

Long Term Care Covid-19 Commission Mtg.

Cuts to Public Health Funding
on Thursday, December 17, 2020



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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom Videoconferencing, with all
participants attending remotely, on the 17th day of
December, 2020, 1:00 p.m. to 2:30 p.m.

1 BEFORE:

2 The Honourable Frank N. Marrocco, Lead Commissioner

3 Angela Coke, Commissioner

4 Dr. Jack Kitts, Commissioner

5

6 PRESENTERS:

7 MINISTRY OF HEALTH & PUBLIC HEALTH ONTARIO:

8 Cathy Campos, Chief Financial Officer, Public

9 Health Ontario

10 Elizabeth Walker, Director, Office of the Chief

11 Medical Officer of Health, Ministry of Health

12 Brent Feeney, Manager, Funding and Oversight,

13 Office of the Chief Medical Officer of Health,

14 Ministry of Health

15 Colleen Gieger, President and Chief Executive

16 Officer (Acting), Chief, Strategy, Stakeholder

17 Relations, Research, Information and Knowledge (SSR

18 & RIK) Public Health Ontario

19 Alwin Kong, Chief Legal Officer and Corporate

20 Secretary, Ministry of the Attorney General

21 Sunil Mathai, Counsel, Ministry of the Attorney

22 General

23 Amy Leamen, Counsel, Ministry of Health and

24 Ministry of Long-Term Care

25 Roopa Mann, Counsel, Ministry of the Attorney

1 General

2

3 PARTICIPANTS:

4

5 Alison Drummond, Assistant Deputy Minister,

6 Long-Term Care Commission Secretariat

7 Ida Bianchi, Counsel, Long-Term Care Commission

8 Secretariat

9 Kate McGrann, Counsel, Long-Term Care Commission

10 Secretariat

11 John Callaghan, Counsel, Long-Term Care Commission

12 Secretariat

13 Lynn Mahoney, Counsel, Long-Term Care Commission

14 Secretariat

15 Derek Lett, Policy Director, Long-Term Care

16 Commission Secretariat

17 Dawn Palin Rokosh, Director, Operations, Long-Term

18 Care Commission Secretariat

19 Jessica Franklin, Policy Lead, Long-Term Care

20 Commission Secretariat

21 Adriana Diaz Choconta, Senior Policy Analyst,

22 Long-Term Care Commission Secretariat

23

24 ALSO PRESENT:

25 Deana Santedicola, Stenographer/Transcriptionist

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The following is a list of documents undertaken to be produced or other items to be followed up

INDEX OF UNDERTAKINGS

The documents to be produced are noted by U/T and appear on the following pages: 19:8, 22:14, 75:15, 75:20

1 -- Upon commencing at 1:00 p.m.

2

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Well, I don't know if everybody knows
5 everybody, but Commissioner Angela Coke and
6 Commissioner Dr. Jack Kitts are the other two
7 Commissioners.

8 We are here, and I am sure Mr. Mathai
9 has explained to you the way we have generally
10 carried on, so I think you can just start whenever
11 you are ready to start.

12 ELIZABETH WALKER: Thank you. So I am
13 happy just to launch right in, unless anybody would
14 like to make any comments before I do?

15 Okay, thank you very much.

16 So I will just introduce myself and
17 Brent who is here, and then perhaps ask PHO
18 colleagues to introduce themselves as well to you.

19 My name is Liz Walker. I am the
20 Director of the Accountability and Liaison Branch
21 here in the Office of the Chief Medical Officer of
22 Health.

23 I would very much like to thank you for
24 offering the opportunity this afternoon to meet
25 with you and provide you with a briefing and answer

1 questions you may have.

2 Unfortunately, Dr. Williams is not able
3 to join us today. I am sure you can imagine his
4 schedule these days, but he has asked us to present
5 on his behalf and answer some questions.

6 So I will just turn this over to Brent,
7 so you can see him and he can introduce himself.

8 BRENT FEENEY: Good afternoon,
9 everybody. Yes, so it is Brent Feeney. I am the
10 Manager within the Funding and Oversight Unit. Our
11 unit is responsible for providing oversight and
12 managing and administering the funding provided to
13 Ontario's Public Health Units and Public Health
14 Ontario.

15 I have been in the Ontario Government
16 since I believe 2001 and the majority of which has
17 been in the public health file.

18 So definitely interesting times and
19 looking forward to having our discussion this
20 afternoon.

21 ELIZABETH WALKER: Thanks very much,
22 Brent.

23 So PHO colleagues, should I turn it to
24 you to introduce yourselves?

25 COLLEEN GEIGER: Thank you, Liz.

1 I am Colleen Geiger. I have met the
2 three Commissioners once before early in your
3 journey as you were getting an introductory
4 presentation about Public Health Ontario.

5 I am, as you know, the Acting President
6 and Chief Executive Officer, and I am joined today
7 by my colleague Cathy Campos, who is our Chief
8 Financial Officer and who will be speaking to the
9 financial slides in the PHO part of today's
10 presentation.

11 So I will turn it over to Cathy to just
12 say a couple of words. Thank you.

13 CATHY CAMPOS: Thanks, Colleen.

14 Good afternoon, everyone. My name is
15 Cathy Campos and I act in the capacity of Chief
16 Financial Officer at Public Health Ontario. I am
17 working very closely with Colleen and the executive
18 team, and I also work closely with Liz and Brent.

19 ELIZABETH WALKER: All right, so thank
20 you very much.

21 I will take myself off video while I am
22 running through the slides because you will either
23 see the top of my head or me doing this for most of
24 the slides, so if you are comfortable with that,
25 I'll take myself off video while I am running

1 through.

2 But please don't hesitate to ask
3 questions as we go, or if you wish to wait until
4 the end and I will put myself back on video and am
5 happy to engage in a dialogue with you, if you are
6 comfortable with that.

7 COMMISSIONER FRANK MARROCCO (CHAIR):
8 I think we are.

9 ELIZABETH WALKER: Okay.

10 COMMISSIONER FRANK MARROCCO (CHAIR):
11 Nobody is objecting. So I think we
12 are, so away we go.

13 ELIZABETH WALKER: We'll proceed, okay.
14 So thanks very much to Amy for running
15 through and operating the slides for us.

16 I understand that there is also some
17 documentation that you have, including an
18 information note and agreements and some sample
19 funding letters that have been shared with you in
20 advance of this afternoon's briefing as well.

21 COMMISSIONER FRANK MARROCCO (CHAIR):
22 I know that we received some documents
23 I think yesterday, if that is what you are
24 referring to?

25 ELIZABETH WALKER: Yes, I think so.

1 COMMISSIONER FRANK MARROCCO (CHAIR):

2 Okay.

3 ELIZABETH WALKER: I will defer to our
4 lawyers around the timing, but yes.

5 SUNIL MATHAI: Yes, sorry, just to
6 interact, Commissioner Marrocco, some documents
7 were sent to you yesterday, including two business
8 cases, that address some of the proposals that are
9 going to be discussed today, but prior to that,
10 documents were also provided on these topics as
11 well.

12 COMMISSIONER FRANK MARROCCO (CHAIR):

13 Thank you.

14 ELIZABETH WALKER: Perfect, thank you.

15 So just in terms of the executive
16 summary, we did receive some questions from you
17 that we understood you have with respect to things
18 like public health modernization and our public
19 health units and Public Health Ontario.

20 So we thought we would do an overview
21 presentation first, and then we are going to get
22 into a little bit more detail around the 2019
23 Ontario budget decisions and financial
24 considerations.

25 We have attempted to answer the

1 questions that you had in the presentation, but as
2 I said, happy to take further clarification or
3 questions as we go or at the end, whichever you
4 would like.

5 So if I can ask to flip over to slide
6 4, we can perhaps start with the public health
7 mandate in Ontario.

8 And as you probably know, the focus of
9 public health is on the whole population rather
10 than just individuals, and its work is embedded in
11 the daily lives of people in Ontario, "where they
12 live, work and play" is a phrase we often use.

13 The work of public health is broad, and
14 it contributes to improving and protecting the
15 health of Ontarians through public health programs
16 and initiatives, the kinds of things that you see
17 on the slide, like childhood immunizations,
18 infectious diseases, safe water, education and
19 inspections related to food handling.

20 Over the years public health
21 interventions have made the food that we eat safer.
22 They have protected us from infectious diseases and
23 environmental threats. They have created healthier
24 environments, and have helped us learn and support
25 informed voices about risks related to things like

1 tobacco and alcohol, for example.

2 Public health also impacts communities
3 around things like healthier environments,
4 responding to public health emergencies, and also
5 social conditions that affect or certainly could
6 improve health. So we call those social
7 determinants of health or just general determinants
8 of health.

9 And through the health units in looking
10 at those different determinants and reducing the
11 health risks to the population, we contribute to
12 reducing the need for other health care services.

13 COMMISSIONER FRANK MARROCCO (CHAIR):

14 Sorry, Ms. Walker, when you said the
15 "health units", did you mean the local units that
16 have a Local Medical Officer of Health, or did you
17 mean a different kind of unit?

18 ELIZABETH WALKER: So I do mean the
19 public health units that have the Medical Officer
20 of Health.

21 The next slide actually will get
22 into -- and maybe we could just go there, and I can
23 go straight into the sort of explanation of the
24 structure in Ontario.

25 So you'll probably hear us refer

1 interchangeably to boards of health and public
2 health units, and I will explain the difference
3 across those as we go.

4 COMMISSIONER FRANK MARROCCO (CHAIR):
5 Okay.

6 ELIZABETH WALKER: So with respect to
7 that model, it is unique in Ontario. Ontario's
8 model is unique across the country, and it reflects
9 the diversity of our population and it also
10 involves shared authority and accountability at the
11 provincial and municipal levels, which is unique.

