Legislative Assembly of Ontario

Assemblée législative de l'Ontario

Official Report of Debates (Hansard)

SP-47

Standing Committee on Social Policy

Estimates

Ministry of Health

1st Session
43rd Parliament

Tuesday 11 June 2024

Chair: Steve Clark
Clerk: Lesley Flores

Journal des débats (Hansard)

SP-47

Comité permanent de la politique sociale

Budget des dépenses

Ministère de la Santé

1re session
43e législature

Mardi 11 juin 2024

Président : Steve Clark
Greffière : Lesley Flores

Hansard on the Internet

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. The address is:

Le Journal des débats sur Internet

L'adresse pour faire paraître sur votre ordinateur personnel le Journal et d'autres documents de l'Assemblée législative en quelques heures seulement après la séance est :

https://www.ola.org/

Index inquiries

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7400.

Renseignements sur l'index

Adressez vos questions portant sur des numéros précédents du Journal des débats au personnel de l'index, qui vous fourniront des références aux pages dans l'index cumulatif, en composant le 416-325-7400.

House Publications and Language Services
Room 500, West Wing, Legislative Building
111 Wellesley Street West, Queen's Park
Toronto ON M7A 1A2
Telephone 416-325-7400
Published by the Legislative Assembly of Ontario

Service linguistique et des publications parlementaires
Salle 500, aile ouest, Édifice du Parlement
111, rue Wellesley ouest, Queen's Park
Toronto ON M7A 1A2
Téléphone, 416-325-7400
Publié par l'Assemblée législative de l'Ontario

ISSN 1710-9477

CONTENTS

Tuesday 11 June 2024

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Tuesday 11 June 2024

Mardi 11 juin 2024

The committee met at 1500 in committee room 2.

ESTIMATES

MINISTRY OF HEALTH

The Chair (Mr. Steve Clark): Good afternoon, everyone. The Standing Committee on Social Policy will now come to order. We're meeting to consider the 2024-25 estimates of the Ministry of Health for a total of three hours. We're joined today by Hansard, broadcast and recording, and legislative research.

From the Ministry of Health, we're so very pleased to have Ontario's Minister of Health, the Honourable Sylvia Jones, with us today. We also understand that the Associate Minister of Mental Health and Addictions, the Honourable Michael Tibollo, will be joining us later, I'm told around 3:50. I want to thank and welcome the deputy minister, Deborah Richardson, and all of the staff who are here from the Ministry of Health for our deliberations this afternoon.

As this is the first ministry before the committee, I'd like to remind everyone that the purpose of the estimates process is for members of the Legislative Assembly to determine whether the government is spending money appropriately, wisely and effectively in the delivery of services intended. In the past, members have asked questions about the delivery of similar programs in previous fiscal years, about the policy framework supporting the ministry's approach to a problem or to service delivery, or about the competence of the ministry to spend the money wisely and efficiently. However, it must be noted that the onus is on members asking questions to make the questioning relevant to the current 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 arranged for the hearings to be closely monitored with respect to questions so that the ministry can respond accordingly. If you wish, you can verify the questions and issues being tracked with the research officer at the end of each appearance.

Are there questions from the members who are here today? Seeing no questions, I am now required to call vote 1401, which sets the review process in motion. We'll begin with a statement of not more than 20 minutes from the Minister of Health.

Minister Jones, you can proceed.

Hon. Sylvia Jones: Members of the committee, thank you for the opportunity and inviting me to speak with you today about how our government is building a more connected and convenient health care system that better serves the people of Ontario.

Our government recognizes that for too long, Ontarians have spent too much time trying to navigate the health care system and have waited too long or have had to travel too far to access the care and support they need. Our government is not okay with the status quo. That is why, under the leadership of Premier Ford, our government is making record investments in our publicly funded health care system to provide people with the care they need, when they need it.

This year alone, our government is investing $85 billion to take bold and innovative action to build a stronger health care system, providing people with a better health care experience during all stages of their life, while making it faster and easier to access care when and where Ontarians need it, helping people to stay healthier and have better health outcomes.

One of the important ways our government is working to provide patients with the right care in the right place is by increasing access to primary care. Timely access to primary care helps people stay healthier longer, with faster diagnostics and treatment, as well as more consistent support managing their day-to-day health, while also relieving pressures on emergency departments and hospitals.

Ontario leads the country with nearly 90% of people connected to a primary care provider. And last year, our government announced significant investments to provide more access to primary care in the community, with $110 million to connect up to 328,000 people to primary care teams and add over 400 new primary care providers and 78 new and expanded primary care teams across Ontario, which will include family health teams, nurse practitioner-led clinics, community health centres and Indigenous primary health care organizations. But we didn't stop there.

In this year's budget, our government went even further, investing $546 million over three years to connect 600,000 Ontarians to primary care. We also made investments to provide a boost to all existing interprofessional primary care teams to help them meet increased operational costs for their facilities and supplies so that

they can continue to provide high-quality care. The new and expanded teams are the result of a province-wide call for proposals that took place in 2023. These proposals were thoroughly reviewed by Ontario Health, based on criteria that prioritized the areas of greatest need, to connect a greater number of people currently without a regular primary care provider with primary care services.

Another one of our government's key accomplishments in 2023-24 was making an additional $330-million annual investment to support pediatric health services at hospitals, clinics and community-based health care facilities across Ontario. This is the largest investment in pediatric care in Ontario's history. With this new investment, more than 100 high-priority initiatives are being quickly implemented to ensure children and youth in every corner of Ontario can connect to high-quality care closer to home. These initiatives include hiring more pediatric surgical staff to increase the number of additional day surgeries, and the number of beds and staff to connect more families to in-patient, post-operative rehabilitation care. We are investing in rapid-access clinics that young people can access instead of going to emergency departments during respiratory illness season, which will increase the number of people who can be seen, triaged and cared for on-site.

This record investment is also supporting increased access to psychosocial supports for children and youth with cancer, as well as eating disorder programs, expanded midwifery care models, including for midwifery services in underserviced communities, and reducing wait times for children and youth to connect to mental health and substance use services.

Through this pediatric funding, our government is investing an additional $444.6 million per year to support children and youth mental health care. This will:

—expand access to live-in treatment services for young people with more intensive mental health needs, through the development of the Ontario intensive treatment pathway;

—expand One Stop Talk to connect even more youth to this innovative, virtual, walk-in mental health counselling service which was launched provincially in September 2023;

—support two new step-up and step-down live-in treatment programs in Sudbury and Waterloo for children and youth with intensive mental health needs, who need short-term supports to step down from hospital care to less intensive, community-based services, or step up from less intensive supports.

In 2023-24 and 2024-25, additional support will be provided for the Complex Transition Fund, which provides short-term, flexible support for children and youth as they transition into or out of community-based, live-in treatment programs. This funding increase will give community-based child and youth mental health providers the resources to expand and improve access to intensive mental health services.

Pediatric investments have also flowed to community mental health and addiction service providers across Ontario, including funding for eating disorder services, mental health and addiction services for Indigenous, LGBTQ+ children and youth, and for Black children, through programs such as the Substance Abuse Program for African Canadian and Caribbean Youth.

Our government is also continuing to expand services for children and youth mental health with 10 more youth wellness hubs across Ontario. The first five of these new hubs will be in Brampton, Oxford county, Port Hope, Thunder Bay and Vaughan, with more locations to be announced. Through these youth wellness hubs, which were co-designed with local youth, families and stakeholders, we are making it faster and easier for young people to connect to convenient and free mental health, substance use and primary care services.

Youth wellness hubs also provide a range of other services and supports, such as education, employment, training, housing and other community and social services tailored to meet the needs of local youth and their families. For example, the Sagamok Anishnawbek First Nation youth wellness hub—Indigenous youth and their families can also be connected to traditional healing and wellness services in a safe, welcoming space.

1510

Since 2020, our government has launched a total of 22 youth wellness hubs, connecting over 43,000 youth and their families to mental health and wellness services, accounting for over 168,000 visits.

In 2023, our government announced an additional investment of $425 million over three years for mental health and addictions services, including a 5% increase in base funding for community-based service providers. This investment builds on Ontario's Roadmap to Wellness, the government's plan to build a world-class mental health and addictions system, supported by a commitment to invest $3.8 billion over 10 years.

Our government also continues to accelerate the reach of the Ontario Structured Psychotherapy program. Through this program, adults who have depression, anxiety and anxiety-related concerns can conveniently connect to free cognitive behavioural therapies and other related treatment options and services through 10 network lead organizations with over 100 service locations across Ontario. To date, almost 80,000 people have enrolled in this program, and it continues to accept new clients.

We also made additional investments to connect Indigenous communities across northern Ontario to safe and effective mental health and addictions supports. This funding to the Nishnawbe Aski Nation, which represents 49 First Nations, will support community-driven, culturally appropriate services and supports, including for crisis response teams and for First Nations schools in Thunder Bay and Sioux Lookout, in response to the Seven Youth Inquest. This investment was part of a $20-million one-time investment in Indigenous-specific mental health and addictions services that was made in 2023-24, as we further support Sioux Lookout and surrounding areas through investments to bring addictions and supportive treatment beds and services to the region through the Addictions Recovery Fund.

Ontario's Addictions Recovery Fund is also boosting capacity for addictions services across the province, supporting the opening of more than 380 new addictions treatment beds and helping to provide care for approximately 7,000 clients per year. We have also invested more than $1.6 billion to support the construction of two new buildings at the Centre for Addiction and Mental Health in Toronto, which will provide enhanced mental health and addictions services to patients from across the province. And we are investing in a new in-patient acute-care unit, which includes an additional 20 mental health beds at the Waypoint Centre for Mental Health Care, which will expand access to specialized urgent mental health and addictions services throughout the Georgian Bay area and Simcoe-Muskoka.

From investing in the redevelopment and expansion of emergency departments in Brant and in the Bay of Quinte, a neonatal intensive care unit in Toronto and a new women and children's hospital in Mississauga as part of the Trillium Health Partners Mississauga Hospital redevelopment project, to improving acute-care capacity at Health Sciences North in Sudbury, our government continues to make major investments in Ontario's hospitals and health care facilities. In 2023-24, approved capital funding for hospital projects through the health capital program was more than $2.2 billion. Last year, we increased the Health Infrastructure Renewal Fund by over 17% and the Community Infrastructure Renewal Fund by over 10%. Together, over $208 million was invested through these programs to support critical upgrades and repairs at 131 hospitals and 58 community health care facilities. We also provided an additional $850-million investment to hospital budgets in 2023-24, representing, on average, a 4% increase from the previous year. That is enabling Ontario's publicly funded hospitals to manage operations and better meet patient needs.

Our $125-million investment in 2023-24 to support the province's Surgical Recovery Strategy brings the total investment to more than $1 billion, increasing the number of publicly funded surgeries and additional hours for MRI and CT diagnostic imaging scans, supporting innovative solutions to address local needs, and training pathways to increase the number of operating room and diagnostic professionals in Ontario.

Our government has made significant progress, providing faster access to care by achieving the shortest surgical wait times of any province in Canada in 2023, eliminating the backlog of surgical cancer screening tests at the end of August 2023, with testing turnarounds returning to the pre-pandemic standard of 10 to 14 days. And as of December 2023, completion rates of pediatric surgeries reached 112% of pre-pandemic levels.

Ontario's hospitals, health care providers and patients have also benefited from our ongoing work to build on our progress to grow and support our health care workforce. And 2023 was indeed a record year, adding 17,000 new nurses, 2,400 new physicians and thousands of personal support workers to the Ontario health care workforce. Since 2018, 80,000 nurses have been added and more than 12,500 physicians have joined the health care system.

And another 30,000 students are currently studying at Ontario colleges and universities to become nurses. Our government's investment of $225 million over four years is expanding nursing education in these institutions, which will increase enrolment by 2,000 registered nurses, 1,000 registered practical nurses and 150 nurse practitioner seats.

Through our 2024 budget, our government is investing an additional $743 million over three years to continue to grow our health care workforce and address staffing needs.

We are undertaking the largest expansion of the medical education system in over a decade, adding new undergraduate seats and residency positions in every single medical school, and opening two new medical schools in partnership with Toronto Metropolitan University and York University. York University's medical school will be the first medical school in Canada focused on training primary care physicians. Our government is training the physicians of the future, continuing to grow our health care workforce for generations, and we are already starting to see the results.

This year, 100% of Ontario's residency positions were filled through the Canadian Resident Matching Service, filling an additional 76 spots matched with more students choosing family medicine as their first choice of specialty. This data, along with the investments our government is making to expand the medical school education system, increase capacity across the health care system and add more primary care teams, shows that students want to become doctors in Ontario, and that doctors want to practise in Ontario.

New as-of-right rules came into effect this past year, making Ontario the first province to allow certain highly trained health care workers who are already registered or licensed in another Canadian jurisdiction to start work immediately when they arrive in Ontario without having to first register with one of Ontario's health regulatory colleges.

We took further steps to break down barriers for internationally educated physicians by establishing the Practice Ready Ontario program, which removes the requirement for these doctors to complete lengthy re-education programs and instead allows them to practise in Ontario immediately.

We provided more support for nurses through the Clinical Scholar Program, which pairs an experienced front-line nurse who acts as a dedicated mentor with newly graduated nurses, internationally educated nurses and nurses wanting to upskill. Since the program began last year, more than 100 hospitals are participating in the Clinical Scholar Program, through which 435 experienced front-line nurses have provided more than 17,000 mentorship touch points to new graduates, internationally educated or upskilling nurses.

1520

Last year, our government also expanded the scope of practice for registered nurses and pharmacists. We expanded

the role of registered nurses to prescribe certain medications, such as for contraception, immunization, smoking cessation and topical wound care. To prescribe these medications, registered nurses must complete additional education requirements that have been set and approved by the council of the College of Nurses of Ontario.

We also further expanded the scope of practice for pharmacies by allowing them to treat and prescribe medications for an additional six common medical ailments, building on the 13 common ailments that pharmacists have already been prescribing for since January 1, 2023. Ontario is now one of the leading jurisdictions in Canada in providing convenient health care services through our community pharmacies.

As of this month, more than one million pharmacists' assessments were completed since pharmacists were given scope-of-practice changes and allowed to treat and prescribe for 19 common medical ailments, with more than 4,800 or 99% of pharmacies across the province participating in the program.

The Chair (Mr. Steve Clark): Minister, you have about one minute remaining.

Hon. Sylvia Jones: We have so many good stories to tell.

Last year, we announced we are adding 300 new paramedic education seats at provincial paramedic colleges. Our Learn and Stay grant, which has now been provided to 227 paramedic students across northern Ontario, is going to make an impact in northern communities.

And to further increase our work with decreasing the time waiting at emergency departments, our government invested an additional $44 million to support local solutions at 163 hospitals across Ontario to make it faster and easier to care.

Of course, we have also announced expansions with Ornge, with their fixed-wing fleet replacement and expansion of an additional four planes—

The Chair (Mr. Steve Clark): Thanks, Minister. I know you could keep going so—

Hon. Sylvia Jones: I hope I get an opportunity to.

The Chair (Mr. Steve Clark): I'm sure you will.

We're now going to move into the question-and-answer portion in rotations of 20 minutes for the official opposition, 10 minutes for the independent member, and 20 minutes for the government members, for our remaining allotted time.

As always, please remember to make your comments through the Chair. And for the benefit of both the staff who are here in person and online, for deputy ministers, assistant deputy ministers, ministry staff, please ensure that at the start of your response that you give your name and title when you're asked to speak so that they can be recorded in Hansard. I just want to remind you of that.

We're now going to start with the official opposition. MPP Gélinas.

