Legislative Assembly of Ontario

Assemblée législative de l'Ontario

Official Report of Debates (Hansard)

M-13

Standing Committee on the Legislative Assembly

Connecting People to Home and Community Care Act, 2020

1st Session
42nd Parliament

Tuesday 16 June 2020

Chair: Kaleed Rasheed
Clerk: Valerie Quioc Lim

Journal des débats (Hansard)

M-13

Comité permanent de l'Assemblée législative

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

1re session
42e législature

Mardi 16 juin 2020

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

Tuesday 16 June 2020

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON THE LEGISLATIVE ASSEMBLY

COMITÉ PERMANENT DE L'ASSEMBLÉE LÉGISLATIVE

Tuesday 16 June 2020

Mardi 16 juin 2020

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

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.

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 members in the room: MPP John Fraser, MPP Sam Oosterhoff, MPP Donna Skelly, MPP Robin Martin and MPP Jim McDonell. The following members are participating remotely: MPP Joel Harden, Madame Gélinas and MPP Christina Mitas. And we are joined via phone by MPP Teresa Armstrong.

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.

Are there any questions before we begin? Good. I welcome all the presenters this morning for our 9 o'clock session.

CANADIAN UNION OF PUBLIC EMPLOYEES (CUPE)

PATIENTS CANADA

ADVOCACY CENTRE FOR THE ELDERLY

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

Ms. Candace Rennick: Thanks so much. My name is Candace Rennick. I'm the secretary-treasurer of CUPE Ontario.

Joining me for the presentation this morning is Michael Hurley. Michael is the president of the Ontario Council of Hospital Unions/CUPE. Also joining us is Charlene Van Dyk. Charlene is the chair of CUPE's Health Care Workers' Coordinating Committee. And we have a staff support, Doug Allan, from our research department, who will be leading our response during the Q&A.

With over 270,000 members in Ontario, CUPE is the largest union in Canada. Over 75,000 of our members work in hospitals, long-term-care facilities, home and community care, local health integration networks and other health services.

This proposed legislation will privatize health care services. It will weaken public oversight, remove legislative protections and undermine home care working conditions and unleash an untested home care experiment. Really, chaos awaits.

Bill 175 is permissive. It allows a laissez-faire framework for home and community care. It repeals the more detailed Home Care and Community Services Act,1994, and it leaves most details to policy or regulation. For example, the home care bill of rights is not in the proposed legislation, but instead, it may be put into regulation. This approach removes public accountability that comes with legislation. Regulations and policies can be changed with little to no public consultation. One would think that in today's world, a home care bill of rights would not be removed from legislation, but that is what this bill proposes.

The Ministries of Health and Long-Term Care will fund Ontario Health. Ontario Health will fund the Ontario health teams, the OHTs, and the health service providers, the HSPs. The OHTs and the HSPs will contract for home care. Home care providers will employ home care workers and take over LHIN coordinating care functions.

This convoluted model creates an obvious conflict of interest. Home care providers will deliver the service and provide care coordination. So, for example, they will get to determine the amount of service. It really is like putting the colonel in charge of the chickens. Compounding this, home care providers are often for-profit corporations, and their focus will first be on profit rather than patients' needs.

The government's plan to kill off the LHINs means that home care and community services directly provided by the LHINs are under threat of privatization.

Michael?

Mr. Michael Hurley: Thank you very much for having us this morning.

Private, for-profit hospitals have been frozen for years, but this bill would modify the Private Hospitals Act to allow them to expand home and community care beds.

Similarly, the ministry is proposing to add unlicensed residential congregate care settings as a location for home and community care services, with no restrictions on for-profit operators. Instead of public hospitals, these unlicensed congregate care homes would provide rehabilitative, transitional or other care. We have learned from COVID-19, however, that inadequate congregate care is a fatal danger for vulnerable populations. Instead of introducing new, lower levels of care, we need to develop and strengthen our best public health care.

Privatization will also come with proposed regulations allowing home care corporations to operate within hospitals. Multiple chains of command within hospitals are a recipe for miscommunication and error. Home care workers moving from one hospital to the next will also be an excellent vector for the spread of infection. Destroying the main public sector organizations in home care completes the privatization of home care begun under the last Progressive Conservative government in the late 1990s. However, problems followed that privatization of home care delivery. The government was forced to impose moratoriums on competitive bidding to deal with the appalling, largely privatized working conditions in this sector. The government had to directly intervene twice to improve wages.

Trying everything but a public sector model—CCACs were first taken over by the province, then cut from 43 to 14, and later folded directly into the LHINs. This new restructuring completely blows up these earlier reforms.

Each of these successive rounds of restructuring was sold as a major step forward, just like Bill 175. The reality was that the privatization was a complete failure that led to successive crises in home care. Deepening privatization now will only make matters worse. This is the wrong bill at the wrong time. Unfortunately, this government is pushing this bill forward even as the province is under emergency orders. We find the timing completely inappropriate.

The COVID-19 outbreak has exposed major shortcomings in our health care system.

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

Mr. Michael Hurley: Thousands of long-term-care staff and residents have been infected, over 1,790 have died, and we are not through this one yet. There is an urgent need for health care reform, but that has nothing to do with this bill. Instead, the focus should be on stopping a second peak of COVID-19, especially in long-term care. This would mean ensuring that residents in long-term care are treated in hospitals and not left to die untreated or unquarantined in understaffed or overcrowded long-term-care facilities. It would mean increasing pay for workers, to attract and retain staff. It would mean increasing full-time work. It would mean weekly testing. It would mean phasing out for-profit long-term care. It would mean increasing the time to care. It would not mean setting off an unrelated privatization of home care, one that will be met with spirited resistance by the health care workforce.

Charlene?

Ms. Charlene Van Dyk: Right now, 14 LHINs contract for home care services within their boundaries. Under the new model, the—

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

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

Ms. Francesca Grosso: Good morning. My name is Francesca Grosso. I am here as the board chair of Patients Canada, which is a charitable organization dedicated to bringing the patient voice to bear on health policy and on services that work for patients. Our community consists of thousands of people who identify as patients, and we reached out to that community prior to my presenting today.

Let me start with a real patient story that directly relates to the proposed Bill 175. A frail, elderly complex patient breaks her hip and has to get it replaced. After her surgery, the surgeon explains to the family that she needs to be placed on a wait-list for a rehab bed and she urgently needs to get out of the hospital to avoid a hospital-acquired infection. The family says, "Great. Let's get her on that list."

0910

But the hospital then explains it has no authority to do so. She has to wait for a care coordinator from a government agency to visit and authorize the physician's orders. They are the gatekeepers of home care. Worse still, the coordinator's visits are on a first-come, first-served basis, and they're backlogged.

It takes fully four weeks for that visit to take place to authorize what the surgeon had advised four weeks earlier. The patient is finally placed on the wait-list—once again, first-come, first-served basis—and two days later, that patient is diagnosed with a hospital-acquired pneumonia and is moved to ICU.

This story, for us, shows the difference between a culture of care, of priority and of urgency versus a culture of administration, of process, of first-come, first served, of lists, of quotas—that of bureaucracy, that of government agencies. In fact, two Auditor General reports have concluded that patients are not well served when government agencies are involved in the direct delivery and management of their care.

To the committee: My presentation thus far was taken practically verbatim from the presentation made by my predecessor, Michael Decter, the past chair of Patients Canada, four years ago, in 2016. At that time, he presented on Bill 41, the Patients First Act. That bill was supposed

to fix home care. Yet, with pressure from vested interests, the bill continued to allow government agencies to run home care, this time the LHINs. We warned at that time that unless there were bold, structural changes made, it wouldn't fix a thing—and we were right. Not one of our recommendations was implemented.

Here we are, four years later, and nothing has changed.

So let's start: Patient journeys are still being bottlenecked by the LHINs that are inserted between the patient and the provider. Where else, I might ask, in the system is a patient's treatment subject to approval by a government agency? Nowhere except home care, and it does not work for patients.

Care coordination is still being done outside of the core care team. Where else in the system is the determination of a treatment plan subject to the dictates of a government agency? Nowhere but home care, and it doesn't work for patients.

What happens when the funder of home care also dabbles in the delivery of home care? Dollars are disproportionately withheld to support the funder's own activities, services are rationed and it doesn't work for patients. On that point, by the way, that is not Patients Canada speaking. That is the finding of the Auditor General report of 2015.

Today we see a bill, Bill 175, that, with some changes, holds the promise of addressing the structural issues that our recommendations spoke of in 2016:

(1) Allow care organizations to determine who should get home care. Bill 175 would permit this. However, we would ask that the legislation be amended by removing the LHINs from having any active role in that determination. Without this, the powerful forces of status quo will prevail, as they did the last time.

(2) Let the responsibility for delivering services together with patients and families—let those responsible for that coordinate them. This would allow that. Once again, we ask that the legislation remove the LHINs completely from care coordination for the same reason I mentioned.

(3) End the bottlenecking. Let primary care providers and hospitals refer directly—

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

Ms. Francesca Grosso: —to home care services. The bill allows for that.

(4) Prohibit the funder from siphoning funds to support some of their own care activities. On this point, the legislation is silent. We believe this conflict of interest needs to be addressed or it will be repeated and will re-create the same rationing.

The role of government and its agencies is to oversee, to hold to account, to regulate and to fund, but it is not to deliver care.

We want to raise one more important concern. We've heard from some patients that during the COVID-19 pandemic, they've received calls from the LHIN cutting their services or putting them on notice that their home care services would be cut. Some of these patients depend on those services, and they have no other options. This practice is not consistent with the Premier and minister's message that home is the safest place, and it certainly isn't consistent with what we understand Bill 175 to be.

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

Ms. Francesca Grosso: Home care is a solution, not a problem. We ask that the LHINs immediately restore home care services.

I thank the committee, and I hope you'll consider our recommendations.

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

I will now call on Advocacy Centre for the Elderly. You will have seven minutes for your presentation. Please state your name for Hansard, and you may begin.

Mr. Graham Webb: Good morning. I am Graham Webb, a lawyer and the executive director of the Advocacy Centre for the Elderly, a legal clinic serving low-income seniors. Ms. Meadus will present and answer questions on our behalf.

Ms. Jane Meadus: Good morning. My name is Jane Meadus. I am a lawyer, and I'm the institutional advocate at the Advocacy Centre for the Elderly.

The Advocacy Centre for the Elderly, known as ACE, is a legal clinic which has existed in Ontario since 1984. We take over 4,000 calls annually on individual matters on a variety of seniors' issues. We get many calls regarding home care. Examples of those issues would be inaccessibility to home care due to wait-lists, insufficient care, poor quality of care, staff not showing up, inconsistent staffing. We also get a lot of calls with respect to what are presently unregulated transitional beds and a variety of types of housing. These facilities are unlicensed, and there are no accountability or oversight mechanisms at the present time.

We echo much of what we heard from CUPE this morning, and I will indicate what some of our specific issues are. Our submissions have been presented to the committee.

First of all, we're demanding the withdrawal of Bill 175 in its entirety. We submit that the bill, which proposes sweeping changes to Ontario's home care system, has been fast-tracked through the Legislature with little or no meaningful consultation at a time when we are dealing with a pandemic which is shedding light on the problems in many sectors of our home care system. We submit that this is not the time for sweeping changes and, furthermore, it's our position that many of the changes are detrimental to those using home care. We ask that the bill be withdrawn and that the government wait until a more suitable time when we can apply the lessons learned during the pandemic to any new legislation, to ensure that the lessons learned during the pandemic ensure that the home care system is truly able to meet the needs of the residents of Ontario.

Should the government move forward with this legislation, we believe that there are fundamental changes that are necessary. Our written submissions detail the same, but I will review some of them this morning.

First, the repeal of the Home Care and Community Services Act: The bill proposes the repeal of the Home Care and Community Services Act and moving the bulk of

that statute into regulation. This would include definitions, the bill of rights, requirements of provider agencies, and complaints and appeals processes. We believe that these areas are all vitally important and should be enshrined in statute, as would be found in other legislation such as the Long-Term Care Homes Act. This would ensure that any future changes in such important areas of the law would have to be brought before the Legislature for debate, consistent with a fair and democratic government.

Secondly, the delivery models: The delivery model proposed includes care coordination being moved from the 14 LHINs to various entities, such as Ontario health teams and other care providers. We submit that this fractured system will result in system inequity and confusion. Furthermore, these entities are not crown agencies, unlike the LHINs that perform those services today. That means that they would not have to undergo the same scrutiny by government, such as by watchdogs like the Auditor General and the Ombudsman. We submit that despite stating that care coordinators will be not-for-profit agencies, the fact that these entities presently have no corporate structure—and, if they do, they will likely be controlled by various for-profit corporations and be not-for-profit in name only. As has been seen in this pandemic, the privatization of health care has not been positive, and we submit that this would not be in the interests of Ontarians.

The final issue that I'd like to address is residential care. Residential congregate care is referred to mostly in the regulations, and it's unclear from the bill how such entities would be set up as there are no sections in the bill specifically dealing with them. However, it would appear that these are intended to be licensed, and without any clear oversight.

0920

At the Advocacy Centre for the Elderly, we receive hundreds of calls every year about people being pushed into these kinds of facilities. We have a great deal of expertise in this and feel that the use of these has to be done in a very specific way. While we agree that a funded level of residential care is required, it must be licensed, have standards, be inspected and have oversights enshrined in legislation, similar to what we see in retirement homes, and be not-for-profit.

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

Ms. Jane Meadus: We're also concerned that these facilities will be used—instead of as a care facility where people will be able to stay between a home before they require long-term care, that instead they're going to be used as transitional care to move ALC patients out of hospitals while awaiting placement in long-term care. Residential care cannot be used in this way.

Our experience has exposed a variety of issues in this type of congregate care use as transitional care. Our experience is that people are pressured to move from hospitals into these facilities that cannot meet their needs. They cannot meet the needs of these people because they require long-term care. These must be used only for people who require some level of care less than long-term care but more than what they're receiving in the home.

We do not want to see these residential care models—

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

Ms. Jane Meadus: —become a substitute for appropriate long-term care.

I thank the committee for the ability to present this morning, and I will be pleased to answer any questions that you may have.

The Chair (Mr. Kaleed Rasheed): Thank you very much for your presentations, to all three presenters.

I do see MPP Logan Kanapathi joining us via Zoom. MPP Kanapathi, can you please confirm that, in fact, it's you, and also the city and the province you are calling from?

Mr. Logan Kanapathi: Yes, I'm joining from the city of Markham, Ontario, Mr. Chair. Thank you.

The Chair (Mr. Kaleed Rasheed): Thank you so much. Now we are going to go to the question-and-answer session. I'm going to start with the opposition. Madame Gélinas.

M^me^ France Gélinas: I would like to start with a question to Ms. Jane Meadus, please. You made a very compelling case to withdraw Bill 175—that there was no consultation, that it is in the middle of a pandemic, that we have to learn our lessons from the pandemic.

What would you say to people who say, "But our home care system is broken; we have to fix it now"?

Ms. Jane Meadus: What I would say is that there are definitely issues with our home care system—there is no question about that—but to do that in the middle of the pandemic, when our eyes are somewhere else, is just totally inappropriate. This is a very complex system. It has to work together very well. It has to take into consideration all of the issues related to access, assessments and ability to provide that care. During a pandemic, when our eyes are on other things, is just not the time to do that.

M^me^ France Gélinas: The next question will be for all three presenters in the order that you presented. You've all talked about human resources issues—either the care was delayed or it was a different person. Do you think that human resources issues should be addressed in the bill, and if so, what would you like to see in the bill when it comes to human resources in our home care system?

I'll start with CUPE. Any one of you can answer.

Mr. Doug Allan: There are very serious threats around human resources and labour relations issues in the bill, all of it completely unaddressed. The LHIN workers, for example, in large part—the whole home and community care side—face the demise of their organizations, even while they're being asked by this government to continue their work in a dedicated fashion. Their work is being transitioned piece by piece out from under them, all with no assurance about their employment future or—even if by some chance, they do have an employment future in the sector—that their conditions will be fair and reasonable, unlike the highly privatized home care industry, which is renowned for its poor wages and working conditions. That is the future that, at best, may await them. None of this is contemplated in the legislation. While CUPE believes that this legislation is irredeemable, cannot be fixed and must be withdrawn—this problem festers.

Indeed, it's a problem, not just for the workers in the system, but for the system itself. The government is apparently expecting the system to continue, even while workers in the LHINs face the demise of their organizations. That is a threat for the government. We believe the government is very fearful of that and has not been forthright in explaining what the future bodes for the LHIN workers. The reality is going to sink home at some point, and without any assurances, the government is playing with fire.

There is also the question of the changes that they've made around the appointment of supervisors and labour relations under the act. The bill introduces heavy-handed amendments to the Connecting Care Act concerning the sale of a business and related employer provisions when a supervisor is appointed. Of course, the whole act should be withdrawn, but failing removal, we would suggest changing the amendments so that the appointment of a supervisor alone shall not indicate that a sale of business or related employer argument can be made.

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

Mr. Doug Allan: This way, the sale of business and related employer provisions would still apply if changes were made that normally would bring those provisions into play.

The Chair (Mr. Kaleed Rasheed): Sorry; can you please state your name for Hansard?

Mr. Doug Allan: Doug Allan, from CUPE.

M^me^ France Gélinas: Ms. Grosso, I heard Michael Decter share the same patient story that you shared.

Is there anything related to human resources that you would like us to make sure exists?

Ms. Francesca Grosso: Yes, a couple of things on human resources: I'm not going to concentrate on LHIN human resources, because they, in my view and in the view of most patients, do not deliver the bulk of the work. The bulk of the work is delivered by the people who are paid the lowest, and those are the personal support workers. Those are the people who are actually going into the homes. They have been forgotten.

I know that there is an interest in blaming provider organizations, but I would say that one needs only to go back and to review what the Auditor General wrote in 2015 that talked about the siphoning of dollars from—at the time, the CCACs—to the providers.

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

Ms. Francesca Grosso: To me, the problem is structural. Until we fix the problem, which is getting the LHINs out from in the middle, we will not be able to ensure the proper funding.

That is what I'd like to see—better funding for the PSWs and those going into the homes.

M^me^ France Gélinas: Jane, if you could; you have 30 seconds.

Ms. Jane Meadus: I think that we have to stop paying the workers piecemeal. They should not be paid simply for being at the home. They have to be paid for travel and include all the proper payment for that.

I think we have to have quality controls within the legislation as well as consistency, and I think that is really important. Our clients complain about different people in and out of their houses all the time. I think that the legislation should gear the system toward having—

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 Fraser.

Mr. John Fraser: Thank you to all the presenters for being here this morning and for your great presentations.

My first question is for the Advocacy Centre for the Elderly and Jane Meadus.

Good morning, Jane. I want to say—maybe not totally appropriate—I keep running into your parents walking down, and I always wave and say hello. They said a couple of times, "We're Jane's parents." So I want to thank you for all their work. They're very proud of you, as well. But that's not what I really wanted to say to you.

We've heard very clearly that you believe this bill should be withdrawn, because we seem to be in a rush to do something in the middle of a time when we're preoccupied with trying to manage a virus in our communities that puts the elderly at great risk.

0930

In terms of the patient bill of rights—that should be, we agree, enshrined in legislation. Should we also be taking a look at that patient bill of rights and adding to that, updating it, making it stronger? Are there any things that you think are lacking in that patient bill of rights right now that we should insert?

Ms. Jane Meadus: Absolutely. I think that the bill of rights does need to be reviewed and expanded. We saw that happen with the long-term-care homes, when it went from the old legislation into the Long-Term Care Homes Act. Adding things like expectation of quality and consistency—would be a really good place to put it in the legislation, so that people would expect consistent care in their home and expect people to provide the care and the time that they're supposed to. For example, if you have an hour of care in your home, they should provide an hour of care, not 20 minutes and then sit there for 20 minutes and leave. That sort of thing could be used to expand the bill of rights.

Mr. John Fraser: Another point in your presentation was with regard to how the accountability in care coordination is being removed, and it's something that's either going to be left up to regulation—something unknown in the future. Are there other risks that are there because of the nature of the organizations—that they won't be accountable to the Ombudsman and the Auditor General, as well? Did I hear that correctly?

Ms. Jane Meadus: Yes. I think that we're going to really lose accountability because they're not going to be crown agencies, so they're not going to have that oversight.

The fracturing of the system will be a really big problem. We already have a problem that the 14 LHINs—one person will go to the LHIN and will get two hours a

day, and another person with the same set of issues will get three hours a day, because of the inconsistencies. This will be magnified across the system.

I agree that there probably is too much administration. I think that it could be streamlined. But I don't think that putting it in hands of the providers in Ontario health teams is the way to change it, because I don't believe they're going to have oversight, and I can foresee problems.

Mr. John Fraser: That's a concern that I have with the bill. Our family has been through different journeys—home care, long-term care, retirement homes, a palliative journey—and seen where home care really works well and where it doesn't work, where it falls down. There's no question about that.

The thing that concerns me most—and I can see that it concerns you—is the ability to appeal to a higher order when you're not getting the results that you want, so there is some level of accountability. What this bill does—and actually, with the Connecting Care Act—is, it takes the governance and places it in downtown Toronto, essentially. There are no governance structures in the family health teams—there's no community in care, there are no community structures.

I think we know that we need change—

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

Mr. John Fraser: Thank you. I was waiting for that—and we have to build a better system. I want to go back to the same point: that we seem to be in a rush right now when we're not all fully prepared to do the things that we need to do.

Is there anything else you want to add, Jane?

Ms. Jane Meadus: One of the things that I think is helpful with the LHINs, for example, is—if you have a problem with home care, yes, you can complain to the home care operator, but in general, we often have more success when we go to the LHIN care coordinator to assist in resolving some of these issues, without having to necessarily go to, say, the Health Services Appeal and Review Board, which is a much more complex process. So having someone who oversees that, who doesn't have any skin in the game as to whether or not the person gets one or two hours—the LHIN doesn't really care. It's the budgets, of course—and that's the other thing.

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

Ms. Jane Meadus: We have to have proper budgeting and have enough money going into home care. That's part of the problem. You can build the structures, but if you're not providing the right kind of funding, it's going to be a problem.

Certainly, I think some oversight is lacking in this legislation.

The Chair (Mr. Kaleed Rasheed): Now we are going to move to the government side. MPP Oosterhoff, you may start.

Mr. Sam Oosterhoff: Thank you to all the presenters this morning. Thank you for appearing before the committee and for all the work that you do for your respective organizations. It's very much appreciated. I know there's a lot of feedback that we've heard this morning already, and over the past day as well, that will help inform our conversations about this legislation, which we believe moves in the right direction and, of course, serves to improve the patient experience. Really, that's why we all believe that it's important that we make these modernization changes and break down some of those barriers between primary care providers and home care providers, making sure that we can focus care around the patient.

I have a few different questions, but I want to perhaps begin by asking Ms. Francesca Grosso a couple of questions, because I think it's very important that we remember in this conversation the need that we have to support the patient. All of us here, as elected members, hear from many, many community members in our ridings about bad experiences that they've had, and of course good experiences, as well. We hear the compliments, the kudos, as well as the critiques. Of course, the other presenters might have thoughts on this—but for Ms. Grosso, representing an organization speaking for patients, is the current system working? That's the fundamental issue here. We, I believe, have seen the failure of the current system. We've seen that take place, and we know that we need to do better. Here are ways that we believe—for a variety of reasons that I can get into, but I've been told often that you have two ears and one mouth, so use accordingly. So I'm just going to ask Ms. Grosso if she could speak to the current system and whether or not that has worked for patients in the province of Ontario before I get into some of my further questions.

Ms. Francesca Grosso: Thank you very much for your question.

In a nutshell, no, it doesn't work at all for patients. And I've heard a number of things that I am a little bit puzzled by. The idea that the LHIN doesn't care whether you get two hours or one hour or three hours of care—that is absolutely not the case. They are the rationers of care. They are the ones who have a budget, and they are the ones who send the coordinators out to determine how many hours, minutes and seconds a person can get.

It is a highly rationed system—and people want more care at home. That's what people want. The idea that we want to wait to fix it until after the pandemic—let me tell you what has happened during the pandemic, because we have not shone a light on home care. We've had people whose care has been cut by the same LHINs that are so caring about the patient. It is the LHINs that have made the phone calls to cut care from people. That's what has happened during the pandemic.

The other issue that has happened during the pandemic—actually, André Picard wrote about this this morning—is that home care in Ontario is dead last when it came to anything in terms of PPE. They were not on the list. The LHINs were all on the list, and all of the other providers.

So, no, it is not working. People don't have access to robust services at home, which they need.

Mr. Sam Oosterhoff: I think that's a really key piece in this conversation—recognizing where the current system has failed patients in our province and where we

must do better. One of the pieces that I think is so important in that is the conversation around technology. Of course, we are very grateful to see that we're beginning to move to a place where we remove the limits on care. We want to ensure that everyone receives the care they need.

If you could speak a little bit to that change in technology, but before you do that, there are a lot of accusations—there are a lot of rumblings from certain sectors around perceived privatization, and I say "perceived," because I'm wondering if you could point to a part in the bill that privatizes health care.

Ms. Francesca Grosso: Well, I should start by saying that Patients Canada does not take any ideological stance. We're not here to promote one group over another. We are a national organization. I think it's well worth mentioning that one of the biggest problems they had in Nova Scotia with regard to deaths actually came from a place called Northwood, a long-term-care home that actually is a not-for-profit.

0940

There are tremendously great not-for-profits in home care. There are also some very good ones on the private side too. We don't get into that debate at all. We believe in very strong oversight, and we believe that when a dollar is given to any organization, regardless of their governance, government does have a role in oversight. I see no reason why the LHINs or any other government agency cannot continue in that kind of role.

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

Ms. Francesca Grosso: But care coordination is not an oversight role; it's a care role. It should belong with the care team. And there could be ample ways to have places where people can call and complain. I would argue that the Ontario health teams, if and when they get up and running properly, should be care organizations.

I won't go down the public-private route, except to say that I think there are plenty of good and bad on both sides. The problems here are really of the system that structurally has failed.

Mr. Sam Oosterhoff: The reason I ask that is because I have yet to see the portion in the legislation that actually states that there is going to be increased privatization as a result of this. I believe that's misinformation, unfortunately, that has been spread about this piece of legislation.

I do think you spoke to a very important piece, and that, of course, is breaking down those barriers. That's what our Ontario health team models are working towards and that's what this legislation is working towards—breaking down the barriers that silo home care, community—

The Chair (Mr. Kaleed Rasheed): Thank you, and apologies to cut you off.

We are now going to move to the independent side. MPP Fraser.

Mr. John Fraser: I'd just like to follow up with Ms. Grosso from Patients Canada. Thank you for your presentation and for your advocacy on behalf of patients.

As I said to Ms. Meadus, our family has experienced some of the journeys that you're talking about with regard to where things really don't work—and sometimes things really work, too. But when they don't work, it's not a good thing.

The deep concern I have about this legislation is, the governance of this is being pulled away from communities and is being centred in downtown Toronto. There's no clear appeals process right now for people if they have a complaint with the new entities. There's no governance locally, and the actual organization, Ontario Health, doesn't have public meetings. They're not bound by that.

Does Patients Canada have any concern about governance and your organization's ability to be able to advocate, given that these things are not in the bill and are not clear?

