Legislative Assembly of Ontario

Assemblée législative de l'Ontario

Official Report of Debates (Hansard)

M-12

Journal des débats (Hansard)

M-12

Standing Committee on the Legislative Assembly

Comité permanent de l'Assemblée législative

Connecting People to Home and Community Care Act, 2020

Loi de 2020 pour connecter la population aux services de soins à domicile et en milieu communautaire

1st Session
42nd Parliament

Monday 15 June 2020

1re session
42e législature

Lundi 15 juin 2020

Chair: Kaleed Rasheed
Clerk: Valerie Quioc Lim

Président : Kaleed Rasheed
Greffière : Valerie Quioc Lim

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.

Hansard Reporting and Interpretation Services
Room 500, West Wing, Legislative Building
111 Wellesley Street West, Queen's Park
Toronto ON M7A 1A2
Telephone 416-325-7400; fax 416-325-7430
Published by the Legislative Assembly of Ontario

Service du Journal des débats et de l'interprétation
Salle 500, aile ouest, Édifice du Parlement
111, rue Wellesley ouest, Queen's Park
Toronto ON M7A 1A2
Téléphone, 416-325-7400; télécopieur, 416-325-7430
Publié par l'Assemblée législative de l'Ontario

ISSN 1180-436X

CONTENTS

Monday 15 June 2020

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON THE LEGISLATIVE ASSEMBLY

COMITÉ PERMANENT DE L'ASSEMBLÉE LÉGISLATIVE

Monday 15 June 2020

Lundi 15 juin 2020

The committee met at 1000 in room 151 and by video conference.

The Chair (Mr. Kaleed Rasheed): Good morning, everyone. I call this meeting to order. We are meeting to conduct public hearings on Bill 175, An Act to amend and repeal various Acts respecting home care and community services. Today's proceedings will be available on the Legislative Assembly's website and television channel.

We have the following member in the room: MPP Robin Martin. The following members are participating remotely: MPP Logan Kanapathi, MPP Jim McDonell, MPP Sam Oosterhoff, MPP Christina Mitas, MPP France Gélinas, MPP Joel Harden, MPP Rudy Cuzzetto, MPP Lorne Coe, MPP Teresa Armstrong, MPP John Fraser and MPP Sara Singh. Thank you all for joining us this morning.

We are also joined by staff from legislative research, Hansard, interpretation and broadcast and recording.

To make sure that everyone can understand what is going on, it is important that all participants speak slowly and clearly. Please wait until I recognize you before starting to speak. Since it could take a little time for your audio and video to come up after I recognize you, please take a brief pause before beginning.

As always, all comments by members and witnesses should go through the Chair.

SUBCOMMITTEE REPORT

The Chair (Mr. Kaleed Rasheed): I have one other item to mention before we begin. The order of the House dated June 2, 2020, gives the subcommittee the authority to determine how to proceed with public hearings. We will not need to vote on this report, but I will read it into the record to make sure all members are aware of the contents.

"Your subcommittee on committee business met on Monday, June 8, 2020, to consider the method of proceeding on Bill 175, An Act to amend and repeal various Acts respecting home care and community services, and determined the following:

"(1) That witnesses be scheduled in groups of three for each one-hour time slot, with seven minutes each for their presentations and 39 minutes for questioning for all three witnesses, divided into two rounds of six and a half minutes for each of the government, the official opposition and the independent members as a group;

"(2) That witnesses be arranged into groups of three chronologically, based on the order their requests to appear were submitted;

"(3) That all witnesses appear virtually by Zoom or by teleconference;

"(4) That the research officer provide a summary of the oral presentations by 2 p.m. on Friday, June 19, 2020; and

"(5) That all witnesses' submissions and committee documents be distributed electronically to all members and staff of the committee."

Are there any questions before we begin?

CONNECTING PEOPLE TO HOME AND COMMUNITY CARE ACT, 2020

LOI DE 2020 POUR CONNECTER LA POPULATION AUX SERVICES DE SOINS À DOMICILE ET EN MILIEU COMMUNAUTAIRE

Consideration of the following bill:

Bill 175, An Act to amend and repeal various Acts respecting home care and community services / Projet de loi 175, Loi modifiant et abrogeant diverses lois en ce qui concerne les services de soins à domicile et en milieu communautaire.

ALZHEIMER SOCIETY OF ONTARIO

VICTORIAN ORDER OF NURSES

ONTARIO COMMUNITY SUPPORT ASSOCIATION

The Chair (Mr. Kaleed Rasheed): I will now call on the Alzheimer Society of Ontario. You will have seven minutes for your presentation. Please state your name for Hansard, and you may begin. Thank you.

Ms. Cathy Barrick: Good morning, committee members, and thank you for the invitation to share our perspective on Bill 175. My name is Cathy Barrick, chief executive officer of the Alzheimer Society of Ontario, and joining me today is Kyle Fitzgerald, our manager of public policy and government relations.

Across Ontario, 29 local Alzheimer societies serve over 160,000 clients each year, including both people living with dementia and their care partners. In every community in the province, the Alzheimer Society is an integrated part of the health care system. We offer system navigation, adult day programs, counselling, social recreation, caregiver education and in-home respite, among many other support programs. We are considered a provider of community support services under the Home and Community

Services Act, and we would be considered a provider of community care services, should Bill 175 become law.

The Alzheimer Society is supportive of the intent of this bill; bringing home and community care providers under the same legislative framework as other health service providers will help advance the goals of the Ontario health team framework which the Alzheimer Society has embraced. All 29 local Alzheimer societies are involved with at least one OHT group. We applaud any progress towards a more patient-centred health care system.

We would like to draw your attention to four details of Bill 175: the removal of maximum service hours, continued copayment requirements, broadening eligible service locations and expanding home and community care to include all non-profit health service providers.

We welcome the removal of service maximums under Bill 175. This is a sign of trust in the sector and removes a constraint not placed on primary or acute care providers. We flag that this move creates the risk for already limited resources to skew towards higher needs clients, further distancing those living with dementia from vital community support services.

Removing service maximums alone will not mean that every home and community care client gets a level of service tailored to meet their unique situation. This is only one step towards that goal. Community support providers are already lean, efficient entities and allocating more resources to some clients will mean giving less to others unless additional investments are made in the sector.

Secondly, the proposed bill would maintain client copayments. The Alzheimer Society makes every effort to accommodate clients regardless of their financial situation. In cases where clients cannot afford their copayment, we try to absorb it, meaning that copayments are now a downloaded cost from the government on to providers. This also creates a de facto service maximum: lower-income clients get access to services their provider can afford to cover, which does not always meet their needs and can change from year to year. This is especially true for higher cost services, such as in-home respite. And even in cases where we offer to cover a client's copay, many decline this help out of a sense of pride.

Thirdly, we are pleased to see service locations expanded to include public hospitals and would encourage continued collaboration between hospitals and home and community care providers as this is rolled out. Offering community care in hospitals allows for continuity in areas like meal support and personal care, lowering the risk of falls or responsive behaviour while in hospital. Admission to hospital is a stressful experience, especially for someone living with dementia, and maintaining some familiarity with routines from their usual day-to-day life helps remove some of this stress.

We would suggest further expanding service locations to include long-term care. A transition to long-term care is often an upsetting experience and, for individuals living with dementia, a change in environment or routine can lead to responsive behaviours. Allowing home and community care workers to continue supporting clients for a short period as the client adjusts to their new environment would be a source of reassurance to the individual and their care partners. This would have to be limited to a well-defined time period, so home and community care resources are not diverted permanently into long-term-care homes. Done right, this would make this step in someone's life a less distressing experience and reduce the risk of a trip to the emergency room—a common occurrence in the weeks following a transition to long-term care.

1010

Our final point concerns the expansion of funding eligibility for home and community care services to include all not-for-profit health service providers. While we welcome collaborative partners, we caution that this could lead to duplication and waste as new providers begin to offer community services without the benefit of decades of experience and expertise. This move could also disrupt long-standing client relationships. Funding and procurement guidelines under this new framework should be evidence-based—

The Chair (Mr. Kaleed Rasheed): Two minutes.

Ms. Cathy Barrick: —taking experience into account to ensure continued value and quality of care.

The Alzheimer Society will be submitting a written brief with our summary of comments. Once again, thank you for considering our feedback. We are happy to answer any questions you may have.

The Chair (Mr. Kaleed Rasheed): Thank you for your presentation. I will now move to the next presenter, VON Canada. You will have seven minutes for your presentation. Please state your name for Hansard, and you may begin. Thank you.

Ms. Jo-Anne Poirier: Thank you very much. I'm Jo-Anne Poirier, the president and CEO of VON Canada. Thank you for the opportunity to provide comments and advice. This legislation is critical to the success of health care in Ontario, as home and community care play an increasingly vital role in keeping people safe and at home.

First of all, a bit about VON: We are the longest-serving home and community care organization in Canada. We have been pioneers. Our nurses have worked through Depressions and world wars, founded community hospitals, and innovated home and community care. We have 123 years in operation, looking after youth and seniors from birth to end of life and palliative care.

We serve 168 communities, ranging from urban centres to small rural communities. Our vision is to have every life lived to the fullest for everyone, regardless of their circumstances. We have over 5,000 employees and about 6,000 volunteers in Ontario. We have nurse practitioners, RNs, recreational therapists, occupational therapists, health care technicians, therapy assistants, kinesiologists, speech language pathologists, social workers, dietitians and support care counsellors. I note that so that you know the breadth and scope of home and community care.

We have professional RNs who train front-line staff in best practices in infection control and professional practices. We have a very solid clinical infrastructure, and we have exemplary standing with Accreditation Canada and

RNAO. What is unique about VON is that we do provide wrap-around services to clients in their homes, self-directed care, adult day programs, Meals on Wheels and exercise programs. We need to move to a bundled care model, which we already practise, which is really about life care and includes social services that reduce and eliminate social isolation and lead to better health.

I'm here today to reinforce the critical role that home and community care play as part of the health care continuum. Over the past two years, a new imperative has become clear for home care leaders to collaborate and create a new vision for patients and their families in the province. We have collaborated with Bayshore and SE Health, and we bring clinical expertise, infrastructure and organizational strength to the province.

As you look ahead to implementing Bill 175, there are some lessons learned from management of the pandemic that I urge you not to ignore. I say "vital" not just because they're key to the sustainability of the home and community care sector, but also because they're key to the health, safety and, indeed, the life of people who benefit from these services. More than that, as we shift the ways that care is offered, there are huge opportunities to make care both more effective for the province, the providers and for people who receive the care. We can help.

Home care enables people who are frail or have life-challenging physical or other conditions to receive care at home, where they want to be. Community care allows people, particularly seniors, to remain healthy and independent and reduces isolation, illness, injuries and hospital visits. Home is not just where people want to be, it's the safest place to receive care. It's also the most cost-effective place to receive care. We need to rethink non-acute care. It's invisible to many, but I wonder, given what we've seen over the last few months, if you've started thinking about long-term care, but at home. That may help build understanding of what our sector can enable.

The pandemic, and its effects, has destabilized the entire sector and our organization. Because of the reduction of home care visits, families have been stranded, and staff have left or applied for CERB. We have about 1,000 employees on leave due to lack of work. Our clients have been placed at risk, and risk ending up in emergency rooms. Yet we have the lowest infection rate in any sector. We need to get people back into home care, working to take care of clients at home.

The future of home and community care needs to be more flexible. It's currently a very transactional model, which makes it difficult to recruit and retain front-line employees. The wage differential with acute care and long-term care exacerbates the situation. Long-term care at home is the way to go. It saves on building beds, has much better infection control, and allows people to stay home, where they want to be. It needs to be redesigned to reduce the high cost of administrative coordination done by the government, as our staff can do assessments and coordinate at a cheaper rate. Accountability need not be jeopardized. Health outcomes can be measured.

The Chair (Mr. Kaleed Rasheed): Two minutes.

Ms. Jo-Anne Poirier: In summary, we need to modernize home care, and we want to be at the table to help you develop those regulations. Home care can and needs to be a stronger part of the health care continuum. Thank you very much for your time, and I will submit my written comments.

The Chair (Mr. Kaleed Rasheed): Thank you very much for your presentation this morning.

I will now call on the Ontario Community Support Association. You will have seven minutes for your presentation. Please state your name for Hansard, and you may begin.

Ms. Deborah Simon: Good morning, everyone. Thank you for the opportunity to appear virtually in front of this committee to provide you with a perspective from the not-for-profit community support services and health sector on Bill 175. My name is Deborah Simon, and I am the CEO of the Ontario Community Support Association. I'm joined by my colleague Patrick Boily, who is our director of policy.

OCSA represents nearly 230 not-for-profit agencies—of which Jo-Anne and Cathy are members—across the province who provide very compassionate, high-quality home care, community support services and independent living to over a million Ontarians.

COVID-19 has changed many aspects of our life, and this virtual committee is just another example of the adaptations that we've had to make to ensure that we successfully manage this pandemic. I'd like to start my presentation by thanking the tireless front-line heroes in the home and community care sector and the broader health care sector for their continued dedication to keeping Ontarians healthy and safe through COVID-19.

Rightfully so, over the past number of months, our sector has been solely focused on responding to the COVID-19 pandemic and not on this proposed legislation. COVID has had a great impact on our health care sector, as Jo-Anne has just spoken to, and has fundamentally changed services across the entire system. We believe that passing Bill 175 should be delayed until the current COVID pandemic has dissipated. This would enable our sector to better understand and incorporate the many key learnings from the pandemic response into this new legislative framework.

The interconnectedness of the health care system during this pandemic has been clearly evident, and therefore we feel it's necessary to take the time to learn and adapt and create a more resilient and sustainable system for the future. We must make the most of this opportunity.

We've appreciated the opportunity to be engaged in the development of this legislation for the home and community care sector prior to the onset of COVID-19. OCSA has been supportive of the need to modernize the legislation for our sector. We urge the province to continue this collaboration with our sector on the development of the proposed regulations and policies. Our support of this legislation is contingent on the province actively collaborating extensively with our sector on the regulations and adopting an open and transparent engagement process as we move forward.

The Home Care and Community Services Act has governed our members and their services for 26 years. Bill 175 proposes to repeal this act and establish the Connecting Care Act, 2019, associated regulations, and policies as an oversight framework to govern the sector. This is a big endeavour that must be done properly. OCSA supports the concept of shifting much of the outdated clinical and service delivery requirements from legislation to regulation, as well as most new community support services and home and community service definitions.

One regulatory proposal we want to bring to your attention is the proposal to maintain, through regulation, the current model of community support services by not-for-profit organizations, and the delivery of home care services by both not-for-profit and for-profit organizations. The important contributions that not-for-profit home and community care bring to the health system cannot be overstated. Its return on investment can be measured in many ways. For example, volunteers provide three million hours of service each year, providing a value of $78 million, for free, to the health care system. We must ensure that these important contributions are not lost in this new legislation and regulatory framework. OCSA strongly supports this inclusion, and our support of this transformation is contingent on the strength of this provision that protects the delivery of community support services by not-for-profit providers.

1020

In our written submission, we propose 11 recommendations to ensure this transformation leads to better outcomes and experiences for clients, better provider experience and enhanced value for money. We would like to highlight three of our recommendations during this presentation.

Our first recommendation relates to public accountability. When the People's Health Care Act was introduced last year, OCSA recommended that the act be amended to mandate open and public meetings for the board of governors of Ontario Health. We are again recommending that the Connecting Care Act be amended to mandate this. In the administration and spending of public dollars, there must be strong and open public accountability.

Our second recommendation pertains to client fees, and Cathy spoke a bit to this. The regulatory summary proposes to maintain the current client fee structure for certain community support services.

The Chair (Mr. Kaleed Rasheed): Two minutes.

Ms. Deborah Simon: Over the past decade, due to the base budget increases for our service provider agencies, client fees have increased at a faster rate than inflation.

Our third recommendation we'd like to highlight relates to the proposal in the legislation that will allow for all not-for-profit providers under the Connecting Care Act to receive funding. We believe that this will be to, as Cathy spoke to—some leveraging and collaboration that needs to be happening with not-for-profit providers. So we strongly recommend that the ministry prescribe, through regulation and requirements, standards for service providers as conditions to receive funding and provide home and community services. These standards would ensure that clients receive high-quality care from reputable organizations. It's very important to us that we see that there be an evenness in that distribution of services.

Thank you for taking the time to examine this critical piece of legislation. At this point, I'd welcome any questions to further explain the rationale behind our recommendations. Thank you.

The Chair (Mr. Kaleed Rasheed): Thank you for your presentation this morning. We are now going to start the first round of questions. For the first round, I am going to ask the official opposition to please start. I do see MPP Gélinas. If you can kindly please unmute her mike. Also, please clearly state which organization you are asking the question to. You have six and a half minutes.

M^me^ France Gélinas: Thank you so much to all three presenters. I very much appreciated hearing from you and seeing you on a little screen. I haven't seen you in a while.

My first question will be to Deborah Simon, from the Ontario Community Support Association. I understand that life has changed for your clients through the pandemic. One of your first recommendations was really the timing of this bill. Could you share with us what would postponing this bill—what are the opportunities to learn? What have you already seen on the ground that could be taken into effect to have a strong and robust home and community care system that allows us to learn from this pandemic, where I would say that every part of our health care system has learned, yours especially?

Ms. Deborah Simon: Thank you for that question, France. The learnings that we've had over the last three months have been absolutely incredible for the entire health care system. Certainly in home and community care, we have absolutely been, on the ground, focused on the delivery of services. It's had a very detrimental impact, but a very positive impact from some of the learnings that we've had during the pandemic.

What I mentioned in my statement around the interconnectedness of this system is that we absolutely learned that human resource staff are very transient and fluid between long-term care and home and community care. Certainly, as we're seeing the pandemic ripping through our communities, the need to have adequate numbers of staff across all sectors has been very important. Long-term care took a very big hit, and that hit actually had a very direct impact on our staffing in home and community care.

There are probably thousands of learnings that we have learned, all the way from supply chain management to communication across systems to just the front-line staff and our ability to interact with clients. I think these are important learnings for this kind of legislation to be able to have the type of strength it needs to carry us forward. We should take the time now, rather than rushing through legislation, to get that learning in.

M^me^ France Gélinas: If I understand you well, you would like this bill to be paused so that we could make sure that amendments are made to it that deal with the supply chain, that deal with labour issues, I'm guessing that deal with PSWs, because we've seen a big shift of PSWs toward long-term care and away from home and

community care during COVID. I would say this is something we would truly support. I will be kind—I see that my colleague Joel Harden is waiting to ask a question, so to Joel.

The Chair (Mr. Kaleed Rasheed): MPP Joel Harden, please go ahead.

Mr. Joel Harden: Thank you very much, everyone, for your presentations this morning and the work you do for so many people with significant needs in our province, particularly now.

My question is also for Ms. Simon. Ms. Simon, thank you for your presentation. In your presentation, you mention that of the learnings you've seen in COVID is the way in which the non-profit sector provides particular value for the province, making sure that valuable money the people of Ontario invest in this important sector isn't lost to profit and isn't lost to excessive administrative compensation.

A question for you: Would you support the idea for all organizations providing care that is publicly funded in the province of Ontario to disclose the degree to which administration chews up the costs of providing care for that organization? In particular, we do support disclosure of executive compensation, particularly for for-profits. Unless they're publicly traded companies, the people of Ontario don't know how much money is lost in administration and how much, in particular, is lost to executive compensation, and in a context where so many PSWs, as we have learned in COVID, are working part-time contracts at very low wages.

Ms. Deborah Simon: Thanks very much for that question. What I would say to answer that is that our sector is completely open and transparent when it comes to sharing and being open around our costs in the system. Certainly, I'm supportive of what you've identified in terms of use of public dollars and transparency and accountability for that.

I have to say that you've opened a Pandora's box for us. We are one of the lowest-paid sectors in the entire health system, and that starts from the executive compensation right down to the front-line staff. We have lobbied hard around our front-line staff, because we know the importance, particularly, of our personal support workers and the needs for moving their salary and compensation up. They do an incredible job in supporting the system.

I would have no concerns whatsoever in terms of the kinds of things that you've spoken to in terms of transparency.

Mr. Joel Harden: Thank you. I'm definitely—oh, Chair, are you trying to—

The Chair (Mr. Kaleed Rasheed): Yes, 30 seconds.

Mr. Joel Harden: Thirty seconds. I just want to say by way of a comment, then, to all of the panelists, particularly Jo-Anne—hi from Ottawa; nice to see you here—and Cathy, for the work you do with folks living with dementia and their families—thank you for all the work you do. I hope what we can talk about in this committee is the fact that for some, the larger operators in the sector that are for-profit, in the absence of any actual compelling disclosure, I fear we are losing a lot of money to administration and executive compensation that could be going directly to you, directly to the important work that non-profits provide.

Thank you for everything you do and for being here with us this morning.

The Chair (Mr. Kaleed Rasheed): Thank you so much. Now we are going to move to the independent. I believe MPP Fraser has a question. You have six and a half minutes. Thank you.

Mr. John Fraser: Thanks to all of you for being here this morning and presenting—great presentations—and for all the work you do to keep people healthy and safe in our communities.

My first question is for Jo-Anne. Hello, Jo-Anne. It's nice to see you again, even if it's just virtually, and not on a Porter flight as it usually is.

1030

You mentioned in your presentation that you have about 1,000 staff who are currently underemployed; is that correct?

Ms. Jo-Anne Poirier: That is correct, yes.

Mr. John Fraser: Are those mostly personal support workers or is it across RNs? Does it tilt any way?

Ms. Jo-Anne Poirier: What we've seen is about a 30% reduction in PSW hours that have been provided. We also know that therapy services were pared back about 60%—so a lot of the out-of-employment staff certainly have been PSWs. We've also seen a reduction in our end services. Some of that is because they couldn't get enough hours so they had to apply for CERB funding. Also, daycare and child care issues have played a part in that.

Mr. John Fraser: Okay. So it's a real challenge right now, if a service call comes up, to be able to fill that as well? If somebody needs 10 hours a week, there are challenges and struggles?

Ms. Jo-Anne Poirier: Yes. This is the part about the business model that a lot of people don't understand. Unlike the acute care sector, where people may be less busy but still on salary, we have to find enough hours to keep people employed, and if they're not employed, they have to seek work in many organizations.

Our preferred model long-term is, for example, instead of having three PSWs come into a home at three different times, if we could have enough hours to employ one PSW to take care of that family's needs, then we would have more stable employment. We could recruit and retain staff more readily. Of course, there's also the wage differential to address.

Mr. John Fraser: Yes. COVID has really shifted how we look at providing care in the home. Actually, it's maybe not shifted, but it's revealed the vulnerability of the sector and the vulnerability of people that it serves because of the nature of the employment.

Ms. Jo-Anne Poirier: It certainly has been a real challenge, and it has brought it to the forefront. We knew those challenges existed, but it certainly has exacerbated them.

Mr. John Fraser: Thank you very much, Jo-Anne. When I look at this bill, my concern is: Why are we doing

this right now when we're still trying to cope with the situation that we have in front of us? I'm not asking you to comment on that, but when I look at this, I'm saying, we're still in the middle of the pandemic. Maybe the R rate is down, but there is a lot of work to be done to stabilize this sector as well as in long-term care.

One other quick question on long-term care: The people that you have who aren't working, does the ministry work with you, or locally, does anybody say—because there's a shortage of PSWs in long-term care—

Ms. Jo-Anne Poirier: Yes, we have been redeploying some staff in helping out in retirement homes and long-term care, but what that has served to do is raise the infection rate because of the congregate settings. That's why we've been advocating for people to stay home where it is safest.

Mr. John Fraser: That's great. Thanks very much, Jo-Anne.

Chair, how much time do I have?

The Chair (Mr. Kaleed Rasheed): Two minutes.

Mr. John Fraser: Deborah, I have just a quick question for you: It's clear that you have expressed that this is not the time for us to be looking at this piece of legislation. There are a lot of learnings. Also, we're in the middle of trying to cope with how this has shifted things, and the possibility of a second wave. I share those same concerns.

One of the other concerns I have is around governance. The way that this transformation in health care is structured, the governance seems to be very much centred on the Ontario Health board in downtown Toronto. That's taken away all the public governance that existed before then. I know that you've restated your call for public meetings. I just want to give you a chance to say some more about that, because it's a concern that I share.

The Chair (Mr. Kaleed Rasheed): One minute.

Ms. Deborah Simon: Thank you for that question. We certainly have stated this previously. We feel very strongly as an association that there will be lots of very thorny issues in home and community care but across the whole health care system that Ontario Health will have to deal with. I think it's important that the public be able to be present to hear some of the discussions that take place at the board level of Ontario Health, and we would, again, as we've stated in our recommendations, recommend that those meetings be open to the public so that they can be held fully accountable for decisions that might impact across the system.

Mr. John Fraser: Thank you, Chair.

The Chair (Mr. Kaleed Rasheed): Thank you so much. Now we are going to move to the government side. I believe MPP Oosterhoff—you may start—six and a half minutes.

Mr. Sam Oosterhoff: Thank you Jo-Anne, Cathy and Deborah for presenting this morning. Thank you so much for the contributions you each make to the sector and the hard work that I know you all do to provide care, and that your members provide significant amounts of care. We're very grateful, and I just want to extend our thanks. I know all members have heard from people from your organizations and from families who have benefited from your work, so thank you very much for appearing this morning.

I want to begin by perhaps pushing back a little bit against MPP Fraser's comments. I have a lot of respect for him, but I think one of the reasons we need to move forward right now is because we need to see that integration continue. We need to see community care functions transition towards the future and make sure that we're able to provide that level of integrated care that we know patients expect and that we want to be able to provide them. We believe this legislation helps provide flexibility in providing that care. We really value your feedback, of course, but I just wanted to engage with my colleague opposite very briefly on that. I think it is an important time to move forward with this type of legislation.

My question—and perhaps I'll start with Jo-Anne—is around the work your organization is doing with Ontario health teams. I know you are member of several Ontario health teams, so I'm wondering if you could speak a little bit to the importance of home and community care functions transitioning into working with Ontario health teams, what that looks like moving forward and how we can break down some of those barriers that prevent integration.

Ms. Jo-Anne Poirier: Okay. Thank you for the question. Yes, we're involved in 12 of the 24 OHTs so far that have been approved. Integrated care, I think, means getting rid of some of the silos. Our belief is that the administrative coordinating function could be transferred only for the complex cases, but the home and community care sector could look after the less complex cases. In many cases, there are many assessments that take place before someone gets an hour of care, and that [*inaudible*] to change. So we could do those assessments. We have proven in I think it was a strike situation in one of the LHIN areas at one point, where the administrative care coordinators were on strike, and in fact we did the assessments and the coordination and it worked very well. So we believe there could be more interaction between primary care and home care.

The other thing too—and what's unique about VON—is that we do coordinate both home care and community support services for clients and their families. So I think more organizations could be doing that and providing for more seamless transition of care between one service and another.

Mr. Sam Oosterhoff: Thank you. I appreciate that. Another piece that I wanted to just bring up—because I know we've seen so many changes over the past couple of decades; I know in my lifetime, a significant amount of changes when it comes to the digitization of health. Of course, not every aspect of it, but a lot of places have been impacted by that digitization. Could you speak a little bit about the investments in home care that are focused on technology and, specifically, how some of those changes have impacted your sector and how we can be supporting that transformation and improvements when it comes to accessing those digital supports?

Ms. Jo-Anne Poirier: Thank you. I will say that digital health is definitely where we are going. The one thing

about home care, because the rates are as low as they have been, it has really challenged the organizations who have to self-fund technology.

1040

So during COVID, we have moved to telephone calls and Zoom calls, but I think that more investments need to be made by the government, in concert with us as partners, to move towards electronic health records and digital health. I believe that we have—

The Chair (Mr. Kaleed Rasheed): Two minutes.

Ms. Jo-Anne Poirier: —learned, as Deborah mentioned earlier, through COVID, and I think we need to leverage that further.

Mr. Sam Oosterhoff: Excellent. Thank you very much.

To Deborah, then, just a question about that experience—if there was one overarching theme coming out of COVID that you would say the message has to be for the home and community care sector. We're trying to ensure that we can provide more flexibility, that there could be more seamless transitions for patients, that there's more access to care, that there's more access to digital technologies and that things are moving more efficiently in the system. But if you can say one lesson that has come out of COVID that you think all members should be hearing, what would that one message—specific to home and community care—be from your perspective?

Ms. Deborah Simon: Thanks for that. I also want to just say that our interest in pausing was not stopping this legislation; it was really to take the opportunity to learn. But what I would say—

The Chair (Mr. Kaleed Rasheed): One minute.

Ms. Deborah Simons: —that has been, I think, a major overarching learning is that this sector prepared itself to be able to be more supportive for the COVID response. I don't think that we were utilized as much as we could and should have been, given all of what Jo-Anne has talked about around the very low infection rates. Where people wanted to be during this pandemic was at home, not in long-term care and not in hospital. I think the best learning could have been: How could we have leveraged the home and community care sector to support the response in order to be able to keep people safe and utilize this incredible system that we have in home and community care to help people stay that way?

Mr. Sam Oosterhoff: I know we have very little time. Do you think this legislation will be able to ensure that there is more integration, then, between primary care and community care to try to be an impetus for some of that leverage that you're speaking about?

The Chair (Mr. Kaleed Rasheed): Thank you so much. My apologies for cutting you off.

We are now going to start the second round. For the second round, we are going to go with MPP Fraser. You have six and a half minutes. Please go ahead.

Mr. John Fraser: My question is for Ms. Barrick from the Alzheimer Society of Ontario. I know that all of your organizations, or most of them, are connected with a family health team. My question is: In terms of the progress of those family health teams since the pandemic, have there been any meetings that you're aware of?

Ms. Cathy Barrick: Thank you for the question. Yes, we are very involved in the development of the Ontario health teams. The meetings have actually carried on. The work to transition to the new way that health care will work has not stopped, actually, as a result of COVID.

Mr. John Fraser: Okay. And during that time, it hasn't prevented you from delivering the care that you need to the people who need it?

Ms. Cathy Barrick: No, it hasn't. I would say, overall, the transition to Ontario health teams has been a large amount of work for our local Alzheimer societies. That said, for us in particular, it's actually the way that we have worked within the system for many years. For us, it's not really a change in how we operate in terms of collaborative partnerships with other system players. But the transition to the new governance structure has taken a lot of time for sure.

Mr. John Fraser: Okay. In terms of the local leads—for instance, what does the local governance structure look like?

Ms. Cathy Barrick: Those haven't actually been established. I would say that they actually vary from team to team. What we're hearing from our local societies who are involved: They are actually feeling fairly comfortable with the governance structures that are starting to come about. For example, I'm in Toronto, so the one that I know the most about is the North York health team. North York General, of course, has taken a lead there, but has actually been very conscious to make sure it's inclusive of all partners and that it's not a hospital-led team.

Mr. John Fraser: In terms of the public-facing part of that governance, are they establishing public board meetings; are they establishing an appeal process? Or is the board essentially an internal board that makes decisions amongst health care providers?

Ms. Cathy Barrick: So far, to my knowledge, they are internal. I don't even think there's a board having been developed, per se. I think, right now it is the internal provider tables that are still talking about how to make decisions etc.

Mr. John Fraser: Thank you very much, Ms. Barrick.

And to my colleague, Mr. Oosterhoff, I'm just going to respond that the public governance and the public face with the Connecting Care Act is all centred in downtown Toronto with the Ontario Health board. There are no public meetings; there are no appeal processes. The government and the Ontario Health board have the ability, in 30 days, to amalgamate any service with no appeal. So it's essentially command and control. I think that we all have to realize—and the minister as well has that exclusive power—that we are ceding governance and the community aspect of care to downtown Toronto.

If I take a look at long-term care—I'm sorry, I'm going into a bit of a soliloquy here—one of the challenges in long-term care that we've had is that all the governance has been centred either at the ministry in downtown Toronto or, in about three quarters of the cases, in corporate board offices in downtown Toronto, and the

community connection to care really doesn't exist in long-term care unless you're in a municipal home or in a not-for-profit home that are the smaller part of the system.

I think one of the things when we're talking about this bill is that we can't forget the governance and the public face of this. The community part of care is going to get lost in the Connecting Care Act because there is no indication that any of those things are changing or there's any willingness on the part of the government to do that.

On top of that, 10 years from now when all of us members—sorry, this is for my colleagues on the committee—are sitting, maybe not as a member anymore, and the minister decides that they're going to take the local Alzheimer Society and they're going to amalgamate you with the Kingston General Hospital—you're just part of them now; you don't have a choice. There's no right of the community to appeal. These are the real risks that we're really centralizing things right now—

The Chair (Mr. Kaleed Rasheed): MPP Fraser, I'm sorry. Are you asking a question here?