M^me^ France Gélinas: Thank you, Minister, for this presentation, and everybody who made time to come here today.

I will start my questions the way I have started my questions in the last 17 years with primary care. That's a big shock to everybody, I'm sure.

There was $20 million given to CHCs, nurse practitioner-led clinics, Indigenous primary care and family health teams—that's about 200 agencies altogether. Was it the hope that the $20 million was going to cover not only wage increases through Bill 124—so retroactive wage increases—but are we also hoping for wage parity?

I will start with nurse practitioners. Is there money in there to bring wage parity for nurse practitioners who provide care in primary care versus hospitals or other sites?

Hon. Sylvia Jones: Thank you for the question.

As I mentioned in my opening remarks, in February we announced an expansion of 78 new or expanded—in some cases, satellite expansions—of primary care practitioner teams. In addition, those teams vary, as you can imagine, in size and the offerings and the clinicians who work within them. We have also, as part of that announcement in February, increased the annual operating for the existing primary care practitioner teams in the province of Ontario.

As you know, when individual primary care teams get together—those multidisciplinary teams—we as a government do not impose wage limits or specifics on who must be hired at a certain wage.

What we are seeing is, we've already had primary care teams start to not only hire, but bring on new patients. And that was always the goal, right? We really wanted to have these primary care multidisciplinary teams to be able to operate and get operational very quickly. We've seen that in Minto-Mapleton. They've already started taking on new patients. Of course, in Kingston, we've seen that operationalized very quickly.

Deputy Richardson, I don't know if you wanted to add more to the specifics of that primary care expansion—

M^me^ France Gélinas: My question is very specific. I think just before Christmas, or January this year, you received a report that Alliance for Healthier Communities and other primary care providers had done to show the wage discrepancy between what community health centres, nurse practitioner-led clinics, Indigenous primary health care and family health teams were able to pay their health care providers, with recommendations for pay increases. Is there any money in the budget anywhere to bring this wage disparity in line, given the report that you've received and the disparity that exists right now?

Hon. Sylvia Jones: Existing operations make the determination of not only the makeup of the clinicians who are going to operate within those primary care multidisciplinary teams, but they also set the wages. In the same way that we do not compel—

M^me^ France Gélinas: But if there are no pay increases, then are you saying that they should let go of a nurse practitioner so they can pay the other one more? If your government is not giving them increases, how are they supposed to give their employees pay increases?

Hon. Sylvia Jones: Chair, I want to be clear: In my opening remarks, I did make reference to not only an

expansion of 78 new or expanded, but some funds were also provided—

M^me^ France Gélinas: Yes, $20 million.

Hon. Sylvia Jones: —to the existing multidisciplinary teams that already operate within the province of Ontario. Local boards and local leadership will make a determination on not only who works within those primary care teams, but also the appropriate pay raises for that community within that facility.

M^me^ France Gélinas: I saw you just received a little note. My question is very specific: Did you take into account the pay discrepancy? And is your ministry going to fund the interdisciplinary teams that exist in a way that would allow us to basically bring pay parity, to at least give their staff pay increases? The idea that they would have to lay off somebody so that they would have enough money to give everybody else a raise is something that none of them are willing to do. They all have long waitlists—2.4 million Ontarians without access to primary care. They need money coming from you.

Hon. Sylvia Jones: Well, as I said, we did provide additional funding in February for the existing teams, so there was an acknowledgement that as costs rise—but I don't believe that we should be, at the Ministry of Health in downtown Toronto, micromanaging how individual multidisciplinary community health teams are approaching their staffing and how they divide up the money and the funds that are provided by the province of Ontario. We leave that to the individual organizations, because, frankly, across the province, they are very different, depending on the community needs.

The Chair (Mr. Steve Clark): I just want to give a gentle reminder for members of the committee to direct their comments through the Chair.

M^me^ France Gélinas: Sorry, Chair.

The Chair (Mr. Steve Clark): Go ahead.

M^me^ France Gélinas: The $20 million is very short of what the report that you've received from the interdisciplinary primary care teams was asking for. Is there hope that you will answer with money to the report that you've received?

Hon. Sylvia Jones: Well, in the 2024 budget, you saw an additional expansion of over almost $350 million set aside for continuing to support our primary care multidisciplinary teams. So I think our government has shown through its actions and in investments that we absolutely see the value of multidisciplinary teams and want to continue to support those expansions within community.

M^me^ France Gélinas: Is this money solely for expansion, as in new sites and expansion, or they can use some of that money for existing staff, existing programs that need pay increases?

1530

Hon. Sylvia Jones: Chair, I think this is the third time I've answered this. There was a portion of the funds that were announced in February—

M^me^ France Gélinas: The $20 million, yes.

Hon. Sylvia Jones: —for existing primary care multidisciplinary teams, community health centres—

M^me^ France Gélinas: So that's it? The $20 million is it? The rest of it—

Hon. Sylvia Jones: —and then, in the 2024 budget, of course, we had another announcement to continue to invest in primary care across Ontario.

M^me^ France Gélinas: I got the list of the 78 primary care expansions that you've announced. It was kind of disappointing that I had to put an order paper question to finally get the list, but I got the list. There's one in there, Homeless Health Peel—they put in a request. They got funded with $1.4 million. They were really happy. They asked to work with the WellFort community health centre, but now Ontario Health has basically told them no, they won't exist anymore, and the community health centre will take over this homelessness program and the $1.4 million. It's weird, because it is Homeless Health Peel that made the request. You selected them. You wrote to them and said, "Congratulations, you are funded for $1.4 million." They started to work with Ontario Health. Ontario Health first said, "We will use an existing transfer payment agency"—which was WellFort community health centre—"to fund you." And now it's, "You don't exist anymore. The community health centre will provide this service."

I'm just wondering if many more of the agencies that have written and received a letter of support from you, telling them that they've got funding, are about to disappear.

Hon. Sylvia Jones: The example that you raised is actually one that was given to me last week. We're exploring the specifics of what is going on with those two organizations.

I will say that as part of our accountability process within the ministry—Chair, I'm sure you can imagine that there are accountability agreements that are signed with the ministry through Ontario Health, and part of that due diligence is, frankly, very similar to the estimates committee. We're making sure that the application and proposal, as prepared and as submitted, is going to be completed as it is written. So the accountability piece will always be there.

Specifically to the example that you raised, I want to make sure that we have all of the facts on the table before we make any additional comments one way or the other. I can assure you that that concern was raised with me last week and we are looking into the specifics of it, but I don't want to comment further because we don't have all the facts on the table.

M^me^ France Gélinas: I thank you for this. I'm the one who handed you the letter, so thank you for following up.

Is it okay to ask the Clerk to make sure that once the answer is there, it is shared with me and shared with the committee members, given that we've talked about it here?

Hon. Sylvia Jones: Chair, of course, you have ultimate say on this, but clearly this is something that has to be dealt with within the two organizations, first and foremost. I would be hesitant to be committing myself and the ministry to something before having all of the facts on the

table and knowing exactly what is going on in that particular circumstance.

M^me^ France Gélinas: Don't share with me things we're not supposed to know, but if you're allowed to share it, please do share it with the committee.

My next question for sharing is that—I do have the list of the 78. Could I have a list of not only expanded primary health care team names and communities, but how much money each of them were allocated?

Hon. Sylvia Jones: The call for interest or call for applications for expression of interest was very much of interest to the province of Ontario and organizations within Ontario—very large interest because, frankly, we haven't seen a primary care multidisciplinary team expansion like this, I think, since multidisciplinary teams were formed in the province of Ontario.

M^me^ France Gélinas: I was told you received $1 billion worth of asks.

Hon. Sylvia Jones: A number of organizations that asked for more received less, knowing that we were trying to get the areas and cover the areas of greatest need.

Again, because these are individual contracts, accountability agreements that are signed by each of the primary care community health centres, I would be hesitant to agree to releasing that information until all of the signatories have happened through the regional Ontario health offices.

M^me^ France Gélinas: I'm a very patient person. I've been working at this job long enough to know that nothing happens fast—but as soon as you have a signed agreement, I can request them. It's just easier, as you sign an agreement and the amount is being known—if you could share that with the committee so that we know how much each of those 78 applicants will be receiving.

Hon. Sylvia Jones: Chair, I'm not a lawyer. The critic is also not a lawyer. I would ask that I be allowed to take that back to our legal counsel to make sure of what is appropriate and can be shared at the appropriate time.

M^me^ France Gélinas: No problem. I have freedom of access of information to accountability agreements all the time, so I feel pretty sure, but I'm not a lawyer. We'll let the lawyers decide. If they say yes, I don't need a copy of the agreement; I just want the amount.

Talking about the selection you've made, you got a billion dollars' worth of requests and you had $90 million to assign, used a selection process that—I live in northern Ontario. The people who put in requests for northern Ontario felt that the selection process was biased against northern Ontario, that those who were selected were selected, really, for—the greatest-need areas were identified by numbers. In numbers alone, southern Ontario always wins versus northern Ontario. There were some announcements made in northern Ontario. In Timmins, you made announcements etc. Is there any way to share the list of criteria that were used to make this selection?

Hon. Sylvia Jones: As I mentioned in my opening remarks, some of it was how quickly the organizations could basically do the hiring and start the process of matching patients who were looking for primary care practitioners. Some of the applications had a high percentage of capital asks, which, again, we know is going to extend the amount of time it would take to build out and actually start operationalizing. Frankly, it's why you saw a number of successful applicants who are already existing but wanted to expand into those satellite areas.

In Innisfil, as an example, there was no primary care practitioner operational there, but they had a facility—a welcome host, if you may—and that allowed an existing primary care multidisciplinary team to quickly be able to expand their offerings.

Some of it was, "Tell us how you are going to operationalize this by hiring appropriate clinicians." So those that submitted applications based on their—

M^me^ France Gélinas: Can I have the complete list? Is this something that can be shared, as to what were the criteria—how quickly, capital asks, are you able to recruit and all of this? They're good criteria; I'm not arguing this. Can we know the list of criteria that were used so that I could calm down some of the many, many interdisciplinary teams that reached out to me that are not happy?

Hon. Sylvia Jones: Chair, part of my hesitation is that the accountability agreements have not all been signed off. So that work is still ongoing.

Part of it is, we have an expansion coming forward, and Ontario health regional offices are already directly working with either the applicants who were unsuccessful and answering the types of questions that the member is raising in terms of, "How do we strengthen our next application as we see the next reiteration of expression of interest?"

1540

Those are ongoing conversations, and frankly they're not consistent because, as you would know from representing northern Ontario, there are some communities where a capital consideration would have to be made in order to allow the expansion to be happening. It was not hard and fast in terms of, "Thou shalt have to have A, B and C." Our first and foremost priority was, "How quickly can you operationalize, and how quickly can you get a percentage of your community to be matched with patients?" I know the critic talks about how southern Ontario, because of its numbers, can always win the numbers game, but it was also a percentage piece in terms of what is already existing in some of those more northern and remote communities, to make sure that we see a higher percentage of the population being able to have access.

I think that we have shown, particularly through the work with Sault Ste. Marie, when we heard the news, unfortunately, of Group Health Centre's change of heart and intention to de-roster—we quickly started to not only work with the existing primary care multidisciplinary teams, but also some other innovative pieces to see how we can work together to make sure that individuals and families continue to have access to health care within their community.

We really pride ourselves, frankly, in the ministry to be able to look at the individual challenges within a community and then drive innovation based on what we're seeing.

The Chair (Mr. Steve Clark): There's about a minute remaining in this round.

M^me^ France Gélinas: Through you, Chair: If I could get the list of criteria, that would be very good, and if the applicants could know the list of criteria to apply, that would be good.

Talking about the Group Health Centre—they put in a request last June. They sent to the minister another request in January, and they were told the day before 10,000 people were losing access that they would finally get the money that they had requested 11 months before. I have to tell you, the hurt in that community is unbelievable. The minister had this request back in January. We all know what the request was—to open up a same-day-appointment clinic for the people who were being de-rostered. To wait until the day before for those people—the stress that we have put those 10,000 people from Sault Ste. Marie through is just incredible. Not a day goes by that I don't have somebody crying on the phone.

The Chair (Mr. Steve Clark): Thank you, MPP Gélinas. That's the end of this first rotation for you.

We're now going to move to the independent member. MPP Clancy, you're going to have a 10-minute question rotation. You can proceed.

Ms. Aislinn Clancy: Thanks to all the folks here who I know work very hard to try to deliver good health care in the province. Just know that I come from a place of gratitude, as well.

I have a few questions.

One of the main concerns I find when I'm talking to people in my riding is a perceived or valid shift to privatization. One focus is agency nurses. As you know, different hospitals have reported that they have ended up using agency nurses, and it has cost them a lot. We don't, that I know of, have a cap on what could be charged per hour for an agency nurse. We know that agency nurses often cost twice as much. They're more likely to make mistakes. When it comes to long-term care and other areas, there is the lack of connectivity; they don't know the residents because they're just hopping in. So it's a benefit for the nurses, where they can make their own schedules; they can make more money etc., but I think it has a negative impact on the overall care. A neighbour of mine shared that she ends up with a nurse beside her who gets paid twice as much and is asking her what to do and how to do it, so there's a little frustration, I think.

Can you describe what the plan is to move away from for-profit agency nursing and the cost that that has on the system?

Hon. Sylvia Jones: I'm going to start—I get very concerned when people talk about, one form is less safe or more safe than the other.

I want to be very clear: The registered nurses of Ontario are all regulated by a self-regulatory body, and they all have the same training.

The flexibility that you referenced in terms of individuals who want to try working in different communities is absolutely there. Temporary staffing agencies have been operating in the province of Ontario, as you know, for decades. The unfortunate reality is that there are northern hospitals that continue to rely on temporary staffing agencies to cover off their important shifts, to make sure that we have those remote northern hospitals operationalized.

In terms of what are we doing to not have to have hospital leadership rely on temporary staffing agencies—it's expanding the number of nurses we are training in the province of Ontario; it is, a month after I was appointed as the Minister of Health, writing a directive to the College of Nurses of Ontario, saying that they must expedite, review and, when appropriate, license.

As I mentioned in my opening remarks, we have seen two historic years, two highs, in terms of how many new trained and licensed RNs are working in the province of Ontario—30,000 nursing students who are getting ready to train, learn and work in the province of Ontario.

What we are doing is absolutely expanding the opportunities for people, for young people—particularly a Learn and Stay program that started under our government, where we cover off tuition and the cost of books for individuals who are prepared to practise in less-served areas.

Ms. Aislinn Clancy: I guess one thing that has come up from the College of Nurses is that many don't renew their licences.

Have you been in discussion with the nursing partners about encouraging nurses to stay in Ontario?

Hon. Sylvia Jones: Absolutely.

Sorry; I just wanted to make sure you're done.

Ms. Aislinn Clancy: Yes, I'm looking for a plan. I didn't hear that there would be a cap on the amount that gets charged—I heard upwards of $300 an hour.

Hon. Sylvia Jones: In terms of retention, we have put in place, working with the College of Nurses of Ontario, a program where nurses who have recently retired can return and get their licence back, and we've actually waived that fee.

Deputy Richardson, if you would cover off a little more of that, I would greatly appreciate it.

Ms. Deborah Richardson: I'm Deborah Richardson, deputy minister.

I'm going to call on our chief nursing executive, Dr. Velji.

Dr. Karima Velji: I'm Karima Velji, chief of nursing and professional practice and assistant deputy minister responsible for the HHR file.

Thank you for the question—big attention on recruitment and retention of nurses, and building upon what the minister has said. We've seen significant, positive impacts out of our strategy. We have a very robust health human resource strategy. In the last two years alone, we've registered a number of new nurses we've never seen before; so last year—the year before, it was 15,000; this year, we are crossing, actually, the 18,000 mark. So more and more new nurses are coming into the system.