Ms. Francesca Grosso: Certainly, governance is always a very, very big issue and a big concern.

We see the splintering of the care coordinators off in a government agency as a very, very bad thing, and we are looking forward to seeing them integrated with the care team.

With regard to governance for patient complaints, that is something we are concerned about. We would like to see something that would give the patient a path to complain. We have assumed that just as the LHINs are not gone yet, there is no reason why they can't continue to have some kind of role in that regard until the Ontario health teams are up and running with proper governance structures. We don't see that as something that's going to happen in a short period of time. Eventually, when they do, we would be very comfortable having the Ontario health teams as a system of care providing that governance. So we see that the residual governance authority resides with the LHIN until these structures are fully gone or moved out into the Ontario health teams.

Mr. John Fraser: Thank you very much for your answer.

I'd just like to direct my next question to CUPE and whomever would like to answer the question. I know there are a number of you on the phone. I see Michael Hurley, who is from Ottawa, and Candace. How are you doing?

I just want to follow up on the kinds of things that are being put into regulation in this bill. I understand and realize that you believe this bill should be—not withdrawn, period, but at least not done in the manner that we're doing this right now. I fully agree.

As to my question with Ms. Meadus—in terms of the patient bill of rights, I understand you believe that that should still be kept in legislation. Do you believe that we should be looking at that bill of rights and updating it, expanding it to include some things that are not there right now? If anybody has any specifics, that would be great. I'll leave it there.

Mr. Michael Hurley: Absolutely, we would favour strengthening the patient bill of rights. You only have to look at the sordid experience of the residents in long-term care who were, effectively, prohibited from transferring to hospital while they had COVID-19, even though they were acutely ill, and denied services—one of only a range of experiences of people in home care and hospitals during this outbreak. So the rights of patients need to be

strengthened, and they need to be strengthened to provide them with protections, including protections from the delivery of services in ways that impact on them in a very, very negative way.

I would take serious exception with the thought that there isn't an impact in terms of care that is delivered in a privately operated way. In fact, in this most recent outbreak, three quarters of all the deaths occurred in privately owned and operated long-term-care facilities. Those same facilities transferred to their shareholders $1.3 billion in profits just at the outset of this outbreak. It's clear that money comes from cleaning and from other services—

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

Mr. Michael Hurley: It's clear from the Canadian Medical Association Journal's work that there's a huge impact on patient morbidity and mortality when services are delivered in a not-for-profit way. People have a right to the best service that this system can provide, and that includes dedicating resources to them and not siphoning it off to people who are, essentially, operating in a parasitic way on these services.

In this bill, the introduction of private hospitals, for example—the proliferation of the private hospitals is obviously an example of the proliferation of private services, which is going to have a significant impact and degradation on the care in rehabilitative and other services that are currently provided on a not-for-profit basis at a very high-quality level by our public hospitals.

The question of capacity and access needs to be addressed. They need to be there for the patients and the residents—

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

We are now going to move to the government side. MPP Mitas.

Miss Christina Maria Mitas: I'll start by saying that our independent colleague stated that he knew that we needed change. I find it interesting that he said that, because I wonder why he and his Liberal colleagues did not make any change for 15 years.

I do have a question for both CUPE and the Advocacy Centre for the Elderly. I'm wondering if you can tell me if you found a section of Bill 175 that specifically states that we are privatizing home care. This is a strictly yes-or-no question.

Ms. Jane Meadus: I think it's not a yes-or-no answer. There is not a section that specifically says that it's being privatized—

Miss Christina Maria Mitas: Okay, thank you.

Ms. Jane Meadus: —but when you look at the makeup of the Ontario health teams, they are heavily infiltrated by the for-profit sector.

Miss Christina Maria Mitas: And CUPE?

Mr. Doug Allan: Yes, the regulations—the discussion paper specifically looked at the idea of turning care coordination over to the home care providers, which are primarily for-profit.

0950

The fact that the government has removed much of the oversight and guts of this legislation—and has removed it from legislation into regulation, at best, or policy—is not a strength of this legislation. It's another way that public accountability has been removed and—

Miss Christina Maria Mitas: I'm so sorry; I just have a few minutes to ask questions, and I have quite a few. I just wanted to say, rather than making assumptions or discussing the strength of what we are putting forward, did you find specifically a section that says that we are privatizing home care? Yes or no?

Mr. Doug Allan: Yes, you are privatizing, because that's what—

Miss Christina Maria Mitas: Did you find a section in Bill 175 that specifically states that we are privatizing home care? Yes or no—not based on assumptions.

Mr. Doug Allan: It's not an assumption. It's what the government has written in its regulation policies.

Miss Christina Maria Mitas: Can you tell me which section that is?

Mr. Doug Allan: It's in the government's regulations—the discussion of regulations, which, if you had read, would clearly indicate to you—

Miss Christina Maria Mitas: I have indeed.

Mr. Doug Allan: —what the government is doing through the home care providers, which are largely for-profit. We do not think that is the way to go.

Miss Christina Maria Mitas: Okay. So I will say that you are answering, but refusing to back up your answer with telling me where you have found it. The Advocacy Centre for the Elderly has told us that it is not specifically in there.

I will go on with another question for CUPE. Are you aware that we posted the regulations on February 14? Yes or no?

Mr. Doug Allan: Yes.

Miss Christina Maria Mitas: You are. Did you submit any comments on the regulations within the 60-day notice period? Yes or no?

Mr. Doug Allan: No, we did not.

Miss Christina Maria Mitas: Okay, thank you.

I now have a question for Francesca. Michael stated that private immediately equates to a lower quality of care. As someone who is speaking to private health care providers, can you speak to that and provide some commentary on that?

Ms. Francesca Grosso: As I had mentioned before, Patients Canada is not ideological. We are very agnostic when it comes to private delivery versus public delivery.

I want to make a point here. It's very saddening to me to listen to a bill that is trying to transform what is wrong with home care—and it seems like every time any government of any stripe tries to make any change, it always ends up coming down to, "How do we do in the private sector providers?" or "How do we ensure that it's only private sector providers?"

I will remind everybody that fully 30% of all of our health care is delivered by private providers—not just

home care, but labs, diagnostics etc. That ratio has not changed, regardless of stripe of government. It sounds to me that this is being used to have a different argument, and one that Patients Canada is not prepared to engage in. We want a change.

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

Ms. Francesca Grosso: We want a change, and we want to see more cohesion of care coordination within the care team. We want more services. We want less administration. We want less bottlenecking. We want care to be done by care providers, and government can do all of the administration and the oversight. How this always gets into a conversation of private versus public—to me, it is a false argument. It's a disingenuous argument and it's not one that serves the public.

I will say what I said before: The vast majority of the deaths, 90% of all the deaths taking place, in the province of Nova Scotia took place in a not-for-profit long-term-care home. I am not suggesting they did a terrible job. We all know all over the world that these centres are petri dishes. But this public-private debate does not serve the patient—

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

Ms. Francesca Grosso: —and we aren't going to get into it.

Miss Christina Maria Mitas: Would you agree with the characterization that the system we're putting forward will not be for-profit, but will allow for private participation?

Ms. Francesca Grosso: Yes, as it should, as is the status quo, as it always has. I would hope that the viewpoint of the LHIN, or whoever is going to be the overseer, will ensure that those providers, regardless of not-for-profit or private, are held to account and their feet are held over the fire to make sure the services are delivered well. That is what we want to see.

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

Miss Christina Maria Mitas: Also, a quick question to CUPE and the Advocacy Centre for the Elderly: Would you agree that, private or public, our number one priority should be serving the needs of the elderly?

Mr. Doug Allan: The record shows very clearly that the privatization has led to an inferior version of—

Miss Christina Maria Mitas: Would you agree that our number one—

Mr. Doug Allan: Let me finish, please. The number one priority is the patients and—

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: I want to say thank you to all the presenters. I know you're very passionate and dedicated to making sure that the funds that are put into care go to the front line, which is patient services.

Some stakeholders have said they have not been consulted on Bill 175. Can the three presenters answer whether or not they were consulted on Bill 175?

Ms. Jane Meadus: We were not consulted on Bill 175.

Ms. Teresa J. Armstrong: I'm sorry; I didn't recognize your voice.

Ms. Jane Meadus: It's Jane Meadus from the Advocacy Centre for the Elderly.

Ms. Teresa J. Armstrong: Thank you. Patients Canada, were you consulted?

Ms. Francesca Grosso: No, we were not consulted in any formal way.

Ms. Teresa J. Armstrong: CUPE, were you consulted in a formal way?

Mr. Doug Allan: No, not at all.

Ms. Teresa J. Armstrong: I think the importance of this discussion that we're having on the committee on Bill 175 is to hear voices that weren't consulted in a very, very serious transformation in health care.

It has been very well articulated how important it is that the funds that we put into patient care or health care must be for care and not for profit. So I will take a stand and specifically say that when we're delivering care, all the money should not be for profit; it should go into care directly. I do not agree that a facility or agency that delivers care should be profiting from a government-funded program.

I also have a question with regard to the transparency piece. We've been talking about this very passionately. If this government decides to continue down the path of allowing more doors open for the expansion of private care delivery, how strongly would you recommend that this oversight should be implemented into the bill? Can I get the first response from CUPE, please?

Ms. Michael Hurley: The expansion of for-profit delivery should not be permitted. The expansion of private hospitals should not be permitted. If we should have learned anything from this pandemic, it's the disaster that is the operation of for-profit services in terms of long-term care and the expansion of those into rehabilitation and complex continuing care and other hospital—subacute aspects of hospital care. The introduction of for-profit delivery of home care services into a hospital setting, among other features of this bill, is something that we think is horrific.

Ms. Teresa J. Armstrong: Patients Canada, would you mind giving us your comments on that, please?

Ms. Francesca Grosso: Our position is that oversight is a very, very important thing. Regardless of whether it is a private or a public deliverer of care, all care delivery has to have extremely rigorous regulation and oversight and a good ability for a patient to complain when things are not working out, and that goes beyond governance of organizations. So we would highly favour a rigorous ability for government, as I said before, to hold the providers' feet to account.

Ms. Teresa J. Armstrong: Jane Meadus, please?

Ms. Jane Meadus: We would agree that it doesn't matter what kind of operator is delivering the services; it has to have rigorous oversight. Our preference would be not to have for-profit agencies taking profits out of our health care system. But oversight would be required no matter who is operating the home care system.

The Chair (Mr. Amarjot Sandhu): Two minutes.

Ms. Teresa J. Armstrong: Joel, you're next.

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

Mr. Joel Harden: Friends from CUPE, it's nice to hear from you this morning.

Ms. Grosso, my question is for you. Who funds Patients Canada?

Ms. Francesca Grosso: It's funded by donations on our website.

Mr. Joel Harden: Is there any funding of Patients Canada by for-profit operators in home care or nursing homes?

Ms. Francesca Grosso: We have been given donations in the past for events that we hold—to help us hold the events. I'm trying to think. No, certainly not within the last two years have we had any.

Mr. Joel Harden: So it's 100% citizen-funded?

Ms. Francesca Grosso: Yes, it's 100% citizen-funded—

Mr. Joel Harden: Okay. Sorry; I only have two minutes. I would submit to you this: I heard and I take what you say very seriously, but in our city, here in Ottawa, 70% of COVID-19 deaths happened in four for-profit care homes—four.

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

Mr. Joel Harden: And the people that I talk to, that you mentioned very articulately, the PSWs who are on the front lines delivering the care, so many of them—I have very rarely met a full-time person working in home care and I have seen too many operators in the for-profit industries restricting sick days, restricting full-time access to shifts, restricting access to PPE.

I take your point about you believing it not being distinctly private and public—but I think the record is very clear. The private operators have a lot to answer for.

To MPP Oosterhoff and MPP Mitas, who both mentioned there's nothing in this bill that allows for privatization: I will point people again to section 23.1, which specifically states that regulation will allow operators in the sector to charge upfront copayments if it's specified in regulation. The government is asking us to trust them. I don't think I've heard in this conversation yet a lot of trust. We want the specificity of public health care—

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

Thank you to all the presenters. If I can just please request all the members to stay on, and if the presenters can exit, please.

We are going to recess now. The House is sitting. The session will start at 1 p.m., but if I may request all the members who are on Zoom or via phone to please join around 12:50 p.m. so this way it's easy for our team over here to quickly vet everyone.

To the members who are present in the room: I believe we have a vote this afternoon. If you can please make sure that you go ahead first to the east lobby or the west lobby—whichever lobby you decide to vote—just go ahead first because it is a half-hour bell and we want to make sure that the members of this committee are all here around 1 p.m.

Thank you so much, and see you all at 1 p.m.

The committee recessed from 1003 to 1308.

The Chair (Mr. Kaleed Rasheed): Good afternoon. Thank you all for joining us. My sincere apologies for the delay.

I'm just going to quickly let everyone know who we have in the room and the members who are joining us via Zoom. We have MPP Christina Mitas, MPP John Fraser, MPP Sam Oosterhoff, MPP Donna Skelly, MPP Robin Martin and MPP Jim McDonell, and I believe MPP Logan Kanapathi will be joining us via Zoom; we have MPP Joel Harden and MPP Gélinas online. Do we have MPP Armstrong?

Interjection.

The Chair (Mr. Kaleed Rasheed): Okay. So we have MPP Armstrong joining via phone.

MR. INNIS INGRAM

ONTARIO FEDERATION OF LABOUR

REGISTERED NURSES' ASSOCIATION OF ONTARIO

The Chair (Mr. Kaleed Rasheed): Thank you to the presenters who are joining us this afternoon for our 1 o'clock session.

I will now call on Innis Ingram to present. You will have seven minutes for your presentation. Please state your name for Hansard, and you may begin.

Mr. Innis Ingram: Good afternoon. My name is Innis Ingram. I wrote something, so I'll just read it.

When preparing this statement, I decided to speak from the heart rather than sit here, quoting various sections and subsections of the bill. I speak from the perspective of a son whose mother had to enter substandard long-term care earlier than she would have had to than if our family could have afforded adequate home care under the current system.

This bill is problematic in that there are myriad systemic problems that must be addressed. This legislation presents yet another step backwards towards the Americanization of one of the most vulnerable sectors in our health care system.

While I realize that your decision on this bill has likely already been made, I still offer my humble opinion for your consideration. My mother suffers from pulmonary fibrosis, a degenerative terminal lung disease. As her health deteriorated, her needs increased to the point that she required regular home care to be able to maintain her apartment and a degree of independence. The care offered by the government was not going to be sufficient, and our family lacks the financial resources and space to be able to care for her ourselves. Giving up her independence was a terrifying concept for her, as she had lived her life as a self-reliant individual who had devoted her life to the care of others, both through her career in the suspected child

abuse and neglect program at SickKids and her role as a single mother.

This bill is being introduced at a time when the way that we as a country deal with senior citizens and those with disabilities has been laid bare. What the COVID-19 pandemic has revealed is not only "deeply troubling," to quote our honourable Prime Minister, but often horrifying. There are systemic problems in both home care and long-term care that should be considered.

There should be an established basic wage for PSWs, PCAs and other caregivers, which would not only attract more candidates to these positions, but the right candidates who wish to pursue a career as a caregiver, and not just a job.

The soon-to-be-formed Ontario Health should be populated more so by doctors whose decisions are guided by their allegiance to the Hippocratic oath, as opposed to a conglomerate of bankers and former board members of for-profit care providers, whose allegiance lies with the bottom line, rather than with the health and well-being of their clients.

There is also the issue of the removal of public and governmental oversight that this bill presents. It will allow these financially motivated corporations to act with impunity, without fear of being held accountable by elected officials or by the public at large. The current system that is in place for the reporting of abuse and/or labour violations is ineffective and is not trusted by the ones who are meant to use it.

These are a few issues that represent the tip of the iceberg.

One of the greatest sources of pride as a Canadian is in our health care system. It's something that sets us apart. This bill is a step away from that pride and a step towards our neighbours to the south. It mirrors the system in the US, where you get what you pay for. When you consider that seniors have spent their lifetimes as taxpayers, why are they not entitled to get what they spent their lives paying for on layaway? In the case of Bill 175, privatization is synonymous with Americanization.

In closing, I hope that I have been able to provide some insight into how this system and the proposed bill have impacted and will impact people, not just the profit margins. This bill, particularly when one draws a connection to Bill 161, will remove the need for accountability by the monolithic care providers, both in home care and long-term care. This is not only unacceptable but, in my opinion, un-Canadian.

Thank you for your time.

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

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

Ms. Patty Coates: Thank you for the opportunity to speak today.

My name is Patty Coates. I'm the president of the Ontario Federation of Labour. With me is Thevaki Thevaratnam, the OFL director of research and education. The OFL represents 54 unions and one million workers in Ontario. We advocate for the rights of workers, whether they are in a union or not.

The decision to move ahead with Bill 175 comes shamefully at a time when COVID-19 has revealed deep-rooted and deadly problems in Ontario's home and community care sector and a lack of workers' protection. The bill dismantles all remaining public governance, public control and public-interest protections of Ontario's home and community care system, and creates a system where most provisions on home and community care will be contained in regulations. This limits public input and oversight. Withdraw Bill 175.

Under Bill 175, Ontario Health, the newly created super-agency, will take over funding of home and community care services from the local health integration networks, or LHINs. The government's appointees to the board of directors of Ontario Health are not subject to conflict-of-interest legislation and are not required to seek public input, hold open board meetings or provide public access to information.

Bill 175 will allow the government to transfer all remaining publicly controlled parts of the home and community care system to a range of provider organizations, including for-profit groups. These organizations are not publicly governed or accountable. They will be allowed to contract, subcontract and operate home care as they see fit, without government or public oversight. Under Bill 175, significant and critical parts of home care can be privatized through transferring public control to Ontario health teams that include for-profit entities. Care coordination functions can also be transferred to various providers that are dominated by for-profit chains.

Bill 175 also allows for the expansion of private, for-profit hospitals into home care and other residential care services, including services that are provided by public hospitals and by long-term-care homes. It is not in the public interest to expand private, for-profit hospitals.

This legislation fails to integrate home and community care systems and allows them to be governed by different providers in different regions. Ontarians will not be well served by a disjointed system.

In the past few months, we have seen the deadly results of care homes rationing supplies and limiting resources allocated to residents. Nonetheless, Bill 175 will further reduce oversight on these facilities, allowing for-profit corporations to determine how many site visits a person may get, the amount of supplies and resources available for them, and how to supervise their care. This is a conflict of interest and will not guarantee quality care for Ontarians. Withdraw Bill 175.

This bill fails to address countless issues in Ontario's home and community care system. Any bill on home and community care must improve access to care, address regional inequalities and ineffective home care assessments, missed visits, quality of care and staffing shortages. It must improve working conditions and employment standards for personal service workers.

Before the 1990s, the home and community care sector was primarily non-profit and unionized. Today, due to privatization, it is a competitive, market-driven sector with for-profit and non-profit providers competing to deliver services at ever-lowering costs.

In 1995, 20% of home care and personal support service providers were for-profit. In 2011, that number grew to 65%. Companies are making profits while the quality of care diminishes. In today's model, home care workers have low wages, minimal benefits, if any, and insecure working conditions, and most are without union protection. More than 60% of PSWs are employed part-time in a sector primarily of women and racialized workers. COVID-19 has already claimed the life of at least one PSW in this province and infected hundreds more.

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

Ms. Patty Coates: With the onset of COVID-19, Ontario locked down nursing homes, making long-term-care facilities inaccessible and driving many families to care for their loved ones in their own homes. These caregivers are now overwhelmed and need help. However, the government's inefficient health and safety protocols, along with substandard legislation on employment and labour standards, limit the availabilities of PSWs.

The government must order training on wearing and the use of proper personal protective equipment.

The OFL demands that the government immediately adopt a strict adherence to the precautionary principle. Precarious work must end. All workers, including PSWs, must have fair wages and benefits, paid leaves and universal access to workers' compensation and union protection.

The OFL also endorses the recommendations and any proposed amendments of the Ontario Health Coalition. For more information, please refer to the—

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

Ms. Patty Coates: —OFL's submission on an economic recovery plan for all Ontarians.

Any bill on long-term and community care must develop a public, non-profit home and community care system that integrates care and is rooted in the public interest. The government must invest in the system and its workers.

Workers' unions and community organizations must be meaningfully involved in the development and implementation of legislation and policies that affect workers and communities. Withdraw Bill 175. Thank you.

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

Before I ask the Registered Nurses' Association of Ontario to present, I just to want to apologize to all the members. I believe their presentation was displayed online while the Ontario Federation of Labour team was presenting.

1320

Now I will call on Registered Nurses' Association of Ontario. You will have seven minutes for your presentation. Please state your name for Hansard, and you may begin.

Dr. Doris Grinspun: I'm Dr. Doris Grinspun, the proud CEO of Registered Nurses' Association of Ontario, RNAO.

I first want to give my sympathies to the family member, Innis Ingram, for the loss of his parent—too many lost lives, including the lives, of course, of several PSWs and nurse Brian Beattie.

I want to speak in support of the bill, with a few caveats. The caveats are what's important in our presentation.

Bill 175 provides several opportunities—I'm trying to manage the slides, but it's not allowing me to go to the next. I'm not sure why. It's simply not working.

The Chair (Mr. Kaleed Rasheed): I believe it should be on your end. If you see on your screen, you should be able to share slides.

Dr. Doris Grinspun: Oh, it's working now. It was not before.

RNAO is the professional association representing registered nurses, nurse practitioners and nursing students in Ontario. We have over 44,000 members. We are extremely involved in policy and practice issues, with both the best practice guidelines program—I believe several organizations shared proudly yesterday that they had BPSOs on health policy. And I don't think there is any Ontarian who has not heard us during COVID-19.

Let me tell you about why we support this bill. We issued already in 2012—the need to reform the health system so that we don't rely only on hospital care, as sadly happened again during COVID-19. ECCO 1.0 speaks about the need to enhance community care to build a robust system—same with ECCO 2.0, from 2014, which previous ministers advanced slightly. ECCO 3.0, which we released on May 12 of this year, speaks about enhancing community care once and for all and entering the system in primary care. It also speaks, in recommendation number 6, about the need to bring long-term-care, nursing homes, which we say are the homes of people, into community care.

We saw what happened during COVID-19—two stories: those in the community who made it to the hospital, for the most part, did well, and in general, we did well with community care; but all the congregate settings actually did pretty horrifically, starting with long-term care. We keep saying that our health system didn't crumble. That is incorrect. The only thing that didn't crumble is hospital care, because we prepared them well, we gave them the PPE, we gave them the resources. That's where we put all the focus. As for home care, it crumbled. They didn't have the PPE, and they were not able to even provide service to people with cancer in their homes. As for long-term care, Mr. Innis Ingram already stated—and we have been speaking about that ongoing. Primary care also crumbled, with the exception of some virtual care—and the list goes on with other vulnerable populations.

ECCO 3.0 speaks about several recommendations:

—universal reach for everybody who needs it, with access to primary care, to ensure that all Ontarians have access to primary care;

—upstream approach to care for all vulnerable populations, and community engagement;

—inter-professional teams with all professionals involved;

—comprehensive care coordination.

In Bill 175, we do speak about care coordination in primary care, but we do not say where the 4,500 care coordinators will be. Those care coordinators with the funding and the resources must move to primary care once and for all. We are afraid that they will disappear and evaporate. They need to be in primary care. There is no system in the world that is actually high-functioning without high-functioning community care and primary care.

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

Ms. Doris Grinspun: We are talking about long-term care with a guarantee of nursing hours—so four hours of nursing and support workers—evidence-based practice and optimal digital and full-practice care. We are saying evidence-based practice is a must. Primary care and community care is a must. This bill allows us to move to the quadruple aim, if we are serious, with good oversight, so we prevent privatization and we actually make more public home care and primary care available to Ontarians in every corner of this province.

Florence Nightingale spoke about the abolition of hospitals. Let me be clear: We are not supporting abolition of hospitals, but we are speaking about the recalibrating of the system, once and for all, with community care, primary care for every person in Ontario and especially for vulnerable populations.

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

Ms. Doris Grinspun: Long-term care must be part of it. Long-term care is the home of people. We keep saying it's the home of people, but we abandoned them during COVID-19. It's time to bring them into the Ontario health teams, and Ontario health teams must move with ECCO 3.0. Now is the moment—care coordination, 4,500 of them, in primary care with solid home care for the benefit of Ontarians.

Thank you very much.

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

Now we are going to start the question-and-answer session. First will be the government side. MPP Jim McDonell, please go ahead.

Mr. Jim McDonell: We're working to enable integrated and innovative models of home care and community care through the introduction of this bill, the new regulations under the Connecting Care Act, 2019. We're breaking down the long-standing barriers that have separated home care from primary care and, in doing so, allowing a seamless coordination of services for patients, while maintaining and strengthening oversight and accountability measures.

A question to Doris: What are some of the challenges that care coordinators face today when seeking to provide patient-centred and integrated care in the current system?

She's muted.

Ms. Doris Grinspun: —that every single one of the 4,500 care coordinators we have, many of them who are members of RNAO, try to do their very best, but the tools are not there to do the best. They are not located in the community; that's the first thing. They are at the LHIN level—and now at the Ontario Health level. They need to be integrated into primary care, where the public is. Community care is where people live. That's where the care coordinators need to be.

They do not need to be hand-holding home care agencies. Home care agencies are not there to suck the system of money. If home care agencies are responsible agencies—Saint Elizabeth, VON, Bayshore, many others—they want to provide good care. Let them do the job and don't restrain them. Care coordinators are to coordinate the care, to also do system navigation—not to take over from an office somewhere.

Mr. Jim McDonell: In our region, our local hospitals and clinics are working together to bring that integrated health care to the region, and I know a number of regions have already been approved. In our case, we're waiting to see—a couple of examples—if we can learn some of the best practices that are being put in place. But, again, it's all about that community care.

I see, in 2012, the RNAO advocated for local health integration and the community care access centres to be placed in the community health centres. I think as a group, as you've talked here today, you see the need for that local flavour to health care, and not being looked after out of the large centres in the big cities hundreds of miles away.

1330

Dr. Doris Grinspun: It's absolutely the case, and if you look during COVID-19 and you look at the Ontario health teams that provided care coordination—just picture if they will have the 4,500. That's a lot of expertise of care coordinators located within those Ontario health teams, located in primary care. Anchoring the system on primary care with robust home care next to it is what we will do for the community.

People don't live in hospitals. With all due respect, people live in the community. Our problem, and the difference between ECCO 2012 and 2014 and today is the answer to Mr. Ingram—the fact that long-term care has been isolated, siloed also to the side. It needs to be brought as part of community care and never forgotten again. We have asked Minister Fullerton, Minister Elliott and the Premier that long-term-care homes must be mandatory for Ontario health teams—mandatory. They can never be forgotten again. We abandoned them. We did abandon them. We told the families, "Stay out. We will take care of your people," and no, we didn't.

Mr. Jim McDonell: That's definitely an issue. I know that a lack of facilities—over the last 20 years, we haven't seen facilities built. I know Minister Fullerton has already approved 8,000, plus about 10,000 redevelopments—

Dr. Doris Grinspun: With all due respect, it's not only facilities. First of all, the homes that have shared rooms never should have been grandfathered or grandmothered into it. That was a mistake for infection control.