12 And really the value of that kind of a
13 model, it allows us to balance provincial
14 consistency, where it is important to have a
15 consistent approach across the province, as well as
16 local autonomy and the ability of the health units
17 to reflect the public health needs of their local
18 communities right down to neighbourhood levels.

19 It also supports and really strengthens
20 the bridge between the health and the non-health
21 sectors. So I referred earlier to the determinants
22 of health. It is a relationship with the social
23 services sector and the education sector that is
24 strong at a municipal level.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 And that is distinct from the Chief
2 Medical Officer of Health?

3 ELIZABETH WALKER: It is. So what --

4 COMMISSIONER FRANK MARROCCO (CHAIR):
5 What is the difference between the two
6 of them?

7 ELIZABETH WALKER: So I'll explain.

8 What you see here is what we call the
9 three legs of the stool.

10 So at the provincial level, we have the
11 Chief Medical Officer of Health who is part of the
12 Ministry of Health and reports in to our Deputy
13 Minister of Health.

14 And then at the local level, we have 34
15 boards of health that employ 34 Medical Officers of
16 Health and serve an area, a geographic area that we
17 call the public health unit.

18 So as I said, sometimes we use those
19 terms interchangeably, but the Medical Officers of
20 Health at a local level report to the boards of
21 health.

22 The Chief Medical Officer of Health at
23 the provincial level is separate and distinct from
24 that, but obviously there is a very close working
25 relationship across them.

1 COMMISSIONER FRANK MARROCCO (CHAIR):
2 All right.

3 COMMISSIONER JACK KITTS: Can I just
4 ask, does the shared accountability model change
5 during a pandemic, or is it just like this shared
6 accountability right through?

7 ELIZABETH WALKER: So in terms of the
8 structure, it is the same, but you will start to
9 see some nuances. Like there will be potentially
10 more section 22 orders from the Local Medical
11 Officers of Health, for example, and our funding
12 relationship will shift to enhanced provincial
13 resources.

14 So there is nuances, but the structure
15 itself remains the same.

16 COMMISSIONER JACK KITTS: Okay, and
17 just during the pandemic, does the Local Medical
18 Officer of Health have the full authority in their
19 area, or do they have to work closely with the
20 Public Health Officer?

21 ELIZABETH WALKER: So at the local
22 level, the Medical Officers of Health, they have
23 the authorities under the HPPA, and those are the
24 same during a pandemic or in regular times. If
25 they feel that there is a risk to health, they have

1 options available to them, so that that remains the
2 same.

3 COMMISSIONER JACK KITTS: Okay, thank
4 you.

5 ELIZABETH WALKER: You are welcome.

6 So I'll just very briefly then touch on
7 sort of at a high level those three legs of the
8 stool.

9 The provincial, which is the Ministry
10 of Health and the Chief Medical Officer of Health,
11 as I mentioned, provides policy direction, guidance
12 and oversight.

13 At the local level, we have the boards
14 of health who are responsible for delivering those
15 programs within those geographic boundaries that I
16 mentioned.

17 And then we also have the third leg of
18 our stool, which is Public Health Ontario which
19 provides scientific and technical advice to the
20 health units, to the Ministry, to ourselves, to the
21 CMOH, to other ministries across government, and
22 also operates Ontario's Public Health Laboratories,
23 which we'll touch on a little bit later in the deck
24 as well.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 I am sorry to stick on this, but I am
2 just a bit confused. I thought that the Chief
3 Medical Officer of Health was supposed to provide
4 advice to the government. Does Public Health
5 Ontario report to the Chief Medical Officer of
6 Health?

7 ELIZABETH WALKER: So there is an MOU
8 and there are various sort of instruments and
9 documents in place where the Board Chair of Public
10 Health Ontario reports in to the Minister of
11 Health. The Chief Medical Officer of Health sits
12 on the Strategic Planning Committee of the Board
13 and is an observer to the overall Board of Health.

14 And then there is what we sort of call
15 the administrative accountabilities and
16 responsibilities that happen between government and
17 a Crown agency that would come through Dr. Williams
18 as well.

19 Is that helpful?

20 COMMISSIONER FRANK MARROCCO (CHAIR):

21 Thank you.

22 ELIZABETH WALKER: Okay. So perhaps if
23 we can go to the next slide, so what we wanted to
24 do was just spend a few minutes providing a little
25 bit more detail with respect to the public health

1 unit leg of the three-legged stool and give you a
2 little bit more information on some of the comments
3 that I have just made.

4 So there are currently 34 public health
5 units or boards of health in Ontario. They are
6 established under the Health Protection and
7 Promotion Act, and they deliver health promotion,
8 health protection and disease prevention public
9 health programs.

10 So I mentioned previously the boards of
11 health. So each health unit is governed by a board
12 of health, and that board is accountable for
13 ensuring the provision of public health programs
14 and services required by the HPPA and Ontario's
15 Public Health Standards, which I'll refer to in
16 just a moment.

17 So most of our boards of health in
18 Ontario, and there is 22 of the 34, have an
19 autonomous governance structure meaning that they
20 are independent corporations separate from any
21 municipal organization.

22 And other boards in Ontario have
23 varying degrees of connection with their local
24 municipal organizations, so some of them, the
25 regional council acts as the board of health, for

1 example.

2 So those boards of health and their
3 geographic boundaries are aligned with municipal
4 boundaries. All of those boards include municipal
5 members, and the majority of the boards, so the
6 autonomous ones, also have provincial appointees as
7 members of their boards as well.

8 COMMISSIONER FRANK MARROCCO (CHAIR):

9 So the regional government can act as
10 the board of health, the local board?

11 ELIZABETH WALKER: Yes, it can.

12 COMMISSIONER FRANK MARROCCO (CHAIR):

13 And can it also own long-term care
14 homes?

15 ELIZABETH WALKER: I am not sure --

16 COMMISSIONER FRANK MARROCCO (CHAIR):

17 Or operate them?

18 ELIZABETH WALKER: Yes, I am not sure
19 about that. I would have to take that back. I am
20 not as familiar with the long-term care structure.

21 COMMISSIONER FRANK MARROCCO (CHAIR):

22 Because if that is correct, it would
23 sort of be a conflict. If the Local Medical
24 Officer of Health found something wrong with the
25 way in which the long-term care facility was being

1 run or not run, if the board of health to whom he
2 would report that, he or she would report that to
3 is the same person operating the home. That is why
4 I asked.

5 But I understood your answer. You are
6 not clear, so you are not certain of what the
7 answer is, so I understand that.

8 U/T ELIZABETH WALKER: And I appreciate you
9 offering the context of which you are asking your
10 question, so we'll certainly take that back,
11 absolutely.

12 So with respect to all of those boards
13 of health, as I mentioned previously, they must
14 appoint a full-time Medical Officer of Health for
15 each of those public health units. That MOH
16 reports directly to the board of health on public
17 health issues and is responsible to the board for
18 the management of public health programs and
19 services.

20 So although the MOH is an employee of
21 the local board of health, his or her appointment
22 must also be approved by our Minister of Health as
23 well, and that is included in the legislative
24 requirements.

25 So I mentioned a moment ago the Ontario

1 public health standards. Those standards have been
2 developed by the province in collaboration with
3 many others, but they do identify the minimum
4 expectation for Public Health programs and services
5 to be delivered by those 34 health units.

6 The standards are published by the
7 Minister of Health under the authority of the
8 Health Protection and Promotion Act under section
9 7.

10 So it is the responsibility of the
11 boards of health to be accountable for ensuring the
12 provision of those standards in that local public
13 health unit catchment area, including the protocols
14 and guidelines that are referenced as part of those
15 standards.

16 And protocols and guidelines to varying
17 degrees set some of those guidelines and
18 expectations around what needs to be done
19 consistently across the province and also provides
20 some guidance as to where local priority-setting
21 and considerations would come in based on local
22 community health assessments that are done by the
23 health units.

24 COMMISSIONER FRANK MARROCCO (CHAIR):

25 Is that any different in a pandemic or

1 does that structure remain the same?

2 ELIZABETH WALKER: Sorry, you mean in
3 terms of the --

4 COMMISSIONER FRANK MARROCCO (CHAIR):
5 Well, defining the work and
6 strengthening accountability. I am just wondering
7 if the decision, the policy-making decision-making
8 changes at all when you have something like we are
9 dealing with.

10 ELIZABETH WALKER: Yes, it does. So
11 every board of health is also required to have
12 pandemic plans or continuity of operations plans in
13 place that would address exactly that kind of
14 situation.

15 So if they are dealing with a health
16 emergency in their area or a particular response
17 that is part of those emergency plans, they would
18 plan out ahead of time what are the kinds of
19 supports and services that they would need to
20 consider varying or what are those local
21 priorities.

22 And it would depend health unit by
23 health unit and emergency by emergency or public
24 health event by public health event, but that would
25 be part of what a board of health would be

1 accountable for ensuring their health unit has in
2 place.

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 So they are all expected to have a
5 pandemic plan, so it is foreseeable in the mind of
6 the Ministry of Health that it may be necessary at
7 some point to resort to a pandemic plan because
8 there is a pandemic.

9 ELIZABETH WALKER: Exactly, yes, that
10 is exactly right.

11 COMMISSIONER FRANK MARROCCO (CHAIR):

12 How long has that been the case, Ms.
13 Walker, do you know?

14 U/T ELIZABETH WALKER: I actually don't
15 know. I am looking at Brent. I am not sure we
16 know. We would have to go back. I would have to
17 have a look. I know it has been a requirement of
18 the standards, but we would have to go back and
19 have a look at when that became part of the
20 standards or the transfer payment agreements it may
21 have been with as well, so we can look back at that
22 as well.