Mr. John Fraser: Yes, I am. I'm going to preamble.

The Chair (Mr. Kaleed Rasheed): Okay, sorry. It just felt like you were making a statement or something.

Mr. John Fraser: No, no. I'm getting to it—pardon me; I lost my screen here.

I guess, Ms. Barrick, I wanted to ask you the question, are you aware that that's what the Connecting Care Act does, in terms of governance and the ability of the government to—

The Chair (Mr. Kaleed Rasheed): You have a minute.

Mr. John Fraser: —make a decision in 30 days that might affect your organization with no right of appeal?

Ms. Cathy Barrick: Yes, we are aware of that and we have spoken about that, obviously, internally. We are obviously very invested in maintaining our own brand and providing service under the name of the Alzheimer Society and the way that we do it. So we most certainly see that as a potential risk.

So far, during our experience within the OHT system, there has been no overt indication that that is what's going to happen. That's not to say, to your point, that it couldn't. But yes, we are aware of that and would obviously not want that to happen in terms of the Alzheimer Society.

Mr. John Fraser: Thanks very much for answering that question.

The Chair (Mr. Kaleed Rasheed): We are now going to move to the government side. MPP Jim McDonell, go ahead. You have six and a half minutes.

Mr. Jim McDonell: I just wanted to say thanks to the VON for coming in. I had the benefit of working with them a year before getting here with the outreach out of SDG, and they were brave partners and looked after outreach centres. It's always good to talk to familiar partners. Thanks, Jo-Anne, for being here.

Just listening to, I guess, a bit of the rant from the previous member and looking at some of the issues we have here, we're trying to bring the system into a more community or a more local role. We've noticed that everything doesn't work best out of Toronto, and our community health teams will certainly allow the local communities to work toward a better health care system.

1050

Maybe I could ask how you feel about being able to work with a local health team that really is looking at how to integrate services best with hospitals versus long-term care, and the programs that we look to be bringing across and in many of the regions have already been approved?

Ms. Jo-Anne Poirier: Thank you. What I would say is that I think the Ontario Health teams will be the way to go to look at what the regional and local needs are and then work from a position of strength with the current partners.

I think we need to touch the floor and the ceiling at the same time. What I mean by that is, each OHT will need to look at its particular components and the population they're serving while having the government provide overall parameters and standards. What we see from our vantage point—because we do serve 168 communities—is, you don't want so many different ways of doing things that it becomes inefficient. It's balancing the needs of a particular community with some overall parameters and standards for the province, I would say.

Mr. Jim McDonell: Do you think it's time to make that change and bring it more local—something they haven't been seeing?

Ms. Jo-Anne Poirier: I think it is time to move forward thoughtfully and to make sure that what has not worked well in the past is being addressed in whatever means that that is. Certainly, as we all know with legislation, the devil is in the details and in the regulations, so we want to make sure that we benefit from COVID and from our past experience with the dire need to modernize home and community care, I would say.

Mr. Jim McDonell: I know that one of our biggest issues back in Stormont–Dundas–South Glengarry is our lack of homes. I went through a process in 2012-13 when they were looking at removing some of the alternative care facilities they had set up at the general hospital because there was such an emergency or lack of care. At the time, I think we were three-plus years waiting for a long-term-care bed. We just really haven't had many new care beds built in almost 20 years. We have a number of projects already approved. I think we have three or four of them approved, with something like 200 beds so far.

Do you see that as an issue: the lack of beds, the lack of being able to really have space in our homes and the ability to move patients around?

Ms. Jo-Anne Poirier: Is your question for me or for Cathy, Mr. McDonell?

Mr. Jim McDonell: Well, for you, with your experience; sorry.

Ms. Jo-Anne Poirier: I think that we are advocating for long-term care at home because congregate settings have their own challenges, as well as the capital costs of building more homes. But it would mean having to schedule and fund home care differently.

I think this is what we are looking at as a sector to advocate for, because if we can defer, if not eliminate, the need for people to move to long-term care, that's even

better. It's looking at that balance between what will keep people safely at home and what will make sure that we can secure a workforce that is stable and that has enough hours to sustain a living. It's those elements that I think we would like to see, because people want to stay home. I think long-term care is a last resort.

The Chair (Mr. Kaleed Rasheed): One minute.

Ms. Jo-Anne Poirier: I think this is something that we have been talking to the government about: that long-term-care—but at home—concept.

Mr. Jim McDonell: I know that one of our retirement homes in Lancaster had a number of home care personal support workers going in—five or six a day. I think a solution would be that locally we could more or less assign one person to stay there. A retirement home is their home. Is that something that you could see working through as well, that local care would be able to assign people to locations where they might spend most of the day or all of the day there?

Ms. Jo-Anne Poirier: Yes. We go where they are, so to speak. In some cases it may be a retirement home, where they require more care than what they're currently getting. I think that when we talk about scheduling and funding home care differently, it means in their home or a retirement home.

The Chair (Mr. Kaleed Rasheed): Thank you so much. My apologies to cut you off.

Now we are going to move to the official opposition. I believe MPP Armstrong has a question. Please go ahead. You have six and a half minutes.

Ms. Teresa J. Armstrong: Hi, there. It's Teresa Armstrong. Thank you all for being here today and presenting. We really appreciate you taking the time and, of course, putting your thoughts on paper and giving us your feedback—your expertise, really.

When I was listening to the presentations, I believe it was the Alzheimer Society that mentioned that they were concerned about the expansion of privatization under this bill. I just wondered, especially in the particular lessons that we've learned from COVID, what concerns the Alzheimer Society has with the privatization, particularly as we are still learning lessons from COVID-19 and the fact that Bill 175 really does nothing to explicitly improve the conditions for home care recipients or staff. Particularly, as well, we know that home care staff are underpaid and overworked. If you could speak to those, I'd really appreciate that.

Mr. Kyle Fitzgerald: Thank you, MPP Armstrong. The concerns that we expressed around expanding access to care relate to expanding the eligibility for providing home and community care to any health service provider. The risk there, really, is that there's duplication, and there's some risk of waste as well, in the sense that if you have new participants entering the field potentially making the same mistakes that players who have been in this sector for decades already made and learned from, then there is the potential there that we're making the same mistakes again. It's really just looking to existing players in the sector to take on a leadership and even mentoring role so that we can guide it and ensure that our expertise and experience is listened to as we expand to welcome new collaborative players into the sector.

Ms. Teresa J. Armstrong: Would you say, though, that we shouldn't continue further privatization, that community and care providers should be not-for-profit? Because there is a piece in that where there is more transparency and accountability.

Mr. Kyle Fitzgerald: Yes, I believe that the protections around ensuring that home and community care providers are registered not-for-profits are certainly welcome, and we'd welcome any strengthening of those protections in the legislation and in the subsequent regulations.

Ms. Teresa J. Armstrong: Okay. I'm not sure if France or Joel had another question?

The Chair (Mr. Kaleed Rasheed): I believe MPP Gélinas has a question.

M^me^ France Gélinas: I think I'm going to go through all three of you, to ask you quickly. I take it that by reviewing the legislation, you noticed that the patients' bill of rights is no longer in legislation; it is now in limbo. I take it the regulations are yet to be made. But, as we know from Bill 74, regulations don't always come quickly.

I will start, I guess, with you, Cathy. Do you have any worries about this?

Ms. Cathy Barrick: Yes, absolutely. I think a patients' bill of rights is critical. Here at the Alzheimer Society, we have a very specific one for people with dementia. I think the intention of this legislation and others is to put your patients first—

The Chair (Mr. Kaleed Rasheed): Two minutes.

Ms. Cathy Barrick: —so I would want to see that included in the future.

M^me^ France Gélinas: Jo-Anne, what do you think about the patients' bill of rights not being in legislation anymore?

Ms. Jo-Anne Poirier: I would agree with Cathy that I think it is about the patients and their family, and that should be a cornerstone of any legislation.

M^me^ France Gélinas: Deborah?

Ms. Deborah Simon: We have had a number of our members, particularly in independent living, who are very concerned about it not being enshrined in legislation, just because of the concern around changes that can happen at the regulation level. It is critically important. Particularly, we've learned through COVID how important those rights are for individuals who are users of the system. So we would support the strongest and the most strict methodology to protect those rights be put in place.

1100

The Chair (Mr. Kaleed Rasheed): One minute.

M^me^ France Gélinas: Okay. Just very quickly: Jo-Anne, you made a good case when you said, basically, "We need a stable workforce within our home care and community care system." Do you see a role for legislation to talk about this issue that is across your sector?

That's for Jo-Anne.

Ms. Jo-Anne Poirier: We do believe there is a role. The legislation should enable us to work with the government very closely to redesign and modernize home care,

how it's scheduled, how it's paid for and how we can recruit and retain a workforce that is much needed, yes.

Mme France Gélinas: I agree. Thank you.

The Chair (Mr. Kaleed Rasheed): Thirty seconds.

Mme France Gélinas: Oh, okay.

The Chair (Mr. Kaleed Rasheed): Are we good?

Mme France Gélinas: Well, no, if I have 30 seconds, the same question to Deborah. I hope you were listening.

Ms. Deborah Simon: Yes, I was listening. I completely agree with Jo-Anne that for sure in home and community care, the HHR component is critical, and so we would support ensuring that any protections that could be put in place to support that are in the act itself or in regulations—

The Chair (Mr. Kaleed Rasheed): Thank you so much. My apologies to cut you off. This ends our second round of questions. Also, thank you to all the presenters this morning, for our 10 o'clock group.

SE HEALTH
BAYSHORE HEALTHCARE
UNIFOR

The Chair (Mr. Kaleed Rasheed): Now, I'm going move to our next set of presenters. I will now call on SE Health. You will have seven minutes for your presentation. Please state your name for Hansard, and you may begin. Thank you.

Ms. Shirlee Sharkey: I'm Shirlee Sharkey, the CEO of SE Health. I'm delighted to be here presenting today.

SE Health, formerly known as St. Elizabeth Health Care, is a national, not-for-profit social enterprise. We are 112 years old. With our staff of personal support workers and nurses in five rehab disciplines we provide over 20,000 visits per day. I like to talk about our services ranging everything from making wonderful scrambled eggs through to home chemotherapy to very specialized rehab services.

We are a proud member of RNAO as a Best Practice Spotlight Organization, and investing clinical expertise and clinical infrastructure.

Personally, I have been with SE Health now since 1992—for 28 years—and did bring with me experience in both the acute and the long-term-care sectors. But I must say that I found my home, I guess, in home care. I very much am believing in SE Health, of course, and in social enterprises, because they are all about successful businesses, yes, but also investment in shoring up gaps in our system. We personally have invested in end-of-life care for the homeless population, in addition to support for caregivers with our Elizz program, and then also building capacity for our Indigenous communities.

Personally, I'm very committed to health care, have been on a number of committees and most recently have had the privilege to be on the Premier's council.

Home care is certainly undervalued, underfunded and misunderstood. There is a systemic bias towards institutional care. We certainly all know that there's a burning platform for change with our aging population, chronic disease and opportunity with digital technology and cost-effectiveness. It's a wonder why we really haven't modernized the system.

Our hope is that with Bill 175, the time is now. Why? Because the current fee-for-service business model and transactional model is broken. It's not meeting the needs of patients and families. It's difficult to access, and it's difficult for them to have confidence that the home care services will continue. It's not meeting the needs of providers in the workforce—a lot of issues related to recruitment and retention of staff—but most importantly, it's not producing the best value and outcomes for all of us as taxpayers.

With the proposed legislation and the regulations, we're very hopeful that this will create an enabling environment for a home-first philosophy to play out, for once and foremost, with less reliance, certainly, on congregate care. This, as we know, is particularly important in light of the current situation in long-term care and the ongoing concerns regarding alternate level of care and also hospital capacity.

We support a more client-focused regulatory system for home and community care. This certainly includes more flexibility with funding, coordination, care delivery and, in fact, virtual visits. Moreover, Bill 175 moves away from the rigid legislation that directs clinical services such as service maximums and the need for multiple client assessments towards a much more customized approach that is going to meet client and family needs. The primary role of the care coordinator should be to make it easier for patients to access home care, rather than focus on care qualifications and eligibility.

We have much to learn from the pandemic. During phase 1, I would suggest that home care was the missing piece. If not, it was all but forgotten, and this is very unfortunate, because home care is actually one of the safest places. When we examine data from four large providers in the province, our infection rates were extremely low. They were actually less than 1% amongst our home care workers.

It is going to be critically important to hear and engage our front-line staff and our service providers during this process. It will also be important to create a transparent plan for a timely move to a transformed system incorporating Ontario health teams. They will be replacing the LHINs.

In conclusion, I want to make it very clear that our support of Bill 175 is contingent on the province's ability and means to actively collaborate with us in the home care sector.

Finally, I did want to note that over the past two years, a group of home care providers have been working collaboratively—Bayshore, SE Health and the Victorian Order of Nurses—to really come up with a new vision for patients in this province in the home care space. This collaboration is called Home Care 2020. Together, each of us as BPSOs—best practice spotlight organizations—brings a commitment to clinical expertise, infrastructure and organizational strength. We look forward to further

dialogue to discuss the types of changes that are necessary in the system, including the very directions that we are exploring today.

The Chair (Mr. Kaleed Rasheed): Thank you so much for your presentation.

I will now call on Bayshore HealthCare Ltd. You will have seven minutes for your presentation. Please state your name for Hansard, and you may begin.

Mr. Stuart Cottrelle: Hello. My name is Stuart Cottrelle. I'm president of Bayshore HealthCare. I have over 30 years of experience in health care leadership. As president of one of the largest home care service providers in this province, we consistently reinvest in innovative care models and digital health solutions that lead to greater patient and family outcomes. We have been recognized as one of the strongest operational organizations and best-managed companies and an employer of choice. We employ over 9,000 people in Ontario, and on any particular day, Bayshore Home Solutions provides home care services to over 35,000 patients in Ontario.

The purpose of Bayshore is to provide out-of-hospital solutions. We have two other divisions, one that specializes in work for non-government payers and a division that is involved in community-based drug therapies. As Shirlee has mentioned, over the past two years we've been working as a group called Home Care 2020, and what we're trying to do is to make sure that, as best practice spotlight organizations, we bring our expertise to make sure we create a better home care system.

I turn you now to our chief nursing and clinical officer.

Ms. Maureen Charlebois: [*Inaudible*] including acute care—I don't know if you can—

1110

Mr. Stuart Cottrelle: Yes, we can hear you.

The Chair (Mr. Kaleed Rasheed): Yes, we can.

Ms. Maureen Charlebois: Thank you—including acute care, long-term care, home care and in digital health. During this pandemic, it became increasingly clear that we are not working as an integrated system. In fact, home care was often forgotten.

My top priority was the safety and well-being of our staff and our clients, even before the pandemic was called. We had to act fast and we had to do what was right clinically. We implemented enhanced precautionary safety measures, infection and prevention control mentorship, and patient and staff screening before every visit. This proved to be a godsend, as our COVID-19 infection rates in home care are extremely low, and most importantly, our staff feels safe.

The number of COVID-19-related deaths in long-term care in May were over 1,200, compared to home care, which had zero COVID-related deaths. Not only has home care offered a safer setting for patients but for our employees as well.

In May, long-term-care homes had over 1,500 staff who tested COVID-19 positive, and as Shirlee mentioned, across our four providers of home care in 2020, only 12 of our staff had tested positive for COVID-19. We definitely have the clinical expertise to support this province as a health system and to care for our most vulnerable: our seniors.

Home care requires strong clinical leadership, the use of evidence-based practice guidelines, and enabling policies and procedures to better support the level of care needed in patients' homes, where they want to be. In fact, according to a previous Canadian Caregiver Coalition research project, evidence indicates that people want to remain at home for as long as possible, and if given a choice, they would prefer early discharge from hospital followed by a provision of home care. Patient satisfaction levels were also found to be greatest for those receiving care in their own home.

As our cornerstone, Bayshore provides inter-professional services that include health support workers, nurses, pharmacists, occupational therapists, physiotherapists and speech-language pathologists who care for individuals in their homes. Home care service providers have the knowledge, clinical expertise and assessment skills to support care coordination in the development of patient-centred care plans. We need to allow our regulated home care service providers to practice to their full capabilities, which will reduce the number of duplicate assessments being completed, which will decrease the burden on our patients.

Instead, home care coordination should be guided by evidence-based interventions and their respective professional practice standards. As a best practice spotlight organization, Bayshore is a home care service provider committed to providing quality services following evidence-based practices and evaluation frameworks. We have helped lead this province in clinical and digital innovative advancements over the past decade. Bayshore has invested in our own digital health centre of excellence and in partnership with Ontario-based technology companies.

As a result, we have the capability to deliver virtual care locally and provincially through virtual care and telepractice. Our nurses and other members of the health care team can securely and conveniently connect with patients and their families to support and guide them to better manage their medical conditions. We also provide virtual counselling and symptom management—

The Chair (Mr. Kaleed Rasheed): A minute and a half.

Ms. Maureen Charlebois:—to support oncology patients.

At Bayshore, our CAREchart@home program has supported 18,000 oncology patients across the province. Our traditional models of care have transformed, and now, more than ever, we need to continue to move from institutionalized care to providing services for patients where they wish to remain: in the comfort of their own home.

I now turn you to Janet Daglish.

The Chair (Mr. Kaleed Rasheed): You have a minute left.

Ms. Janet Daglish: Thanks very much, Maureen. I've got 25 years of experience in health care and over 17 years at Bayshore. Bill 175 must support a larger vision for

home and community care, as an integrated and essential part of the health care system. We must be able to meet patients where they live, virtually, in person, 24/7.

COVID has been a lesson for governments across the world for the need to build a resilient local economy. Ontario needs partners like Bayshore, as well as government recognition of our ability, to create exceptional patient experiences and drive health system outcomes. Home care was not included in regional planning tables for COVID and, as a result, patient outcomes were compromised. Our vision is to create a new value for Ontarians, provide more fulsome care packages across the care journey led by professional practice teams, bringing their strengths—

The Chair (Mr. Kaleed Rasheed): Thank you so much for your presentation, and my sincere apologies to cut you off.

Now I'm going to move to the next presenter, Unifor. You will have seven minutes for your presentation. Please state your name for Hansard, and you may begin. Thank you.

Ms. Naureen Rizvi: Good morning. My name is Naureen Rizvi. I am the Ontario regional director for Unifor, elected to represent the interests of our 160,000 members across the province.

It's great to see many of you—France, Joel, how are you? With me as well is Andy Savela. He's the director of our health care sector within Unifor.

Unifor is Canada's largest union in the private sector. We represent more than 315,000 members in all major sectors of the economy, but that also includes members working in a range of public services, including health care.

First, I would like to raise our concerns with how this legislation and subsequent regulations were developed and introduced without any consultation with health care workers and their unions. If passed, the legislation would gut existing home care legislation and shift key legislative responsibilities to regulation. The move would dramatically diminish public accountability and oversight of the home care system while paving the way for further privatization of home care and possibly other aspects of our health care system related to transitional care and rehabilitative care.

The proposed legislation would dismantle the local health integration networks that have played a central role in the placement and care coordination of home care in communities across the province. In their place, coordination functions would be assigned to an array of organizations that are not publicly governed or publicly accountable, most likely to the Ontario health teams.

Unifor's concern is of two points. The Ontario health teams not only have zero accountability to the public that relies on them, but they include for-profit providers that prioritize profits over care. The quality of care will not be equally distributed throughout the province. Removing the public governance structure of LHINs and replacing it with a private, unaccountable governance that includes for-profit companies, non-profit organizations and primary care providers is simply reckless.

This unabashed delegation of power and responsibility will pave the way for further contracting out of home care functions to for-profit entities with little oversight. This is a clear attempt at shifting the provisions of health care services from the public to the private sector, which threatens the public system and the quality of health care in the province, and ensures that public spending that should be spent to improve care, instead, lines the pockets of private corporations.

When we look around today at Ontario's health care system, anyone can see the truth: Privatization doesn't work. In communities across the province, we've already felt the impact of decades-long moves to privatize health care services. Profit-driven models of care compromise the quality of care that seniors receive in for-profit, long-term-care homes, sometimes with devastating effects.

Contracting out hospital services to large corporations influences the quality of services and erodes the wages and working conditions of health care workers at these sites. Meanwhile, private clinics that perform private diagnostic testing and minor surgeries, amongst others, are known to inflate government costs and increase the number of unnecessary tests and treatments in their drive to maximize profit.

The failures of for-profit health care are well documented. Ontarians need a strong, publicly administered system with trustworthy and accountable oversight. The proposed legislation further damages our public system. The failures of government to invest in health care and the greed of for-profit health care companies have been revealed as a lethal concoction through the COVID-19 pandemic.

Though this government has taken some steps to correct past wrongdoings, for-profit providers still prioritize profits over patients and employees. For instance, at a time when governments are temporarily managing the worst-run, long-term-care homes and we have taken the dramatic step of asking Canadian Armed Forces personnel to work in long-term-care homes that have a severe outbreak of COVID-19, for-profit providers have not changed how they operate.

1120

An executive of a for-profit long-term-care company was overheard mocking and calling the residents of a beleaguered Vaughan long-term-care home. She said, "Here comes another bloodsucking lawsuit" following a virtual town hall meeting.

I urge you not to surrender your duty to provide the best possible care to for-profit providers who can disrespect families and residents in the most tumultuous times.

The shift of home care away from the LHINs and to the different Ontario health teams will result in vastly different models for—

The Chair (Mr. Kaleed Rasheed): Two minutes.

Ms. Naureen Rizvi: We know this because Ontario health teams function differently, so there is a lot of uncertainty about how home care will be delivered in each region. Rather than making improvements to integrate home care within the health care system, the regulation will dismantle public governance over home care and

leave it to an array of unknown and unaccountable service providers themselves.

Enabling for-profit corporations to both coordinate care and be the providers of care is an irresponsible proposal that will further compromise care. In what industry do we allow service providers to regulate themselves? These companies will be able to determine how many visits a person can have, the resources allocated to them, and supervise the company's own care. The dominance of for-profit homes in the long-term-care sector and the impact on the management of care should have been enough warning to prevent this legislation.

The provincial government needs to be upfront about its privatization agenda and then cast it aside. Listen to the people and commit to publicly administered care and not-for-profit services with any restructuring of the system.

Thank you for hearing our views on this issue. We refer you to our written submission that will be coming forth as well.

The Chair (Mr. Kaleed Rasheed): Thank you so much to all three presenters. We are now going to start the round of questions. The first one will be from the government side. I believe, MPP Kanapathi, you have a question. Please go ahead.

Mr. Logan Kanapathi: Thank you to all the presenters. My question is to the Bayshore HealthCare presenter Stuart Cottrelle. Thank you for your presentation. I know we've learned so many things through this difficult time about how we can develop home and community care in our community. I understand as my mother has been in palliative care for some time, being treated for two to three years. I went through a difficult time in the last three or four years. She's still in the [*inaudible*] dementia.

I know you talk about—I read the article from February of this year. There was an article published in the Toronto Star, quoted by your president, that highlighted the need for change in home care, calling for home care to focus on patient needs and not patient time. How does this legislation help buttress that issue? Would you explain, Stuart?

Mr. Stuart Cottrelle: I think Shirlee Sharkey emphasized that point as well. We need to make sure that we focus in on what is the right care plan for patients instead of how many minutes of care we're going to provide.

In the case of your mother, it's important to have the right journey for her on her palliative journey, that she gets the right care. That care should be very focused.

We should remember that in home care, the first people who are front and centre are family members, and that we have to have a care plan that, first of all, works with the family and does that. Right now, we've got so many layers along the way that we miss the concept of where the family fits in; we miss the concept of the best care plan and when caregivers are willing to work. We're proposing a system that's far simpler, but far more focused on family.

Mr. Logan Kanapathi: Thank you, Mr. Chair.

The Chair (Mr. Kaleed Rasheed): The next questioner is MPP Martin. Please go ahead.

Mrs. Robin Martin: Thank you very much for your presentations. It's always very informative to hear from you. I know that there have been some challenges during COVID-19.

I guess my question would be for Stuart as well, for Bayshore, anyway—Stuart or Maureen, or Janet, for that matter. How has your company worked with the Ontario health teams so far? And how do you find that this model may help us deliver better home and community care in Ontario?

Mr. Stuart Cottrelle: We didn't work as well as we could have, and that's what I think the opportunity for change here is. All of our low-level patients were discharged, and they shouldn't have been. Those low-level patients are now showing back up at the hospital. So this is a chance that we need to do things a little differently and we need to make sure, again, the patient is at the centre.

Mrs. Robin Martin: Thank you.

For Shirlee Sharkey: One of our primary goals with the Ontario health teams is to ensure that our home and community care system is better integrated with primary care, and a seamless experience for patients. How do you think SE Health will be able to be a part of that kind of a transition and make patient experience more seamless?

Ms. Shirlee Sharkey: Thank you for the question. I think that probably all of the home care provider organizations will need to work collaboratively within the Ontario health teams, with shared values and a shared commitment that ultimately is about a client and the family and care that they need.

It's a good point you raise. Both with primary care and home care, there needs to be much more collaboration. The current transactional model seems to have things broken down into even greater silos with home care being specific primary care, separately, acute care and long-term care. I think the notion of working collaboratively within these clusters, within different geographies, is that all of us will have a shared voice and a shared plan to come up with what the best structures and designs for care for people are, in particular, care for people in the community, where they want to live and where they want to stay.

Mrs. Robin Martin: One of the things that I'm most concerned about with home care is the recruitment and retention of personal support workers in home care. That has been a problem exacerbated recently because of the pandemic.

The Chair (Mr. Kaleed Rasheed): One minute.

Mrs. Robin Martin: How do you see the new model of integration through Ontario health teams helping PSWs to feel like they're more part of a care team?

Ms. Shirlee Sharkey: I think it's greater than the new model. I actually think the starting point needs to be from a values point of view: Do we actually value seniors? Do we actually value home care in the community? And then, do we properly fund the resources so that we can actually recruit and retain, in particular, home care staff in general, but personal support workers?

Part of the problem, too, is to create a work environment for them where it's not transactional, 15-minute visits, half-an-hour visits. Many PSWs, as we know, say that they love their work because of the relationship that

they have with the family, so we need to design new models of care that allow that to happen. Then we need to make sure that we value that, that we want to keep them in their home, and then we need to make sure that there are the resources to make that happen. That's why I answered the question that the starting point needs to be: Are we still—

The Chair (Mr. Kaleed Rasheed): Thank you so much. My apologies to cut you off.

Now, we are going to move to the opposition. MPP Armstrong, I believe you have a question.

Ms. Teresa J. Armstrong: Hello?

The Chair (Mr. Kaleed Rasheed): Yes. Go ahead.

Ms. Teresa J. Armstrong: Thank you. If Shirlee wants to finish her thought, can you do that? And then I have a question after you're done your comment.

Ms. Shirlee Sharkey: Thanks very much. I just wanted to say that, are we finally going to move beyond our obsession with institutional, medical-based care to what I would suggest is even broader than health and social: life care for people? Because unless we move into that direction, no matter what model we have, we'll never get it right. Thank you.

Ms. Teresa J. Armstrong: Can you hear me? Okay.

Thank you, Shirlee. You had mentioned that you wanted to see things moved in a timely way. Were you consulted prior to Bill 175? And based on your comment about wanting to see the legislation moved in a timely way, do you have concerns around the magnitude of the pandemic and that with this legislation, perhaps, the government is moving it too fast? And what kind of timeline would you be thinking would be reasonable so that we can incorporate the lessons from the pandemic into legislation going forward?

1130

Ms. Shirlee Sharkey: It's a difficult question to answer because, on one hand, certainly, there are many lessons that I think we are beginning to learn from the pandemic; on the other hand, this is 30 years too late, when we've been really not able to make the shift that we need to make with home and community care. So I'm not convinced that a timeline is critical, but more the process to engage the various stakeholders in the system. And I think there is now a real commitment and a real urgency to begin to move on things, so it's a combination of how we quickly learn from the pandemic, share those findings and then move forward with these changes that are critically necessary. I personally don't think we can wait any longer.

Ms. Teresa J. Armstrong: Have you been consulted, though, prior to Bill 175, and do you—

Ms. Shirlee Sharkey: Yes. My apologies; yes, I have. SE Health has been consulted in relation to Bill 175 and then also, obviously with my participation in the Premier's council, there was certainly much discussion about modernizing the home care system.

Ms. Teresa J. Armstrong: Okay. My colleague Joel has a question.

The Chair (Mr. Kaleed Rasheed): MPP Harden, please go ahead. Your mike is unmuted now.

Mr. Joel Harden: Thank you. There's just a delay, Chair, in unmuting.

Thank you to all the presenters. Naureen and friends at Unifor, it's particularly nice to see you this morning.

We've been talking a lot so far—and I suspect we will be—about the learnings from COVID-19. One of the things that clearly has been said is that the litmus test of having a workforce that is itinerant, almost completely part-time, shuttling between facilities, does not keep the public safe; nor does it allow caregivers or their families adequate protection.

I'm worried that Bill 175 doesn't have required disclosure for all operators receiving public funds to disclose the amount of money spent in administration, in providing care and particularly in executive compensation. When workers are receiving often barely above minimum wage, I think it's incumbent upon their employer to disclose to the workforce how management, and particularly senior management, is being compensated. Mr. Cottrelle, what are your thoughts on that?

Mr. Stuart Cottrelle: Transparency is critical. It has always been the goal of Bayshore and most of the providers that we work with to get as much money to the front line as possible. In terms of hours of work, I will tell you, our current average hours of work of our field force is 37 and a half hours a week at this current time. That's not quite right. It should be lower. That means we're running into too much overtime, so that's a problem. But in terms of transparency, executive pay etc., it should all be there. Right now, we do produce financial statements that go to Ontario Health. They've gone there for the last 10 years. And there is a point where we do make a small return, and it's very important that that small return, which we've done consistently over the years, is reinvested back into the business.

Mr. Joel Harden: Mr. Cottrelle, would you be prepared to have those documents that you distribute to Ontario Health disclosed to the public? Is there a figure that you can share with us this morning about the percentage of cost allocated to administration and executive compensation given the government contracts you currently have?

Mr. Stuart Cottrelle: I can certainly get back to you on that. In terms of executive compensation, it's a very, very small part of it.

The Chair (Mr. Kaleed Rasheed): One minute.

Mr. Joel Harden: The overall thing that families I talk to—because I have to admit: Long before the pandemic, I had the occasion, knocking on doors here in Ottawa Centre, to meet many personal support workers, who talked about what their lives were like living on these short-term contracts, shuttling around the city, not being paid for transportation costs. On that issue, in particular, Mr. Cottrelle, I'm wondering if you could help us understand why the industry, it would seem, as a whole has moved away from financing and subsidizing transit between seeing patients. In many cases, we're finding situations where, if workers are non-unionized, their transportation between 15-minute increments isn't covered. Is

that something you would support changing for the industry as a whole?

Mr. Stuart Cottrelle: That's up to an employer in the situation. We do a lot of covering of transportation, so to say that transportation is not covered and is not protected—

The Chair (Mr. Kaleed Rasheed): Thirty seconds.

Mr. Stuart Cottrelle: —by union agreements is not accurate.

Mr. Joel Harden: No, I was talking about—

Mr. Stuart Cottrelle: If you compare us to most collective agreements, we're higher.

Mr. Joel Harden: But for the non-unionized sector, sir, would you support a shift approach of someone being paid for seven or eight hours of work as opposed to 15-minute increments? That's my specific question.

Mr. Stuart Cottrelle: What I would propose is that we follow what Shirlee Sharkey had said: that we go to client-centred care. We're going to end up with larger amounts of care per patient—

The Chair (Mr. Kaleed Rasheed): Thank you so much. My apologies to cut you off.

We are now going to move to the independents. MPP Fraser, please go ahead. Thank you. You have to unmute.

Interjection.

The Chair (Mr. Kaleed Rasheed): He's saying it's us.

Interjection.

The Chair (Mr. Kaleed Rasheed): From our side, you have been unmuted.

Mr. John Fraser: Thank you. I wasn't there for a while. I was trying to click and nothing was happening; you weren't letting me do it. But that's okay. Don't worry about the time.

I just want to go back to the comment of my colleague Mr. Harden. I just want to underscore it, because they were very good comments. I think that the challenge that's in front of us is to stabilize the workforce. That's the thing that this pandemic has shown us, revealed to us, that was always the challenge. I think that's our top priority. I don't see how this bill addresses it. Can each of the participants comment on that?

The Chair (Mr. Kaleed Rasheed): Who would like to go first?

Mr. John Fraser: In order of the participants; start with Shirlee.

The Chair (Mr. Kaleed Rasheed): SE Health?

Mr. John Fraser: SE Health.

