit the population of Ontario. In addition to having health administrative data, the data platform will also very soon feature COVID-19 vaccine data, public health data, clinical data from hospitals, all the laboratory data, and even electronic health records. Some of these have never been made available for health research until now, while others may never have been made at the level of detail or the scale that is now included in the Ontario Health Data Platform.

About the process: We were well-supported by the provincial expertise—by bringing on Dr. Jane Philpott, a former physician, former federal minister and, of course, the current dean of the Queen's faculty of health sciences, as a special adviser to our Minister of Health and also to Minister Bethlenfalvy, President of the Treasury Board. Dr. Philpott chairs a table of experts, the Joint Ministers' Roundtable, which I was able to attend on several occasions. It provides recommendations to the ministers on the design and implementation approach. The members of the round table include experts in public health, research, privacy, and in various areas of clinical expertise. I thank them for their leadership in ensuring that the data is used for public benefit and in a way that protects privacy.

Really, what the OHDP does is, it bridges gaps in information-sharing and facilitates knowledge mobilization to put evidence into action. That's really what it's all about: allowing researchers and to support efforts to do important things like increase the detection of COVID-19, understand the risk factors in vulnerable populations, even predict where and when outbreaks may happen—if we can see around corners like that, we will actually get well ahead of this pandemic and we'll be part of the solution, in addition to the vaccine—evaluate how preventive and treatment measures are working, and give us information that will help us allocate where equipment and other resources might be best used. So I think this is a very encouraging development on the landscape of the health care system. Again, I'll go back—it just happens to be that you're asking questions, but it's a legacy of the pandemic that will allow us to realize real improvements in health data, which I think is what it's really all about.

I will introduce Greg Hein, the assistant deputy minister of the digital health division, who has been working tirelessly on this. He'll be able to answer some more questions about the OHDP.

Greg, introduce yourself.

**Mr. Greg Hein:** Good afternoon, everyone. As the deputy said, I'm Greg Hein, ADM of digital health at the ministry.

It's a great opportunity to build on the remarks of the minister and the deputy and to talk about an initiative that is really exciting to us because of what it has done so far and because of its potential.

Under the leadership of Dr. Jane Philpott, the Joint Ministers' Roundtable met from June 2020 to February 2021, with four strategic working groups formed to provide advice on various topics that were critical to the design of the platform.

The first, the equity and engagement working group, developed a strategy to establish public trust through equitable engagement on the use of patient data and tangible benefits from research. It also looked at evaluating equity considerations through the research process.

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The intellectual property working group informed IP policy and the development of an IP stewardship model that maximizes health, social, economic and other benefits while fostering domestic innovation and prosperity. The data supply chain working group developed plans for the strategic on-boarding of data sets to OHDP, prioritizing those most useful to immediate research supporting the COVID-19 response. Finally, the data governance and infrastructure modernization working group explored what was needed to support public stewardship of citizenship data, including pursuing legislative and regulatory reform to unlock the potential of Ontario's health and social data through the creation of a new data authority.

With the guidance of the round table, I'm proud to say that OHDP has been open for business since July 15. It initially leveraged existing computing infrastructure at the Institute for Clinical Evaluative Sciences, which is also funded by the ministry; but now, a separate, new, state-of-the-art computing environment was added this past winter. As the deputy said, it's fully optimized for advanced data science, including machine learning.

All OHDP-related data access is made available at no cost to the researcher. The government is funding the platform in order to accelerate research, knowledge creation and innovation related to COVID-19.

Using OHDP, researchers identified patterns in the available data to make more reliable predictions of how the virus is spreading and the impact it has. Early results included the identification of communities with greater vulnerability to contracting or those at risk of severe outcomes, showing sociodemographic impacts on geographical variation of COVID-19, informing our understanding of the impact of policies on care for newborn infants, and providing insights into surge capacity planning for hospitals.

Since its launch, OHDP has supported 49 research and analytics projects and 25 applied health research questions that have helped hospitals predict ICU capacity and surges in COVID-19 infections, informed testing strategies for public health units and the province as a whole, and helped identify the disproportionate impact of the virus on immigrants, refugees and other newcomers.

In addition, the ministry also launched the COVID-19 Challenge Questions Initiative to mobilize researchers accessing OHDP to provide answers to pressing questions needed to support a COVID-19 response. Challenge questions were developed through discussions with key advisory committees, practitioners, researchers, data experts, policy knowledge users, as well as patient and family advisers. The field responded with expressions of interest on vaccine strategy, pandemic waves, containment strategy, vulnerable populations, health equity and more.

Ultimately, OHDP enables better access to integrated linked health data for the pandemic response to provide insights into what is working, what is not, and to predict what and where more is needed to better manage the pandemic and protect front-line providers and citizens. The platform allows for faster and more transparent access to an unprecedented volume of rich, connected data to researchers.

Previously, health researchers had to approach every health care organization individually to collect the data needed to conduct research. This was a time-consuming process that took months, if not years, to negotiate, often resulting in lengthy delays and barriers in completing research. Now, OHDP provides a one-window streamlined approach for researchers to get access to the data they needed.