23 COMMISSIONER FRANK MARROCCO (CHAIR):

24 That is fine, thank you.

25 ELIZABETH WALKER: Okay, so just

1 carrying on, the standards also, just to finish off
2 on that very quickly, the standards also include a
3 public health accountability framework and
4 organizational requirements, transparency and
5 demonstrating impact and public health indicator
6 and transparency frameworks, which are part of
7 that.

8 So for slide 8 then, for funding and
9 accountability, part of the accountability of each
10 of those boards of health that I had mentioned
11 includes setting priorities, where it is within
12 their authority to do so, and also establishing the
13 budget for each of their public health units to
14 deliver on those standards, including how they will
15 be operationalized in each of those communities.
16 And it is the board of health that is responsible
17 for establishing and approving the budget that it
18 needs effectively to meet those legislated
19 requirements.

20 Under the legislation, it is actually
21 the municipalities who are required to pay for that
22 budget of the boards of health and the health
23 units, and then the Minister of Health may make
24 discretionary grants for the purposes of the
25 services underneath the Health Protection and

1 Promotion Act, but it is actually not legally
2 obligated to do so, and that is outlined in the Act
3 as well.

4 However, historically, the Minister of
5 Health has provided funding to boards of health for
6 the purpose of delivering programs such as the
7 standards, and this has varied over time.

8 So there is an appendix to the deck
9 that shows you some of the variation over the last
10 few years.

11 We call it the cost-shared portion, but
12 in addition to that, there is some provincial
13 programs that are funded at 100 percent. They are
14 not cost-shared with the municipalities.

15 I should also note that there are areas
16 in the province that are called unorganized
17 territories where they don't have an organized
18 municipal track, and in those instances the
19 province pays that percentage as well.

20 The provincial funding for public
21 health units is usually based on a calendar year,
22 which equates to the municipal fiscal year, and
23 provincial funding decisions are made on the
24 Ministry's review of budget submissions received
25 from the boards of health and subject to the

1 Minister's approval.

2 I want to also mention --

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Can I just ask you to clarify for me,
5 the local board establishes its budget.

6 ELIZABETH WALKER: Yes.

7 COMMISSIONER FRANK MARROCCO (CHAIR):

8 So it sets its own budget, and then the
9 municipality has to pay it?

10 ELIZABETH WALKER: Correct.

11 COMMISSIONER FRANK MARROCCO (CHAIR):

12 If the municipality doesn't approve the
13 budget, they are obliged to pay it, to fund it?

14 ELIZABETH WALKER: That is correct.

15 You know, I will just ask, and maybe I
16 can just turn this over, and again, apologies for
17 the movement, but maybe Brent could just add a
18 little bit to that.

19 BRENT FEENEY: Yeah, hi, everybody.

20 So yeah, it is the local board of
21 health that approves and sets the budget, and it is
22 the municipalities that are legally required to pay
23 it.

24 But I do think it is important to note
25 that, you know, the majority of members on that

1 board of health are municipal members. There is a
2 regulation under the Health Protection and
3 Promotion Act that sets the number of municipal
4 members per board of health, and each municipality
5 within that health unit has representatives on the
6 board.

7 So the municipalities in essence have a
8 say in terms of the board of health budget that it
9 approves. They are mostly represented on the board
10 of health.

11 COMMISSIONER FRANK MARROCCO (CHAIR):

12 Where the region is also the board of
13 health, then the budget would be set by the region?

14 BRENT FEENEY: You got it.

15 COMMISSIONER FRANK MARROCCO (CHAIR):

16 So that then would be a little
17 different.

18 BRENT FEENEY: Yes, in an autonomous
19 board of health, that autonomous board of health
20 approves the budget, and then under legislation it
21 has to actually provide a notice to the
22 municipalities in their area, which would include
23 the amount that municipality has to pay and the
24 timeline.

25 Within a regional board of health, it

1 is the regional government that approves its own
2 budget of what it pays.

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Okay, thank you. And just lastly, let
5 me just ask you one other thing. These situations
6 where the region is also the board of health, are
7 they historical or is there some -- what is the
8 rationale for that, if you know?

9 BRENT FEENEY: I don't know
10 specifically the rationale, but it is definitely
11 historical.

12 As far as I know, under the Health
13 Protection and Promotion Act, there are basically
14 three types of boards and they have been in the
15 Health Protection and Promotion Act for a number of
16 years. I can actually look back and find out
17 exactly when it was.

18 So you have got your autonomous boards
19 of health that have been established under the
20 HPPA; you have your regional boards of health; and
21 we also have single-tier boards of health as well.

22 So we do have some single-tier councils
23 in the province that also act as the boards of
24 health, so City of Toronto and City of Hamilton.
25 That has been the structure for public health, you

1 know, at least as far as I know, back to the late
2 '90s. I would have to see if there was a different
3 structure prior to then, but that has been the
4 structure in public health as long as I have been
5 around at least, for over 20 years.

6 COMMISSIONER FRANK MARROCCO (CHAIR):

7 Okay.

8 ELIZABETH WALKER: Okay. So just one
9 more thing to note with respect to again what we
10 sort of call the cost-shared portion of the funding
11 of the health units is that if the board of
12 health's approved budget actually exceeds the
13 Ministry's approved funding level, then it is the
14 responsibility of the obligated municipalities to
15 pay for that difference in cost.

16 So one example of where that occurs is
17 that starting back in 2006 and in order to manage
18 within approved allocations within the Ministry,
19 the Ministry of Health began implementing caps on
20 growth funding, so at this time the municipalities
21 began to provide funding over and above their 25
22 percent share, for example.

23 So in 2019 the Ministry was aware that
24 there was about two-thirds of the provincial
25 municipalities that do actually provide more than

1 their 25 percent share, and some up to as much as
2 40 percent, in order to cover the costs of those
3 health units.

4 So I just wanted to make it clear that
5 it is not necessarily a strict 75 or has been a
6 strict 75/25 percent reimbursement. It is actually
7 a capped allocation model.

8 COMMISSIONER FRANK MARROCCO (CHAIR):
9 Okay.

10 ELIZABETH WALKER: So with respect to
11 our funding, the funding is governed by the public
12 health funding and accountability agreement, which
13 is an evergreen agreement that came into effect and
14 it started on January 1st, 2014.

15 And that accountability agreement
16 requires public health units to achieve specific
17 and measurable results. They have to have
18 governance and administrative structures in place.
19 They have to provide periodic reports on financial
20 status and relevant financial and program results
21 achieved to us, and they also permit the recovery
22 of provincial funds or the discontinuance of
23 ongoing funds in the event of public health unit
24 non-performance or non-compliance.

25 COMMISSIONER ANGELA COKE: Could I just

1 ask a question. You had mentioned before that some
2 of the programs are 100 percent provincially
3 funded. Are those sort of one-time special
4 initiatives, or is that an ongoing stream of
5 funding for certain programs?

6 ELIZABETH WALKER: It can be both. So
7 I am trying to think, so the Ontario Seniors Dental
8 Program, for example, is a hundred percent funded,
9 and that is an ongoing amount. In other instances,
10 some of the one-time time-limited is also a hundred
11 percent provincially fund.

12 COMMISSIONER ANGELA COKE: Okay.

13 ELIZABETH WALKER: So if we move to the
14 next slide, we can start talking just a little bit
15 about public health modernization.

16 And as you are probably aware, there
17 was several reports over the last twenty years and
18 we have included or cited some of them here who
19 have identified challenges in how the public health
20 structure or public health sector is structured;
21 for example, the misalignment of health, social and
22 other services, duplication of effort, inconsistent
23 priority setting, the variation in capacity across
24 health units.

25 So as part of the 2019 Ontario budget,

1 which was released in April of that year,
2 government committed to modernize the public health
3 sector in order to address some of these issues and
4 balance fiscal responsibility as well.

5 So as part of that budget, government
6 committed to do a few things.

7 It committed to adjust the
8 provincial/municipal cost-sharing of public health
9 funding.

10 It also committed to establishing ten
11 regional public health entities that would be
12 governed by ten regional boards of health that had
13 a common, consistent, single governance model, so
14 to take away the variability that you have heard us
15 talk about between the autonomous and regional
16 boards, for example.

17 The third was to modernize Ontario's
18 public health laboratory system by developing a
19 regional strategy to create greater efficiencies
20 across the system and reduce the number of
21 laboratories, and also protect what matters most by
22 ensuring public health agencies focus efforts on
23 things like providing better and more efficient
24 frontline care and looking at removing back office
25 inefficiencies through digitizing and streamlining

1 some of those processes.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 But can I just ask you, Ms. Walker,
4 these ten regional public health entities, how does
5 that fit with the 34 units, the 34 health units?

6 ELIZABETH WALKER: So part of the
7 discussion and the proposal at the time that has
8 now been put on hold, and I can explain some of why
9 it has been put on hold in a moment, but those ten
10 regional entities were developed based on the
11 current -- or a consideration of current health
12 unit boundaries and also looking at some of the
13 Ontario Health region or other boundaries or
14 regional office structures across the province to
15 look at some consistency of alignment to enable the
16 better working relationship between the health
17 units and their partners, where we were looking at
18 some of those collaborative efforts.

19 COMMISSIONER FRANK MARROCCO (CHAIR):

20 It is just that it is the same
21 province, and you have 34 local health units and
22 then somehow intermingled with that there is 10
23 regional public health units.

24 And I was just wondering how all of
25 these units -- there would obviously be overlap,

1 but I just wondered how they fit together, or maybe
2 they don't.