Ms. Shirlee Sharkey: Hi, John. Thank you for the question. I think, certainly, stabilizing the workforce in home and community care is critical. This is a completely talent-driven service, so it's absolutely critical. Part of what impacts an organization's ability to hire salaried employees, full-time employees, is the business model that we use. That's what I was getting to.

The fee-for-service transactional model that comes into play doesn't allow any provider—public sector, for-profit or not-for-profit—at this moment in time to actually hire full-time workers with proper support in that dimension. Instead, we have a fee-for-service model that needs to change, where we could be bringing in full-time employees, definitely, because we know that there is much less of a turnover, and that we have to properly fund those resources differently than we see in the hospital sector, for example.

So let's stay focused on where the problem lies: in the model that's been put in place and the funding that exists. I do hope that this legislation will address those components through the regs.

Mr. John Fraser: Thank you, Shirlee, and thank you for all your work in palliative care and Journey Home Hospice—everything SE Health does in that regard. That's kind of the rub: the regulations. They're unknown and unseen.

Stuart, please.

The Chair (Mr. Kaleed Rasheed): Bayshore HealthCare is next.

Mr. Stuart Cottrelle: Patients first has to be patients first, but part of what patients want most, as the most important, is continuity of care. If we have care plans that are put together by layers of people in the administrative process, then all of a sudden, we have inconsistent care plans, where we're having multiple caregivers, very short care and we're not maintaining people at home. The level of home care compared to the level of care that you can get in long-term care—there's no comparison, and that's not right.

We need to have a stream upward so that home care is an alternative to long-term care and that there's the funding of a package of care that's equivalent to long-term care. Then we'd end up with consistent caregivers that stay with organizations for a long period of time. Because, as Shirlee said, caregivers ultimately—it's about the client experience for them.

Mr. John Fraser: Thank you.

The Chair (Mr. Kaleed Rasheed): Unifor?

Mr. Andy Savela: Hi. Andy Savela. On this subject, I would say, with respect to home care, I think the comments around stabilizing the workforce are good ones. However, I'm not aware of anything that would stop a home care provider from hiring full-time people and providing a decent living wage and benefits and full-time work so that they commit to one job and make a living. One of the reasons we're having problems getting home care workers is because of what has been mentioned on this call: They're travelling from client to client, often uncompensated, and frankly, when they find work that provides them with more stability, they gravitate to that work. So, with respect to doing that, I think there's no room for the for-profit sector because, frankly and simply, the money that goes into feeding the profits comes out of the care that's being provided in home care and in long-term-care facilities. I think one way to attract people and get workers in the system again is to give them full-time positions with good, decent wages, benefits and full-time work. Thank you.

1140

Mr. John Fraser: Thanks very much. Chair, you can move on.

The Chair (Mr. Kaleed Rasheed): Thank you so much.

For the second round, we are going to start with the opposition. I believe MPP Gélinas has a question.

M^me^ France Gélinas: Thank you, everybody, and thank you for what you've shared so far.

I wanted to go back to a comment that you made, Shirlee, where you said that you support it but it's contingent to collaborations with the home care sector. Is there anything in this bill that gives you a link to the government to have this communication with the government between health care? The way I see it, with the health care teams, between the hospital and long-term care, you guys are the ones who are most likely to be eaten alive, where other providers will say, "Oh, no, no. We can do home care," and then all of the knowledge, the skills and the expertise that you have will suddenly disappear because a hospital decides that they are better than you are at doing home care.

Ms. Shirlee Sharkey: Yes. One could say it's sort of faith and trust that I have, but we know how far that might carry us.

M^me^ France Gélinas: I'm in opposition—not very far at all.

Ms. Shirlee Sharkey: However, I actually hope that the public will force us to have a voice at the table. In particular, right now, with the options with long-term care and retirement homes and the situation with the pandemic, which is so devastating for all of us, I believe the public will push to really have us examine other alternatives for people in the health care system, and then that will help bring the home care sector to the table.

I think it's a very good point you raise, France. For many, many years, it has been a challenge to have this conversation heard and then implemented and changed, which amazes me. Myself, as a visiting nurse, 30-some years ago, we have not advanced; in fact, we have actually moved back. So I hope there'll be public outcry to have us make sure that we create things in a very different way. I just can't wait for all of us as home care providers to come to the table and demonstrate our expertise and worth. I'm not worried actually about the hospitals and their expertise—well-founded, well-understood, but I do think that there is a time, and the time is now, for the home care system to be heard—all of us, our talent, our organizations and our clients and families.

M^me^ France Gélinas: I would feel better if we were to wait till after the pandemic so that everybody understands. The level of knowledge about your sector is still very low, but I like your faith. I will support your faith once again. My question—

Interjection.

M^me^ France Gélinas: Sorry. Go ahead.

Ms. Shirlee Sharkey: I was going to say—and I would agree—but my concern during the pandemic, and I'm concerned even wave two, we saw decreases from 20% to 70% in home care. We saw vulnerable seniors actually under this disguise of, "It's an emergency. We're cancelling. We'll see." I don't think we can do that in the next phase of this, and I think that these discussions will push that issue to change up, because it was very hard for us in the home care space to be heard when all of this was happening in phase 1.

M^me^ France Gélinas: Agreed, agreed.

My next question is for Unifor. Could you describe the standard collective agreement you have for PSWs in home care? What kind of wages do they make? What kind of benefits are you able to bargain? Lay out a picture as to what it looks like to be a unionized PSW in the Ontario home care system.

Ms. Naureen Rizvi: I'm going to refer that question to Andy, who actually bargains in that sector and would be able to provide more information. Thank you so much for that question, France. It's very, very important.

Mr. Andy Savela: Thank you. In our collective bargaining in the home care sector, you have rates that are, for the most part, substantially lower than even in long-term-care facilities, because the operators are smaller—

The Chair (Mr. Kaleed Rasheed): Two minutes.

Mr. Andy Savela: A huge, huge presence in home care in, say, the GTA, so our experience would be more in smaller communities. We have a lot in northern Ontario. I can tell you that I've sat in collective bargaining with them, and it's been very, very difficult to get enhancements and better collective agreements for our members, because the system isn't funded appropriately and because many people know about the situation in home care with respect to casual work, no benefits, low pay, and also the demands and expectations put on them in terms of making their visits, which, if you look into it, there are a lot of missed visits in home care, particularly in the private sector.

I could say that there's a lot of room to grow, a lot of room to make enhancements on behalf of home care workers, but you have to appropriately fund them to have full-time work, meaningful work, so that they can create a living wage off one job.

M^me^ France Gélinas: I'm really sorry—that was supposed to be Joel's question. You're all good? Okay.

So, basically, what you've said is that although they are organized and you get to sit down and bargain, even with this behind them, you're still being paid less than long-term care, you have no benefits, you have no pension plan and you have very little stability. I think it doesn't matter where we are, from Shirlee to Stuart to you, we're all saying the same thing. If we want to solve the problem in home care, we have to make home care jobs good jobs. They have to be—

The Chair (Mr. Kaleed Rasheed): Thank you so much. My apologies to cut you off. Now we are going to move to the independent: MPP Fraser.

Mr. John Fraser: Our family has had the experience of home care, palliative home care, long-term care and a retirement home, so I'll give you a story—a very quick story. My father was diagnosed with inoperable oral cancer. He was supposed to get three palliative radiations. I was supposed to hear back in a week; I didn't hear back in a week. We called repeatedly and finally got things sorted out a week later. He finishes his three palliative radiations, and then we call his home care worker. This is

just before Christmas; he has six months to live, or less, five months to live. The home care case coordinator says, "I'm retiring. Someone will get back to you in January," as we were talking about upping his palliative needs in home care.

So my question is this, to each of the presenters: Do you believe that a patients' bill of rights should be enshrined in the legislation, as it is right now?

Thank you. You may start in order, starting with Shirlee, and how the presenters went.

The Chair (Mr. Kaleed Rasheed): SE Health, please go ahead.

Ms. Shirlee Sharkey: As we know, the starting point with all of this is about our patients, clients and families. I do think that, probably, as a beginning point, a patients' bill of rights being enshrined in the legislation is, I would suggest, the starting point. How it then gets really executed in the work that we do—in your particular example, we've heard a lot about layers and layers in home care where there are coordinators, there are assessors, there are visits, there are transactions. To be honest, that's what actually is creating some of the inability to have full-time workers, because it's very piecemeal and there's no predictable work. It's feast or famine. It could be visits today, none tomorrow or 100 tomorrow—very, very difficult to schedule.

1150

I think your point is very well taken that, unfortunately we have to ensure that the rights of patients and families and seniors are enshrined in the legislation. I say that that's unfortunate because we know that Canadians in general and certainly Ontarians want to live in their home, want to stay in their home, want to get care in their home and actually want to die in their home. That's well over 93%.

So, yes, I think it's important that we reinforce that, and if legislation is the only way that helps accommodate that, then I think that's the route to go.

Mr. John Fraser: Thanks.

The Chair (Mr. Kaleed Rasheed): Next is Bayshore HealthCare.

Mr. Stuart Cottrelle: The first thing that should happen with patient rights is the right of home care. The fact that someone retires is great, but those layers of bureaucracy have to be eliminated. You have a service provider. "What should we do now with respect to my dad?" Because you're at the most stressful time in your life, you want to keep him at home and you don't have the capability. To me, the first thing is the right of home care.

In other places where they've made sure that home care is front and foremost, it changes how things are done. A patients' bill of rights is important, but more important is the recognition that they have a choice of where they want care, because it may not always be the care home.

Mr. John Fraser: Thank you; that's a very good point.

The Chair (Mr. Kaleed Rasheed): Next is Unifor. You have two minutes.

Mr. Andy Savela: Thank you. My response would be that I think we'd be supportive of not only the bill of rights but, frankly, helpful regulation and oversight. There are a lot of standards and compliance that take place in long-term-care facilities and home care, but none really related to where it needs to be. I think something we've all raised on this call is that we need a standard of care for residents in long-term care and home care in terms of oversight or regulation.

Right now in long-term care and home care there's no minimum standard. There's no standard of care in place that a health care organization needs to meet to show that they're caring appropriately for a resident in a home or in long-term care. I think that's what needs to be done first. You look at long-term care when the government relaxed inspection standards, how that has played a role in this pandemic. Things weren't caught up on as quickly as they should have been, which would have frankly maybe saved lives.

The reality is that the most important thing we need is a standard of care that is provided to all seniors based on their needs, and operators have to be held accountable to meet those standards.

Mr. John Fraser: Thank you very much. Thank you, Chair.

The Chair (Mr. Kaleed Rasheed): Thank you so much.

Now we are going to move to the government side. I believe MPP Jim McDonell has the first question.

Mr. Jim McDonell: It's interesting when you hear some of the discussions going on and MPP Fraser talking about the layers and layers of work. I think that that's why we need this legislation now, to make those changes so that we can get into health teams and patient-centred care.

Maybe I could ask Stuart: How do you see the new system working so it will allow you to work and to give patients the service they need, whether it be at home, which everybody agrees is the first choice for almost everybody, or, if they are more serious cases, they have to move into long-term care?

Mr. Stuart Cottrelle: I see the model working where patients and their families are assessed by a service provider and given a proper level of care. That model can be clearly audited to make sure that it's the right level of care and that there's a stronger relationship to make sure we're providing continuity of care and the right level of care to families.

The other piece that's involved in all of this and we've forgotten about is that primary care is part of the solution. Right now, primary care is nowhere to be seen in home care. They're not allowed to have anything to do with home care, effectively.

Those would be the fundamental changes to create the better family experience and, more importantly, it's going to keep people at home. At the rate that we're going with care homes, we can't keep up. We need a far more robust home care system to stop those referrals coming into long-term care.

Mr. Jim McDonell: Thank you. My mother passed away a number of years ago, but was able to stay at home. She would occasionally visit some of her brothers who were in long-term-care homes and actually made the family promise that she'd never be put in a location like

that. It just spoke about the services we were offering at the time.

I know my colleague Sam has a question next.

The Chair (Mr. Kaleed Rasheed): Mr. Oosterhoff, please go ahead.

Mr. Sam Oosterhoff: My question was really just about the coordination piece. Perhaps Shirlee would be able to speak a little bit more about this because I think it is important that we look at that care coordination piece that's so pivotal for the patient experience. Could you speak a little bit more about how that integration should look and why that integration is important?

Ms. Shirlee Sharkey: Thank you for the comment. I think coordination needs to be part of the entire role within the health practitioner that's providing the care. We've designed a model that really doesn't have coordination. It really has resource control under the title of coordination. So that's problem number one.

We should ensure that there's fast access to home care services. We actually know with Ross Baker's study that if we can provide home care within 24 hours of a hospital discharge, it will reduce admissions by 39% going back into the hospital. So we need access that comes quickly. We need the point-of-care health professional talking with the family, getting into the home, understanding what the individual and the client is all about. And then we need to personalize and package that care effectively for them.

I think right now we have layers of coordinators, resource discharge planners, front-line nurses going into the home; it's very, very confusing for everybody.

To Stuart's point, then you have the family physician calling and going, "Does anybody know who is taking care of this patient here?" Typically, the health professional who is actually in the home, whether it's the personal support worker, the nurse or the therapist, many times they're the last person that someone connects with. But they're the ones who have all the information. So it will be critical, I think, to reform the coordinator role, put it into what we mean—

The Chair (Mr. Kaleed Rasheed): Two minutes.

Ms. Shirlee Sharkey: —and then also move some of those functions into primary health care. To Stuart's part, we need to bring primary health care and home care together because that's where people live in the community. You'd figure out a very different model for them using all of the coordinators and all of our health professionals in a much more effective way.

Mr. Sam Oosterhoff: And to that point, that's one of the intents, I believe, of our legislation around the Ontario health team model. Today's legislation that is being addressed: Do you feel that it would work towards that integration in a more streamlined fashion?

Ms. Shirlee Sharkey: Yes, I certainly hope so. It's the first time we've seen language with the care coordinator changed up. I think that is fundamental right now. It has been a barrier to entry for people. It's reinforced this transactional, task-oriented model. It's impacted how we have been able to recruit people who are inspired and want to work in home care, because there's such confusion. At the end of the day, the most important people, patients and families, are absolutely confused with that.

I'm absolutely delighted to see the language in changing the care coordinator function that currently has existed for over 25 years in home care. At least there's a beginning to look at it and a hopefulness that it could be changed.

Mr. Sam Oosterhoff: Yes, and we know language matters. It's something, definitely, that's come up in conversations with constituents in my riding, that lack of integration sometimes. Even though they love their primary care provider and they can love their home care provider, sometimes the two aren't conversing the way that they need to be, right?

Thank you very much for your comments. I don't have any other comments.

The Chair (Mr. Kaleed Rasheed): Thank you so much, MPP Oosterhoff. Thank you to all the presenters for your presentations. As a reminder, if you would like to send your presentation, please send it to the committee Clerk—

The Clerk pro tem (Mr. William Short): Or any other documents.

The Chair (Mr. Kaleed Rasheed): Sorry?

The Clerk pro tem (Mr. William Short): Or any documents.

The Chair (Mr. Kaleed Rasheed): Or any other documents that you would like to send, please send them to the committee Clerk.

Thank you so much to all the presenters this afternoon. As I see right now, it's about noon time, 12 o'clock. This committee will be in recess and we will reconvene at 1 p.m. Thank you.

The committee recessed from 1200 to 1300.

The Chair (Mr. Kaleed Rasheed): Good afternoon and welcome back, everyone.

I do recognize MPP Jane McKenna. If you can please confirm that you are MPP Jane McKenna, and from which city and province you are calling us.

Ms. Jane McKenna: Thank you so much, Chair. I am Jane McKenna, the MPP from Burlington, and I am calling from Burlington at my office on Brock Avenue.

The Chair (Mr. Kaleed Rasheed): Can you just confirm the province?

Ms. Jane McKenna: Pardon me, Chair: Ontario.

The Chair (Mr. Kaleed Rasheed): Thank you.

If I can just confirm via telephone, it's MPP Teresa Armstrong—if you can please confirm that, in fact, it's you.

Ms. Teresa J. Armstrong: Teresa Armstrong. It is me. I am here in Toronto, in Ontario.

The Chair (Mr. Kaleed Rasheed): Thank you so much.

I do recognize that MPP Gélinas has a quick, 20-second comment you want to add.

M^me^ France Gélinas: Thank you, Chair. I just wanted to tell Hansard or—I'm not sure if it's the Clerk: When the representative for Bayshore was there from 11 till noon, he talked about a financial statement that he has been sending to the ministry for the last 10 years, as well as

executive compensation, following questions from MPP Harden. He said that he would send those documents. I just wanted to make sure that Hansard—

The Chair (Mr. Kaleed Rasheed): No, he said that he would look into it but not that he has been sending anything. I remember him saying that he will look into it, and if he does send it, it will come to the committee Clerk.

M^me^ France Gélinas: Can I ask the Clerk to follow up with him?

The Chair (Mr. Kaleed Rasheed): If those documents are going to be sent, then absolutely, the committee Clerk will distribute those documents. But it's up to the presenter or the executives at Bayshore whether they want to send it or not.

M^me^ France Gélinas: Can we remind them to send those to us?

The Chair (Mr. Kaleed Rasheed): As a Chair, I cannot remind the presenters to send their—at the end of the presentation, I did mention to all the presenters that if there are any documents, kindly send them to the committee Clerk's attention. Thank you so much.

M^me^ France Gélinas: Thank you.

MS. LIN GRIST
TORONTO SENIORS' FORUM
MS. HILDA SWIRSKY

The Chair (Mr. Kaleed Rasheed): I would like to welcome everyone back. We are going to start with our first presenter. I will now call on Lin Grist. You will have seven minutes for your presentation. Please state your name for Hansard, and you may begin.

Ms. Lin Grist: My name is Lin Grist. Good afternoon, ladies and gentleman. I live in Guelph, Ontario. Thank you for the opportunity to comment on Bill 175.

Before retirement, I managed a home care program and later helped develop policy for home care services in Ontario, and so have some expertise in this sector. I am concerned about a number of aspects of this bill, but given time constraints, I will limit myself to major concerns.

First, the client is not the centre around which service and program delivery is built. In fact, it would appear that the patient bill of rights, which is the only protection clients now have, is simply absent from the new legislation.

There are 750,000 Ontarians currently receiving home care services. There is a waiting list in the current program which literally runs out of money before year end, and so clients are left without services to fend for themselves. I see no provision for improved access to care, public oversight of monitoring of quality of care, or addressing the chronic staff shortages which plague this sector.

There is no right to community-based care in this legislation for those who need it. Decisions on who gets community care and in what circumstances have been left to regulation, which will be set by provincial cabinet without benefit of public input or scrutiny. There is a mention of copayment, but we have no idea what this is or who will be expected to copay and at what level because again, it's in regulation set by cabinet without benefit of public scrutiny.

I note with huge distress that this government has taken the opportunity in a bill which purports to connect people to home and community care to include legislative provisions which will amend the community care act of 2019, giving overall control of the services to the new super-agency. I searched to see if these new Ontario health care teams would be putting in place public governance and public oversight. They are not. They are in the business of planning and delivery, apparently in a vacuum, because there appears to be no provision for input or scrutiny by the public, who actually foots the bills for all of these programs.

There appears to be no governing body for home care services either provincially or regionally. Apparently the providers themselves will oversee such governance with no public oversight, a bit like having a fox take care of the henhouse, or perhaps more charitably, a flagrant conflict of interest.

I appreciate that there is a pandemic that is changing how we do things in the public arena. However, this is not an opportunity for our provincial government to abandon public consultation on a piece of legislation that affects not only 750,000 Ontarians but the families of these vulnerable people. In fact, I would have thought that this provincial government would want to behave in such a way to have our continued support and trust as we move through this very, very difficult time period. There was no consultation with the general public on changes to a publicly funded program which affects three quarters of a million people, about 11.3% of the population.

I will spend the last few minutes I have speaking to you all personally. I live in Guelph with my partner of 49 years, and we care for each other. I am fortunate enough to be reasonably healthy and not require home care. However, I am in the cohort that will likely need help to remain in my own home so as not to require long-term-care facility support.

A child of Depression-era parents, I am acutely aware of the cost of institutional care. It's critical for a portion of the population, but it is equally important that our health care system ensures that we have services, programs and systems in place that allow people to age in place, and, speaking as an economist, to help manage our public purse expenditures. I am part of the age cohort whose taxes paid for the introduction of health care coverage that was designed to be based on need regardless of income, along with expanding public hospitals, public education and publicly funded universities to be in place for the generation to come after us, a legacy I can be proud of.

I am, to put it bluntly, terrified of becoming sick and unable to care for myself because of this bill. I have watched with increasing distress during the worldwide pandemic the appalling care that is provided through contracts, predominantly in the private, for-profit sector. I learned this week from social media that one such company, an international corporation, managed to spend $300,000 on additional care to keep vulnerable, frail,

elderly seniors safe; at the same time, this company provided its shareholders with $10 million in a dividend. There is something wrong when a government thinks that the rights of shareholders outweigh the rights for a safe and nurturing and infection-free environment for those who are unable to advocate for themselves during a pandemic.

I cannot in good conscience support this bill. I would respectfully suggest that you begin again and have the public service complete a full and open consultation. For the future, I want the taxes paid by the people of Ontario, including me, used by a home care program that:

—puts the clients at the centre of the service;

—has a governance model that provides for public oversight of all services;

—ensures that all programs are available to Ontarians and that eligibility for these programs is enshrined in legislation; and

—ensures that there are inspections of all home care programs—

The Chair (Mr. Kaleed Rasheed): If I may interrupt, Lin. My sincere apologies. Can you please just tilt your screen a little bit down, as on the broadcast, the mouth area is cutting off?

1310

Ms. Lin Grist: Okay. Is that better? Can I sit up closer?

The Chair (Mr. Kaleed Rasheed): Yes, that is much better. Thank you so much. I appreciate it.

Ms. Lin Grist: No problem.

So that's the program that I want in the future. I would respectfully suggest to you, as committee members, that profit and health care are an oxymoron. To the south of us, we have a private, for-profit system which costs 17% of GDP, and some 50 million Americans have no health care. In contrast, in Canada we spend 11.6% of GDP for a publicly funded, publicly administered, universal health care program. If the pandemic has taught us nothing else, it has taught us all that if you are poor, you are much more at risk than if you are middle class or rich.

If we are to continue to have a high-quality universal health care system that provides for everyone, regardless of income, we need to ensure that delivery is not compromised by the need to provide dividends to a small cohort of the population, at the expense of the population as a whole. Thank you for listening to me.

The Chair (Mr. Kaleed Rasheed): Thank you so much for your presentation.

I will now call on the Toronto Seniors' Forum. You will have seven minutes for your presentation. Please state your name for Hansard, and you may begin.

Ms. Janet Maher: Good afternoon. My name is Janet Maher. I'm with the Toronto Seniors' Forum, and I have a short presentation to make.

The Chair (Mr. Kaleed Rasheed): Go ahead, please.

Ms. Janet Maher: Thank you. I just want to thank you for the opportunity to share our concerns and our ideas.

First of all, the Toronto Seniors' Forum consists of Toronto residents who volunteer their time and knowledge to ensure that the city provides services equitably to all senior residents as part of the commitment to the age-friendly city. It also adheres to the values and planning principles of the Toronto Seniors Strategy—which are equity, respect, inclusion and quality of life—by applying a senior's lens to all services and activities.

A senior's lens, in case you need a definition, is a critical perspective to guide and audit policy, planning, health and social development for seniors, typically at the end of their working lives, who can be living with multiple conditions that limit their mobility or otherwise affect their ability to participate fully, at the same time as they generally must contend with a fixed income.

We know that about one in six seniors do not have adequate income to support life in an expensive community like Toronto. Some have survived long-term or irregular employment in low-wage sectors like the caring professions and service and retail sectors and/or have contributed to workplace pensions which disappeared with the organizations that employed them. They are left with inadequate income and inadequate access to housing and other supports through no fault of their own. Our position emphasizes, as you will see, supports focused on the most vulnerable.

We think it's also important to remind listeners that aging in place is a strategy that has been very successful for most of the past 20 years in maintaining healthy older adults, as Ms. Grist talked about, in the community. It has been a critical element in slowing the demand for effective long-term care, which provides more consistent, continuous and specialized care for frailer adults than is feasible in community settings.

The demographics of boomers who began to reach age 65 in 2011 will only increase that pressure, so the need for high-quality home care, community care and post-acute supports will be central to avoiding the so-called "grey tsunami."

We acknowledge that the objective of Bill 175 is to provide for the integration and coordination of home and community care in the Ontario health teams—again, some of this has already been covered by my colleague. We support the objective, with the following cautions and concerns, which come, among other things, from our very recent and continuing experience with COVID-19 in long-term-care settings.

We have a number of principles we want to talk about. The system must first and foremost be centred around meeting human needs with respect, dignity and support for seniors to remain healthy—not ability to pay—and to live independent and connected lives, with staff adequately trained and remunerated to deliver those supports.

We think this is the time to eliminate, not to repeat, the failures of the current system, including its overreliance on large private sector entities that give priority to investment return—

The Chair (Mr. Kaleed Rasheed): Two minutes.

Ms. Janet Maher: Yes. So let me move, then, directly to the recommendations. We have five of them.

We support the coordination of home and community care services in an integrated health system using the following principles:

(1) Ensure that a patient bill of rights reflecting age-friendly principles is included as part of the legislation itself and not something that can be diminished or rerouted to rule changes that have no effective political oversight.

(2) Focus on non-profit, publicly accountable and person- and community-centric models that build on local service integration and community partnerships and meet enforceable standards of care.

(3) Expand home and community care to include a focus on rehabilitation programs designed to improve balance, prevent falls and improve range of motion for those aging in place.

(4) Actively promote the effective embedding of home care staff within primary care teams and partnering community agencies in a circle-of-support approach.

(5) Funding should only cover the costs associated with provision of direct services and direct operating expenses, with caps on management and administration.

That's my presentation. Thank you for the opportunity to present.

The Chair (Mr. Kaleed Rasheed): Thank you so much. I appreciate that.

The next presenter: I will now call on Hilda Swirsky. You will have seven minutes for your presentation. Please state your name for Hansard, and you may begin. Thank you.

Ms. Hilda Swirsky: Good afternoon. Thank you for this opportunity. My name is Hilda Swirsky. I'm a registered nurse, an involved community member and a daughter who had close family members who were recipients of home and community care.

As the previous speaker stated, the majority of seniors want to age in place while remaining independent, productive and engaged. Their homes provide comforting familiarity and routine, especially important in optimizing health. Therefore, here are my recommendations:

(1) Leave Bill 175 as a legislated bill. Transforming Bill 175 from a stand-alone legislated bill on home and community care to a regulatory bill is not in the best interests of the health of our population. Our population is aging, and we all want to live in dignity, with our health needs addressed throughout the continuum of health care. We want responsive care that includes reducing the length of unnecessary hospital stays, reducing overcrowding and facilitating appropriate care. I am here to voice concerns about the impact it will have on every constituent who requires responsive assistance to address their health needs in order to be able to remain independent in their home.

In this bill, the regulations have not yet even been created and will be easily amended by cabinet, with extraordinary regulation-making power in camera, without a public hearing process, public debate from opposition politicians and public vetting through consultation. Regulations have not yet been identified, and therefore unrestricted contracting-out of services could occur, with non-profits redirecting funding to for-profits, and just like in long-term care, for-profits could take over most of the home care sector.

1320

In the midst of this pandemic, there is not enough time to appropriately transform home and community care in a thoughtful, responsive consideration. More time is needed for stakeholders and consultation. Two days is a rush for adequate input from stakeholders. This uncertainty is increasing hardships, staff shortages and inefficiency. Some 3,500 nurses have no clarity about what will happen to them. Clarity is needed and appreciated by the care coordinators, who are, currently, skillful registered nurses. They should be incorporated into primary care and continue to lead interprofessional teams in a timely transition to Ontario health teams. They should direct the level of consistent care our clients need.

As we know, many complaints to the office of the Patient Ombudsman have been about poor care coordination. Incorporate and utilize examples of what is working well: assessment and integrated, inclusive care that is occurring in community care centres, such as Unison, in high-risk, marginalized areas of the city, and not reproducing silos. The initial assessment is done by a registered nurse who is skilled at identifying the complexities of services required to keep someone home in their community. Care is then planned with the interdisciplinary team to meet that individual's holistic and culturally specific health requirements.

How will the government maintain publicly governed accountability and address chronic underfunding and guarantee decent working conditions and pay? How will quality-of-care issues that are current be resolved? How will there be adjustments made to inflation in home care funding and guaranteed decent working conditions and pay?

Existing gaps have not been addressed appropriately. An appropriate skill mix—

The Chair (Mr. Kaleed Rasheed): Two minutes.

Ms. Hilda Swirsky: —and identified human resource strategy, utilizing providers [*inaudible*]. Standardized, high-quality, optimal consistency and standardization in assessment and quality-of-service enforcement throughout Ontario is missing. Residential congregate care models are not clearly defined, and they do not include shelters, hospitals, halfway houses and the homeless.

To enhance and expand virtual home and community connections and care for patients and their families, we need to use increased technologies, such as Zoom meetings, smart phones, but not to take away from in-person care. Developing technologies are changing the way clients want to reach out to their care team.

The patient bill of rights: There's no protections for clients, and they deserve that. The bill of rights has been removed, and not even a draft proposal is in this bill. And there is no plan to partner with clients to have their input.

In summary, Bill 175 is a drastic change for Ontario constituents, replacing the only stand-alone legislation on home and community care with a regulatory bill not in the best interests of Ontario constituents, with certain gaps not addressed. Clients and their families want to remain in their homes for as long as possible as productive,

independent and engaged members of their community. Prior to passing this bill, the voices and wishes of clients and their families should be listened to and heard.

The Chair (Mr. Kaleed Rasheed): Thank you very much for your presentation.

We are going to start the first round of questions here. I'm going to request the opposition side to please start. You will have six and a half minutes. May I know who's going from the opposition first? Okay. MPP Harden, please go ahead.

Mr. Joel Harden: Thank you to all the presenters this afternoon. I'm sure I was raised the same as everyone else participating in this process. I was raised by my grandparents to listen to my elders, so it is of great benefit to hear your perspectives this afternoon.

What I heard you saying is that you're very concerned about the increasing creep of private, for-profit operators in the home care sector. What I heard you say was that you are very worried that the patient bill of rights, which has been previously involved in this legislation since 1994, has been taken out. And what I also heard you say is that we are ill-prepared for the demographic changes that we are about to face with an increasing number of elders in our community.

To frame my question, I want to just comment a little bit on the last of those. I want to encourage us as a committee and as a panel, so we can have a conversation this afternoon, to not embrace the words that I have heard some folks talk about—this isn't a coming tsunami or a coming crisis. I actually think the best thing that could happen to our economy is to have caring professions, like the ones involved in your industries and, Ms. Grist, that you ran yourself for many years, get the status and compensation they deserve. We would hope that would happen in a context where the amount of seniors in Ontario is set to rise precipitously, by a factor of three or four, depending upon who we believe.

Given that that is in front of us, that we have a huge obligation to increase our capacity in the caring professions, to make sure seniors—and people with disabilities, I might add—could age safely in place, I'm wondering if we could talk just a little bit—I'll begin with you, Ms. Grist, because you've worked in the sector. Could you talk just a little bit about the increasing role of for-profit operators in the sector?

Earlier, in a panel you missed, I asked the president of Bayshore if he would be willing to disclose the financial records of his organization, because they, by and large, are funded by the public, to reveal the degree to which Bayshore spends on administration and, particularly, executive compensation. I received a commitment in that conversation for that information to be forthcoming, and I hope I can work with my friend the Chair to remind my friend at Bayshore that we need that information, so the people of Ontario are making the right decisions about Bill 175.

Could you help us understand, from your perspective in the home care industry, Ms. Grist, what we have to do to get it right? Who should be valued, and what specific concerns do you have with for-profit operators in the home care sector?

Ms. Lin Grist: I think my major concern is that people who are doing the front-line work—these would be personal care workers, they would be nursing assistants, they would be nurses, physical therapists and staff—are adequately compensated.

I would suggest, with due respect, that you put a cap on what can be, as Ms. Maher said in her presentation, spent on administration. United Way of Ontario is a perfect example of that. They look really carefully at how much money on administration is spent by anybody they give money to, and it's capped. If you go beyond that, then they just don't fund you. I think that publicly we should be doing the same thing. It's absolutely ludicrous that we don't have enough money to pay good wages to keep people in the sector. It's chronically difficult to keep people in the sector and at the same time not have any idea how much private companies are spending on either administration, senior staff costs and also how much money they're giving in the way of dividends—

Mr. Joel Harden: Dividend payments.