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

Dr. Doris Grinspun: But now we are asking for a guarantee for nursing homes, a basic care guarantee—four hours of direct care from nursing and support workers. Just 0.8 hours, 48 minutes of an RN in 24 hours: Is that too much? Or 60 minutes of an RPN: Is that too much in 24 hours? Or 2.2 hours of a PSW: Is that too much for direct care? If that is too much, you tell that to the face of Mr. Ingram—and then let's say we have handled them, because that's what we have done.

In 2017, the previous government said, "We will implement the four hours." It never happened. Now is the chance.

Mr. Ingram, we are with you.

Mr. Jim McDonell: Well, we're working and providing that service to be moved back to the community, where these workers are and typically you know the patients. I think it's time that we do some of that.

I know you've been working with some of the health teams, your group, and looking at providing capacity.

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

Mr. Jim McDonell: Do you have any comments on the new health teams and what they'll bring?

Dr. Doris Grinspun: Fantastic—and they should be stepped forward. They don't need to be tested anymore. The only thing: Let's bring long-term care into the Ontario health teams as mandatory—ame as primary care, home care and hospital care. Long-term care must be mandatory. Bring the 4,500 care coordinators to the Ontario health teams. Let's fast-forward the model and let's start to provide the care that people need, which is in the community, not only in the hospitals.

Mr. Jim McDonell: As I say, as we move ahead, we're moving that service closer to the community. We're letting the communities decide how best to coordinate. And a big part of our health care system is long-term care and home care. It's something that has lacked attention, but with our large group of seniors moving through, it's something we see, and this bill will provide us with the allowances to make that happen.

The Chair (Mr. Kaleed Rasheed): Before I move to the independent member, if I may just request all the members to address whoever you're asking the question to. Let us know in advance. This way, for the broadcast team, it's easier for them to unmute their mike while you're asking the question. Thank you.

Now I'm going to move to MPP John Fraser.

Mr. John Fraser: I want to thank all the presenters for taking the time and for your excellent presentations.

I want to start with Mr. Ingram. I want to thank you very much for sharing your story. Those stories aren't easy to share. Patients and families should be at the centre of what it is we're trying to do here.

My question to you is really simple. I've heard very clearly that you think we shouldn't be moving forward with this legislation right now. But excluding that, in terms of what we're doing here, what's the most important thing that you believe we should be doing in this bill?

Mr. Innis Ingram: To me, the timing of this bill is what stands out the most. Like the previous presenter mentioned—if I interpreted what she said properly—it's hard to distinguish home care and long-term care because to the residents of these long-term-care facilities, that is their home. So how do you distinguish between the two?

The fact that the governing body, if you want to call it that, over Ontario Health—it switches it from a legislative procedure to a regulatory procedure, which I find extremely problematic, because COVID-19 highlighted what happens when these corporate entities are left to their own devices.

I don't think the members of Parliament are aware yet of the Trillium report that was done on Camilla Care Community. I just received it; it was just released to the families last night. The cost-saving measures that these corporations went to that literally caused a mass death in Canada, which—we like to think that sort of thing doesn't happen in our country—is shocking. From my understanding, the Globe and Mail will be publishing an article with regard to the content of that report—either they just published it or will be publishing it.

Any basic business model operates on a simple—the simple fundamental of any business is: keep costs low, keep overhead low, keep profits high. So when you're handing the power to the corporations, we've seen what happens. We're living right now, today, with the consequences of what happens when these corporations are left to that kind of power.

The rationing of things like health care products in long-term care and home care is something that, in my opinion, should never happen. Even just the verbiage that's associated with these things—we use everything from "patients" to "residents" to "clients." Each one of those I find problematic. If I was a person living with a disability, I wouldn't want to necessarily be called a patient for the rest of my life. I think "people in care" is probably a more politically correct way to refer to people.

The biggest sticking point for me is just that it further privatizes this industry—again, I even feel weird calling it an industry, because these are people that we're talking about. I saw a very powerful piece of artwork recently where it was elderly people on a conveyor belt. The symbolism in that is clear.

Again, with what we've literally just seen and what we're still experiencing—I was at the candlelight vigil at Camilla Care last night, where we placed 70 candles at the bases of crosses for the 70 people who died in that one long-term-care facility alone. Eighty-four people died in total in that home since the outbreak began, and it's easily arguable that some of those deaths are a result of a decline in the quality of care that they were receiving because of the number of staff who were off due to illness.

There's no basic wage in place for a lot of these workers. It's impossible to really address one issue with this bill—

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

Mr. Innis Ingram: —without addressing other ones, but there's no basic wage for these PSWs and PCAs. In a lot of cases, they're making just above minimum wage.

There's no basic set of qualifications that are required that I'm aware of. On the Sienna Senior Living website, for example, during the pandemic they put out a job posting saying "no experience necessary," meaning you could go from flipping burgers at McDonald's one day to being responsible for bathing my mother the next. I think the problems with that speak for themselves.

There are just a lot of steps that I feel haven't been taken before anything like this should even be on the table, and the timing of this is the worst possible timing there could possibly be, as we're still reeling from the mass deaths in Canada. It took me chaining myself to a tree outside of Camilla Care on a hunger strike for three days to get provincial intervention.

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

Mr. Innis Ingram: We like to think that we live in a country where people don't have to resort to things like hunger strikes to stop mass deaths. And to call it anything short of "mass death" is completely inaccurate and doing a disservice to all of the people who died.

1340

I was gobsmacked at the level of hypocrisy from Prime Minister Trudeau, Premier Ford and various other members of Parliament, who were speaking about the bravery and sacrifice of our veterans, being that we just celebrated D-Day and VE day, when it's those very same veterans who are being left to rot in un-air-conditioned closets, to spend the remainder of their days. This generation that went overseas and fought for my ability to sit here right now and talk to you are being completely forgotten about and neglected, both in home care and in the long-term-care industry. It's absolutely deplorable, and I can't—

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

We are now going to move to the opposition side. MPP Teresa Armstrong is joining us via phone.

Ms. Teresa J. Armstrong: Thank you to all three presenters. I really appreciate your input on this bill.

I first have a question for Patty Coates, president of the OFL. May I ask if your organization was consulted on Bill 175?

Ms. Patty Coates: No, the OFL was not asked to consult on Bill 175.

Ms. Teresa J. Armstrong: You raised the conflict-of-interest piece, stating, of course, that the Ontario Health board of directors—there's not public input. I want to get your view on—when this government talks about a structural change, and why they would set up a system like this, where there is the missing piece, where you have strong accountability. In the context of the pandemic, we've seen what can happen when there's not oversight and transparency. Can you talk about how important this is in this legislation going forward?

Ms. Patty Coates: Thank you for that question.

Yes, it's actually very important. That's why we're just shaking our heads and wondering why this bill is coming forward at this time, when we're not even through the pandemic. We've seen the devastation of this pandemic. We've seen what happens when there isn't that accountability. We know that the public, as the previous speaker, Mr. Ingram, said—it breaks my heart to know that they're pushing this bill through so fast and we're losing some of the things that we need in our public system.

I know it's not quite part of your question, but I also want to comment on something that I think is really important. Earlier, the government was talking about having this located in the community, with community people caring for the people in care. I just want to point out that what's really important is that we have this in the public realm, not in for-profit, because we know that in communities, these for-profit companies, such as CarePartners, take that care and centralize it in southern Ontario somewhere, and they leave that community without the very people and without those care coordinators in the community who know the patient, who know the people in care, who know the workers. We've seen this happen again and again. This just happened a year ago, and we know that it continues to happen.

I think we need to put a pause on this bill. We need to withdraw this bill, because we need to look at what has happened with COVID-19, what's happening with those people in care, what's happening with the workers, and ensure that everyone has the training they need, the pay and benefits they need, the paid leave they need, and that their working conditions are the best—because workers' working conditions are the people in care's home conditions, their residents' conditions. It's where they live and are cared for.

Ms. Teresa J. Armstrong: I'm going to pass the next question to France Gélinas.

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

M^me^ France Gélinas: First, I want to thank Mr. Innis Ingram for talking to us today. It takes a lot of courage to do what you're doing today, and I appreciate it. I am sorry for what happened to your family.

I have a couple of questions for you. You piqued my curiosity when you talked about the Trillium report. Are you able to share with us the Trillium report that you made reference to?

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

Mr. Innis Ingram: I'm not sure that I can, because there are legal implications. The email that I received very clearly states that the contents of the email are confidential and stuff. My understanding is that some of it was leaked to the press, being the Globe and Mail. One thing that I'll mention is an example of a cost-cutting measure is, the PSWs and nursing staff in Camilla Care Community were issued garbage bags to use as PPE during the COVID-19 pandemic.

M^me^ France Gélinas: Yes, we saw the pictures.

So the story you told us is really a story of your mother, your family; she wanted to stay home. Had the home care system been robust enough, as in, if she had had enough hours of care, she would have stayed with your family. Am I right?

Mr. Innis Ingram: Yes. The reality of her condition means that she would eventually have had to go into long-term care—

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

Mr. Innis Ingram: —but because of our lack of financial resources, we were unable to pay for the additional care she needed to receive to stay in her home.

This bill, in my opinion, just furthers the class divide that's emerging within Canada. Again, it just likens us to Trump nation to the south.

M^me^ France Gélinas: To the Americans; I agree. Basically what you're saying is that home care should be part of medicare, where the care you need and receive is based on your needs, not on ability to pay, and there is no artificial cap as to, you cannot receive more than, for a reason—you would receive the care that you need at home, is what you want, what we all want. Right now, the funding for home care is so limited that very few people actually get the care that their loved ones need and end up—

Mr. Innis Ingram: Just to respond quickly, before we get—

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

Now I'm going to move to the independent member. MPP Fraser, please go ahead.

Mr. John Fraser: My next question is going to be for Ms. Coates from the Ontario Federation of Labour.

But I want to make a comment for Mr. Ingram, just to follow up on your earlier answer to my question. Indeed, the legislation is exceptionally permissive. It's like a gigantic leap of faith on a whole bunch of fronts. I can understand people's concerns about how these entities are going to be governed—what's the accountability in terms of families like yours? Why are we not enshrining in legislation a patient bill of rights? These are all critical things that we need to debate and actually nail down, in the sense that, if anybody goes to change that, they're going to have to do the work that we're doing here. By putting things into regulations, it is very easy for the next government to change something or for the current government to change something else. There are things that are appropriate in regulations, but not all things. I just wanted to relate that to you.

To Ms. Coates: As you can see, there are many things that they're pulling out, in terms of the accountability—pulling out, in the sense of saying, "We'll put it into regulations." But there's no clear accountability, and in fact, they're removing the patient bill of rights from the current legislation and saying, "We're going to put it into regulation." Number one, do you think that's appropriate? And number two, if we were to debate that patient bill of rights, are there things that we should be doing to update it right now?

Ms. Patty Coates: Thank you, MPP Fraser, for that question.

I think that moving things to regulations is actually very scary. There is no accountability. There is no way for the public to know what is happening within their communities, within the home care and long-term-care sector. So I think it's very, very important that we have mechanisms to ensure that we have that accountability—government accountability, those health care teams' accountability and public accountability. I think that is extraordinarily important.

1350

When it comes to the bill of rights, I think we have to have all of those who are part of the community, whether it's families, whether it's unions and their workers, and others, be part of building that bill of rights.

Ms. Thevaki Thevaratnam: Can I—

Ms. Patty Coates: Absolutely, Thevaki. Go ahead.

Ms. Thevaki Thevaratnam: Bill 175 is a missed opportunity to address a myriad of issues that are plaguing the home care system right now.

What we wanted to see was improving access to home care, to address these regional inequities in terms of home care standards, because it's unstandardized at the moment. We wanted to see a remedy for missed visits. We wanted to see improved quality of care in addressing staffing shortages. And, of course, we wanted to see an increase, or a lift, to employment and labour standards for those workers who are actually in the home care system providing these services to home care patients. We didn't see any of that. We didn't see an increase to decent work or wages or paid sick leave, as Patty mentioned before. Those things need to also be ingrained into the legislation.

Mr. John Fraser: My next question is for Dr. Grinspun. Thank you very much for being here and for all your advocacy—not just for nurses, but obviously for primary care and everyone in the community.

You talked about connecting long-term care and home care, which is not something we're doing in this bill. There is nothing in that bill that says this has to happen. Should we do that? How can we do that?

Dr. Doris Grinspun: I believe absolutely we do. Let me tell you, the regime of accountability and oversight that we have had and that everybody is talking about in home care and long-term care obviously is not working. It didn't work. We failed.

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

Dr. Doris Grinspun: We failed in home care and we failed in long-term care.

What we think we need to do is to give the nursing home basic care guarantee and the home care basic care guarantee. What are the hours of care that people deserve in nursing homes and home care? We need to provide equal rights for the workers—full-time, whatever they're working, not this piecemeal approach in home care where you have 20 people coming to your house in a week. We need to stop the fee-for-service and give the workers the meaningful work they need, whether it is in home care, to my colleague Patty—three different jobs for a PSW in home care is the same. We need the nursing home and the home care basic care guarantee for people in all sectors with equal rights so that people are not jumping from one place to another.

The bottom line: the residents, the people in homes get the care they need.

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

Dr. Doris Grinspun: They need comprehensive care, not what we have now. The current accountability and

oversight regime, with all due respect, is not working. It has not worked ever.

Mr. John Fraser: Are you going to be putting forward any suggested amendments to this bill, or is that in your package?

Dr. Doris Grinspun: It's in our package. MPP Fraser, it's ECCO 3.0. We have been talking about it since 2012. We are just pushing it fast-forward now, alongside the nursing home basic care guarantee. It will all be in our submission.

The Chair (Mr. Kaleed Rasheed): Now we are going to move to the opposition side. MPP Joel Harden, please go ahead.

Mr. Joel Harden: It's so great to see familiar faces. Thevaki, Patty and Doris, it's really nice to see you all in the conversation this afternoon.

Mr. Ingram, I just want to echo what everyone else has said. Thank you for bringing the grassroots perspective to this conversation. It does take a lot of courage. I'm thinking in particular about your comments about what's happened to this industry in recent decades. As we've had this conversation with the committee, we have noted how the managed competition model has created a situation in which we've been competing on labour in Ontario in home care and in nursing care for a long time, to the detriment of the people working in this sector, often racialized newcomer women. And that's got to stop.

I've got to admit—and this is a conversation I want to have with you, Doris. You mentioned the caveats and ECCO, and I will read your submission with interest. But I struggle with the notion of trusting the large, for-profit organizations like Bayshore, like ParaMed, like CarePartners. CarePartners had a strike in 2019, when they forbade sick days for their workforce. That was something they were willing to prosecute a labour dispute for 10 months over.

So why wouldn't we seize this moment of COVID-19, when the for-profit organizations, the large ones, anyway—I actually know a lot of good, local, for-profit home care providers, for the record, and nursing home providers. But the large organizations who competed on the backs of the low-income precarious workforces they presided over—why would we give them another lease on life?

And before I hear one of my MPP colleagues from the government say something to contradict this, let me point our collective attention to section 23.1 of this legislation, which says explicitly that copays are not to be extracted from people for home care, community care, except if defined in the regulations. So this bill very clearly leaves the door open to for-profit organizations operating in the home care sector.

Doris, I'm wondering, as someone with three nurses in my family, why wouldn't we want to prohibit the continuation of large, for-profit organizations in the sector? Why wouldn't we want to make sure care stayed in public hands? What do you think?

Dr. Doris Grinspun: I am going to separate home care and long-term care, with your permission.

First of all, as it relates to home care—you commented on Bayshore. I can comment on Bayshore, VON, Saint Elizabeth—all providing outstanding care. They're best practice spotlight organizations of RNAO. They are providing what they want, and they will tell you that they want no piecemeal approach. They want to be able to send a nurse or a PSW for the entire day for the person—and not this piecemeal approach that we have had—with all the guarantees that we mentioned, accountability etc. It's a disaster.

Nursing homes: Let's be very clear. We all know that not-for-profit delivers better, at lower cost. Can we close 58% of the nursing homes? No. This is why what we are saying is, a nursing home basic care guarantee that not-for-profit and for-profit must deliver—and that needs to be set in the act.

Mr. Joel Harden: I understand. But back to home care—because it still is about home and community care. You're quite right; home can be the nursing home of the future. This is what we want. But I am struggling—particularly in an industry where there is no disclosure of executive compensation, there's no disclosure of administrative costs. I asked some of the large operators in the course of these committees if they're prepared to share information that they share with the Ministry of Health with the rest of us, so we can know what many studies are telling us—how much is being lost to the personal care worker. She would love to have full-time work. She would love to work with a predictable amount of patients. And those patients would love to work with them. It would appear to me, absent of any information, that we may be losing a lot in administrative costs.

Patty, Thevaki, over to you: How can we improve this bill to make sure this care remains in public hands? And what are your thoughts about disclosure of executive compensation and administrative costs and making sure the public has a right to know that?

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

Ms. Patty Coates: Thevaki, I'm going to pass it over to you.

Ms. Thevaki Thevaratnam: When we're talking about the home care system—that's so integral, and we are protecting the most vulnerable among us, seniors, and if we're going to be putting public money into it, then it needs to be accountable. But what this bill does is allows the Ontario health teams—by the way, their board of directors has been hand-selected by this government, who probably also share its pro-privatization agenda—they're now able to channel that funding, whatever is left of the publicly funded home care system, to other providers, and those providers can be for-profit. When we're talking about an integrated system, it makes very little sense to me that you would allow these providers to be able to determine how they operate something, how they structure something, how they contract something. It makes it much more fragmented, so it serves the opposite purpose of trying to bring together a collective system.

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

Ms. Thevaki Thevaratnam: To your point, MPP Harden, about executive pay: That doesn't serve the public

interest at all. That takes money away from patients and home care recipients, for those who are already wealthy.

The for-profit system in Ontario and home care gets a profit of about 8%. We should not be making money on the backs of our most vulnerable people in this province. That money needs to be funnelled back into the public system, back into the areas that we actually need to be fixing.

1400

Mr. Joel Harden: I wholeheartedly agree.

Any closing thoughts, Patty? You get the last bit of time.

Ms. Patty Coates: I agree completely with Thevaki. These are people. They're people and they deserve the best. They deserve the best care. They deserve the best workers, who are paid well, who enjoy their jobs, to be able to care for them in their last years of their lives—

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

Now we are going to move to the government side. MPP Skelly.

Ms. Donna Skelly: My question is for Dr. Grinspun. Doctor, the Registered Nurses' Association of Ontario has been a strong advocate for primary-care-led care coordination models. How does this bill enable the RNAO's vision?

Dr. Doris Grinspun: I am very cautious on any government these days, in believing anything will move us where we need to move.

Let me tell you what we are asking—because we were hopeful in 2012, in 2014 and now again, and that's why this time we are saying that we need some guarantees. We need to know that the 4,500 care coordinators will be located in primary care and will not disappear, that they will be embedded with interprofessional teams. We need to know that investments will go to home care and primary care.

On the issue of compensation: Absolutely, I agree that compensation should be for all—for-profit and not-for-profit—transparent. It is in the hospitals, and look at their salaries—they're out of this world. Previous governments, this government, future governments—that has to stop.

We have a Canadian health care system that believes in universal access for everybody. That's where we need to strive and that's where our eggs are going, into that basket.

Ms. Donna Skelly: I'm going to stop you. That's all the time that we have. Thank you all.

The Chair (Mr. Kaleed Rasheed): Thank you all for your presentations this afternoon.

SEIU HEALTHCARE
KINGSTON HEALTH COALITION
ADULT ENRICHMENT CENTER INC.

The Chair (Mr. Kaleed Rasheed): Welcome to all the presenters who are presenting for our 2 o'clock group. Before I request all the presenters to present, kindly just note that if you are sharing a screen during your time of presentation, please wait until you are recognized and then you can share your screen for the presentation.

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

Ms. Tali Zrehen: Hello, members of the committee. My name is Tali Zrehen. I serve as the director of the home and community care sector at SEIU Healthcare, which represents over 60,000 front-line health care workers in Ontario.

SEIU is the largest union in the home care sector, but, like others who have come before this committee, we were not consulted on Bill 175. We thought it was important for the committee to hear directly from workers on the front line, so my time will be shared with two PSWs from the sector, Gloria and Jodi.

While we provided a written submission to the committee, I want to offer a brief summary.

The recent COVID-19 pandemic must serve as a sobering wake-up call to government and other stakeholders in the health care sector. Our system needs fundamental change on how front-line care is funded and delivered. Unfortunately, Bill 175 does nothing to respond to the pressing demands for meaningful change. Instead, the legislation proposes a series of largely irrelevant structural reforms that fiddle with the administrative apparatus of the system while leaving unaddressed the core stresses on the system: too few workers, too little economic security, with too little time to deliver dignified care.

Bill 175 fails to address the health human resource crisis in home and community care and the exploitative conditions of employment that leave so many with so little. The challenges our system faces will only grow as the demand for services continues to increase. SEIU Healthcare is once again calling on this government to immediately address our system needs for evidence-informed policy and thoughtful reforms that take into account the voices of the people who continue to care for Ontario's most vulnerable.

When the outcome of the bill is to largely shift oversight from legislation to regulation, it scares the heck out of the clients and the workers who care for them, when the government's own long-term-care minister touts the reduction of regulation as a key health care deliverable.

I will now pass it on to Gloria.

Ms. Gloria Turney: My name is Gloria Turney. I am a proud personal support worker, and for the past eight years I have provided service to families who need home care. Working through the pandemic has revealed even more starkly the challenges I face personally as a dedicated home care personal worker. As a home care worker, I am asked to provide an availability of 110 hours in a two-week period, but as a government-mandated worker, I am only guaranteed 60 hours of assignment. If I should make myself unavailable at any time during this period, it voids my government-mandated position, meaning that my employer will not honour the 60 hours if I fall short.

I am a dedicated personal support worker, but I am afforded no paid sick leave. I am a committed personal support worker, but I work without any hope of a good pension. In my life, I care deeply at work, but I struggle greatly in my personal life. Bill 175 does absolutely nothing to help me remain in this job that I love and that society deems essential but, under our laws, the provincial government does not.

Members of this committee, I am doing all I can, but I have nothing left in me to give. The companies that employ PSWs like me have taken everything, so if you truly want to improve the delivery of home care, then I ask you to help PSWs like me on the front line, because this government hasn't done it. Instead, Bill 175 leaves PSWs in the cold.

I will now pass it over to Jodi.

Ms. Jodi Verburg: My name is Jodi Verburg. I have been a home care PSW for 10 years. If any of you walked a day in my shoes, you'd very quickly confront the fear of the unknown that I face each and every day. Behind each door are clients with mental health issues, clients with a history of violence that is not being shared with front-line staff, or you have the spouses who themselves are very aggressive.

I have been backed into dark corners. I have heard the determined words, "I'm going to kill you," more than once. I have seen the paralyzing look on the faces of clients' husbands who have blocked the doorway—

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

Ms. Jodi Verburg: —as I attempt to leave their homes. On any given day, I face these scenarios alone. The simple act of opening a closed door can trigger my PTSD.

So what will Bill 175 do for PSWs like me? Absolutely nothing. But how could Bill 175 possibly ever help PSWs like me when we weren't consulted in the first place?

Members of the committee, when PSWs like me are against the legislation and for-profit companies are for it, ask yourself: Whose interest is it really advancing?

Thank you for your time.

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

I will now call on Kingston Health Coalition. You will have seven minutes for your presentation. Please state your name for Hansard, and you may begin.

1410

Mr. Matthew Gventer: Thank you for allowing me to appear. My name is Matthew Gventer, and I'm a resident of Kingston, Ontario. I'm co-chair of the Kingston Health Coalition, an affiliate of the Ontario Health Coalition. We monitor and mobilize in the Kingston metropolitan area and have supporters from a wide range of backgrounds. I've been active in the Kingston Health Coalition for over 15 years, keeping track of health care developments and government policy related to health care.

I considered the thinking of the government that led to this legislation, and I perceived that they had three reasons for this act: the increasing high cost and demands of health care, the inadequacies and failings of the current system, and a view that health care represents an economic opportunity. They think that current costs are made worse by constraints of organized labour and bureaucracies, that the capacity to react and reorganize the system is hampered by resistance to change, and that the demand can be managed if people pay their share. They also think that delivery of services has been impaired by reporting regulations, by under-utilized technologies that could be provided by the private sector, and by uncoordinated services; that alternative care patients in acute hospitals need to be moved into home care and congregate settings that can provide lower-cost care; that people contracting for their services will lead to low-cost, good services. They hope that allowing profit to be made in the health care system will be an economic boon; that it will attract financial investment, professionals and innovation into Ontario; that lower taxes will make Ontario more attractive and encourage personal spending.

It sounds good, but not only is it not realistic and not only does it undermine public scrutiny and run counter to health care for all on an equitable basis; it is a road to disaster.

We have just seen the consequences of lax oversight of care delivered with a for-profit motive in the long-term-care sector. Thousands—yes, thousands—of people have been killed by a lack of preparation for the crisis, by bottom line motivations that have undermined staffing levels and availability of supplies, and by four-bedded wards for the poor and private accommodations for the more affluent.

Kingston avoided having any case of COVID-19 in long-term care. How? A public agency, the KFL&A public health unit, set up a strict monitoring and reporting regimen in all health care facilities. The health unit mobilized its own and hospital and university resources to do testing early and well. The labs were provided with expertise and resources over the years that led to capabilities in place to do this right. This was done despite hospitals not being compensated for services outside the acute hospital mandate. But profit was not the motivator. Devotion to public service was the motivator. The public health unit generated co-operation and a common spirit in all, public and private. The existing system wasn't deformed; it was mobilized and unified by public leadership.

Even prior to the pandemic, we have seen in Kingston the consequences of for-profit care in home care and long-term-care settings. Bad employment practices and precarious work models saved money and allowed profit, but at a cost: staff recruitment difficulties; low care standards leaving patients sicker; increased rates of violence; injury from falls; failure to follow health plans. This is documented in my written attachment. In home care, reports are received of missed appointments because agencies fail to replace absent workers. People never know if they will get the same worker from appointment to appointment. Patients have refused to have workers back because of poor care practices. That's what we hear in Kingston. Is it different elsewhere?

The model you are proposing will likely exacerbate the inadequacies. Bringing outside workers to deliver care in hospitals will undermine the authority of the hospital boards, and extra fees will make services less accessible.

We often hear from home care workers of their frustration at not being able to provide needed help to clients because it is not mandated. The private sector is enamoured with monitoring workers and tight scheduling, often unrealistic.

But who will determine those service mandates? This legislation allows private companies delivering the service to manage care assessments that will determine workloads and costs. Is this not a conflict of interest?

We in Kingston are quite conscious of the issue of freeing up hospital beds. Queen's University and Kingston Health Sciences Centre staff have been strong and early proponents of moving care into the community, but we have seen how governments and agencies have dealt with such a mandate in the past. Over the years, I've followed the way psychiatric patients were deinstitutionalized. I have followed them right into the prisons in which I worked. I have seen them homeless on the streets of Kingston. We have rooming houses with five or six in cramped, substandard quarters. Where were the support services promised?

There's an assumption that the people waiting for alternative placement need less care.