3 ELIZABETH WALKER: I see, yes, so the
4 34 boards would actually have been collapsed and
5 ten new regional public health entities and boards
6 would have taken their place.

7 So for example, in the north we would
8 have looked at bringing together a number of the
9 public health units that are currently existing in
10 the north and bring them into one regional entity,
11 and the same with the southwest and the east.

12 So it would actually be a bringing
13 together of the existing health units in certain
14 areas to create greater capacity and try and
15 balance out, for example, where there are smaller
16 health units, smaller catchment areas, a lack of
17 capacity and size of health unit and numbers of
18 staff, for example, and create more consistency
19 across the province.

20 So it would actually replace the
21 existing structure.

22 COMMISSIONER FRANK MARROCCO (CHAIR):

23 Okay.

24 ELIZABETH WALKER: They wouldn't be
25 running in parallel.

1 COMMISSIONER ANGELA COKE: So I am
2 assuming, though, they map to some municipal
3 boundaries, because that is obviously who you are
4 cost-sharing this with, so it is ten reconfigured
5 but matching somehow municipal boundaries so that
6 people know exactly which part of that they would
7 be paying for?

8 ELIZABETH WALKER: That is correct.

9 So again, I sort of want to just note
10 that this was put on hold. It was subject to -- we
11 were having consultations with respect to what
12 those proposed boundaries would be looking like,
13 and that was put on hold for a few reasons, not the
14 least of which was the pandemic.

15 But the boundaries of the regional
16 health entities were considered based on -- and I
17 am trying not to use the amalgamation idea because
18 that feels like it is taking over, whereas it was
19 really a coming together of the capacities that
20 exist. But for example, the health unit
21 boundaries, I gave the north as an example, so
22 those existing seven, I think it was, health units
23 and their boundaries would come together to create
24 the one entity that would still have those
25 municipal boundaries.

1 There was a slight variation in a
2 couple of the areas in what was proposed to ensure
3 alignment with the Ontario Health regional
4 boundaries and others, the MCCSS regional
5 boundaries, for example, so there was a slight
6 variation, but they were, again, on those municipal
7 boundaries.

8 So you are correct, it would have been
9 clear as to which municipality belonged to which
10 health unit still or regional entity.

11 COMMISSIONER ANGELA COKE: So with this
12 consolidation, I am asking is the expectation that
13 that you would have less FTEs in this new model?

14 ELIZABETH WALKER: So again, that was
15 part of the consultation. There would certainly be
16 opportunities for efficiencies, so where, for
17 example, some of the back office functions wouldn't
18 necessarily need to be duplicated as those health
19 units joined together.

20 There may also have been opportunities
21 to review some of those budgets and increase some
22 of those frontline services.

23 So there wasn't particular decisions
24 made on that.

25 COMMISSIONER ANGELA COKE: No, I was

1 thinking more just in terms of the skills and
2 capacity. You know, you have a certain number of
3 resources now of FTEs with whatever skills and
4 capacity you need, and I am trying to understand
5 how that capacity and skills would be maintained in
6 this new structure or not.

7 ELIZABETH WALKER: So again, that would
8 have been part or was part of the consultations
9 that were underway. The intent was to build on and
10 strengthen the public health system in response to
11 some of those recommendations. So that would have
12 been absolutely part of the considerations in the
13 deliberations that would have come out of those
14 consultations.

15 So I'll continue on just with some of
16 the points on this slide to say that in August of
17 2019 and in response to some of the concerns that
18 were raised by municipalities with respect to what
19 was committed to in the budget, the government
20 announced that it would actually modify some of the
21 financial impacts that were originally stated and,
22 as I mentioned, would also then launch
23 consultations with municipalities that would inform
24 the design and implementation of that local public
25 health modernization, including the discussion that

1 we have just had with respect to the number of
2 regional health entities and what that would look
3 like and the related timing and financial
4 considerations of that.

5 So one more slide and then I am going
6 to turn it over after this one to Brent to get a
7 little bit more into some of the details, but just
8 to finish off on the consultations, so in October
9 of that same year our Minister announced that a
10 gentleman by the name of Mr. Jim Pine would be the
11 government's advisor on public health
12 modernization, and then the following month, in
13 November, the government launched the consultations
14 which included the release of a public health
15 discussion paper.

16 And following that release, the
17 Ministry has received over 500 submissions from
18 organizations and individuals providing their
19 feedback and advice in response to the discussion
20 paper and the questions that were included within
21 it.

22 Also, we had met with over 300
23 participants in over eight regional in-person
24 consultations, but then unfortunately back in March
25 those in-person consultations and any further

1 decisions with respect to public health
2 modernization were put on hold as we needed to
3 enable and support the public health sector to
4 respond to the pandemic.

5 So consultations and modernization of
6 the public health sector continues to be a priority
7 for the government and for the Ministry. And once
8 the pandemic is managed - I won't say over,
9 although I would love to - but certainly when it is
10 managed and contained and those key risks are
11 mitigated and it is feasible operationally both for
12 the field and for the Ministry, we will be moving
13 forward and consider the changes that need to be
14 made and have been proposed and will continue on
15 with those consultations looking to modernize and
16 strengthen public health services.

17 So on the next slide, I am actually
18 going to turn it over now to Brent to take you
19 through some of the next set of slides.

20 BRENT FEENEY: Thanks, Liz.

21 So as was mentioned, so the 2019
22 Ontario budget announced changes to public health
23 units that supported the government's commitment to
24 achieving fiscal balance and to better coordinate
25 access at the local level and to also increase the

1 role for municipalities.

2 Notably with respect to public health
3 units and funding, there were a few ways in which
4 the government was looking to accomplish this, one
5 of which was, as Liz had walked through, was the
6 establishment of the ten regional public health
7 entities effective as of April 1st.

8 And I think what is important to note
9 on that piece is that as public health units and
10 boards of health are established under legislation,
11 any changes to the structure of public health units
12 and governance would require legislative changes,
13 so I think that is an important piece to note, that
14 any changes to structure or governance would
15 require changes to legislation.

16 Another piece that was recommended and
17 announced through the Ontario budget was the
18 government had proposed that it would adjust the
19 provincial/municipal cost-sharing of funding from
20 the current, from what was the 75 percent
21 provincial/25 percent municipal cost share and it
22 would change to a -- it would change to a different
23 set of cost-sharing for different entities over a
24 three-year period. And the final ratios would have
25 been set based on the population size of the new

1 regional entity to recognize the variation across
2 Ontario.

3 So basically, what the proposal at the
4 time was is that we would be shifting provincial
5 costs as part of a 75/25 arrangement and we would
6 be shifting costs from the province over to
7 municipalities.

8 So there wasn't an intent to reduce the
9 budget of the health unit, but to just shift the
10 responsibility between the province and
11 municipality of costs.

12 So I am not going to go in too much
13 detail of what those cost-sharing arrangements
14 were, but just quickly, the plan at the time was
15 effective April 1st, 2019, the provincial/municipal
16 cost-sharing arrangement were to be changed to a 60
17 percent provincial/40 percent municipal for the
18 City of Toronto and a 70 percent provincial/30
19 percent municipal for all other public health
20 units.

21 In that first year, the Ministry had
22 planned to give one-time mitigation funding to cap
23 the municipal increases at 10 percent as a result
24 of the change in the cost-sharing.

25 In year two, which would have been

1 effective as of April 1st, 2020, the
2 provincial/municipal cost-sharing arrangements were
3 going to be maintained at a 60/40 for Toronto and a
4 70/30 for all other proposed regional entities, but
5 the one-time mitigation funding was to be removed
6 so there would be no cap on increases for
7 municipalities.

8 And an end state effective April 1st,
9 2021, the province had planned to move to a 50
10 percent provincial/50 percent municipal for the
11 proposed Toronto regional public health entity, 60
12 percent provincial/40 percent municipal for those
13 six regional public health entities that had
14 populations of over 1 million, and then for the
15 three smaller regional public health entities with
16 populations under a million, it would remain at a
17 70/30.

18 So these actions, and what I mean by
19 "actions" is the establishing of the ten regional
20 public health entities and the adjusting of the
21 provincial/municipal cost-sharing arrangements,
22 these actions would lead to an annual provincial
23 savings target of approximately 200 million
24 dollars, and that 200 million dollars was to be
25 achieved by '21/'22, and that was announced as part

1 of the 2019 Ontario budget.

2 But as Liz had mentioned, you know,
3 following the release of the 2019 budget, the
4 public health and municipal sectors did react
5 strongly to the planned change and the cost-sharing
6 arrangements, including the inability of
7 municipalities to build in or absorb the increased
8 costs especially in the first year.

9 So in response to these concerns, on
10 May 27th, 2019, the government committed to
11 maintain the current cost sharing arrangement for
12 2019, so a 75 percent provincial/25 percent
13 municipal, to provide municipalities with more time
14 to find efficiencies.

15 So in May, the government announced
16 that we were going to maintain 2019 cost-sharing at
17 a 75/25 arrangement, no changes to funding for 2019
18 in terms of the cost share programs.

19 Further, in August 2019, as part of the
20 Annual Conference of the Association of
21 Municipalities of Ontario, the Minister of Health
22 announced a revised public health modernization
23 plan than what was proposed originally as part of
24 the 2019 Ontario budget.

25 This plan included, you know, the

1 government's commitment to consult more broadly on
2 public health modernization to begin in the fall,
3 as Liz had walked through earlier. And so with
4 that commitment to consult further on the
5 structure, that meant that the existing structure
6 and total number of health units, which at the time
7 was about 34 health units, would be maintained
8 pending the outcome of the public health
9 modernization consultation.