Ms. Lin Grist: Yes, absolutely. I'm sorry; that thing just really stood out for me last week, which is why I mentioned it. I'm not mentioning the company; I don't want to pull anybody out in particular. But I thought that it was really egregious, especially in the time of a pandemic.

Mr. Joel Harden: I would completely agree with you.

MPP Armstrong, did you have anything you wanted to add?

The Chair (Mr. Kaleed Rasheed): MPP Armstrong.

Ms. Teresa J. Armstrong: Yes, I would like to ask a question, if that's all right.

The Chair (Mr. Kaleed Rasheed): Please go ahead.

Ms. Teresa J. Armstrong: Okay. Thank you all for presenting. I wanted to ask about the bill of rights, because you spoke very passionately about the fact that this government has taken it out of legislation, which was enshrined to protect people under the bill of rights, and put it into regulation, which can be, of course, changed any time. It's very hard to keep track, and that means we can't really debate any changes. Because it's in regulation, it doesn't come back to the Legislature for debate.

1330

I just wanted to ask Ms. Grist—you had talked about how you would be terrified of becoming ill, having to rely on this bill. Can you describe how you see your future, should this bill of rights not be enshrined in legislation? If this bill passes the way it is, without any changes, how would you see it affecting your care in the future?

Ms. Lin Grist: I think the first thing is, I have no idea what I would need, how ill I would need to be at home to get care—that's the first thing—

The Chair (Mr. Kaleed Rasheed): Less than a minute.

Ms. Lin Grist: —because there's nothing in place. I'd be afraid that I wouldn't know when I could get care, I wouldn't know the quality of care that I was going to get, I wouldn't know that it would be consistent. I would have

no idea how much I would pay or how much I could afford to pay. It would be absolutely terrifying to me, that I could be at home and ill, and if my spouse, God forbid, couldn't help me out, I'd be in really serious trouble. And I'm one of 750,000 people. It's a lot of people, 11% of the population. So, please, I urge you to do something about it.

Ms. Teresa J. Armstrong: Thank you.

Ms. Lin Grist: You're welcome.

The Chair (Mr. Kaleed Rasheed): Thank you so much.

We are now going to move to the independent side. I believe, MPP Fraser, you have a question?

Mr. John Fraser: Thank you very much for your thoughtful presentations and for being here today. I want to follow up on my colleague Teresa Armstrong's question with regard to the bill of rights and the importance of having that in the legislation because those are the principles on which we're organizing access to critical home care services.

The question is two parts. I think I heard correctly that all of you were supportive of having that bill of rights enshrined into legislation. If you can explain why, again, you think that's important, that would be great.

I'd also like you, if you can, to tell me what you think is important to have in that bill of rights, as a guiding pillar or principle of how home care is going to be going forward. We'll start with Lin Grist, and just go through as the presenters did with my last question, please.

Ms. Lin Grist: Okay, so two parts. The first part is why would I want it enshrined in the legislation. It's because that would be public, and if it's enshrined in legislation, it couldn't be changed by a government without the benefit of some kind of public consultation, and that's really important to me. I want openness and I want transparency.

What would I want in the bill of rights? Boy, that's a really long laundry list, but let's start with I want a bill of rights that puts me, as the client, in the centre of the program. I want a bill of rights that allows me to have services when I need them. I want a bill of rights that says that if service is not forthcoming, that there's actually some way in which the government and the providers can be held to account. I'm sure others have lots of others, so I'm going to leave it there.

Mr. John Fraser: Thank you.

The Chair (Mr. Kaleed Rasheed): Next would be the Toronto Seniors' Forum.

Ms. Janet Maher: I don't have a lot to add to what Ms. Grist said, but I think that I actually may take the opportunity to tell a small story. Just about 25 years ago now, my mother was coming into her declining years in Thunder Bay, Ontario. She, like I, was a chronic kidney care patient. She had been on dialysis by that time for about 10 years, but was told that if she were to go to long-term care, she would have to go to Sudbury, Ontario. I notice there aren't any northern members on your committee today, but that's a distance of about 1,500 kilometres, and a place where she had never even been before, let alone have any family or anything else like that. As I look forward—I'm not on dialysis, but I am a chronic kidney care patient here in Toronto. I guess the concern I have is access to services, probably in addition to the points that Ms. Grist made.

Mr. John Fraser: Thank you.

The Chair (Mr. Kaleed Rasheed): The third presenter was Hilda. Please go ahead.

Ms. Hilda Swirsky: So a patients' bill of rights, just like it is in the hospital—you walk into a hospital and it's posted everywhere. This bill of rights would be a way of communicating to patients what their right is in home care and they would know the process.

In the bill of rights, I would like to see a process so that they know that if they're not pleased, there's some process they can access so that their voice and what they want is incorporated, they know that they are in partnership with the rest of the team, and it also produces a standardization. Sometimes you think the big cities have better care or better facilities. The bill of rights would be our rights right across Ontario. There would be more chance of standardization right across the province, and we would not have hotspots where suddenly you find places really in bad shape. It would be consistent right throughout the province.

The Chair (Mr. Kaleed Rasheed): A minute and a half.

Mr. John Fraser: I'll just say very quickly that I want to thank you all again for presenting today. The other thing I think I heard very clearly from you is that the lack of public oversight is a concern, especially given that most of the governance for all of Ontario will be essentially with the super-board and the minister. Basically, it's going to take the community out of care.

There's no question that we have to reduce the levels and the layers of things like assessments and access to care. But as you said very clearly, it's important that these local health teams respond directly to individuals' and their communities' needs and be accountable locally for that.

So I want to thank you again for your presentations. They were thoughtful. Thank you for taking the time today to speak to us.

The Chair (Mr. Kaleed Rasheed): Thank you so much. I appreciate that.

Next we will move to the government side. I believe MPP Martin would like to start from the government side.

Mrs. Robin Martin: Yes.

The Chair (Mr. Kaleed Rasheed): Please go ahead.

Mrs. Robin Martin: Thank you, Chair, and thank you to all of our presenters for your comments on the home care legislation that we're bringing forward. I was interested that you all talked about the importance of care being client-centred. Certainly, Hilda Swirsky mentioned that she is the daughter of somebody who used home and community care services. I think that probably describes the experience of a number of us, myself included.

What we're trying to do here with this legislation is to make sure that we have a patient-centred system which is responsive to the needs of patients and flexible enough to

respond to what they actually do need. For example, we've taken out the service maximums and put the decision-making for home care coordination in a more adaptable setting so it can be delivered, for example, at the primary care level or at the hospital level as people are leaving, so we have less people who have to go back into hospitals or long-term-care settings.

I think you all commented that people would like to remain at home and have care that allows them to be independent—I think that word was used by Janet—and dignified, so that they can have the dignity of good care in their home.

Certainly, that is where this legislation is directed, to try to change things to make sure that we have care that is responsive to the needs of people. I guess what I was wondering is if, in that regard, any of you—well, let's start with Hilda. If Hilda would like to tell us about some of the challenges that you may have encountered, either with your own family or with people that you were working with, in getting home and community care in the current system.

Ms. Hilda Swirsky: That is one reason why I am speaking today. Several of my family had home and community care, and we were able to keep them home for as long as possible.

1340

It's very important to have home care that is responsive. At that time they started cutting their hours, which was really hard on them. My mom, my dad, my father-in-law, my mother-in-law: What they wanted the most was to stay at home. There came a point when the home and community care was not responsive enough to be able to let them stay at home so they had to go into long-term care, which was not a choice of any of us.

Here we have a chance where we can really be more responsive to the needs of patients, to bring in an interdisciplinary team and so keep people at home as long as possible by making sure we that really do this well and that people have the care they need in their home, rather than have to be hospitalized, and are able to coordinate care effectively so they can stay at home.

Mrs. Robin Martin: Thank you, Hilda. Janet, would you also like to comment on that—Ms. Maher?

Ms. Janet Maher: Sure. Just a couple of points—or maybe one basic point—which is that home care is really cost-effective in our current health system. Nobody has really talked about that very directly. But if you think that the average home care expense per individual is something like about $45 per person, compared with—I don't know exactly the per diem cost today of long-term care, but I think it's a factor of about 12 to 15.

Mrs. Robin Martin: Yes, I think you are right on that point. It certainly is important for all of us to recognize that fact. That's why the purpose of this legislation is partly to push as much care as possible out into the home and community and keep people at home as long as possible, because that's obviously where most people would like to be as long as they can be there. That really is the purpose of this legislation.

I also wanted to ask about the importance during the changeover—we've made sure that there is a lot of continuity between what exists now, but legislation we think needs to change because of some of the hurdles we've discussed. For example, we've made sure that the minister can continue to subrogate and recover costs and to fund Indigenous communities directly. We've kept that. That's a continuity.

Another one is, for example, the Excellent Care for All Act and the jurisdiction of the Patient Ombudsman. Some people have mentioned accountability as important—we think it's important too—and that the jurisdiction of the Patient Ombudsman over home care will continue in the new act. And we've amended the Private Hospitals Act to exempt residential congregate care models, once they're defined in the regulation, so that these models, which are not intended to be private hospitals, don't get captured as private hospitals.

We've put all these things in to try to maintain continuity as we change over. We think that's very important because—

The Chair (Mr. Kaleed Rasheed): Thirty seconds.

Mrs. Robin Martin: —we don't want to leave patients without care in the interim. Can you just comment on how important the continuity of care is for patients, Hilda?

Ms. Hilda Swirsky: It is extremely important. This is one thing we really want to make sure happens. People in their home—

The Chair (Mr. Kaleed Rasheed): My apologies to cut you off. I'm sorry about that.

We are now going to go to our second round of questions. We will start with the independent member. MPP Fraser, please go ahead.

Mr. John Fraser: You can finish your answer. Our last presenter, you can finish your answer.

Ms. Hilda Swirsky: I think it is extremely important to have continuity. The one thing about continuity also is that when somebody is at home and there's a subtle change, that person looking after the person knows that something is not right. But if you just come in and you have no continuity, you see somebody once and you've never seen them before, if something is wrong you don't pick it up.

Mr. John Fraser: That's great. Thank you very much. I'm going to go back and direct the question to all the presenters in the order that they presented. I heard in a number of the presentations with regard to public oversight and the ability of people to have a right of appeal is not something—it's actually being taken out of the legislation. There's no clear way or a path forward for people, which is not a good thing. So the question is, to each of you, how do you see that right to appeal? How should we do that? How important is it to you? I'll direct it again, and we'll start with Lin and then go through all the presenters, please.

Ms. Lin Grist: Pretty simply, it needs to be enshrined in the legislation so that it's public and transparent and open so we can actually see it as the public. I think that's probably it. That's most important for me, anyway.

Mr. John Fraser: Thank you.

Ms. Janet Maher: I would only add that I think that the process needs to be well-communicated both to the patients or the consumers, and also to their families so that we don't await the kind of silliness that we've seen with the COVID-19 situation that's just passing us over, I hope.

Mr. John Fraser: Thank you.

Ms. Hilda Swirsky: I agree. It has to be enshrined, as we saw with COVID-19 and long-term care and the horrific results we had when there is no place to go. Families felt absolutely helpless having no way to communicate. There has to be very good communication so that patients and families are very much partners in this and they know where to go to communicate. There are lots of patient councils everywhere, but yet, somehow, the voices of patients and their families were somehow missed in all this long-term fiasco.

Mr. John Fraser: Thank you. Again to all the presenters very quickly: Given that most of the province has come through the first wave of this pandemic—we're not out of it yet—and that a lot of home care and community care organizations are struggling with things like staffing and the utilization of their workers, how surprised are you that the government is moving forward with this legislation right now, given all those things? I'll start with Lin again.

Ms. Lin Grist: I can only speak about Guelph because that's what I know. Our home care workers in Guelph—I know nurses who go into home care at the moment who were given one pair of gloves and a mask to go around to 20 people in a day. Think about that: In a pandemic, they were going to 20 different vulnerable people. So that's all I can say about that. It was appalling to me. It's one of the reasons I'm absolutely terrified that I will not have proper care if I ever get sick.

Mr. John Fraser: Thank you.

Ms. Janet Maher: I'm not sure I have anything to add—

The Chair (Mr. Kaleed Rasheed): Two minutes. Go ahead.

Ms. Janet Maher: I have nothing to add to what Ms. Grist has said other than that I'm terrified as well. We had a lot of situations among our members who require home care of simply not getting it in the middle part of April.

Mr. John Fraser: Thank you.

Ms. Hilda Swirsky: I'm really surprised that the government is going ahead with this because they haven't got the details figured out yet. They haven't been able to address any of the gaps—the gaps in funding, the gaps in the skill mix, the gaps in—what are they going to do with these coordinators?

1350

They're transitioning now to Ontario health teams. Without even transitioning, they're going into a new bill. They haven't even had the Ontario health teams working well and settled and being comfortable before they're wanting to make more changes, changes without having any oversight about what is going to happen if there's a problem. There's nothing yet picked out in the legislation where families can go.

Mr. John Fraser: Thank you very much.

The Chair (Mr. Kaleed Rasheed): Thanks a lot.

Now we are going to move to the government side, MPP Jim McDonell. Jim?

Mr. Jim McDonell: Okay, there. Can you hear me now?

The Chair (Mr. Kaleed Rasheed): Yes, we can.

Mr. Jim McDonell: I guess my question to the presenters would be—we've just gone through a time period where we've seen a lot of issues, a lot of inflexibility. We've heard different speakers talk about the ability to make changes. With the silos in place, it's hard to get people in—and maybe some discussion about the new health teams, which will allow the local communities, through their health teams, to decide what the best way of providing care for either long-term care or home care is, as well as hospitals and physicians. Maybe, Hilda, if you could suggest how you see the changes—and is that a wish, that we move back towards community deciding how best to serve its own regions?

Ms. Hilda Swirsky: I hear that the Ontario health teams have worked well, that it has been a good change, that it has been one of the highlights in this pandemic. They have worked well and there's more coordination. We want to continue to see that happening. We want to see them roll out more and make sure that there is interconnection and accountability in this bill, more than the bill is pointing out.

Mr. Jim McDonell: I know that there has been talk about the bill of rights not being included, but it is on the registry. We have put it there, which allowed for 15 days of comment. What we feel is a good thing about it being in regulation is that it is flexible. It can be changed as need be. It has been there; I think back in February it was added to the registry. That's why we're looking at it.

Now, is there an issue with proceeding that way? Once it's in legislation, as we saw before, it's very difficult to change, very hard to move with changing conditions. There's no question that over the last four months, I guess, we've seen some drastic changes in the way we run the business, and changes are necessary sometimes.

Maybe a question to Janet, if she sees the fact that it's published, that it's there for comment. We were taking those comments, and we'll be putting it in place with further consultations.

Ms. Janet Maher: It's Janet here. I think that whether it's in regulation or in legislation, it can equally be rigid and inflexible and stuff like that. What this takes is goodwill. I particularly want to speak on behalf of seniors, who have worked, many of them, for 40-plus years, building this province and this country. Accommodating what we need and want and what will help our families should be paramount, rather than concern over what's flexible and not flexible.

Mr. Jim McDonell: I know that, through our office, over the last 10 years, we've had a lot of seniors come in, a lot of families come in, trying to get a place for a loved one. I've had friends who have basically taken their spouse into the hospital and then sent home when clearly they couldn't be sent home. I think of one case in particular

where a person went in one day and was sent home. He went back the next day. He was sent home again, and passed away the next day. Obviously, it came down a lack of long-term care.

The Chair (Mr. Kaleed Rasheed): Two minutes.

Mr. Jim McDonell: Okay, thank you.

The home care that was sent home quickly saw and assessed the issue, but it was all about having a system that was not adequate for the number of seniors we've had. Our time in our office was constantly spent trying to find locations for patients who just could not be home any longer. So not only was our home care stretched but also our long-term care—and really no plan. We've seen no new beds built in almost 20 years when obviously the case was there. We saw Auditor General report after Auditor General report talking about the long wait times, but nothing was ever done. I think this legislation is looking at making those options available.

We've already approved over 8,000 beds to be built, but it needs more than beds. It needs that local coordination. I think that when we're looking at this, this bill starts that process, along with Ontario health teams. In the end, we're going to see better systems.

Maybe a comment on that integrated system from possibly Janet, if you're there—what do you think of it, where these decisions are made with the family and locally?

Ms. Janet Maher: I think that the issue of a bill of rights has not got anything to do with whether or not a government has the will to build enough or to support enough spaces, either in—

The Chair (Mr. Kaleed Rasheed): Thank you so much. My apologies to cut you off.

Next we have the opposition members. I do see Madame Gélinas. Please go ahead.

M^me^ France Gélinas: Good afternoon, everyone, and thank you for presenting. My first question, and I will go from Lin to Janet to Hilda, has to do with—I'm from northeastern Ontario. Right now, our case coordinator has a standard tool that they use, and they grade your level of needs to see, first, if you qualify, and second, what you qualify for. In northeastern Ontario, if you grade 18 on the level of needs, you get two baths. But if you score 18 in the Ottawa region, you get a much fuller basket of services. So, depending on the amount of money that goes to the different LHINs, it doesn't matter what your needs are; you will get different services.

My question to you is: Would you support a standard needs assessment that leads to a standard basket of services available to the home care recipient? I'll start with Lin.

Ms. Lin Grist: Yes, of course I would support that; absolutely. Everybody pays into the system, or has paid into the system, in Ontario, and everybody has the right to the same access to care and the same basket of services.

The only thing I would say is that we keep things in place for people who are in rural and isolated communities, and that we have a little more for them. Because, frankly, it's easier to get services to me in Guelph—God forbid that I should ever get sick—than it is to somebody in rural Wellington, for example, in Mount Forest. But in terms of the services themselves, absolutely: Everybody should be able to get access to all of the same services and not be left out because they happen to be in northwestern or northeastern Ontario. No, that's just not right.

M^me^ France Gélinas: Thank you. Janet?

Ms. Janet Maher: The only thing I would add is that whatever basket you come up with has to be based on need and not on ability to pay.

M^me^ France Gélinas: Agreed. Hilda?

Ms. Hilda Swirsky: Yes, I agree. That is one of the gaps right now. There's no standardization. Especially if you're talking about Indigenous populations and marginalized populations and you happen to live outside a big city, then you are not going to get the care you need. You're down on the totem pole just because you're not in a big city. It should be a regionalized standardization right across Ontario, and that is something that is missing right now.

1400

M^me^ France Gélinas: Thank you. I agree with you, and this is something we'll try to put into the bill. To my colleague Joel.

The Chair (Mr. Kaleed Rasheed): MPP Harden?

Mr. Joel Harden: Thank you. I focused most on Ms. Grist, and in the last round I wanted to give an opportunity to Ms. Maher and Ms. Swirsky to give us a sense of whether it's actually possible. We talked about, and many people have talked about, the broken nature, the transactional nature of the current system. Is it possible—let me just be candid, because it's in the legislation—to give a person with a disability or a senior a bath in 15 minutes?

Ms. Janet Maher: It's happening now, is all I can say.

Mr. Joel Harden: But is it appropriate, Ms. Maher, is my question.

Ms. Janet Maher: I think it's a bit tight. I'm glad that I don't have to depend on my shower or bath for a 15-minute home care appointment.

Mr. Joel Harden: Right. Ms. Swirsky, my question to you: There are some organizations in this sector representing employees who have said they're challenging people in Ontario to take a picture of themselves about what they look like six minutes after they wake up in the morning, because for many people who do the care directly in someone's apartment, in someone's home, that's how much time, often, between transportation—which is not paid by many organizations—that's how much time people have to provide the care. What do you think about that? I know what I would look like six minutes after I wake up in the morning. What would that be like for you?

Ms. Hilda Swirsky: That would be terrible. Most people need their cup of coffee or something before they can speak. I think you can't time it that tightly. Everybody's different. You're talking about different people, different disabilities. You cannot just have it—standardization cannot just include that you're going to do things in 10 or 15 minutes. You have to have a range, because

people are unique individuals. Maybe in five minutes you can do somebody's face and then bath, but somebody else—and if they're having a bad day and they want to talk for a few minutes. Having a bath is very special. It's not just a physical thing. You're also assessing them. You're assessing: What are their needs for the day? Do they have problems that they want to talk about, something that's really bothering them? You may take 20 minutes because they want to stop and talk to you for a few minutes, and you have to give that time if you're doing holistic care.

Mr. Joel Harden: Right. What I remember reading is that Tommy Douglas once said that there are many unfinished parts of medicare. Would you consider home care to be an unfinished part of public medicare, that we need to bring this back into public ownership so that we can make sure that the people who are doing that care and work aren't rushed from task to task, that we're using every last dollar to make sure that person that you're talking about gets the care and the support that they need?

Ms. Hilda Swirsky: For sure. Also, home care is the way we want to go. We don't want people in long-term care if they don't have to be. The way they are looking at care is being changed. We're looking at physical design. Who do you know that wants to really live in an institution? You want to live in a home.

The Chair (Mr. Kaleed Rasheed): Thank you very much for your presentation. I appreciate that. Thank you to all three presenters.

ONTARIO NURSES' ASSOCIATION
MR. MERVYN RUSSELL
MR. JULES TUPKER

The Chair (Mr. Kaleed Rasheed): We are going to move to our 2 p.m. group. I will now call on the Ontario Nurses' Association. You will have seven minutes for your presentation. Please state your name for Hansard. You may begin.

Ms. Vicki McKenna: Good afternoon. I'm Vicky McKenna. I'm president of the Ontario Nurses' Association. ONA is the largest nursing union in Canada, and we represent over 68,000 registered nurses and health professionals working in every sector in our health care system, along with 18,000 nursing student affiliates.

Due to the nature of this proposed bill, and in particular the vast amount of health policy removed from the legislation and put into proposed regulation, we will comment on both the legislation and the proposed regulation as a combined reform package.

With our experience in COVID-19, the landscape of health care in Ontario has seismically shifted. Issues that were once ignored are now front and centre, and the public is paying very close attention, especially given the consequences for seniors' care and in long-term-care homes.

In light of this, I want my message to MPPs to be clear: The legislative proposal involving Bill 175 is inappropriate, untimely, unclear and untested. Bill 175 never did—and, in a post-COVID world does not now—respond to the challenges in our community care. The core and root causes of service delivery problems are left unaddressed, and in some instances the legislation leaves us more questions than answers.

ONA's primary concern with the legislation is the future of our thousands of care coordinators, who Ontarians, by the way, rely on very heavily for holistic care. We will speak to their concerns first. We will also raise our concerns in the public interest about creeping privatization and the erosion of public accountability that is in this legislation. Finally, we will comment on what we believe are two gaping holes in the legislative proposal: funding and the health human resource shortage.

For care coordinators: For those who are unfamiliar, care coordinators are the health system problem solvers in Ontario. They're registered nurses—

The Chair (Mr. Kaleed Rasheed): My apologies to cut you off here, Vicki. If you can kindly please move your computer screen a little bit down, as when you are speaking your mouth area is cutting off.

Ms. Vicki McKenna: Oh. Okay. I can't see that. Sorry, I don't see that.

The Chair (Mr. Kaleed Rasheed): That should be much better.

Ms. Vicki McKenna: Is that better?

The Chair (Mr. Kaleed Rasheed): Yes. Thank you.

Ms. Vicki McKenna: All right. Okay. I hope that isn't off my minutes—my seconds.

Care coordinators: For those who are unfamiliar, care coordinators are the health system problem solvers in Ontario. They are RNs, social workers, OTs and others who connect patients with appropriate services and resources. They are true heroes. They enable a sustainable and dignified return home from hospital, and quality care for patients who are living at home. In our regard and reading of this legislation and regulation, ONA's leaders and members are left with more questions, as I said, than answers. Here are just a few that remain unclear to us and are unanswered. We would be interested in the position on these.

Will care coordinators at the LHINs have their employment automatically transferred to the new OHTs, or will they be required to reapply? Why does the legislative package fail to precisely describe the nature and roles of care coordinators in the system? Will this legislation create a gateway for home care contractors to conduct both care coordination and assessment, and manage home care? And if so, doesn't that risk creating a conflict of interest for profit-making companies? Who will provide the oversight for quality and value for money? After all, if they control assessments, they will have the power to increase the delivery of service from which they themselves profit; meanwhile, taxpayers are being billed.

One provision states that home care assessments are to be performed by a regulated health professional. Will this provision exclude care coordinators who are currently performing the role, such as social workers, from the jobs in the new system? After all, Ontario social workers are

not regulated under the RHPA. At a time of serious staffing shortages, we cannot afford to lose experienced professionals because of an arbitrary, bureaucratic requirement deciding, without consultation with the front lines.

The legislative package suggests that clients will remain with individual service providers throughout their care, but how will this work as the client's conditions and needs change? Some service providers in Ontario generally specialize in specific types and levels of care.

Finally, why doesn't the legislative package include any mention of standardized assessments? Without standardization, there is a risk that service delivery will vary across the province. It's unnecessary for care coordinators and their clients, and it threatens the quality of service that Ontario depends on. This shouldn't be so, and it doesn't have to be.

The public accountability and expanded profit-making that we see in the current legislation is worrisome, and it also opens [*inaudible*] more profiteering in home care and a significant loss of public accountability. The legislation and its regulations open the door for profit-making and home care companies to enter and expand their presence in our public hospitals. We also see language in Bill 175 that removes the prohibition on bed expansion in private hospitals. This will likely result in the provincial government paying more and more for beds in private hospitals that cost more because of the profit margins.

On the public accountability side, this legislation downgrades the importance of the home care—

The Chair (Mr. Kaleed Rasheed): A minute left.

Ms. Vicki McKenna: —patients' bill of rights. More than ever, given Ontario's experience during the pandemic, the public deserves mechanisms for accountability from all health care—

Failure of sound system.

The Chair (Mr. Kaleed Rasheed): I guess the video is frozen, right?

1410

Ms. Vicki McKenna: This renders it malleable rather than steadfast and removes the public scrutiny. We do not understand why this government finds this decision acceptable, which appears to weaken the mechanism for public accountability.

On the health human resources side, like never before—

The Chair (Mr. Kaleed Rasheed): Thank you so much for your presentation.

Ms. Vicki McKenna: Okay.

The Chair (Mr. Kaleed Rasheed): My apologies to cut you off.

Our next presenter is Mervyn Russell. I will now call on you. You will have seven minutes for your presentation. Please state your name for Hansard, and you may begin.

Mr. Mervyn Russell: My name is Mervyn Russell. Mr. Chairperson and honourable members of the committee, first of all, I thank you for giving me this opportunity of making known to you my views regarding Bill 175, the Connecting People to Home and Community Care Act.

I'm a Canadian citizen who was born in England at the beginning of the Second World War. I'm a retired clergyperson who was ordained in 1968 and who has served in England, Scotland, the United States, Canada, and St. Vincent and the Grenadines. I've spent many hours visiting the sick, frail and elderly in all of these places. I've always been a social activist and a community organizer. I live with my wife, Patricia, in Oakville, and Patricia, in previous years, was in fact a home care worker.

Let me begin by acknowledging that my comments are strongly based on the analysis provided by the Ontario Health Coalition. The first thing that strikes me about Bill 175 is that its focus is on administration. It certainly does not seem to be setting out any enlargements of the scope of the service and improvements to the quality of care, because no mention is made of any such additions or improvements, even though it is generally recognized that improving the provision of reliable, competent, dependable, sufficiently resourced home care is desirable and urgently needed.

Another feature of Bill 175 that stands out for me is the consistent intention it expresses to lessen the responsibility of the provincial government for the provision of home care. At present, accountability to every level is to the Ministry of Health through its appointed representatives. Under Bill 175, Ontario Health, which is a small cabinet-selected and appointed body of unelected citizens, selects and appoints Ontario health teams composed of representatives of health providers in a local jurisdiction. The health teams then award contracts for providing home care either to themselves or to competing companies.

The resulting relationship of delivered home care to the Minister of Health, the cabinet and the Legislature is consequently much more tenuous and distant. It is disappointing and disturbing that the provincial government would not want to have a much closer involvement and responsibility for maintaining the dignity and health of our older, incapacitated and sick citizens in the context of these people's own homes, their relatives and communities.

The withdrawal of the government's presence makes available another development which Bill 175 facilitates. This is a much greater role for private, for-profit companies in the provision of home care. Health teams are not non-profit-based as are the LHINs. Membership and management of the health teams will, in all likelihood, be dominated by the resource contributions of corporate business chains, who will need to satisfy shareholders that being part of a health team is a profitable development.

The new management model of Bill 175, therefore, increases the business orientation and, consequently, the profit focus of providing home care. This business focus will undoubtedly generate a stress relationship with a quality health care focus. In such instances, business management for corporate profit usually wins.

Bill 175 revokes a number of pieces of legislation controlling the delivery of home care. The existing legislation will not be replaced with new legislation. Instead, the passing of Bill 175 will result in home care being

controlled by regulation, presumably determined by the Minister of Health. This change dovetails very nicely with the ministry, cabinet and Legislature having a more—

The Chair (Mr. Kaleed Rasheed): Two minutes.

Mr. Mervyn Russell: I beg your pardon?

The Chair (Mr. Kaleed Rasheed): You have two minutes left.

Mr. Mervyn Russell: —distant and detached relationship with the provision of home care and with the development of a variety of health teams providing home care in a variety of ways.

Equally, regulation rather than the law makes it much easier for difficulties and disagreements to be handled without the interference of political debate or testing in the courts.

As I see it, the problem of ruling by regulation means a lack of stability, certainty and accountability. These are characteristics that do not fit with the fragility and dependence of persons requiring home care. To feel safe, they need stability and dependability.

What makes the ruling by regulation more problematic is that Bill 175 provides no right or means of access for public input from the clients of care, organizations of or for those receiving health care, professional bodies or the general public.

I'm left with the overall impression of a piece of legislation with little understanding and compassion towards those who would be most affected by it. I think Bill 175 should be withdrawn.

The Chair (Mr. Kaleed Rasheed): Thank you for your presentation. I appreciate that.

Next I will call on Jules Tupker. You will have seven minutes for your presentation. Please state your name for Hansard, and you may begin.

Mr. Jules Tupker: Good afternoon. My name is Jules Tupker. I am an advocate on social justice and health care issues here in Thunder Bay. I was the union representative with the Canadian Union of Public Employees and, as such, represented workers in health care, including home care workers, so I think I have a fair understanding of the issues in home care.

I believe that Bill 175 will do nothing to improve the abysmal state of home care services that are currently being provided. I will now tell you why I believe that. Home care has been inadequate and dysfunctional in Ontario for many, many years. The Conservative government of Mike Harris was the main cause of this situation. His government opened the door to privatization of home care by creating community care access centres and opening the concept of competitive bidding on home care contracts. The result of competitive bidding lowered the standard of care through lowballing of bids by private contractors to get those contracts. It started a race to the bottom to see who could provide a minimum of service for the least amount of money.

Today, we have a large number of home care agencies in Ontario, most of which are privately owned, each with their own administration and each making a profit at the expense of services that should be provided to patients trying to live in their homes.

In 2014, the Thunder Bay Community Elder Abuse Prevention Committee held a home care forum here in Thunder Bay, and we heard many, many stories from home care recipients of missed visits, late visits, untrained staff and inconsistent staff. From home care staff we heard about the lack of time to properly perform their duties at each location, ridiculous shifts, exhaustion, burnout, insufficient resources and poor pay.

In talking to home care recipients and staff over the past few days, things have not gotten any better. In fact, a number of concerns were raised, including concerns about PSWs doing RPN duties because of the shortage of RPNs willing to work in home care. The idea of virtual nursing is also raising alarms among staff and care recipients.

In reading Minister Elliott's speech in the Legislature introducing Bill 175, I didn't notice any mention of improving the problems I just mentioned. She talked about better-coordinated patient care "because health care providers would be empowered to work together with a full picture of the patient's needs, while still operating under strong oversight and accountability."

By "accountability" I assume it's the accountability of a service provider to the patient.

My interpretation of the bill is that anyone having a complaint about the service that they are receiving would complain to the service provider, and if not satisfied would have to go to the health team, which is governed by a number of service providers, including the service provider that did not provide the proper service in the first place—a classic example of the fox guarding the hen-house. I doubt very much that a satisfactory outcome would result from this process.

I see this bill attempting to create a seamless health care process from birth to death. This is something that has been a dream of governments for many years in order to make the administration of health care more efficient, but this bill does nothing to address the inherent problems being encountered by home care patients and workers. That is where change needs to happen.

The Ford government has decided to eliminate the LHINs and replace them with a super-agency called Ontario Health, which would fund community health teams which would be made up of service providers—hospitals, long-term-care homes, physician clinics, home care providers and possibly other services—in communities across the province.