When it comes to privacy and security, OHDP features a data visitation model where the researchers must work with the data within the computing environment, and all the tools to support the analysis are available on the platform too. In this model, we say that the researchers can take away their insights, but not the data. Moreover, any sensitive information, such as a person's name, is hidden or removed, and no other personally identifiable data, in any combination or form, can be removed from the platform.

OHDP is only available to authorized users such as researchers affiliated with academic and research institutions providing critical research. Access to the platform and use of the data is closely managed, tracked, audited, monitored and secured. A series of control functions protects the privacy and integrity of any data made available, to allow research use of the data to be monitored. OHDP is also protected against potential cyber security attacks, through strict measures that meet or even exceed industry standard defences.

To gain access to the platform, researchers must submit formal data access requests, and projects are reviewed and selected to ensure alignment with government priorities for COVID-19. These data access requests must be accompanied by a robust research ethics review from a qualified institution such as a university or hospital to



ensure compliance with the highest standards of research ethics. In these ways, the ministry oversees both the privacy and ethical use of the data. For further transparency, once approved, information about research projects taking place on the platform is publicly available to Ontarians through the platform's website.

Researchers accessing data within OHDP are governed by the platform's terms of use, applicable agreements and the Personal Health Information Protection Act, of course called PHIPA in short. Furthermore, access privileges to the platform may be revoked, along with other types of organizational penalties being applied, depending on the nature and severity of the contravention. To further protect the people of Ontario, there are severe fines and penalties if the data is accessed or improperly used.

The ministry naturally consulted with the Information and Privacy Commissioner on the design of the OHDP and will continue to work with them as a partner to ensure that Ontarians' personal health information is protected.

In addition to protecting privacy, the ministry also took steps to ensure that if there are any innovations—which there will be—such as new treatments developed from the use of data on the platform, Ontarians are the first in line to get access. This represents a significant change and it's been achieved through a model of government stewardship of intellectual property. Responsible stewardship of the rights to new inventions, solutions and information is essential in demonstrating the use of data for public good and in promoting Ontarians' continued trust and confidence in the use of their data for research purposes. This is really important for the platform's architects and operators, that maintaining of public confidence.

Shifting to upcoming activities: Although we have achieved excellent progress, there's still more work ahead. First, we are in the process of bringing new data sets onto the platform, and the deputy mentioned some of them. It really is a treasure trove of data that the province has. We'll be spending the next few years taking in more data and adding to the value of the platform, and that's what's really exciting. Second, the ministry is looking for ways to accelerate research and integrated knowledge translation to ensure that results and findings are disseminated broadly to support COVID response. Third, the ministry is working with the Ministry of Colleges and Universities to implement the new IP policy for OHDP.

Looking into the future, with the necessary investments OHDP can evolve into an ongoing, government-sponsored research platform. Beyond supporting the response to the pandemic, OHDP has tremendous potential to support the overall transformation of the health system. OHDP will also contribute to the burgeoning marketplace of made-in-Ontario health technology.

We all recognize that data has the power to generate tremendous health, social, economic and other benefits for Ontario. However, the use of citizen data on this scale has never been contemplated before and our existing policy frameworks do not adequately address the necessary enablements and protections required.

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Ontario's health data ecosystem is hampered by challenges across a number of domains, such as technology, privacy and data quality. Making a paradigm shift, therefore, is an imperative. For these reasons, the Ministry of Health will be launching a public policy consultation, called the dialogue on data, to confirm and validate the policy requirements for the future state of the health data ecosystem, which includes, but is not limited to, OHDP. The ministry will consult with patients, the health sector and subject-matter experts in such areas as population health, research, genomics, precision medicine, risk management and cyber security. The ministry will also be establishing governance to seek additional expertise on a longer-term strategy and vision for OHDP and other important data policy topics as part of this dialogue on data.

OHDP is currently designed, as has been mentioned, to be used for COVID-19 purposes, and access currently is limited to researchers in academia, public health and government.

**The Chair (Mr. Peter Tabuns):** You have two minutes left.

**Mr. Greg Hein:** Thank you.

While the private sector has no direct access to OHDP at this time, there are important questions to ask Ontarians about their expectations for how their own data should be used. Twenty years ago, a stack of paper with information about you was just that. Now, it's a digital footprint that tells many of the details of your life. So now is the time to ask, how can we realize greater health care benefits for our citizens through the use of data, especially when health care expenditures are such a considerable part of the provincial budget? What is the public interest to be protected in the use of citizen health data? These and other important questions will be answered through this dialogue on data.

In closing, I want to thank my ministry colleagues and all of our OHDP partners who have worked extremely hard to help us deliver on this important priority. This includes Dr. Philpott herself, the Institute for Clinical Evaluative Sciences, Queen's University, Ontario Health, the Vector Institute, the University of Toronto and many others who have contributed their time and expertise. The successes we have talked about today would not have happened without their commitment and determination.

Thank you.