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

Mr. Matthew Gventer: People in hospital may not need acute care, but they often need rehabilitative services and significant care for chronic illnesses. We lack chronic care beds. Instead, this act foresees creating congregate care facilities that will provide even less care and more warehousing than our long-term-care facilities. Where is the analysis of the real care that would be required by those pejoratively called "bed blockers?" The act allows for fees charged to those housed in these congregate care facilities. Burden the sick and lame—what a shame.

Finally, I want to deal with the economic philosophy underlying this act. I agree that the not-for-profit sector does not have a monopoly on good intentions. There are many excellent, caring and moral entrepreneurs. But the marketplace also rewards those who rise to the top through legal malpractice—think of Boeing and the 737 Max jet, think of the tobacco industry, think of the inflictors of the 2009 substandard mortgage crisis and the rating agencies that gave them the green light. I think it's terrible—

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

Mr. Matthew Gventer: Thank you. In reality, private services cost more in the long run. We need to see what the public inquiry shows about the impact of for-profit care on safe and good care.

The act needs serious revamping, and a pandemic does not facilitate this. In fact, there are so many changes needed that the bill should be withdrawn. As the Fram filter advertisement warned, pay now or pay later—such are the thousands of deaths in long-term care.

Thank you for listening to me.

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

I will now call on Adult Enrichment Center Inc. You will have seven minutes for your presentation. Please state your name for Hansard, and you may begin.

Ms. Joanne Bouchard: Hello, members of the committee. Good afternoon, everyone. My name is Joanne Bouchard. I am the founder/operations director of Adult Enrichment Center here in Sudbury, Ontario. Today with me is my colleague Lisa Martin, a candidate for nurse practitioner, as well as Haley Ransom, an OTA and PTA with Adult Enrichment Center.

Adult Enrichment Center has been providing quality individualized care and services to young adults with developmental disabilities in Sudbury and Sault Ste. Marie since 2014. Individuals purchase our services or care for community participation; respite services; shared residential services, including employment and volunteer opportunities; physiotherapy; speech therapy; music therapy; community inclusion; and programs that are appropriate in building life skills that will allow each and every individual to become self-sufficient in their homes and in their communities. We have created and developed a care and service plan that meets the needs of each client and support for their families or caregivers in order to keep them in their communities and in their homes.

Adult Enrichment Center provides one-stop shopping under one roof for the services that individuals with developmental disabilities require. With a team that promotes the overall health and well-being for individuals with developmental disabilities, care and service plans are based on individuals' needs, as well as their primary caregivers' and families'. Our goal is to identify the individuals' needs, as long as they can stay in their homes and community.

Policies that should be considered for implementation: The government of Ontario can provide, through the private sector assessments of needs without using a transferable agency, direct funding to parents, guardians and primary caregivers or to agencies and private sector service providers of the individuals' choice. They can provide comprehensive needs assessment services; day programs that can minimize or decrease health care costs and mental health issues; preventive medicine; preventive diagnosing, which then becomes preventive care; standardized assessment needs as needed to provide daily care to clients with developmental disabilities; comprehensive needs assessments to provide quality services under one roof.

When looking at group homes or long-term care, individuals with developmental disabilities tend to overwhelm the emergency rooms and long-term care. These young adults may not be able to be in their homes or their apartments on their own, but they also do not fit the criteria for long-term care. What they need is access to funding and services that can allow these individuals to share accommodations and to receive quality care in order to live in their homes or in a safe and meaningful home setting, just like you and me.

The bill is adding regulations that provide flexibility so that we can adapt to changes to the regulatory processes for the future. As we identify and modify those services, we can provide for the individuals' needs as they are, as they change and as the community changes. We support Bill 175 using regulations. The bill will allow us to be flexible to the needs and the voices of the clients and the families.

1420

We believe that funding should be direct to the client's primary caregivers or to the service providers of choice, as guidance from their families or siblings who know them best—their son, their brother, their uncle or their sister—requires. They have been advocating for decades for these family members. The families are best suited to oversee and administer funding with a service provider on behalf of their child, their sibling, their grandchild or their ward.

It's time to remove the administrative empire. Changes need to be made so clients are getting more of their funding that assessment fees and policies are based on: clients' needs. A primary caregiver should be responsible in completing an annual assessment that outlines the care and services that are being provided by the service providers.

We need to see a change in the funding. We need to stop funding administration and start funding clients. Hundreds of millions of dollars are dissolved in administrative fees. Turn the service over to the family and oversee the services for the service provider's choice. Millions of dollars are lost in administrative fees—

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

Ms. Joanne Bouchard: —agencies. We will save hundreds of millions in lacklustre administrative fees to transferable agencies. For the last 30 years, we have built an administrative empire that reduces the effectiveness and funding to the most vulnerable people in Ontario.

Standardization of care in order to meet the clients' needs—needs required to be appropriate and not limited to services. This has to be done with standardized care inspections. We support standardized regulations for the public and private sector. We want to see inspections. We want to see a system of honest and working policy-creators, annual and semi-annual unscheduled inspections, and transparency for the public and for the private sector. We want to be assessment-driven, and we want standardized flexibility, driven by the needs of the client through professional assessments, standardized care, and a day program in group homes.

COVID-19 has changed and identified weaknesses and flaws in our system.

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

Ms. Joanne Bouchard: We support standardized regulations and services as well as physical structures. We are advocating for semi-annual inspections to ensure Ontarians are protected.

We are in agreement with:

—the government's approach to modifying the ability to inject flexibility into Bill 175;

—the need to change and the need to change as a community;

—feedback from our communities to meet the needs of vulnerable Ontarians;

—working with community groups and changing environments by using an approach where regulations are key to flexibility in order to meet the needs of Ontarians with developmental disabilities; and

—policy creations to avoid one falling between the cracks, which is often seen.

The private sector needs direct access to funding in order to provide quality care and services that will minimize emergency mental health crises, police supports and overcrowding in hospitals. Funding to the private sector for medical, physiotherapy, occupational health—

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

We are now going to start the question-and-answer session. The opposition members are the first ones to go. MPP Teresa Armstrong, please go ahead.

Ms. Teresa J. Armstrong: Again, thank you so much to all the presenters.

My question is to the SEIU PSWs who gave their presentation. I want to thank you for all the work that you've done during this very stressful time. I can't imagine what you have had to face day to day, but you truly have done a wonderful job, and we do value the work that you do.

In saying that, there was a comment made that there is not meaningful change under this bill and there are some things that are missing. One of the suggestions, of course, was in HR and resources. I wanted to ask the PSWs, and you can take turns, or either one can answer: What do you think is missing in this bill that will enhance what you do so that we can actually incentivize experienced, highly skilled workers like you to stay in home care and community care? Can you give us that feedback? What has the government missed in this bill when it comes to an HR strategy?

Ms. Gloria Turney: What the bill is missing—and what we have been saying for years is that home care [*inaudible*] for PSWs are not paid properly. We don't have guaranteed hours. We don't have a pension. We don't get paid sick days. But we're expected to work through anything and everything; for example, COVID-19. We have been working because it's a job we love. For PSWs to remain in this job, it has to be looked at where we are better paid and we have some better benefits. That would have people staying within the job.

Ms. Teresa J. Armstrong: This bill is about structural change. I want to ask Kingston Health Coalition: Do you see any funding that comes with this structural change, and if not, do you think this structural change will actually strengthen home and community care, as it's proposed?

Mr. Matthew Gventer: No. From what I can see in the bill, there's no funding connected to it, because it all gets centralized with the minister and the cabinet. The bill doesn't have standards built in. We don't know what we're getting in terms of regulation. We do know that public

monitoring and opportunities to appeal mismanagement are reduced in this bill. Those are the kinds of things we fear. I don't see any funding promises. And if there's anything in saying, "Well, we're going to give money to people; let them spend it"—you don't know what you're getting with that, and you're getting into a competitive market where you don't have clear standards built in. I don't see an advantage in that regard in this bill.

I hope I answered your question.

Ms. Teresa J. Armstrong: Thank you. The next question will be from France Gélinas.

The Chair (Mr. Kaleed Rasheed): Madame Gélinas.

M^me^ France Gélinas: Gloria, thank you for answering the question. I would like Jodi to also answer the question.

Jodi, you've been in home care, on the front line, for 10 years. You have a lot of experience. What would make a home care job a good job? What would you like to see?

Ms. Jodi Verburg: For me and my fellow—

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

Ms. Jodi Verburg: —members in this area, just like Gloria—I have to echo her. It's the rate of pay and appreciation. We are not appreciated as home care workers. We are always neglected by governments. Whichever government is in power, we seem to be left behind. While the long-term care and hospital sectors are getting more improved, we are still being overlooked.

M^me^ France Gélinas: Do you have a pension plan? Do you have benefits? And do you care to share with us how much you make an hour? Don't, if it makes you uncomfortable, or give us a range.

Ms. Jodi Verburg: It doesn't make me uncomfortable. I'm not proud of what I make an hour. I make $17 an hour from my employer. We have no pension. We have no paid sick days—

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

Ms. Jodi Verburg: We basically live paycheque to paycheque, which is a very horrible thing to say in 2020.

M^me^ France Gélinas: Do you see recruitment issues within the agencies that you work for? Are there people who don't get the care they need because we just cannot recruit PSWs with the conditions you describe?

Ms. Jodi Verburg: Yes, I do, most certainly. There have been lots of PSWs who are leaving home care to go other places. Why would you put wear and tear on your own vehicle and pay for your own things when you really don't make enough money to do it? So people are leaving for places like McDonald's, because you make basically the same wage but you only have to go to one person.

1430

Tali also wants to answer that question.

Ms. Tali Zrehen: I just wanted to chime in and echo Gloria and Jodi. We hear the same—

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

Next, we have independent member MPP Fraser. Please go ahead.

Mr. John Fraser: Tali, you can finish your answer.

Ms. Tali Zrehen: Just to echo the similar sentiment from other members we speak to—we talk about the human resources problem within health care. But when you actually look at the job that's required out of these health care workers—like they said, it's underpaid, overworked. A lot of them get paid travel time, so they're sitting there for—possibly giving 120 hours of availability in a two-week period but only actually working 30 to 40 of those hours and having to be available. Most of them do not have a retirement savings or pension plan. So people work to make ends meet and don't have any money to save at the end of it. There are very few benefits. You have to work full-time or be eligible to actually work full-time hours to receive benefits. Of course, we know with a lot of home care agencies, there's no sick time and no sick pay.

So when we're talking about, what is the interest in coming into the home care sector and how do we push more people into the sector to work—well, these are some of the very serious concerns that this bill does not address. It doesn't address any of that. In fact, it doesn't address the major concerns from front-line workers because they were never consulted in the actual development of this bill. If they were, then Gloria and Jodi and the several hundred health care workers across Ontario would have articulated the exact same thing: that this is a job which needs to change from a job to a career. A career has a pension, benefits, money that you can make so you can live and you can save, and it's a place where you can dedicate your work instead of having precarious work and going to several different employers, like we've seen happen within COVID-19.

So just to allow some background in that—and give a little bit of an explanation of what Jodi and Gloria were stating, as well.

Mr. John Fraser: This pandemic has revealed the value and the importance of the work that your members do—Jodi and Gloria, in particular.

When we look at our biggest challenge right now, it's recruitment and retention and people being able to earn a living—and not that they don't want to work hard, but that they want to be able to have a secure job, so that if they can work hard, it will help them feed their family. Aren't our parents worth that? I hear you really loud and clear.

I want to ask Jodi and Gloria, do either of you work in a long-term-care home—or had colleagues who worked in a long-term-care home, who had to stop working in a long-term-care home and their wages or hours were cut?

Ms. Gloria Turney: Are you referring to during the pandemic?

Mr. John Fraser: Yes.

Ms. Gloria Turney: I do have friends and colleagues who work in long-term care. What happened to most was, they were told to work in one place. There were a lot more hours. Because people were assigned to just one location, most people ended up working more than they would have worked under normal circumstances. There was a shortage of PSWs, so they picked up a lot more overtime.

For home care, we lost big time, because a lot of people went through [*inaudible*] service. We weren't getting hours, so there was nowhere to go. People chose not to have people in their homes during this time. So for home

care, that's the difference: We didn't have hours. Most people had to go off on EI or CERB.

Mr. John Fraser: It's interesting; you were mentioning that a lot of people were concerned about workers coming into their homes, but the actual transmission rates are a lot lower in home care for the delivery of service than they are in all the other congregate settings.

What I've heard you very clearly say is that, as workers who are—

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

Mr. John Fraser: —a critical part, the most critical part, of the delivery of the service, you weren't consulted on this bill, and that the thing that is really the largest concern right now is not addressed in this bill, which is the ability of people working in home care—PSWs, RPNs—to be able to actually support their families. Would that be a fair assessment of what I've heard from you?

The Chair (Mr. Kaleed Rasheed): Sorry, who is your question to?

Mr. John Fraser: Oh, sorry; Tali—or anyone.

Ms. Gloria Turney: That is exactly what it is, because we find that as PSWs, we are at the bottom of the pile. Everything involves HR, getting—the companies are funded; they take their money. I was privileged to sit on my bargaining committee all of last year, and we had to fight—

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

Ms. Gloria Turney: —to get a 32-cent raise. So for the next three years, I will only get 32 cents in a raise, and that's what we fight for every day. Can you imagine, if you now give these private people control completely—as I said, we have no pension. There's no pension for us. We are not able to make our bills. We have to be living paycheque to paycheque, because I have to give all this availability with no hours of work.

The Chair (Mr. Kaleed Rasheed): Now we are going to move to the government side. MPP Oosterhoff, please go ahead.

Mr. Sam Oosterhoff: Thank you to those who have presented today. It's very appreciated—all of the work that you do in your respective sectors, and of course the important contributions that you've made to the conversation today around home and community care and some of the work that we are bringing forward.

I know that some of my colleagues also have some questions, so I'm going to keep it brief, but I wanted to engage with one of the comments that was made. Our intent, of course, in this legislation is to ensure that we have a patient-focused health care system, one that acknowledges the importance of supporting patients as much as possible.

My question—and I have a few of them; just for the sake of time, if you can answer them as a yes or no—is to Tali. Tali, in your introduction and comments, you stated that this bill makes irrelevant changes to the home and community care sector, and so I have a few questions about that assertion.

First, do you believe that using digital technology to improve patient outcomes in health care is irrelevant? Yes or no?

Ms. Tali Zrehen: No, I don't think it's irrelevant.

Mr. Sam Oosterhoff: Second: Do you believe that removing service maximums for patients needing care is irrelevant? Yes or no?

Ms. Tali Zrehen: No.

Mr. Sam Oosterhoff: Do you believe that breaking down barriers between community and primary care is irrelevant? Yes or no?

Ms. Tali Zrehen: No.

Mr. Sam Oosterhoff: Those are my questions. I believe some of my colleagues also had some. Thank you very much.

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

Mrs. Robin Martin: Thank you to all the presenters. I have to say, I am the parliamentary assistant to the Ministry of Health, and I understand that, in fact, we did meet with SEIU Healthcare prior to the introduction of the bill. Obviously, we'd love to talk to every PSW prior to the introduction of the bill, but that is a challenge, because there are many PSWs—not enough, but there are many.

I'm delighted that you've brought two of your PSWs here to the committee with you, Ms. Zrehen, because I think it's very important to talk to the PSWs and hear what they have to say. I was really struck by the testimony offered by both of you, but Jodi, I wrote down that you said, "We're not appreciated. We're always neglected. We're always left behind. We're tossed to the wayside or overlooked." I think those were your words. We certainly don't feel that way about PSWs, and not just since the pandemic, not just since COVID-19. In fact, since our government was elected, we have been really focused on trying to figure out how we can improve this home and community care sector in particular, but also long-term care and, frankly, the role of PSWs across the health care system in home and community care, in long-term care and also in hospitals, where they also play a role. It's really important to us to try to address a lot of your concerns.

While a piece of legislation is not the place to put a health human resource strategy or funding—it never goes into legislation—what the legislation tries to do is set up a framework to address some of these concerns.

1440

One of the things that I heard in talking to PSWs is that they're not part of the health care team around their patient. Essentially, they don't get to contribute what they know about how the patient, or patients, that they're looking after has maybe a change in condition, maybe they're not the same as they were the day before. You're the person there, you see them every day, and yet there's no way for you to collaborate with their primary care doctor or surgeon or palliative care doctor or nurse or whoever you would otherwise like to be able to tell what you know about what's changed with this patient.

So one of the things this piece of legislation tries to do is to enable that kind of communication between the PSW in the home with the patient and the other members of the care team. This is what our whole Ontario health teams transformation is about.

Jodi, I'll ask you: Is that something that you would like to hear—

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

Mrs. Robin Martin: —and is it a way to make your voice valued?

Ms. Jodi Verburg: I'm sorry, could you repeat the question? It cut out on me.

Mrs. Robin Martin: Sorry. Is that something you would like to be able to do—to collaborate with the other members of the health care team caring for your patient at home? And would that make you feel more valued as a member of the care team?

Ms. Jodi Verburg: I'm going to defer that to Tali.

Mrs. Robin Martin: I'd rather hear from you because you're the PSW, if you don't mind—you or Gloria.

Ms. Jodi Verburg: Well, we actually try to communicate with the care team now, but it seems to fall on deaf ears. I've been fighting for one of my clients for a year and a half now and haven't gotten anywhere with the care team that's supposed to be providing care for this certain client.

Mrs. Robin Martin: This is one of the things we're trying to fix.

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

Mrs. Robin Martin: I'll just pass it over to my colleague, Miss Mitas.

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

Miss Christina Maria Mitas: My question is for Joanne from the Adult Enrichment Center. You said you support the use of regulations because you like the flexibility being offered. I was just wondering if you can elaborate on that.

Ms. Joanne Bouchard: Absolutely. When writing a comprehensive piece like the legislation, I think it would be very beneficial to capture the present and future demands for the needs of our community and from the individuals. So flexibility is what is key to meeting the needs of our Ontarians.

Miss Christina Maria Mitas: Thank you. I have another question. You talked very passionately about these changes being advocated for for decades—

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

Miss Christina Maria Mitas: —and that they'll help remove the administrative empire. I was wondering if you could speak to why funding administration less and having those funds go directly to patients is helpful, and how that will benefit them directly.

Ms. Joanne Bouchard: I see it directly in my program right now where—

The Chair (Mr. Kaleed Rasheed): Apologies to cut you off. Maybe in the next round.

We are now going to go back to independent members. MPP Fraser, please go ahead.

Mr. John Fraser: I just want to direct some questions to Tali. You can give me a simple yes or no, too.

Do you think that it's important that we enshrine in legislation a patient/consumer bill of rights like is currently in the legislation right now?

Ms. Tali Zrehen: I'm not going to engage in yes or no, but what I'm going to say is that I think one of the biggest concerns for this bill is taking legislation and making it regulation, and we all know that regulation is less democratic oversight. That, of course, is definitely a major concern for us that we want to address and that isn't being addressed.

Mr. John Fraser: Do you believe that care coordination should have some oversight and an ability to appeal decisions or non-decisions about access to care? Should that be public and transparent?

Ms. Tali Zrehen: Yes, I think it should be public and transparent, but I also think it's very important that the public is aware of what is happening and that the legislations that are taking place are discussed with the various parties, including front-line workers like PSWs, who have not been spoken to about this bill.

Mr. John Fraser: With the patient/consumer bill of rights inside this bill—do you think we should have an update on that; that we should be looking at different things that are currently there and placing that in legislation? Are there things that we need to add?

Ms. Tali Zrehen: I think it's important that we look at these bills consistently and refresh them based on our current situation. With COVID-19 there have been a lot of changes that have taken place. But I think what's really important is that we consistently get the input of front-line workers and community members who can have a say in what happens in their day-to-day lives.

Mr. John Fraser: I direct my next question to Mr. Gventer—and then following to Joanne Bouchard, the same question.

Do you think that it's critical that the patient/consumer bill of rights be put in legislation and not left to regulation? And, if so, do you believe that we should review it and update it? I think it has been since 1994—since there have been any changes in that. And if you do, is there anything in particular you would like to see added?

Mr. Matthew Gventer: Absolutely. I think that we have to have, in legislation, clear standards. A bill of rights is one part of making sure those standards are met. We've been advocating for four hours of minimum care, for example, in long-term care, and that we want it legislated. We want it in so it's enforceable. Governments have not moved in that direction. Yes, it should be. The bill of rights is essential. People have to know what rights they have, and they have to have the means to present where the rights are violated.

I can't say that I'm fully cognizant of the changes that are needed, but from our perspective there are a bunch of changes that are needed—and we've recommended them—that would improve the level of service that people get.

The government says these are patient-centred changes, but they don't provide the guarantees and they don't ensure, enshrined in legislation, the guarantees that make it a successful patient-centred system. That's reflective of the need for a bill of rights.

Mr. John Fraser: Joanne, I know your organization is very focused on access to care for your clients. Do you care to comment on that same question?

Ms. Joanne Bouchard: Yes, if you can repeat it.

Mr. John Fraser: Okay, not to worry. Right now, there is a bill of rights that ensures that certain things are ensured in legislation.

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

Mr. John Fraser: That's not going to be in this bill, in legislation, so that's easily changed, which is not necessarily a thing you want to easily change. You want to enshrine those rights, like they were in 1994; they lasted. Do you have any thoughts about that or anything in particular you think should be in there?

Ms. Joanne Bouchard: Exactly like I said earlier—the bill of rights is essential and needs to be regulated. People's needs change. Our community changed—just like with COVID-19, France, I believe, mentioned that in terms of home care. I provide services to over 70 to 75 young adults with developmental disabilities. When COVID-19 came out and we had to close our centres, my clients didn't go anywhere, so we had to provide these services in-home. Like I said earlier, writing a comprehensive piece of legislation would be beneficial, absolutely, to capture the present and future demands of the needs of our communities, so it needs to be flexible.

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

Ms. Joanne Bouchard: We shouldn't have to go to the legislation all the time to make changes. There should be some type of flexibility in there, which is very key, that meets the needs of Ontarians—in my case, for people with developmental disabilities. There needs to be regulation, but there needs to be flexibility, because times change. We've seen it with COVID-19. The clients don't go anywhere; they still need the care.

The Chair (Mr. Kaleed Rasheed): Now we're moving to the government side. MPP Mitas, please go ahead.

Miss Christina Maria Mitas: Hi, Joanne. Actually, I would love for you to finish answering, but I'll frame the question again. You very passionately did talk about these changes having been advocated for, for over a decade, and you talked about dismantling the administrative empire and taking these hundreds of millions of dollars and putting them directly to the patients. I'm wondering how you think this will help the patients, and exactly how you see it playing out. What is your vision of this?

1450

Ms. Joanne Bouchard: Based on my experience over the past six years dealing with young adults with developmental disabilities, they are able to access funding from different sources—their main one is the Passport Program—where they can hire individuals to help them with their everyday things.

When looking at trying to alleviate that transferable agency and the empires that we have created over the years, we're saving millions and millions. I have a business experience where a client was receiving 12 hours of day support, and the budget for that individual was well over $150,000 a year. When you have the right clinical team and the right team that is there to offer, like I said earlier in my presentation, what we do at the Adult Enrichment Center, we are able to decrease those costs. The amount of money that this individual has attached to them—there's no accountability for funding.

How many times have you looked at the Ombudsman's reports where there are clients that are receiving up to $300,000? Like I said, in my business experiences, I've seen it. There's over $80,000 that is just tied up sometimes in administrative fees when that can supply at least three or four other clients the services that they require to keep them in their homes and their communities, receiving the care—all of the services under one roof, having a team that's accountable, working with communities.

Stop funding these administrative empires and give the funding directly to the clients.

Miss Christina Maria Mitas: Absolutely, and I—

Ms. Joanne Bouchard: Every year, there should be an assessment, I said. I know; I'm very—

Miss Christina Maria Mitas: No, that's okay.

Ms. Joanne Bouchard: —for what I do.

In terms of what we've seen during COVID-19—people need to be responsible for their services. Who better than the client and the primary caregivers in terms of: What are the services? What are you happy with? What are you not happy with? They should be like—it was mentioned today, it's a market out there for services of care.

Miss Christina Maria Mitas: Thank you for illustrating how this really helps strengthen that direct relationship between the care provider and the patient.

Thank you so much for the work that you do.

I have no further questions.

The Chair (Mr. Kaleed Rasheed): No further questions? Okay.

We are now going to move to the opposition side. Madame Gélinas, please go ahead.

M^me^ France Gélinas: My first two minutes I used to question the two PSWs. It's your turn, Haley. I would like to know what motivated you to join the Adult Enrichment Center rather than another place of employment. What does your employment with them look like?

Ms. Haley Ransom: I actually started working with the Adult Enrichment Center right before the pandemic hit, so my experience has been short but amazing. Before, I was working as an occupational and physiotherapy assistant and rehabilitation assistant at some different agencies, so I was in home care the entire time.

Once I started working with Joanne, it's been really great. I definitely agree with her in terms of, we do need to look at having a clinical team under one roof instead of having all these different agencies that come in, and then you go through intake and intake and intake. We're spending all these dollars when we could be looking at having a client access A, B and C.

For me, working here has really been an eye-opener, for clients with disabilities and developmental disabilities and mental health—in how their needs could be met, but how they're not being met by how the government is currently running home care. I think a lot can change and a lot can

move forward if we provide them with more access to their own decisions. Did that make sense?

Mme France Gélinas: Yes, absolutely. That's good.

MPP Harden is next in line.

Mr. Joel Harden: My question is also for Joanne. I'm intrigued. You sound like so many of the smaller home care operators or developmental disability operators that I've had the great chance to meet across Ontario who are so passionate about the families and the people they work with.

You mentioned the administrative empire. I wanted to explore this a little bit. Something that broke recently, a couple of weeks ago, was news that Extendicare—the large organization that doesn't only operate nursing homes; it operates home care services with its affiliate, ParaMed—was issuing a $10.7-million dividend to shareholders. As we think about this administrative empire, we put a lot of resources into the hands of these huge firms—not small firms that cater to families, like yours—that would appear to have lots of money to send elsewhere to investors.

How does it make you feel, as a care provider wanting to maximize every dollar, to hear news like that?

Ms. Joanne Bouchard: I don't like that, because I see how the money and the funding is dissolved in administrative fees. I worked in the public sector, and that is what had driven me to go private. Individuals who receive Passport funding can receive anywhere from $5,000 a year up to $40,000, let's say, as a maximum that we've seen. Again, the assessment is based on their needs. It's not very individualized.

Lisa and I were talking about this earlier today. I had a young gentleman come to me about four years ago, just when I opened. He graduated from the secondary school. At the age of 21, there is not very much for young adults with developmental disabilities, so the vision that I wanted to put out there for them was that next step for when they were done with the education system. They can volunteer, they can work, they can do everything like you and I can do, but unfortunately, without the resources—our access to OSAP, like you and I would be able to access—they have nothing. They have the Passport Program that will give them $5,000. Well, this young gentleman was at our Kirkwood site, which is one of our mental health institutions. He was there for three months because he thought his life was done. He went into a very bad mental health state, and the psychiatrist here in Sudbury recommended him to our program.

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

Ms. Joanne Bouchard: Within six months, this gentleman was working at Kuppajo. What we were able to do and put into place for this gentleman and where he is today clearly proves that those millions of dollars that are tied up in the administrative fees, if those were distributed directly to clients—$10,000, $15,000, $20,000 has a huge impact on all of these clients. They're working in their community, they're volunteering, and they're living a normal life, like you and me. They're not getting the funding; they're getting $5,000. Last year I put $55,000 back into my program to help these young adults; I get $5,000—that their families either have a disability or an intellectual disability or don't have the means for them. So it's a population that's just being forgotten.