Ms. Aislinn Clancy: Are you tracking those who don't renew and leave the province, and exploring why?

Dr. Karima Velji: Yes, we certainly are. We keep a very close eye on the College of Nurses data. I am very pleased to share with you that attrition is very stable in the province. We have not seen an increase in attrition. People may leave one agency to go to another agency or they may leave hospital sector to go to a community sector and vice versa. Movement is normal in a system, but we are not seeing a significant attrition of staff from the system. We have four or five very robust programs that are targeting retention of nurses.

Ms. Aislinn Clancy: We are hearing from nurse practitioners about the pay parity, but also about staffing ratios.

Have you been exploring ways to improve patient-to-nurse ratios?

1550

Hon. Sylvia Jones: The challenge with just putting in a policy without having the sufficient health human resources means the policy is going to fail. I think it's really important for us to give hospital leadership the ability to manage their staff and their system. In the same way that not all hospitals offer all of the same services, we have to make sure that we don't put policies in place that actually limit their use of innovation.

When we empower hospital leadership to make changes based on what they are seeing in their community, we have seen really positive success. That can be upskilling, as an example—a nurse who has traditionally been on a ward floor, who wants to upskill up the ladder, and now they have access through some government programs to train to be an emergency department nurse or an ICU nurse.

That's the flexibility that we are trying to offer, to Dr. Velji's point, to encourage the retention piece. If we give people some flexibility in what their career looks like, whether it is additional mentoring, whether it is the opportunity as a more senior nurse to mentor young nurses, we are seeing really positive feedback, and not only from nursing students. I was just at a small community hospital a couple of weeks ago, and all of the nursing students who are participating in the extern program talked about the confidence they had working in that team, in the hospital environment. When they went back to continue their nursing progress, the professors were commenting on how much more confident—and how they had seen a dramatic increase. So those programs are the ones that are making a difference.

Ms. Aislinn Clancy: I know you spoke a lot about increased investments. In prep for this, I reached out to my community health centre and family health team. Maybe the money is coming, but the family health team said they hadn't had a boost in funding—

The Chair (Mr. Steve Clark): There's one minute remaining.

Ms. Aislinn Clancy: —in 20 years, and the community health centre hadn't had a boost in 12 years to their base budget. Is this because maybe the money is at project or hasn't come in yet? That's the feedback that I heard from those local arms.

Hon. Sylvia Jones: The community health centres would be part of the primary care multidisciplinary team, and they would have received an injection and addition to their base funding in the announcement in February.

Of course, with our physicians, we have a physician services agreement that is currently in process; there's an arbitration process going on right now, so I won't speak to more specifics on that.

Ms. Aislinn Clancy: Do you think it's because of inflation they don't see it as a boost? Maybe we will have to look into why they haven't experienced a boost. Or is it just the inflationary—

Hon. Sylvia Jones: Well, the announcement was made in February.

Ms. Aislinn Clancy: I spoke to them yesterday, so I'll have to—

Hon. Sylvia Jones: CHCs, in particular—community health centres.

The Chair (Mr. Steve Clark): Thank you, MPP Clancy. That's your first 10-minute rotation.

We'll now move to the government's first 20-minute rotation. MPP Pierre.

Ms. Natalie Pierre: Thank you, Minister and to the ministry staff, for your remarks and presentation this afternoon.

My question is around mental health and addictions.

Minister, many Ontarians in communities across Ontario are facing challenges when it comes to mental health and addiction. The government has made historic investments in this area through the Roadmap to Wellness, and the most recent budget continues this trend.

Can you please provide more details on how the government is supporting mental health and addictions? And if you could also please touch on the important work the government is doing to help improve the mental health of children and youth in the province, it would be greatly appreciated.

Hon. Sylvia Jones: I will let the associate minister cover that.

Hon. Michael A. Tibollo: Thank you for the question. I'm very happy to be here today to talk about the work our government continues to do to advance high-quality mental health and addiction services for people in the province of Ontario.

Four years ago, we released our comprehensive mental health and addictions strategy, the Roadmap to Wellness. It sets out our vision to build a high-performing and sustainable mental health and addictions service system, designed to meet the mental health and addictions needs of people across the population and throughout their life, from childhood to old age. Since 2019-20, we've flowed approximately $860 million in new base funding into the mental health and addictions services, across the lifespan. These investments show our government's ongoing commitment to connecting people in Ontario with the mental health and addictions services they need where and when they need them.

We aren't just flowing new money into services; we're actually taking stock of the entire service system. So we have been able to make strategic investments and, frankly,

to begin to set right some historic inequities in how our system was designed.

For instance, we've taken it on ourselves to address long-standing gaps in the addictions sector. Everyone in this room and across Ontario has been touched in some way by substance use issues, and communities across the province are struggling with the impact of opioid addiction and the increasing toxicity of the drug supply. If you look back, addictions treatment was the poor cousin in the system, receiving less funding and oversight than either adult mental health or child and youth mental health.

Our government has increased base funding for community addiction services by over $150 million since we released the Roadmap to Wellness. Since 2022, we've been making key investments through the Addictions Recovery Fund—a one-time investment of $90 million over three years, which has just been renewed for $124 million for another three years in this year's budget. Our ARF investments are funding a range of services, most critically including nearly 400 new treatment and recovery beds. It's important to stress as well that over half of these new beds from this fund are or will be in northern Ontario, where we know needs are particularly high.

But connecting people to care is about more than increased funding. Sometimes it requires innovation in how we deliver and design care. Across the continuum of care, our government has been introducing innovative ways of improving access to care.

An example of innovation in the addictions space is Renascent's new Virtual Intensive Treatment Program for addictions and substance disorders—a six-week, intensive, evidence-based program that uses secure virtual technology so individuals can access the program from the comfort of their home.

Another example of innovation is One Stop Talk, a virtual counselling program offering children, youth and families across Ontario immediate access to counselling by a mental health clinician. Clients can access this care over the phone, by video conference, or by text or chat.

Mobile mental health and addiction clinics are another example of how we're funding new ways to connect people to care. We've launched five mobile clinics across Ontario, in Peterborough, Kenora, Haldimand-Norfolk-Niagara, Manitoulin Island, Hastings-Prince Edward county. These clinics are providing traditional mental health and substance use treatment to people who otherwise may not be able to access these services.

We're also developing new programs to fill major gaps in the continuum of care. The adult mental health services system we inherited was designed to respond to deinstitutionalization. The focus, rightly so at the time, was to meet the needs of the people leaving those institutions—people with serious, chronic and complex mental illness. In this model, there were few opportunities for people with mild and moderate issues to receive care. For instance, adults with mild to moderate forms of the most prevalent mental health conditions in society, like anxiety and depression, had trouble accessing publicly funded treatment. Our government decided that needed to change and that people who had mild to moderate needs deserve to have those needs addressed. We realized that investing in upstream services made sense. An ounce of prevention is better than a pound of cure. Why wait until a known problem becomes severe before intervening? We filled this gap in care with the Ontario Structured Psychotherapy program, which is designed to address mild to moderate forms of anxiety and depression, the most common mental health disorders. OSP offers a range of services, from low-intensity, Internet-based cognitive behavioural therapy and self-directed skill-building supported by a coach, to group and one-on-one psychotherapy. Treatment options are matched to client need, based on clinical assessment upon referral into the program.

Ontario has also been addressing the historic failure of the mental health and addictions system to accommodate the needs of transition-aged youth. Statistics show that youth between the ages of 16 and 25 have the most need for mental health and addictions treatment of any age group, yet they have access to the least. Late adolescence and young adulthood, the period of transition-aged youth, is a distinct developmental stage, and this group has unique needs, but our traditional care continuum is silent on this pivotal stage of life. We have services for children and youth under the age of 18, and then adult services for people over the age of 18. We're fixing this fundamental issue.

1600

Since 2020-21, we've provided base funding for Youth Wellness Hubs Ontario, a coordinated, provincial network of integrated youth services that offer youth between the ages of 12 and 25 integrated mental health, substance use and primary care in youth-friendly, easy-access locations. The hubs are designed by and for local youth and their families. Every hub receives Ministry of Health funding for a core clinical team. This makes up the youth wellness team. But evidence shows that youth tend to avoid purely clinical settings. So, guided by research on what it takes to increase help-seeking and access to care among young people, Ontario's youth wellness hubs co-locate clinical care alongside a range of other services, including wellness, recreation, education, and other skill-building services. This co-locating of services is a new approach to mental health care, and one that emphasizes the importance of community involvement and youth participation. It's a primary care approach to mental health, where youth are supported throughout their care with system navigation supports and are connected to promotion and prevention activities through welcoming, youth-friendly engagements. If you visit one, you'll find things like cooking classes, yoga, crafting, sports activities being offered on evenings and on weekends, along with educational, employment and other services and supports.

The adaptability of the youth wellness hub model to local needs has furthered our equity goals, enabling partnerships with Indigenous health service providers, francophone agencies and other organizations serving priority populations. For example, one I'm most proud of is the youth wellness hub in Sagamok Anishnawbek First

Nation. This was entirely co-designed with Sagamok Anishnawbek youth, their families and leaders. It provides culturally appropriate treatment and traditional healing and wellness services to youth when and where they need them most.

Through youth wellness hubs, we're also making first-ever dedicated funding for developmentally appropriate youth addictions care. It's a sad fact that problematic substance use can start as early as elementary school and that substance use becomes increasingly common through middle and high school. Again, the system of care we inherited was silent on these issues.

Ontario is building a robust mental health sector dedicated to serving children and youth under the age of 18, and we recognize the need to equip the sector to address substance use issues. We're addressing this systemic gap by supporting developmentally appropriate youth addictions treatment through the Youth Wellness Hubs Ontario program. Clients as young as 12 can now go to a YWHO location and receive evidence-based medical care and treatment for problematic substance use. In situations where youth needs exceed the hub's capacity, they're connected to more intensive services and supports that can meet their specific needs.

I'm proud to say that in our interactions with the federal and other provincial governments, it has become clear that Ontario is now regarded as a leader in integrated youth services. Ontario officials are often called on to profile the YWHO model, and the executive director of YWHO, Dr. Jo Henderson, is regarded as a national and international thought leader in this space. This is something that all Ontarians should be extremely proud of.

I want to talk about some of the meaningful investments we've made in evidence-based prevention and early interventions. For decades, governments across Canada treated mental health and addictions issues as something to react to. We're not making that same mistake. When it comes to mental health and addictions, our government is active, not reactive. We've made strategic investments in evidence-based substance use and eating disorder prevention and early intervention for children and youth.

Let me start with eating disorders. Eating disorders have had the highest mortality rate of all mental illnesses. Once someone develops an eating disorder and the condition takes hold, it can be extremely difficult to treat. That's why evidence-based prevention and early intervention in eating disorders are so critical. But historically, the province's investments were almost entirely clustered around hospital-based care for people with the most severe levels of need. There was no capacity in community or hospital outpatient programs to address lower levels of acuity or to focus on prevention and early intervention.

As with all mental illnesses, there was a need to build out a continuum of care for eating disorders, and through the Roadmap to Wellness, we've started to build that continuum. We have flowed the first-ever dedicated funding for evidence-based eating disorder prevention and early intervention. A team at UHN is working with Ontario, Canadian and global eating disorder experts to provide training and support for child and youth mental health agencies, schools and others who work with youth, because these sectors are seeing higher rates of disordered eating but have traditionally not had the capacity to intervene and address these issues in a safe, evidence-based way. The UHN team is also building out an evidence-based prevention program, hiring eating disorder prevention specialists in every Ontario Health region, who will deliver services targeted to children and youth under 25, along with their caregivers.

As I pointed out earlier, we're making these important investments in upstream services, and the significance of these first-ever upstream investments is profound.

The prevention and early intervention program we're building is actually the first of its kind in the world. I'm very proud of that.

Shortly after announcing this upstream funding, a table of eating disorder physicians and medical specialists for pediatric eating disorder hospital programs across Ontario was convened to talk with staff from the Ministry of Health and Ontario Health. In that round-table discussion, every physician spoke positively about our government's investments in prevention and early intervention. According to one physician, there used to be nothing standing between her and an extremely sick child or young person entering her hospital's emergency room. Our government, through these crucial investments, is changing all of that.

Turning to substance use prevention, Ontario has introduced the PreVenture program, an evidence-based substance use prevention program aimed at students in grades 7 to 9. Research shows that the earlier a youth engages in substance use, the worse the outcomes will be, and the higher the likelihood that youth will develop a substance use disorder in adulthood. PreVenture seeks to delay early-onset substance use by identifying preteens and early teens who have known risks for substance use and teaching them cognitive behavioural therapy coping skills as a protective factor against substance use.

The PreVenture program has been tested in randomized controlled trials across the world, and the results of the program have been remarkable. An over 50% reduction in drug use and an over 50% reduction in alcohol consumption among youth have been seen through this particular program.

In closing, I want to emphasize that balance is the key principle behind the concept of a continuum of care. As is the case with physical health, we need to focus on acute care and the most severe needs, but there's also the need to identify problems as early as possible and to have the supports put in place so they don't become more significant over time. Our commitment was laid out in the Roadmap to Wellness. We continue to invest in a full continuum of care whose supports are balanced across all levels of need and the stages of life. This is what we're doing to ensure that we meet the needs of all our population throughout the province of Ontario.

Ms. Natalie Pierre: I'm interested specifically in the youth wellness hubs. I appreciate the government's approach to prevention and early interventions. I'm hoping you can

provide more detail around the services that are offered at the youth wellness hubs and perhaps some of the investments that our government has made in the most recent budget.

1610

Hon. Michael A. Tibollo: The youth wellness hubs were a model that we looked at early on. They were piloted, I believe, initially with seven of them, but we started seeing early on the results that were coming in with a number of youth who were attending the youth wellness hubs. If I recall correctly, the first 17 that were opened saw 160,000 visits and 43,000 unique individuals. That is staggering, when you think, where would these kids have been if they didn't have a place to go to like a youth wellness hub? If you visit any one of them, they are all modelled a little differently because each one of them caters to the needs of that specific community and the children from that particular community. You'll see in some cases that they'll have a small room where they will watch films. You'll see that they've got teachers or people to assist them in the preparation of a résumé to be able to get a job; you'll see them getting snacks in the kitchen, but there's also someone there who will show them how to prepare a meal—a lot of skills that we would otherwise consider to be basic and, perhaps, should have been learned at home. This is providing them the opportunity where maybe that gap existed.

But the most important thing, I think, when we look at the youth wellness hubs, is that it's created by them, for them. I went to one in Toronto where the majority of the kids were LGBTQ2, and I could tell really quickly that these kids felt at home and felt safe, and that's really important, when you think about the youths' encounters in community and sometimes being bullied. Being in an environment where they can feel safe gives them that opportunity to share, to talk and to really ramp themselves up and build that resiliency that we need to see in kids if they're going to be successful later on in life.

We are now at 27 youth wellness hubs in the province of Ontario, and we're continuing to build them because we recognize the need to provide these supports and services to our youth.

With upstream investments, I say this all the time: We need to deal with the problems that we have and react to the issues that we have, but unless we're making upstream investments and assisting and providing those resources to young people—

The Chair (Mr. Steve Clark): You've got about a minute left in this rotation.

Hon. Michael A. Tibollo: —we're going to have to continue to build more resources. The statistic is, for every dollar invested in our children and youth in prevention, it saves us $17 later on. So we either pay now or we pay later.

Mr. Lorne Coe: How much time do we have left?

The Chair (Mr. Steve Clark): You have 37 seconds.