10 The Minister also announced that the
11 cost-sharing arrangement would be changed, and
12 effective January 1st, 2020, a consistent 70
13 percent provincial/30 percent municipal
14 cost-sharing ratio would be applied to all public
15 health units. So the original three-year phased
16 approach was no longer being applied. The
17 government committed to a 70/30 cost-sharing ratio
18 to be applied to all health units, and that would
19 be effective as of January 1st, 2020.

20 And then finally, the Minister had
21 announced mitigation strategies and that one-time
22 funding would be provided to public health units
23 for 2020 to ensure that no municipality would
24 experience an increase greater than 10 percent as a
25 result of the cost-sharing change moving from a

1 75/25 ratio to a 70/30.

2 Through the public mental health
3 modernization consultation process, which again
4 began in the fall of 2019, municipalities continued
5 to raise concerns regarding their inability to fund
6 increased public health costs once the one-time
7 mitigation funding was to be removed in 2021,
8 effective January 1st, 2021.

9 In response to these concerns, on March
10 17th, 2020, the government announced that it was
11 extending the one-time mitigation funding for
12 public health units for an additional calendar
13 year, so it would be extended into 2021 to ensure
14 that the municipal adjustments would remain capped
15 at 10 percent and recognizing the considerable time
16 and necessary resources that were required for
17 health units to respond effectively to COVID-19.

18 And as Liz mentioned earlier, at that
19 time in mid-March the public health modernization
20 consultations were also put on hold to allow public
21 health, the public health sector to respond to
22 COVID-19.

23 And then further, in August of 2020, on
24 August 17th, 2020, the Minister of Health announced
25 that the Ministry would be increasing the one-time

1 mitigation funding for public Health Units to fully
2 offset the increased costs of municipalities from
3 going from a 25 percent to a 30 percent in both '20
4 and '21 so that municipalities are not impacted at
5 all by the cost-sharing change during this critical
6 time.

7 So I know that is a lot of info, and as
8 you can see on this slide, given the changes that
9 have taken place since the original announcement
10 through the 2019 Ontario budget, the original
11 provincial savings targets, as you can see on this
12 slide, are not being realized at all.

13 So what was originally proposed as a
14 200 million dollar provincial savings target to be
15 achieved by '21/'22, as you can see below that
16 table, we are now no longer looking to achieve any
17 provincial savings as a result of public health
18 modernization at this time.

19 COMMISSIONER FRANK MARROCCO (CHAIR):

20 So in essence, everything remained the
21 same; is that right?

22 BRENT FEENEY: Not entirely true.
23 Everything remained the same in terms of the
24 cost-shared funding amount but --

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 I'm sorry, that is what I was referring
2 to, that the financial arrangement did not --
3 whatever was intended -- I am just trying to make
4 sure that I have it clear in my own head. Whatever
5 was intended for a variety of reasons did not
6 change?

7 BRENT FEENEY: You are correct. The
8 only thing I would clarify is the cost share did go
9 ahead, so we did go to a 70 percent provincial and
10 30 percent municipal effective as of January 1st,
11 but what the government has committed for two years
12 is that we would fully offset the municipal
13 increases as a result of that cost-sharing change.

14 So there is no impact to the public
15 health unit or the municipalities as a result of
16 these changes.

17 COMMISSIONER FRANK MARROCCO (CHAIR):
18 All right, okay. Commissioner Coke?

19 COMMISSIONER ANGELA COKE: Yes, I
20 understand what you are saying in terms of no
21 change at this time, but was the anticipation --
22 you are downloading this cost to the
23 municipalities. Were the other modernization
24 initiatives going to enable them to have the
25 savings to respond to that? Was that the thinking?

1 BRENT FEENEY: Yes, partly that was
2 part of the thinking of any savings, any potential
3 back office savings that would have resulted from
4 us moving to ten regional entities would be also
5 applied to any municipal costs.

6 COMMISSIONER ANGELA COKE: I see.
7 Okay, thank you.

8 BRENT FEENEY: Okay, so before we get
9 into Public Health Ontario, I just wanted to walk
10 through some COVID-19 provincial support that has
11 been provided to the public health units.

12 So we definitely acknowledge the
13 extraordinary and continuing efforts of the public
14 health sector, including public health units, to
15 monitor, detect and contain COVID-19 in the
16 province.

17 Ontario's public health system has
18 demonstrated a remarkable responsiveness to
19 COVID-19 as the outbreak has evolved locally and
20 globally.

21 For the '20/'21 fiscal year, the
22 Ministry has increased public health sector
23 investments to ensure there is sufficient capacity
24 in the province to manage and respond to COVID-19
25 and ensure that other critical public health

1 programs and services in Ontario are not
2 compromised due to the COVID-19 pandemic.

3 So back in March, around the same time
4 that the government had put a pause on the
5 consultations for modernization, the government's
6 Ontario Action Plan Responding to COVID-19 included
7 up to 100 million dollars in additional funding -
8 and this was at 100 percent provincial funding, so
9 not to be cost-shared with municipalities - 100
10 percent in additional funding for the public health
11 sector, including public health units, to ensure
12 that they have the capacity required to monitor,
13 test and do appropriate case and contact management
14 in their local area.

15 In addition, as part of Ontario's Plan
16 for the Safe Re-Opening of Schools in September,
17 the Ministry approved up to 62.5 million in
18 additional funding for public health units to hire
19 up to 625 additional school-focussed nurses for the
20 '20/'21 school year.

21 In addition, as part of the province's
22 COVID-19 fall preparedness plan, that plan also
23 included additional funding to add case and contact
24 management staff to support the public health
25 sector to identify and follow up with new COVID-19

1 cases and outbreaks to avoid further spread.

2 And the government also approved
3 additional funding through what was called the
4 Temporary Pandemic Pay Initiative to help frontline
5 staff, including public health unit nurses who
6 worked and are experiencing severe challenges and
7 are at heightened risk during the COVID-19
8 outbreak.

9 And then finally, there has been a lot
10 of support for the local municipalities, and in
11 partnership with the federal government, the
12 province also provided up to 4 billion dollars in
13 one-time assistance to Ontario's municipalities as
14 part of the Safe Restart Agreement.

15 So the Ministry --

16 COMMISSIONER FRANK MARROCCO (CHAIR):

17 So -- and sorry to interrupt.

18 BRENT FEENEY: No problem.

19 COMMISSIONER FRANK MARROCCO (CHAIR):

20 So in terms of testing and contact
21 tracing, that is 1.5 billion dollars?

22 BRENT FEENEY: So for the public --

23 COMMISSIONER FRANK MARROCCO (CHAIR):

24 And sorry, let me be clear, 1.5 billion
25 dollars was made available for that purpose?

1 BRENT FEENEY: So these are investments
2 that were specifically for public health units and
3 part Public Health Ontario. There are a lot of
4 other additional investments as well.

5 There was a 1.4 billion dollar
6 approval, which I believe we reference later on,
7 that was approved through the government's fall
8 preparedness plan to support laboratory testing.

9 COMMISSIONER FRANK MARROCCO (CHAIR):
10 Okay.

11 BRENT FEENEY: So if we can move on now
12 to Public Health Ontario, and very similar to
13 public health units, we'll provide a bit of an
14 overview of Public Health Ontario, including
15 funding and accountability.

16 We'll walk through some of the impacts,
17 some of the commitments that were made through the
18 budget that had an impact on Public Health Ontario
19 and go through some of the COVID initiatives as
20 well.

21 So following major public health events
22 such as Walkerton in 2000 and SARS in 2003,
23 numerous external reports, Naylor, for one, the
24 Walker Report and the Campbell Report, recommended
25 the creation of a public health agency for Ontario.

1 The 2004 government report titled
2 "Operation Health Protection" then committed to
3 establish an arm's length public health agency by
4 2006/07.

5 The Ontario Agency for Health
6 Protection and Promotion Act was passed in 2007 to
7 establish a board-governed agency, known as the
8 Ontario Agency for Health Protection and Promotion,
9 which operates as what you likely know them as is
10 Public Health Ontario.

11 In accordance with this Act, Public
12 Health Ontario's legislative mandate includes
13 providing scientific and technical advice and
14 support to the health and public health systems in
15 the areas of infection prevention and control,
16 communicable diseases, environmental health and
17 chronic disease prevention.

18 The agency also carries out and
19 supports activities such as public health research,
20 surveillance, epidemiology, planning and
21 evaluation, and operates and provides public health
22 laboratory services in public health laboratory
23 centres across Ontario.

24 In 2011, the Ministry of Health's
25 public health science and epidemiological functions

1 were transferred to Public Health Ontario, creating
2 a key dependency for Ontario's Chief Medical
3 Officer of Health to perform his or her legislative
4 duties.

5 I had mentioned the public health --
6 COMMISSIONER FRANK MARROCCO (CHAIR):

7 I'm sorry, what do you mean by a "key
8 dependency" for the Chief Medical Officer of
9 Health? What does that mean?

10 BRENT FEENEY: Well, I will give this a
11 go. So what it means is that the Chief Medical
12 Officer of Health has a separate arm's length
13 agency that it can rely on for advice and support
14 in areas of science and epidemiological functions.

15 COMMISSIONER FRANK MARROCCO (CHAIR):

16 So "dependency" means that the Chief
17 Medical Officer of Health can rely on that agency,
18 not that the Chief Medical Officer of Health is
19 dependent on that agency?

