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LEGISLATIVE ASSEMBLY OF ONTARIO

Monday 12 May 2025

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

Lundi 12 mai 2025

The House met at 0900.

The Speaker (Hon. Donna Skelly): Good morning, everyone.

Prayers.

ORDERS OF THE DAY

PRIMARY CARE ACT, 2025

LOI DE 2025 SUR LES SOINS PRIMAIRES

Ms. Jones moved second reading of the following bill:

Bill 13, An Act respecting primary care / Projet de loi 13, Loi concernant les soins primaires.

The Speaker (Hon. Donna Skelly): I recognize the minister.

Hon. Sylvia Jones: Thank you very much, Speaker, and good morning.

I will be sharing my time with both of my parliamentary assistants—MPP Anthony Leardi, the member for Essex, and MPP John Jordan, the member for Lanark–Frontenac–Kingston—incredible, outstanding advocates for their communities and for building a strong, patient-centred health care system focused on meeting the needs of people and their families.

I would also like to express my deepest appreciation to Ontario's extraordinary doctors, nurses and many other health care allied professional workers in our province. Each and every day, Ontario's dedicated health care workers provide incredible care to patients and their families. They are pillars in our communities and have a tremendous impact on so many Ontarian lives. Our government is very grateful for everything our health care workers do to support the people of Ontario.

One of our government's critical health care priorities, of course, is to increase Ontario's access to primary care. Primary care provided by a family doctor, a nurse practitioner or primary care team is the first point of access to health care services for most Ontarians. Primary care is a foundation of our province's health care system, providing comprehensive and coordinated care at every stage of life, and connects patients to specialists when needed. Primary care can help prevent trips to the emergency department or, indeed, hospitalizations, helping patients get the right care in the right place.

Health systems with strong primary care have better health outcomes, and they help reduce the reliance on more costly forms of care. Studies have indicated that primary care visits are 33% of the cost of a visit to, for example, an emergency department, and there are 36% fewer emergency visits for those connected to a primary care provider.

In recent years, our government has announced a number of investments to increase access to team-based primary care, as well as providing support to all existing interprofessional primary care teams through ongoing operational funding for their facilities and their supplies so that they continue to provide high-quality care to the people of Ontario.

In February of 2024, we announced an investment of $110 million in 2024-25 to connect up to 328,000 Ontarians to primary care teams, as part of 78 new or expanded interprofessional primary care teams. These new and expanded teams included family health teams, nurse practitioner-led clinics, community health centres and Indigenous primary health care organizations.

In the 2024 budget, our government invested to a total of $546 million over three years starting in 2024-25 to connect approximately 600,000 Ontarians to new and expanded interprofessional primary care teams.

In the fall of 2024, our government appointed Dr. Jane Philpott as the chair and lead of a newly established primary care action team with a mandate to connect every person in Ontario to primary care by 2029. The team has developed and is implementing a primary care action plan to help achieve this objective.

In January of this year, our government announced an investment of more than $1.8 billion to add more than 300 new primary care health care teams across Ontario. This investment includes $1.4 billion in new funding, alongside more than $400 million in already approved funding for primary care. These historic investments in primary care will connect two million more Ontarians to a publicly funded family doctor or primary care team within four years, enabling us to accomplish our goal of connecting everyone in the province to a family doctor or a primary care team.

Last month, the province launched a call for proposals to create and expand up to 80 primary care teams that will connect 300,000 more Ontarians to a family doctor and primary care team this year. To support this call for proposals, we are investing $213 million, which is part of the $1.8-billion primary care investment.

Today, we are taking another step forward and building on the tremendous progress we have made in primary care by introducing the Primary Care Act, as well as investing up to $300 million to support 17 primary care teaching clinics, which will train and grow the supply of new family doctors and other health care professionals, helping support the expansion of primary care capacity and high

quality patient care in Ontario. If passed, the Primary Care Act would set out a long-term enduring vision for the future of Ontario's primary care system.

The proposed legislation would establish six objectives for the government's design, implementation and maintenance of Ontario's primary care system, informing what Ontarians should expect when accessing primary care. If passed, Ontario would be the first Canadian jurisdiction to establish an enduring vision for primary care by legislation.

The first objective is that the primary care system should be province-wide. This means that every person across the province who is insured through OHIP should have the opportunity to have a documented and ongoing relationship with a primary care clinician or team.

The second objective is that primary care in Ontario should be connected, providing insured persons with the opportunity to receive primary care that is coordinated with existing health and social services.

Convenient primary care is the third objective, meaning that insured persons should have access to timely primary care services.

The fourth objective is that the primary care system must be inclusive. Insured persons should have the opportunity to receive primary care that is free from barriers.

The fifth objective is that primary care empowers patients. Insured persons should be able to access their personal health information through a digitally integrated primary care system that connects patients and clinicians involved in the insured person's care.

The final objective is that primary care should be responsive. The primary care system should adapt to the needs of the communities it serves and should have access to information about how the system is performing and adapting.

The proposed legislation is in alignment with existing health care legislation, obligations and accountability structures, including service agreements, and we intend to provide opportunities for organizations, for partners and the public to provide their feedback and input about the objectives and framework we have proposed should this legislation move forward.

0910

Through our government's record investments in primary care, Ontario has achieved the highest rate of access to a regular health care provider in the country, including family doctors and primary health care teams. But we are not resting on this achievement. Our government has made a clear goal to connect every person in the province to primary care over the next four years, and I am confident that with our investment and Dr. Philpott's leadership that the primary care action team will keep our province moving forward.