I would like to tell you a quick story about an attempt to create one of these "teams" by Mike Harris's Conservative government in 1994-95 in Fort Frances. The concept was to create what is called a comprehensive health care organization, or CHO, quite similar to an HMO in the United States. At the time I was a service representative with CUPE. When my co-worker and I researched the concept, we realized that people would have to "roster," or register, to join the CHO and that the CHO could refuse to accept you as a member based on the acuity of your health. When this was made public, the public raised their voices in objection, and the concept was withdrawn by the government.

Today's community health teams bear a startlingly similar appearance to the CHO in Fort Frances, and I feel that, if implemented, many people will lose the universal health care that they enjoy and require.

1420

In reading Bill 175, I see the creation of Ontario Health, which would have a board that is not subject to Ontario legislation and that is made up mainly of appointed bankers, business people and corporate executives. There will be no public input into the members and there will be no public board meetings or access to information from the board.

The LHINs that Ontario Health will replace had a similar board formation process, but the LHINs were required to hold public board meetings and were responsible to the Ontario Legislature—not just the governing party's cabinet, as Ontario Health will be. Similarly, the independent organizations or health teams that Ontario Health funds will be independent of government oversight and run by independent service providers, many of whom are for-profit agencies who are not elected by the public and whom the public and publicly elected Legislature have no control over.

The Chair (Mr. Kaleed Rasheed): Two minutes.

Mr. Jules Tupker: Bill 175 seems to replace legislative control with regulations controlled by the health teams and the ruling party. If this process does not work, the provincial Legislature will not be involved in making changes. Public input has been eliminated. The government is under the impression that every community will be able to create a health team, but I feel that will probably never happen, and certain communities will be left behind. What happens to those communities? I also believe that services provided by each of these health teams will vary across the province, thereby destroying the concept of universal health care.

There is no doubt that home care is dysfunctional and is absolutely in need of improvement. But it's clear to me that Bill 175 will not provide the fundamental changes to home care that people wanting to heal in their home from illness or injury, or die in their home with respect, need.

The concept of a continuum of service is one worth pursuing. However, the complete dismantling of the existing home care legislation that this bill proposes is wrong, and Bill 175 should be withdrawn. Thank you.

The Chair (Mr. Kaleed Rasheed): Thank you very much. We are now going to start the questions and answers from the government side. MPP Coe.

Mr. Lorne Coe: Thank you, Chair, and through you, thank you all for your delegations.

I have a question for Mr. Tupker, to begin. While this legislation changes how home care is supported, and funded in the back end, it doesn't change the scope of services that patients are able to access. In fact, it expands that by removing service maximums. Do you agree with our decision to maintain the status quo for patients while optimizing the structure of the home and community care system?

Mr. Jules Tupker: As I started off in my presentation, the status of home care right now is brutal. It's terrible. As I said, when we had our forum back in 2014, I heard nothing but people complaining—the residents and the people living in their homes, complaining about missed services, cancelled services, not being there on time, leaving early and not having the proper equipment. If you are telling me that you're going to maintain that, then I think you have a real problem, because being maintained the way it is now is not appropriate.

Mr. Lorne Coe: Thank you for you answer. Chair, through you to MPP Martin, please.

The Chair (Mr. Kaleed Rasheed): MPP Martin.

Mrs. Robin Martin: Thank you for your presentations. The legislation is actually trying to put patients at the centre of home care and address some of the very issues that you have raised. We all know—and you said the whole system is dysfunctional and in need of improvement, Mr. Tupker—that this system has existed for 25 years with legislation brought in by the former NDP government at the time. The legislation put a lot of operational details in and thereby was very difficult to modify and change, in response to changing needs for patients. We certainly do have an increasing number of elderly in our society, and we know—I think 93% was the number quoted of them—that they would prefer to remain at home as long as possible and therefore need the home care to support them.

The purpose of the legislation, really, is to try to maintain the continuity, in the sense of having the same rights as people had in home care before, but also to provide better services that are more responsive to the needs of the patients, and I think we already mentioned not having service maximums as an important one. But we still will have continuity in the sense of having a primarily contracted model, with both for-profit and not-for-profit, and some direct delivery. We hope that this will minimize labour and service disruption, because we know how important it is to keep the continuity of services to patients. Then the government can also continue community support services through this legislation being directly provided by non-profit organizations.

Again, we're going to continue with the self-directed models and have restrictions on fees for home care services other than those permitted by regulation, just as they are now. Clients would continue to have a right of appeal to the health services appeal board. We don't want to take anything away from patients. By the way, providers would continue to be required to have a complaints process, and we'd still have the Patient Ombudsman.

What this legislation is about is enabling improvement in a system I think everyone agrees we need improvement in. So I was wondering if you could tell me, are you defending the existing system—this would be a question for you, Mr. Tupker—which I think we'd all agree is failing our seniors, and if not, then what kind of changes would you like to see to make sure we have a better home care system for them?

Mr. Jules Tupker: Am I defending the current system? No, obviously I'm not defending the current system. If you heard my speech, I was telling you about all the problems that people in home care are experiencing. The system is flawed. I don't see any language in the legislation of Bill 175—

The Chair (Mr. Kaleed Rasheed): Two minutes.

Mr. Jules Tupker: —that says they are going to improve; that's my concern. There has got to be some way of improving that, and I don't see anything in the legislation that says there is going to be more funding. What I see is that the legislation is going to open the door to more privatization. There is not going to be any control. You're saying there's going to be an opportunity to appeal. As I said in my presentation, who do I appeal to? I appeal to the health team which is run by the organization? One of the organizations in the health team is going to be one of the organizations that's providing the service to me. That's ridiculous. It doesn't make sense to me, and I don't see anything in the legislation that changes that.

Mrs. Robin Martin: The appeal would be to providers' complaint processes—

The Chair (Mr. Kaleed Rasheed): One minute.

Mrs. Robin Martin: —but also to the Patient Ombudsman and the Health Services Appeal and Review Board, as it is now.

Carrying on from there, I know you're concerned about the state of our PSW workforce, Mr. Tupker, and so am I. What I think this legislation allows us to do is—along with another initiative such as developing a comprehensive health human resource strategy to support the delivery of personal home care services, we're also looking in this legislation at improving working conditions, improving better scheduling which is so important for PSWs, improving training and new models of care to allow them to stabilize their incomes, because it doesn't matter how much we pay them if they only get two hours a day. The point is to have a full day of work.

The Chair (Mr. Kaleed Rasheed): Thank you so much. Apologies to cut you off.

We're going to go to the opposition side. May I know who is starting from the opposition side, please? If you can just raise your hand, I'll know. Is it MPP Armstrong? Okay. Awesome. Thank you. MPP Armstrong, please go ahead.

Ms. Teresa J. Armstrong: Thank you so much to all the presenters for the information you provided. I wanted to ask ONA: You had talked about the erosion of public accountability, the lack of funding, that there is no HR strategy, and how this bill opens up the expansion of privatization of community care and home care, how service providers are now going to be assessors and how that could be a conflict of interest when they're doing case coordination; and then, of course, opening it up to privatization, and, in effect, that there is no definition for the residential congregate centres. There is a lot in this bill, given most of the details are missing and left up to regulations. How confident are you that the reforms that we need in home care will actually occur under Bill 175?

Ms. Vicki McKenna: Thank you for summarizing, actually, most of our submission. It's absolutely correct. We don't have confidence in the bill as it's laid out. We're very concerned about the lack of transparency and public accountability, particularly when there are often discussions from government about value for money. Those pieces do not seem to be in the bill as it's laid out. The patients' bill of rights absence and the move to regulation is highly concerning to us.

The HHR, the health human resource piece, which I didn't get a chance to get into so much here, but it's certainly in our submission—I heard the government talk about PSWs. PSWs are very much an important part of home care. But the level of care needs in our homes needs registered nurses, registered practical nurses and nurse practitioners.

1430

The government is hyper-focused, I think, a bit much, and should be looking at the needs of Ontarians. When the needs of Ontarians and their health care are clear, then you decide which providers need to be in those homes, and the services.

We're very concerned about the company being the assessor of the needs. And there's the standardization piece: That is missing in that as well. This bill seems to be written as almost a business plan as opposed to patient care. That's very much a concern for us.

On the service cap piece that I think I was hearing about earlier, I'll just say this: The service cap piece and the removal of it seems good, except that it isn't clear that there is funding to support the removal of a service cap, if that's the case, and based on patient care needs, not profit. That is a piece that allows for a whole bunch of flexibility that I'm quite certain that this government—

The Chair (Mr. Kaleed Rasheed): You muted yourself. I think you muted yourself by mistake. Yes, I believe you are muted. I'm sorry. Vicki McKenna, I think you are muted.

Ms. Vicki McKenna: Sorry. There's construction going on around me, and they're digging, so sometimes I lose my computer feed. I'm going to pass it over to Lawrence or Bev to finish, please, because I'm not sure I'm going to have a line much longer.

Interjection.

The Chair (Mr. Kaleed Rasheed): To Bev? Okay.

Ms. Bev Mathers: There. Now I'm unmuted. My apologies.

I think where Vicki was going with all of this is, at the end of the day, the focus seems to be on PSW care. We know that in home care, patients are more acutely ill than they ever have been, and they require RN, RPN or nurse practitioner care in the homes. This can't be done if, first and foremost, there is no reform in home care that deals with the low-paying jobs—

The Chair (Mr. Kaleed Rasheed): A minute and a half.

Ms. Bev Mathers: —no full-time work and poor working conditions that our RNs, NPs and RPNs are experiencing now.

That goes to, as well—one of the key roles at the moment of care coordination is that they provide both initial care planning and assessment of home care patients. They provide that on an ongoing basis based on feedback from the home care providers. They ensure consistency of care across the province and they provide oversight of those home care providers who often simply, because of shortages and retention and recruitment issues, can't actually provide care in homes.

The Chair (Mr. Kaleed Rasheed): Thirty seconds.

Ms. Bev Mathers: Were there additional questions, or would you just like me to carry on?

The Chair (Mr. Kaleed Rasheed): MPP Armstrong, if you have any further questions, you have roughly 20 seconds.

Ms. Teresa J. Armstrong: Okay. Well, then, I'll just wrap it up and thank everyone for their expertise and their discussions around this bill. I can only tell you that the people who have presented today—everyone has very much legitimate concerns around health—

The Chair (Mr. Kaleed Rasheed): Thank you very much for your questions.

Now we are going to move to the independent side. MPP John Fraser.

Mr. John Fraser: I'd like to thank everybody for being here today and for your presentations, and all of the efforts that you put in and all of the efforts that you do to help and care for and represent the people you do.

We began the discussion of the removal of the service cap, which we'd all agree is a great thing. There does need to be money to make that happen. It did strike me that—I'm not sure, given my read of the Connecting Care Act, that that service cap can't be established through regulation. It's just simply being taken out of legislation. So there's no guarantee that that's not going to happen somewhere down the road in a non-legislative process.

One thing I do notice about this bill is that it doesn't establish a service minimum. It doesn't establish a right to service. I would like to ask each of the presenters if they support enshrining a patient bill of rights into legislation, and if they do, what they believe should be in there. We can start with Ms. McKenna.

The Chair (Mr. Kaleed Rasheed): I don't see Ms. McKenna online.

Mr. John Fraser: Or anybody from ONA can answer.

The Chair (Mr. Kaleed Rasheed): She's not there. Bev, do you want to go ahead?

Ms. Bev Mathers: Thank you. The bill of rights needs to be there. It needs to enshrine in place what patients can expect, what rights they have, the minimums, who's paying for what, and the expectations they have when care providers come into their homes.

It's true: At the moment, the system is incredibly fragmented. There are ways to fix the existing system. One of the ways to fix the existing system, and any system in the future, is to move to an all-publicly-funded model, take the for-profit out of the model, and reinvest the money that would have gone for profit back into care. That is a way to pay for upping the service limits. It's also a way to provide and pay the workers who work in this sector, who are grossly underpaid, the appropriate wages so that this could be and should be a desired job and a career. Then, home care patients would move vastly towards the care they deserve.

Mr. John Fraser: Thank you.

The Chair (Mr. Kaleed Rasheed): Next would be Mervyn, I guess.

Mr. Mervyn Russell: Yes, I certainly think that there should be a patient bill of rights. Obviously I'm not closely involved in providing home care, not like the ONA. Also, I speak on behalf of the union of persons who work in that service, so I'm not able to say in detail what kind of items should be included in a bill of rights.

All I would say is that, from my experience of visiting people over many, many years in these situations, very often these persons will need an advocate on their behalf. It will be very difficult for them oftentimes to be their own advocates, and so there needs to be some provision, if there is a bill of rights, for someone, if required—

The Chair (Mr. Kaleed Rasheed): Two minutes.

Mr. Mervyn Russell: I beg your pardon? Yes, okay—to be able to speak on their behalf.

Mr. John Fraser: Thank you.

The Chair (Mr. Kaleed Rasheed): I think now it's Jules.

Mr. Jules Tupker: I agree with both the previous speakers. A bill of rights is important. Again, the minimum standard has to be met, and it isn't met now. A minimum standard has to be established, of some sort, and if that's enshrined, then that's even better.

I'm still concerned about the whole idea of this bill creating more and more private home care. As Bev Mathers has said, privatized—they're just skimming money off the top instead of putting that money into the service that the home care people require.

I'm also concerned that the whole process now is privatized. There is no way for me to be at a board meeting. I used to go to the LHIN board meetings and listen to what was going on, and if I wanted to raise a concern, I could do that. I could write a letter to the editor. I could do all kinds of things to oppose or agree with what the LHIN was doing. That is not available now.

1440

The public has lost all input into the whole process of home care, and that is very troubling. As far as I'm concerned, it's very troubling. It doesn't allow for the public to have input. I still don't think that the appeals process is going to be very worthwhile for anybody making an appeal. Again, if it's as difficult as it is now—most people in home care are older and are not able to do a very good appeals process. I've had experience over the years as a union member, as a union rep. I can do these sorts of things, but a lot of people I know haven't got the ability to do that properly—

The Chair (Mr. Kaleed Rasheed): Thank you very much, and apologies to cut you off. We are now going to go back to the opposition side. If I may know who would like to ask the first question from the opposition side?

Madame Gélinas, please go ahead.

M^me^ France Gélinas: Thank you. I will start with somebody from ONA. I want to focus a little bit on the care coordinators. They have been there for a long time. They know our community inside out. They are the ones who know that on Wednesdays in Dowling, the Lions Club does Meals on Wheels, although Meals on Wheels is not available to that area usually.

What will happen once those positions are not there anymore? How do you seed this knowledge that has been there to use so people stay in their own homes safely? How are we going to maintain this, and what's the risk, on the flip side, of losing it all?

Ms. Vicki McKenna: I'll start—and I might lose my Internet again, so if you can't hear me, then Bev will pick up. That is exactly what we're worried about. We have years and years—decades—of experience in care coordination out there right now. We know their communities, we know the services and we know what's available. We are very concerned, as they are, about what that will do to the community care that they're able to coordinate on behalf of Ontarians.

It's a very important piece. They know the communities. They know the residents who are on ongoing—remember, many of these folks are on ongoing services. We have episodic around hospitalizations, but we have ongoing service provisions for people to allow them to stay in their homes. What we fear is that that won't happen. They won't be able to access the services. Service providers won't know and won't understand their community. They could be coming from a call centre who knows where. That's not okay for us. That's not acceptable. We believe it should be much better than that.

M^me^ France Gélinas: If I go to Mr. Jules Tupker from Thunder Bay, do you have any position on that?

Mr. Jules Tupker: No, I don't think I can add any more than what Vicki has put on.

M^me^ France Gélinas: Okay, thank you. My next question has to do with standardized assessments. I think you were on when I was talking about it. I'm from the northeast. You get assessed, and if you get an 18, you get two baths a week. But if you score 13, you get zero; you don't qualify for home care. But in Ottawa, 13 qualifies you for home care, and at 18, you get a basket of services that meet your needs a whole lot more than two baths a week.

You're from the northwest, Jules. How do you see those differences? Would it be important to address this in this legislation so that we have standardization across the province?

His mike is still not on.

The Chair (Mr. Kaleed Rasheed): No, it's on. It's on.

M^me^ France Gélinas: No, he's muted.

Mr. Jules Tupker: Thank you.

The Chair (Mr. Kaleed Rasheed): There we go.

Mr. Jules Tupker: It's pretty basic. Universal health care: That's what Canada is famous for. Everybody has the same health care, no matter where you live. Clearly, that is not happening. Anything we can do to ensure that everybody has the same health care—it doesn't matter where you live, if it's in Ottawa, Toronto, Thunder Bay or remote communities. Smaller communities have even more problems trying to get the health care that people in larger communities get, so if we can do anything to improve that and standardize that, I'm all in favour of that.

M^me^ France Gélinas: I agree, and it should be in legislation. My colleague Joel is waiting to speak with you.

The Chair (Mr. Kaleed Rasheed): MPP Harden?

Mr. Joel Harden: Thank you, Chair. How much time is left?

The Chair (Mr. Kaleed Rasheed): You have about a minute and 30.

Mr. Joel Harden: Okay. I will just begin by thanking all the health care providers for what you are doing, standing up for your members. There are many nurses in my family. Thank you for standing up for them. Mr. Tupker, thank you very much for being a voice for northwestern Ontario. Mr. Russell, thank you for weighing in today.

I will only just say this: I think that what we can see very clearly from the home care sector is that we've been competing on labour for the last number of decades, and we've allowed this to happen. What I'm a bit frustrated by is that the explanation we've heard from the industry is that the blockage really appears to be nurse coordinators, and the blockage doesn't appear to be organizations that have bid the whole industry down and have been competing on labour.

What's your reaction when you hear industries like Bayshore, for example, earlier, telling us that the blockage we have is with these coordinators and the lack of integration of services? What do you think the problem is?

Ms. Bev Mathers: Hi. I would strongly disagree with that. The fact of the matter is that some of that is about policy within the LHINs itself, in home and community. It's not about the care coordinators. The care coordinators are constrained by the policies in which they work. Our care coordinators tell us all the time that they would like to assess patients and reassess patients and give them the care they deserve, but they are constrained by policies, by upper limits and all of those pieces that we've been talking about already. There is a way to fix it—

The Chair (Mr. Kaleed Rasheed): Thank you so much. Apologies to cut you off.

We are now going to move to the independent member, MPP John Fraser. Please go ahead. MPP John Fraser? Yes, you have to unmute on your side.

Mr. John Fraser: I had my mouse upside down. That's what happens. I had the wire around the end of it. Thank you very much, Chair.

Thanks to everybody again for your presentations. I just want to go back to a comment that Mr. Russell made. I think it's a really critical comment that we haven't heard yet in these hearings, and that's that people need advocates. It's very important. I'm very concerned when people don't have families, or don't have families that are present and able to advocate, or have to do it from a

distance. It's a great challenge. Having been through that ourselves and being able to advocate and knowing how it works and knowing who to call made it a lot easier.

I guess one of the questions that I want to get people's thoughts on is with regard to—there's a removal of the community governance of the health care services that people are receiving, and there isn't, in this bill, any ability for people to appeal. That is taken out of the legislation, so there is no process by which people can say, "I'm being treated unfairly," or "I've been ignored," or "I've got this need, and what they've given me is not enough."

So I would just like to, again, go through everybody in succession of how they presented, starting with the ONA and Ms. McKenna or whoever wants to speak. Could you give me some thoughts on whether you think that that's important to have in this piece of legislation and, if you do, why you think it's important?

Ms. Vicki McKenna: Well, an appeal process, how someone—an individual or a family—could reach out for help, absolutely needs to be there. It's not clear, even though I heard some explanation a few minutes ago about, "Well, you can go to this board or that board." These are lay people, and these are Ontarians. We can't have some complicated, bureaucratic set-up for people to appeal or make issue or appeal for more services.

1450

I can tell you that care coordinators appeal every day for additional services. As Bev just described, policies in the organizations restrict them to saying, "No, they can only have one bath. I know their situation is a bit different, but, no, you can't do that. Our policy says X." That is what is the most frustrating thing, I think, for care coordinators right across this province.

But that's them advocating, let alone people who are afraid to speak out and are fearful that their services would be cut even further, which is what we've heard in some cases. People are afraid to speak out. They accept what is given to them even though it doesn't do anything to improve their health or increase their safety or keep them at home at the end of the day. So, it's absolutely needed, John—absolutely needed, very clearly.

Mr. John Fraser: Thank you very much. Mr. Russell?

Mr. Mervyn Russell: One of the things that disturbs me most about this bill is its lack of accountability—

The Chair (Mr. Kaleed Rasheed): Two minutes.

Mr. Mervyn Russell: Thank you—and that it's not going to have the—well, the present situation, as I understand it, under the LHINs, is that the LHINs are a non-profit body. They are appointed by the government. They are accountable to the government, and I presume care coordinators are accountable to the LHINs, so in actual fact, they, too, are government representatives.

I'm very concerned that this bill, as it were, puts the provision of home care at a tenuous and distant relationship to the Ministry of Health and to the Legislature. It's the Legislature that should be absolutely assessing the contents of home care, and to be able to raise these things in the legislation, put the questions to the minister and so on. This whole process seems to be removed. It's autocratic. I find it to be an exceptional kind of thing, in a liberal democracy, for this kind of set-up to be put in place, quite frankly.

The Chair (Mr. Kaleed Rasheed): Thirty seconds.

Jules? Okay. Thank you very much. I appreciate—

Mr. John Fraser: Have I got 20 seconds left?

The Chair (Mr. Kaleed Rasheed): You have 15 seconds.

Mr. John Fraser: Okay. I'll save it for another time. Go ahead.

The Chair (Mr. Kaleed Rasheed): Okay. Thank you very much.

Next, we are going to move to the government side. MPP Jane McKenna, please go ahead. Your mike should be unmuted.

Ms. Jane McKenna: Through you, my question is for Mr. Russell. Mr. Russell, the purpose of Bill 175 is to make a system that is failing those who need it to be more patient-centred. We're hearing a lot of feedback on privatization on this committee presently. The one thing no one is mentioning is that our family doctors and specialists are private, for-profit businesses. So my question: Personally, I think that medical professions are the most qualified to determine the appropriate level of care for patients. Unfortunately, this is not the case today. Are you not concerned, under the current system, that patients who need care are not receiving it because of administrative bureaucracy?

Mr. Mervyn Russell: Let me try to answer your point from the experience of my wife, Patricia, when she was a home care worker. When she started in the job, it was a low-pay job but, in fact, they had time to be able to give the care that patients needed, and they also got their travelling expenses. When the Harris government came in and the system changed, it become a rotten job because she didn't have the time—you're very limited in time, getting from patient to patient. You are very limited in the time that you could actually give to patients when you were there, and you had your travelling expenses removed. That made it a rotten job, and many people left at that time. It hasn't improved since.

I'm hearing lots of assurances that things are going to be better, but those are simply assurances. They are not things [*inaudible*] the legislation. So we can't be sure of it, and when the thing is handled under regulation, which can be simply implemented by the minister without any discussion in the Legislature, my confidence, I'm afraid, is very low.

The Chair (Mr. Kaleed Rasheed): MPP Martin.

Mrs. Robin Martin: Thank you again for all your comments. It's really useful to hear the discussion. One thing that you said, Mervyn, was that this legislation seems distant somehow and not attached to the Ministry of Health. I guess one of the purposes of this legislation is to directly put home care in the Connecting Care Act, which is our main health care piece of legislation, to make sure that home care is as much a part of health care as any other type of health care. I think it's quite the opposite: It's not

distant in any way. In that legislation, there are enshrined provisions about community engagement, for example, which I know has been a focus of some of the comments.

But I wanted to talk about the importance of care coordination. We think these are critical functions within an integrated care system, and the proposed changes would allow those key coordinated functions to be provided at various points of care within the system. We've acknowledged ONA's concerns on this score. We think that care coordinator providers are dedicated health professionals who provide important services for the clients and they're a necessary part for how our health system operates. We're planning to have this health system transformation preserve continuity of care going forward.

One of the things, though, that we hear quite a bit about from patients—

The Chair (Mr. Kaleed Rasheed): Two minutes.

Mrs. Robin Martin: —and I think Madame Gélinas also asked about this—is how assessments can be very difficult for patients, because the patient who's going to receive home care has an assessment at the point of care, at the LHIN care coordination table or in talking to the LHIN care coordinator at the service provider organization, and then again with the person providing the care. So, in a sense, they're having to tell their story four different times. I know when my own mother went through this, it was very confusing and disorienting to have to keep repeating everything over and over again. I wondered if you had any comments about that, Mr. Tupker?

Mr. Jules Tupker: Well, what can I say? If you have to explain your story three or four times, it becomes a problem. If there's some way of coordinating that, I think it would—

The Chair (Mr. Kaleed Rasheed): One minute.

Mr. Jules Tupker: —certainly improve. Again, it's a tough situation, and if there was coordination, then that would solve that problem. I'm only thinking—

Mrs. Robin Martin: Sorry. I was just going to say that one of our objectives is to embed that care coordination within the Ontario health teams, within hospitals, for example, so that before you leave the hospital, it's already set up that your home care will be coming on a certain day and what you'll be getting, so you don't have to wander off and wait and hope someone shows up.

Mr. Jules Tupker: Well, I'll have to take your word for that. I don't know that that can be done. I don't know that I have that much faith in the government to enable to have that done. I've been doing this work for many, many years after my retirement, and I've had promises from governments to improve things and—

The Chair (Mr. Kaleed Rasheed): Thank you very much. My apologies to cut you off.

Thank you to all the presenters, the group for 2 p.m.

ARCH DISABILITY LAW CENTRE

HOME CARE ONTARIO

The Chair (Mr. Kaleed Rasheed): Now I am going to welcome the group presenting between 3 and 4. I will now call on the ARCH Disability Law Centre. You will have seven minutes for your presentation. Please state your name for Hansard, and you may begin.

Ms. Hina Ghaus: My name is Hina Ghaus, and I'm here with my colleagues Gabriel Reznick and Dianne Wintermute from ARCH Disability Law Centre. ARCH is an Ontario-based specialty legal clinic that is dedicated to defending and advancing the equality rights of persons with disabilities. We are pleased to have the opportunity to present our recommendations on Bill 175 today.

1500

Bill 175, if passed, will repeal the Home Care and Community Services Act, also known as HCCSA, and its regulations. In its place, Bill 175 will shift some fundamental elements of HCCSA into regulations under existing laws. This shift is problematic and concerning for at least two reasons.

First, regulations are intended to be a vehicle used to fill in details of a statute. They're not meant to address entire and fundamental aspects of that statute, which is what Bill 175 would do. Second, the content of regulations can be altered without the oversight of the Legislature. Given what is at stake, this can significantly contribute to a lack of oversight and transparency. Recommendation 1 is that fundamental aspects of Bill 175 be addressed comprehensively in the legislation rather than be left to regulation. These aspects could include, but are not limited to:

—the scope of services;

—consumer eligibility for services;

—eligibility of service providers;

—content and assignment of care coordination functions;

—a consumer bill of rights;

—consumer complaints;

—procedures for addressing consumer complaints; and

—appeals to the Health Services Appeal and Review Board.

Now I'm going to expand on two of these fundamental aspects just listed. If Bill 175 is passed, detailed expectations of care coordination functions are left to be outlined in policy. Care coordination functions are central to the delivery of services and at the heart of many barriers and difficulties that consumers experience in this sector, for example, developing and updating a consumer service plan and managing issues and delivery. Moving such essential parts of services to policy is alarming, because having a large volume of agency-specific policies creates the risk of inconsistency and unpredictability. Our recommendation 2 is that details on expectations in care coordination must be identified under legislation and/or regulation, but not left to policy.

Care coordination functions are also going to be the responsibility of health service providers, who have the

discretion to assign care coordination functions to contracted providers or partner organizations. Ambiguity around what kind of oversight these contracted agencies will have, if any, is distressing to consumers about the standards and conditions in these places. Recommendation 3 is that all health service providers that are responsible for care coordination functions have strict reporting requirements where they must report to the ministry and/or the Ontario Health agency on prescribed areas.

Next, the bill of rights, which is currently found in subsection 3(1) of HCCSA, is proposed to be moved into regulations as well. The bill of rights is an essential element of the current legislation and of utmost importance to consumers. This is evidenced by the fact that the current legislation explicitly states it "shall be interpreted" to advance the objectives of the bill of rights. Our recommendation 4 is to ensure that the bill of rights is enshrined in the legislation, rather than regulation.

The Chair (Mr. Kaleed Rasheed): Sorry, who is the next speaker in this group? Is it Gabriel? Please go ahead.

Mr. Gabriel Reznick: Thank you. With the repeal of HCCSA, a number of key provisions and safeguards that were in this act have been omitted from Bill 175 in its amended legislation. Effectively, these omissions will result in less-than-adequate oversight of agencies and organizations that provide home and community services.

Bill 175 is silent on the importance of consumer preferences based on ethnicity, language and cultural factors. For services to be effective for persons with permanent mobility disabilities, it is critical that these services be provided in accordance with an individual's preferences, this especially so, given the very personal nature of services provided. ARCH's fifth recommendation is to amend the Connecting Care Act to include a revision which specifies that individual preferences are protected, as in subsection 1(d) of HCCSA.

We understand that the majority of professionals who provide services in the home and community setting do so in a caring, appropriate and compassionate way. We also know that from time to time, services may be less than professional and, on occasion, consumers are subject to abuse. Unfortunately, there is a long and—

The Chair (Mr. Kaleed Rasheed): A minute, 30 left.

Mr. Gabriel Reznick: —well-documented history of individuals with disabilities being subject to abuse. As such, ARCH has grave concerns that section 26 of HCCSA, which speaks to the prevention, recognition and dealing with abuse, is nowhere to be found in Bill 175 or its attached regulations.

Our sixth recommendation is for a provision on prevention of abuse and neglect policies to be incorporated into the Connecting Care Act. The tragic circumstances that this province has just witnessed in the long-term-care sector—the COVID-19 crisis—remind us of just how critical it is that organizations entrusted with the delivery of personal services need to be properly equipped and competent to deliver those services.

At the heart of this issue is the need for proper oversight and protection. HCCSA, at section 5(1)(ii), speaks to the issue of oversight by mandating service providers to exercise "competence, honesty, integrity and concern for health, safety and well-being of the persons receiving the service." These critical elements are completely absent in Bill 175 and the Connecting Care Act. ARCH's seventh recommendation is that this omission must be corrected by introducing a section similar to section 5(1)(ii) of HCCSA into the Connecting Care Act.

Throughout these submissions, ARCH has flagged some issues in home and community services that must be addressed when reviewing Bill 175. Please note that our detailed legal analysis and written submission is forthcoming, with additional recommendations.

The Chair (Mr. Kaleed Rasheed): Thank you very much for your presentation, and my apologies to cut you off.

We are now going to move to our third presenter, Home Care Ontario. Sandra is not here yet, so we are just going to go ahead. I would ask Home Care Ontario to please go ahead. You will have seven minutes for your presentation. Please state your name for Hansard, and you may begin.

Ms. Sue VanderBent: Good afternoon. My name is Sue VanderBent, and I'm the CEO of Home Care Ontario. Joining me is Janet Daglish from Bayshore HealthCare. We're here representing Home Care Ontario, which is the voice of home care in Ontario. My members are at the front line of home care delivery. They provide millions of hours of care to loved ones across Ontario every year and employ more than 28,000 staff who provide high-quality home care to over 350,000 Ontarians. It's our pleasure to be here with you today to give you our feedback on Bill 175. This is a pivotal piece of legislation which will support the provincial home care system and the new Ontario health team sector.

The Minister of Health has been a strong advocate for transformation in our sector, and we support the transformation efforts. Today, a strong home care system is even more important due to COVID. What we learned during the pandemic and what we continue to learn is that your home is the safest place for you to be. That is why we believe home care is the safest choice and it is an important [*inaudible*] system to transform itself to support.

We welcome Bill 175, and we do have some significant suggestions to improve and clarify the current legislative approach in a few specific areas. We're proposing amendments we believe are essential, and we respectfully urge you to address at committee, to ensure the stability of home and community care going forward. Specifically, the areas we recommend you address are: (1) removing potential conflicts of interest for health service providers; (2) inserting key definitions that are currently missing; and (3) clarifying the ability to contract for home care services. Before I talk about these suggestions, I would like to go over many of the positive things that we believe will come out of this bill.

First of all, we collectively worked with the Ontario Hospital Association, the Ontario Community Support Association and representatives from primary health care

over the past year to look at what our vision of a modernized home care system would look like. We believe much of what our colleagues support takes us to our shared goal.

1510

First, the new bill would allow all health care providers to work directly with one another to offer quality, coordinated care. This is a critical and much-needed step. Second, it eliminates the current practice of patient service maximums, with the new goal of ensuring patients receive the right level of care in order to stay safe and stable in their own homes, up to and including end of life. Third, the legislation takes steps to redefine the role of care coordination, which will help reduce unnecessary duplication in the system and greatly improve the patient experience. Finally, the legislation would also give patients the ability to access their own care and have their care plan accessible to everyone in digital format.