20 BRENT FEENEY: Sorry, I'll just give it
21 to Liz here.

22 ELIZABETH WALKER: Sorry, we are trying
23 to minimize the vertigo here.

24 BRENT FEENEY: Yes.

25 ELIZABETH WALKER: So one example is

1 surveillance. So there was surveillance capacity
2 that is required by the Chief Medical Officer of
3 Health to undertake his legislative duties under
4 the HPPA, and as part of the 2011 changes, that
5 capacity was moved over to Public Health Ontario.

6 So rather than having that capacity
7 within the division, it is now within Public Health
8 Ontario, so it is a function that the CMOH relies
9 on, and that is where we are talking about key
10 dependency. So for him to be able to make
11 decisions, to make recommendations to government
12 and to Cabinet, as you reflected earlier, Judge,
13 those are the kinds of key dependencies that are
14 now under Public Health Ontario that the Chief
15 Medical Officer of Health would rely on.

16 COMMISSIONER FRANK MARROCCO (CHAIR):

17 But he can't command them because they
18 belong to Public Health Ontario and that is an
19 independent agency managed by a board. Have I got
20 that right?

21 ELIZABETH WALKER: That's right. That
22 is where --

23 COMMISSIONER FRANK MARROCCO (CHAIR):

24 So he is dependent?

25 ELIZABETH WALKER: Yes, that is right.

1 COMMISSIONER FRANK MARROCCO (CHAIR):

2 That is the dependency. They have to
3 agree with what he wants to do, or she, but
4 Dr. Williams is a he. They have to agree?

5 ELIZABETH WALKER: So there is a number
6 of different I don't know if "labours" is quite the
7 right word, but there is certainly a number of
8 structures in place where that happens, so the
9 annual business planning process between Public
10 Health Ontario needs to submit to the Ministry for
11 approval, the legislated objects that require the
12 agency to undertake those specific functions. I am
13 trying to think of a couple of others, and Colleen
14 and Cathy may be able to refer to some of those as
15 well.

16 BRENT FEENEY: It is actually on the
17 next slide, I think.

18 ELIZABETH WALKER: Oh, is it on the
19 next slide as well?

20 BRENT FEENEY: Yeah.

21 ELIZABETH WALKER: The CMOH is also
22 able to issue directives to the agency, so there
23 certainly are options there that support that key
24 dependency role so that it enables that to happen
25 as an independent Crown agency.

1 So I'll pass it back to Brent.

2 BRENT FEENEY: So as a Crown
3 agency, Public Health Ontario receives ongoing
4 transfer payment funding from the office of the
5 Chief Medical Officer of Health, Public
6 Health of the Ministry of Health for its base
7 operations/legislative mandate.

8 Funding is provided by the province on
9 a global basis, meaning that Public Health Ontario
10 has the flexibility and ability to allocate the
11 funding that the province provides to meet their
12 legislative mandate activities.

13 The Ministry, as Liz was referencing,
14 we do have several accountability mechanisms in
15 place with Public Health Ontario to ensure the
16 prudent use of funds and to ensure that they are
17 meeting their legislative mandate activities.

18 The reporting requirements of Public
19 Health Ontario are defined and outlined by the
20 Ontario Agency for Health Protection and Promotion
21 Act. There is a Memorandum of Understanding that
22 is in place between Public Health Ontario and the
23 Ministry that ensures that Ministry deliverables
24 are met and value for money is achieved.

25 There is one important piece to note

1 about the Memorandum of Understanding that I wanted
2 to flag in the context of the current COVID-19
3 pandemic.

4 The existing MOU that is in place
5 between the Ministry and Public Health Ontario
6 includes a requirement that should Public Health
7 Ontario not be able to find an offset for unplanned
8 emergency outbreak costs, the Ministry of Health
9 and Public Health Ontario shall work together to
10 take any necessary steps to meet this financial
11 requirement.

12 And I will provide a bit more detail on
13 the COVID-19 supports in a few slides.

14 We also, as we do with public health
15 units and as actually the Government of Ontario has
16 with any transfer payment agency, we do have an
17 evergreen transfer payment agreement in place that
18 has been signed between Public Health Ontario and
19 the Ministry of Health. When we say "evergreen",
20 we mean that it is ongoing, that there is no end
21 date. And that also builds on the requirements and
22 provides for enhanced reporting mechanisms.

23 And then there are a number of
24 directives that the province issues and requires
25 that provincial agencies abide and comply with, one

1 of which is the agencies and appointments
2 directive, and that sets out the rules and
3 accountability framework for provincial agencies,
4 as well as the remuneration guidance for government
5 appointments.

6 So moving on to the next slide, because
7 I know there was a question about whether PHO in
8 our view has met their deliverables. Have they,
9 you know, met their legislative mandate since the
10 creation post-SARS.

11 So the government definitely values the
12 important service that Public Health Ontario
13 provides to Ontarians. Public Health Ontario's
14 mandate and work continues to directly support
15 government priorities through its focus on
16 improving public health promotion and prevention
17 within the health care system.

18 It does this by providing scientific
19 and technical advice to Ontario's Chief Medical
20 Officer of Health and by performing public health
21 laboratory testing services for the provincial
22 health system. The role of public health labs is
23 fundamental to the work of the health system
24 overall.

25 An internal audit of Public Health

1 Ontario was conducted by the Ontario Internal Audit
2 Division in 2015, and that found that there are
3 processes in place to ensure public resources are
4 allocated and used with regard to value for money,
5 and Public Health Ontario is meeting the objectives
6 of the approved annual business plan.

7 There was also a mandate review of
8 Public Health Ontario conducted in July 2016 that
9 confirmed that, given Public Health Ontario's
10 specialized expertise in providing scientific and
11 technical advice with a public health focus, that
12 their functions are best performed by the agency
13 rather than by a Ministry, another agency or
14 entity.

15 The mandate review also noted that
16 further opportunities exist to align its services
17 with the Ministry of Health and the broader health
18 sector.

19 We also wanted to note that public
20 health laboratory volumes, and I know Public Health
21 Ontario is going to speak a bit further about this
22 later, their laboratory volumes and related costs
23 have increased significantly over the last few
24 years, which are becoming a challenge for Public
25 Health Ontario to manage within its own budget.

1 Over the past two years, the Ministry
2 has been working closely with Public Health Ontario
3 to identify operational efficiencies, to mitigate
4 these increased costs, including the development of
5 a Public Health Laboratory Modernization Plan which
6 was announced as part of the 2019 budget, which
7 I'll go into right now.

8 So if we go to the next slide, so the
9 2019 Ontario budget also announced that the
10 government would streamline Public Health Ontario
11 to align with the new public health system.

12 Part of this streamlining included
13 modernizing Ontario's public health laboratory
14 system by developing a regional strategy to create
15 greater efficiencies across the system and reducing
16 the number of laboratories.

17 As a result, provincial savings targets
18 for Public Health Ontario were to be graduated,
19 starting in 2019/20 associated with the
20 modernization of Ontario's public health labs
21 system, approximately 3.7 million in 2019/20 and
22 1.3 million in '20/'21.

23 So 3.7 million in 2019/20 were proposed
24 savings, and 5 million dollars in '20/'21
25 associated with the lab modernization plan.

1 However, very similar to the public
2 health unit piece, it is important to note,
3 however, that the public health laboratory plan
4 approved as part of the 2019 Ontario budget has not
5 been implemented, nor has any of the original
6 provincial savings targets approved been realized.

7 So there have been no changes to the
8 laboratory system as it is currently structured
9 today.

10 COMMISSIONER FRANK MARROCCO (CHAIR):

11 So do I understand basically there has
12 been no change, neither financial nor physical,
13 basically been no change because of the pandemic?

14 BRENT FEENEY: That is correct,
15 although I will clarify --

16 COMMISSIONER FRANK MARROCCO (CHAIR):

17 Excuse me, that there was increased
18 funding, as you have -- when I say "no change", I
19 recognize there was increased pandemic funding, but
20 these kinds of changes that were envisioned in the
21 budget never happened?

22 BRENT FEENEY: Correct, although, and I
23 will go through right now that there were some
24 funding adjustments that were made to Public Health
25 Ontario that I think is important to walk through,

1 which I can do right now.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 Sure, go ahead.

4 BRENT FEENEY: So as I was mentioning,
5 so the laboratory plan was put on hold for a few
6 reasons.

7 One, there was a recent laboratory
8 services optimization study conducted by the
9 Ministry of Government and Consumer Services which
10 also looked at government-run laboratories. The
11 public health modernization consultations which are
12 also looking at the mandate and role of Public
13 Health Ontario in a modernized system are currently
14 on hold. And of course, the COVID laboratory
15 activities currently underway and the increased
16 capacity required from all Public Health
17 Ontario-run laboratories.

18 So as you can see on this slide, the
19 table at the top shows a summary of the funding
20 allocations that were approved for Public Health
21 Ontario.

22 Although Public Health Ontario's base
23 funding allocation was adjusted in 2019/20 to
24 reflect the provincial savings targets pertaining
25 to public health laboratory modernization, overall

1 provincial funding has remained at the same levels
2 over the past few years, approximately 155 million,
3 not including the COVID investments being made,
4 which I will go through in a few minutes.

5 In '19/'20 and '20/'21, one-time
6 laboratory transition funding was provided by the
7 Ministry to Public Health Ontario while
8 implementation of the public health modernization
9 plan is on hold.

10 So Public Health Ontario's base funding
11 allocation was adjusted to reflect the laboratory
12 savings. However, because the laboratory plan is
13 on hold and is up for further discussion through
14 modernization, we have offset those adjustments
15 through providing one-time transition funding.

16 Another key component that we wanted to
17 raise as part of the April 2019 -- if you can just
18 go back one slide, sorry.

19 So one of the key components of the
20 April 2019 Ontario budget was a commitment to
21 combine a number of existing provincial health
22 agencies and the Local Health Integration Networks
23 into one new agency, Ontario Health, to streamline
24 health care oversight and reduce administration.