Dr. Philpott is helping us across the finish line for connecting all Ontarians to more convenient primary care by 2029. Dr. Philpott has extensive experience and is eminently qualified for this role. She is a family physician who previously served as the dean of the faculty of health sciences at Queen's University and director of its school of medicine. Dr. Philpott previously held a number of senior roles in the government of Canada, including the Minister of Health, Minister of Indigenous Services and President of the Treasury Board, and spent more than 30 years in family medicine and global health. She was previously appointed as the chair of the Ontario Health Data Council.

Dr. Philpott has also worked with partners from the Frontenac, Lennox and Addington Ontario Health Team to develop the innovative health home model, a new approach to primary care originally called the Periwinkle model.

Drawing from the health home model of care, our best-in-class models of primary care in Ontario and the input from primary care health care leaders across the province, Dr. Philpott is leading the implementation of the primary care action team to further expand effective, team-based primary health care across Ontario and close the gap for the remaining 10% of people in the province in need of primary care, which is supported by our government's historic, transformational investment of $1.8 billion in funding for primary care.

Through our province's primary care action team, we are implementing a broad series of initiatives in collaboration with primary care leaders and health system partners. In addition to attaching everyone in our province to a primary care clinician or team, we are also focused on making primary care more connected and convenient and supporting primary care clinicians.

To ensure transparency, we will provide regular public updates on the progress and performance of the plan, with reporting on how the system delivers on the following matrix:

—the number of people who have ongoing attachment to primary care, with a goal of 100%;

—the percentage of primary care providers who work in publicly funded interdisciplinary teams;

—how timely is access to comprehensive primary care, by identifying the percentage of people who can get an appointment on the same day or next day when needed.

The proposed Primary Care Act would also support this work, committing the Ministry of Health to issue an annual public report outlining how the government is working to achieve the objectives provided in this legislation and how we're performing on our promise to attach Ontarians to a primary care clinician or team.

Another way the province has supported efforts to make primary care more connected and convenient is by working to modernize Health Care Connect to improve the user and provider experience with the goal of establishing a wait time target of no more than 12 months to be connected with a family doctor, nurse practitioner or primary care team.

Health Care Connect is a provincial program to help Ontarians who aren't attached to primary care get attached. The program refers people to physicians and nurse practitioners who are accepting new patients in their community. In addition to establishing a wait-time target,

the province prioritizes attaching everyone currently on the Health Care Connect wait-list to a primary care team.

To further support connected and convenient primary care, we are looking to leverage Health811, the province's free, secure, confidential service that people can call or access online 24 hours a day and seven days a week to get health care advice from a registered nurse or to find health services or information in their community. We are looking to leverage Health811 so people are able to view online health records, book an appointment with a primary care provider and discover care options.

We are also enhancing digital tools for providers and patients, improving patient navigation, reducing administrative burden, modernizing information sharing and improving the referral process. And we are going to set regular performance indicators of primary care teams, including the number of patients attached, to ensure teams reach their maximum impact in connecting people to care.

Another pillar of building a strong primary care system is providing support to primary care providers. The province is introducing targeted strategies to recruit and retain the workforce needed to support primary care teams, including family doctors, nurse practitioners and other allied health care professionals.

Supporting primary care clinicians also means continuing to address the administrative burden they face by supporting the use of digital tools, targeted recruitment and retention strategies for, in particular, northern and rural communities that can face additional human resources challenges and ensuring all of Ontario's highly qualified health care professionals can work to their full scope of practice.

We are also adding and expanding the number of primary care teaching clinics in collaboration with academic institutions and other partners. These new and expanded teaching clinics would support new primary care learners, such as physicians, nurse practitioners, nurse assistants, physician assistants, and in communities across Ontario, prioritizing underserved communities as new learners often choose to practise where they have trained.

Last week, it was indeed a pleasure to be joined by the Minister of Finance; the Minister of Colleges, Universities, Research Excellence and Security; the Associate Minister of Women's Social and Economic Opportunity; and Dr. Philpott at Toronto Metropolitan University's new campus in Brampton to announce an investment of up to $300 million to support 17 primary care teaching clinics.

Ontario currently has 39 teaching clinics, and given the significant increases made for family medicine seats through the expansion of physician education and nurse practitioner seats in nursing schools, there is also a need to increase the number of teaching clinics.

In 2023, Ontario invested over $225 million over four years to expand nursing education in universities and colleges by increasing enrolment by 2,000 registered nurse, 1,000 practical nurse and 150 nurse practitioner seats. Because of these investments, 8,000 additional nurses will join the health care workforce by 2028.

Primary care teaching clinics are a recruitment pipeline for future years. Teaching clinics are team-based supportive environments, which help attract family doctors, nurse practitioners and other allied health care professionals to comprehensive primary care. Primary care teaching clinics are particularly important for recruitment in rural and northern communities, and there is research indicating that physicians who are educated in rural and northern Ontario are also more likely to set up practice and stay in these communities.

Speaker, our government has made significant investments in medical education, in implementing the largest medical school education expansion in more than a decade. This includes adding 340 additional seats for family medicine by 2028-29, representing a 67% increase in family medicine learners.

Our government has also expanded medical school education by adding 551 postgraduate positions to the medical system and, of course, creating a new medical school, with the Toronto Metropolitan University School of Medicine that is set to open in the summer of 2025 right in Brampton, and supporting York University in establishing a new medical school in Vaughan. York University's medical school will be the first in Canada that is primarily focused on training primary care doctors and will help ensure that everyone in Ontario who wants to have a primary care provider can have access to one.

0920

Our government has also announced that, starting in fall 2026, new legislative and regulatory changes would, if passed, require all Ontario medical schools to allocate at least 95% of all undergraduate medical school seats to residents in Ontario, with the remaining 5% reserved for seats from the rest of Canada.