The three areas we think need to be addressed are: removing potential conflicts of interest for health service providers; inserting key definitions that are currently missing; and clarifying the ability to contract for home care services.

For number one, we recommend that current publicly funded home care services must be contracted, as the LHINs in the current arrangement act as custodians of public funds. However, with the creation of Ontario Health and the teams, Bill 175 is expanding the definition of "health service provider" to accommodate these new organizations and the way that health care will be delivered. Bill 175 also proposes that health service providers can deliver home care services directly, and this is problematic. We believe health service providers are meant to act as custodians of the public purse and provide the appropriate oversight of public funds. They should not be permitted to directly deliver services.

Second, the regulatory summary the government issued this spring [*inaudible*] indicated a number of definitions that would be laid out in legislation. These include a new umbrella definition of "home and community care services," as well as two subcategories of "home care services" and "community care services." These definitions are foundational and must be included—

The Chair (Mr. Kaleed Rasheed): Two minutes.

Ms. Sue VanderBent: —in the Connecting Care Act. They cannot be left to regulation.

Further, we recommend the new categories of "home care services" and "community care services" also be defined in the act.

And finally, the government has stated its intention for home care to continue to be primarily a contracted service. However, Bill 175 gives no direction on this fact. We recommend the bill specifically state the government's intention to keep home care as a contracted service.

Thank you very much for having us here today. Bill 175 is a pivotal and crucial piece of legislation, and with these amendments, Bill 175 will help establish a modernized home care system for the 21st century. Thank you.

The Chair (Mr. Kaleed Rasheed): Thank you very much for your presentation. The opposition side for questions and answers: MPP Armstrong, please go ahead.

Ms. Teresa J. Armstrong: Thank you so much. I wanted to ask a question to ARCH. You had pointed out some very, very serious concerns with respect to the abuse portion and the honesty and integrity portion that were in the HCCSA, now that they're not in there any longer in the new legislation. Can you please speak to and stress how important you feel about that, and what kind of negative impacts it can produce when these protections aren't there for consumers?

Ms. Hina Ghaus: If you could unmute all three of us, please.

The Chair (Mr. Kaleed Rasheed): Please unmute Hina, Gabriel and Dianne. Thank you.

Ms. Hina Ghaus: Perfect.

Mr. Gabriel Reznick: Perfect. In speaking to prevention of abuse, this is significantly important. This provision ensures that individuals receiving services are protected, and not only protected and prevented from receiving abuse, but also when abuse occurs that there's a system in place to deal with that abuse. There's many stats that have been done, many statistics, that have shown that individuals receiving services, individuals in the disability community in general, have a higher probability of being subject to abuse. It's important that such a section be included to ensure that this important aspect is remembered and is heralded in legislation. By removing it, it just appears the government is avoiding such an important provision that protects the rights and the individuals receiving these services.

That's echoed, as well, with the competence, honesty and integrity piece. We have had many clients who have had serious problems with the way services are provided. This provision just ensures that—and to be clear, section 5 in HCCSA outlines that the ministry approves agencies as long as they meet certain criteria. One of the criteria they have to prove is they can provide services of competency, honesty and integrity. It's important to ensure that oversight of the government ensuring that agencies provide these services in a way that meets these criteria, mainly to ensure that individuals are treated respectfully and that they're given the ability to be independent in society.

Ms. Teresa J. Armstrong: Okay. Do you think that this is maybe an oversight on the government's part, and we can strongly petition them to put those things back in in order to make this legislation protect consumers?

Mr. Gabriel Reznick: Yes. I believe that it is possibly an oversight. These are really important provisions. I don't want to assume that the government's goal is to not prevent abuse or not ensure competency, honesty, integrity in providing services. But I want to just ensure that these provisions are included, as when HCCSA was removed—HCCSA was a stand-alone bill. The Connecting Care Act, as Ms. VanderBent put it, is going to be integrating the entire system, and so, maybe in doing so, they missed some very, very important points about ensuring recipients

of home and community care services are protected, and these should be included in the bill.

Ms. Teresa J. Armstrong: Great. I believe that France is going to ask the next question.

The Chair (Mr. Kaleed Rasheed): Madame Gélinas, please go ahead.

M^me^ France Gélinas: You made a point of saying that it is important to have the patients' bill of rights in legislation rather than in regulation. Could you tell us why it is important that it be in legislation, not regulation?

Ms. Hina Ghaus: Absolutely. The consumer bill of rights, what it essentially does is it lists about nine rights that all consumers who receive services from all of these service providers have. HCCSA, as it currently stands, also says that these rights are enshrined in every single relationship with a consumer and a service provider. So that gives the ability to a consumer to be able to enforce their bill of rights either through court or some other process—tribunal—and so, moving the bill of rights to something like regulations decreases that protection for consumers.

What it also does is that any input or public consultation that may be done in order to develop the bill of rights could be deemed moot because regulations can be changed in a different way than legislation, where they don't have the same oversight of going through legislated officials or even the public being aware of these changes occurring. Those are some of the reasons why it's really important to bring the consumer bill of rights back into legislation rather than pushing it farther away into regulations.

Ms. Dianne Wintermute: And if I could just add—

The Chair (Mr. Kaleed Rasheed): One minute.

Ms. Dianne Wintermute: —it's a legal recognition that consumers of home and community services are the focus and are rights-bearing persons under the legislation. To shift it to regulation is to take away the protection of the bill of rights and to leave consumers of services without any kind of enforceable rights or responsibilities.

1520

M^me^ France Gélinas: Thank you.

The Chair (Mr. Kaleed Rasheed): Thirty seconds.

M^me^ France Gélinas: Oh, I do? Okay. My next question, then, has to do with care coordination. You talked about the inconsistency by moving it to policy. Where would you like this to be, and what would you like it to look like?

Ms. Hina Ghaus: We're okay with care coordination being both in legislation and the details being outlined in regulation. The concern is moving it into policy. When it's agency-specific policy, there are inconsistencies, there—

The Chair (Mr. Kaleed Rasheed): Thank you so much. Apologies to cut you off.

Next, we are going to move to the independent member, MPP John Fraser. Please go ahead.

Mr. John Fraser: Thank you, Chair, and I thank everyone for being here today and for your really very thorough presentations.

I would like to go back to the bill of rights and just understand, very clearly, what I think I've heard in this round. The bill of rights is something that should be enshrined in legislation because there are basic fundamental rights that, while they may not be immutable, they should be permanent. I'd like to not just get your thoughts on that, but I know there are nine pieces to the consumer bill of rights. Is there anything else that you think should be in that bill of rights in the legislation? That's for anybody in ARCH who would like to answer that question.

Ms. Hina Ghaus: Yes, absolutely, we do think that the bill of rights does need to be expanded. But ARCH Disability Law Centre always defers to the disability community and consumers in this aspect. So we would recommend that there be public consultations in order to determine what else should be enshrined in the bill of rights. I know the regulations mentioned that there would be public consultations, but the dates were prior to when COVID hit, and that kind of put everything on hold. So we do recommend that a new public consultation be opened up as to expanding the bill of rights and addressing issues that are key to the community themselves.

Mr. John Fraser: Yes, and I guess the overriding concern, too, is that regulations can be changed pretty darn quickly.

Ms. Hina Ghaus: Mm-hmm.

Mr. John Fraser: I know that people can say, "Well, we can expand it more quickly," but you can also diminish it more quickly as well.

I want to thank you for your presentation, especially around the provisions regarding abuse. I think that is definitely an oversight—I would hope an oversight—on the government's part, in terms of this piece of legislation. I think the bill of rights is as well. So I want to thank you very much.

My next question is for Sue and Janet; nice to see you again. I want to actually go back to the last round of questioning, when we were talking with regard to the ability to appeal the services that you're getting, whether it's the access to those services or the services themselves and people knowing where to go to. It's not very clear in this bill—actually, it's not in this bill—as to how that's going to work.

I can remember, when I had the good fortune to do about 16 consultations with regard to palliative care, I heard consistently in home care that this was navigation and the ability to reach someone or a body to enable you to get what you need for your client or the person you're caring for. I heard this repeatedly from people who were involved in health care—people who were nurses, nurse managers, sometimes physicians—that it wasn't very clear. So we know that there's a challenge in the system for that. What it seems like is that we're not actually even removing what was there. Can you tell me what you think we need to do to ensure that people have an ability to have a right of appeal when it comes to decisions that are being made about their care by agencies and by health teams?

Ms. Janet Daglish: Thank you, MPP John. We want to reinforce that we believe that Ontarians have the right to access home care. It's critically important, and I think

that's something that needs to be reinforced as a health system. We believe that patients should be able and have the right to be able to receive those services where they live, in virtual or in person, 24/7. That is absolutely what we're reflecting in reviewing this legislation, but we want to reinforce that the role of home care should be a first choice. Currently, about 90% of our referrals for home care services come through the hospital, and 10% come from community. We would like to see a total flip to that, so that seniors have the ability to choose to stay at home, remain at home and not have to go to the hospital in order to access home care.

The Chair (Mr. Kaleed Rasheed): One minute left.

Ms. Janet Daglish: That places them at risk because once they're in the hospital, they may or may not be able to be discharged. So having the ability to support access, but also to support that patient and their family across their care journey, is critically important. They want to remain at home.

Mr. John Fraser: Thank you very much. Thank you, Chair.

The Chair (Mr. Kaleed Rasheed): Thank you so much. Now we are going to move to the government side. MPP Jim McDonell, please go ahead.

Mr. Jim McDonell: Thank you, Chair, and thanks to the deputants for their deputations. When we talk about the need for change, the need for allowing people to have choice—and I see that we've eliminated the need for service maximums to help patients and care providers in the home care sector. So maybe some comment from Home Care Ontario just on the benefits of eliminating those maximums and some of the directions you'd like to see it go.

Ms. Sue VanderBent: I'd be happy to do that. Thank you very much for that question.

The elimination of maximums allows the sector, both the home care provider and the funder, to work together to make sure people get the care they need, not a specific maximum. Maybe that's a half an hour of care or 15 minutes of care or whatever that care is. It's too short a time, generally speaking, to give people enough care so that they don't have a fall or are cared for properly. So eliminating the service maximums just really gives us an opportunity to make sure that the patient is safe and stable in the home. Similar to what Janet said, we're confident that the patient and the family, who provide the majority of the care, have a good sense of what they need and they can work with the care provider, the service provider, that's in the home to determine those levels.

We need to cut away a lot of the bureaucracy that currently exists in our system. This bureaucracy doesn't add a great deal to the patient experience, and we've seen that many times in different reports, most notably the Donner report, Bringing Care Home. So the removal of these maximums helps us as a system to be more responsive to the needs of patients and their families to keep their loved ones at home, where they want to be.

Ms. Janet Daglish: Sue, just to add to that, I think it's critically important to recognize that we have a vision to move away from this transactional nature of home care to one that is really focused on what the patient and family needs are. The only way to do that is to have the patient and the family driving the articulation of what their need is. We have examples where we send our PSWs into support with personal care with a patient who is experiencing dementia, and they may only be allowed 15 minutes to get in and provide that care. The patient needs time and does not need to be received based upon the transactional allotment that a care coordinator is provided. We need to be more respectful of Ontarians and be able to better support our seniors to be able to remain safely at home.

1530

Mr. Jim McDonell: You talk about the flexibility. Maybe you can comment on the benefits of redefining the role of care coordination and removing the requirement for formal reassessment, allowing the care coordination role to be embedded in the Ontario health teams.

Ms. Janet Daglish: There's a significant—sorry, Sue. You go.

Ms. Sue VanderBent: I'll start, and maybe Janet can take the perspective from the service provider. But the assessment process has become unnecessarily complex. In fact, in other parts of the health care system, there are much cleaner and leaner assessment protocols that can be used, and can be used by the service providers. These are algorithms that are tried and true—

The Chair (Mr. Kaleed Rasheed): Two minutes.

Ms. Sue VanderBent: —tools are well known. It is to the patient's benefit to assist a service provider in the home to support that assessment. We believe that is something that should be instituted in our new system.

Janet, over to you if you want to add anything.

Ms. Janet Daglish: Care coordination has become a methodology for allocating resources. What real true care coordination is is more what I would call system navigation. Supporting a patient who is challenged with respect to more of the socio-economic factors such as housing, they need some supports that are outside of the health system. That's where a value comes forward in helping these Ontarians who may be challenged in having other access to services that, combined, help to create better outcomes on that individual level. That's where the need for focus should be, and again, very patient-centric and making sure the family is included in that review. But care coordination from an assessment perspective best sits under the regulated professional practice of those individuals who are actually providing the care.

The Chair (Mr. Kaleed Rasheed): Thirty seconds.

Mr. Jim McDonell: Just quickly then, do you see this legislation reducing the red tape and empowering providers to play a strong role in health care?

Ms. Janet Daglish: That's certainly our vision and we would align that we believe that that is the vision of this legislation.

Ms. Sue VanderBent: I would agree with that.

The Chair (Mr. Kaleed Rasheed): Much apologies to cut you off. We are now going to go to the independent

member, MPP John Fraser. MPP John Fraser, is your camera off?

Mr. John Fraser: Okay, I'm good. Thanks. My Internet went down, so I had to sign back into the meeting. My apologies for delaying, Chair.

A quick question for both presenters, and anyone from any organization can answer this question. Are you aware that, as we fold this act into the Connecting Care Act, in terms of a governance change—which is ceding the governance for all this care to the super-agency Ontario Health and the minister—that that minister, through that board, has the ability to close, amalgamate or direct any service in Ontario with 30 days' notice and no right of appeal? What do you think about that? And is there anything that we should do in this piece of legislation to address that? Thank you.

Ms. Sue VanderBent: Janet, I'm going to defer to you as a service provider at the front line in terms of the amalgamation question.

Ms. Janet Daglish: Okay. Thanks, Sue. It's a very good question, and thank you for asking.

We believe there is a need, and this is the time for change, for home care to be at the forefront as an essential service within our health system. We do have quite a bit of trust that this is the shared vision across the health system. We do believe that there is a need for more collaboration in order to support a patient and family journey across a complex care experience.

We need to all be fully aligned on what that positive patient experience needs to be. How we work together is outlined in the Connecting Care Act, and we do believe that integrated service delivery networks, also known as Ontario health teams, do share that grassroots opportunity to unite locally in bringing the systems and services together in the best way, as guided by the Quadruple Aim. And we do fully align for the need of a strong evaluation framework to ensure that all members of the care team are held accountable for the level of quality of care that is delivered to Ontarians.

Mr. John Fraser: Thank you.

The Chair (Mr. Kaleed Rasheed): MPP Fraser, do you have more questions? You have about three minutes.

Mr. John Fraser: I was going to refer it to ARCH as well. That was to both presenters.

The Chair (Mr. Kaleed Rasheed): Sorry, so—

Mr. John Fraser: The question was to both the presenters.

The Chair (Mr. Kaleed Rasheed): To ARCH Disability as well.

Ms. Dianne Wintermute: Thank you. We do agree with many of the comments that Sue and Janet have made. But one of the things that we want to emphasize is that many of our clients receive services at home and are not hospital patients or are not in acute or chronic care facilities. We want to make sure that that community of persons is not left behind.

One of the things that isn't clear to us is the government's introduction of what are now called congregate care settings. That creates quite a concern that we will expand on in our written submissions—

The Chair (Mr. Kaleed Rasheed): Two minutes.

Ms. Dianne Wintermute: —but I also think needs to be acknowledged in Bill 175 itself. Patients are not consumers of services and consumers need to be able to direct and control their own services and support so they can participate in the community as the rest of us do.

Mr. John Fraser: Thank you very much.

The Chair (Mr. Kaleed Rasheed): Now we are going to move to the government side. MPP Rudy Cuzzetto, go ahead.

Mr. Rudy Cuzzetto: Good afternoon and thank you, all. I was fortunate to have my mother live at home until the age of 90, and she only had home care come in a few times at that point. She died six days after her 90th birthday. Unfortunately, I lost my father when I was 18, so having [*inaudible*] in my home was really important to me.

This bill is designed to allow health care providers, including those in primary care, hospital, and home and community care to work directly together. How will Ontario benefit from home care being better integrated with other parts of the health care system? This question will be for Sue.

1540

Ms. Sue VanderBent: Thank you very much. For us to be able to work with other parts of the system is critical. I can give you a short example. A good place to talk about that is with palliative care. In a palliative care situation, where we hope to see many, many Ontarians end their days at home—because that's what they say they want to do, to end their days at home—we need support from the whole system, really. We need all of our home care staff, with all the different therapies and the different staff who would support that person.

We need virtual care so that the system knows what's happening to this patient. We need primary care so that family doctors are very, very involved in the process. We need access to any specialist care or any other community support care that is coming in to support the family. The family feels well supported in a palliative death when everybody in the whole system is involved.

This is a goal that I think the system that we're trying to create would aspire to. We have to make sure that anybody who chooses to end their lives at home has a good experience, and generally that's when we have our family around us and we have our pets. We want to have an end-of-life experience that is not crowded and rushed and institutionalized.

In order to do that, we have to be focused on a full patient experience that really supports the involvement of all of their care providers, whoever they might be. That, I think, is a real goal, hopefully, of our new system so that people aren't ending their days in a rushed ER visit and up to a medical bed where they spend maybe the last two weeks of their lives separated from their families. It's a vision, and I think it's something that other countries do very well and we could do a whole lot more of.

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

Mr. Rudy Cuzzetto: I just want to say one thing that is still in my head. My mother always used to say: A mother can watch five children, but five children cannot watch a mother—and it's true.

I'll pass this on to Sam.

The Chair (Mr. Kaleed Rasheed): MPP Sam Oosterhoff.

Mr. Sam Oosterhoff: Thank you all for your presentations today—a lot of very interesting perspectives. I really value the work that you all do in the sector as well.

I wanted to ask a little bit about the digital aspect. We're seeing, more and more, the changes that have been in place in home care and in every aspect of health care—primary care as well—in the last couple of decades. One of the intents with this piece of legislation is to validate that and make sure that we have in place a recognition of the role that digitization and technology play in providing health care. Could you speak to that, and perhaps provide perspective on where you think we should be thinking of what's coming ahead of us? It's hard to see the future of course, but 20 years ago we couldn't necessarily have predicted how far we could go in that place.

What can we do to break down some of the barriers that perhaps prevent people from being able to access care through digital means or prevent providers such as yourself from being able to be engaged in that? To Sue maybe, or Dianne. Anybody, really.

Ms. Janet Daglish: Sue, you're on mute.

Ms. Sue VanderBent: Right now, the home care provider—I'm going to let Janet speak to this as well—cannot view or contribute to the patient record. This is a glaring problem. It means that if the person has been to their family doctor in the afternoon and has had something changed in terms of their treatment, their medications—when the home care nurse gets there at night, she may very well not know what has happened because we do not have a digital aspect to our care and, as a result, may not be able to care for that patient. This would be corrected if we were able to view and contribute to the patient record.

As home care becomes more and more extensive and we begin to use it more in a transformed and modernized—

The Chair (Mr. Kaleed Rasheed): Thirty seconds.

Ms. Sue VanderBent: —we need to be a part of that digital support.

Janet, I don't know if you have any other questions or comments.

Ms. Janet Daglish: Sure. Thank you very much, Sue. I think that's a really strong point. This legislation identifies the possibility of being recognized as a health information custodian. So we're in full agreement, and thank you very much for understanding that. We now need—

The Chair (Mr. Kaleed Rasheed): Thank you so much, and apologies to cut you off.

We are now going to move to the opposition side, I believe MPP Joel Harden. Please go ahead.

Mr. Joel Harden: Thanks to the presenters for their contributions this afternoon. Hello to friends from ARCH Disability legal. I'm going to ask most of my questions, though, to folks from Home Care Ontario.

I'm just mindful, as we've been talking about this bill today, we've made reference to lessons learned from COVID-19. One particular one that rings true for us, and certainly for me as the party's disabilities and seniors critic, is some of the problems we've built up over time—and we've had an itinerant workforce, a lot of folks working small contracts, going from place to place, and often not being paid between those visits. That's been a shift in the sector.

My first question for you is, can you reflect on whether or not it's worth, as an industry, with a piece of legislation like this, making a shift where front-line care workers are paid on a shift basis? We're eliminating maximums or minimums, but what about making sure that care workers can string together a comparable day, a full shift, to make sure that they're not piecing together 15- or 30-minute increments, so they're not rushed between patients but, importantly, they can be well remunerated by working for a small amount of people? That would certainly help us contain the spread of an awful virus like what we're facing today. What do you think?

Ms. Sue VanderBent: I think that's an excellent comment, and it's something that the sector has been advocating for with government—and I think they are hearing us—that we need client-partner scheduling. We need to be able to put in those shifts of care to individuals, to develop long-standing relationships—

Mr. Joel Harden: Pardon me. Just so I'm clear, your colleague Linda Knight from CarePartners, in a labour dispute in 2019, insisted upon the workforce that they actually had to give up a lot of their travel grants. They lost. For many personal support workers that I'm familiar with, given the reporting from the time, they went down from a $5,000 reimbursement over a six-month period to a $1,200 reimbursement, because the employer, in that case, was insisting on a piecework process for the remuneration of PSWs.

Are you saying, as the representative for home care operators in Ontario, that we should be moving to a salary-based model where PSWs and front-line staff are paid well for working with relatively few clients?

Ms. Sue VanderBent: What I was saying was, we need to—and from a patient-centred perspective—look at creating blocks of time and shifts of time that support patient care. That also contributes to PSWs, mostly PSWs who would be there for long periods of time with a patient, to support them in terms of not having chunked-up days where they—

Mr. Joel Harden: Okay. I'm going to interpret that, with all due respect, because I don't have a lot of time, as a yes. We need to work towards meaningful, full shifts and meaningful time with patients.

I also want to note that the Auditor General's report from 2015 mentioned that only 72% of resources that are being transferred from the public to, often, for-profit providers are being used in direct care. That's something

that troubles me a great deal, when administrative capacities are being reproduced. In our conversation today, there's been a lot of talk about care coordinators and a lack of integration services.

But what I read the Auditor General as saying, four years ago or five years ago, is that there's a lot of repetition of services among for-profit providers that are redoing administrative costs and wasting it. We have seen, from the Auditor General's report, a lot of money in paying out either dividends to shareholders or in administrative costs.

Earlier, I asked the president of Bayshore, Sue, if he would be willing to disclose what Bayshore as a corporation pays out in administrative costs and salaries to executives in its organization. Is that something you would support in this bill, mandatory disclosure of full administrative costs and executive compensation?

Ms. Sue VanderBent: I have read the Auditor General's report, and it certainly speaks to issues related to executive compensation. On page 22, it goes into that in a fair degree of depth. So that's—

1550

Mr. Joel Harden: So is that a yes? Would you agree to that full financial disclosure?

Ms. Sue VanderBent: I think that gets into a whole discussion—

The Chair (Mr. Kaleed Rasheed): Two minutes.

Ms. Sue VanderBent: —bifurcated answer. Sorry.

Mr. Joel Harden: Well, no, but I think the people of Ontario, after decades of moving in a certain direction in delivering this care—we went through the managed competition model. Many for-profit organizations outbid public organizations competing on labour—competing, basically, on the most expensive part of the business, which is labour. So I think people in Ontario, certainly people with disabilities and seniors, deserve to know how much an organization is spending on administration and executive compensation. Do you agree?

Ms. Sue VanderBent: I think that's something that I would have to, respectfully, say—again, the Auditor General's report was not as black and white about that as you suggest. I'm happy to talk more about it. It's not a direct—

The Chair (Mr. Kaleed Rasheed): One minute.

Mr. Joel Harden: I'm going to take that as a no, which is too bad because I actually think there's a lot of great for-profit operators out there in home care, many of whom would be happy to disclose how much they spend on administration. I think some of the larger operators, like Ms. Knight at CarePartners, should be doing the same.

The one thing—

Ms. Sue VanderBent: If I could add to that—

Ms. Janet Daglish: I could add to that—

Mr. Joel Harden: No, I'm sorry; I'm in the middle of formulating a thought. Something that MPP Cuzzetto talked about and my friend from Stormont–Dundas–South Glengarry, my neighbour, talked about was reducing red tape. I have to say, every time I hear my friends in the Conservative Party talk about reducing red tape, I worry about the working conditions of folks in the home care sector and I worry about the living conditions for seniors. We've seen in the OMNI report, we've brought forward measures to this government, asking for them—

The Chair (Mr. Kaleed Rasheed): Thank you so much. My apologies to cut you off. We are done with this set of presenters this afternoon, so thank you.

UFCW CANADA LOCALS 175 AND 633

ALLIANCE FOR HEALTHIER COMMUNITIES

HAMILTON AND DISTRICT LABOUR COUNCIL

The Chair (Mr. Kaleed Rasheed): Moving on, I welcome the presenters who will be presenting between 4 p.m. and 5 p.m. I will now call on the United Food and Commercial Workers Canada. Also, just to mention here that since we no longer have the independent members, the Q&A timing will increase from six and a half minutes to nine and a half minutes for each recognized party, and it will be done in both rounds. So the official opposition will have nine and a half minutes to ask Q&A for both rounds as well as the government side.

United Food and Commercial Workers, you will have seven minutes for your presentation. Please state your name for Hansard, and you may begin.

Mr. Tim Deelstra: Thank you, Chair. My name is Tim Deelstra. I'm the engagement and media relations strategist for UFCW Locals 175 and 633. Good afternoon, committee, and thank you for this opportunity to present.

UFCW Locals 175 and 633 is a union which represents over 70,000 workers, from every workplace sector in Ontario, including retail, industrial and health care. On behalf of the more than 700 members of Local 175 who work in home care, I'm pleased to appear before you to take this opportunity to address the union's thoughts on Bill 175.

In general, my union is concerned with many aspects of the bill and believes it should be withdrawn by the government. Our members in home care have been on the front lines during this pandemic. We are proud of the exceptional job they have done to take care of Ontario's population. Our members in home care work hard to care for our loved ones, friends and neighbours in their own homes and in congregate residential settings, work which has always been important and valuable. In this world of COVID-19, the ability for people to receive care at home seems all the more valuable now that the devastating impact the virus has had on congregate care settings, such as retirement and nursing homes, is apparent.

UFCW Locals 175 and 633 believes Bill 175 is extremely problematic. It will result in major restructuring of the home care industry, significantly reducing oversight, creating a new tier of residential congregate care and opening the door for further privatization efforts. We are particularly concerned with the following aspects of the bill.

The move away from LHINs to a new super-agency model, Ontario Health: This will result in far less transparency for the public as there appear to be no requirements for the board to take public input, have open meetings and have publicly accessible information. The board of Ontario Health also appears to be exempt from conflict-of-interest regulations and seems to have a significant amount of members who are drawn from private interests. Decision-making around the contracting of services, currently handled by the local health integration networks, will be transferred to an array of different organizations, possibly including the Ontario health teams or primary care agencies, with little structure or oversight. Funding decisions not only impact services offered, but have a direct impact on the livelihood of our members, making it crucial for us to understand how decisions are made. This system will result in a confusion of regional differences in terms of different entities using different models to determine what services are offered.

The creation of a new tier of unlicensed residential congregate care settings: This tier is not well defined and has the potential to lead to a devolution of services already offered in settings such as long-term care and hospitals. Local 175 represents a number of workers in long-term care and retirement home settings, as well as assisted-living settings. This new tier makes it unclear if some of those services that are performed in long-term care or retirement could be transferred elsewhere, something that we would oppose. Our belief is those industries need appropriate care and attention to ensure that they are operating properly and that side-shifting of services to an even less-regulated setting will result in far worse outcomes all around.

The bill opens the door to further privatization of the industry. We believe that the best outcomes in health care services come from public non-profit sources. When profit is introduced as a primary goal for employers, we have seen examples of where services are reduced and corners begin to be cut. This has been most apparent recently when looking at the difference in experience in long-term-care homes throughout the COVID-19 pandemic. The private, for-profit homes have had worse results, and this is something we would want to avoid in other health settings.

The lack of consultation around this bill has also been a major concern. There are major changes which have been undertaken quickly and with no discussion or consultation sought from our union, other unions, workers' rights groups or health care advocates. A key stakeholder in the system are the workers who perform the care and services, and they have not had a voice in this process at all. The introduction of the bill was a surprise to us and the speed with which it moved through the legislative process has left us and others scrambling to understand the full implications of what the bill will do. The rationale for why these changes must happen now is very unclear.

We believe in a system that can provide the best possible service to the people of Ontario. A review of the existing operational framework of how home care and residential services are provided is not the problem. In fact, it would be welcomed by my union. Right now we're all grappling with the worldwide crisis in the COVID-19 pandemic, which should be the primary focus for us all right now. A review should be done in a fully public and transparent—

The Acting Chair (Mrs. Robin Martin): Sorry to interrupt, sir. You have two minutes left.

Mr. Tim Deelstra: Thank you.

A review should be done in a fully public and transparent way once all the parties involved can focus on the task and give home care services the attention it properly deserves.

UFCW Locals 175 and 633 believe this bill is too problematic and recommends that it be withdrawn by the government. The union believes in the need for a comprehensive review of the industry that includes all stakeholders and would gladly participate in such a process in the future once the uncertainty from the COVID-19 crisis has passed. Thank you again for your time today and I look forward to any questions you may have as they come up.

The Acting Chair (Mrs. Robin Martin): All right. Thank you for your presentation.

Now we have Meghan Perrin from the Alliance for Healthier Communities. Meghan, can you state your name for Hansard, and then you will have seven minutes.

Ms. Meghan Perrin: Bonjour. Je m'appelle Meghan Perrin. I'm the francophone and resource policy lead at the Alliance for Healthier Communities. The Alliance is the voice of a vibrant network of over a hundred community-governed primary care organizations, including community health centres, Aboriginal health access centres, community family health teams and nurse-practitioner-led clinics. This alliance of community primary care organizations shares a commitment to advancing health equity through the delivery of comprehensive primary health care.

The Alliance for Healthier Communities is pleased to see that, with Bill 175, this government is working to modernize the home and community care sector and, in doing so, hopefully expanding a more person-centred approach based on client needs. However, it is imperative that this modernization happens in conjunction with the transformations occurring in the health system, through the lens of integrated care and Ontario health teams, as well as using the current landscape to shape next steps in consultation with communities and the people of Ontario.

1600

In the months since this bill was first tabled, ensuring that Ontarians can remain in their homes and in their communities to receive their care has become increasingly important and evident. The home and community care and comprehensive primary health care sectors have been strongly focused on the response to the COVID-19 pandemic and ensuring equitable access to care based on the needs of their clients. The alliance echoes our partners at the Ontario Community Support Association's belief that the timing is not right to move forward on this legislation.

The COVID-19 pandemic has had a great impact on the health sector and has fundamentally changed how services are being delivered. The passing of this bill at this time would be irresponsible and should be delayed until we are better able to understand and incorporate key learnings from the pandemic response and to engage our communities appropriately. This would enable open and transparent collaboration between the government, the home and community care sector, other key stakeholders in other sectors like primary care, and, more importantly, consulting clients, families, caregivers, providers and other front-line staff. We must make the most of this opportunity.

In response to the bill, our recommendation is that we really welcome a shift from embedding clinical and service delivery requirements from the legislation under HCCSA to the less rigid regulations and policies, as is the case in most health care sectors. This will enable adopting a regulatory system that is based on client needs, moving away from service maximums and the need for client assessments, and shifting—again, this should happen in conjunction with local planning for integrated care through a standard framework, as applicable.

We at the alliance believe that our model of health and well-being, which will be in our written submission, sets the foundation for an equitable integrated care system. This is care that is grounded in community development, based on the determinants of health. It is interprofessional, integrated, coordinated, accessible, based on the needs of the population, accountable, efficient, anti-oppressive and culturally safe.

Home and community care services are an integral part of ensuring comprehensive integrated care that is person- and community-centred. That's inside of Ontario health teams or outside of those. In looking ahead at the health care landscape in this province, prioritizing locally sustainable home and community care innovations will allow for more equitable care and healthier Ontarians.

We have five recommendations that would help enable this. This includes:

—creating locally based, equitable approaches to home care delivery that is based on client needs and improved working conditions for workers;

—committing to living wages and proper working conditions for PSWs;

—embedding care coordination within comprehensive primary care teams with broadened scope, including social prescribing;

—renewing commitment to health equity in home and community care, including the collection of socio-demographic and race-based data; and

—a commitment to not-for-profit service delivery.

I'll go through a few of these, but in case we run out of time, those are the five recommendations.