25 There was initial consideration of

1 including Public Health Ontario as one of the
2 agencies to be moved into Ontario Health. As a
3 result, there was an adjustment of approximately
4 9.5 million for 2019/20 related to efficiency
5 savings.

6 So as you can see, if you look at the
7 base funding, their base funding from '19/'20 -- or
8 sorry, my apologies, from '18/'19 to '19/'20 was
9 adjusted by 13.2 million, so that included the 9.5
10 million for the agency, the Ontario Health Agency,
11 and then the 3.7 million for the laboratory
12 modernization savings.

13 However, the movement of Public Health
14 Ontario into Ontario Health was put on hold pending
15 outcomes of public health modernization
16 consultations, and the base funding was restored in
17 2021. This was also mitigated by one-time funding
18 in 2019/20.

19 And if we could go to the next slide,
20 so with respect to COVID-19, Public Health Ontario
21 has played an extraordinary role in the pandemic
22 response, including and not limited to COVID
23 laboratory testing and scientific support, COVID
24 data collection, monitoring, analysis and
25 reporting, COVID case and contact management,

1 including resource support for the public health
2 units, and providing scientific and technical
3 advice and guidance to the public health units and
4 other parts of the health care system, as well as
5 other sectors.

6 COMMISSIONER FRANK MARROCCO (CHAIR):

7 So do I have it right that with respect
8 to contact tracing, that remained the
9 responsibility of the local health unit, but it was
10 funded this way?

11 BRENT FEENEY: No, so the funding -- so
12 to clarify, Public Health Ontario and public health
13 units are separate agencies.

14 COMMISSIONER FRANK MARROCCO (CHAIR):

15 Yes.

16 BRENT FEENEY: So the local public
17 health units, the funding that we provide to the
18 local public health units to support their local
19 work with case and contact management, we provide
20 funding directly to the public health units to
21 support that work, as well as any other work that
22 they undertake with respect to COVID-19.

23 ELIZABETH WALKER: I think the
24 additional piece that you may be referring to --
25 and sorry, here goes the camera again. So there

1 has been surge capacity that has been developed in
2 partnership with Public Health Ontario to enable
3 some of those additional contact traces that have
4 been brought on board to be able to move across the
5 province virtually.

6 So if Peel, for example, required
7 additional support as their cases spiked, there was
8 surge capacity at Public Health Ontario to enable
9 that.

10 And then if it was Ottawa's turn and
11 their cases spiked, there was surge capacity at
12 Public Health Ontario to enable that.

13 So there was a bit of a layered
14 response, and the funding followed that layered
15 response.

16 COMMISSIONER FRANK MARROCCO (CHAIR):

17 So the initial response, the initial
18 responsibility for funding contact tracing would
19 have been locally, apart I guess from these units
20 where the regional municipality or the municipality
21 is the unit, but forgetting that for a minute,
22 where you had a local health unit, it had its
23 budget for contact tracing and you provided
24 additional funding because, of course, the contact
25 tracing required would dramatically increase

1 because of the pandemic?

2 BRENT FEENEY: You are absolutely
3 right. Like for a local public health unit,
4 regardless of the governance structure, a local
5 public health unit as part of the Ontario public
6 health standards is required to comply and deliver
7 infectious diseases control programming. A major
8 part of that work, especially with respect to
9 outbreak management, is case and contact
10 management. It is a major component of the role
11 and legislative responsibility of the local public
12 health unit.

13 Normally, if there is a local outbreak,
14 a local public health unit would fund those costs
15 within its existing budget, within its existing
16 funding, but COVID-19 has required a level of
17 response that goes way beyond that.

18 And the same can be said with Public
19 Health Ontario with their lab testing. The costs
20 for lab testing and the costs for the local
21 response case and contact went way over and above
22 their approved budgets, and that is why the
23 province had announced additional funding so that
24 any pressures that the public health units incur
25 and any pressures that Public Health Ontario incurs

1 we would offset at 100 percent through these
2 different initiatives that I have identified
3 through the slides.

4 COMMISSIONER FRANK MARROCCO (CHAIR):

5 So if you had a long-term care home, it
6 is in a local health unit, and if you wanted to
7 contact trace all of the cases that arose and were
8 connected with that unit, the local health unit
9 would pay for it but the additional costs caused by
10 the fact that this all arises from COVID-19 would
11 have been funded by the province.

12 BRENT FEENEY: Correct.

13 COMMISSIONER FRANK MARROCCO (CHAIR):

14 So in your view, was there ample
15 funding to permit that kind of contact tracing to
16 go on?

17 ELIZABETH WALKER: So I think that --
18 sorry, and I'll turn the camera over again.

19 I think that is hard to answer just
20 because the scale of the response is like nothing
21 we have envisioned before.

22 So in a normal year, let me go back to
23 that, in a normal year if there was an outbreak at
24 a long-term care home of flu, for example -- or no,
25 that is not -- of a reportable disease that

1 required contact tracing, it would be within the
2 capacity of the health units. If it went above
3 that, extraordinary costs would be covered to bring
4 in additional expertise to enable that. I think in
5 some of the health units, the capacity for scaling
6 up, for finding some of those resources has been
7 quite significant.

8 So it is sort of hard to say health
9 unit by health unit.

10 COMMISSIONER FRANK MARROCCO (CHAIR):

11 But when you say find those resources,
12 I thought you were saying earlier that the
13 additional funding or your colleague was saying
14 earlier that the additional funding required
15 because of the pandemic was provided to the local
16 health units because the local health unit's budget
17 wouldn't sustain that.

18 And so therefore I was trying to
19 understand whether in the province's view there was
20 sufficient funding provided to the local health
21 units to permit them to do the contact tracing that
22 they had to do?

23 ELIZABETH WALKER: So funding is
24 absolutely a fundamental part of that. The other,
25 and if I use a colloquial expression, is the warm

1 body to fill the position.

2 So the pandemic has put an enormous
3 strain on all of the health human resources across
4 the province. There has been an awful lot of work
5 done to find creative solutions for things like
6 contact tracing, for example, and the kind of
7 expertise that could be brought in, but there is a
8 number of factors that would go into that.

9 So it would be hard for us to be able
10 to provide a definitive response on that as to
11 whether the funding was sufficient because the
12 response, funding is part of it but there is a
13 number of other factors with respect to that
14 response.

15 COMMISSIONER FRANK MARROCCO (CHAIR):

16 But the funding portion of it, is it
17 your view that the funding portion of it was
18 sufficient, regardless of the personnel issues, for
19 example?

20 ELIZABETH WALKER: So the extraordinary
21 costs of the health units, if they had been
22 identified through the additional funding, were
23 being covered or have been covered by the province,
24 yes.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 And the people to do the contact
2 tracing, that would have been the responsibility
3 then of the local health unit to find the people to
4 do it? Assuming that you have provided them with
5 the money, then they would have the responsibility
6 of going out, and I just picked contact tracing
7 because that is where we are at, and finding the
8 people to do the contact tracing; is that right?

9 ELIZABETH WALKER: So there has been a
10 shared response to that. So absolutely, that has
11 been the role of the public health units to bring
12 in additional capacity if it is required.

13 There has actually been a portion of
14 our Ministry, and we would have to bring this back
15 for further discussion because there is other folks
16 who have been a lot more involved in that contact
17 tracing discussion and plans, for example, than we
18 have, but through that effort, there has been
19 additional capacity identified, as I mentioned, at
20 a provincial level. So there were opportunities
21 then for that surge capacity.

22 So I am more than happy if you have
23 sort of more -- to be able to bring this back and
24 perhaps get someone to speak with you that has a
25 little bit more detail than we do on how some of

1 those contact tracing capacity, how that was
2 supported.

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 So just to pick one aspect of the
5 capacity, finding the people to do the contact
6 tracing after the province has provided the money
7 was a shared responsibility between the province
8 and the local health unit?

9 ELIZABETH WALKER: So yes, again, I
10 would have to refer I think to -- I wouldn't want
11 to go too far down here because I have not been
12 involved directly with that capacity side, but we
13 could certainly bring it back and I could refer the
14 question to the area who has been a lot more
15 involved than we have to deal with that and --

16 COMMISSIONER FRANK MARROCCO (CHAIR):

17 I wasn't -- sorry, go ahead, I didn't
18 mean to interrupt.

19 ELIZABETH WALKER: No, that is okay,
20 but they would be able to provide you with a more
21 definitive response on how that has actually worked
22 out than we would be able to.

23 COMMISSIONER FRANK MARROCCO (CHAIR):

24 I really was trying to understand
25 whether the responsibility for finding, for

1 example, the people to do contact tracing was the
2 local health unit's responsibility or the
3 province's responsibility, and I took your answer
4 to be it is a shared responsibility, and that
5 because there is 34 health units and there is 34
6 stories about what was involved, I was just trying
7 to understand who had the responsibility.

8 ELIZABETH WALKER: Understood, so yes,
9 it is both of us. So the way that the additional
10 surge capacity has been established is that public
11 health units absolutely would be, as they are for
12 all of their hiring decisions, they are responsible
13 for providing or for seeking and bringing on board
14 additional capacity as they need to.

15 But there was also in parallel to that
16 an initiative at the provincial level to bring on
17 additional contact tracing capacity and warm bodies
18 again at the provincial level that public health
19 units could request additional support for.

20 COMMISSIONER FRANK MARROCCO (CHAIR):

21 So if they were doing contact tracing
22 because somebody in a long-term care residence
23 tested positive, the contact tracer, just to pick
24 one specific example of the support, would be a
25 responsibility of both the local health unit and

1 the province?