Mr. Lorne Coe: I'll wait until the next round. Thank you.

The Chair (Mr. Steve Clark): We'll move on to MPP Gélinas for your next 20-minute rotation.

M^me^ France Gélinas: I will start my rotation on public health.

When you first started, public health was to see a $100-million cut, going from 34 public health units to 10. All of this is gone. But if you look at the public accounts, we can see a $234.3-million cut, which is about 13%. Basically, $47 million comes from a cut to the Ontario Agency for Health Protection and Promotion, and $117 million comes from local public health agencies.

Before I dig into this a little deeper, I just wanted to know, the $15 million that you intend to save by not doing waste water surveillance—is that part of that $117-million cut from public health, or is it separate?

Hon. Sylvia Jones: First of all, the changes that are happening in the 34 public health units across Ontario currently are all related to COVID-19—the COVID-19 vaccine program, COVID-19 testing and COVID-19 school-focused nursing initiatives. Of course, we have expanded public health funding considerably—even when you take out the amount that we added to our public health partners. The percentage increase of public health units across Ontario—Deputy Richardson, I'm going to call on you for the exact number; I think it's 17%, but I don't want to make a mistake in front of the committee.

Ms. Deborah Richardson: Just to speak on some of those line items in that vote item, which is the 1406-4—the one is the COVID-19 vaccine program. We've seen a significant decrease in usage across the province, but getting vaccinated is really important for us. Obviously, we still want to encourage people to get vaccinated. It's the best way to remain protected.

Individuals can still get COVID-19 vaccination, and to date, over 41.4 million total doses have been administered across province. To support the work associated with administering the vaccine, we did continue to give one-time funding, it would be considered, for public health units and public hospitals, if required. The ministry also will reimburse per schedules, as applicable, for physicians and pharmacists, based on submitted claims. That's why we're seeing a reduction in that line item, as less are submitting claims because there's less uptake in—

M^me^ France Gélinas: Would the $15-million cut that comes with the waste water not being done in Ontario anymore—is that part of that $234-million cut?

Hon. Sylvia Jones: It is not, Chair. As I mentioned, public health units across Ontario—excluding COVID-19-related expenses—have gone up by 17.4% since 2018.

Specifically as it relates to your question regarding waste water, that funding was actually flowed through from the Ministry of the Environment, Conservation and Parks, and it was to our university partner labs who were doing COVID-19-related testing. We have confidence that the federal government will and has agreed to expand the number of testing locations across Ontario for waste water, so we are removing a program that has become duplicative, and it specifically related to COVID-19 testing.

M^me^ France Gélinas: Chair, just so you know, Ontario had 58 sites where we tested not only for COVID, but for influenza A and B, RSV and Mpox. We had 58 sites; the

federal government has four, all four of them in Toronto. They are looking at putting in another four, so there will be five communities—rather than the 58 we had before. All 34 public health units used to have this waste water testing available—now it will be, if we're lucky, five cities that will have them. So how we call this "duplication" I don't know, because for the 58 to eight—there are 50 communities that will not have waste water testing anymore, when we know very well the detection of pathogens can signal outbreaks, certainly help front-line health providers keep us safe, and all this for the $50 million that it cost the province.

Hon. Sylvia Jones: Chair, I think it's also important to remind the committee members that waste water testing was not the only testing that was happening across the province of Ontario, or previous to COVID-19. Of course, we continue to do laboratory testing for respiratory infections in our local public health units. Outbreak information gathered from congregate living and congregate care settings continues, emergency department visits due to respiratory-infection-like illnesses continue to be submitted and monitored, and hospitalization and ICU admission due to respiratory viruses also continue and is part of our continuity of testing monitoring in the province of Ontario. The waste water that the critic is mentioning was very specific to COVID-19.

M^me^ France Gélinas: What evidence was used to inform the decisions to eliminate the waste water surveillance, and could that body of evidence be shared with the committee?

Hon. Sylvia Jones: As I mentioned, the partner labs that were participating were university labs. They rightfully, as we see a decline in COVID-19 and as we see it transitioned into a respiratory illness that is packaged with all of the respiratory illnesses that we see regularly in the province of Ontario, whether it's influenza or RSV—they requested that they have their lab capacity back. We worked with the federal government to ensure that the waste water monitoring that the federal government has been doing and will continue to do and has committed to expand in the province of Ontario will be part of it, but I think it's really important for committee members to understand it is not the only point of testing and monitoring that happens and continues to happen in the province of Ontario.

1620

M^me^ France Gélinas: The rest of the testing that the minister was talking about is all personal testing, as opposed to waste water, for which you do not have to interact with a person. You just go and you can test for many pathogens that make us sick.

The idea that there's a 17% increase in public health funding does not show up in the budget, so I'm happy to hear it—but how could it be that you're telling us that there's a 17% increase when we know that the Healthy Babies Healthy Children Program are letting go of staff because they haven't got the money to keep them on? Waterloo region has been forced to cut two of their staff. There are layoffs in other public health that runs the Healthy Babies Healthy Children Program. How do you reconcile those two?

Hon. Sylvia Jones: Well, as I said, the numbers show that since 2018, there has been a 17.4% increase in public health unit budgets—

M^me^ France Gélinas: And this year?

Hon. Sylvia Jones: —outside of COVID-19.

The reference of staff who may have been assigned or hired as a result of the activity that was related to COVID-19 and to vaccine rollout—those are rolling into more traditional models through our pharmacy partners, through our primary care practitioners, multidisciplinary teams, community health centres—

M^me^ France Gélinas: Chair, am I getting from this that we will see other Healthy Babies Healthy Children programs close and hope that the mom makes her way to the pharmacy?

Hon. Sylvia Jones: Again, I would say that we have leadership boards in our local 34 public health units that make determinations based on community needs.

One of the things that we haven't spoken about today is, as part of the commitment that we made to encourage voluntary mergers of public health units, we actually have also tasked the Chief Medical Officer of Health to do a review and assessment to ensure that public health units across Ontario have a consistent mandate in terms of what their roles and responsibilities are. I think that is an important piece to ensure that not only do public health units have the necessary investments and commitments from the province of Ontario, but we also ensure that there is a consistency in what public health units offer their communities to stay safe. That focus has very much—

M^me^ France Gélinas: Coming back to estimates, Chair: The minister talks about a 17% increase for the last six years. I'm interested in this year's estimates, which, if we look online—

Hon. Sylvia Jones: Chair, the program that the member opposite is referencing is actually not funded out of the Ministry of Health. My apologies. It is funded out of a different ministry. Again, I point to a 17.4% increase in public health unit funding.

M^me^ France Gélinas: For the six years—but I want to know for this year.

Hon. Sylvia Jones: I don't I have that number.

Deputy Richardson?

M^me^ France Gélinas: I can tell you it's a cut of 13.2%.

Hon. Sylvia Jones: No, it's not. That is COVID-19-related programs that have wound up—respectfully; sorry, Chair.

The Chair (Mr. Steve Clark): Thank you, Minister.

M^me^ France Gélinas: And the 17% is not?

Hon. Sylvia Jones: I think I've answered it. Since 2018—17.4% increase. The change is, we are winding down the COVID-19-related expenses that are now moving into community, whether it is vaccines with primary care physicians, in long-term-care homes, in hospitals and, of course, through our pharmacy model.

M^me^ France Gélinas: Just to my question about waste water surveillance—the minister is saying that it was only

for COVID; I disagree. The waste water surveillance included other things: influenza A and B, RSV, Mpox. How are the 50 communities that are losing their waste water surveillance going to do that? RSV is still present, and influenza A and B are still present, and Mpox is still present. How is that going to continue? Going from 58 labs to eight labs means that there are 50 communities that are not going to get it, which means many of the 34 public health units.

And coming back to 17% since 2017—this is not the number I'm looking for. I'm looking at the estimates book that has been shared with us, and it is a 13.2% cut. You can say that it is COVID all you want; you haven't answered my question as to, how much did it go up this year? It's not 17.2%; I can guarantee you that.

Hon. Sylvia Jones: No, you're right, because it has been, since 2018, an increase of 17.4%, and the changes are as a result of winding up three specific COVID-19 programs. We continue to monitor through other methods, as I've mentioned: laboratory testing for respiratory infections; outbreak information gathered from congregate living and congregate care settings; emergency departments; and ICU hospitalization from respiratory infections.

We are continuing to monitor using a number of different pathways, not relying exclusively on our federal government. We're expanding the federal government program beyond what they are doing in the province of Ontario—but I want to assure the members of this committee that we continue to do a number of access points to ensure and see prevalence in our communities.

M^me^ France Gélinas: But those access points won't include waste water testing, which all 13 universities that participated in this program will tell you brought forward a lot of good information that allowed us to prevent outbreaks—

Hon. Sylvia Jones: During COVID-19, absolutely.

M^me^ France Gélinas: —but time will go by quickly.

I want to talk a little bit about emergency room closures and hospital closures. We can talk about Chesley or Clinton. We can talk about Port Colborne, Almonte, Arnprior or Campbellford. We can talk about Carleton Place, Glengarry, Hawkesbury, Kemptville, Lakeridge Health or Listowel. We can talk about Seaforth, Red Lake, Port Colborne, Palmerston or Norfolk. We can talk about St. Marys, Thessalon or Walkerton. We talked about 868 ER closures last year, 316 urgent care closures—two outpatient labs, 11 obstetrics, one ICU, and one labour and delivery. The labour and delivery is closed long-term.

Who in your ministry keeps track of this data?

Hon. Sylvia Jones: We receive the information directly from the various hospital corporations, and then it is prepared so that we in the ministry have a day-by-day assessment of where the pressure points are. We have worked directly with and directed Ontario Health regional offices to work very closely when a hospital can predict that there is going to be a staffing shortage—I very carefully use the word "predict" because, unfortunately, there have been a few examples of equipment failure or, frankly, damage and vandalism that resulted in an emergency department having to close for a short period of time. But for the predicted closures, Ontario Health, regionally, worked very closely to avoid and assist hospitals in getting short-term coverage. It has been an all-hands-on-deck approach, and I'm proud of the work that our ministry and regional Ontario Health has done—it's only because we have physicians in the province of Ontario who are prepared to step in at, often, very short notice to finish and cover off the shifts that are needed to ensure that emergency departments can safely remain open. Ultimately, it is also the hospital CEO and president—to make sure that as these temporary closures occur, we first and foremost keep the safety of the patient involved.

I would like to turn it over to Deputy Richardson and, perhaps, Dr. Velji to talk to the specific programs that have been put in place to allow us to have good success, particularly in northern and rural Ontario.

M^me^ France Gélinas: That's not my question, Chair.

I've named you the ones that closed last year. Where can I find the list of the ones that have closed since January 1? You've told me that you get this information directly from the hospitals. Who puts this together? Where can Ontarians gain access to all of those closures?

1630

Hon. Sylvia Jones: There is quite a stringent policy and procedure in place when a hospital must make a determination and decision to have a temporary closure. The process includes notifying, of course, the local community, the EMS, the paramedic, police, fire services, the hospital staff. All of the hospitals that have unfortunately had to experience these temporary departmental closures know exactly the process that they must do prior to a planned shortage—and again, I must say, a planned temporary closure.

M^me^ France Gélinas: Most of them, 99% of them, are planned. We know that they're happening—and you have to go to the local media or local website.

Where in your government can we find all of the closures that have happened?

Ms. Natalie Pierre: Point of order, Chair.

The Chair (Mr. Steve Clark): MPP Pierre, point of order.

Ms. Natalie Pierre: We're here to talk about estimates, and I hear the member from the opposite side talking about hospital closures. So I'd just respectfully request that we stick to the topic at hand today, which is the estimates.

The Chair (Mr. Steve Clark): Thank you.

Do you want to continue?

M^me^ France Gélinas: Absolutely.

There are millions of dollars of cuts to our hospital system that lead to those hospital closures. There are steps that the government could take for recruitment and retention of staff—certainly, staffing ratios; certainly, putting limits on staffing agencies. There are many steps that could be taken. None of them are in the budget for this year.

How do we reconcile 868 ER closures last year with the fact that the government does not have a website where they keep track—

The Chair (Mr. Steve Clark): Minister, you've got about one minute left in this rotation.

M^me^ France Gélinas: It's not important enough for the ministry to keep track of it and make that information available?

Hon. Sylvia Jones: Chair, the member is asking for what policies and changes we've put in place. I would love for Dr. Velji to highlight some of those and how they have impacted—ensuring that remote and rural hospitals have that capacity.

M^me^ France Gélinas: So the government does not keep track, does not make that information available province-wide. Individual communities do it, and they do a very good job of letting you know that your ER is going to be closed and letting the paramedics know that the ER is going to be closed. But the government does not keep track of it, does not put a website out. Nobody can gain access to it.

The Chair (Mr. Steve Clark): You've got about 11 seconds left.

Hon. Sylvia Jones: I'm going to say, in the interest of time, for the last two years, our government has invested in hospital operating budgets an average of 4% for two years. So we are making the commitment, and we have the hospitals' backs.

The Chair (Mr. Steve Clark): We'll now move to MPP Clancy for your second 10-minute rotation.

Ms. Aislinn Clancy: I want to talk about the amount that's paid to doctors. We know that family medicine is in a crisis. A lot of them are burdened by a lot of administrative costs. There are 2.3 million Ontarians without a family doctor. They are paid $38 for each patient visit, while a pharmacist would be paid $75 for a phone appointment.

Is there a way that you can address the family doctor shortage by creating a new billing system?

Hon. Sylvia Jones: Chair, I made reference to it earlier on, but the Physician Services Agreement, of course, is a negotiated agreement between the Ontario Medical Association and the Ministry of Health. Those negotiations are in active arbitration right now, and it would be inappropriate for me to get into further detail on what the substance of the negotiations and arbitration is.

Ms. Aislinn Clancy: I look forward to hearing the update.

Minister Tibollo shared a lot about the prevention and investments in mental health and addiction care. I think there are a lot of organizations that are working without ministry funding or with minimal increases because of the drug crisis. My community is impacted greatly by the poisoned drugs. There were 3,600 deaths in 2023, and we haven't seen a commitment to expand harm reduction treatment, safe consumption, especially in the north, where I know it's triple the rates of drug toxicity harm.

For example, Thresholds, in my community, of their own volition, using donor dollars, is putting beds that divert people with mental health and addictions away from emergency rooms.

Sanguen—I have our health care van, which provides health care. I'll pass you that information. They're waiting to hear back on the health clinic they offer out of a van to folks who face homelessness and addiction.

Our CTS staff haven't received an increase, and they are grossly underfunded and are waiting for news.

And our CMHC—they have a mental health and addiction program that diverts police calls, and they were hoping for 24-hour care. A man who was in a psychotic episode died because there was no access to mental health care support.

So while I appreciate the investment in mental health care, I'm hearing from quite a number of folks who treat people facing drug addiction and homelessness, who aren't seeing that investment and are hopeful to have sustainable base funding increases—or funding at all, in many cases. Can you speak to your investments in this area—or why I'm not hearing that?

Hon. Sylvia Jones: For sure. It's a really important topic. Thank you for raising it.

In last year's budget, we announced a 5% across-the-board increase in all mental health and addictions agencies serving in communities. It was really important to stabilize a sector that, frankly, has had a lot of additional pressures that I think all of us understand and appreciate.