Our government is further breaking down barriers for Ontario students to become family doctors by expanding the Learn and Stay grant to include students who are studying family medicine. Starting in 2026, the government is investing an estimated $88 million over three years to expand Learn and Stay grants to 1,360 eligible undergraduate students that commit to practise family medicine with a full roster of patients upon graduation. It is estimated that this total investment will enable the connection of an additional 1.36 million people to primary care, based on average attachment rates for family doctors.

The Learn and Stay grant funding will cover all tuition and other direct educational costs like books, supplies and equipment in exchange for a term of service as a physician in any community across Ontario. The Learn and Stay grant has already provided learners in eligible nursing, paramedicine or medical lab technology programs with funding, which is helping pay for their post-secondary education and is helping to bring in-demand health care workers to underserved communities across Ontario.

Our government has also continued to create new pathways to connect more people to primary care through the Practice Ready Ontario Program. Announced in December of last year, this program will break down barriers for 100 internationally trained family physicians

so they're able to be licensed more quickly and practise medicine in a rural or northern community this year. Each internationally educated physician who participates in the program is required to complete a 12-week assessment to ensure they have the skills and competencies needed to practise in Ontario. This includes training in all aspects of rural family medicine across a variety of practice settings, including in-office, in-hospital, emergency department and long-term-care and home-care settings. The Practice Ready Ontario Program requires physicians to complete a three-year return of service as a family doctor in a rural or northern community, and this is expected to connect an additional 120,000 people to care that they need.

Nurse practitioners are also at the forefront of patient care in many communities and have been instrumental in improving access to care, especially for people living in rural, northern and remote areas across Ontario. In partnership with Ontario's universities, our government has added 150 additional nurse practitioner training positions, bringing the total number of government-funded education seats from 200 up to 350, increasing the number of nurse practitioner education spots at schools by nearly 60%.

Through our primary care investments, we are already expanding and establishing new nurse practitioner-led clinics with the opportunity to do even more in the months and years ahead. This helps build on the important publicly funded care delivered by Ontario's existing nurse practitioner-led clinics, which is supported by $46 million in provincial funding each and every year. This is another way our government is building on our progress to provide comprehensive, accessible and integrated family health care services to more Ontarians, including those who may face challenges accessing primary care while also bolstering our exceptional nursing work force.

Since 2018, nearly 100,000 additional nurses have been registered to work in Ontario. We've seen the number of nurse practitioners registered to practise in the province grow by 40%—to nearly 5,000—and more than 15,000 doctors have registered to work in Ontario.

Our government's investments to expand medical education, training and supports is a critical part of our work to increase access to primary care providers. It helps support our vision that every person in Ontario has access to a publicly funded primary care team close to where they live, with each person attached to a family doctor or a primary care nurse practitioner where they will be able to receive ongoing, comprehensive, patient-centred, culturally safe, responsive and convenient care. And people will be linked to a broader network of health professionals such as nurses, physician assistants, social workers and midwives and other wellness services and be seamlessly connected across the broader health care system.

Primary care can be organized similar to how the public school system is accessible to Ontarians no matter where they live. As people move within Ontario, they should be able to have an opportunity to have an ongoing relationship with a family doctor, a nurse practitioner or team in their community for continuous access to local care.

Primary care will the front door to our health care system. It will be reflective of the populations it serves, and it will align with the government's objectives for the primary care system. Designed to work for both people and health care professionals, our government is continuing to build a primary care system with the objective that no matter where you live in Ontario, you will be connected to a primary care clinician or team.

The proposed Primary Care Act is another important way our government is building on our progress in health care and getting it done for the people of Ontario.

Speaker, it is now my pleasure to share my remaining time with my parliamentary assistant the member for Essex, who will speak further about how our primary care initiatives, including today's proposed legislation, are integral to addressing the needs of the people of Ontario. Thank you.

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): I recognize the member for Essex.

M. Anthony Leardi: Merci à la ministre de la Santé. Ses conseils et son leadership ont joué un rôle essentiel dans le maintien et l'élargissement de l'accès des Ontariennes et Ontariens aux soins primaires.

Le projet de loi, Loi sur les soins primaires, établira un cadre solide pour les soins primaires en Ontario. Il confirme le rôle fondamental que jouent les soins primaires dans notre système de soins de santé financé par les fonds publics, notamment en affirmant que les soins primaires doivent être le premier point de contact pour les personnes assurées qui cherchent à obtenir des soins de santé en Ontario Il reconnaît les avantages des soins primaires pour les systèmes de soins de santé dans son ensemble et le fait que les systèmes de soins de santé fondés sur des soins primaires solides améliorent la santé de la population, réduisent les coûts des soins et rendent plus équitable l'accès aux soins.

Nous reconnaissons également que les soins primaires dispensés en équipe peuvent accroître la capacité du système de santé et améliorer les résultats en matière de santé pour les patients tout en contribuant à la satisfaction des membres de l'équipe des soins primaires. Dans le cadre de ce projet de loi, nous envisageons un système de soins primaires fondé sur un ensemble d'objectifs établis en fonction des données probantes et des pratiques exemplaires. Il va également dans le sens de l'idée qu'il est essentiel pour assurer la promotion de la santé et l'efficacité du système de soins de santé de donner aux personnes les connaissances et l'information nécessaires pour assurer leur bien-être.

0930

Le projet de loi répondra aux critères énoncés dans la Loi canadienne sur la santé en matière de gestion publique, d'intégralité, d'universalité, de transférabilité et d'accessibilité. Le projet de loi va améliorer également l'accès aux services de soins primaires financés par les fonds publics dans le respect de la dignité et des droits de la personne des différentes communautés de l'Ontario, notamment les francophones, et les Premières Nations, les Inuits et les Métis.