2 ELIZABETH WALKER: So the initial case
3 investigation, so when a positive case comes in,
4 the initial case investigation is done by the
5 health unit and then followed up with further
6 contact tracing of that individual's contacts by
7 the health unit.

8 But if the contacts, for example, on a
9 daily basis became more than they had the capacity
10 to be able to follow up with in a timely way, they
11 were able to reach out to the province for that
12 additional surge capacity. So that is where it
13 became a shared responsibility. We were working
14 jointly with the health units to support that.

15 COMMISSIONER FRANK MARROCCO (CHAIR):
16 All right.

17 ELIZABETH WALKER: Does that answer
18 your question?

19 COMMISSIONER FRANK MARROCCO (CHAIR):
20 More or less. More or less.

21 COMMISSIONER JACK KITTS: Can I follow
22 up on that? Could we go back to slide 5? I want
23 to further explore this shared accountability to
24 see if I actually understand it now.

25 So it is a unique model that involves

1 shared authority and accountability of both the
2 province and the municipal levels, and the province
3 would be Public Health Ontario and the Chief
4 Medical Officer of Health, the three-legged stool?

5 ELIZABETH WALKER: Yes, for different
6 functions, yes.

7 COMMISSIONER JACK KITTS: Okay. So
8 Commissioner Coke asked -- or sorry, Commission
9 Marrocco asked about the swabbing and testing and
10 contact tracing.

11 Could you give me an example of how
12 that shared accountability lines up in the pandemic
13 plan? You have said that the local plan is to be
14 created by the local public health units - and I
15 assume the provincial plan is by Public Health
16 Ontario and the Chief Medical Officer of Health -
17 how they line up and then specifically how would
18 the PPE supply or IPAC measures fit into that
19 shared accountability.

20 ELIZABETH WALKER: So I am not sure I
21 would be able to provide you with that level of
22 detail.

23 In terms of the roles and
24 responsibilities, as you see them there, they would
25 apply regardless of whether it was swabbing or

1 contact tracing or however, whatever aspect of the
2 pandemic.

3 But with respect to the particular
4 pandemic plans that each of the health units would
5 have or the provincial pandemic plan that is put in
6 place by our Health System Emergency Management
7 Branch, we wouldn't be able to -- I wouldn't be
8 able to comment on that. I don't have that level
9 of knowledge.

10 COMMISSIONER JACK KITTS: Okay, and so
11 I wonder if you could check with someone about how
12 they lined up that shared accountability, their PPE
13 and IPAC measures specifically, but the alignment,
14 I guess.

15 U/T ELIZABETH WALKER: Absolutely so PPE
16 and IPAC, yes, we can certainly do that and I can
17 bring that back to the right folks.

18 COMMISSIONER JACK KITTS: Yes, and the
19 pandemic plan.

20 U/T ELIZABETH WALKER: And the pandemic
21 plan, yes, okay.

22 So I am not sure there is anything
23 further from us on the slides. I don't know if
24 there is anything or any further questions?

25 Otherwise, we are happy to turn it over

1 to colleagues at Public Health Ontario to provide
2 their presentation.

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Well, it doesn't seem like we have any
5 further questions.

6 ELIZABETH WALKER: Well, we'll
7 certainly be here if there are.

8 CATHY CAMPOS: Okay, so I think we are
9 ready to go.

10 Thank you, Brent and Liz.

11 We'll start with this slide, and really
12 it is a follow-up to the commentary that Brent has
13 made in terms of the implications of funding to
14 PHO.

15 So I think Brent had mentioned, and it
16 is a very important point, that PHO's annual base
17 funding allocation had been flat since 2013 fiscal,
18 and during that same period, as was mentioned,
19 PHO's volumes, and these would be the non-COVID
20 volumes, had increased materially by 25 percent.

21 It was in '19/'20 that, as you saw,
22 PHO's base funding allocation was reduced by 13.2
23 million, equivalent to 9 percent, and this further
24 increased PHO's opening deficit.

25 As a result and in fiscal 2019/20

1 compensation and non-compensation budget reductions
2 were made to PHO's cost structure. The financial
3 impact of those reductions was 13 million dollars.

4 So on April 24th, 2020, when we
5 received our '20/'21 funding letter, we then
6 realized that the funding allocation had changed,
7 and rather than a 9 percent reduction, it was a 3
8 percent funding reduction. And while this is
9 improved, it is still a funding reduction.

10 And like '19/'20, as Brent had
11 mentioned, these funding reductions in base funding
12 have been added back or reinstated on a one-time
13 basis only.

14 And as a result of this, again, because
15 of our volume growth over time and the fact that
16 our base funding has decreased, it continues to be
17 a risk for PHO, especially with the growing demands
18 of the agency.

19 As Brent mentioned, and just to
20 clarify, COVID-specific costs have been separately
21 funded through a reimbursement process. So when we
22 refer in these slides to base funding operations,
23 this would exclude specific costs that we have
24 incurred related to our COVID-19 response.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 Is there a process? If the funding is
2 being reimbursed for COVID, do you have to have a
3 process where the funding is approved before you
4 spend the money in order to get reimbursed for it;
5 is that how it works?

6 CATHY CAMPOS: Yes, what we refer to is
7 guidance in the procurement directive that sets out
8 approval requirements during emergency situations.

9 So there are instances, and depending
10 on the amounts, where there is prior Ministry
11 approval required and there are instances where
12 that delegation sits within the authority of the
13 agency.

14 COMMISSIONER FRANK MARROCCO (CHAIR):

15 Okay, so some expenses you can incur on
16 your own, and others you need permission before you
17 can -- well, you can incur them, but before you
18 can -- some you can decide to incur on your own;
19 others, if you want reimbursement, you have to get
20 approval?

21 CATHY CAMPOS: That is correct.

22 COMMISSIONER FRANK MARROCCO (CHAIR):

23 Okay.

24 CATHY CAMPOS: The next slide really
25 speaks to what has been the impact to PHO as a

1 result of both the base funding reduction in 2019
2 and '20 and the cumulative impact of flat-lined
3 funding over the prior years, and we have
4 highlighted the key points.

5 The first is that there has been a
6 reduction in our labour force as a result of the
7 compensation reductions I referred to.

8 Because of our fixed or flat funding
9 envelope, it has made it challenging to proactively
10 repair aging infrastructure because we do not have
11 access to separate funding or a separate stream of
12 funding for aging infrastructure.

13 And the same would apply to the next
14 point, that, again, within that same base funding
15 allocation we need to carve out funding to support
16 technology, especially updated laboratory
17 technology. So we haven't been able to invest
18 especially in areas of automation.

19 And the last point is that the agency
20 has had what we would refer to as a public health
21 science contingency fund budget, and that fund
22 served as a provision for outbreaks, and in these
23 emergency circumstances and when faced with
24 flat-lined funding and in terms of budget
25 reductions, that over time we have reduced and

1 virtually eliminated that emergency fund.

2 But to be clear, that emergency fund
3 was not material enough or designed for the massive
4 financial impact that COVID has had.

5 So I'll pause there.

6 COMMISSIONER FRANK MARROCCO (CHAIR):

7 And, sorry, I just missed that last
8 sentence. Could you just repeat what you just
9 said?

10 CATHY CAMPOS: Yes, the contingency
11 fund over time has been reduced, and I was just
12 clarifying that the budgetary value of that
13 provision that has been reduced would not be
14 material -- was not material in comparison to the
15 amount that has been spent or realized related to
16 COVID expenditures.

17 COMMISSIONER FRANK MARROCCO (CHAIR):

18 So does that mean the fund was
19 sufficient or the fund was insufficient?

20 CATHY CAMPOS: That fund in particular
21 that we are referring to would not have been
22 nowhere near intended for a response as big as
23 COVID-19.

24 COMMISSIONER FRANK MARROCCO (CHAIR):

25 So there was a need for -- in order for

1 you to do what you are supposed to do, there was a
2 need to subsidize you or fund you to do that?

3 CATHY CAMPOS: Absolutely, over and
4 above our base funding, in order --

5 COMMISSIONER FRANK MARROCCO (CHAIR):
6 And over and above the contingency
7 fund.

8 CATHY CAMPOS: Yes, yes.

9 COMMISSIONER FRANK MARROCCO (CHAIR):
10 Okay. Well, if that's it, thank you
11 for a very thorough presentation. It will give us
12 some food for thought, and we will consider this as
13 carefully as we can and try to understand.

14 The goal is to try to understand, where
15 there wasn't sufficient resources to assist the
16 long-term care homes, to try to figure out whether
17 that was material or not to what happened to the
18 people who were in those homes. And this is a very
19 important first step in us understanding that.

20 So thank you all very much for the time
21 and the obvious effort that was put into this.

22 COMMISSIONER JACK KITTS: Yes, thank
23 you.

24 COMMISSIONER ANGELA COKE: Thank you.

25 ELIZABETH WALKER: Thank you for the

1 opportunity.

2

3 -- Adjourned at 2:40 p.m.

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1 REPORTER'S CERTIFICATE

2
3 I, DEANA SANTEDICOLA, RPR, CRR,
4 CSR, Certified Shorthand Reporter, certify:

5 That the foregoing proceedings were
6 taken before me at the time and place therein set
7 forth;

8 That all remarks made at the time
9 were recorded stenographically by me and were
10 thereafter transcribed;

11 That the foregoing is a true and
12 correct transcript of my shorthand notes so taken.

13
14
15
16 Dated this 17th day of December, 2020.

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22 NEESONS, A VERITEXT COMPANY

23 PER: DEANA SANTEDICOLA, RPR, CRR, CSR
24
25

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