We have, I'm very proud to say, in this year's budget, for those organizations that were relying on one-year funding and having that stress of, "Perhaps we will have the funding, and perhaps we can keep our staff and our services available"—we've annualized that funding, which, I can tell you, having spoken to many of them, has been very well received, knowing that they can have some continuity and consistency in their communities. Minister Tibollo, in his remarks, talked about the additional 500 treatment beds that are available. I have to say, in my own community of Dufferin–Caledon, we have an amazing organization, Pine River Institute, that has been serving young people with mental health and addictions issues. Knowing that there has been an expansion in that program that has been so desperately needed for, frankly, decades is a welcome relief to the families who are looking for that very intense residential treatment piece.

The mobile crisis intervention teams that you referenced—again, I'm very pleased that, working with Minister Kerzner, in Solicitor General, and myself, those programs that have historically been one-year application-based are now going to three-year. Again, that continuity of having a mental health worker partnered up with a police officer to assess and go to mental health calls directly—a program that we probably don't talk about enough—and that is working with our paramedics, offering a diversion path away from an emergency department, when the patient agrees, voluntarily diverting them to other pathways of treatment; in some cases, it could be a long-term-care home, a mental health treatment facility, a detox centre. We worked directly with paramedic chiefs

and paramedics, to say, "How can we assist you as you interact with a population that is in very high need?"

We have not relied on only one pathway for assisting people. I think that our approach of saying that we need to ensure there are treatment pathways—whether it is OAT therapy, whether it is safe sobering sites, whether it is an addition to mental health treatment beds, we want to make sure that there is access not just to, frankly, safe supply, because, while we could have a conversation about it, I'm not sure there's such a thing as safe supply for illicit drugs that are killing our young people, our friends and our neighbours in our community.

1640

Ms. Aislinn Clancy: I think there is a good amount of evidence that there is a lot of overdose prevention, and maybe I would like to see the consistency with our Thresholds program. It's not funded by the Ministry of Health—it's through donors, and there are other programs in my community that are waiting to hear back. I'll approach you separately, perhaps, about those programs. I know that it's like a ladder, and if we just have the middle rung and we don't have some of those lower rungs, which I believe these organizations are—and I hope, perhaps, there could be some oversight into a plan to address the poison drug crisis. I appreciate the investments in mental health and addiction, but I think we need to dig a bit deeper. It's a crisis, and there are lots of people dying.

I'd like to discuss investor-driven centres. I'm curious why we aren't moving to not for-profit centres instead, knowing that for investor-driven centres, their focus is shareholders and profits over patients. There's a worry in the sector that it poaches staff. And we know from Alberta that it doesn't mean shorter wait times or lower costs; in fact, it leads to longer wait times and higher costs. Why have you chosen a for-profit focus of clinics instead of trying to open up the under-utilized ORs in our hospitals that exist already—and try to make it possible to staff those and address wait times by opening them up by two hours a day? There's a lot of evidence that that could alleviate our wait times.

Hon. Sylvia Jones: Chair, as the Premier has often said, it's not an either/or. We've actually done both. Even a number of years ago, we had almost $1 billion set aside for a surgical recovery fund, and that was very focused on hospitals, to say that if you can show—

The Chair (Mr. Steve Clark): Minister, you have about one minute remaining.

Hon. Sylvia Jones: —innovative ways to increase your surgical capacity, then you have a willing partner to do that.

When we increased capacity within Ontario in four centres that already existed for cataract surgeries, we saw the wait time for cataracts, which was, frankly, the highest of all of the surgeries in Ontario, go right back down—70,000 people having access to cataract surgery faster.

We often talk about having access to care closer to home. One of the ways that we can do that is to expand our diagnostic and surgical pathways in communities. That's what we're doing. We're not favouring one format or one model over another.

Ms. Aislinn Clancy: I hear again and again of people being charged thousands and even being upsold for these very surgeries.

Hon. Sylvia Jones: It's because when you have cataracts, in particular, if you choose to have the cataract surgery, which is a basic OHIP-funded surgery—

The Chair (Mr. Steve Clark): Thank you, Minister.

We'll now move to the government's second 20-minute rotation. MPP Coe.

Mr. Lorne Coe: Thank you, Chair, and through you to the Minister of Health: Thank you, Minister, for being here, and your staff.

You weren't able to get to one part of your speech—it's an issue that the government takes very seriously, and that is what the ministry is doing to address ambulance off-load times. There are two characteristics of the work that the ministry has been doing. Minister, I'd like you to highlight in your response, please, one, because it informed our four-part strategy that we have in place, that has been very effective with municipalities across Ontario, including my own in the region of Durham. Underpinning that process was a robust engagement of our stakeholders. So can you speak, first of all, to the robust engagement that took place—and it's my understanding that it involved at least 60 specific stakeholder groups—and then share, if you would, please, with the committee members some of the highlights of the four-part strategy, because it is very effective.

Hon. Sylvia Jones: Thank you for that opportunity.

I have to give a shout-out to the ambulance and paramedic branch within the ministry, because there has been a lot of engagement not only with paramedic chiefs but with hospital leadership, with paramedic associations directly, to deal with what I believe is one of the most challenging parts of our health care system. When people need access to care—they always talk about how exceptional the clinicians, the hospital, the nurses, the physicians that they worked with are—it is that concern, fear, hesitancy of waiting in an emergency department, waiting for the surgery. That's where the anxiety really begins, and that's what people talk about to me about more than anything. It is frustrating when, for all the right reasons, we triage individuals who come into our emergency department based on the severity and the immediacy of how they are treated, but unfortunately, that can mean that we have people waiting for longer than they are comfortable with.

Working in partnership with our paramedic services, we said, "How can we provide high-quality and responsive emergency care across Ontario?" Last year, we announced that one of the ways is expanding the number of paramedics. We've announced an additional 300 new paramedic education seats at provincial colleges, and the Learn and Stay program that many of you would be familiar with. We started with registered nurses. We've actually expanded that program to paramedic students in northern Ontario, because we saw a greater need. That is providing

277 paramedic students across northern Ontario, tapping into that program.

To specifically address ambulance off-load times, our government is investing an additional $51 million over three years in the Dedicated Offload Nurses Program. Imagine that you have an individual paid 100% by the Ministry of Health—the public tax dollars—who is assigned to work directly with patients who come to the emergency department through the paramedic service. We fund nurses, respiratory technologists or paramedics, and last year we were able to provide 30 municipalities with more than $33 million to help address emergency department transfer times and help get paramedics back into the community faster. Deputy Richardson will correct me if I'm wrong, but it is my understanding that every single municipality that has applied for that Dedicated Offload Nurses Program has been successful and received the funds from the ministry. Over the past year and a half, this program has decreased ambulance off-load times across the province by nearly 50%.

To further increase access to emergency care, our government has invested an additional $44 million to support local solutions. These are these community-driven, innovative ideas that we hear directly from hospitals, to support 163 hospitals across Ontario to make it easier and faster to access care. For the first time, this funding includes hospitals in rural communities. This funding is an addition to the $90-million annual investment the province provides to emergency departments that put in place innovative solutions to reduce wait times. The hospitals have the flexibility to decide how they implement local solutions that will help people receive care faster and reduce their length of stay in an emergency department. I'm very specifically talking about innovation. These are not ideas that are driven, necessarily, from the ministry. What we are able to do is show the success of other communities and hospitals that have implemented programs, and we can show those to other communities that are experiencing similar challenges.

In 2023, our government also provided upper-tier municipalities and designated delivery agents with more than $811 million to support land ambulance services, representing a 6% increase provincially from the previous year. Last year, we announced an investment of more than $108 million to expand Ornge air ambulance's fixed-winged fleet with four additional state-of-the-art planes, and replacing their existing eight fixed-winged planes, while also providing Ornge with nearly $10 million to relocate their Sudbury base to a larger hangar in the same city. This investment will ensure Ornge's air ambulance service can continue to provide Ontarians, especially those living in northern, rural, remote and Indigenous communities, with reliable, timely access to high-quality urgent care.

1650

I could go on, but I think the most important point is that as we hear and as we learn of innovation, we are funding those with investments.

I think the city of Guelph had some very serious wait times in their emergency department. By implementing dedicated off-load nursing programs, by putting in place some of the partnerships that we've talked about—911 models of care—they've actually decreased their wait times by 86%. We're now using that Guelph hospital model as an example of something that other hospitals and other hospital leaderships can look at and start using in their own communities.

Mr. Lorne Coe: Thank you, Minister, for that response.

Through you, Chair, a supplementary on a different topic: primary care. You did have an opportunity, to some extent, in your opening remarks to talk about primary care. I know the government is taking action on many fronts to enhance primary care across the province. What I'd like to do is give you a little more time to advise how the government is expanding primary care access—which, as I go to the doors in my riding, is something that I hear. If you could speak to how we're doing that—and also tell us, within the time we have, what other initiatives are in place to support primary care and, in particular, our providers.

Hon. Sylvia Jones: I'm going to use the time to ask Deputy Richardson and perhaps Dr. Velji to go over the specific programs.

I think it's really exciting; not only are we now moving forward on two new medical schools—and I have to say, the last medical school that opened in the province of Ontario opened with a Progressive Conservative government; of course, it was the Northern Ontario School of Medicine. We now have students, in September 2025, who will start learning in Brampton at Toronto Metropolitan University. We're really excited that the second school, in Vaughan, will focus exclusively on training our primary care practitioners.

I know Dr. Velji has many other programs that we have already seen succeed in terms of uptake and interest. I'd like to turn it over to her, if I may.

Dr. Karima Velji: Thank you so much for that great question—something very close to my heart: primary care access.

In terms of health human resource strategies that are directed to bolstering the supply of primary health care practitioners, the first thing I would draw attention to is what the minister spoke about, which is a historic expansion of the medical education programs in the province, including the birthing of two new medical schools: one at Toronto Metropolitan University, followed by the school at York University, which will be predominantly focused on the creation of physicians whose practice will be family medicine. We're very pleased to see that expansion. I would say, in the last two years, the expansion has begun. Last year, we added 60 more medical seats to the province, and 76 this year. As the expansion continues, at maturity, we will have 260 additional undergraduate medical seats and 449 postgraduate seats. And 60% of the expansion is directed to the family medicine speciality—that's physicians.

I also want to draw attention to CaRMS match. When we did the resident matching process just a few weeks ago,

Ontario filled all its specialty seats, including all of our family medicine specialty seats. We're very, very pleased to see it's an attractive profession for physicians.

In addition, of course, we're moving to an interprofessional model for primary care, so there is emphasis on nurse practitioners and other members of the health care disciplines as well. To that end, we've now added 150 new nurse practitioner seats in the province, which will make the total number of seats 350. Of the expanded number, 150, 121 have already been activated, many in the northern areas of our province, where, of course, the access issues are more challenging. So we are very, very pleased to see that expansion.

Lastly, I would draw attention to other channels of primary care. Yes, there is a traditional way of accessing primary care services, but there are other approaches to primary care access, including using the pharmacy channel and the nursing channel.

You've seen our work in minor ailments with pharmacy—with 19 minor ailments alive, as we speak. We used to be a straggler in this area, and we've not only caught up, but we've become a leader in the area of improving primary care access through the pharmacy channel.

We've also finally birthed the RN-prescribing program in Ontario, much after other provinces had done this a while ago. RNs now, once they gather a little bit more education in their ability to assess and prescribe, will actually be having prescriptive authority in Ontario.

So there are a variety of ways in which we are trying to create the HHR capacity to improve primary care access.

There is additional information that Assistant Deputy Minister Buchanan could add, if you were so inclined.

Mr. Lorne Coe: Yes.

Hon. Sylvia Jones: There's good news to share.

Ms. Teresa Buchanan: I'm Teresa Buchanan. I'm the assistant deputy minister for physician and provider services division.

I'd like to provide further supplemental information to that which the minister has been speaking about today in primary care, but also round out a bit of our discussions and to support that which my colleague has highlighted about the expanding seats and talk about investments in interdisciplinary team-based care, and just touch on that recent success that we've spoken a bit about today.

These teams of interdisciplinary primary care providers are designed to provide patients with a range of health care professionals. I think that's important, because they all work together to provide comprehensive care services so patients can access the care they need—and that's bringing it as close as possible to patients in an interdisciplinary fashion. In fact, in 2023-24, as part of Your Health: A Plan for Connected and Convenient Care, the ministry announced a plan to invest $60 million in these expansions over two years, and that was focused to help vulnerable, marginalized people as well as those without a primary care provider to access the resources that they needed. We've spoken a bit about that today. I thought it would be important to highlight for the committee that interdisciplinary primary care teams can include family health teams, nurse practitioner-led clinics, community health centres and also Indigenous primary health care organizations. Interprofessional groups can include nurses, dietitians, social workers, pharmacists and other health care professionals. These groups work alongside family physicians to deliver a wide range of programs and services for their patients.

Each interprofessional funding model—and these are funding models—has a specific focus, and it ensures Ontarians are receiving care in a particular way, as they need it. For example, that family health team—you may hear them referred to as FHTs—provides services based on local health and community needs, focusing on health promotion, disease prevention, chronic disease management, and can include mental-health-and-addiction- specific supports as well as diabetes management, which we know is important to so many Ontarians, in terms of managing their chronic disease as they age and deal with that disease in their life. These groups are contributing to a number of local and provincial health care priorities and provide faster access to care through same-day and next-day appointments.

Another group—and I've heard a question in the committee already around community health centres, or CHCs. Those have a primary focus on improving the health and well-being of populations that traditionally have been faced with barriers in accessing health services. These organizations develop partnerships, which has been so important to working in a team-based way across Ontario, and focus on broad health as well as social issues which can have impact on the health of Ontarians.

Turning now to Indigenous primary health care organizations, which are Indigenous-led organizations that address the physical, spiritual, emotional and mental well-being of Indigenous peoples and communities—helping to promote high-quality care through a needs-based approach, where culture is treatment.

1700

Ontario is the first province in Canada that has publicly funded nurse-practitioner-led-clinic programs. We've spoken a bit about nurse practitioners today, so I importantly note that there are 25 nurse practitioner-led clinics across Ontario and that recent investments have expanded some of those but also added two net new clinics, one in the Ottawa area and one in the Grey-Bruce area. It's important to note those. These offer comprehensive, accessible, coordinated health care services targeting Ontarians, again, who have difficulty accessing primary care. They, too, are looked to to provide fast access to care through same-day and next-day appointments.

Starting in 2023, expanding these teams, the ministry and Ontario Health co-managed that province-wide expression of interest where applications for new teams were encouraged—or to expand existing ones. The minister spoke about that. That process was informed by guiding principles such as improving attachment and access; focusing on promoting health equity among marginalized populations; a commitment to understanding local community needs, because not everything is identical to To-

ronto across this great province of ours; but also engaging Ontario Health and the Ontario health teams that are taking root in Ontario. The responses we received from the sector spoke to the need for increased access to interdisciplinary primary care.

In response, the investment, as stated, in that $60 million, but also in the 2024 budget that is informed in these estimates, provided over three years, will strengthen interdisciplinary primary care in Ontario. We expect the investment to have a far, wide-reaching effect and to help provide improved access to Ontarians. It is anticipated that the investment will connect approximately 328,000 Ontarians with team-based care and will create 78 new or expanded teams.

For example, the ministry is investing more than $4 million in Kingston to connect up to 10,000 people with interdisciplinary—

The Chair (Mr. Steve Clark): There's one minute left in this round.

Ms. Teresa Buchanan: Thank you very much.

Peterborough, I will highlight, had more than $3 million to connect 11,000 people to team-based care; that's through a newly established community health centre, which I told you a little bit about earlier in my remarks.

This is all part of the expansion—it is looked to see that through this increase, we will see more Ontarians having team-based care from a suite of health care providers in the primary care space.

I could go on, Minister, and speak a bit about the expansion of the Northern Health Travel Grant Program as well, which is being expanded this year, but I think—sorry, was that a one-minute warning?