Mr. Joel Harden: I would agree.

Joanne, Lisa, Haley, thank you for all the work you do with people with disabilities.

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

Mr. Joel Harden: Okay. Gloria and Jodi, thank you for bringing the front line into this conversation.

Gloria, what have you not heard so far that you want to make sure gets discussed, from a PSW perspective? What has been missing from our conversation so far?

Ms. Gloria Turney: While I'm all for patient-centred care, that the patient is the centre of all of this, we are not hearing anything about we who will provide the services, PSWs. We are hearing about the owners of the business and all the money going to them so they can decide or help the client. But what about the PSWs like myself and Jodi who will provide these services, who will be the ones at the forefront? What about us?

Mr. Joel Harden: I can tell you, we are demanding, in amendments to this legislation, to make sure that there are not only standards of care, but industry standards. It would seem that the Ministry of Health—

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

Thank you to all the presenters who presented during this session.

UNIFOR LOCAL 1451, RETIRED WORKERS CHAPTER
COMMUNIST PARTY OF CANADA (ONTARIO)
ONTARIO HEALTH COALITION

The Chair (Mr. Kaleed Rasheed): Now we are going to move on to our next group of presenters. I'd like to welcome Unifor Local 1451, retired workers chapter. You will have seven minutes for your presentation. Please state your name for Hansard, and you may begin.

1500

Mr. Larry Aberle: Good day, Chair Kaleed Rasheed, Vice-Chair Vijay Thanigasalam, ladies and gentlemen of the Standing Committee on the Legislative Assembly. Thank you for the opportunity to make this presentation.

I want to give you some information on my group before I talk about Bill 175. Unifor Local 1451 retirees worked in an auto parts plant in Kitchener that stopped production about 10 years ago and several years later declared bankruptcy. The bankruptcy cost us our benefits, but we saved our pension. We still hold monthly meetings, which have been suspended because of the pandemic. Normally, we would be holding our picnic on Thursday, with hundreds of people there. There are well over 1,500 retirees and their spouses across Canada, but the majority are in Ontario, and most are in the region of Waterloo. We have members in long-term-care homes, assisted-living

homes, some in the hospital and most still at home, often getting community care. Unfortunately, a significant number of our members are not on the Internet, and that is an ongoing problem.

On a more personal level—it's not community care—my wife has a nurse coming into our home to teach us how to do an infusion to boost my wife's immune system. I have a daughter who had been a PSW in community care; she now works part-time as a cashier. Friends and family have received community care. And one sister, now retired, worked in a for-profit long-term-care home.

Hopefully, we can agree that good community home care could be part of the solution to hallway medicine. Community home care would prevent relatively minor problems from becoming major problems requiring a hospital bed. Community home care can reduce both the need and the wait times for long-term-care homes. Community home care should give people a better quality of life. I'm sure that most people would strongly prefer to remain in their own homes. Their friends and family would prefer to see them in their own homes rather than in a long-term-care home, as long as they're receiving an appropriate level of care.

With the recent pandemic, we all saw on the news the problems with for-profit long-term-care homes that were significantly worse than the non-profit long-term-care homes. These problems are not new and they have existed for many years. There are far too many horror stories. Staff, like my sister, were doing jobs they were not trained for because of shortages. Yet homes did not charge less for not having enough staff. Privatization is not a solution. This sector should not be privately run.

There should be more non-profits running home care for themselves. The focus needs to be on care, not on profit. There should not be an option to contract out services. In most cases, the only way to bid lower is to cut wages and benefits. Health care money should go for health care, not for profit. The drive to cut is what has created many of the problems. Assessment of care for clients should be done by a government employee rather than a private corporation. Private corporations have that focus on profit.

Bill 175 has something called a residential congregate care model. What is that and how would it work? There is also concern about Ontario Health. The Ontario Health board seems to be heavily sided towards business people, with few health care professionals. There seems to be no one representing staff or the public or patients. The meetings are closed, and there are no minutes made available. Other provinces have tried so-called super-agencies. Generally, there are no savings. Transparency should be one of the requirements of Ontario Health.

I have concerns about this drive for efficiency. Efficiency at the expense of equity and fairness will ultimately become inefficient. When I worked, a time study could tell how long a job took. It's not realistic to do this with elderly people, who may need different levels of care day to day. Rush jobs do not work. It is the contracting out and constant drive to cut costs that creates one of the major problems, and this is the same problem in long-term-care homes. As the problem is not really dealt with in this bill, PSWs and other health care professionals who provide the care are not being taken care of themselves.

There's a high degree of expectation regarding PSWs and other professionals, from clients, families, management, society, governments. I am referring to PSWs, but the problem should apply to all health care professionals. People do not like constant change in their—

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

Mr. Larry Aberle: —community care provider. I hear that from our people all the time.

PSWs face higher tuition costs. They often are female and have child care costs. They're poorly paid, often with a lot of responsibility. They're often part-time, with no benefits. They tend to be members of minorities, with those associated problems. In community care and home care, transportation is expected and their payment for the use of the car is minimal, and there is often no pay for the time driving.

Clients' health needs often worsen as they age, but there is no training for these complex needs. Personal protective equipment is often lacking, and there is little training for the use of it. My daughter contracted C. difficile. This is a painful disease that is difficult to treat.

There have been some suggestions that temporary foreign workers can solve this problem, and I'm not sure that's an appropriate response. It would be better to encourage appropriate people to immigrate with their families. These new—

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

Mr. Larry Aberle: —Canadians will be part of the solution and of our communities.

Often PSWs sign confidential agreements, supposedly to protect patient privacy. In reality, they're used to protect the corporations. All PSWs need to have a living wage, benefits and a full-time job. They need ongoing training. They need proper personal protective equipment, to protect everybody. They deserve respect for their job, and it's the bidding contract that slashes away—

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

On to our next presenter: I will now call on the Communist Party of Canada (Ontario). You will have seven minutes for your presentation. Please state your name for Hansard, and you may begin.

Ms. Helen Kennedy: My name is Helen Kennedy, and I am representing the Communist Party of Canada (Ontario). We are the second-oldest political party in Canada, celebrating 99 years of fighting for working people across the country. We're a party that organizes within the working class and opposes oppression of all types—oppressions that are so prevalent under the current capitalist system.

CPC (Ontario) is the provincial expression of our central party. We are also the party of Dr. Norman Bethune, one of the earliest advocates and active practitioners of public health care. We are pleased to be here

today and to offer our insights and opposition to Bill 175, Connecting People to Home and Community Care Act.

I'd like to start with the home care sector worker demographics. I know you are probably all aware of these facts, but it is important to put your proposed restructuring of home and community care in its proper context.

In 2015, the Ministry of Health and Long-Term Care estimated that there were 100,000 personal support workers across the province, with about a third working in home care.

A 2015 survey of PSWs in Ontario by researchers at McMaster found that 94% were women, 69% were age 45 or older and 41% were not born in Canada. In urban centres like Toronto, Ottawa and Hamilton, PSWs are predominantly racialized women. They are the lowest-paid workers in the health care sector, with many working for less than minimum wage when travel-time costs are factored into their wage packets. Some 62% of PSWs in home and community care are currently employed part-time. According to Home Care Ontario, PSWs provide 74% of the care in the sector.

Currently, only 32% of PSWs in the home and community care sector are unionized. It's a sharp drop from 1995, when the Conservative government of Mike Harris restructured health care in order to maximize profits for private health care companies at the expense of these predominantly racialized women. Contracts that were held by non-profit agencies like the Red Cross and VON were outbid by for-profit corporations who slashed labour costs by undercutting unionized contracts. The then-Tory government also eliminated successor rights, so that the women who were unionized and receiving decent union wages and benefits lost their jobs, and those who were hired in their place had their wages slashed and their benefits eliminated.

Today, for-profit corporations provide over 65% of home care personal support services, compared to the 18% that they provided in 1995. This has been a deliberate policy of all provincial governments since Harris. It has reduced home and community care standards to the lowest common denominator.

1510

I worked in one of the poorest neighbourhoods in Toronto for over 30 years. In this community and many others like it across the city of Toronto, a large percentage of women work as PSWs. They are predominantly Black and racialized women. They live in social housing and low-rent apartments because that's all they can afford on a PSW wage. They fight for their children in the public education system to ensure that they are not streamed into basic classes. They fight for their children who are policed in school hallways and who are stopped multiple times within their neighbourhoods and their local malls by the police. These women may work for two or three home care agencies in order to make enough money to pay their rent and feed their families, and they often work over 12 hours a day. These women are the face of systemic racism in our province.

It is time to make amends, to address the fact that PSWs are essential to the health and community care sector, and to demand that they are paid decent wages and benefits and that they be given full-time jobs, vacations and sick days. This is not possible under the for-profit model presented in Bill 175, nor is it in the current system of home and community care.

We've seen the impact that for-profit care has had during the COVID-19 pandemic. If you were unfortunate enough to be in a private care home, you were four times more likely to get infected and die than if you were in a municipal home. It is ludicrous that the provincial government is proposing the further deregulation of home and community care, given the track record of these private homes during the pandemic.

For-profit corporations take money out of the sector and put it in the pockets of their shareholders and executives. For example, former Premier Mike Harris has a part-time job, much-better-paid than the PSWs, as chair of the board of Chartwell. He was paid $229,500 in 2019. The Star reported that he has an additional $7 million in Chartwell holdings. He's certainly making a lot of money. These earnings are accruing because he and his government restructured the long-term-care sector to provide opportunities for private businesses to make money from providing substandard care, paying workers less, providing fewer supports and fewer hours of care, and even rationing incontinence supplies for residents.

The current government has continued these practices and should be ashamed. More importantly, they should urgently reverse course.

I listened to these hearings yesterday and heard that some members of this committee believe that this bill does not further the privatization of home and community care. We disagree. The bill entrenches the unaccountable and private-sector-infested model of oversight called Ontario Health. This new super-agency has a board that is populated by many of the for-profit lobby groups that have influenced elder care policy since Mike Harris was first elected in 1995. The 14 LHINs will be replaced with the newly formed Ontario health teams, which will be over-represented by for-profit agencies. Neither Ontario Health nor Ontario health teams have accountability to the public. The OHTs will be the ones transferring care coordination functions to provider companies that are also predominantly for-profit chains. Which companies do you think they'll choose for the contracts? Private, for-profit home care agencies will be the big winners in the Bill 175 lottery.

If this bill is enacted, the big losers will, once again—

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

Ms. Helen Kennedy: —be the most vulnerable. There is already a huge waiting list for home care—and the ongoing problem of missed visits, which directly impact care. Elderly clientele will be the recipients of fewer services, with little or no recourse for missed visits. The workers in the sector—mostly PSWs, whose wages are already the lowest in the sector—will be maintained in low-hourly-wage work, without compensation for travel time between clients, pushing them further into the gig economy that has failed workers so dramatically during the current pandemic.

The Communist Party demands that the provincial government withdraw this bill and begin a process to bring all home and community care agencies back into the public sector. Take the profit that is currently lining the pockets of lobbyists, former Premiers and the 1% and invest it into public health care, where it belongs. We demand quality care for our seniors, dignity of care for the disabled, and decent wages, benefits and working conditions for all home and community care workers. Thank you.

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

Now I will call on the Ontario Health Coalition. You will have seven minutes for your presentation. Please state your name for Hansard, and you may begin.

Ms. Natalie Mehra: My name is Natalie Mehra. I'm the executive director of the Ontario Health Coalition.

Bill 175 amends or repeals at least 11 other acts that have been passed by the Legislature. We're extremely concerned because what it will result in is the wholesale restructuring of home and community care from bottom to top. It also, through the regulations, reaches beyond home and community care to establish a new tier of congregate residential care, unlicensed. It also, in the regulations, reaches beyond home and community care to cover home care delivered by private companies in public hospitals. And in the legislation itself, it reaches beyond home and community care into private hospitals, as well.

This legislation is so misguided in its conception and so flawed in its execution that we're taking the unusual step of calling for it to be entirely withdrawn. We are appalled that the government would move forward with this legislation to wholesale restructure home care and hospital and congregate care and private hospital care in fundamental ways, in the middle of a pandemic.

The main thing this bill does is that it repeals the Home Care and Community Services Act, and in so doing, it guts all of the public interest protections that exist in that act. In the summary regulation package—which are not even the actual regulations that are drafted; it's a summary of what might be drafted down the road—it proposes to move and possibly change some of these provisions. And then a number of other provisions are just not there at all. Among the ones that have been removed from the act with the repeal of the act:

—the definitions of the actual services to be covered;

—the bill of rights for clients in home care;

—requirements of the provider agency, such as the development of a plan of service in accordance with regulations, rules and standards;

—provision of a service within a reasonable time frame;

—requirement to put people on a wait-list if that service is not readily available;

—prohibition of charges for professional or personal support services in accordance with the plan of care.

Those are vital public interest protections to be entirely removed and not mentioned in the regulations.

The ability for the minister to enforce the bill of rights—through the minister's ability to approve or disapprove of agencies who do not comply with the bill of rights. That similar power for the minister is removed with regard to ensuring that the agencies are financially capable of providing the service.

A similar provision is removed with regard to the ability of the minister to assure that the agency provides services with competence, honesty, integrity, and concern for the health, safety and well-being of the persons receiving the service. All of that is removed.

A similar provision regarding the minister's ability to not approve agencies where the premises are not suitable for the provision of community care services—currently, the minister may impose terms and conditions on financial assistance. That's removed.

The requirements of the provider agency are to be removed—public filing of records; notice to clients in writing of the bill of rights; the name of the service provider; procedures for making complaints; how to request a record; where the client can access the service's accountability agreements; a plan for preventing abuse, including physical, mental and financial abuse. These are vital public interest protections. They belong in legislation.

As the committee knows, when something is in regulation, it can be changed by cabinet without ever going back to the Legislature for a vote. In this way, this bill takes us back more than 25 years in terms of the development of public interest protections in home care.

In addition to the gutting of the existing home and community care legislation, in the regulations this bill sets up an entirely new system of providing home care that is not actually a system. It would fragment home care into thousands of different potential permutations and machinations around Ontario. It takes the funding part of the LHINs—the LHINs are currently crown agencies, fully public—and siphons that off to Ontario Health. The previous presenters, Larry and Helen, already talked about Ontario Health—that the board is dominated by bankers, private financial interests, real estate investment trusts, private long-term-care industry and so on. There are no normal public governance protections for Ontario Health. There are no open board meetings, no minutes, no access to information etc.

Then, the powers to do placement coordination and care coordination, vital functions that are currently public, would be siphoned off to a set of middleman companies—

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

Ms. Natalie Mehra: —including the Ontario health teams, which are loose coalitions of for-profit and not-for-profit companies with no governance whatsoever—no boards of directors for the OHTs, no public governance norms, no protection for the public interest whatsoever—primary health care providers, including the whole array of private, for-profit primary health care providers, non-profits or other third parties. They would then be able to take care coordination and contract it and subcontract it, and the other direct care provision services, to private, for-profit or not-for-profit care companies.

1520

This change is significant, and it means that vital parts of home care would be privatized and put into the control of companies that often have conflicts of interest. It would be chaotic. It means that the structures emerging for home care and community care across the province—

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

Ms. Natalie Mehra: —will vary dramatically from place to place, and it would create a conflict of interest in which for-profit companies can both do care coordination and provide the care itself, therefore deciding how many supplies people get, how much care they get, and profiting from that service.

It would also send privatized care into public hospitals, and in the act itself, it allows private hospitals to expand into a new tier of unregulated, unlicensed congregate care, which is set up in the regulations—as if we have learned nothing from the appalling record of the spread of COVID-19 in congregate care settings.

For all of these reasons, we find this bill to be fatally flawed, we are extremely disturbed at the process, and we're calling for the government to withdraw it and undertake a proper consultation process that is democratic—that does not just include provider companies to reform health care in their interests, but actually operates in the public interest. Thank you.

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

We are now going to go to the government side for the questions. MPP Martin.

Mrs. Robin Martin: Thank you very much to the presenters for coming today and for giving us their thoughts on the bill.

This is a very important piece of legislation. It is about modernizing the home and community care sector. We think that is critical. The current legislation is over 25 years old and does not reflect the realities of today—and really has a siloed approach to care, creating barriers, frankly, to addressing client and caregiver needs. That's why I don't think anyone thinks the current system that we're under is working very well. So we need to change it. That's what the whole intent of this legislation is about. We've put forward legislation which is enabling legislation, and we're trying very hard to make sure that we do not disrupt the important care that people are receiving in the interim. We want to make sure that there's continuity of care for people who are looking for home care services and community care services, because we know how important those are to them.

The legislation has some goals, including making it easier for people to access home and community care and to connect with their care providers. We have noted that home and community care provision can be an isolating experience for the people providing that care, and for the people receiving it, frankly, so we want them to be more connected to their other health care providers. Part of what this enables is virtual connections, which should have happened a long time ago. So a PSW would be able to provide input into what they've noticed about the care of the patient that they're looking after to the other health care providers.

We also want to provide more choice for people with high care needs so that they can get into new community settings. And we want to keep people healthier and keep them at home.

I was listening to what Larry had to say in his presentation, and I noted that he said that he wanted good community care, that it could be part of the solution to hallway health care, that he wanted to make sure that our elders have a better quality of life, that they could remain in their own homes—they'd prefer to do that—and that the focus should be on the patient. I took that down as well, that Larry said that.

I agree, Larry: Those are what the bill is intending to get us to, and we're trying to find this model of integrated care. That's where we're headed. The legislation is about breaking down those bureaucratic barriers. Our Ontario health teams will work in partnership with home and community care service providers to provide a flexible, innovative, integrative delivery model, including care coordination. And home care services will be delivered as they are now—without patient copayments, if that's the way they're delivered now. The Connecting People to Home and Community Care Act, if passed—and the proposed regulations make that clear, actually.

By the way, when we tabled the bill, the regulations were posted, or summaries of the regulations were posted, on the regulatory registry for public comment for a 60-day period. So there is, of course, a way to input into regulations when those are changed, and that's a very important aspect of it. We have received submissions from people on the regulations and are taking that into account as we go forward and develop them further.

There are a lot of other things I could talk about. One thing is the public consultation that we've had through our Premier's Council on Improving Healthcare and Ending Hallway Medicine and through the minister's own consultations on various health care issues.

Bill 175, of course, has been debated in the Legislature and will continue to be, and our regulations were posted, as I said, for 60 days for public comment and were taken down on April 14. We're working very hard to make sure that this legislation is a solution to our problems in home and community care. We'd like to see—

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

Mrs. Robin Martin: — some changes.

I want to just address the privatization concern. There are no provisions in this legislation that are aimed at privatizing health care in general or home and community care. We did have an earlier presenter who said that this is a disingenuous debate that does not serve patients well and that we shouldn't be talking about whether it's private or public; we should be talking about whether the patient is at the centre. I firmly agree with that. I think we get buried in this conversation and we forget about the patient.

Do you believe that the most important priority, Larry, in reforming home care—I know your daughter was a PSW—is the patient and the care and outcomes for the patient? Do you agree with that? Yes or no?

Mr. Larry Aberle: To say yes or no probably—

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

Mr. Larry Aberle: I agree, but you've got to recognize that there's far more to the question.

Mrs. Robin Martin: Well, I agree, Larry. I just wanted to ask you that question, yes or no.

Let me ask you another question. Your daughter was a PSW, and she stopped being a PSW and is now a cashier. That's what you said.

Mr. Larry Aberle: Correct.

Mrs. Robin Martin: So that is a loss to the system. We want to keep PSWs working in the system. Do you think that some of the changes proposed will help PSWs to be taken more seriously by other care providers—for example, a virtual connection with the doctor so that their opinion about what's happening with the patient could also be considered. I have been told by many PSWs that they don't feel their opinions are respected. What do you think, Larry? Do you think that would be helpful?

Mr. Larry Aberle: No. Actually, I'm going to have to—

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

We are now going to move to the independent member. MPP Fraser, please go ahead.

Mr. John Fraser: The question I'm going to ask is going to be for everybody in sequence of their presentation.

Before I get to the question, I just want to say that this whole idea of public and private and having this debate—it's very clear that the legislation is permissive and open in that regard. It's allowing for things to happen, and there are some serious questions right now about the provision of care and what has happened, as we see in long-term care and as we see with employees, PSWs, who are serving in home care. I think they are legitimate questions.

The thing that really troubles me is that we're removing accountability and governance, not just from the public but from ourselves. No matter where you stand on what you think should be inside this box, to actually abdicate the legislative pieces that enable us as members to be able to take action and do things on behalf of our constituents—making sure that that structure is around this thing is really critical. It's not an academic debate. We have a responsibility.

I don't think anybody in this room wants care not to be the best care. We're all in the same spot. It's how we actually ensure that on an ongoing basis. I've sat on both sides of the table. That's what I'm trying to express, and that's why I'm asking this question in particular right now.

I'm very concerned about the patient bill of rights being pulled out and put into regulations, because I think it's something that we should decide, as a Legislature, is the right thing to do. We did that in 1994. It lasted this long. It needs to be updated.

1530

To all the presenters: Do you agree that it should be in legislation? Do you think that we should actually look at that patient bill of rights in a broader sense, to look at what we have to update? On top of that, is there anything you think we should add to that patient bill of rights?

The Chair (Mr. Kaleed Rasheed): We can start with Unifor. Larry, please go ahead.

Mr. Larry Aberle: I agree that the bill of rights needs to be in regulation. I think that's pretty simple. And there needs to be some oversight as to what is happening, generally.

The only thing I mentioned earlier that I think is missing here is, we have a significant number of members who are not on the Internet, so when you talk about virtual and somehow doing something—that's a problem and I'm not sure how you get around it.

Mr. John Fraser: It should be in regulation or legislation?

Mr. Larry Aberle: It should be in legislation; not regulation. I'm sorry if I wasn't clear.

The Chair (Mr. Kaleed Rasheed): Next, we'll go with the Communist Party. Helen.

Ms. Helen Kennedy: Yes, I believe that there should be a bill of rights in legislation. It shouldn't be in this legislation, because this legislation is so bad.

I think that beyond just a bill of rights for patients and clients, we need to have home and community care legislation that actually accepts and embraces human rights. This does not embrace human rights for those PSWs who are making the lowest wages in the sector without sick time, without benefits, without a livable wage. That has to be addressed. We've seen huge marches in the streets, and they're marching for the elimination of systemic racism. And this government can do it with this piece of legislation—not this piece, but a piece that addresses the restructuring of home and community care to respect the human rights of the PSWs.

The Chair (Mr. Kaleed Rasheed): Next is the Ontario Health Coalition.

Ms. Natalie Mehra: To the member's comments: The legislation actually goes beyond being permissive on privatization. The last section, on the Private Hospitals Act, section 9—

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

Ms. Natalie Mehra: —changes the definition section of the Private Hospitals Act to enable private hospitals to expand into this new congregate care section. That would, for the first time since the inception of the public hospital system in Ontario, allow private, for-profit hospitals to expand. So it actually goes beyond being permissive.

In terms of the regulations, it expressly describes a system in which most of the existing public functions in home care would be privatized.

In terms of the bill of rights, it absolutely should be in the legislation. The diversity section is out of date and needs to be modernized. In addition, patients need to have a positive right to access home care so there is actually a floor, and if they can't access the service, then they have to be put on a wait-list so there's some measure of how many people—

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

Ms. Natalie Mehra: —can't access the service. LHINs have just cut off everyone who has moderate care needs or below because of funding constraints. The caps issue is irrelevant, because when you don't have enough funding, you just can't provide the care.

In addition, there need to be other protections, including, fundamentally, protections against abuse, which are now pulled out of the act—that's shocking—and the complaints process. People need to be able to make meaningful complaints, have them answered in writing, have a process to do that. This bill sets it up so that you would have to complain to the provider company itself. Good luck to you in getting anything addressed in that way. We already see the problem with that.

In terms of the whole system, what this act does is hand over, and the regulations together—and they're a one-two punch. The act completely guts the existing legislation. Everything is moved into the regulations.

Respectfully, to the member who just spoke—

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

Now we are going to move to the opposition side. MPP Teresa Armstrong is on the phone. Go ahead, please.

Ms. Teresa J. Armstrong: I'm very interested to let the Ontario Health Coalition finish their remarks, please.

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

Ms. Natalie Mehra: Okay, thank you. With respect to the first member who asked questions, from the governing party: In her comments she said that the—sorry, I've just lost my train of thought for a second. I'm sorry, I've just lost it.

Ms. Teresa J. Armstrong: I appreciate your comments very much.

To all the presenters, thank you.

I strongly disagree with not having a debate between public and private. I think that has to be on the table when we're talking about health care because any time public money is going into private hands, they're squeezing dollars out for profits, and that takes away from the front-line care for patients. So I respectfully disagree with my colleagues around the table. This is not a debate about public or private.

The long-term-care situation clearly indicates that when there are not the proper inspections and oversight, things get buried. Thank goodness for the Canadian military exposing those things. No one in that system has ever come forward and publicly addressed the egregious acts that were happening. There have been reports after reports, and governments have ignored them.

So I just wanted to ask the Ontario Health Coalition to expand a little bit on the conflict of interest and how detrimental that can be to public health care.

Ms. Natalie Mehra: I did remember. The government speaker said that the regulations were posted, but I just wanted to clarify: A summary of the proposed regulations and two appendixes, not the actual regulations, were posted, with very—almost no one even received the notice. It was during the pandemic.

On the question of elaborating on the conflict of interest: In this legislation, the funding would be given to Ontario Health, the board of which is dominated by for-profit companies. The LHINs currently provide placement coordination, direct care in terms of school-visiting nurses, some direct PSW nursing, health professionals' care where there are contracted companies providing it, and then also, vitally, the care coordination function. In the new act, the care coordination function, and apparently the placement coordination functions, would be hived off to an array of provider companies who would then sub-contract care coordination right through to the direct provision of service.

If you're providing care coordination and you're determining whether or not someone can access a service, how much of that service, how many supplies and so on, and then also providing that service—and there is no oversight. There's no governing body. The LHINs are gone. The CCACs are gone. There is no public body providing any oversight whatsoever. Your company is the only place that patients can go to complain to you about any of this stuff, and you're a for-profit company that has an interest in pulling as much money out for profit as possible. And if you're a for-profit chain or company, you have an interest in gaining as much market share as possible. That is a conflict of interest.

There are no protections in the legislation and in the regulations, such as they have been proposed—a summary has been proposed—to provide for any protections whatsoever. They set up, expressly, this conflict of interest.

Ms. Teresa J. Armstrong: My colleague France Gélinas has a question.

The Chair (Mr. Kaleed Rasheed): Madame Gélinas, please go ahead. You only have two minutes.

M^me^ France Gélinas: I want to start by telling all three presenters that it's not because an MPP asks you for a yes-or-no answer that you have to provide this. You didn't do anything wrong. You don't have to answer questions that you don't want to answer, no matter if they're rude, if they're shouting at you or whatever else. You answer the question the way you want to. We're happy to hear from you.

1540

My question to you has to do with the standards. You come from different parts of the province. Are you able to talk about the need to have a standard of care that would apply to all regions of the province? I will start with Larry, then Helen, then Natalie, if we can all be brief.