Le projet de loi établit la vision du gouvernement en matière de soins primaires afin que les personnes assurées sachent à quoi s'attendre lorsqu'elles y accèdent. Le projet de loi établira six objectifs pour la conception, la mise en oeuvre et le maintien par le gouvernement du système de soins primaires financé par les fonds publics de l'Ontario : les soins primaires doivent être accessibles à l'échelle de la province, reliés aux services de santé et sociaux existants, et commodes; les soins primaires doivent être exempts d'obstacles, et les patients doivent jouir d'une autonomie grâce à un système intégré numérique qui améliorerait les liens entre les patients et les cliniciens; et le système de soins primaires doit être réactif.

Le projet de loi exigerait que le ministère de la Santé prépare un rapport annuel qui décrit les efforts déployés par le gouvernement pour atteindre les objectifs énoncés dans le projet de loi concernant la conception, la mise en oeuvre et le maintien du système de soins primaires financé par les fonds publics. Le projet de loi prévoit la présentation au public par le gouvernement de rapports annuels dont le premier doit être présenté 12 mois après l'entrée en vigueur de la loi. Cela comprendrait l'obligation de rendre compte du pourcentage de personnes assurées qui entretiennent une relation continue avec un clinicien ou une équipe de soins primaires, ainsi que d'autres indicateurs de rendement clés qui seront définis dans la réglementation.

Le gouvernement crée pour le système de soins primaires un cadre durable et transparent qui guidera toute adaptation future avec les principaux partenaires du système tels que les associations des cliniciens, les associations de patients et Santé Ontario, entre autres, et ce, de manière cohérente et uniforme.

Pendant le processus législatif, nous offrirons aux parties intéressées et au public d'autres possibilités d'examiner les détails du projet et de faire connaître leur point de vue. Lors des premières consultations, les intervenants ont exprimé leur soutien au mandat de l'équipe d'action pour les soins primaires et ont fourni des conseils utiles qui continueront d'éclairer les plans de mise en oeuvre du ministère. Nombre d'entre eux ont apprécié le fait d'avoir été consultés dès le début du processus et se sont montrés favorables aux consultations et aux discussions futures.

Le ministère mobilise ses partenaires à mesure que le cadre des soins primaires est déployé, notamment les Premières Nations et les autres partenaires autochtones, afin d'assurer l'intégration d'approches distinctes qui répondront aux besoins particuliers des Premières Nations, des Inuits et des Métis et de leurs communautés partout en Ontario.

Alors que l'Ontario met en place un système de soins primaires qui couvre l'ensemble de la province, il est essentiel de tenir compte des différents besoins locaux et régionaux au sein d'un système de soins primaires plus vaste afin d'assurer la prise en compte des différences de niveaux de service et des exigences régionales particulières. Et nous avons vu comment nos investissements existants dans les soins primaires répondent aux besoins particuliers des collectivités locales.

Par exemple, à Toronto, nous avons investi plus de 14 millions de dollars pour relier jusqu'à 49 000 personnes grâce à 11 équipes de soins primaires nouvelles et élargies, notamment dans l'est de la ville, où un centre de santé communautaire et une équipe interprofessionnelle s'agrandiront et ajouteront de nouveaux emplacements mobiles et satellites afin de rendre les soins primaires plus accessibles aux jeunes, aux personnes âgées et aux patients atteints de maladies chroniques complexes.

Ailleurs à Toronto, les investissements dans les soins primaires soutiendront plusieurs initiatives, notamment une nouvelle navette médicale mobile et d'autres services mobiles, un programme collaboratif de visite à domicile pour les personnes âgées, des services de soutien pour la santé mentale et la lutte contre les dépendances, et un accès élargi aux soins primaires dirigés par des Autochtones, qui intègrent à la fois les soins dispensés par les guérisseurs traditionnels et les services axés sur la culture, ainsi que les soins primaires interdisciplinaires contemporains.

À Peterborough, un financement de plus de 3 millions de dollars permet au centre de santé communautaire de Peterborough de mettre jusqu'à 11 375 personnes en contact avec les soins primaires. Les programmes et les services comprendront des soins primaires complets, des services de santé mentale et la prise en charge des maladies chroniques. L'inclusion de soins culturellement sécuritaires et adaptés prodigués par des praticiens du bien-être traditionnel constituera un élément important du centre, qui servira également de centre de coordination des services sociaux, des soins à domicile et de la collaboration avec les partenaires du secteur des soins de santé et les partenaires autochtones de la communauté.

À Kingston, un financement de plus de 4 millions de dollars aide jusqu'à 8 000 personnes à accéder à des soins primaires dispensés en équipe au site modèle de la maison de santé. L'équipe fait partie de l'équipe Santé Ontario de Frontenac, Lennox et Addington et s'intégrera aux hôpitaux et aux organismes communautaires pour prodiguer des soins aux patients en périnatalité, aux nouveau-nés et aux personnes qui ont obtenu leur congé de l'hôpital et ont besoin de recevoir des soins de suivi en temps opportun, notamment les personnes atteintes de cancer.

Grâce à un investissement de 2,2 millions de dollars dans le financement des équipes de soins primaires, l'équipe de santé familiale de Hamilton et ses partenaires de l'équipe Santé Ontario du Réseau de santé du Grand Hamilton ont permis à plus de 6 000 personnes qui n'y avaient pas accès auparavant de bénéficier de soins primaires dispensés en équipe. Ce travail comprend plusieurs initiatives, y compris les soins de santé au Centre Eva Rothwell, une nouvelle clinique de soins de santé primaires située dans un centre communautaire local qui sert les personnes et les familles qui vivent dans la pauvreté.

Grâce à un investissement de plus de 900 000 $ dans le financement des équipes de soins primaires, la clinique dirigée par des infirmiers praticiens—Lakehead—améliore l'accès et l'aiguillage vers les soins primaires interprofes-

sionnels à Thunder Bay et dans les environs en collaborant avec des partenaires locaux pour aiguiller environ 700 personnes de plus vers des soins primaires dispensés en équipe.