The Chair (Mr. Steve Clark): Yes. You have 20 seconds.

Ms. Teresa Buchanan: Well, I doubt I can get through—

Interjections.

The Chair (Mr. Steve Clark): Thank you, Minister.

Hon. Sylvia Jones: Very well received. We announced it in Thunder Bay.

The Chair (Mr. Steve Clark): Now we'll move to the third round of comments and questions. MPP Gélinas.

M^me^ France Gélinas: I'm on vote item 1416-1, just if anybody is interested in estimates. On this, we can see that hospitals are seeing a cut of $180 million; specialty psychiatric hospitals, a cut of $69.8 million; acquired brain injury, a cut of $5.9 million; assisted living centres, a cut of $53.4 million; community health centres, a cut of $36.8 million; community support services, a cut of $89 million; child and youth mental health, a cut of $22.8 million.

How do we reconcile what the estimates tell us versus what the minister tells us—that all of those programs are getting an increase in budget when the estimates tell us the exact opposite?

Hon. Sylvia Jones: The number you were highlighting is actually numbers that the Financial Accountability Officer has brought forward to assist the committee. The Ministry of Health, respectfully, does not agree with the FAO's assessment because they are taking a snapshot in time where—as we roll out the investments, as we don't give all of the money up front, you will see that incrementally increase.

Deputy Richardson, I'm going to turn it over to you for further clarity.

Ms. Deborah Richardson: Just to clarify that, when you look at the estimates site at the FAO site—they're unaudited. Like the minister said, it's point-in-time data to project spending in the 2023-24 fiscal year, as well as publicly available reporting documents released by the government of Ontario, including the expenditure estimates and the public accounts of the province.

So the government does not agree with the presentation of data as done by the FAO, because it includes unaudited data, and the ministry cannot comment on the final 2023-24 spending until public accounts are released. The draft, unaudited 2023-24 data presented in the FAO report does not include all of the ministry's transactions in its entirety. The ministry finalizes its year-end position through the public accounts process—which I'm quite familiar with, because of having been deputy at Treasury Board—and it's currently undertaking post-year-end activities to ensure that the 2023-24 actuals are complete and accurate. Our ministry's final year-end position will be known with the culmination of the public accounts process after all required accruals, entries and adjustments have been incorporated into its results.

In addition, the FAO data is not restated, meaning it does not account for changing ministry structures over time—although our ministry didn't change over this time. As such, the FAO's presentation of data may misrepresent spending variances if there are ministry changes or new announcements. By contrast, the government's expenditure estimates include restated data to ensure year-over-year program spending data is comparable with comparable data at a more detailed level, also included in estimates briefing books.

All ministry spending for the 2023-24 fiscal year will be reported in the 2023-24 public accounts, which will be audited by the province's public Auditor General.

I should note, and I'm really proud of this, actually—and I'm non-partisan, by the way: We have had clean, unqualified audit opinions from the Auditor General, and it's because of the fabulous work of the public service over the last six years.

M^me^ France Gélinas: It's rather interesting that whether we look at hospitals or community health centres or specialty psychiatric hospitals, we see a decrease in investment, but when we look at private clinics, we see an $86.2-million increase this year.

Why is it that all of the public delivery of our health care system is looking at budget deficits, but the private clinics are at $86.2 million—and that's from the estimates; that's not from the FAO—and you have a request for proposals for more private clinics in diagnostic imaging? How do you reconcile the two? Why is it that the only ones that are guaranteed to get money are the private clinics? They got $86.2 million last year, and they're guaranteed to get even more this year.

Hon. Sylvia Jones: Chair, specifically as it relates to the operating dollars to our hospitals, we have seen, for two years running, an average 4% increase to their operating base funding. We do have some variance between, as the member referenced, a small, medium, community-sized or large hospital; teaching hospitals; psychiatric institutions, but overall, for two years running, we have seen a 4% increase in Ontario's hospital operating dollars.

We also have programs—Pay-for-Results Program would be one example. The surgical recovery fund of almost a billion dollars, again, is available directly to our hospitals across Ontario, to ensure that we are focusing on the areas where we are seeing the greatest needs, the longest wait times. Those opportunities have made Ontario, frankly, the leading jurisdiction in the lowest wait times.

I know that we can do more, and I know our hospital partners are continuing to find those innovative changes, whether it is working with organizations and their staffing clinicians—

M^me^ France Gélinas: Chair, that has nothing to do with my question.

Hon. Sylvia Jones: —to be able to keep their operating facilities over the weekend.

The Chair (Mr. Steve Clark): Thank you, Minister.

MPP Gélinas.

1710

M^me^ France Gélinas: The minister's answer is that there is a 4% increase to the base budget, but when I ask hospitals, they always say, "Oh, no, a lot of this is one-time funding." They would love for that 4% to be 4% to their base budget, but a lot of that 4% is money for one-time funding.

How much of the 4% went to base budget increases versus one-time funding?

Hon. Sylvia Jones: I'm going to let ADM Kaftarian explain the nuance of that. It's not one-time funding; it's an increase to their base.

Mr. Peter Kaftarian: I'm Peter Kaftarian, associate deputy minister of clinical care and delivery at the Ministry of Health.

Thanks for the question.

Looking into the 1416 vote, there is 4% growth that's built in for this year as a base funding adjustment for hospitals. We're in the process of rolling that out right now, so hospitals are going to understand, I'm going to say, in the coming days the specific amount associated for them. It will go into their base. It is not one-time. There are some things that roll out as one-time initiatives, but not that base. So hospitals will be receiving a lot more than just the 4%, but that's the base amount.

M^me^ France Gélinas: Okay. As an aside, while I think about it—and I don't want to run out of time—is the centralized referral wait-list. The government, in the Your Health plan, included a promise to centralize referral systems for referrals from primary care providers, to a centralized wait-list shared by a team of surgeons or providers. I cannot find any money in estimates allocated to this project. How much money is allocated to this initiative, and when will it be accessible to the people of this province?

Hon. Sylvia Jones: It's a really great question.

I'm very excited about it. Imagine those internationally educated physicians who want to best serve their patients. Having a central—

M^me^ France Gélinas: How much money, and when?

Hon. Sylvia Jones: —referral is going to make it much easier for people to access the diagnostic and surgery.

I will turn it over to ADM Kaftarian.

Mr. Peter Kaftarian: I'm searching for the answer to your question. I may need to phone a friend. If you could go to your next question and come back, I'm going to see if I can get you that answer.

Hon. Sylvia Jones: See? I can talk about how it's going to make an impact.

M^me^ France Gélinas: The two questions I asked are—how much money will the centralized wait-list cost, who is working on this, and when can we expect this to be rolled out, and is this something that will be rolled out province-wide or in pockets and then rolled out? What do we know?

I see somebody standing up with a pile of paper.

Hon. Sylvia Jones: Michael Hillmer, I hope, is coming to save me.

We do have some pilots that have been very successfully rolled out in Niagara–Hamilton.

I'll turn it over to you, Michael Hillmer.

Mr. Michael Hillmer: Thank you.

I'm Michael Hillmer, assistant deputy minister for digital and analytics strategy.

The centralized wait-list program has been funded for the past several years, and there are a couple of components to it. The investments so far have actually built up a process such that almost 95% of hospitals have the ability to see each surgeon's wait-list. So this is a functioning program that is the basis for some of what the minister was saying. Now that surgeons and hospital administrators can actually see each surgeon's wait-list, they're able to understand the supply and the demand and do what's called "load balancing" in the hospitals. I think that has been a major achievement over the past several years.

I think some of the next steps to really move that line of sight further up to the referral pathway is to keep building the referral network—and we have a number of our primary care physicians and community specialists, upwards of 70% who are sending electronic referrals. Part of the minister's plan, the Your Health plan—one specific initiative was known as "axe the fax," and I think a lot of these initiatives get wrapped up into this "axe the fax" initiative. Right now, the referrals get sent by fax—I'm sure you know this; everybody has had a referral that has probably been sent by fax. Increasingly, with investments under this "axe the fax" initiative, we'd like to make all the referrals electronic—

M^me^ France Gélinas: So what you're telling me is that there is no specific money allocated to this, because what primary care physicians are saying is that they waste an awful lot of time making a referral to a specific surgeon,

who tells them, "I have a two-year wait-list"; then they try the next one, who's at 18 months, and then they try the next one, who's at six weeks. Everybody wastes time.

In order for this to be implemented—yes, hospitals do have access to that information. They're not able to have a centralized wait-list without investment into the infrastructure that allows this to happen. That investment comes from you. How much is it, and where is it?

Hon. Sylvia Jones: ADM Hillmer already referenced that 70% of physicians have some form of buying into the process. It's an ongoing program that has proven to be successful, particularly in the areas of the province that have had a higher uptake. It is an ongoing investment that we are making to ensure patients before paperwork, and that work will continue.

M^me^ France Gélinas: There is no way that 70% of family physicians have access to a centralized wait-list—so 70% of what?

Mr. Michael Hillmer: Many of the physicians in the community can send electronic referrals to one another—

M^me^ France Gélinas: Yes, but still to one surgeon—no fax; you can do it through electronic, but you don't do it to a central wait-list.

I'm asking about how much money to put the central wait-list in place.

Mr. Michael Hillmer: Those are plans that we're working on this year, so I think that's probably why they don't show up in the estimates, which reflect past spending—

M^me^ France Gélinas: The estimates include your budget for next year.

Mr. Michael Hillmer: Right. I'm going to speak to some of the investments in the centralized wait-list management program, which are investments that have been made to date that have set up the hospital-based system, and then I'd have to get back to you for the specific investments that we're going to deploy to build the more centralized repository that you're speaking about.

Hon. Sylvia Jones: Chair, I would just be a bit cautious in terms of putting numbers out in the public domain, because there is a procurement piece that will be part of this rollout, and having numbers out in the public domain could tend to impact the bids that come in.

M^me^ France Gélinas: When would the bids be going out? This year? Next year? Next decade?

Hon. Sylvia Jones: I cannot speak to the specifics. Sorry.

M^me^ France Gélinas: You made a promise. Family physicians are waiting for this to happen, and the only answer they get is that—

Hon. Sylvia Jones: It's in process.

M^me^ France Gélinas: —it's in process. We don't know if it's a year-long process, a decade-long process, a century-long process—are any of those answers good?

Hon. Sylvia Jones: No.

M^me^ France Gélinas: Which is the good answer, then?

Hon. Sylvia Jones: We are actively working on ensuring patients before paperwork. We want to make sure that all the system—

M^me^ France Gélinas: For the 25,000 burnt-out family physicians who want this to happen now, Minister, this is not an acceptable answer.

Hon. Sylvia Jones: Chair, is the member opposite suggesting that we do this without due diligence, without ensuring that we have the number of interested parties participating and ensuring best value for the money?

M^me^ France Gélinas: By now you should have an idea. You've made this promise.

The Chair (Mr. Steve Clark): If we can politely put your comments through the Chair and just move on—MPP Gélinas.

M^me^ France Gélinas: This is a promise that this government has done. This is something that family physicians are waiting for. This is something that we know how to do. Ontario has the knowledge; it has the skills to have a centralized wait-list. What we're waiting for is money from this government to fund it. I'm at estimates, and I'm asking: Show me in your budget where the money is. Tell me which line item it is included in. But nobody is able to tell me this. That leads me to believe that there is no money to make that happen. That leaves all of the family physicians waiting for this. It leaves them to happen—it will happen after the next election? It won't happen. It needs money to happen.

This is estimates, and we're asking: Which line item is it in? Is it going to happen? Is there a dedicated fund to make this happen?

Hon. Sylvia Jones: I can assure the member that we are actively working to ensure that these procedures can continue. The actual dollar value for last fiscal was $31.5 million—the centralized wait management, in particular. The commitment is there. The work is being done. We just don't want to implement or impact any future procurement conversations that we have, requests for bids etc.

1720

The Chair (Mr. Steve Clark): MPP Gélinas, you've got just under three minutes.

M^me^ France Gélinas: Okay.

This is a one-off. There's minimally invasive bleb surgery for treatment of glaucoma. The hospitals need to buy some devices to be used in surgery. The surgery means a whole lot less follow-up, so for people up north, it's something that they want. Right now, there are very few hospitals able to do this.

Is there money in the health care budget for what's called MIBS, minimally invasive bleb surgery, for people with glaucoma? Is there money in the budget for a hospital to be able to buy these devices needed for surgery?

Hon. Sylvia Jones: In last year's budget, the ministry actually announced an innovation fund. It was very much targeted to hospitals that had some clinically sound, innovative approaches, where they just needed a little bit of an investment to prove that it was going to make an impact to the patient outcomes. That innovation fund is something I'm pretty excited about, because there are, to your point, new and emerging technologies where sometimes the local hospital leadership has a challenge in funding—taking that leap of faith, if you will, to try a new

approach—and I think that this innovation fund will be one pathway for clinicians and hospitals to be able to tap into—

The Chair (Mr. Steve Clark): There's one minute left.

Hon. Sylvia Jones: —to improve the patient outcome in community and on an ongoing basis.

Mme France Gélinas: So what I hear is that a hospital that wants to provide this surgery could apply through the innovation fund to purchase the surgical devices needed to do the surgery.

Hon. Sylvia Jones: I'm not going to speak specifically to the example that you raise. As you know, most hospital equipment—with some notable exceptions in the cancer field—is funded through local fundraising initiatives. But there are opportunities—

Mme France Gélinas: Unless you're private—then you could get a facility fee every time you use it. But if you're public, then you have to fundraise.

Hon. Sylvia Jones: Which question would you like me to answer, Chair?

Mme France Gélinas: It's okay.

The Chair (Mr. Steve Clark): Thank you.

MPP Clancy, you've got your next 10-minute round.

Ms. Aislinn Clancy: I'm going to loop back to the for-profit service provision. I've read some stats about various surgeries costing sometimes double what it would cost in a hospital setting.

The FAO stated that Ontario spends the lowest amount per capita in Canada on health care.

Why are we choosing a more expensive kind of service when we're dealing with these budget constraints of being lowest per capita in Canada?

Hon. Sylvia Jones: Respectfully, I am completely comfortable in Ontario having the lowest per capita hospital care services when I also see that Ontario has the lowest wait times for surgeries across the Canadian provinces and territories. Ontario has the highest number of individuals who are matched with a primary care practitioner. That statistic suggests to me that what the Ministry of Health and the province of Ontario have been doing, under the leadership of Premier Ford, is to actually get excellent value.

We see incredible work being done at the Hospital for Sick Children, at UHN. When we are literally leading the world in innovative surgeries, in having people from across the world coming to Ontario and getting services at SickKids, that says that I'm pretty proud of the work that we do at the Ministry of Health and the province of Ontario with our clinicians.

Ms. Aislinn Clancy: Thank you. I do appreciate the innovation in the province, and I admire the work being done in our hospitals.

My question was about for-profit care. When we charge upwards of double or more for a surgery, that's ultimately more that a taxpayer is paying, and it's an investor-driven for-profit model whose primary focus is to make money.

Why is there not a move to not-for-profit care, which has way better stats fiscally and outcomes-wise? I think that's a concern a lot of people have.

Mme Dawn Gallagher Murphy: Point of order.

The Chair (Mr. Steve Clark): MPP Gallagher Murphy.

Mme Dawn Gallagher Murphy: I think the member opposite is trying to get into policy, and we're talking about estimates here. Chair, I would ask her to keep to the estimates.

The Chair (Mr. Steve Clark): Thank you.

Go ahead, MPP Clancy.

Ms. Aislinn Clancy: I believe it's a fiscal responsibility question. So I'd like you to answer the question about why we would pay double for a surgery. I think it's about the estimates. It's about the budget and how we spend those dollars, which is why we're here.