Mr. Larry Aberle: I'm familiar with the Waterloo region, so I'm not sure how far that would go across the province—

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

Mr. Larry Aberle: I think, especially in the rural areas, it probably would be more of a problem, and I'm not quite sure what you do there. There is no easy answer to this question, but I think there has to be some general discussion about how to deal with it.

Mme France Gélinas: Would you agree that we do need a standard of care—that no matter where you live, the care should meet your needs?

Mr. Larry Aberle: Absolutely, we need a standard of care. We need something that is significant, that's a minimum standard for anybody who needs care.

Mme France Gélinas: Ms. Kennedy?

Ms. Helen Kennedy: I'd rather talk about a maximum level of care. All home and community care should be at a community level, not at a huge LHIN level where people are travelling all over the place. That's what I would say.

Mme France Gélinas: Ms. Mehra?

Ms. Natalie Mehra: Yes, absolutely. We agree that there should be a host of clear standards regarding care and—

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

For this round, we're going to go to the independent member, MPP Fraser. He is saying that, Natalie, you can continue your thoughts.

Ms. Natalie Mehra: Thank you very much. We agree there should be a standard around access to care that says that clients, people who require home and community care services, should be able to get the services based on their assessed need for those services. If they can't get them immediately because they're not available, they should be wait-listed, so at least there is a way to measure how many people are not able to access care and how insufficient the care is. Currently, that is required, actually, in the legislation for the provider companies. In the new proposed legislation regulations, it does not exist.

Then other standards should be around access to culturally appropriate—more than that, culturally sound services; sorry, I'm trying to think of the correct word—compassionate care, equity in terms of care and so on.

Mr. John Fraser: Thank you very much for your answer.

I just wanted to respond to one of my colleagues, in case they may have misunderstood what I said in my remarks. I think we should be debating public and private care here. I think it's important that we do this. It's an important debate. The thing I think is really critical right now that's missing in this legislation is that we need the public-facing part of it, the governance. The enshrinement of rights around governance, around your rights to appeal and having clear access are not in there. It's all on good faith.

I just want to ask Ms. Mehra again—I realize that you want to withdraw this legislation. I think you're right. We should at least take a pause on what we're doing right now, because we're in the middle of a pandemic. In terms of the things that really are critical to be enshrined in the legislation, what do you believe those things are?

Ms. Natalie Mehra: The definitions of what the legislation covers should be in the legislation, not in regulations. The rights of clients should be in the legislation. The powers of the minister to disapprove of agencies based on their compliance with the bill of rights, based on their financial soundness of operations, based on their record of operation, based on the soundness of their premises—all of those protections that have been pulled out came out of decades of advocacy for improvements.

The level of care that is actually provided must be in legislation. If anyone was to create another tier of congregate care, that would need to be in legislation with all of the intended protections that people need when they live in those places. I think, hopefully, we'll have learned the lessons of COVID-19 regarding that.

The rights for complaints: What is a complaint? What isn't a complaint? How do you do it?

The rights to access information: There should be governance. There should be public oversight.

The entire structure is gone, and there is nothing there, and, I'm sorry, I'm shocked at that.

Mr. John Fraser: I don't know if Mr. Aberle or Ms. Kennedy would like to make a comment on that.

Mr. Larry Aberle: I think there are areas where it makes sense to have private corporations. I think there are areas where it makes sense not to have them. It makes no sense, as far as I can see, to have private, for-profit companies in the health care sector, generally. I just think that's one sector that should not have for-profit corporations.

Ms. Helen Kennedy: Yes, I agree with that.

I think the government member has mentioned several times over the last couple of days that this bill hasn't been amended in 25 years. Well, 25 years ago, the private sector was only 18%—

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

Ms. Helen Kennedy: —of community and home care services. They were providing only 18%. I think that's a good place to start and go backwards from there in terms of taking out the profit margin from looking after our seniors and our disabled in this province.

Mr. John Fraser: I'd like to thank all the presenters again for taking the time on your great presentations and your comments. I appreciate it very much.

The Chair (Mr. Kaleed Rasheed): Now we are going to move to the opposition side. Madame Gélinas, please go ahead.

Mme France Gélinas: The reason for the bill is because our home care system is broken. It fails more people than it helps. It doesn't meet the needs.

If you had to tell me what the top three things are that would really go into fixing our home care system, what would they be? I will go backward this time, from Natalie to Ms. Kennedy to Mr. Aberle. Ms. Mehra.

Ms. Natalie Mehra: Fundamentally, home care in the new system proposed and in the existing system is fragmented. There are 14,000 different billing codes, there are hundreds of agencies—there's all kinds of duplication at every level. All of that was created because of the desire to bring in the for-profits and contract out home care. None of it would be necessary without that.

To get money to care, looking at what's happening right now—according to the Auditor General's report, the 2015 special audit of the CCACs, the companies are charging between $58 and $70 an hour for nursing care; $29 to $49 for PSW care. Nurses in home care might get $30 an hour;

PSWs might get $15, $17 an hour. The markups are extraordinary. All of that public money is being siphoned off for profit. In addition to that, there are multiple duplicate administrations at that level. Then there's the tier above and so on.

This new system actually makes that worse. It fragments care even more, and it takes away all governance so it just says, "Here, provider companies, have at it. Divvy up home care how you want." That is not acceptable.

The way that a home care act, if it was to be reformed, should happen is that there needs to be strengthened public governance, strengthened clarity around standards, strengthened equity in the provision of service, less tiers of administration—much more of a public, not-for-profit home care service, where the money goes directly to the actual providers of the service.

In the last session, you heard from PSWs on the front line. They get the last tier of money after it's gone through umpteen tiers, and that wouldn't change under this legislation.

There are no additional protections for access to care, no additional protections for people who have missed visits, which is very, very common for the staffing shortages. Those things would need to be addressed in new legislation that actually shunts the existing public money to home care and then improves funding and improves the requirement to provide care based on people's needs.

M^me^ France Gélinas: That's more than three, but it's very good.

Ms. Kennedy.

Ms. Helen Kennedy: I agree with Natalie and the position of the Ontario Health Coalition, but I also think that we need to start over. We have a system that is broken. If you look at a system that is publicly managed and one system—it's a public health care system that also does community and home care—you eliminate immediately millions of dollars that have gone to private corporations and more millions of dollars that are in separate administrations of all the different private companies that are in the business. I think that there are savings, and those savings deserve to be invested in the people who are actually providing the work.

1550

I think it is time that we made amends. If we continue with the same system, we will have PSWs who will still be underpaid and struggling to survive. That is not acceptable, especially because in the major cities they are Black and racialized women who are at the bottom of the pile. We need to address these concerns in how we deliver our community and home care.

M^me^ France Gélinas: Larry?

Mr. Larry Aberle: First of all, I agree with the previous speakers.

Specifically, for my members: They want independence, so I think it has to be an ease of access—of how they can get this care. There has to be some way that they can—

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

Mr. Larry Aberle: —know that they're getting competent and appropriate care. I have seen what I would call a cognitive decline in some people. I've worked with a lot of these people for 30-plus years, so I can remember them in the past. Some of them have trouble dealing with the system as it is. They may have family members who help them; they may not. Somehow, we have to make it easier to allow them some independence, and yet we also have to protect them. That's a balancing act you're going to have to work through.

M^me^ France Gélinas: Joel, there's not much time, but if you want a closing comment, go ahead.

Mr. Joel Harden: Thank you to my friends Larry, Helen and Natalie. It's nice to see you weighing in.

What I've heard loud and clear from all of you is that we need to make sure that people on the front lines are given the support and all the public funding they deserve. I take that absolutely to heart.

I hope it wouldn't surprise you—just to read into the record—that some of the folks participating in this debate are part of political parties that have taken big donations from for-profit operators. I just want you to know that that part of the conversation is going to be on the record in the months ahead. And I hope my friends in government are going to stop taking the advice of the wrong people.

The Chair (Mr. Kaleed Rasheed): Thank you very much, opposition members.

We are going to move to the government side. MPP Martin.

Mrs. Robin Martin: Thanks again for your comments. I've been listening with interest.

I do want to just correct for the record: First of all, I am entitled to ask a yes-or-no question, and I appreciate you giving a yes-or-no answer when I do. That's the way we control the time. So I appreciate the fact that Larry did that. Thank you very much, Larry. I think that's how we also get answers to the questions—and I know my colleagues have used that method, as well, to make sure that they can ask the questions they would like to ask.

Secondly, the regulations were posted on the regulatory registry on February 14. So contrary to what Ms. Mehra indicated, they were not posted during the lockdown. That started on the 17th or 18th of March. So there was a full month when they were posted before that time, and they were not pulled down until April 14.

I also wanted to comment that, unfortunately, Ms. Mehra, I think you have misread the section on private hospitals. The amendment to the Private Hospitals Act—I'm a lawyer, by the way, and I've checked it again—is specifically drafted to exempt residential congregate care models, once defined in regulation, from this act. These models are not intended to be private hospitals. We want to make sure that they're not accidentally captured as private hospitals. That is the reason we drafted the amendment that we did to the Private Hospitals Act, which is exactly the opposite of the interpretation that you proffered.

That's all, Chair. We don't have any further questions for these witnesses.

The Chair (Mr. Kaleed Rasheed): Thank you to all the presenters for the 3 p.m. group.

DR. MICHAEL RACHLIS
CENTRE FOR INDEPENDENT LIVING IN TORONTO
CHIEFS OF ONTARIO

The Chair (Mr. Kaleed Rasheed): Thank you to all the presenters who are joining us for the 4 p.m. group. I will now call on Michael Rachlis. You will have seven minutes for your presentation. Please state your name for Hansard, and you may begin.

Dr. Michael Rachlis: My name is Dr. Michael Rachlis, and I'm a private consultant in health policy and an adjunct professor at the Dalla Lana School of Public Health in Toronto. As my CV has indicated—I should just double-check with you, Chair: I believe that you have slides that I sent to the committee yesterday, and if that is correct, I will briefly go through my slide presentation. Can you confirm that, Chair?

The Chair (Mr. Kaleed Rasheed): Yes, they were emailed to the committee members.

Dr. Michael Rachlis: Thank you. Then you have my CV. The only thing I'll highlight that I'm very proud of is that I have presented to committees of this Legislature I think every decade for five decades now. I've consulted with every government in this country, including the Ontario government, and I'm very pleased to be allowed to make this presentation on this bill.

As others have said, even though the aims of this bill and the aims of almost every government's health care reforms for decades now have been to develop better-integrated care, coordinated care etc., I think there are going to be many inadvertent problems created because of changes in reporting and accountability. Notwithstanding its official name, I'm afraid that Bill 175 doesn't address some of the fundamental issues pertaining to home and community care. Finally, I want to talk to the committee about this just to broaden your minds a bit from what you might think home and community care might be and identify its links with long-term care and with the long-term-care crisis that we're facing.

The inadvertent problems are that this is like, as in slide 5 of my presentation, a children's game of telephone. There has always been a serious issue with lack of accountability, I would say with Ontario's health system—more than in some other provinces. In other provinces, you might have something a bit tighter. In Ontario, I can see quite easily, going back almost 50 years that I've lived in this province, how it has evolved over time with different governments, and how governments have not been focused particularly on managing a system, as opposed to trying to deal with something that, essentially, they never wanted, which was a publicly financed health care system. Some governments have done better than others. I don't think governments have done perfectly in this province in actually making it run as a public system, as opposed to, "Let's identify some providers and give them some financing."

With the changes of accountability, some of which have been outlined, where you're now having a Ministry of Health, Ontario Health, which has different accountabilities than the previous LHINs had, and now Ontario health teams—some of which are composed of wonderful, creative people who will do amazing things, and maybe others are going to be in for terrific problems. And when you get down to the contracting and subcontracting that can be allowed, it gets very complicated to figure out where the accountability for public money is going to be.

1600

Bill 175 does not address some of the important, fundamental issues of home and community care. Here are two of them: One is, who is going to do the work? There just aren't personal support workers in Ontario that weren't personal support workers last year. As more and more jobs develop in retail paying at least as much, why will people want to do personal support work in the community? Or if they start to pay better in long-term-care facilities, which I think is quite likely for a number of reasons, then that will just draw people out of the community sector. There needs to be funding to support otherwise welcome relaxation of legislative service maximums.

What I think Bill 175 could do if it were bold, aside from serious concerns I have about it, is to provide long-term-care-level funding for long-term-care-eligible people living in the community. There are 2,000-plus deaths that have occurred in long-term-care facilities. There were about 2,500 elderly people waiting in hospital beds for long-term care. There are almost 40,000 people who are eligible for long-term care waiting in the community and they're going to fill up our hospital beds—

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

Dr. Michael Rachlis: Thank you. They will fill up the hospital beds once they're open. Communities and families have been struggling. I've heard some terrible stories; I'm sure the elected members have been hearing many stories from their constituents of trying to cope with older people at home and the stress that this has been on already-stressed families.

I'm forecasting that this is going to be a lot worse and that we can do something about this besides waiting 10 years and building 30,000 long-term-care beds we might not need.

I just want to highlight that one of the alternatives would be to consider a planned program of intensive community-based care, which a group that I've been working with, inspired by an American program, actually, out of San Francisco that I've seen for over 30 years—our BEST program, our Best Environment for Seniors to Thrive would integrate all the care for seniors around the patient in the community and would provide an institutional level of support for people living in the community, either by themselves or with family. The outcomes of this model in the US are reduced use of acute-care and long-term-care facilities, reduced overall health care costs, longer life expectancy, improved quality of life, reduced staff turnover and—

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

Dr. Michael Rachlis: —of course, you can avoid the capital costs of building 30,000 beds. Plus every government has promised that for decades and we've never built them, thank God.

I would be happy to talk more about that, and I'm happy to talk more about the legislation and some of the previous discussion that you folks have been having.

Thank you very much, again, for inviting me to speak to you today.

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

I will now call on the Centre for Independent Living in Toronto. You will have seven minutes for your presentation. Please state your name for Hansard, and you may begin.

Ms. Wendy Porch: Good afternoon. My name is Wendy Porch. I'm the executive director at the Centre for Independent Living in Toronto, also known as CILT. I am co-presenting today with John Mossa, CILT's independent living skills coordinator. John and I both identify as disabled people. CILT is an organization by people with disabilities for people with disabilities. We help people with disabilities to learn independent living skills and integrate into the community. CILT operates on the philosophy of the independent living movement, which was developed in response to traditional rehabilitation service models. CILT's aim is to develop and implement dignified social services that empower people rather than create dependencies.

CILT is also the provincial administrator for the Direct Funding Program, a 25-year-old program that enables currently 1,000 people with disabilities in Ontario to live independently in the community by enabling them to recruit, hire and manage their own attendants. Without the Direct Funding Program, many participants would be living in long-term-care facilities. Instead, they are at home, where they are active and important parts of their families and their communities.

According to Statistics Canada, 22% of the Canadian population has a disability. There are many people in Ontario who will be impacted by the changes in Bill 175. It is also important to note that legislation that forms the community and home care service context in Ontario is of immediate and direct importance to disabled people who rely on those services to support their day-to-day lives.

We at CILT have a number of concerns related to Bill 175. John and I will speak to these now. Number one, we are concerned about the repeal of the bill of rights. People with disabilities have fought to be recognized as people with a right to live in the community and to make choices about our lives. The values of dignity, autonomy and respect are well articulated in the current bill of rights. Bill 175 will repeal this. We understand the government intends to develop a new bill of rights, but this time in the regulations accompanying the bill. This sends a message that these rights are no longer as important as they once were.

My colleague John Mossa works day to day with people with disabilities who are working to try to have access to dignified and respectful social services. I'd like to invite John to comment on this.

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

Mr. John Mossa: Thank you very much for this opportunity to speak. My name is John Mossa. I work at the Centre for Independent Living in Toronto.

For the last 20 years, I have been working with people with disabilities on self-advocacy, especially with regard to attendant services. For the last 39 years, I have had lived experience of being a consumer, not a patient, of attendant services. I have directed my services from the then community care access centres to outreach attendance services to currently now living in supportive housing.

It is extremely important to have the bill of rights in the act. When I work with consumers who use attendant services and are having problems, they sometimes don't know that they have rights in the law. Knowing that they have rights entrenched in the law makes them feel that they can advocate for quality services they deserve. Putting the bill of rights into regulation means the government has more leeway to change its contents without the oversight of going through a vote in the Legislature. It means the government can change it or omit it altogether.

The bill of rights and the complaints procedure are also part of every service contract currently under the Home Care and Community Services Act. This is important because both the attendant service provider and persons with disabilities know that they have rights entrenched in their contracts and in the law. It affirms to people with disabilities that they have a right to dignified attendant services without abuse.

I'll pass it back to Wendy.

Ms. Wendy Porch: Thank you, John.

We also have concerns, number two, with the language used in Bill 175. I think it's important to remind everyone that it was only a mere 50 years ago—

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

Ms. Wendy Porch: —that in Ontario, children with disabilities were moved into hospitals, as young as seven, and were expected to live their whole young adult lives there. Once they aged out of, for example, the Home for Incurable Children—which is a real hospital and is now known as Holland Bloorview hospital, and is a good example of ableist language and the importance of language. When these folks aged out of those institutions, they were fully expected to move into long-term-care homes and never get a job, never fall in love, never have a family and never undertake any academic accomplishments. People with disabilities who lived in those institutions fought hard against this restrictive view of their lives, and they won the right for supports to live in a community.

Throughout Bill 175, we see that the language has shifted from "services" to "care." For people with disabilities, who have long fought against the idea that they are only objects to be given care, this shift is troubling. As well, we see people referred to as "patients." This, again, is a troubling shift for us.

For disabled people who rely on these services to live their lives, they are not patients needing care; they are people or consumers simply requiring services. Just having a disability does not make you sick. We see the shifts in language as being indicative of a loss in the independent living philosophy in Bill 175, and we worry that this means that we have lost our hard-earned recognition as people who have a right to services and have become, once again, patients needing care.

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

1610

Ms. Wendy Porch: Finally, we're concerned about the privatization of home care and community services. We know that the COVID-19 pandemic has demonstrated significant and profound issues related to the oversight and regulation of long-term-care homes, with the vast majority of deaths being in privately run homes. We believe the government would be wise to consider slowing down the passage of this legislation and allowing for a public review that answers some of the questions related to private regulation and oversight of private homes.

So our recommendations on Bill 175 are to include the bill of rights in the legislation to ensure that the rights of all Ontarians to dignity and autonomy and their service provision are respected—and we ask that you revise the language to refer to "people" and "services" instead of "patients" and "care," in order to maintain the forward momentum we have had as people with disabilities.

We also ask you to consider delaying the passage of this legislation until the results of an investigation into the impact of COVID-19 on—

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

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

Chief R. Donald Maracle: Good afternoon. I'm presenting today with Carmen Jones, the director of health at the Chiefs of Ontario. My name is R. Donald Maracle. I'm the elected chief of the Mohawks of the Bay of Quinte. I have presided in the office of chief for 27 consecutive years. I have a strong passion and conviction for assisting with and addressing health care needs and requirements for all First Nations in Ontario, especially with respect to home and community care and long-term care.

I began working in the political field with the Tyendinaga Mohawk Council, as a council member in 1979. I studied accounting and finance at Algonquin College, and I took a night course in French at the University of Ottawa. I have been at committee [*inaudible*] care with the province of Ontario. I have been a past director of the First Nations Technical Institute and a member of the expert panel on drug addiction. I am a member of the AFN First Nations housing and infrastructure committee, as an adviser. I am a long-standing member of the Ontario Chiefs Committee on Health, representing AIAI. The Ontario Chiefs Committee on Health is a politically mandated body within the Chiefs of Ontario that was established to ensure responsiveness on health issues and in partnership with both the provincial and federal partners.

While I welcome the opportunity to present to you today, I am obliged to state that the lack of prior consultation and the haste in moving forward with changes to home and community care appears to be out of step, particularly in light of recent events. Given that Minister Elliott has appointed a new Patient Ombudsman, who will address quality-of-care issues, including home and community care, and before the independent commissioner's review of long-term care in general, which will highlight the enormous problems within long-term care, home and residential care settings—and perhaps a more current, thoughtful, integrated approach to home and community care support services is required.

Many First Nations in Ontario and throughout Canada continue to experience a greater health challenge and disparities than the national population. Our citizens are vulnerable at all ages—youth, adults, special-needs, and of course the aging and elderly. A recent study that was conducted in partnership with the Institute for Clinical Evaluative Sciences verified that First Nations members have been determined to experience frailty at the age of 45, compared to the provincial age of 65. That is a 20-year gap, indicative of just how critical this issue is for home and community care and long-term care.

I am committed to addressing the home and community care and long-term-care needs of First Nations in Ontario. You may be familiar with the Mohawks of the Bay of Quinte's 128-bed elder and disability long-term-care-home project. This is something that we've been working on in our community, in collaboration with the province, since 2017, with the previous associate deputy minister of the Ministry of Health and Long-Term Care. I co-chaired a special committee, a chiefs' tripartite committee on long-term care. Once constructed, our new, modern facility will set a new standard for elder and disability care in First Nations communities, with all private rooms and a unique model of elder and disability care catered to our community but integrated into our regional long-term-care-home system. This project is unique, but it shouldn't be, and it is my sincere hope that it will be the model for change for our First Nations long-term-care-home system.

I have first-hand experience of the hardships many of our members are experiencing here and throughout the province. There's a lot of elderly frailty early in life, multiple comorbidities, dementia, falling, wandering, poverty, shortage of beds in long-term care and accessibility, up to two-year wait-lists—a crisis in long-term-care homes and hospitals, with no beds and impacts to hospitalization.

Impacts on First Nations directly are the lack of services, especially home care and PSWs; 61 communities have boil-water advisories; there's a lack of affordable housing for seniors and elderly people and disabled people. The RRAP program, which helps the elderly and poverty-stricken elders fix their homes, is going to be cut in half this year, down to $1.6 million for the whole province. Then Ontario has the lion's share of boil-water advisories—61 of them.

While I recognize that Bill 175 was introduced primarily to deal with the structural, administrative issues

specific to the local health integration networks and the Ontario health teams—OHTs—this sudden transformation of the system is proving problematic for many First Nations communities.

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

Chief R. Donald Maracle: While some First Nations had relationships with their local LHINs, many did not. This lack of representation is being carried over into the new Ontario health teams structure. If this is just a rebranding exercise, if the old LHIN system is just being renamed "home and community care support services" and the structure as it relates to our First Nations will remain the same, I wonder what this means for First Nations who in the past have had poor and, in many cases, non-existent relationships with the LHINs.

I need to be clear: As the province moves forward with Bill 175, you must ensure that the First Nations governments are dealt with on a nation-to-nation basis. We will not agree to a generic Indigenous treatment that does not respect each nation's unique community wellness and health needs.

Last year, on behalf of the Chiefs of Ontario, former Chief Elaine Johnston made a presentation to the Standing Committee on Social Policy regarding the Ontario health care act and also to express similar concerns.

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

Chief R. Donald Maracle: These concerns still stand today. It continues to be our expectation that the province will continue to respect our inherent Aboriginal and treaty rights in all government legislation moving forward.

In your government's briefing material, the claim is made that the new structure preserves Ontario's ability to enter directly into agreements with Indigenous organizations that will maintain the nation-to-nation relationship between the parties. The Chiefs of Ontario leadership and our respective community providers require confirmation on how this nation-to-nation relationship will be embedded into the legislation concerning Bill 175 and not only in the government's promotional material. The province needs to ensure it respects First Nations governance over our respective communities. The promotion of enhancement, access to care, quality care, staffing shortages and public oversight in critical areas are not addressed in Bill 175.

Our existing experience, arising from COVID-19—

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

We are now going to start the questions. First, the opposition side: Madame Gélinas, please go ahead.

M^me^ France Gélinas: Thank you, all of you, for your presentations—very different angles, but all very interesting.

My first question will go to Dr. Rachlis. I would like you to give us an example as to what would the BEST community-based model look like in Ontario. Describe it as an example.

Dr. Michael Rachlis: This is based on a US program called the Program of All-Inclusive Care for the Elderly, or PACE, which was first established in San Francisco in the 1980s. I visited for over 30 years. It is truly amazing.

In the 150 communities that PACE operates in, if you are deemed eligible for long-term care—just as we have eligibility testing in Ontario and every other province, so they do, by state, in the United States. If you're eligible for long-term care in that part of San Francisco or in 150 other communities in the US, you can choose to go into a nursing home or you can choose to go into a PACE program, in which case, that program provides all the care that you need so that you can live a good life. But that doesn't mean they provide housing necessarily. People typically have their own housing—either supportive housing, or many live with family. They are given wraparound, community-based care by a small team of people, and that means 24-hour home care. It means that the home care PSWs work closely with the same nurses who work with the same doctors. The doctors can talk immediately to the PSWs on the phone, see a patient if needed. As a result, the care for patients is so good that they virtually never develop crises.

1620

One of the fundamental parts that makes the PACE program work, and would make BEST work, is to have a lot of the services focused through a congregate day centre at least two days a week, and these day centres are open 12 hours, seven days a week. The participants in the program can go to the centre, they get meals, socialization-specific rehabilitation; some offer specific rehabilitation services, like swimming etc. Additionally, it keeps good care of them so that people know there are no crises for BEST patients. As a result, even though all of these patients have to be eligible to be in a nursing home to enter the program, on any given day only 5% are actually in a nursing home. The other 95% are, in fact, living their lives in the community. Most die living in their community residence.

Of course, I don't want to take the additional time to explain all the details, but I think it's important—maybe the two key points are that it's everything that people could imagine for palliative care, where you have a small team of people typically providing your care, and you have a physician group that is fully integrated, that won't do things like just send the patient to a hospital; and, at the same time, they have this day facility which maximizes their health promotion and ensures they stay healthy.

I read through some of the outcomes in my presentation. They seem too good to be true. They cost something like 20% less than people who don't go into PACE programs, and yet they live longer and they feel better. It's a bit like magic because these programs really maximize the health promotion aspect. So it's like the best home care you could imagine with palliative care combined with a focus on health promotion, and it's all done for less than what the overall health care costs would be for these people if they went into a nursing home.

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

Dr. Michael Rachlis: Sorry.

M^me^ France Gélinas: It's all good.

My next question is for Donald. What would a good relationship look like, and what do you want to see in Bill 75 to be respectful of the needs, to provide services to First Nations? What would you like to see change?

Chief R. Donald Maracle: First of all, there have been decades of systemic underfunding issues that have plagued First Nations in all aspects of community life. So there would need to be more money to pay proper wages for home care, for personal support workers and homemakers; that there's flexibility to provide the level of care that's decided by the nurse who's in the community, what level of care is required instead of a cookie-cutter approach to—

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

Chief R. Donald Maracle: —so many hours per day. It doesn't meet the needs of the people. And consultation: that you reach out to the communities to determine what their needs are and listen to what their input is.

The front-line workers know best what needs to be done with the people they're caring for, and right now there should be a survey of what the needs are—a joint survey with the Chiefs of Ontario and our communities in the field of home care and long-term-care needs.