Les capacités supplémentaires de la clinique ont été utilisées en particulier pour servir les patients souffrant d'insuffisance cardiaque congestive, de bronchopneumopathie chronique obstructive, de fragilité et de diabète. La clinique a également lancé un programme pour le bien-être des nourrissons et des enfants, qui s'adresse aux petits de zéro à cinq ans et aux mères jusqu'à 12 mois après l'accouchement, ainsi qu'un programme de dépistage du cancer du sein.

0940

L'investissement dans une nouvelle clinique dirigée par des infirmiers praticiens à Ottawa permettra d'aiguiller 6 400 personnes de la région vers les soins primaires et de se concentrer sur la fourniture de soins interprofessionnels complets aux personnes qui vivent avec des problèmes de santé mentale et de dépendance. Et une nouvelle clinique dirigée par les infirmiers praticiens de l'Ordre de Victoria à Grey Bruce favorisera la prestation de soins de qualité, accessibles et centrés sur la personne dans le comté de Grey.

Notre gouvernement a également investi jusqu'à 3,9 millions de dollars dans la construction d'une nouvelle clinique permanente de soins primaires pour l'organisation des soins de santé primaires autochtones des Algonquins de Pikwàkanagàn.

Dans l'est de l'Ontario, notre gouvernement a investi près de 22 millions de dollars pour orienter plus de 73 000 personnes vers des équipes de soins primaires, y compris :

—une nouvelle équipe de santé familiale du comté de Lanark, qui est axée sur le soutien aux personnes vulnérables, particulièrement aux personnes âgées qui sont actuellement sans fournisseurs de soins primaires;

—une nouvelle équipe de santé familiale du comté de Renfrew, qui se concentre à offrir du soutien pour la santé mentale et la lutte contre les dépendances ainsi qu'à aider les personnes âgées à gérer leurs problèmes de santé chroniques; et

—des services élargis dans une équipe de santé familiale existante à Campbellford, qui comprennent des membres du personnel infirmier praticien supplémentaires, des heures de service prolongées de la part des fournisseurs des équipes existantes et un nouveau promoteur de la santé qui mènera des programmes d'éducation et de formation dans la collectivité.

Nous avons investi près de 6,4 millions de dollars pour aiguiller plus de 23 000 personnes vers des équipes de soins primaires dans la région de London, à Lambton et à Chatham-Kent. Des initiatives nouvelles et élargies de soins primaires interprofessionnels comprennent :

—de nouveaux services mobiles afin qu'une organisation de soins de santé primaires autochtones puisse soutenir les membres des communautés inuites, métisses et des Premières Nations dans le comté de Middlesex, et un nouvel autobus mobile pour orienter les personnes autochtones dans les régions rurales et urbaines de Lambton–Kent–Middlesex vers des services de soins primaires dirigés par des Autochtones qui sont culturellement sûrs et adaptés; et

—une nouvelle équipe de santé familiale pour London et les environs, afin d'élargir les services par l'entremise de carrefours communautaires supplémentaires dans l'ensemble de la région, qui aide à orienter les personnes sans abri ou susceptibles de le devenir vers des fournisseurs de soins primaires qui tiennent compte des traumatismes et des actes de violence.

Notre investissement de plus de 5 millions de dollars met également plus de 16 000 personnes en contact avec des équipes de soins primaires dans le nord-ouest de l'Ontario. Cela comprend la création d'un nouvel emplacement pour une équipe de soins primaires autochtones afin d'aider les communautés autochtones de Fort Frances et de la région à avoir accès à des soins primaires holistiques et adaptés à la culture qui n'étaient pas accessibles auparavant, ainsi que de nouvelles équipes de soins primaires autochtones à Kenora et à Sioux Lookout afin de donner aux personnes dans des douzaines de communautés des Premières Nations l'accès à des services de soins primaires.

Dans le cadre de l'appel de propositions d'avril 2025, les équipes potentielles devraient montrer, dans leur formulaire de demande, comment elles vont permettre au plus grand nombre de personnes situées dans leurs codes postaux désignés d'avoir accès à des soins primaires.

Les centres de soins primaires et les cliniciens qui fournissent des soins aux personnes situées dans les codes postaux désignés qui comptent le plus grand nombre de personnes sans un fournisseur de soins primaires étaient invités à soumettre des propositions afin d'obtenir du financement par l'intermédiaire de leur équipe Santé Ontario et de leur réseau de soins primaires connexes.

Afin de montrer dans quelle mesure ils sont bien placés pour répondre aux besoins en soins primaires de leurs collectivités, les cliniciens et les centres de soins primaires étaient encouragés à travailler de concert avec l'équipe Santé Ontario et le réseau de soins primaires de leur localité dans l'optique de repérer des possibilités de collaboration et d'harmonisation stratégique.

Les centres de soins primaires et les cliniciens qui travaillent avec leur équipe Santé Ontario ont été invités à soumettre une proposition afin de créer ou d'élargir l'un des modèles de soins offerts par des équipes, c'est-à-dire les équipes de santé familiale, les centres de santé communautaire, les cliniques dirigées par du personnel infirmier praticien et les organismes de soins de santé primaires autochtones.

À partir de ce premier appel de propositions, nous devrions sélectionner et annoncer les candidats retenus à l'été 2025 et lancer un deuxième appel de propositions en septembre 2025.

Madame la Présidente, sous la direction du premier ministre, notre gouvernement a fait des investissements records dans les soins de santé, y compris des investissements historiques dans les soins primaires. Et par l'intermédiaire de la Loi sur les soins primaires proposée,

notre gouvernement continue de prendre des mesures pour mieux faire en sorte que la population de l'Ontario ait accès à des soins de santé plus complets, interconnectés et commodes.