Hon. Sylvia Jones: The investments and the funds that the Ministry of Health flows to our hospital partners is for operations and capital of the hospitals.

When we have partnerships with community diagnostic and surgical centres, which, by the way—there are over 800 in the province of Ontario today, right now, and they've been operating in the province of Ontario for 30-plus years. That means that every government in the past 30 years has seen the value in ensuring that we have diagnostic and surgery options within our communities.

When we make a partnership with those community surgical and diagnostic centres, we pay per procedure. If we were to transition to a model where hospitals were paid only for the procedures that they did, we would have a serious challenge in terms of ensuring the almost 140 hospitals across Ontario could continue to operate.

We are doing a very strategic expansion to ensure that something that, as I say, has existed in the province of Ontario for 30-plus years can continue to be integrated and not take anything away from the hospital system, but in fact augment and ensure that they are looking after our most acute, our most serious patients.

I will turn it over to Deputy Richardson to expand on any further things that I've missed.

Ms. Deborah Richardson: I'll call on Assistant Deputy Minister Patrick Dicerni, who leads this file.

Ms. Aislinn Clancy: Thank you.

Yes, I think with the recruitment and retention concern, and there hasn't been—they call it "poaching" worries. There is a limited amount of human resources, and as people move to these for-profit centres, it exacerbates that.

Hon. Sylvia Jones: Specifically as it relates to that, when we brought forward the legislation—it clearly states that part of the application process will be for the integrated community and surgical centres to articulate exactly where their health human resources are coming, to your point, to ensure that we are working as a system, that we are not pitting one organization from another, and the applications that we are going to be reviewing actually articulate that very clearly for anyone who is applying for an application.

I don't know if you wanted to add to that, ADM Dicerni.

Ms. Aislinn Clancy: Just that disparity on how much surgeries cost—can you speak to that?

Mr. Patrick Dicerni: I'm happy to. I'm Patrick Dicerni. I'm the assistant deputy minister in our health

programs and delivery division, and I'm responsible for the ICHSC expansion.

Thank you for the question.

Just reaching back to a previous comment the minister made related to the for-profit and not-for-profit split, in no way to contradict the minister, but I think we're north of 900 of our existing ICHSC clinics, and 90% of those clinics are for-profit clinics—and has been that split or so since the inception of what was formerly known as the IHF program. So the for-profit aspect of insured service delivery is not new to the province.

You ask a good question with respect to how to attempt to compare apples to apples around whether it be in a hospital environment, quality-based procedure pricing and the amount of money we provide to—formerly known as IHFs, now known as ICHSC clinics. To step back and look at how we could compare them apples to apples, it's important to bear in mind that hospitals are funded through several different mechanisms, whether that be global budgets, whether that be quality-based procedures for a set suite of activities, as well as the capital support that's provided by the government to a public hospital.

1730

When we look into the community setting or the ICHSC licence holders, the funding structures are different. We compensate those clinics for what are now referred to as facility costs. That augments some of the—whether it be infrastructure costs, whether those be capital acquisition costs, equipment costs, all of which would be able to be, in part, accounted for or offset within a hospital's global budget. An independent community health facility doesn't have those types of global budget resources to draw upon.

With respect to the physician payments or physician fees that are billed to the Ontario health insurance program, whether those be occurring in a hospital environment or be occurring in a community environment, those physicians are billing OHIP services.

So it is difficult to straight-line hospital costs and ICHSC costs given that there are indirect costs that are accounted for within the community system.

Ms. Aislinn Clancy: Thank you.

My next question is about alternative levels of care. I've heard a lot of feedback from folks in the community that we have people who need more than four hours but less than 24 hours, and also from our ADP program that there is equipment that could help people transition to home that's not covered.

Can you explain the plan to help people leave hospital when they need this middle-ground level of support? We know there's an aging population, and through these efforts to have more home care—between the four and 24—and also more equipment, we could achieve more independence and more people moving out of our hospitals.

Hon. Sylvia Jones: Great question. I'm actually glad that we're talking about more of the system, if I may.

We as a government have made—

The Chair (Mr. Steve Clark): You've got about a minute left, Minister.

Hon. Sylvia Jones: Okay—quite a focus on expanding home and community care. There are a couple of models, in particular, that have been rolled out called hospital at home. It is essentially ensuring that as a patient transitions into their home and community care, there is a pathway, frankly, back to the clinician to ensure that if the patient does better than expected or has a change in their treatment and recovery pathway, they can very quickly go back into hospital without having to go into an emergency department. When we see these programs in place where that PSW, that physiotherapist, that RN who is working in community, in home has a direct conversation and pathway back to the surgeon, the primary care practitioner, we're seeing really good outcomes. And as we expand almost a $3-billion investment in home and community care, we very much anticipate an expansion in the program.

The Chair (Mr. Steve Clark): Thank you, Minister. That's the end of that rotation.

We'll now move to the government's third round of 20 minutes of questions. MPP Smith.

Ms. Laura Smith: Through you, Chair: First, I want to thank everyone for being here—the ministry team, the staff, the minister, the associate minister and deputy ministers—and for taking the time out of their schedules to be here today.

I'm going to prelude everything by saying that Thornhill is a vibrant community. While I was knocking on doors, they were very interested in a medical school—and this has been going on for quite some time. It was with great joy that we were able to provide that information to the community—specifically, family medicine.

We talked about the youth wellness hubs and the other injections that are happening throughout the province.

One of the things I'm going to focus on in my question is the children across this province, especially during the pandemic, which further exacerbated the challenges in terms of accessing care.

I would like the minister to please tell the committee a bit more about the investments that our government is making specifically having to do with pediatric health services, especially surrounding surgical recovery, and the results that have been acknowledged at this point in time with what has been done.

Hon. Sylvia Jones: I'm happy to talk about the changes and investments and innovation, frankly, that is happening in this space.

You will recall, two winters ago, it was a very challenging RSV season, particularly for our pediatric patients, and the stress that that put on our families and caregivers. As a result, we made an investment of $330 million across Ontario specifically related to enhancing and expanding the pediatric access. I recall one pediatric CEO saying that it was a historic announcement; he has never seen an investment of $330 million. I think it's important to remind the committee that this money was not all directed through the Ministry of Health to Ministry of Health funding partners, but actually, we worked directly with our partners at MCCSS. Holland Bloorview here in Toronto

was, of course, a beneficiary, to be able to expand and augment their services. I remember speaking to a pediatric hospital CEO, who said, "If your government hadn't invested in eating disorder programs that were available in one of our five pediatric hospitals," they would have been "slammed" as the RSV season came forward.

So ensuring that we have put programs—I believe over 100 different programs, but I'm going to turn it over to Deputy Richardson for clarity—to ensure that we did make sure that, post-pandemic, we were bringing down those pediatric surgeries, because we know the implication if they are, unfortunately, left languishing on a surgical wait-list.

I'll turn it over to Deputy Richardson.

Ms. Deborah Richardson: Thanks for that, Minister.

One of my very first meetings as Deputy Minister of Health was actually in Sudbury. I was visiting the hospital, and we had a call with all of the hospitals that were responsible for pediatric care—and just hearing about how, historically, I think, children are almost the poor cousins in the world of pediatrics, and this investment made the world of difference and got all of those pediatric hospitals working together. It was so encouraging to hear. So now we're going to set up quarterly meetings with them.

I would like to share that this investment extended not only to health, as the minister said, but it also supported the Ministry of Children, Community and Social Services, for children and youth. Out of the $330 million, $285 million, or 86%, was for the Ministry of Health, and $45 million, or 14%, was for the Ministry of Children, Community and Social Services.

I'd also like to point the committee to a recent Toronto Star article published on May 6, 2024, entitled "Children Facing Health Crisis, Report Says: Association Calls for Boost in Government Funding, Creation of National Strategy." This article referenced a new report from Children's Healthcare Canada, pushing for all levels of government to commit to rightsizing the pediatric health care system. The same article said that Ontario and Nova Scotia are the only provinces to date to have committed new funds for children's health services. In July 2023, Ontario announced that it was giving children's hospitals new annual funding of $330 million, as the minister spoke to. That same article cites wait times for surgeries and the need to address wait times for kids and families so children get early diagnoses and interventions—especially important for mental health and developmental needs.

I do have to say, I have a child with mental health issues, so when I see that type of announcement—anything to do with mental health and kids—I'm just so happy. It was also for developmental needs. I'm pleased to say that we've invested in both those areas, with funding to address surgical wait-lists and over $44 million invested in children's mental health.

The Ministry of Health's investment is supporting implementation of over 100 high-priority initiatives to ensure children and youth in every corner of the province—every corner. As a First Nations woman, that's very important to me. It can connect to emergency care, surgeries, ambulatory services, diagnostic imaging and mental health services. We've already seen positive results from the rapid implementation.

1740

I want to turn it over to Catherine Wang. I do need to say, we're so lucky to have her in the province. She's the assistant deputy minister of hospitals and capital, and we did second her from UHN, so we're very blessed to have her here. She's going to provide the detail about some of the 100 initiatives being implemented across the province and what has been achieved to date.

Ms. Catherine Wang: Thank you, Deputy. My name is Catherine Wang. I'm the ADM for hospitals and capital. As the deputy said, I've joined government recently, with 20 years of working in hospitals behind me, some of it in pediatrics, so this is a topic that is very near and dear to my heart. I have lived through the challenges as well as the opportunities that this investment now brings.

I'm pleased to speak to you today to provide a bit more overview regarding what has led us to this investment and the positive results that we've seen already across the health care sector. Like the deputy said, I, too, have been meeting with the CEOs of pediatric hospitals, and this has been said to be game-changing for them.

Before I go into the investments and our achievements, I just want to take a few minutes to talk about how this all started and what we were hearing from our stakeholders.

The ministry received a proposal, Make Kids Count, from the Children's Health Coalition indicating that pediatric health care was facing significant pressures resulting from the pandemic. They outlined a plan of action and needed investments. I must say that the CEOs have all talked about how the collaboration that they created through this has also been really significant in a system really acting together.

The Children's Health Coalition includes many of our key stakeholders that we collaborate with every single day and that represent some of Ontario's leading health care providers. This includes CHEO, Holland Bloorview Kids Rehabilitation Hospital, the Children's Hospital as part of London Health Sciences Centre, McMaster Children's Hospital as part of Hamilton Health Sciences, SickKids, Children's Mental Health Ontario, Empowered Kids Ontario and the Kids Health Alliance—quite an allegiance of providers coming together and working together.

Together with Ontario Health and the Ministry of Children, Community and Social Services, through careful analysis of the Make Kids Count proposal and many other proposals coming across the ministry and through consultations with internal and external partners, we identified a list of priority areas requiring immediate investment, including acute mental health; community outpatient mental health; community-based rehab; diagnostic imaging; critical care; emergency department access and diversion; in-patient rehab; outpatient ambulatory care; palliative care; primary care; surgery; and emergency transportation—truly a comprehensive list of health care.

We identified that investments were needed across these priority areas to support development of a provincial

pediatric strategy that would address current priority pressures, promote system recovery and build long-term, comprehensive pediatric care in Ontario. This provincial approach would support integrated care enabled by Ontario Health regional structures within the broader health care system.

Our ministry acted quickly, recognizing that the fall viral season was rapidly approaching, and gave organizations as much lead time as possible to recruit and expand programs. We recognized that the earlier the sector could expand programs and reduce wait-lists, the faster children could access health care services and realize better outcomes and quality of life.

I would like to take a few moments now to describe some of the investments under the $330-million pediatric recovery plan and what this has meant for the health care sector. While these investments include surgical recovery investments, they extended to other areas of the health care system to support the continuum of care for children and youth. This has truly been a strategy for all pediatrics.

Our investments in Belleville, Kingston and the Thousand Islands region are increasing access to psychosocial supports for children and youth with cancer in Kingston Health Sciences Centre's pediatric oncology clinic, to help them better cope with the changes occurring in their lives because of the illness; providing additional staff with specialized pediatric training; and supporting hiring of new staff and purchasing specialized pediatric surgical equipment to support increasing pediatric volumes at Kingston Health Sciences Centre.

Our investments in eastern Ontario include CHEO—this includes increasing the number of surgeries being performed to reduce surgical wait times and backlogs; connecting children and youth to faster access to MRI and CT scans; and reducing wait times for children to connect to care in local emergency departments by increasing access to care in other, more appropriate settings, such as rapid-access clinics—when I had the opportunity to visit CHEO, I saw this first-hand—increasing the number of beds and staff to connect more families to in-patient post-operative rehab care; implementing an immunization catch-up program for children and youth in eastern Ontario with the Children's Hospital of Eastern Ontario and Ottawa Public Health; and increasing access to both mental health supports for youth experiencing eating disorders and psychosocial care for children and youth with cancer.

Our investments in the Durham region, including Ontario Shores Centre for Mental Health Sciences and the Grandview Children's Centre, are creating a new Adolescent Eating Disorder Day Treatment program that connects people to the right level of care and ensures smooth transitions between services, including an eight-hour daily treatment program; reducing wait times for people to connect to specialized mental health supports after being discharged from the eating disorder treatment centre, by expanding the adolescent eating disorder day community-based outpatient program; and supporting the hiring of additional staff to expand the adolescent eating disorder in-patient unit and lowering the patient-to-staff ratio to help people connect to more direct therapeutic care.

Our investments in the Hamilton region, including Hamilton Health Sciences centre, McMaster Children's Hospital, West Lincoln Memorial Hospital and St. Joseph's Healthcare Hamilton, are supporting the hiring of more pediatric surgical staff to increase the number of surgeries for children at McMaster; supporting new life-saving technologies like the tele-resuscitation program that uses two-way, high-definition video conferencing to connect patients at McMaster with community partners to provide faster access to emergency care; supporting emergency department diversion programs to reduce ED volumes at McMaster and ensure children receive timely care; reducing wait times and increasing access to both specialized psychological and mental health supports for kids with cancer and eating disorder programs at McMaster; increasing access to reproductive health, pregnancy and childbirth services at West Lincoln Memorial Hospital, as well as connecting rural families to more postpartum care at home and in their community.

Our investments in Waterloo region and Guelph are increasing the number of children and youth who can be seen, triaged and cared for on-site at Grand River Hospital by supporting a rapid-access clinic to connect families to care in the right place instead of going to emergency departments; increasing access to pediatric surgeries close to home; and supporting access to pregnancy, birth and postpartum care for underserviced communities by expanding midwifery programs and services offered at the Guelph Community Health Centre.

Our investments in the Niagara region, including the Niagara Health System, are increasing the number of children and youth who can be seen, triaged and cared for on-site in the Niagara Health System's St. Catharines site, by establishing a rapid-assessment clinic and ambulatory care clinics that connect people to care in the right place, instead of going to the emergency department.

Our investments in North Bay and Muskoka, including North Bay Regional Health Centre and Muskoka Algonquin health centre, are enhancing support for children and youth at Muskoka Algonquin Healthcare after receiving surgery, including providing pediatric mental health training for staff.

Our investments in Peel and Halton region, including Halton Healthcare and the Mississauga Ontario Health Team, are expanding access to mental health services and supports at Halton Healthcare to connect children and youth struggling with an eating disorder to social workers, dietitians, nurse practitioners, psychiatrists and a pediatrician to help them re-establish consistent eating patterns through their individual care and recovery plans; expanding Halton Healthcare's Navigator Program so it can provide more support to children and youth who are at risk of hospitalization and who are transitioning to home from the in-patient setting or the emergency department; increasing the number of people who can be seen, triaged and cared for at Trillium Health Partners and Halton Healthcare by expanding emergency department diversion

clinics, such as the Mississauga pediatric care clinic that connects people to care at the right place, instead of going to the emergency departments.