When we talk about locally based, equitable approaches, what does that mean? It means that we must use what is happening on the ground and providers who know the needs of the clients and value the work of home care providers. One such example is in rural communities, where the current regional approach to home care is not working. It's failing clients and home care workers, most notably PSWs. Large geographic regions and travel times and centralized supplies lead to no-shows and to PSWs or other home care providers having to travel great distances just to pick up supplies to come back into rural communities to provide these services.

By ensuring a local approach with an emphasis on local hiring and training, such as—an example could be PSWs being members of a comprehensive primary care team or rural hub—will not only improve health outcomes of the clients by reducing no-show appointments but also ensure proper working conditions for PSWs by providing stable employment and remuneration, reducing travel times, and boosting local economic development through local employment opportunities.

The Chair (Mr. Kaleed Rasheed): Two minutes.

Ms. Meghan Perrin: Hand in hand with this is, as I heard when I came onto this call, others calling for a commitment to living wages and proper working conditions for PSWs. COVID-19 has really reminded us as a province that PSWs are the backbone of many health care sectors, including home and community care. Wages and working conditions, including insecure employment across multiple employers, further amplify existing inequities for these workers, who are most often women, racialized, Black or from recent immigrant communities. In addition, there are salary inequities among PSW roles across the health care system, for example in acute care versus community care.

PSWs support or are already supporting this overburdened health care system to free a vital primary care provider and other nursing resources, so we need to treat them the way they deserve to be treated. While the pandemic response has led to a temporary increase in their wages in certain settings, a long-term permanent solution has not been put in place. We call on the government to incorporate, at the bare minimum, a living wage and proper working conditions for PSWs.

As far as embedding care coordination in primary care, increasingly we know that integrated care systems with a foundation in primary care have greater population health care outcomes. This applies in the context of connecting people to home and community care.

Care coordinators should connect clients to equitable and appropriate care, rather than their current narrow focus on care qualifications and patient eligibility. This should include social needs and the social determinants of health, which could include using social prescriptions to refer, navigate and track the impacts of social care in conjunction with clinical care for those receiving home care and community care. The Ministry of Health does recognize social prescribing as an important facet of integrated care, so we would like to see that reflected in this bill.

The Chair (Mr. Kaleed Rasheed): Thank you so much for your presentation, and apologies to cut you off.

I will now call on the Hamilton and District Labour Council. You will have seven minutes for your presentation. Please state your name for Hansard, and you may begin.

Mr. Anthony Marco: Hi. My name is Anthony Marco. I'm the president of the Hamilton and District Labour Council. For those of you who aren't familiar with labour councils or aren't familiar with the one in Hamilton specifically, we represent 50,000 unionized workers across the city of Hamilton and the area, and a lot of them are health care workers. Obviously, they are a group of workers that is going through some real trials and tribulations right now. As was said in the previous discussion, many of them are women, many of them racialized workers, many not making a living wage, many of them working three or four part-time jobs at the same time, and all of them are being called "essential" and "front-line heroes" while doing all of that.

Hamilton's urban areas have some of the largest areas of poverty in the province right now—and even in the country. We're facing cuts to public transit, we're facing increases in rent, we're facing renovictions and we're facing seniors who, many times, can't even afford medicine.

When I hear about the concept of privatization in home care, it really bothers me, not only at a local level but for across the province as well, because home care workers are doing valiant work. When you talk about the front-line health care workers, these workers do everything they can to help people stay at home and be able to live at home while taking care of some of these health care issues. They ultimately reduce the strain on hospitals and they give a quality of life to Ontarians who would struggle on their own.

Because I represent a group of workers—I don't know if anybody in previous sessions said this, but let's understand: We have workers here who travel in bad weather through a lot of the year, travelling from place to place to place. There are unknown worksites; there are completely unknown health and safety scenarios at every single address that they go to. My day job is as a schoolteacher, and when I walk into a workplace—when I walk into a secondary school, which I'm hopefully going to do this fall—I want to know that my health and safety is intact. To do that, I know what every single place in my facility is like. A home care worker doesn't get to do that; they're walking into a completely different environment every single time.

Oftentimes, because they feel a duty and because they're told that they have to take care of so many patients, they have unknown shift times. They might be told that they have eight hours to take care of everybody, but if that turns into nine hours or 10 hours, sometimes you have to get the job done, and that scenario can be scary when you've got a family to take care of.

Handing off home care, warts and all, and all the problems with it, to Ontario Health is like cutting off your entire face to spite your nose. I intentionally flipped that around because I think it's an overreach. I think that what we're doing here is trying to solve a situation by doing a huge, huge cut that we don't necessarily need to do.

Ontario Health confuses me to begin with. When I hear the word "super-agency," it makes me feel like the US Space Force. I'm not exactly sure what that might be, but I know it's nebulous and I know it's something that I generally bristle at when I think about the fact that we're adding a step between transparency, we're adding a step between accountability and we're adding a step of people who don't necessarily have the best intentions of public home care at heart.

If the government of Ontario is finding challenges in regulating the industry and simply passing the buck to Ontario Health, then I think we need to build the capacity instead of passing the buck or, in this case, passing billions of bucks, because we know that we're talking about a lot of money here.

Let me be clear, and I've seen this over my 51 years: The only measure of profit in health care is health and wellness. That, literally, should be your measure of profit: Are people healthy? Are people well? That is your measure of profit. If you're thinking about anything else when you attach profit to health care, that becomes a problem. So we need to think about health care as investments rather than just tax burdens that we're trying to get rid of.

1610

What I've seen about the bill, and what bothers me, is that it leads to virtual autonomy for some of these privatized home providers. That kind of bothers me because I've seen some of the same things echoed with regard to long-term care right now. We're seeing some of the gaps and some of the chasms, in some cases, in some private long-term-care facilities. I have a partner who works in long-term care, and I hear some of the cutbacks and how it impacts the residents who are living in those facilities. I fear that some of those cutbacks and some of those efficiencies might ultimately be the same thing that we have to deal with, with regard to home care.

Also, from what I've read in the bill—and this is kind of scary too—it could potentially allow a private corporation to come in and deal with their home care people in local hospitals as well. As far as I'm concerned, if somebody goes into a hospital, it should be hospital workers who are dealing with people, and not necessarily a privatized home care provider that walks into that hospital.

Privatization doesn't help health care because efficiencies to corporations means saving money—

The Chair (Mr. Kaleed Rasheed): Two minutes.

Mr. Anthony Marco: —and success is defined by a profit that's a monetary profit. And home care, we have to realize, is an exponential investment in our health care system. I don't know what the stat is on how much it costs to put somebody in a hospital for a night or two, but I have to guess that the value of that versus the value of having them stay in a home and being able to live at home and investing in a strong home care system is probably going to be the best value you can get. So consistency and value are important words here.

I'm all for getting the best value out of a tax base, but I'm also not bemoaning my taxes paying for a valuable regulated public service like home care. It's timely that during this pandemic, we're seeing gaps in long-term care,

because I'm afraid that those things are going to come to home care if home care goes private.

Corporations have a fiduciary responsibility to shareholders, not to patients, and you might hope that someone says that the best treatment of patients is the best way to do business. But ultimately, if you're trying to satisfy shareholders, the best treatment is only good business until it's not. Privatization puts profits over people. Wages get driven down; part-time workers increase. Multiple jobs, dropped shifts and inconsistent care isn't good for any patient.

The Chair (Mr. Kaleed Rasheed): One minute.

Mr. Anthony Marco: Let's treat home care as an investment where we have direct oversight over it and keep it public.

Our simple recommendation is this: Either withdraw this bill—hopefully—or find new ways to amend it to add value to it as a public investment instead of making patients a liability on a balance sheet.

I'm happy to take any questions. Thank you.

The Chair (Mr. Kaleed Rasheed): Thank you very much for your presentation. We are now going to start with the government side. MPP Sam Oosterhoff, please go ahead. And just to remind everyone, the government and opposition sides both have nine and a half minutes for both rounds of questions.

Mr. Sam Oosterhoff: Thank you to the presenters this afternoon for taking time to come before the committee to speak to their concerns and to speak to the perspectives of their various members. It's very much appreciated, I know, by all members on this committee to hear the perspectives of so many different regions and different people on this important legislation. I know that even if people come at it from different perspectives, there's an agreement that the system we have has failed our seniors, and we can and should do better—not just for seniors, but for those who need home care.

I know that many of your members would agree. Many of you have had a lot to say about the failings of this system, and we've heard that consistently. We know that we can and we must do better, and that's what we're committed to doing. We're committed to bringing Ontario's home care and community care services into the 21st century.

We know that, whether it's breaking down those bureaucratic barriers between primary care providers and community care providers or home care providers; whether it's removing service limits for patients and ensuring that they're able to be treated according to their need, not based on a quota or of how many hours they should be getting. We know that breaking down these barriers is going to mean that people are able to access health care when and where they need it.

There are so many different pieces that come into play, and I know, speaking from labour perspectives, many of you are representing the most valuable members of health care: those who are on the front lines, those who are doing such important work. We know that those are the people we want to ensure are able to do their work with all the support possible, and that's really the intent of our legislation—whether it's looking at modernizing digitization and ensuring that we're able to provide them with access to what they should be able to access when providing care for patients.

But I want to also be very clear, before I perhaps get into some of the questions, that there is nothing in this bill that encourages or supports privatization. This does not change the funding format when it comes to how we see both not-for-profit and for-profit players in this sector. This does not open up or change that formula. It's important that we recognize that, because I think there has been some confusion, perhaps, around that.

This legislation is focused around flexibility and ensuring we can support delivery models and improvements to our existing models. I think we've all seen how without some improvements, our system can let people down. I know that's going to be one of my questions, around where, over the course of COVID-19, we've seen some of the vulnerabilities in this sector, particularly, when it comes to not having that collaboration between the primary care sector and the home care sector.

So my question then is: When you look at the system currently and you think about some of these changes, specifically around digitization, if there was a particular area that you would want to see the regulations, as this legislation moves forward and hopefully the House passes it—there is a lot of flexibility being built into the work that can be done through regulation, because we recognize that this is a fluid sector and we have to listen to the sector, and we want to listen to the sector. In that regulation aspect of it, what particular recommendations would any of you have when it comes to the government's willingness to collaborate with partners such as yourself in this space? Could you speak to what some of those regulations should look like, pieces that you feel should perhaps stay in regulation or should be in legislation, and your reasons for that?

The Chair (Mr. Kaleed Rasheed): MPP Oosterhoff, your question is to?

Mr. Sam Oosterhoff: Sorry. Why don't we begin with Tim? And then we can go through the rest of the deputations.

The Chair (Mr. Kaleed Rasheed): Okay. Tim, please go ahead.

Mr. Tim Deelstra: Thank you for the question. One of the concerns that we have with this current bill is that, as a stakeholder, the people who represent the workers, we haven't been consulted about this process. There's a lot of confusion about what exactly the intent of this bill is.

Thank you for your comments about the funding model. Part of our challenge and concern about it is, when we start seeing that areas are being taken away from the LHINs and they're being provided to other agencies, and that could be different agencies in different areas, it starts to provide a great deal of uncertainty to us about how that funding is actually going to flow, compared to the situation we have now where we do have a crown entity that that is at least somewhat publicly responsible if we need to question it.

With respect to the idea of what should stay in legislation and what should go into regulation, again, we have some concerns as an organization about a move to put things into regulation, from the purpose of transparency and making sure that services are provided in a way that works for the public. The Ontario health teams seem to contain a number of entities who are from private providers. Our concern around those things has always been that there is a for-profit motive that goes into that, and we're concerned about that.

So what we would like to do with this at this point is to pause the whole thing. We think the government should stop the program. Once we get through COVID-19, we should be brought back as stakeholders—all around, all stakeholders—to assist them and have a full and complete and public discussion about what the home care system should look like so that we can make sure that people get the services they need in the most appropriate fashion.

Mr. Sam Oosterhoff: Perhaps I can put a little bit more of a point on the question. Within the sector, would you not agree that there needs to be flexibility, given the changes we see within the sector since the last time we've had legislation come forward and the rapidity of that change? Would you not agree there should be flexibility within that system and this bill helps provide some of that flexibility?

1620

Mr. Tim Deelstra: I agree that as things change, there needs to be an ability to reveal these situations and to find solutions for them. Again, our concern is that we want to make sure that services offered are a public good and that they're provided appropriately, so that's part of the focus that we would want to go through. Part of our concern around this bill is that it seems to shift from that and it also happened very quickly with no consultation.

Mr. Sam Oosterhoff: Meghan, perhaps tied around that, when it comes to the digital aspect of this and making sure that we're able to adjust to the technological changes as well that we've seen, what would your perspective be on how we can make sure that we're able to respond quickly in technology as we move forward?

The Chair (Mr. Kaleed Rasheed): Two minutes.

Ms. Meghan Perrin: Perfect. So I'll answer that, and I'll give additional comments to your previous point. For digital strategies, I think it's important to have systems that can talk to each other—currently, for example, looking at CHRIS in primary care and [*inaudible*] in our members. How do the systems talk to each other versus looking at what are different and new systems, and what can we do to build up infrastructure for digital capacity in the province?

I think when you're talking about legislation versus regulation, we do welcome a lot of the shift to regulation; however, similar to the Connecting Care Act last year, it made a commitment to equity and to promote equitable health outcomes for our public health care system. We would like to ask, with this bill, that there is a commitment to health equity directly in the legislation, not only in regulation, similar to that in the Connecting Care Act, which would include for Francophone and Indigenous communities—

The Chair (Mr. Kaleed Rasheed): One minute.

Ms. Meghan Perrin: —and in addition to the commitment which has been expressed by the government during the COVID-19 pandemic, actually in a press release that came out just before we spoke, around collecting socio-demographic and race-based data, because we cannot address what we cannot measure. I think that those are very important to have outlined in the legislation—that commitment to equity—and then regulations can follow under there.

Mr. Sam Oosterhoff: One of the key pieces that this legislation has a real focus on is ensuring that we see that integration of home and community care with other parts of the health care system. Could you speak a little bit to some of the challenges that we've seen under the current system, navigating this system and some of the difficulties for people that you represent?

Ms. Meghan Perrin: An issue, for example, where currently there are many LHIN care coordinators co-located in community health centres or other members, but their scope is very limited—

The Chair (Mr. Kaleed Rasheed): Thank you so much. Apologies to cut you off.

Now we are going to move to the opposition side. MPP Teresa Armstrong, please go ahead.

Ms. Teresa J. Armstrong: Yes, thank you. If you want to finish your thoughts, please go ahead.

Ms. Meghan Perrin: Thank you, yes.

Just to go back to talking about care coordinators—I believe that was what I was speaking to—currently with co-location of certain care coordinators in primary care, for example, there are opportunities for integrated care and for more conversations between the primary care providers and the care coordinators who are working together as a team. However, the way the system works currently, they're still rigid within their current scope. I think more opportunity to expand the scope of care coordinators and to make them part of teams versus working in silos is one piece, and the other piece would be making sure that there's a local approach so that staff are not travelling to and from various locations—let's say they live in a community, are travelling to go get supplies, are travelling because that's where their office is based out of, and then having to travel back to these communities. It's not very sustainable or efficient to have people travelling in the conditions that we have here in the province. How can we work on that, in addition to working more closely with the primary care teams, as a member of the team and not just in consultation?

Ms. Teresa J. Armstrong: Thank you very much.

I wanted to ask each of the presenters individually first. Now I know the UFCW hasn't been consulted. But has the Alliance for Healthier Communities been consulted, and has the Hamilton and District Labour Council been consulted?

The Chair (Mr. Kaleed Rasheed): Sorry, your question is to—

Ms. Teresa J. Armstrong: Both the Alliance for Healthier Communities and the Hamilton and District Labour Council. Has either one of them been consulted on Bill 175?

The Chair (Mr. Kaleed Rasheed): Kate, please go ahead. Oh, sorry; Meghan? Meghan, please go ahead.

Ms. Meghan Perrin: Previously, we were not consulted on the bill before it was tabled.

Ms. Teresa J. Armstrong: The Hamilton and District Labour Council?

Mr. Anthony Marco: As an organization, Hamilton and District Labour Council—usually local labour councils aren't consulted, but the consulting would have probably happened at the Ontario Federation of Labour level. I know that the representative here, Tim from UFCW, is an integral part of some of the organizations at the Federation of Labour, and I know they have major concerns with this bill as well. So the consultation, I'm assuming, didn't happen in any meaningful way at that level either.

Ms. Teresa J. Armstrong: From what I can tell, United Food Commercial Workers haven't been consulted, Meghan hasn't been consulted and, Anthony, you think possibly the OFL was consulted.

My question then is: Why do you think that, as organizations that represent front-line workers, you wouldn't have been consulted, and why is there a lack of strategy around retention and working conditions around the front-line workers who are the heroes—so we're always told, and so they are—of the home care system? Could I ask each one of you to respond individually to that?

The Chair (Mr. Kaleed Rasheed): We can start with Tim.

Mr. Tim Deelstra: Thank you for the question. As to why this legislation was tabled the way it was, I would refer you back to the government who tabled it. I'm not really clear as to why it was tabled in the way it was and why there wasn't consultation that was provided. Certainly, had we been consulted, we would have had a number of things to say, particularly about the workforce and how conditions are and ways to try to improve it to provide the best outcomes that there possibly could be.

Hopefully, our recommendation is considered by the government: that this particular bill be stopped for the time being and that we move into a much more broad consultation where we can find the best possible version of this system that we can.

The Chair (Mr. Kaleed Rasheed): Next, Meghan. Your mike is unmuted; go ahead.

Ms. Meghan Perrin: Thank you. I think that one of the key pieces here is that this seems to be happening in a disjointed manner, where there are local conversations happening, there are OHTs being designated and people that are still in development. Different communities are at different stages of this health care transformation. While Ontario health team candidates have been asked to re-imagine home care and looking at how they can work together through partners, where our members are involved in the OHTs that are in their areas, these conversations were happening locally. They were saying, "What are your thoughts? What are you proposing for home care delivery in your region?" And then this bill gets tabled. It seems to be happening in a disjointed manner where the local conversations are where this planning is happening but they haven't been consulted or weren't part of those conversations.

The Chair (Mr. Kaleed Rasheed): Next, Anthony, please.

Mr. Anthony Marco: I believe that the main reason why labour groups and groups that represent workers probably weren't consulted with regard to this is that quite simply we know that when we talk about "finding efficiencies" in a system or, in some cases, "finding flexibilities" in a system, oftentimes that's borne on the backs of workers. We also know that usually the highest cost out of any system that is publicly run is wages. I think there's a very logical assumption that if you start to enter discussions with worker groups, with unions, with labour groups, and start to talk about how we are going to find efficiencies, it's not—like I said in my comments earlier, where we should be talking about efficiencies as levels of care, we are talking about efficiencies in many ways in terms of costs. And when we talk about costs, like I said, the number one cost to health care is generally front-line workers.

I think that probably not wanting to raise the ire and raise the concerns of some of these groups, like ourselves who are delegating right here now, is why we weren't brought in right off the bat.

The Chair (Mr. Kaleed Rasheed): Do you have further questions? Okay.

Madame Gélinas, please go ahead.

1630

M^me^ France Gélinas: Thank you, everybody, and thank you for your presentation. I'll do a little bit like Teresa did: the same questions to Tim, Meghan and Anthony.

The first question I have is, I don't know how familiar you are with the home care system, but Ontario since the Mike Harris era uses a bidding system; that is, different companies, some for-profit, some not-for profit, bid to get a contract. It used to be that VON just provided—

The Chair (Mr. Kaleed Rasheed): Two minutes.

M^me^ France Gélinas: —agency-provided care. I'm just curious to see if you've given any thoughts to changing this competitive bidding process. Tim, you're first.

Mr. Tim Deelstra: Thank you for the question. I think we would investigate and take a serious look at all kinds of different solutions. A difficulty with the bidding process is that it usually is going to go to whoever presents the least amount of money, and as Anthony expressed fairly well, a lot of times where people will try to cut corners in terms of bidding is on labour costs, and that leads to some pretty bad outcomes down the road.

Certainly, I think we would be prepared to look at alternate models for how services are sought and provided. Again, from our perspective as a labour organization, we would want a focus put on the workers who are providing that service.

M^me^ France Gélinas: Thank you. Meghan?

Ms. Meghan Perrin: I think it's really evident right now during this pandemic, the gaps between the for-profit and not-for-profit sectors and—

The Chair (Mr. Kaleed Rasheed): One minute.

Ms. Meghan Perrin: —really needing to bolster the investment in the not-for-profit providers.

I also think that when you're looking at how care and health services are organized in other areas, you're looking at population need and you're looking at using existing providers, for example, that can provide those services. I'm thinking of some of our members who have both primary care and CS services all under one roof, working for their community. They're a community-governed organization, which means that they're accountable to those local clients, and those local clients are informing those decisions.

Looking at how we can move forward, yes, moving away from a bidding system seems appropriate.

M^me^ France Gélinas: Anthony in 20 seconds or less.

The Chair (Mr. Kaleed Rasheed): Thank you so much. My apologies to cut you off. It's your time.

Now we are going to move to the government side, and I believe it's MPP Coe.

Mr. Lorne Coe: Thank you, Chair. Through you, my question is for the Alliance for Healthier Communities.

To the point about consultation: The consultation has been wide. It's patients, caregivers, providers, workers, health system and academic experts. That has been my experience in the riding that I represent in Whitby, and it's also true of the region of Durham.

One aspect, though, that is equally clear is that the Ontario health teams, in partnership with home and community care service providers, would have the flexibility to develop innovative integrated delivery models, including care coordination. That's another aspect that I heard clearly throughout the region of Durham and in my riding.

Through you, Chair, to the question: Under the proposed legislation, Ontario Health would fund non-profit health service providers, such as community health centres or hospitals, to provide home care services directly or indirectly as part of an integrated model—and that's something else that we heard. Do you have any suggestions on how community health centres could play a role under this new model?

The Chair (Mr. Kaleed Rasheed): Okay, Meghan, go ahead.

Ms. Meghan Perrin: I think that while many of our members would definitely welcome being able to hire workers directly—because this would impact the care of their communities, the clients they serve. They would be part of this interprofessional team and it wouldn't result in a purchase of service, but rather fair, equitable wages would have to accompany this type of move, and being able to provide those workers with better working conditions—for example, having only one employer.

There are a lot of different factors to be taken into consideration when looking at this type of delivery model. Looking at purchase of service versus direct employment: We welcome the idea of direct employment and broadening the ability for other providers, such as community-governed organizations. However, we really want to re-emphasize the commitment to the delivery of not-for-profit health care.

Mr. Lorne Coe: Thank you for your answer. Through you, Chair, to MPP McDonell.

The Chair (Mr. Kaleed Rasheed): MPP Jim McDonell, please go ahead.

Mr. Jim McDonell: Thank you for that. We went through a session over the last number of years where people have told us things they want changed. I know, through my office, that people were not happy. We had patients coming in or clients coming in, not happy with the response, trying to get services and not able to get them. So we heard loud and clear that we needed change.

Of course, in the last election, people spoke that way. Over the last, well, now two years, but the year and a half before this pandemic, we've had the Premier's Council on Improving Healthcare and Ending Hallway Medicine consulting with patients, caregivers, providers, workers. We've had our Minister of Health, Deputy Premier Christine Elliott, going around the province. I was attending a number of meetings. I sat in on one in Ottawa, where we talked with our eastern Ontario groups. We had all of the major players at those meetings talking about the need of bringing in the health teams, more change, so we can get the local input into how health care is provided. The biggest complaints I get locally are that Toronto is a long distance away, and it doesn't know what eastern Ontario—what's right for Stormont, Dundas and Glengarry. Health care is a lot different in the largest cities in the country.

We're making this transition, and we certainly have been out there consulting. There is a lot of change that's needed, and people are demanding that. As we come through this COVID-19 pandemic, we certainly see those views being reinforced, that changes are working.

Now, this bill does not change the per cent of privatization versus not-for-profit. It's something I hear a lot, but that's not what this bill is about. It's about trying to improve community health care for the seniors, or home care or long-term care. We've been taking those steps, and we need to get past this. We talk about the pandemic. We've already put together a commission that will be reviewing how our system is handling the pandemic.

There is no question that there are gaps; there need to be changes. But we need those answers right away. Some of the people on the committee are saying we should wait. Well, how long do we wait? We need to see—this pandemic has the potential to go on for years. We need to improve those situations today. Changes are necessary.

Maybe I could ask Meghan her thoughts on that, on whether the system is working and we don't need to change it or are there changes really needed?

Ms. Meghan Perrin: Thank you. I think that it's not an either/or situation. As much as COVID-19 will be a part of our lives and part of the health care system in considerations for the near and potentially longer-term future, I don't think that this is the appropriate time. As we're in

month three of the pandemic response, a lot of the members, a lot of front-line care providers are still dealing with this day in and day out and responding to this crisis. I think if you want to have proper consultation that includes communities and providers on this bill and its regulations, I think that's where—and we're not saying delay it indefinitely, but at least not currently as it stands.

The Chair (Mr. Kaleed Rasheed): Further questions? MPP Logan Kanapathi.

Mr. Logan Kanapathi: Thank you to all the presenters for coming out and doing this presentation. This question is directed to Meghan. Meghan, you passionately talk about how the current system is not working and you mention about—we all agree that the current system is not working. You also mentioned about, locally, what's happening on the ground and failing client services, and you recommended local hiring. Part of your recommendations is hiring local PSWs. They understand the community. I understand. My mother has been in palliative care in my sister's house for three or four years' time with dementia.

1640

The Chair (Mr. Kaleed Rasheed): Two minutes.

Mr. Logan Kanapathi: I went through this process. Tell me your experience with the current home care system. What are some of the shortcomings that have an impact on patient care? Could you please expand on that?

Ms. Meghan Perrin: To reiterate what we mentioned before, by having a local solution—I'm thinking of some of the community health centres, whether that's rural or not, that would be able to have PSWs as part of members of their team, to be able to hire them locally, to hire local staff who could then visit local clients. You're building relationships. You're having culturally appropriate care for Indigenous communities, for francophone communities, for Black and racialized communities, for LGBTQ+ communities.

By having proper frameworks and competencies in place, you're also ensuring that the relationships between the clients and their providers are maintained. I think that by having those types of solutions, we're going to see more equitable outcomes. I think we need to look, also, when we're planning these types of home care services and community care services, at the resources existing in the province. It's not necessarily reallocating people to areas where they're best suited.

The Chair (Mr. Kaleed Rasheed): Thirty seconds.

Ms. Meghan Perrin: From my experience previously working, actually, at a community centre in MPP Gélinas's riding, having to deal with people who are, for example, francophone and not able to have PSWs or care coordinators who are francophone—meanwhile, there are staff that speak French, but they're assigned to a different region or portfolio. Especially if you want to look at digital-first, how can we make sure that members of our community are getting equitable care in the language and culture—

The Chair (Mr. Kaleed Rasheed): Thank you very much. Apologies to cut you off.

Now we're going to move to the opposition side. Madame Gélinas.

M^me^ France Gélinas: My next question will also be for all three presenters. We often hear that there are serious existing problems in our home care system. It often has to do with how they cannot recruit and retain a stable workforce.

I would start with you, Tim. In the membership that you support, what would be the top one, two or three things that you would see so that we can recruit and retain a stable workforce of PSWs in home care?

Mr. Tim Deelstra: Thank you for the question. There's no doubt about it that our membership, who provide home care services—it's very much what Meghan and other presenters in previous sessions have talked about. We see a lot of part-time work and not a lot of steady hours in terms of where they're going, and a lot of uncertainty. A lot of our membership also service rural areas and are not centralized, so that makes it more difficult to attract PSWs.

This is sort of a layered process, a layered problem that we've seen in our union, where we're now seeing people attracted to long-term-care homes, who generally have wages that are considerably better and, in some cases, hours that are better. We lose those people in long-term care in urban settings first; then we see a lot of retirement pickup there; and often we're finding that there's difficulty with our home care providers finding staff. Finding a solution to provide steady, regular employment and income would go a long way to solving that problem, from our perspective.

M^me^ France Gélinas: So, really, give them full-time employment and a living wage and we're on our way to solving.

Meghan, would you like to answer the same question?

Ms. Meghan Perrin: I think I'll potentially cede some more of my time to Anthony, since I believe I've answered this previously. But again, making sure that we're having, at a minimum, living wages for our PSWs—that includes full-time conditions; that includes working conditions that are equitable for them, making sure that we're having conversations around what it looks like to have a workforce that is sustained, and is able to thrive and is able to best meet the needs of their clients, when they themselves are able to work for one employer or are having to travel for multiple workplaces. I think I'll leave that as my comment.

M^me^ France Gélinas: Anthony, would you like to add?

Mr. Anthony Marco: Sure. I think, at the best of times, home care is a very, very tough job, made tougher by the fact that if you are a part-time employer or a precarious worker who is making minimum wage or slightly better, the biggest problem that we have heard is with regard to dropped shifts. If we have workers who are working two or three different part-time jobs at the same time and they can make $16 an hour at one job and they're only making $14 an hour at another job, they're going to take a shift where they can go and make $2 more an hour because sometimes that's the difference between feeding their family or not. That becomes a huge problem.

We talk about a living wage, and a living wage is different in different places around the province, and that's

certainly a great start. But ultimately, if we're going to establish a consistency of care and deal with people seeing the same patients, the same people in their homes over and over and over again and not just have new people every time—which helps everybody, like I said—a living wage is a good start. But we have to start to think even beyond that. We have to think that retention also gets rid of the need of consistent training; and also make sure that we have a standard of care which is going to be respectful of not only patients but also of the workers who are there as well.

M^me^ France Gélinas: Agreed. The care provided in home care is often very personal. Most people get a bath; to strip naked in front of a different stranger two times a week is not on for anybody. It's disrespectful. It is really difficult.

It's now my colleague, MPP Harden, please.

The Chair (Mr. Kaleed Rasheed): MPP Joel Harden, please go ahead.

Mr. Joel Harden: How much time do we have left?

The Chair (Mr. Kaleed Rasheed): You have roughly about six minutes.

Mr. Joel Harden: Six minutes; okay.

First of all, I just want to thank all the presenters for giving life to our conversations. You are right there on the front line working with people in the direct provision of services. I've got to tell you, I am hearing everything you've said about the failed experiment that this province has embarked on for decades with managed competition. I have heard from small-scale home care providers who were forced out of this industry a long time ago because big companies that can compete on labour swooped in. What really worries me is that on the one hand, we are calling the people you represent, the people you work with, health care heroes, and on the other hand, we are passing legislation that caps pay increases at 1%. We promised pandemic pay that never arrives. I'm very concerned with where this industry is going.

Earlier today, we had some discussion about the huge demographic challenges that Ontario faces. There's no doubt we do, but I'm wondering if in the time we have left you could talk about this not as a crisis but as an opportunity. What concretely could we do to increase the prestige of extremely skilled workers in home care and attendant care—people who go around and work with our neighbours all the time? How could we talk about these jobs as being crucial jobs, as important and as prestigious as the banking or lawyer or engineering professions? I worry that a lot of us don't even understand the level of skill that it takes to work with people in their own homes. I'm wondering if you could talk a little bit about that—Meghan, maybe beginning with you and continuing to Anthony.

Ms. Meghan Perrin: Again, it goes back to our people being valued through being able to get a wage that is meaningful, to be a livelihood, and being respected by having wages that reflect that, by having working conditions where you're not having to choose, as my colleagues here on the call have stated, between different organizations that might pay you a dollar or two more an hour because you need that extra income. How to lift, for example, PSWs or home care providers in being seen as meaningful and valuable and essential work, making sure that these people are actually valued in a way that's meaningful and that makes their work truly valued, would be wages and not precarious work environments.

Mr. Joel Harden: Fair enough. Anthony, before we move to you—and Tim, I have to say something I forgot to mention earlier that was given to me by a local union representative in home care: the revelation that CarePartners, one of the major operators in the sector, in 2019 refused its workforce, in November 2019, sick days. They actually thought that sick days weren't important. Think about the context of that, given what we're dealing with now. So how do we get our priorities better? I take what Meghan is saying: better pay, better working conditions. But what are some industry-wide things? I know that in some other parts of the world, there are central bargaining tables for people in these sectors so employers aren't competing on labour. There's an emphasis on bringing employers around the table on common standards. Anthony and Tim, what do you think?

1650

Mr. Anthony Marco: With your question and also with some of the comments that were happening earlier, there has been a lot of talk—in this past hour, anyway—with regard to flexibility and modernizing.

The Chair (Mr. Kaleed Rasheed): A minute and 30 seconds.

Mr. Anthony Marco: I'm thinking: What are the gaps that exist right now within this government, within the Ministry of Health, that don't allow for flexibility and modernizing? In other words, why do we have to seek it elsewhere, with all the experts that I'm sure we have at the Ministry of Health, with the fact that companies are clamouring to be part of a revenue stream that includes home care? Why is it that we cannot take advantage of the experts that we have within the Ministry of Health ourselves? Once we start to do that—and I think modernizing and flexibility are great things. Let's do that for the workers. You want them to feel more respected? Take a bit of the burden off. Make them feel safe; make them feel respected. That's ultimately what any worker wants.