J'encourage tous les membres de cette Assemblée à appuyer ce texte législatif important et à soutenir l'amélioration des soins primaires pour la population de l'Ontario.

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): I recognize the member for Lanark–Frontenac–Kingston.

Mr. John Jordan: I want to start by thanking the member from Essex for his speech today, and the Minister of Health and the Associate Minister of Mental Health and Addictions for their commitment to continuing to improve our health care system.

I am confident that we are on the right track. The importance of primary care and working upstream cannot be overstated. Getting people the care they need when and where they need it, that's our goal—increasing our health human resources, creating many training and career opportunities.

Last week, I met with the Christian Labour Association of Canada, and they were thanking us for the improved staffing levels within their long-term-care homes.

Increasing our hospital capacity: There are over 50 capital projects across the province.

Increasing the education and scope of practice for our health care professionals—nurse practitioners, nurses, pharmacists, community paramedics—so important.

And most important: increasing our access to primary care, especially team-based care.

The scope of practice does increase our capacity, specifically expanding the scope of practice for nurse practitioners to form a wider range of medical tasks such as diagnosing conditions, prescribing medications and managing patient care independently. This can lead to shorter wait times for patients, more personalized care and increased access to health care services, especially in underserved areas. By taking on these additional, nurse practitioners can help distribute the workload more evenly among health care providers, allowing doctors to focus on more complex cases and procedures—full scope of practice.

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Through Your Health, a plan we're all familiar with now, a plan for connected and convenient care, our government is delivering faster access to care, providing the right care in the right place, and hiring more health care workers. We're building new hospitals, adding more beds, building more medical schools. The expansion of the Carleton University programs near my riding will produce, when fully operational, 200 additional nurses every year.

Just this weekend, I was involved in long-term-care groundbreakings in Parry Sound and Sudbury. The Belvedere Heights in Parry Sound—we broke ground for an additional 22 beds, which will bring them to 123. And then, later the next day in Sudbury, Finlandia Village, we broke ground. We broke ground, and I was joined by my colleagues from Nickel Belt and from Sudbury, and thanks for joining. It was a great day. Finlandia Village: another 32 beds in that village, which is a great model with retirement living and long-term care on the same campus.

To give you an example of how important these long-term-care builds are, relative to the ALC problem that we have in our hospitals, is there was a Finnish fair going on while we were there, and it really represents the culture of the Finnish, and we had the opportunity to meet the ambassador of the Republic of Finland. One of the things she told me that I didn't know was the Finnish people are the happiest people in the world, so you learn something every day. There's a piece of trivia for us.

So we are making significant investments in health profession education and workforce training, making it easier for health care workers who want to work in Ontario and maximizing the skills and expertise of our world-class health care workers. We are improving access to home and community care, mental health and addiction services, and care and community paramedics provided through local pharmacies. My riding has seen the expansion of the Ottawa Valley Family Health Team from Almonte into Carleton Place, and a new family health team in Perth. And my constituents tell me what a great difference that makes. Even if they aren't able to get rostered immediately, the Perth Family Health Team is providing clinics for unattached patients, which is very well-received. This also was the coming together of three family health organizations to form this family health team.

We are expanding and bringing together primary care, and thank you again to the ministers for that work. We are making an unprecedented $1.8-billion investment in primary care. We have established a primary care action team, led by Dr. Philpott, that is doing great work. There is a clear commitment to provide every Ontarian with access to a primary care provider or team over the next four years.

The proposed Primary Care Act will establish a strong foundation for connected and convenient primary care now and for years to come. Ontario health teams provide a means for our health care providers to collaborate and work together. Having support staff and allied health professionals working alongside our physicians and nurse practitioners builds their capacity and helps more people get the care they need.

As our government has continued to make investments and build a stronger system of primary care, health care partners and stakeholders have commented on these initiatives. I want to share these testimonials because stakeholders have to work with government decisions, and they know best what is happening on the ground and the impact of our decisions.

The CEO of the Ontario Medical Association, Kimberly Moran, stated, "Congratulations to Dr. Philpott and her team ... and the government of Ontario. This is a significant investment in primary care and Ontario's doctors are encouraged with the goal to attach more patients to family medicine over the next four years.... There is a substantial amount to do to ensure every Ontarian has access to a family doctor and we look

forward to partnering with Dr. Philpott and the government to co-design this plan."

Dr. Doris Grinspun—many of us have had the opportunity to hear Dr. Grinspun speak. She's very passionate, particularly about registered nurses and nurse practitioners. She's the CEO of the Registered Nurses' Association of Ontario and has stated, "The expansion of primary care—and in particular the enhanced utilization of NP expertise alongside RN prescribing—will unlock timely, safe and quality care for Ontarians. Better care and health outcomes also lead to lower system costs—a win for Ontarians as patients and as taxpayers. We are pleased that the government is demonstrating commitment to publicly funded, team-based primary care," which, she believes, "will begin transforming the health system for all and especially for marginalized and vulnerable populations."

The president and CEO of the Ontario Hospital Association, Anthony Dale, has said, "The Ontario Hospital Association thanks the government of Ontario for making new investments in primary health care teams, which will improve access to high-quality primary care and address some of the capacity pressures on hospitals by keeping more Ontarians well and less likely to require hospitalization. Demand for health care services is expected to rise dramatically in the years ahead as Ontario's population grows and ages. Continued investments in all areas of health care services are needed to allow care to be delivered in the most appropriate setting and in the most cost-effective manner. We look forward to continued collaboration and innovation with the province and our health system partners to ensure that Ontario's health care system is prepared to meet the future demands that will be placed upon it."