Our investments in Simcoe county, including Royal Victoria Regional Health Centre, are supporting the hiring of social workers at Royal Vic to support pediatric admissions for diabetes diagnosis, eating disorders and mental health treatments, and increasing access to treatment; and supporting the hiring of child life specialists at Royal Vic in partnership with the regional women and children's network, to help avoid unnecessary emergency department visits, as well as connecting family to surgical recovery and mental health supports.

Our investments in southwestern Ontario, including Windsor Regional Hospital, are increasing the number of people who can be seen, triaged and cared for on-site in the emergency department at Windsor Regional Hospital by expanding an after-hours pediatric emergency diversion clinic to seven days a week at its Metropolitan Campus, which will expedite care by reducing the amount of time pediatric patients spend in the emergency department.

1750

Our investments in northwestern Ontario, including Thunder Bay Regional Health Sciences Centre, are supporting the establishment of a specialized newborn transport team of health care professionals at Thunder Bay Regional Health Sciences Centre, serving remote communities to ensure medically safe transfers to critical services.

Our investments in the GTA, including the Hospital for Sick Children, Holland Bloorview, the Centre for Addiction and Mental Health, the Toronto East Health Network and St. Mike's hospital, are supporting the hiring of more pediatric surgical staff and expanding access to ORs, to increase the number of surgeries performed at SickKids and partnering community hospitals; supporting the hiring of additional RNs to increase the number of children and youth who can be treated at SickKids; adding more in-patient rehab beds at Holland Bloorview Kids Rehabilitation Hospital; hiring more staff at Holland Bloorview and SickKids to connect families to more mental health supports; increasing the number of people who can be seen, triaged and cared for on-site in emergency departments at the Toronto East Health Network and the Hospital for Sick Kids by expanding programs that connect people to care in the right place, instead of going to EDs; reducing wait times for children and youth with cancer to connect to psychological care at SickKids; connecting children and youth to more MRI and CT scans at SickKids; and helping more expectant mothers conveniently connect to St. Mike's postpartum midwifery-led clinic, which provides specialist care to infants and families.

And finally, our investments in York region, including Oak Valley Health and Southlake Regional Health Centre, are supporting the assessment, diagnosis and treatment of more children and youth over the age of six months who are experiencing urgent, non-life-threatening conditions at the children's rapid-access clinic located at Oak Valley Health's Community Health Clinic in Stouffville; helping more expectant mothers conveniently connect to Oak Valley Health's Markham Stouffville Hospital's Alongside Midwifery Unit, which provides specialized birthing care to infants and families in a more relaxed and comfortable environment; providing complex continuing care to home by expanding the complex clinic at Oak Valley Health and upskilling staff; and increasing the number of people who can be seen, triaged and cared for on-site in the emergency department at the Southlake Regional Health Centre and Oak Valley Health's Markham Stouffville, by supporting ED diversion clinics—

The Chair (Mr. Steve Clark): There's one minute left.

Ms. Catherine Wang: —that connect people to care in the right time and right place, instead of going to the emergency department.

These are a number of examples that show how the system is working together and how the investment has really made a profound change to pediatric care.

Ms. Laura Smith: Thank you. Time?

The Chair (Mr. Steve Clark): You have 39 seconds.

Ms. Laura Smith: I would pass it over to my friend MPP Billy Pang, but I don't think we could continue.

I'm just going to ask, specifically, one more question about pediatric results—what it was and what it is and the percentages pre-pandemic.

Hon. Sylvia Jones: Well, I'm going to start by saying that we had surgeries having to be shut down because our pediatric hospitals were overwhelmed two winters ago, and now we are in a situation where our pediatric hospitals have caught up and we're actually at 117%—

The Chair (Mr. Steve Clark): Thanks, Minister.

The final rotation for the official opposition will be eight minutes and 20 seconds. MPP Karpoche.

Ms. Bhutila Karpoche: Minister, you will be familiar that the Assistive Devices Program is an essential service for a lot of people who rely on these devices to live—especially people who need these highly specialized devices.

I don't know if you will remember: Back in February, I handed you a letter from a local business in my riding—but of course, they're not alone; there are so many small businesses that provide these highly specialized devices. They have not seen a price adjustment in a very long time. The one that I'm specifically thinking about in my riding is Recovery Garment—they have not seen their price adjustment since May 2016. They provide custom-made compression garments for burn survivors. They are the only Canadian company that specializes in manufacturing this type of garment, and because the ministry has not updated the price list, they are now at a critical juncture in their business and are not sure if they can continue to exist. Of course, at the end of the day, this is going to actually harm burn survivors and victims, because they are in need of the compression garments, which they will not be able to access through the ADP.

So my question is, one, why is there a $1.4-million cut to the ADP when in fact there should be an increase in the investment, given that there are many businesses that are

struggling to survive simply to be able to provide that specialized care to people who need them?

Hon. Sylvia Jones: The Assistive Devices Program is actually application-based, so as the need for devices related to and within the purview of ADP expands, then the budget is reflected. Our annual budget right now is $500 million, as I recall, serving approximately 400,000 Ontarians every year. As I say, because it is application-driven, because it is based on the needs—

Ms. Bhutila Karpoche: But on the business side, it's not application-driven. They simply provide it, and the ministry gives a price list that they will cover—

Hon. Sylvia Jones: To be clear, you are asking that a private business that is operating within that space—you're asking for their compensation to be increased under the ADP budget?

Ms. Bhutila Karpoche: They've requested the ministry to review, because they want to be able to continue to provide the compression garments for burn survivors, but they have not seen the ministry—actually, they have not seen the ministry even reply to their emails and letters. The program has not replied to them. I inquired on behalf of my constituent, and I, too, did not receive a reply to the question.

So I'm asking—in order for Ontarians who are burn survivors, who are burn victims, to be able to access, it is essential that the only Canadian company that provides these devices exists, to provide that service. So why aren't the minister and ministry reviewing it?

Hon. Sylvia Jones: I'm just getting a bit of advice from my left and my right, and that is that, again, you're referring to the FAO report. In fact, the estimates show that the Assistive Devices Program has had an increase of $18.9 million. The FAO is looking at a moment in time. We have not completed the full submissions for the previous year.

I'm going to turn it over to ADM Dicerni to get into further detail, if you would like.

Mr. Patrick Dicerni: Thank you very much for your question.

Further to the minister's comments, there is an $18.9-million net base increase to reflect utilization growth within the program.

To address the core of your question around the pricing or lack of pricing review for compression stockings or compression garments, the ministry does undertake regular cyclical reviews of our device categories to assess whether the—

Ms. Bhutila Karpoche: What is "regular" as per your definition? This hasn't happened in almost 10 years.

Mr. Patrick Dicerni: We take an assessment of the 19 or so device categories we have. We do take input from our vendors, where they are often submitting invoices from manufacturers to us, to assess the increasing or decreasing price of the device. For instance, most recently, we reassessed the pricing related to home oxygen provision.

I don't have the schedule for cyclical review in front of me, but I would be happy to look into that—and further to your comments around un-replied letters, I will look into that, as well.

Hon. Sylvia Jones: The only other piece I would raise is, as there is innovation in this space, we are very much relying on what clinicians are using for assistive devices and encouraging their patients to utilize. As those changes happen, we also make assessments on the ADP products that are already available in the system.

I hope that helps.

The Chair (Mr. Steve Clark): MPP Gélinas.

1800

M^me^ France Gélinas: I want to go back to the millions of dollars that were invested into the private clinics. I know that we have 900 of them; 90% of them are for-profit. Only five are surgically based, and those are the ones that extra-bill and those are the ones that basically charge patients double bills and all of this.

The 1-888-662-6613 and the protectpublichealthcare@ontario.ca does not work. People are being charged for things that should be free. Talk to anybody who has had a cataract surgery—the great majority of them have been overcharged; the great majority of them have been sold things that they didn't know they could say no to. To leave it on a system where the patient has to put in a complaint does not work. Plus, the complaint system that we have in Ontario is really inadequate. They will phone 1-888-662-6613, and it takes three weeks to get a call back.

Why is it that—

Ms. Natalie Pierre: Point of order, Chair.

The Chair (Mr. Steve Clark): Just before the point of order—we've got about one minute left.

Point of order, MPP Pierre.

Ms. Natalie Pierre: I don't believe we're here today to talk about the complaint process. We're here to talk about estimates for the Ministry of Health.

The Chair (Mr. Steve Clark): Okay.

You've got about 50 seconds, MPP Gélinas.

M^me^ France Gélinas: There is $86.2 million in these estimates that shows that we continue to invest into for-profit clinics. We need a more robust system, because those are the clinics that overcharge, those are the clinics that double-bill, those are the clinics that upsell the patients, and the system we have in place does not work.

You intend to increase by millions of dollars the number of those private clinics that provide surgery.

You need to protect the patients from overbilling and overselling. Where is the money to do that?

Hon. Sylvia Jones: I hope the member opposite will support the change that we have implemented, ensuring that all independent surgical and diagnostic centres are under the purview of Accreditation Canada.

The Chair (Mr. Steve Clark): Thank you, Minister.

This concludes the committee's consideration of the estimates for the Ministry of Health. Pursuant to standing order 69, it requires that the Chair put, without further amendment or debate, every question necessary to dispose of the estimates. Are the members ready to vote?

Shall vote 1401, ministry administration program, carry?

M^me^ France Gélinas: Recorded vote.

Ayes

Babikian, Coe, Gallagher Murphy, Pang, Pierre, Laura Smith.

Nays

Clancy, Gélinas, Karpoche.

The Chair (Mr. Steve Clark): I declare the motion carried.

Hon. Sylvia Jones: Point of order, Chair.

The Chair (Mr. Steve Clark): I'm sorry, Minister, but I've got a number of votes pursuant to standing order 69, so just bear with me.

Shall vote 1402, health policy and research program, carry?

M^me^ France Gélinas: Recorded vote.

Ayes

Babikian, Coe, Gallagher Murphy, Pang, Pierre, Laura Smith.

Nays

Clancy, Gélinas, Karpoche.

The Chair (Mr. Steve Clark): I declare the motion carried.

Shall vote 1403, digital data and analytics program, carry?

Ayes

Babikian, Coe, Gallagher Murphy, Pang, Pierre, Laura Smith.

Nays

Clancy, Gélinas, Karpoche.

The Chair (Mr. Steve Clark): Shall vote 1405, Ontario health insurance program, carry? All those opposed? The motion is carried—

Interjection.

M^me^ France Gélinas: Chair, a recorded vote for all the votes.

The Chair (Mr. Steve Clark): Okay. Fine.

Ayes

Babikian, Coe, Gallagher Murphy, Pang, Pierre, Laura Smith.

Nays

Clancy, Gélinas, Karpoche.

The Chair (Mr. Steve Clark): I declare the motion carried.

Recorded vote on 1406, population and public health program.

Ayes

Babikian, Coe, Gallagher Murphy, Pang, Pierre, Laura Smith.

Nays

Clancy, Gélinas, Karpoche.

The Chair (Mr. Steve Clark): I declare the motion carried.

Recorded vote on vote 1412, provincial programs and stewardship.

Ayes

Babikian, Coe, Gallagher Murphy, Pang, Pierre, Laura Smith.

Nays

Clancy, Gélinas, Karpoche.

The Chair (Mr. Steve Clark): I declare the motion carried.

Recorded vote on vote 1413, information systems.

Ayes

Babikian, Coe, Gallagher Murphy, Pang, Pierre, Laura Smith.

Nays

Clancy, Gélinas, Karpoche.

The Chair (Mr. Steve Clark): I declare the motion carried.

Recorded vote for 1416, health services and programs.

Ayes

Babikian, Coe, Gallagher Murphy, Pang, Pierre, Laura Smith.

Nays

Clancy, Gélinas, Karpoche.

The Chair (Mr. Steve Clark): I declare the motion carried.

Recorded vote, 1407, health capital program.

Ayes

Babikian, Clancy, Coe, Gallagher Murphy, Pang, Pierre, Laura Smith.

Nays

Gélinas, Karpoche.

The Chair (Mr. Steve Clark): I declare the motion carried.

Shall the 2024-25 estimates of the Ministry of Health carry?

M^me^ France Gélinas: Recorded.

Ayes

Babikian, Coe, Gallagher Murphy, Pang, Pierre, Laura Smith.

Nays

Clancy, Gélinas, Karpoche.

The Chair (Mr. Steve Clark): Declared carried.

Shall the Chair report the 2024-2025 estimates of the Ministry of Health to the House?

M^me^ France Gélinas: Recorded.

Ayes

Babikian, Coe, Gallagher Murphy, Pang, Pierre, Laura Smith.

Nays

Clancy, Gélinas, Karpoche.

The Chair (Mr. Steve Clark): I declare the motion carried.

Minister, thank you. Did you want to say something before we adjourn?

Hon. Sylvia Jones: Just one point of order. My apologies, Speaker.

We did respond through the MPP liaison account to MPP Karpoche's email in January 2023, but I will commit to this committee to resending that response.

Ms. Bhutila Karpoche: On the same point of order, Chair.

The Chair (Mr. Steve Clark): Yes, same point of order.

Ms. Bhutila Karpoche: I did receive an email that essentially said nothing, to which I replied and asked for a proper answer, and I have not received a proper answer.

The Chair (Mr. Steve Clark): With that, that concludes the committee's business for today. The committee now stands adjourned—oh, sorry. What?

M^me^ France Gélinas: I just wanted to go through—there were a number of questions for which I did not get answers. I would like to make sure that those questions are sent so that we could get answers.

The Chair (Mr. Steve Clark): Are you asking to do that right now—or are you asking it to be circulated to the committee?

M^me^ France Gélinas: What is easiest for you, Sandra?

Ms. Sandra Lopes: Typically, once draft Hansard is available, I review my notes with those, and then they're circulated through the Clerk to the committee—the outstanding questions.

M^me^ France Gélinas: I'm happy with that.

The Chair (Mr. Steve Clark): Good.

Well, then, we're adjourned.

The committee adjourned at 1808.

STANDING COMMITTEE ON SOCIAL POLICY

Chair / Président
Mr. Steve Clark (Leeds–Grenville–Thousand Islands and Rideau Lakes / Leeds–Grenville–Thousand Islands et Rideau Lakes PC)

Vice-Chair / Vice-Présidente
M[me] France Gélinas (Nickel Belt ND)

MPP Jill Andrew (Toronto–St. Paul's ND)
Ms. Aislinn Clancy (Kitchener Centre / Kitchener-Centre G)
Mr. Steve Clark (Leeds–Grenville–Thousand Islands and Rideau Lakes / Leeds–Grenville–Thousand Islands et Rideau Lakes PC)
M[me] France Gélinas (Nickel Belt ND)
Mr. Hardeep Singh Grewal (Brampton East / Brampton-Est PC)
Hon. Natalia Kusendova-Bashta (Mississauga Centre / Mississauga-Centre PC)
Mr. Billy Pang (Markham–Unionville PC)
Ms. Natalie Pierre (Burlington PC)
Hon. Nolan Quinn (Stormont–Dundas–South Glengarry PC)
Ms. Laura Smith (Thornhill PC)

Substitutions / Membres remplaçants
Mr. Aris Babikian (Scarborough–Agincourt PC)
Mr. Lorne Coe (Whitby PC)
M[me] Dawn Gallagher Murphy (Newmarket–Aurora PC)
Ms. Bhutila Karpoche (Parkdale–High Park ND)

Clerk / Greffière
Ms. Lesley Flores

Staff / Personnel
Ms. Sandra Lopes, research officer,
Research Services