I'll cede the rest of my time to Tim.

Mr. Tim Deelstra: Thank you for the question. Very quickly, I think that there has been a lot of discussion through this whole pandemic about all kinds of workers who we, as a society, probably took for granted for far too long, and we need to continue to focus on that to value people for the work they do, to recognize that it's worth it. But part of what that means is that we have to invest in them as people and as workers in order to get those more positive outcomes. It's fairly empty rhetoric to say that people are heroes but then treat them like they're disposable.

If there's something that could happen better, it would be some regulatory oversight in order to provide better outcomes in terms of employment. That will make people feel very valued and heard, and that their work is well-

regarded, if they are treated appropriately in the workplace.

The Chair (Mr. Kaleed Rasheed): Thank you very much for your presentations this afternoon. Apologies to cut you off.

CITIZENS WITH DISABILITIES–ONTARIO
MS. SIYING CAI AND MS. TOVA HOUPT
CHATHAM-KENT HEALTH ALLIANCE

The Chair (Mr. Kaleed Rasheed): Now we're going to move to our next set of presenters, starting the 5 p.m. set. I will now call on Citizens with Disabilities—Ontario. You will have seven minutes for your presentation. Please state your name for Hansard, and you may begin.

Ms. Tracy Odell: Thank you. My name is Tracy Odell. Good afternoon, and thank you for permitting me time to make a presentation today. I am the president of Citizens with Disabilities–Ontario. A slide presentation was provided, so I do invite you to follow along. I will indicate which slide I'm on.

On slide 2: Our organization is a cross-disability organization, which means that we represent people with any kind of disability, whether physical, sensory, cognitive or episodic.

Slide 3: We believe in full integration, so that people with disabilities can participate fully.

Slide 4: We actively promote the rights, freedoms and responsibilities of persons with disabilities through many activities, including making presentations to decision-makers like yourselves.

Slide 5: The bill emphasizes "care," which is medical terminology and does not reflect services that promote independent living. The issue is that this language reinforces stereotypes that people with disabilities like me can only be objects of pity or charity, or be considered a sick person.

Slide 6: Our concerns that the term "care" to people with disabilities is paternalistic rather than rights-based—

The Chair (Mr. Kaleed Rasheed): Sorry, Tracy. My apologies. Are you sharing any slides?

Ms. Tracy Odell: I have slides, and I was told that everybody had them and could follow along.

The Chair (Mr. Kaleed Rasheed): Okay, so we emailed everyone.

Ms. Tracy Odell: Is that okay?

The Chair (Mr. Kaleed Rasheed): Yes, please. Continue.

Ms. Tracy Odell: Thank you.

So the term "care" does not allow for autonomy or the ability to direct services yourself; you're simply someone who has to be looked after, not someone who could be independent with appropriate services and supports. The medical model dominates the lives of people with disabilities, but we are people first and foremost and we have rights.

Slide 7: Our concerns have been validated. People with disabilities are choosing medical assistance in dying rather than moving into nursing homes because of fear of how they would be treated in those settings. Nursing home residents have been neglected, victimized and even murdered in homes that were supposed to be providing care. This was common knowledge even when I was a youngster. It was the driving force for people like me to press to be able to live in the community outside of the medical model of service.

Slide 8: I'm going to spend the next couple of minutes telling you about my story. I was admitted to a hospital for children with physical disabilities when I was seven years old. So at the age of seven, I left my family forever. My parents and their advisers felt that my life would be better if I went to live in a residential care facility that offered therapy and schooling. But as I became a teenager, the vision for me was that I would be living in a nursing home for the rest of my life. This was unacceptable to me and seemed extremely unfair.

By the time I was old enough to sign myself out of the institution, pilot projects were springing up around the province which allowed people to live in the community with non-medical attendant supports in their own apartments. This was the beginning of the rest of my life. We paid our own rent, bought our own groceries and entertainment and lived in the community. I chose to go to university. So today I sit before you as a person who was able to work full-time for over 30 years, pay taxes, get married, raise two children and give back to the community through volunteering. I chose to volunteer with organizations that provided services that help people live in the community as people first, not as patients only.

My life is so different from what was originally imagined for me. If I had been in a nursing home, I probably would have died years ago. I would not have received the quality of service I receive in the community when I can direct my own attendants. Staff in nursing homes simply would not have had the time or resources to provide me with the quality of services that I need.

The Chair (Mr. Kaleed Rasheed): Two minutes.

Ms. Tracy Odell: I live in fear that services might erode or backslide so that people like me will be forced back into institutions. When I read the term "residential congregate care settings" in the act, it made my blood turn cold. Is this a sneaky way to force us back to nursing homes? Few policy-makers understand the importance of community-based services and how much they protect the quality of life and our freedom to live in the community. Changes to this act must ensure that service models include self-directed services in the community.

Slide 9: We are requesting to:

—keep the word "services" in the act, not just the word "care";

—refer to "rights for patients, consumers and clients" in the act;

—hold broad consultation on the act, including the right of people to receive and direct their attendant services;

—recognize self-directed care models as well as medical models of service delivery; and

—keep institutions out of our homes while allowing services to flow in and out as needed.

So I will leave it there, but please feel free to ask me any questions. Thank you very much.

The Chair (Mr. Kaleed Rasheed): Thank you very much.

Next I will call on Siying Cai. You will have seven minutes for your presentation. Please state your name for Hansard, and you may begin.

Ms. Siying Cai: Okay. Good afternoon, everyone. My name is Siying Cai and I am a graduate of the Seneca College social service worker – gerontology diploma program. Today I'm going to do this presentation with another fellow graduate, Tova. Tova will start.

Ms. Tova Houpt: Thank you, Siying. Hi, my name is Tova Houpt. With me is my former classmate. We're both recent graduates from Seneca College's social service worker and gerontology program. We're presenting because we'd like to share our first-hand, personal experiences seeing the lack of proper funding in private, for-profit institutions, the long-term-care crisis, inadequate home care services across Ontario and how these negatively affect senior life.

1700

This is in protest to Bill 175, the Connecting People to Home and Community Care Act, which follows the initial Bill 74, The People's Health Care Act. The issues we see now have existed long before the current pandemic crisis we're in. It's upsetting to see that the government officials are only listening and willing to discuss systemic issues after the military report. The report reiterated what unions, PSWs, nurses, social workers etc. have been saying for a while now.

As we all know, LTCs—long-term-care centres or nursing homes—have seen the worst end of the stick in this pandemic. Homes that were privately run, for-profit, most of the time did not supply proper PPE to staff. Staff went home sick in droves. They were too afraid to enter their workplaces due to unhygienic processes or lack of standardized protocols. There seems to have been a complete lack of proper outbreak protocol and understanding of the nature of this virus, even as more information was spread globally through other medical professionals. The fact that staff were using medical PPE and therefore spreading the contagion is nothing new. This type of practice develops as a bad habit in response to low home budgets and the need to restrict expenses. The actual companies who run these homes were never going to send more money to these spaces.

We have seen the military findings first-hand while training in the field. This is something we witnessed in long-term-care centres due to their chronic understaffing in private, for-profit homes. There was a lack of consistent and sufficient protocols to care for residents etc. Some long-term-care homes underwent Canada accreditation or quality assurance methods. This didn't seem to do very much during pandemic times. We need to see a full government regulation taking place consistently. PSWs are at further risk of spreading contagion, and as we're nowhere near close to being out of pandemic, we need to amend this issue immediately for the long term.

Residents in long-term care are severely impacted by social isolation and aren't always allowed to see family members. People suffering from neurocognitive disorders like dementia will find this upsetting and confusing. We need to introduce a standardized safety procedure province-wide for them. Isolation's impact on seniors is so underestimated, and now this pandemic brings this issue to the surface. Instead of making our elderly population become more isolated, we need to address this issue and to fix the core of the crisis, which is the system.

Home care support is also directly affected by this bill. There is little understandable mention towards an improvement in this area. Government-funded PSW supports were bare minimum pre-pandemic. Now, with increased social isolation, we need to increase the hours of assisted living people receive at home. Not everyone has family who can support them.

Our list of requests are as follows: It seems that there's an ongoing request by organizations to have a public inquiry into all long-term-care centres across Ontario. We would like to see it happen as soon as possible.

It seems there is consensus that Bill 175 isn't going to support our population, and as the aging population is set to increase over the next decade, this must be considered now before it's too late.

We're tired of the bureaucratic excuses and legal jargon that doesn't make this understandable or approachable by the general public, including families of residents or even trained professionals like ourselves. We would like to ask for future transparency around home and community care proceedings from the Ford government.

We would like to ask that the government makes all LTC homes government-funded homes that are fully regulated and that all—

The Chair (Mr. Kaleed Rasheed): Two minutes.

Ms. Tova Houpt: Okay, thank you—and that all inspector visits be done without prior notification. We have a long-term-care act and a retirement home act, and yet it seems that they are not being enforced.

We would like to ask that the government commit a provincial budget towards increasing the number of homes available, updating infrastructure as needed in older homes and decreasing the wait-lists that are already extensive.

We would like to ask that the government makes it a law that all PSW workers in long-term-care centres be given full-time jobs so that further risk of homes spreading contagion is eradicated; that the ratio of worker to residents be decreased to seven residents to one worker; and that these workers be given a full $2-per-hour wage increase.

We would like the government to increase or take over regulation of retirement condominiums if they are providing assisted living—

The Chair (Mr. Kaleed Rasheed): One minute.

Ms. Tova Houpt: Thank you—in a memory care or long-term-care setting.

We would like to see a minimum of 12 hours per week provided to clients receiving in-home assistance and care rather than the bare minimum of two.

I would also like to see eligibility requirements of home care services expanded to include more incapacity, according to the assessment and priority scale RAI-CHA, and social worker and social service worker approval on OHT referral.

There's two more requests at the bottom here which are really quick, but I'm running out of time. So thank you for the chance to share our piece. Again, if you have any questions, we will try our best to answer them.

The Chair (Mr. Kaleed Rasheed): Thank you so much for your presentation this afternoon.

Next presenter: I will now call on the Chatham-Kent Health Coalition. You will have seven minutes for your presentation. Please state your name for Hansard, and you may begin.

Ms. Shirley Roebuck: Good afternoon, everyone. My name is Shirley Roebuck, and I'm the co-chair of the Chatham-Kent Health Coalition. We are a volunteer group that promotes public health care. My presentation probably won't take seven minutes, so I guess that's good for everyone.

Within the Chatham-Kent Health Coalition and also two other health coalitions that I work with, the Sarnia-Lambton Health Coalition and the Wallaceburg and Walpole Island health coalition, we believe that this entire bill has been put together too hastily and does not serve the needs of Ontarians. We think that it should be withdrawn totally and redrawn, if you will.

Home care has been with us for a number of years. It used to be a volunteer service that people received, and in the recent past, numerous governments have had their chance to revise and improve home care services. At present, the rules that we're living under come from the Liberal government. Our present government now would like to revise and remove most regulations that the act—and I'm sorry, everyone; I forget the name of the act. I'm very sorry. The present bill, Bill 175, seeks to get rid of a lot of regulations; to get rid of public oversight; to allow privatization of home care to a further extent; and to allow privatization of public hospitals and long-term care by moving services to their own for-profit companies. These things are not good for Ontarians.

The previous speakers—I want you to know that I commend you. I'm not sure that I can come up with any more asks of the government. But I want to tell you, just in a few minutes, some of the things that are going on now with the present legislation, and I want you to know that there is nothing within Bill 175 that will address these problems.

A gentleman from Lambton county recently had open-heart surgery. His doctor ordered home care for the first several weeks after he was discharged home. He never got a call from home care, so he was left without any support systems.

1710

An elderly lady who had surgery and was discharged home was waiting for a call from home care. Her doctor had ordered home care support for her in the first three weeks of her convalescence. A worker showed up in the fourth week who didn't know what she was supposed to do.

In a nurse-practitioner-led clinic in Sarnia, Ontario, they were concerned because they were always getting calls from PSWs asking how to use current wound care supplies. This is a huge thing; I know it sounds rather small, but there are so many people out there, elderly people with bedsores etc., and if you don't know how to use the current supplies, then what good are they? They go from special bandages up to stem cell protocols.

I'd also like to talk to you about the fact that with many of these elderly clients—

The Chair (Mr. Kaleed Rasheed): Two minutes.

Ms. Shirley Roebuck: —thank you—elderly clients, coming into their homes, there is a—sorry; you broke my train of thought, Mr. Rasheed.

The Chair (Mr. Kaleed Rasheed): My apologies. I have to let presenters know.

Ms. Shirley Roebuck: Yes. Many of the elderly folks that do receive home care services use not only the physical services but they look forward to their home care workers to provide some sort of social interaction. When there's no therapeutic relationship set up by having the same home care worker come to that one person day after day, or weekly, or whatever, it's not beneficial for the client.

I won't take up any more of your time with examples, but the recommendation of our groups is simply to please withdraw this bill. I know that the government can do better. You can do better for Ontarians. Leave public oversight in place. There is no part of the legislation that speaks to public oversight or a complaint process. Ontarians receiving home care are going to be better off—

The Chair (Mr. Kaleed Rasheed): Thirty seconds.

Ms. Shirley Roebuck: —with a publicly supervised home care system, not any private, for-profit companies.

The Chair (Mr. Kaleed Rasheed): Thank you very much for your presentation this afternoon.

We are going to start with the opposition. MPP Armstrong, please go ahead.

Ms. Teresa J. Armstrong: Thank you so much for being patient with your presentations, because you're the last of the day, so we're really excited to hear from you.

I wanted to ask the presenter for the CWDO—that would be Tracy—to expand a little bit more on what she referred to as self-directed service in the community, and then self-directed care models in the community. Could you expand on those two concepts, please?

Ms. Tracy Odell: Yes. Self-directed care is a person like me with a physical disability who hires my own attendants and explains to them what I need. I schedule my own services within the hours allocated to me. This is administered through the Centre for Independent Living in Toronto for anyone in Ontario who qualifies. There are, I believe, over 1,000 people in this situation. It's not well known, so I really appreciate your question. It is often forgotten about.

For instance, attendants that come to our homes are allowed to do certain kind of procedures that might not

normally be permitted under home care because we know how to do them and we can direct. For example, an insulin injection, changing a catheter, enemas—things like that can be done because we can direct. We are in charge. That is the nature of the self-directed services to which I refer.

Ms. Teresa J. Armstrong: And then what about—I don't know if it's a difference or not—you said "self-directed services" and then you said "self-directed care." Is that the same terminology, then?

Ms. Tracy Odell: Yes, I'm sorry. That's probably a typo. Yes.

Ms. Teresa J. Armstrong: That's okay. And then you also talked about—you were kind of repulsed, I guess, by the residential congregate care centres that they put in the bill. As you know, they haven't defined them. Can you speak to what your concerns might be around not knowing why that hasn't been defined in this bill but yet referred to?

Ms. Tracy Odell: Oh, yes. Because we don't know what it is, what if somebody says, "It's not economical to send individual attendants to your own home anymore"? What if they decide, "Right now we want you all under this same roof because now it's going to be easier. Attendants won't to have to travel between people. Their hours will be more defined." The needs of consumers like me will be the last things thought about. That is a concern about being steered into more and more institutional settings again.

Ms. Teresa J. Armstrong: I have one last question; then I'll pass it over to my colleague. On slide 5, you had highlighted the bill of rights, so you're probably aware that it's no longer legislation; it's passed off to regulation. How do you feel about that with regard to the people that you represent, your population that has experience with disability and has higher needs when it comes to home care, but yet the bill of rights isn't enshrined in legislation? It's just subject to regulation.

Ms. Tracy Odell: I feel very strongly that it should be in the highest form of law possible, so right in the act, as it is now. As we see, even though it's in the act, we still have problems, right? You've got the report on all the nursing homes. All the rights that were written on paper didn't do those people very much good. If anything, those rights need to be strengthened.

Ms. Teresa J. Armstrong: Okay. My colleague—I think it's France—is up next for questions.

The Chair (Mr. Kaleed Rasheed): Madame Gélinas.

M^me^ France Gélinas: Thank you to all four presenters—very interesting. I would like to ask the same questions about the bill of rights. You saw that the bill of rights is not in legislation; it is now in regulation. I was wondering—I'll start with Siying and Tova. Do you have something to share about this?

Ms. Tova Houpt: It's news to me. I did not recognize that that was going on until now, so I can only agree with Tracy. To take that away from people in an institutional setting and only try to regulate it—we already have ongoing problems regulating long-term-care living as it is. How are you going to go about making sure that a home that's private, for-profit, that claims they're doing everything by the book and looks good on paper when you audit them, is actually holding up their end of the bargain and making sure that the resident bill of rights is being implemented the way they're supposed to?

M^me^ France Gélinas: Agreed. Did you want to add something?

Ms. Siying Cai: Yes. When I was looking for Bill 175, I just want to share my personal experience, because me and Tova both did our placements in—I was doing a placement in a long-term-care facility. Before this pandemic, I already saw how—I don't know how to say it. The residents already faced a staff shortage. For example, I saw the staff rush the residents to feed them breakfast. Before the pandemic, as a placement student, I would be assigned to a secure unit to help the residents, to do the assisted feeding, and we helped them to facilitate the activity program, so they really enjoy it. As I have my experience working in the secure unit, I understand how important it is to have trained professionals to assist these residents.

1720

But when this pandemic happened, volunteers and everybody was sent home. They sent us home, and we were suspended from placement. We were very concerned about the residents—their isolation. As we stated in our written submission, the residents, especially people with neurocognitive disorders, were very confused. Also, we saw the news. The city of Ottawa banned the loved ones from visiting the residents—the window visits. So we're really concerned. We ask you to amend this bill because we feel that a lot of—

The Chair (Mr. Kaleed Rasheed): Two minutes.

Ms. Siying Cai: Yes, sorry. Because we feel that a lot of rights have been taken away.

M^me^ France Gélinas: Thank you.

Shirley, did you have any thought about if the bill of rights should be in the legislation or if it's okay to have it in regulation?

Ms. Shirley Roebuck: Yes, of course. I think the bill of rights should be front and centre. I believe that we have to look at home care and long-term care differently. I think the bill of rights should be front and centre within any legislation. Regulations aren't going to do it. The previous speakers are right. The present government is not even doing regular inspections of long-term care. I don't know if they've ever even done an inspection of a home care agency. I do know—

M^me^ France Gélinas: No, they don't inspect long-term-care agencies. They have accountability agreements that nobody looks at either.

Ms. Shirley Roebuck: No. There's no accountability at all within the private sector—

The Chair (Mr. Kaleed Rasheed): One minute.

Ms. Shirley Roebuck: —and that's not good enough for Ontarians.

M^me^ France Gélinas: One quick question, then: I think, Tova, you were the one who said you want to see a

resident-to-staff ratio. You used "one worker to a maximum of seven residents." Would you like to see something like this, a minimum standard of care for home care, also in the bill?

Ms. Tova Houpt: It doesn't necessarily apply to home care. I was referring mainly to long-term-care centres, where the ratio is regularly twice that. Usually PSWs or nurses to residents are 14 to one, which would definitely strip a bill of rights—

The Chair (Mr. Kaleed Rasheed): Thank you very much. My apologies to cut you off.

We are now going to move to the government side. MPP Martin, please go ahead.

Mrs. Robin Martin: Thank you for all of the presentations today. It was very interesting to hear from all of you and the different perspectives that you bring. I was listening very carefully to what Shirley was saying—the examples that you were giving of care that was inadequate, shall we say, in some of the home care situations that you described. I think that makes the case for change, which is really why we're here today. We're talking about home care, of course, now. The legislation that we have for home care, HCCSA, the one that we will be repealing, is over 25 years old and doesn't reflect today's realities. It promotes a siloed, barrier-ridden system for addressing client and caregiver needs, and that's why it's not really seen as a positive framework. The Auditor General released two reports about home and community care in 2015 citing concerns about equity, consistency and cost-effectiveness of that home care delivery model.

So what are our goals in this legislation? Easier access for people to connect people with their care providers through video conferencing securely, if they want to use that, remote monitoring, and also more direct interaction with their actual providers because we know it's also important for care providers to be more integrated. It can be a very isolating experience to be providing home care and to not have anyone to talk to about the care of the patient.

Another thing we want to do is provide more choice for people to make sure that they can get care in new community settings and keep people healthier. That's health promotion, which everybody seems to agree is a good thing. Keep people home as long as possible.

I just want to state, before asking the question, that the government's priority is to strengthen the publicly funded health care system and make it better for patients, families and caregivers. There are no changes regarding charges. The same home care services that are delivered without patient copayments will be continued without copayments. This act that we're talking about, Bill 175, if passed, and the proposed regulations—which, by the way, were posted at the same time as the act was brought forward and have now had a 60-day period for comment which was open to the public—it's made clear that this is our intention.

In addition, the government is maintaining the requirement that health service providers or Ontario health teams, to provide home and community care services, must be not-for-profit. This requirement is clearly set out in the legislation. So Ontarians can continue to rely on the publicly funded health care system and publicly funded home care. So that's sort of what we're trying to do here.

Shirley, because you mentioned those examples, I guess what I would say with this preamble is that you've mentioned some cases where it's clear that our current system is not meeting the standards and is not providing the seamless kind of care that our home care patients deserve and expect. Do you not agree that it's time to move forward with a more integrated system that does help patients access that care?

Ms. Shirley Roebuck: Ms. Martin, I don't agree with Bill 175's version of the items that you mentioned that the government is trying to implement. You're not going to be able to provide better care by downloading things to regulations. You're not going to be able to provide good care with private, for-profit companies whose main goal is profit. We need to keep—

Mrs. Robin Martin: Okay, but we have currently—

Ms. Shirley Roebuck: No, I'm sorry, ma'am. I'm sorry; please let me finish.

Mrs. Robin Martin: Sorry; I thought you were done.

Ms. Shirley Roebuck: I believe that there is nothing in the act that I could find to say that public oversight would be maintained and that there would be a complaint or concern process. I have no faith at all in any for-profit company changing their company rules because someone complains.

Yes, I mentioned all of those examples, and if you look at my presentation, ma'am, you will see that I say that I do not believe that Bill 175 takes on these challenges. I don't believe it will. We need a public system for home care, period. I have dealt with for-profit home care providers. The level of education that their supervisors have is not at all the same as any public agency. Again, I believe this is for-profit. I strongly, strongly encourage the government to do better and to keep home care under a public health services scenario.

Mrs. Robin Martin: Thank you, Shirley. Just to clarify, there is a process for appealing if there are any concerns, first to the provider—every provider has to have a complaint process—second to the Patient Ombudsman and finally to the Health Services Appeal and Review Board, which is what the current process is for appeals, just to clarify.

1730

I think my colleague Mr. Coe also had a question, so maybe I'll cede to him.

The Chair (Mr. Kaleed Rasheed): MPP Coe.

Mr. Lorne Coe: Thank you, Chair, and through you, my question is to the Chatham-Kent Health Alliance and their co-chair. What is really clear by the conversations I've had within my community is that the government is maintaining—maintaining—that health service providers or Ontario health teams that provide home and community care services must be not-for-profit. This requirement is clearly set out in the proposed Connecting People to Home

and Community Care Act, 2020. It's clearly there. The same home care services that are covered by OHIP would continue to be covered. The community services would continue to be directly provided by non-profit organizations in almost all cases.

The Chair (Mr. Kaleed Rasheed): Two minutes.

Mr. Lorne Coe: What we're looking at here is improving the patient experience. That's an expectation my constituents have, and they've had for a lot of years. I've lived in Whitby for 30 years. I hear it every day, regardless of COVID, that health care is uppermost in people's minds. So how can your members be a part of this work?

Ms. Shirley Roebuck: Sir, I believe it is our mandate to make sure that we put forth practical, realistic public health service recommendations to our government. As far as your saying everything is going to be delivered by non-profit, we do believe there are for-profit home care companies already operating.

I can only say that all I see within your legislation is a fragmented delivery service, as different agencies all over the province look at home care and supervise it. I don't see that there's much good or much improvement to be had by Bill 175.

Mr. Lorne Coe: All right. Thank you, Chair.

The Chair (Mr. Kaleed Rasheed): Thank you very much.

Now I'm going to move to the opposition side. Who is asking the question? MPP Joel Harden, please go ahead.

Mr. Joel Harden: Thank you, Chair, and thank you speakers for engaging with us today. It takes a lot of courage. As you know, we are at the end of day, as my colleague MPP Armstrong mentioned, so it takes some fortitude. I want to thank you all for putting yourselves forward and speaking on the record.

Tracy, do you mind if I use your first name? I'm going to assume it's all right. First of all, Tracy, I was really deeply moved by your story, and thank you for sharing it. The notion of being able to access services and to direct those services yourself, and what you faced growing up with society's prejudice, which many people have made the case to me still exists, is a powerful one.

I'm wondering about the extent to which this legislation also worries you from a disability rights standpoint. I know that Mr. David Onley did a review of the Accessibility for Ontarians with Disabilities Act. This government has been in possession of that review for quite some time now, for the better part of a year. But we as yet do not have a priority list, a sense of enforcement or where we're moving towards Ontario being a fully accessible province by 2025, which is our obligation under the act.

As we're having the discussion, as I'm listening to you as someone who has fought for the right to direct your own care, to have care in the community, do you feel that our lack of willingness to pursue access to home care services, community services, directed care services for people with disabilities is symptomatic of a larger problem?

Ms. Tracy Odell: I guess from my perspective, it does feel like things are being downloaded, to use the same term that I think Shirley was using, and being fobbed off.

I do like to see that there are a range of service options available for people and that each of those options are adequately resourced so that people can get the right level of service that they rightly deserve. That would be a key thing of mine.

I know that there has been some discussion about putting some health care standards out there that would be accessible health care standards. We still have a lot of services that are not accessible: doctor's offices that don't have accessible examination tables or lift equipment, for instance. That's a long-standing thing. That might be outside of the scope of this bill.

I just wanted to speak specifically to alert people to the notion that if it's all about "care" and medical services and nursing homes, we lose an important piece of the picture for people that can live independently in the community despite very serious disabilities. Some people are on ventilators and are being fed and toileted and everything else and are living successfully in the community and having very meaningful and productive lives. That was a piece that I personally wanted to speak to today. I don't want to be an expert on all the rest of the things that are put forward in the bill. But that was a concern, and that's what motivated me to come forward.

Mr. Joel Harden: Thank you for doing so. I just wanted you to know that we also heard today from ARCH Disability legal services. But really if I'm remembering the day correctly—and it has been a lot of work in one day—you are the second person to make the disability rights case for access to attendant services and directed home services, so again, I just really want to appreciate the work that your organization does in that regard.

Shirley—do mind if I call you Shirley? Is that okay? Yes. All right; thank you, Shirley. Over to you: When you had your dialogue just a moment ago with MPP Martin, who is somebody I have a great deal of respect for—at the same time, I'm a little worried that the assurance you got doesn't quite fit the bill that I've had the occasion to read. I just want to read you a passage in Bill 175. You tell me if you're assured that there won't be any additional copays for users of home care.

Section 23.1 of Bill 175 reads: "If a health service provider or Ontario health team provides a home and community care service to an individual, the provider or team shall not require payment from the individual for the service"—that sounds good, also in addition to what MPP Coe said—"and shall not accept a payment made by or on behalf of the individual for the service"—wait for it—"except as provided for in the regulations." Uh-oh.

Here is where a lot of people from the opposition caucuses are starting to worry about not specifying the scope of services in the act itself and allowing things to be dealt for in the regulation. What I'm worried about is that the government is giving itself wiggle room by hoping to clarify these issues later in the regulation. It may lead to

Tracy and to other folks that I work with all the time here in Ottawa Centre finding out later that Bayshore or CarePartners or ParaMed is going to actually be charging them a fee for a service for something that, I think you and I can agree as defenders of public medicare, should be part of the public medicare system.

Having heard that aspect of Bill 175, does it make you more worried, or are you satisfied with the answer you got from the government?

Ms. Shirley Roebuck: I've been worried for years. Yes, I do not believe that there is anything, including the section that you read, within Bill 175 that prohibits any for-profit company from starting to slip little copays in. I don't.

Other than that, I think Bill 175 is a bunch of gobbledygook. It should be removed and it should be redone. It should be redone not only with Tory experts but also with opposition experts and, I would say, home care receivers and possibly public health advocates.

Mr. Joel Harden: Absolutely. Thank you for that.

Siying—did I get your name right? Siying? Is that correct? Okay, great—and Tova: I hope I can use your first names as well. I'm actually interested, genuinely interested—I think it's relevant to our discussion of Bill 175. What drove you to want to study to become part of the caring professions? I want to know the answer to this question, because we have a huge recruitment issue. In Ottawa, we have a 60% turnover rate—a 60% turnover rate—of personal support workers, and that was pre-COVID. So we have a lot to do.

In our conversations today, we've heard the idea of more pay, but I'm always inspired by people who decide to dedicate themselves to the kind of public service you're doing taking the time to flag the concerns you're flagging with us today. What drove you to do the work you're doing and what would make you want to stick with it for a lifetime?

Tova or Siying, either could start.

Ms. Siying Cai: I will start, sir. When me and Tova, we enrolled in our program, our professor said one thing—

The Chair (Mr. Kaleed Rasheed): Two minutes.

Ms. Siying Cai: Oh, sorry.

The reason why I want to be in this field is because I just want to graduate to be a social service worker in the field of geriatrics to assist and to increase the well-being of our seniors and also protect our seniors—basically, to help the seniors. To increase their well-being, to help them, to assist them to live the best they can live each day, no matter if they're in the long-term setting, institutional setting or a community centre. Thank you; this is my answer.

Ms. Tova Houpt: Sorry, just to add to that really quickly, before we run out of time: To clarify, we are not PSWs; we're social service workers. So that was our aim—to support. It's part of our role, actually, to advocate for the general public and the betterment of society.

Mr. Joel Harden: I just want to say to both of you, you've done a wonderful job of that today. I hope, as a community, in this call and in subsequent calls, we can remind our friends in government that we have a vision of public medicare. Public medicare is something that should be included in all facets of care. You've made a compelling case, all of you, today that home care should be held in public hands, so I want to thank every single one of you for helping us make that case.

The Chair (Mr. Kaleed Rasheed): Thank you very much. Any further questions? No. Seeing none—awesome. Thank you very much. I guess none from the government side, so that concludes our business today.

As a reminder, the deadline to send in a written submission will be 6 p.m. on June 17.

The committee is now adjourned until 9 a.m. tomorrow, when we will meet to continue hearings on Bill 175. Thank you, everyone, for your cooperation. I really appreciate it, and have a wonderful evening.

The committee adjourned at 1743.

STANDING COMMITTEE ON THE LEGISLATIVE ASSEMBLY

Chair / Président
Mr. Kaleed Rasheed (Mississauga East–Cooksville / Mississauga-Est–Cooksville PC)

Vice-Chair / Vice-Président
Mr. Vijay Thanigasalam (Scarborough–Rouge Park PC)

Ms. Rima Berns-McGown (Beaches–East York ND)
Mr. Michael Coteau (Don Valley East / Don Valley-Est L)
Mr. Faisal Hassan (York South–Weston / York-Sud–Weston ND)
Mr. Logan Kanapathi (Markham–Thornhill PC)
Mr. Jim McDonell (Stormont–Dundas–South Glengarry PC)
Miss Christina Maria Mitas (Scarborough Centre / Scarborough-Centre PC)
Mr. Sam Oosterhoff (Niagara West / Niagara-Ouest PC)
Mr. Kaleed Rasheed (Mississauga East–Cooksville / Mississauga-Est–Cooksville PC)
Ms. Sara Singh (Brampton Centre / Brampton-Centre ND)
Ms. Donna Skelly (Flamborough–Glanbrook PC)
Mr. Vijay Thanigasalam (Scarborough–Rouge Park PC)

Substitutions / Membres remplaçants
Ms. Teresa J. Armstrong (London–Fanshawe ND)
Mr. Rudy Cuzzetto (Mississauga–Lakeshore PC)
Mr. John Fraser (Ottawa South / Ottawa-Sud L)
M^{me} France Gélinas (Nickel Belt ND)chn
Mr. Joel Harden (Ottawa Centre / Ottawa-Centre ND)
Mrs. Robin Martin (Eglinton–Lawrence PC)
Ms. Jane McKenna (Burlington PC)

Also taking part / Autres participants et participantes
Mr. Lorne Coe (Whitby PC)
Ms. Sara Singh (Brampton Centre / Brampton-Centre ND)

Clerk pro tem / Greffiere par intérim
Mr. William Short

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