Dr. Jobin Varughese, a family doctor and president of the Ontario College of Family Physicians, has commented, "This is great news for family physicians and Ontarians. The Ontario College of Family Physicians ... is encouraged by the quick progress made by the Ontario primary care action team, led by Dr. Jane Philpott, and today's commitment to expand access to integrated primary care teams and enhance digital tools for family physicians. This announcement recognizes the foundational role family physicians play in our health care system and reflects the OCFP's long-standing advocacy for team-based care and the use of new technology to better support family doctors. The implementation of this plan will be critical—we look forward to continuing our collaboration with the government and Dr. Philpott to ensuring every Ontarian has access to a family physician and receiving the primary health care they deserve."

Dr. Michelle Acorn, the CEO of the Nurse Practitioners' Association of Ontario, and Barbara Bailey, president of the Nurse Practitioners' Association of Ontario, have stated, "The Nurse Practitioners' Association of Ontario ... is thrilled by the recent announcement from the Ontario Ministry of Health regarding the allocation of additional funding towards expanding interprofessional primary care and existing programs. This is a significant investment that will support nurse practitioners, as integral health care team members, in ensuring Ontarians receive the high-quality, timely care they deserve. NPAO looks forward to continuing to work with the Ministry of Health to advance our shared goals of comprehensive and accessible health care delivery."

Jess Rogers, the CEO of the Association of Family Health Teams of Ontario, has said, "This investment acknowledges the critical need for accountability and the right support to drive meaningful progress. The Association of Family Health Teams of Ontario ... representing 190 member organizations across the province, is encouraged by this commitment and remains ready to collaborate with the government of Ontario. We are focused on ensuring that every Ontarian has access to high-quality, team-based primary care. As we move forward, we must recognize that the job ahead is complex and requires a co-design approach. True success will come from working together—government, health professionals and communities—to ensure that investments are targeted in the right areas and that primary care leadership plays a central role in the design, implementation and integration of new initiatives. The work ahead is vital, and the AFHTO is committed to being a key partner in shaping solutions that will benefit all Ontarians."

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These partnerships are so important to be sure that we get it right. Our government is grateful to these organizations, many other health care partners and our front-line health care workers for their efforts to connect Ontarians to primary care and all they do to support patients and families across our province. The proposed legislation sets out the government's vision for publicly funded primary care in Ontario as we continue to make progress with expanding and supporting primary care and implement our action plan.

We will continue to collaborate and work with our health care providers, and this collaboration goes beyond just the Ministry of Health. This collaboration involves many ministries working together in collaboration, as well. As I mentioned, it's so important that we also expand our access to long-term care across the province and continue to build 58,000 new and reconditioned long-term-care beds, new staff in every home to get to our four hours of care, which—as I've mentioned earlier, the Christian labour association has thanked us for that initiative. We will continue to work for the people of Ontario in improving our health care system.

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): Questions?

MPP Robin Lennox: There's a lot in this Primary Care Act that are big ideas, but we're lacking the details to actually make the implementation work. You spoke about primary care teaching clinics; that's where I worked for many years, training medical students and residents. What we know is that we're actually not filling the number of family medicine residency spots that we have. In the last match, we had 276 unfilled spots in the first round. So before we talk about expanding the number of seats, how are we actually going to fill the seats that we have?

And for the most number of medical trainees that I speak to, the barrier is that they don't want to be business owners and they don't want to spend 20 hours a week on administrative work on top of the 40 hours a week they spend seeing patients. So, do we have a commitment from this government to actually alternatively fund family physicians in a salaried model and make meaningful change to our system to reduce the administrative burden? Because the very best retention plan that we could have for physicians is keeping the ones that we are training in Ontario.

Hon. Sylvia Jones: Thank you for raising the teaching clinics, because it's something that many people don't really understand. When you expand the number of medical seats, of course, you also have to expand those teaching opportunities, those residency spots. And, in fact, I note with a little bit of humour that you only talked about the first round of the matching. If you actually get to the complete matching, we 100% over the last three years have matched family physicians with their primary specialty. That's the success that we have when we actually invest in our physicians, in our primary care providers.

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): The member for Don Valley East.

Mr. Adil Shamji: I'd like to extend my gratitude to the Minister of Health for reaffirming the principles of medicare and some of the other values such as ensuring that our health care system is province-wide, connected, convenient, inclusive and empowered. I agree with all of these things.

In my perspective and from my read of this legislation, however, there are a couple of major flaws. I would draw your attention to section 5, which says very explicitly that this legislation does not establish any right to these things by an Ontarian nor does it impose any duty by this government to deliver on the principles of the Canada Health Act or these additional values. If these things are so important, why does this legislation not empower Ontarians with the right to these things nor impose a duty to provide them by this government?

Hon. Sylvia Jones: Of course, the Canada Health Act is paramount and is always there. We have made sure through this legislation and through all of the investments that we have made—whether it's in capital or, absolutely, in our people—to ensure that we have respected the tenets of the Canada Health Act, and we will continue to do that. There's no surprise there, Speaker.

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): I recognize the member from Simcoe–Grey.

Mr. Brian Saunderson: My question to the minister is about teaching clinics in rural communities, like my riding of Simcoe–Grey. I have two hospitals, and the local health teams are very closely connected to the hospitals. In fact, in Collingwood, we have the ROM Program, the Rural Ontario Medical Program, that's led by Dr. Wells that deals with all the placements, training and mentoring for physicians coming out of med school and who are moving to rural Ontario, which we so dearly need.

I'm wondering if the minister could talk about the role of teaching clinics and how that's going to enhance recruitment and retention for physicians in rural Ontario, please.

Hon. Sylvia Jones: Absolutely. Great question.

The 17 teaching clinics that we announced last week and will be in the budget on Thursday are really an acknowledgement that we know—as I said, as we expand medical seats, we also have to expand the component where we do the teaching clinics.