Right now, we have less than one quarter of 1% of long-term-care beds in the whole province of Ontario. That's how serious this systemic problem of lack of services has been in First Nations communities. The province is well aware that there's a lot of serious illnesses in First Nations people and they become seriously ill at a much younger age. Oftentimes, the families are not well themselves to be in a position to look after elderly and frail—

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

We are now going to move to the government side. MPP McDonell.

Mr. Jim McDonell: A question for Chief Donald: I'm just wondering where you are. It looks like you're in the middle of a snowstorm, with the scenery behind you.

In our area, we have the reserve Akwesasne. Chief Abram Benedict is doing a great job there. They've got a relatively new seniors home on Cornwall Island that some of my neighbours had worked at. I'm just wondering if you've had a chance to look at it. They seem to be quite happy with it. I don't believe it's an older building; it was built in the last 20 years. But it certainly serves the community, and it's a model for our region. Do you have any comments on that institution they have there?

Chief R. Donald Maracle: A few years ago, they were looking for money to fix the roof there. I'm more familiar with the one at Oneida.

I'd like to also point out that none of the long-term-care facilities in First Nations had any COVID-19 illness or any COVID-19 deaths. They instituted protective measures much earlier, before they were announced by the medical officer of health. They were committed to providing excellent care.

The home is an older home. I'm not sure what Akwesasne's plans are in terms of that, but I know that a few years ago, they were looking for money to fix the roof.

There has to be capital, as well, to undertake the repairs that are needed in long-term-care facilities, and it has to be responsive to the needs that are in the community.

Mr. Jim McDonell: To the coalition for independent living: I've had the opportunity over the years to speak to our local organizations, community living organizations, in Stormont, Dundas and Glengarry. I believe we have three of them. The current situation, of course, was, over the years, a lack of funding, a lack of ability to provide respite time. Group homes were in very short supply. Hopefully, this bill will address some of those issues going forward. So maybe some comment just on the current state of where you are, over the last decade or so?

Ms. Wendy Porch: I can start—and John, if you'd like to chime in too. Just to clarify, we're the Centre for Independent Living in Toronto. The kinds of services that I think you are referring to are actually offered by centres for community living. The folks that we support are people who generally have physical disabilities and are in a position to direct attendant services.

There are not many group homes in terms of the population of folks that we serve. The majority of people that we serve live either in supportive housing, as John does and can speak to, where they live in an accessible apartment and they receive attendant services through an organization like the March of Dimes, for example, or people in our Direct Funding Program live in their own homes and they receive services through the attendants that they hire and recruit themselves.

John, I wonder if there's anything that you would like to add there?

Mr. John Mossa: Just that I have been seeing in this health sector that increased amalgamation of bigger service providers swallowing up smaller service providers, and the fact that people with disabilities are losing their voice to a more medical model with these service providers.

Ms. Wendy Porch: I think some of the issues that were raised earlier today around PSW supports and the funding that's available to support PSWs to provide these kinds of services—there is definitely a need for an increase in funding in terms of providing these kinds of services, as well. One of the main problems that we see in terms of our community is actually a lack of accessible housing. It is very hard for people to find a place to live—

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

Ms. Wendy Porch: —in the community and then also to be able to engage in these kinds of services. So there are a number of elements to this kind of issue.

1630

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

Ms. Donna Skelly: My question is for Chief Maracle. You mentioned that you felt that Indigenous communities were not well served by the current LHIN model. We believe that what we are proposing under Bill 175 is a change that will provide a more integrated continuum of care. I'm just curious if you believe that Indigenous communities can benefit—or maybe you can share, how do you think Indigenous communities can benefit with a

better relationship with the local health teams that we are proposing, the Ontario health teams?

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

Chief R. Donald Maracle: I think, first of all, that the situation needs to be assessed right across the province, because it's different with each community. Some communities have a very positive working relationship with the LHINs and others have no relationship whatsoever. Why that is, I don't know, but there has to be a relationship with the funder. As there are investments to provide and improve health care for other people in the province, there have to be corresponding investments in First Nations as well. Right now, we haven't seen that happen to any great extent.

The workers, particularly the PSWs, have to be properly paid. Right now, they are mostly paid a little bit better than minimum wage. That's why you had a lot of people looking, not having full-time work—

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

We are now going to move to the opposition side. MPP Joel Harden, please go ahead.

Mr. Joel Harden: Chief Maracle, please finish your thought. You were in the middle of talking about wages and working conditions for PSWs.

Chief R. Donald Maracle: First of all, a lot of the federal positions are grossly underpaid. First Nations are always looking for own-source revenue to top up wages to keep people. If someone dies, then of course there are less hours, so there's a fluctuation of the hours that the PSWs have. Oftentimes, they will look for work in the nursing homes simply because there are regular hours of work and more predictability. And these people have families too; they have to provide housing and they have an electric bill and utilities to pay. They find the fluctuation of it no good. It would be better if there was a core of staff kept on permanent payroll to respond to the need. That's not how the system works.

The number of hours of care: People who are frail, especially if there's lifting involved—with the very elderly, it takes longer to bathe them and dress them and get them ready for the day. Oftentimes, they're only allowed two hours and so many days a week. So there are big gaps in services.

Usually, these people end up being taken to the hospital, because they've fallen; they're falling on the floor. Oftentimes, they have no family who live in the area to take care of them, or the family members are too elderly and frail themselves or they have a serious disability. In one case in our community, the person had both their legs off, was in a wheelchair—the daughter. She was in no position to take care of her family. She was in and out of the hospital and had diabetic complications herself. You have to assess the health capability of the community to look after them.

The other thing is that a lot of people have to work. Both the husband and wife have to work to pay their bills, their mortgage, their car payments and to maintain their employment. They can't take a holiday from employment to take care of someone or else they will lose their house.

Mr. Joel Harden: Yes, I take your point. Just so you know, this has been a big issue that's come up, but it's very good to know from your perspective that that's something that matters to you.

Chief R. Donald Maracle: And there was a case where she—her father served in both the First and Second World Wars, a very distinguished veteran—took care of her mother at home until she was 102 years old. When her mother needed care, her daughter tried to look after her in the home. She was losing a lot of sleep, because her mother started to get dementia, and a year ago in April, she wandered outside and froze to death.

Mr. Joel Harden: Oh, my goodness. I'm sorry to hear about that. That is absolutely awful.

I'm compelled as our party's disability critic—Wendy, John, thank you so much for being here this afternoon. Given what you heard from Dr. Rachlis earlier—that really inspiring and interesting example that comes out of California—and the work you do for so many folks who want to live independently in the community, if we were to do a reset on how we can do community care and home care better for consumers of important services, what might it look like?

Chair, how much time do I have left, just so my friends have a sense?

The Chair (Mr. Kaleed Rasheed): You have about three and a half minutes.

Mr. Joel Harden: Okay. Wendy and John, if you could just give us a better sense from a disability rights perspective, what would a home care and community care system that was enabling for all Ontarians look like?

Ms. Wendy Porch: It's a great question. Thank you.

It would centre the independent living philosophy, which says that people with disabilities are the people to make choices about the services they need and to direct those kinds of services. It would provide an opportunity for changing that power dynamic that we were talking about around the language in Bill 175, so that people with disabilities are the ones to say what kinds of services they need and how they would like to have those services delivered. That would definitely be a restart for us.

The other thing is, more places for people to live—if we're going to be in the community, we need to have somewhere to live in the community. That's part of this overarching message. People want to be at home. They want to be part of the community. They need to have somewhere that's accessible for them to be able to access these home care services.

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

Mr. John Mossa: I agree with the need for more accessible and supportive housing. The Centre for Independent Living in Toronto has a Direct Funding Program that saves money across the board for government and taxpayers, and empowers people with disabilities to hire, train and [*inaudible*] their own PSWs in the community, so that they are in control. There are a thousand people across Ontario who are using this. It eliminates the

middleman. It eliminates service providers with their administrative costs. While it's not for everybody, it is for people who really need this. Currently, we have a waiting list. It almost goes to what Dr. Michael Rachlis was saying—

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

Mr. John Mossa: —with that program in the United States. It's just expanding the Direct Funding Program further, because if people with disabilities need professional services, they're still able to get nursing on top of the Direct Funding Program.

Ms. Wendy Porch: The program is 25 years old, so it has been a success for a long time. As John was saying, we have a waiting list for the program. The fact that the individual themselves, the consumer themselves is the person who decides who it is that provides them with services and what kinds of services they need—they also train them in the way that they want to receive those services—it changes the power dynamic quite significantly. As John has pointed out, it is much more cost-effective than our current system.

Mr. Joel Harden: It sounds like we need to give you folks a lot more money and federate across the province.

Ms. Wendy Porch: If you like.

The Chair (Mr. Kaleed Rasheed): We are now going to move to the independent member. MPP Fraser, please go ahead.

Mr. John Fraser: I'd like to thank all the presenters for their presentations this afternoon. I apologize for missing my first round of questions. As usual, something came up at home. I will try to get everybody in, so I'll get right to the point.

I'll begin with Dr. Rachlis. I want to thank you for presenting for the umpteenth time, probably, in front of one of these committees or in front of somebody else in the Ontario government.

What I think you're driving at is, essentially, community-based care, where a community has ownership of that, and it delivers the needs of the people in that community. Am I right in making that assessment? And do you want to talk a little bit about San Francisco, keeping in mind that we'd like to hear from some other presenters, too?

Dr. Michael Rachlis: I've always been interested in innovation in health care. I started my career working at the South Riverdale Community Health Centre in 1976 as a family doctor, and later did my public health training, and mainly worked as a consultant for the last 30 years. I do strongly believe in that model of community-based care, of communities trying to democratically decide what their needs are and trying to meet them in as social of a way as possible, without just waiting for people to be sick so they can be treated by doctors.

1640

This program in San Francisco was developed by the Chinese community—actually, led by a dentist in the community in the 1980s. They were dissatisfied with both institutional care for their seniors as well as the fact that you couldn't get intensive-enough community services to keep people at home. That's how the program arose.

We have had a fair bit of interest, I would say, in the last year in this kind of a program. Ironically, we have found that, even though I hope some of the Ontario health teams will do some creative things in the next while, just the destabilization of eliminating LHINs and bringing in the Ontario health teams and trying to settle governance—and it's complicated; you've also got for-profit entities involved—is making the decision-making much slower. But I think everybody sees the sense in not trying to build 30,000 long-term-care beds and looking at building maybe fewer and looking at intensive community-based models.

I just wanted to quickly add that one of the key success factors includes that these are not-for-profit organizations. I do feel that, in general—the evidence is not as stark as some people might say, and I've reviewed the evidence on at least a couple of occasions—everywhere in health care, from hospitals to nursing homes to community-based care, you do get differences in quality between for-profit and not-for-profit care. They're not necessarily gigantic, but they're there.

In this particular model where you're providing, in many ways, envelope funding for care, you do not want to do it without having some sort of strictures on it. You can't just give it and then let those providers underservice people so badly that they just end up in hospital, but the public entity is paying the money anyway. To me, it's an extra measure of insurance.

For all the members, I would just ask them, how would they feel if Humana, one of the big US health corporations, was running their community's hospital? I don't think they would feel very good. I don't think they would ever win an election by running on that. I don't think that we should have large corporations running parts of our health care system that touch patients. Making pills and bedpans: The private sector is good at that.

Mr. John Fraser: Thank you for all your advocacy around community-based health for over 50 years.

I'd like to direct my next question to Wendy Porch, in terms of the repeal of the bill of rights and provisions around appeals. I understood from your testimony that you feel very strongly that that should be in the legislation; it shouldn't be put into regulation. Is there anything that you feel we should be doing to strengthen that patient/consumer bill of rights? Are there additional members? Is there some way for us to update that, or any particular measure?

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

Ms. Wendy Porch: It would be great to have an opportunity to consult with the communities about what the bill of rights says for them and what it doesn't say for them. I think taking it out of the legislation—and this was the main point of my testimony—sends a message that it's not important, that these rights are not entrenched in the legislation, and also that the oversight is changing dramatically and that it can be changed without anybody really knowing. All of those things are very troubling to our community, in particular, who, as John said quite clearly, rely on the bill of rights as a kind of grounding force to be

able to work towards services that are respectful and support their autonomy.

There could be a consultation undertaken around the bill of rights, but it would only be really appropriate, I think, in the context of understanding that it was staying in the legislation. I would be concerned about inviting a consultation to a bill of rights that then was just going to be relegated to the regulations.

Mr. John Fraser: Because legislation gives it some permanency and some structure—

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

Mr. John Fraser: I agree with you on that.

Chief Maracle, thank you very much for your presentation, as well. Do you have any comments with regard to the things that are being put into regulation; specifically, the patient bill of rights or consumer rights, appeals processes, abuse provisions?

Chief R. Donald Maracle: To ensure adequate care, there have to be basic things in place, like safe drinking water, no overcrowding in the houses where elders are living. They don't have a lot of quiet time if there are 20 people living in the house where they are, so it's really an unhealthy environment for people to live in. The lack of housing is very serious in First Nations communities—and the poverty that a lot of elders have suffered historically because of being shut out of the economy and always having lower-paid jobs, not being able to pay into the Canada pension fund.

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

Chief R. Donald Maracle: There's a lot of poverty. A lot of the issues stem from poverty. There has to be strong investment in the area of capital to address the housing—also, the supports that First Nations need. The systemic underfunding is what needs to be addressed by the government.

The Chair (Mr. Kaleed Rasheed): Now we are going to move to the government side. MPP Martin, please go ahead.

Mrs. Robin Martin: Thank you to the presenters for coming today and for giving us your thoughts.

Dr. Rachlis, I have followed your career for some time. I'm a bit of a policy nerd myself, so I've read some of the things that you've produced in the past.

I'm very interested in the model that you've put forward—both the one in San Francisco and you have one you're calling BEST, which is a potential Canadian or Ontario model. This kind of model is currently something we can't get to in Ontario, given the very legislation that we're trying to repeal today. Part of the reason we've put together this legislation, Bill 175, in the way we have, with a lot of stuff in regulation, is to enable the kind of innovative models of care that you are presenting to us today. I'm fascinated by this. I'd like to understand more about it. Perhaps you could give us a little detail on how it's working in San Francisco, how you think it could work here, and why it would be a good way of dealing with our elderly.

Dr. Michael Rachlis: Thank you, first of all, for your kind words.

I think the outcomes speak for themselves.

I do know that when I've spoken to a lot of senior people within the Ministry of Health—the minister is probably interested. I think her office has shown some interest. Everybody is interested in this concept. The problem is that once you get on the ground—it's always true; it doesn't matter which government does it or how. I saw how destabilizing LHINs were 15 years ago. When you change the structures of the system, then things go all over the place. So it has been very destabilizing.

I feel that some of the best existing networks did great during COVID-19 because people knew each other, they trusted each other. I think they've done a good job in my community. Michael Garron Hospital is just one of many examples across the province of where I think people have come together in a crisis to do good work.

But I don't see a lot of planning around integrated services for frail seniors, the mentally ill, homeless, high-risk groups. I don't see that happening because there are still huge [*inaudible*] barriers to organizations [*inaudible*] their staff and giving them to other organizations so they can be integrated.

If Ontario really wants to let a thousand flowers bloom and get those creative juices going, and yet make sure it's going in the right direction, I really feel—this is true for every province, really—we have to just human up. We have to run our jurisdictions like Scotland or New Zealand. You might well know their websites. Go to them and see goals for government. Here are the performance indicators for different areas. They have directions for their creative people at the coal face to do their work.

1650

In Ontario, we do not have a strategic plan. The previous government, in their LIHN legislation in 2006, mandated that there would be a strategic plan for the Ministry of Health and it never came out. We have no guiding documents for any government in this province for what it should be doing, and that goes down to OHTs.

I do believe a lot of people want to have these kinds of innovative programs put in place, for frail seniors especially. I just feel, unfortunately, that, again, we may be missing a beat with letting too many things go to the periphery with chaos and not enough appropriate steering by our central agencies.

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

Dr. Michael Rachlis: I would like to see the government be much more directive: "This is what we're trying to accomplish; this is how we're going to measure it." And then you can throw it down to communities to do good things. Sorry.

Mrs. Robin Martin: No, that's fine. Thank you very much for your perspective on that. I do think it would be impossible to achieve any of the innovations that you've presented to us, which sound wonderful, if we didn't amend or repeal HCCSA, because it actually prescribes so much operational detail. That's the very reason why we're trying to get rid of it and have legislation that allows us to innovate so we can provide better care. So thank you for bringing that to my attention.

I just finished reading Dr. Atul Gawande's book, Being Mortal, for the second time this year, which seemed very apt. It's a very good book. I've also started reading the book by Dr. Reichman about psychiatry in long-term care, which is a bit above my scientific or medical background, I have to say. But geriatric psychiatry care is also different from dementia care, and it is an increasing issue for the elderly. People are living longer and many people have dementia, whether they're in home care or long-term care. So does this model that you've presented work for people with both geri-psychiatric, sometimes aggressive behaviour or dementia? How does it work?

Dr. Michael Rachlis: Yes. It's literally people who are—imagine if one of our parents needed long-term care in Ontario and we had them panelled, "Yes, you need long-term care"; they would have a choice. They could either go into a nursing home and through that process—

The Chair (Mr. Kaleed Rasheed): Apologies to cut you off. Thank you to all the presenters for the 4 p.m. group. Thank you all for joining us this afternoon.

ONTARIO MEDICAL ASSOCIATION
INTERFAITH SOCIAL ASSISTANCE REFORM COALITION
ONTARIO HOSPITAL ASSOCIATION

The Chair (Mr. Kaleed Rasheed): Welcome to all the presenters for the 5 p.m. group. I will now call on the Ontario Medical Association. You will have seven minutes for your presentation. Please state your name for Hansard, and you may begin.

Dr. Samantha Hill: My name is Dr. Samantha Hill. I'm president of the Ontario Medical Association and a cardiac surgeon.

On behalf of Ontario's 32,000 practising physicians, thank you for the opportunity to share our perspective on Bill 175. As Minister Elliott stated, Bill 175 builds a modern and nimble system to deliver home and community care services, bringing this outdated system designed in the early 1990s into the 21st century. From the physician perspective, this is certainly long overdue.

Physicians are frustrated that the existing siloed system is cumbersome and inefficient. It does not allow patients timely integrated access to the care they need, and it's extraordinarily difficult and time-consuming for all the stakeholders to navigate.

The OMA sees this as an opportunity to address long-standing issues and inefficiencies and examine critical areas that affect delivery of home and community care, including:

—enhancing physician ability to access home and community care for their patients;

—improving communication between physicians and community care;

—improving the efficiency of changing care needs to reflect changing clinical scenarios;

—reducing the need for assessment and improving consistency in assessments; and

—increasing the rapid delivery of service.

I further commend the government for including references to the elements of Dan's Law. The OMA has been extremely vocal in its support, ensuring that Canadians relocating to Ontario who require end-of-life care [*inaudible*] health care coverage when and where they need it most. While [*inaudible*] care is a valuable resource, patients deserve the option, where medically feasible and safe, to remain in their own homes. Furthermore, this will improve hallway medicine and hospital wait-lists by freeing the scarce resource of hospital beds.

In the end, the regulations and policies will need to reflect the real world. The OMA looks forward—

The Chair (Mr. Kaleed Rasheed): My sincere apologies. I believe you're moving the papers around. It's making some background noise. Or is there anyone else who's—everyone else is muted. We just saw you moving some papers, and then there was a noise.

Dr. Samantha Hill: Apologies. I'm not currently moving anything.

The Chair (Mr. Kaleed Rasheed): It's all good now. Thank you.

Dr. Samantha Hill: Thank you. In the end, the regulations and policies will need to reflect the real world. The OMA looks forward to working with the government to provide practical advice and guidance as specific regulations and policies are drafted, while recalling that all of this is only possible with a strong and well-funded home and community care system.

I turn it over to Allan O'Dette.

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

Mr. Allan O'Dette: Good afternoon, members of the committee. My name is Allan O'Dette. I'm the chief executive officer of the Ontario Medical Association. Thanks for the opportunity for us to present today.

Our society and our health care system are facing multiple challenges in light of the COVID-19 pandemic. I don't think it's a secret to anyone on this committee that our population is aging, and many of us are aging very quickly. The modernization of our home and community care framework has never been more necessary or, certainly, more timely than it is now.

As confirmed by the Financial Accountability Office, the wait-list for long-term care increased nearly 80% from 2011 until the end of 2019, from about 19,000 to nearly 35,000. While we appreciate that the Ford government has made a significant commitment of 15,000 new long-term-care beds, no government is ever going to be able to meet the surging demand we're all facing.

In addition to capital expenditure—Home Care Ontario reports that it costs about $126 a day to care for a patient living in a long-term-care facility. The cost of care for someone in a hospital, when it's not medically necessary but there are insufficient home supports available—nowhere else safe to go—is about $842 a day. The cost to provide a day in home care is about $50 or $60. So I ask you to really think about what we need to do to invest in this sector.

While a highly functional and well-funded home care system is the right thing to do for patients and their long-term outcomes—

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

Mr. Allan O'Dette: Okay. Thank you very much. I'll pass it over to Dr. Wright.

Dr. James Wright: My name is Dr. James Wright. I'm a children's orthopaedic surgeon and chief of economics and policy research at the OMA. I'm appreciative of the opportunity to speak.

We have provided a written submission, but I want to address a core issue today: What is the role of the care coordinators, and where does their functionality reside? These care coordinators are critical. They're much more than just brokers of service.

There are three questions that we have identified.

What is the role of the more than 4,000 existing care coordinators currently? The OMA strongly recommends that they focus not just on care coordination, but also patient navigation. There is an essential role for them to play in helping patients with chronic and complex conditions navigate the system. Ultimately, integrated care will impact the success of Ontario health teams and will be a key line of defence against hallway medicine.

The second question: What will be the linkages between home and community care supports? This is most important. The OMA suggests there should be direct communication between the primary care providers and community care. Also, there needs to be access to care coordinators after hours, easy exchange of information, regular and clear updates to primary care and a reduction in paperwork and red tape.

1700

We believe, ideally, that care coordinators—

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

Dr. James Wright: —could be localized in primary care offices. This is a separate linkage between government and doctors. We believe, to remain voluntary and nimble, this is best achieved by not—I emphasize not—designating physicians as health services providers.

The last question is, how will the care coordinator role evolve? A one-size-fits-all approach will not be effective, particularly when considering the social determinants of health. We believe co-design of the role with physicians and patients will be essential.

Two other issues—services needed beyond care coordination. Consider the social perspective. This could mean even transportation to a doctor's appointment or to a local grocery store. And, finally, the government will need to ensure that funding is equitable across the entire province, with everyone having equal access.

The OMA strongly recommends that primary care be recognized as a critical hub for care coordination, and we look forward to working—

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

I will now call on the Interfaith Social Assistance Reform Coalition. You will have seven minutes for your presentation. Please state your name for Hansard, and you may begin.

Rabbi Shalom Schachter: Good afternoon. I'm Rabbi Shalom Schachter from the Interfaith Social Assistance Reform Coalition. Page 3 of our submission, in the introduction, indicates the broad interfaith coalition that we consist of, and page 8 indicates specific faith groups that are part of the coalition.

I'd like to start by expressing comfort to the families and friends of those who have perished during COVID-19 and to those who have insufficient care. Our members provide spiritual support services to congregants who are home care recipients and to their family members. We try to comfort those during their infirmities and those who are unable to secure the care that they need.

In the same way, through our intervention in the Gillese inquiry, that we were able to point out flaws in the long-term-care system, we've experienced, through our congregants, the problems in home care. So the first point we want to make is that while we support the principle of connecting people to home care, we do not believe that the bill does anything of the sort [*inaudible*] let alone the quantity and quality of the care that they need.

There is a massive reduction in hospital beds in the province—we have one of the lowest in the Western world. The process was accelerated by the Health Services Restructuring Commission, with the previous Conservative government, with the promise that there would be appropriate investments in home and community care, which never materialized. There is also an insufficient number of long-term-care beds—and COVID-19 shows why people would prefer to age at home rather than in long-term-care homes. There are insufficient resources in home care, even though the cost is probably less expensive than warehousing seniors in long-term-care homes.

One of the problems is that there are caps in the regulation as to how much home care can be provided. One of the reasons is to control expenditures and another is because there are an insufficient number of workers who are willing to work in the system. Workers prefer other health care employers because of low pay, because there is no job security because of the contracting-out system, and because there is no effective collective bargaining system because there are no successor rights when contracts are switched.

A second point we wish to make is dealing with the format. The move to virtually everything into regulations is an abdication of legislative responsibility and an invalid delegation of legislative power. It will likely lead to costly litigation. The difference between having things in the law and having things in regulation is that cabinet can change those regulations unilaterally. There is a denial of accountability in this process to the public, because there would be no meetings of the Legislature and committee hearings like this to look at changes in regulation.

The next point deals with what is taken out of the act. There is no guarantee that in the regulations there would be any accountability. Boards will not be responsible to the communities. There will be a removal of transparency.

There is no guarantee that there would be public meetings, that there would be access to freedom of information and that compensation would be recorded in the Public Sector Salary Disclosure Act. There would be removal of things from the statute like the bill of rights, which is very crucial. We don't know [*inaudible*] if and when [*inaudible*] included in the regulations and whether there will be the enforcement mechanisms that exist in the act right now, such as requiring courts to interpret the legislation in light of the bill of rights and allowing residents to enforce their rights because it's a deemed contract.

Finally, we believe that the legislation, the changes, will facilitate privatization. We've seen, again through COVID-19 and long-term-care homes anecdotally, that the rate of death and infection has been higher in for-profit homes.

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

Rabbi Shalom Schachter: We know that for-profit homes have lower staffing levels, and it's just logical that when you have a fixed amount of money that is paid to a provider, if some of that money is siphoned off into profits, then there's less money available to actually provide front-line care.

I look forward to your questions. Thank you very much.

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

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

Mr. Anthony Dale: Hello, everyone, and thanks for having me. As the president and CEO of the Ontario Hospital Association, some might wonder why I'm here today to speak about a bill related to home and community care. Historically, these parts of the health care system have operated quite separately, but that is precisely the problem that Bill 175 begins to address.

The OHA works closely with our counterpart associations in home and community care, as well as the Ontario Medical Association, who we're pleased to be here with today, and I understand you had a chance to speak with the home and community services associations yesterday. They are the experts in home and community care, but I am pleased to be here to discuss the interdependent relationship between our two sectors.

Especially as our population ages and grows, modernizing home and community care is a key part of the solution to hospital overcrowding and ending hallway medicine in two important ways. First, there is a growing number of patients referred to as alternate-level-of-care, or ALC, who are waiting in hospital to be discharged back home with the appropriate home or community supports. Second, home and community care can prevent unnecessary emergency room visits or premature institutionalization by helping people live independently for as long as possible.

In short, hospitals rely on home and community care to help them reserve space for those who truly need hospital services, particularly acute care. More importantly, patients and caregivers deserve to receive the right care in the right place, which is in their own homes, whenever possible. That's why we're supportive of Bill 175, which will allow providers to collaborate more directly and deliver new models of care, including through Ontario health teams.

Ultimately, increased flexibility and openness to innovation removes barriers to integrated care and creates a more seamless experience for patients and their families. In particular, the legislation would allow hospitals and other not-for-profit health service providers to arrange for the provision of home and community care. It gives hospitals the flexibility to use their resources to increase capacity in home and community care and to work directly with local partners without third-party intermediaries and as much red tape. This direct, collaborative relationship should assist hospitals in reducing overcrowding and hallway medicine. It would also mean patients and families spending less time and energy trying to navigate a complex and confusing system.