**The Chair (Mr. Peter Tabuns):** Thank you. And with that, we've come to the end of your 20 minutes. We now go to the official opposition. We've got about seven minutes. MPP Gélinas, the floor is yours.

**M<sup>me</sup> France Gélinas:** The first question is really simple: What does OHDP stand for? Your voice was too low when you started, so I did not catch this.

**Ms. Helen Angus:** It's Helen Angus. Ontario Health Data Platform.

**M<sup>me</sup> France Gélinas:** Thank you.

And I would go back to, I guess, ADM Fraser about the breakdown as to, how did we come up to \$650 million to

address the backlog of surgeries and procedures? I think ADM Fraser was interrupted as she was just starting.

**Ms. Melanie Fraser:** Thank you. Associate Deputy Minister Melanie Fraser, health services.

To answer your question, Madame Gélinas, it's not just purely an investment in volumes, but also an investment in all of the support services that help to complete those volumes. I'll run quickly through the funding. There was funding for premiums on volume-funded surgeries, premiums and funding for pediatric hospitals, private hospitals and diagnostic imaging of about \$234 million. There was then \$8 million in specialized supplies to go along with those. One-time funding to various independent health facilities for additional volumes: That was \$5.5 million. Operating funding to Mackenzie Health to help open was \$23.17 million. Funding hospitals in Ontario Health regions for centralized surgical wait-list management projects was \$12.9 million. So that totalled about \$283.7 million, and then additional incremental surgical volumes—again, more pediatric hospitals, more diagnostic imaging—for \$211 million.

We did fund some surgical smoothing and coaching. What that does is it actually optimizes the use of surgical suites around the province. You could almost consider it like a lean-type program, although some of these programs have been developed at Harvard and elsewhere, and they really help to manage the throughput on surgical rooms. So that was another million dollars.

There's \$30 million to support a surgical innovation fund, which the sector was really, I would say, very excited by and supportive of. It really, again, helps us to drive higher volumes and support hospitals with ancillary costs associated with maximizing the volumes they can produce. Then there's some funding for a centralized surgical wait-list management project of \$18 million.

So, I think that was an additional \$300 million, and I'm not sure if I've got everything there, but those are the figures I have in front of me.

**M<sup>me</sup> France Gélinas:** You are very close to \$610 million.

**Ms. Melanie Fraser:** Yes, I thought I was close.

**M<sup>me</sup> France Gélinas:** All right. The one that was interesting to me was \$5.5 million to IHFs. Are they just for surgical or are those for procedures?

**Ms. Melanie Fraser:** I'm going to actually defer to my director, Kristin Taylor, on the line, because I will give you one answer, but she will be able to answer with a whole other level of precision. Kristin, please introduce yourself.

**Ms. Kristin Taylor:** Hi. I'm Kristin Taylor. I'm the director of the provincial programs branch at the Ministry of Health. The \$5 million was for surgical procedures only.

**M<sup>me</sup> France Gélinas:** Oh, okay. And Mackenzie Health, \$23.1 million: Was this for procedures or surgery?

**Ms. Kristin Taylor:** I'm going to answer this, although it is my colleague James's, but I believe that was to support their early opening, to support the ICU capacity, and then also that we support surgical backlog.

**M<sup>me</sup> France Gélinas:** Okay. And when the ADM started with premium volume of \$230 million paid by procedures, that's for the—I forget how we call those, but the hips and knees and the uh—

**Ms. Kristin Taylor:** The QBPs?

**M<sup>me</sup> France Gélinas:** Yes, thank you.

**Ms. Kristin Taylor:** The quality-based procedures: It was for quality-based procedures, but also broader; it was for cardiac, neuro—anything that we volume-fund, we paid a premium on last fiscal.

Also, I would just like to go back and say that some of the funding for IHFs was for diagnostic imaging. My team is rapidly messaging me.

**M<sup>me</sup> France Gélinas:** All right. It all works.

Then, when we go to \$251 million for increased volume in imaging, then that's outside of IHF? It would be mainly in our hospitals?

**Ms. Kristin Taylor:** Right. That's MRI and CT imaging.

**M<sup>me</sup> France Gélinas:** Okay. That concludes my questions on the surgical backlog, except for the fact that—how many procedures and how many surgeries did you base those investments on? The DM talked about a wait-list of 173,000; is this what it was based on?

**Ms. Kristin Taylor:** I can—

*Interjection.*

**Ms. Kristin Taylor:** Oh, are we at time?

**M<sup>me</sup> France Gélinas:** You have 30 seconds. Use it wisely.

**Ms. Kristin Taylor:** Whew—stressful. We did a calculation based on what we believe can be done in the province, and then applied that. We know the backlog is going to take more than just one fiscal year, so we worked with our Ontario Health partners to estimate what could be achieved—

**The Chair (Mr. Peter Tabuns):** I'm sorry to say this, but that's all the time we have available today. The committee is now adjourned, and we'll return following routine proceedings tomorrow. Thank you all.

*The committee adjourned at 1800.*



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