The COVID-19 pandemic continues to be a serious threat to hospital capacity and gives new urgency to this work. Today, hospitals must protect surge capacity and manage growing occupancy levels while at the same time restoring access to elective activity and supporting long-term-care facilities in their ongoing rescue effort. Some 80% of the standby capacity created in hospitals at the onset of this pandemic has now been filled, and the number of alternate-level-of-care patients waiting in hospitals has surpassed 5,300 overall, which is an all-time high, and here it is the month of June. Nearly 800 of those patients would be able to return to their homes today if they had access to the home care or community support services they need to do so safely.

Should a second wave of COVID-19 collide with the arrival of the flu, it would add significant pressures to hospitals already experiencing significant demand. That's why there is an urgent need for widespread expansion of access to home care and community services to promote independent living and also reduce pressure on hospitals.

1710

COVID-19 has forced many organizations to find new ways to deliver better and more efficient care, and there's no reason to turn back, certainly, once the pandemic has passed. We must also enhance the use of virtual care and leverage technology as an untapped opportunity to help some frail seniors live safely at home.

In the longer term, COVID-19 has exposed the desperate need to examine the complex quality-of-care issues facing frail seniors across our health care system. In addition to a more resilient long-term-care sector, Ontario needs a true revolution in access to primary care and home and community care to keep people healthy and at home and to return them to their home as quickly as possible once their time in hospital is over.

Bill 175 lays important groundwork for much-needed modernization, but it's just the first step. We must be prepared to make bold, decisive changes to fundamentally improve the integration of health and social services

locally around patient, resident and client needs. Fortunately, this is a concept we at the OHA have been exploring for some time. For nearly two years, the OHA has been working closely with Home Care Ontario and the Ontario Community Support Association to improve collaboration between hospitals and home and community service providers.

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

Mr. Anthony Dale: In the fall, we convened representatives from the three associations to share knowledge, expertise and ideas about high-level priorities and objectives for a new model of home and community care. To our knowledge, this is the first time in Ontario's contemporary health care history that our sectors have collaborated at this scale and in this degree of detail.

In January, we shared some of the key features that emerged from these discussions with the government, and we hope that they will be helpful for everyone as we all attempt to move forward.

We'll continue to collaborate with all our partners and hope to offer expertise to government as they continue the difficult work of modernizing home and community care, because it's only by working together that we can ensure that all Ontarians have access to the high-quality care they need and deserve, whether it's in hospital or at home.

Thank you very much. I'll turn the proceedings back to you, Mr. Chair.

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

Now we are going to start the question session with the government side. MPP Logan Kanapathi, please go ahead.

Mr. Logan Kanapathi: I'd like to thank all the presenters for your insight, information, knowledge and passion with regard to Bill 175 and for home care and health care in Ontario.

Thank you to the primary care providers on the front line for their work during this difficult time. I thank you for your leadership at the OMA.

My question is to the OMA. I believe Bill 175 will make it easier for primary care providers and physicians to deliver better care for patients. I believe we agree that physicians and primary care providers, with their knowledge and experience, are critical to moving forward with the new, integrated model of home and community care.

I could ask either Samantha or Allan or Dr. Wright: How does the OMA better empower physicians and primary care providers to ensure their voice is heard as you look to reform the system?

Dr. James Wright: We see this as a key part of the government's and our joint aim to integrate care. That's what everyone has been searching for for decades, and the Ontario health teams is the vehicle by which we believe that vision can be achieved.

As you probably are aware, primary care has to be at the centre of Ontario health teams. We know that the person who probably best knows your health care needs, who can best serve in the coordination is your primary care physician or, in some cases, an advanced practice nurse—but your primary care provider is the key person. That's why we're arguing very strongly for removing the red tape and using these care coordinators, who are serving a very important role now, but they could expand their role and become navigators so that they could work with the primary care providers and interface, be it with the hospital, be it with the home and community care, be it with all the specialists. They could provide that kind of integrated service that patients and families are so desperate for.

We think that the red tape that currently exists in terms of how the assessment of the needs is done and the communication between the primary care provider and the home and the community provider—if we can remove those barriers and allow them to communicate seamlessly, that really will be a huge step forward in achieving the integration that we all aspire to.

Mr. Logan Kanapathi: Thank you, Doctor, for that answer.

I will ask a follow-up question. As one of the key organizations in this discussion, can you speak to some of the challenges that the physicians have experienced with the current care coordination of the home and community care model in Ontario? And do you believe that Bill 175 adequately addresses or speaks to your challenges?

Dr. James Wright: What I understand is, the referral goes from a primary care provider—and close to 80% of home and community care arises from needs in the community. While post-discharge is incredibly important from hospitals, the majority of it comes from primary care and from the community. That referral then goes to a care coordinator, who has to assign someone to determine the level of care that is provided. That level assessment, that needs assessment, is quite variable across different providers; there's no uniformity. There is then, finally—and hopefully—a care coordinator who ensures that the home and community care is delivered to the client, the patient in the family. If, however, there is a change in the clinical state, that is fed back through the care coordinator and may or may not be fed back to the primary care provider. So that inability for the primary care provider to have a seamless share of information—which could be digitally or it could even be telephone—that ability to go back and forth and change those needs and to inform the primary care—

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

Dr. James Wright: —of what the needs are and the community care provider can work together. That's where we see the regulations as being essential. So Bill 175 lays the groundwork; the regulations are where the rubber hits the road.

Mr. Logan Kanapathi: Chair, how much time do I have?

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

Mr. Logan Kanapathi: Okay. I'll ask my question to the rabbi from ISARC. My riding is Markham–Thornhill. Markham is the most ethnically diverse city in all of Canada. Over 60% of the residents were born outside of Canada. I was speaking with the different faith groups,

cultural groups and seniors who [*inaudible*] my community. If possible, can you speak to what we need to do as a government to ensure that home and community care is culturally sensitive?

Rabbi Shalom Schachter: Well, home and community care needs to be delivered—

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

Rabbi Shalom Schachter: —through agencies that are accountable to the public, and that's why we believe that there should be a governance structure for the agencies that are delivering the care that is accountable to the public, responsible to the community that they are serving, and in that way, they can reflect the needs of the community and have better communication and understanding of what the needs of the community are.

Mr. Logan Kanapathi: Thank you for that answer.

The Chair (Mr. Kaleed Rasheed): Now we are going to move to the independent member MPP Fraser. Please go ahead.

Mr. John Fraser: Thank you, everyone, for your presentations and for being here late on a Tuesday afternoon. I very much appreciate your input.

My first comment is with regard to care coordination. I'm addressing this to the Ontario Medical Association. I understand what your—position in care coordination as a kind of a navigation aid as well. Where do you see those care coordinators being housed, and what is their accountability to primary care providers and their patients?

Dr. Samantha Hill: That's a great question. I'll take a first stab at this and then turn it over to Jim, who might have some more information to add. We primarily see these care coordinators being housed, if possible, with primary care physicians, enabling them to really get that seamless kind of care and that seamless navigation going.

1720

One of the issues, when the navigators seem to be separate from a primary care physician, that does sometimes occur is that lapse of communication and the challenges—I'll turn it over to Dr. Wright to add a little bit more information to that now.

Dr. James Wright: Thanks, Mr. Fraser. Virtual care, as you know, has been exponential in this province—and it has shown how much we can do with virtual care. In some cases, these care coordinators might actually be physically located in a family health team or a community health centre. In other cases, it may be virtual, but we think that functionally they need to reside within a multidisciplinary team, with primary care at the core, serving—as you've nicely emphasized—both the care coordination but also what we see as a navigational role.

As you know, Ontario health teams aspire to have this navigational role, and we think these 4,000 coordinators are an incredible resource that can be leveraged and pivot into this need.

Mr. John Fraser: I have some concerns with regard to the accountability around care coordination, and I can understand how in regulations you may want to create some relationships. The thing is, speaking of relationships, I know that the OMA—and particularly all physicians, but primary care physicians are very patient-focused.

One of the concerns that I have in the bill, and this has been expressed throughout the afternoon, is that we actually, right now, have a patient bill of rights—it's a structure to which people can get some expectation of how things should be delivered, what should be delivered, things like quality and access. That bill of rights is not only there for the patient, but it's obviously there for their primary care physician. This bill is taking it out of the legislation and leaving it to regulation, which is good for some things, but not good for things that you want to put in that are foundational pillars. I don't know if you have any opinions on that, or any concerns.

Dr. James Wright: My view is that the Ontario health teams, which are clearly in a germinal, inchoate beginning stage—that's where the accountability could reside. It's not just accountability for home and community care; it would be accountability for the entire continuum of care. That's why I'd like to see the four pillars be the foundation on which we base Ontario health teams.

I think one of the other speakers spoke to the need for public involvement and public patient engagement as a key part of the governance—so you would have the important insight of the patients, who are the recipients. You would have an accountability framework that goes through an OHT, and you would have primary care and home and community care as equal partners in delivering that continuum of care.

Mr. John Fraser: My next question is for Rabbi Schachter.

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

Mr. John Fraser: Thank you. Almost exactly the same question—I know you've spoken about the importance of having a patient/consumer bill of rights in the legislation. By the nature of what legislation is, it's very different from regulation. I don't know if you have any comments on that.

Rabbi Shalom Schachter: I can't overstate the importance of having key provisions in the legislation itself and not in the regulations. Those go to both the basic rights to receive care, as well as the structures for the delivery of care and the accountability and governance structures to ensure that there is an effective enforcement mechanism for those rights.

The Chair (Mr. Kaleed Rasheed): Now we are going to move to the opposition side. MPP Joel Harden, please go ahead.

Mr. Joel Harden: Thank you, friends, for what you've offered us this afternoon. I take MPP Fraser's point. It's late in the day, so good for you for having the endurance and the commitment to be with us.

I wanted to begin on this notion of waste and inefficiency in the system that was flagged, to some extent, in the OMA presentation. Something that has been raised with me and that I've raised in our proceedings is whether or not the public has a right to have financial disclosure and to be aware of all of the billings and all of the records

of operators in the home and community care industry. Does the OMA have a position on that?

Mr. Allan O'Dette: No, we have no position on that.

Mr. Joel Harden: Okay. Well, I appreciate the answer.

Rabbi Schachter, you named very clearly something that many of our presenters have talked about: the fact that we have an unfinished public medicare system, many aspects of which cost the public a lot, and the returns for which we've been receiving in these committee hearings a lot of complaints. Did you want to elaborate on any of that?

Rabbi Shalom Schachter: Again, when we are looking at the costs of health care, it's important not only to look at the costs that are paid for out of the public purse, but those costs that are paid for by individuals who are accessing the care. We want all health care, not just hospital care and medical care, to be available to people based on need and not based on ability to pay. That's number one. We know that a single-payer system is much more efficient than having multiple players looking after administration and financing.

The other thing is transparency. The public needs to have access to information on the costs of different elements of the system so that we can make informed decisions, in relation to our elected representatives, as to whether to choose one system over another system. So I think it's crucial, whatever is done with Bill 175—whether it's removed for a proper consultation or whether you proceed with it now—that transparency and accountability be written into the system, that there be full access to information under freedom of information, that costs be publicized, that compensation be covered under the Public Sector Salary Disclosure Act, so that we can make those kinds of assessments as to how to best structure the system.

Mr. Joel Harden: Chair, I'd like to give the remainder of my time to MPP Gélinas.

The Chair (Mr. Kaleed Rasheed): Madame Gélinas.

M^me^ France Gélinas: Similar to the question that was just asked—but I'm going to ask it of the OHA. There is a number of transparency and accountability—of our hospitals. We know how much you make. We know how much you receive. We know your budget. We know all of this. This brings a level of confidence in our hospitals because we have this. I think the same amount of accountability, transparency, having freedom of access of information to our home and community sector could be beneficial.

Anthony, you lived through the transformation of this accountability. Would you say that it ends up being positive for your hospital relationships to the community?

Mr. Anthony Dale: Obviously, transparency is always the best policy.

In the case of home and community services, there's certainly a huge opportunity to introduce widespread performance measures and evaluation, particularly around quality of care. I think the point of the bill and what it aspires to do is to tear down some very rigid, very prescriptive, provincially implemented controls that, above all, were about rationing.

Really, the design of the current system is about rationing increments of services and steering as much volume through as the system can afford on the limited resources that it receives. Our message for, easily, 15 years is that it's not enough to simply invest small, incremental increases each year in home and community services and expect a revolution in access.

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

Mr. Anthony Dale: COVID-19 is a huge turning point for our province. The fiscal footprint is under enormous pressure in the current operating year—let alone the amount of debt we're taking on. We need to rethink the entire federal-provincial funding relationship if we're going to get serious about expanding access to home and community services alongside the reforms that this legislation seeks to enable. We are pretending that home and community services are medically insured.

1730

Successive governments have done so, but they have not invested to nearly the scale that is required. Instead, they've drained hospitals of resources and, on one hand, the efficiency story of hospitals is something we should be very, very proud of, because it shows, as you've suggested, France, a real commitment to performance improvement and using the taxpayers' resources wisely. But we're at the point now where I wouldn't advise any government to try to extract any more significant efficiencies. It's time to make some pretty revolutionary investments in home and community care, and obviously, as my colleagues in the OMA have directly suggested—

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

Mr. Anthony Dale: —it greatly strengthened and expanded the role of primary care within our system, particularly as the foundation element to preventive care for patients.

M^me^ France Gélinas: I would agree with you that if we are serious that we want our home and community care system to meet the needs of the patients, the 5,800—I forget—people who could be at home, there needs to be more than just moving a whole bunch of stuff from legislation to regulation, and hoping for the best. We need real investment. We need real changes. We need real accountability. We need to take home care and community care seriously—

Mr. Anthony Dale: Yes, 100%.

M^me^ France Gélinas: And none of that is in the bill—

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

We are now going to go back to our independent member, MPP Fraser. Please go ahead.

Mr. John Fraser: I'll just follow on with Mr. Dale. Thank you very much for being here. I've been listening to Madame Gélinas's questions and your responses.

There's the rub: Where does the money come from? How do we square that up? I would argue that the provincial government is not taking on debt at the level which the federal government is, in terms of income replacement. Here in Ontario, we talk about $10 billion in deferrals. It's not $17 billion that was put into this. So, I

think one of the challenges is going to be how we pay for this, and the integration of those services, especially hospitals—your anchor, core institutions—in the community. I guess the question is: How do you see us paying for that? I know it's not particularly relevant to this bill, but that's the challenge. It's all well and good to say we've got to do this. We've all been saying this, and we've been saying it for 20 years. How do we do that?

Mr. Anthony Dale: If you think of home and community care as a business, which it is—health care is still a business whether it's not-for-profit or for-profit—we need a massive injection of capital.

The legislation enables a far more creative and flexible way of allowing providers to organize care around the needs of patients and clients, but the truth is, short of the provincial government finding new access to a significant amount of investment, we need a new partnership with the government of Canada.

COVID-19 has revealed the truth, which is that the provinces are at the outer limit of their ability to fund many public services today, let alone the kind of expansion that's required to meet the full promise of home and community services. COVID-19 is a historic turning point for this province and this country. We cannot go back to sleep, or as France suggested a few minutes ago, "go along to get along," and each year, through a series of micro-budget decisions and individual compromises, fail to meet the needs of patients.

I can tell you right now, in the midst of a historic pandemic, it's masked and camouflaged because of relatively low levels, still, of hospital occupancy, but we are at all-time historic highs in terms of the numbers of alternate-level-of-care patients. We're probably at 5,400 all together, acute and post-acute, and the transition care units. Could we hit 6,000 by the end of the summer? Possibly, because long-term care is simply not in the position to absorb the discharge of patients the way we historically have relied on it to do. And therein lies the potential of home and community services—not only quality of care, but improving access, as my colleagues at the OMA have suggested. The place to be is at home. If the patient is clinically able to live independently with supports, why don't we aspire to do everything we can to marshal the resources to make that happen? The math didn't add up before COVID-19; it sure doesn't add up right now, and it won't add up when the pandemic is over.

Mr. John Fraser: No, it certainly doesn't feel that way. I'm not surprised that you're at record levels of ALC because of the movement of patients into long-term care—and home care was actually the last thought in this pandemic. At least, that's what's been expressed to us by people working in home care, home care associations, community support associations. So it's not ready right now, and that injection of cash right now—it'll be a challenge to meet that capacity.

I only have one other question, and it's with regard to governance. I know through the OHA and hospitals in my city that governance is a really important issue—

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

Mr. John Fraser: —and you've done a great job with that. One of the concerns I have is the model of governance and oversight for these changes. They're not very clear right now. In actual fact, it's meeting up with a piece of legislation that lets the minister make any change, essentially, that they want—30 days, no appeal. I think that would be a concern to anybody, whether you're hospital or home care. What do you think about governance? It's not in this bill. How are we going to make it work?

Mr. Anthony Dale: I think you're asking a pretty significant question, John. Ontario health teams have a huge amount of promise and their emergence concept is really—just before COVID-19, we had a wave of approved Ontario health teams almost as early-stage, early doctors, but the good side has been remarkable progress in cementing new relationships and ideas that have actually gone on to help tremendously in the COVID-19 response.

I'm certainly not suggesting that COVID-19 and the way our province has had to adapt to this emergency offers a permanent solution. On the contrary, however, it proves what we can do when it is the need of patients and residents that is paramount and we're able to bulldoze our way through all sorts of barriers—obviously, there's some great sensitivity to many of these, particularly in the area of labour relations, and that's not the intention or purpose or focus of my comment. However, where there's a will, there's a way and when we're in a more stable position, it is time for a serious rethink about health system governance in this province, based powerfully on the COVID-19 experience.

Mr. John Fraser: I appreciate all the work that you've done and that your hospitals have done in my community of Ottawa in regard to long-term care.

The Chair (Mr. Kaleed Rasheed): Now we are going to move to the opposition side. Madame Gélinas.

M^me^ France Gélinas: My first questions will be for Rabbi Schachter. You've heard the conversations this afternoon—and I know you've been following. How ready do you think the not-for-profit home and community care sector is for the challenge ahead? Are we ready for this? Is there a willingness within the not-for-profit home and community sector to take on this challenge?

Rabbi Shalom Schachter: As most of the speakers have said, there's a question of resources—how much public resources are we going to make available? In terms of human resources, right now, it is not possible to deliver the home care that is needed by the public because there aren't sufficient people willing to work in the sector because of poor working conditions.

So if there is an investment by the province, in combination with the federal government, in providing financial resources, and if the province restructures labour relations in home care so that, first of all, there will be more full-time, steady job security, that there will be compensation that allows people to pay the bills and recognizes the importance of the work they are doing—primarily women's work, which is undervalued. We never fully implemented pay equity, and we don't have a system of collective bargaining that allows home care workers to organize and

to effectively engage in collective bargaining. If those changes are made, then I'm sure the not-for-profit operators, as well as community groups, will rise to the challenge.

1740

M^me^ France Gélinas: To the OMA: How much of the frustration you've shared with us regarding our existing home care system is linked to the fact that patients cannot get discharged from hospital because home care is not ready—the patients need that level of service, but there's only that level of services available. How much of the frustration you've shared with us, Dr. Hill, has to do with the fact that our home care system is not up to the task—not really the way it's structured; simply, there isn't enough home care to meet the needs of your patients.

Dr. Samantha Hill: Certainly, discharging patients from the hospital is a major issue when patients need more than minimal amounts of care. That's something that contributes to hospital wait-lists and to hallway medicine, as we all know. As far as the quantification of what portion of it, I'm going to have to defer to Dr. Wright, our chief of policy.

Dr. James Wright: I'm not sure I can put a percentage on it. I would only say that that is a component. The bigger issue for me is the coordination.

To go back to a previous question: I think that's where the savings come from, is the elimination of red tape.

I would say that if you put health care workers together—that's one of the most edifying and satisfying aspects of my career in health care and medicine. When you put health care workers together and you give them the problem of looking after patients, they rise to the challenge. It's an amazing workforce when you give them the tools that they need.

So I think coordination is the issue.

M^me^ France Gélinas: But we still have [*inaudible*] of family physicians still work fee-for-service, by themselves. They have no way of working on an interdisciplinary team. So all of those concepts, if we get a group together and they will do great work, is still—yes, I'm all for it, but we're not there.

Mr. Dale, the same question to you: How much of some of the data you shared with us—the 5,400—is linked to the fact that patients being discharged cannot access the level of home care or wait-lists for home care?

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

Mr. Anthony Dale: At the heart of ALC are not anonymous figures and numbers. Each one of those numbers is a person with a story to tell.

Ultimately, alternate-level-of-care patients—it's about quality of care for, primarily, seniors. ALC patients tend to be elderly people with chronic comorbidities, many conditions that contribute to the state of their health. After they finish their time in hospital, especially in acute care, if they can't be discharged—they're probably in exactly the place that they don't need to be, because, putting the infection prevention efforts during the COVID-19 pandemic aside for a minute, hospitals are places where people can catch infections.

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

Mr. Anthony Dale: When that happens to a frail senior, we know that the outcome isn't positive.

Absolutely, the frustration in hospitals relates to wanting patients to get the right quality of care in the right place at the right time, and by relying on hospital [*inaudible*]. We're also not using our scarce resources as efficiently as we can. If we had the ability to instantly discharge all those ALC patients to another more appropriate setting, we could tackle wait times and reduce the amount of time that other people are waiting for any number of clinical procedures.

Again, the bill does offer the kind of framework for a new, more flexible and creative approach that is definitely much more patient-centred and client-centred, but it also ultimately has to be—

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

We are now going to move to the government side. MPP Skelly.

Ms. Donna Skelly: Dr. Dale, please finish your thoughts.

Mr. Anthony Dale: Only my mother thinks I'm a doctor, because I work with the OHA—

Ms. Donna Skelly: Okay. Mr. Dale.

Mr. Anthony Dale: —but it's a pleasure to be here with physician colleagues.

I was simply going to say that we do have to match the aspiration for change that the bill architects with the realization that we do need to significantly invest far more in these very important services if we're going to rebalance the health care system and deal with the quality-of-care issues that are at the heart of our discussion today.

Personally, I feel that the government of Canada has no option, has no choice, especially after what COVID-19 has revealed, but to rethink its level of support for all provinces when it comes to health and social services. The federal government has been on the retreat from the Canada Health and Social Transfer arrangement for well over 10 years, leaving very significant financial responsibilities at the feet of the provinces.

I think that in our case, hospitals have delivered remarkable efficiency results and have risen to the challenge that successive governments have laid before them. But now, as France Gélinas has alluded to, we can't just go along doing the same thing every year and expecting a different outcome from what we have today. We need to invest far more significantly in these very important services.

Ms. Donna Skelly: That leads me to my next question. I'm from the Hamilton area, and when we introduced our Ontario health teams, I had an opportunity to reach out to stakeholders across the city, but specifically from Hamilton Health Sciences and the St. Joseph's Healthcare system.

I'll be honest with you: I was overwhelmed with the level of support that they gave the decision of this government to put forward this model. They felt it was long overdue. They, too, were frustrated with the inability to have that continuum of care. They embrace it. I want you

to speak to that and how it could transform long-term care and continuum care right across Ontario.

Mr. Anthony Dale: I could certainly invite others to comment on this. There are many excellent people working within our health care system on the administrative side, including local health integration networks, but I think the verdict was in, at the time the government proposed Ontario health teams, that the model had become a very, very top-down, very prescriptive model with what I would call an excessive degree of oversight and control over even operational decisions of health providers.

That, I think, was impeding what Jim Wright was just alluding to a few minutes ago: the creativity and capacity of individual health providers—both individuals as people but also organizations—to work together around the needs of individual patients. By allowing—within, obviously, a new regulatory environment—those providers to work more directly together, to self-identify the local opportunities and design new models of care around those patient, resident and client needs, it does afford more patient-centred care and, ultimately, better use of our scarce financial resources.

At the same time, at the moment, OHTs are definitely on pause, but the COVID-19 emergency response has proven the benefit of those relationships and the work that had been done to date around individual patient and community health and social needs, and has been of great benefit in the response. All we're saying is that after the emergency is over, we really need to step back and think about what's important in terms of how we work together, even beyond Ontario health teams.

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

Mr. Anthony Dale: I don't have a specific model in place, but arguably there's some even greater urgency around the imperative that led to Ontario health teams being presented as a concept in the first place. In other words, we probably need to accelerate the model quite significantly.

Ms. Donna Skelly: That's interesting. If you've been following the proceedings, you've probably heard push-back from a number of people who testified or spoke to us today. Many suggested that a COVID-19 crisis is not the time to consider an overhaul of our health care delivery system in Ontario. Your thoughts?

1750

Mr. Anthony Dale: I think that we should be evaluating the successes and areas for improvement in the pandemic response right now, while the situation has stabilized. For instance, we believe strongly that until the long-term-care sector is—

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

Mr. Anthony Dale: —as strong and stable as we want it to be, there continues to be a role for acute-care organizations in assisting and supporting those organizations, and it's only because of the needs of those residents. We think we need to be very carefully evaluating the stability of retirement homes and other congregate settings with vulnerable populations, because it's a humanitarian imperative, and it also has the happy benefit of keeping people out of acute care as well.

These are patient-oriented observations about what happened in a crisis. I'm not suggesting that as some kind of permanent oversight role, but what are we going to do to lend the clinical expertise of hospitals to support long-term care now, seeing, of course, the acuity and relatively short length of stay of your average long-term-care patient? Ten or 20 years ago, length of stay was measured in years, and now it's just over 12 months. Their clinical needs are clearly far more complex than I think the system is designed to provide in some instances, so what can we do—

The Chair (Mr. Kaleed Rasheed): Thank you so much. My sincere apologies to cut you off. This is the hardest part of this Chair position, to cut speakers off.

Thank you to all the presenters for this afternoon, our 5 p.m. group.

That concludes our business today. As a reminder, the deadline to send in a written submission will be 6 p.m. on June 17. Just a reminder to please log in to Zoom at 8:30 for a pre-meeting conversation tomorrow morning.

The committee is now adjourned until 9 a.m. tomorrow, when we will meet to continue hearings on Bill 175. But again, as a reminder, for the pre-meeting—

Interjection.

The Chair (Mr. Kaleed Rasheed): Oh, my apologies. Yes, Madame Gélinas.

M^me^ France Gélinas: How many written proposals have we received? I'm not sure if I got them all or not. It doesn't have to be answered right now. If we could just get a little email with a list of who has sent written proposals—because I've realized that some of them I hadn't seen.

The Chair (Mr. Kaleed Rasheed): Yes, absolutely. The Clerk just mentioned to me that they will look into it and will inform you.

M^me^ France Gélinas: Thank you.

The Chair (Mr. Kaleed Rasheed): This meeting is now adjourned until tomorrow at 9 a.m. Thank you very much, and I appreciate all your support and co-operation.

The committee adjourned at 1757.

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. John Fraser (Ottawa South / Ottawa-Sud L)
M^{me} France Gélinas (Nickel Belt ND)
Mr. Joel Harden (Ottawa Centre / Ottawa-Centre ND)
Mrs. Robin Martin (Eglinton–Lawrence PC)

Clerk pro tem / Greffier(e par intérim
Mr. William Short

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