I think it's really important for people to understand that, while the 17 teaching clinics are obviously attached to medical schools, they do not physically have to be in the same location. This is the really exciting opportunity we have, to make sure that those teaching clinics are in communities that perhaps have had historic challenges in terms of recruiting new physicians into their community.

There's more news to come, but I think it's a really important opportunity to—more targeted—ensure that communities that have historically had issues recruiting have an opportunity through these 17 new teaching clinics.

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): The member for Hamilton Centre.

MPP Robin Lennox: My question is back to the Minister.

Just to correct you, there were still 94 unfilled spots after the second iteration.

Interjections.

MPP Robin Lennox: Yes, and expanding them—

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): Put your question through the Speaker.

MPP Robin Lennox: Yes. Through the Speaker, there were still 94 unfilled spots after the second iteration, so we're still not seeing any meaningful change to actually ensure that family medicine residents can see a career for themselves in full-scope family medicine.

But even on the issue of this call for expanded family health teams, I heard from many family health teams that, a three-week turnaround on a proposal doesn't give anyone time to do anything well, and also, the proposal doesn't include wage increases for community-based allied health professionals.

So saying that there's funding available but not actually increasing the salary range—what we're hearing from family health teams is, "Sure, we can put out a posting, but we're already losing people because we're not paying them enough."

What's the plan to actually increase wages for our community-based allied health so that programs like these will actually work in the long term?

Hon. Sylvia Jones: Well, it's odd that you would suggest that there was too short a turnaround time because those applications have now come in and I can absolutely assure you that there is interest and there are applications from all across Ontario.

The important piece is that we already had a call for application in 2024. Many of the organizations that were not able to get that first round of applications—those 78 that happened in February of 2024—have tweaked their

applications, perhaps combined with other organizations, and have resubmitted. And, Speaker, of course, they will have another opportunity in the fall of this year. It's not done yet.

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): The member for Don Valley East.

Mr. Adil Shamji: Just a brief reflection on the minister's last comment: Of course there is enormous interest for funding. When this government has rejected 75% of primary care funding in the last round last year, of course people are going to be desperate and reaching out for more cash.

But back to the issue at hand. The next and second major flaw with this legislation is that there is no requirement for any legislation, act, directive or policy to actually comply with this legislation. Section 6 makes it very clear that no other law, no other policy or directive is required to be in compliance with this bill.

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If this government is actually serious about respecting the Canada Health Act—delivering health care as empowered, responsive, connected, province-wide—why does it explicitly state that there is no requirement for any policy, law, directive, instrument or action to be in compliance with it?

Hon. Sylvia Jones: I'll be short and concise. Two words: accountability agreements.

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): The member for Mississauga–Malton.

Mr. Deepak Anand: My question is actually to the member for Essex.

Madam Speaker, through you: As we all know, family physicians play a critical role in our health care system by helping Ontarians manage their health, receive timely vaccination, and avoid unnecessary visits to the urgent care clinics or emergency rooms.

Thank you to Dr. Vijayaraghavan for being my doctor. And you know what? Truthfully, you're a family member.

So in my riding, we heard from many constituents who are already seeing the benefits of the investments in primary care. To the member: Could you provide an update on the progress that has been made so far to connect more Ontarians with a family doctor or primary care provider?

Mr. Anthony Leardi: Yes, I'd be happy to do so. For example, in the first investment that this government made, we made a multi-million-dollar investment in the creation and expansion of 78 new or expanded primary care teams right across the province of Ontario, and these are helping to connect over 300,000 people in Ontario with a primary care provider closer to home. In addition to that, we've announced the call for proposals from various parties, which will unleash the $1.8-billion project over the next three years to connect even more people to primary care in the province of Ontario.

That call for proposals has been very well received. I can tell you that I've received feedback—not only from my riding, but also in other ridings as well—of the great interest in these people who are putting forth proposals to build primary care teams and other types of primary care providers to get more and more and more people in the province of Ontario connected to primary care.

Second reading debate deemed adjourned.

MEMBERS' STATEMENTS

CANCER ASSISTANCE HALTON HILLS

Mr. Joseph Racinsky: I rise today to celebrate and recognize Cancer Assistance Halton Hills's 25th anniversary. Their mission is to provide support and hope to those dealing with a cancer diagnosis, their families and friends in the town of Halton Hills.

Cancer Assistance is a registered charity, and they offer services such as transportation; lending of equipment and supplies such as hospital beds, walkers, canes, and transportation chairs; as well as health and wellness support.

These can be some of the darkest days in the family's lives, and every single one of us knows someone that has struggled with the scourge of cancer. When families are working through this devastating news, it is so important to have the community rally around them and show them support. This is what Cancer Assistance Halton Hills does.

Cancer Assistance is proud to receive no government funding, but is completely supported by donations from the community. Their motto is, "Give where you live."

This is just one of example of the many incredible volunteer-driven organizations in Wellington–Halton Hills that seek to help those in need.

So again, to the Cancer Assistance Halton Hills team—Julie Liddle, Laurie Robinson, Wendy Molnar and Janice Welfare, as well as to Rod and the countless volunteers—congratulations on 25 incredible years. Keep up the great work.

HOSPITAL PARKING FEES

Mr. Jeff Burch: This week, the government will release its annual budget, and I am calling for the inclusion of my motion to eliminate hospital parking fees, a move supported by the Canadian Cancer Society and now the Ontario Nurses' Association, and support is growing every day.

Recently, the CBC reported on a case that has become all too common in Ontario. When Marie Grgic's mother was diagnosed with cancer, her father had to use his retirement funds and sell his home to finance costs related to her treatment, including parking fees. Marie was diagnosed with cancer herself and spent about $400 a month on hospital parking passes when she underwent treatment.

Increased hospital parking fees in Ontario have made life even more unaffordable and placed a painful and unfair burden on patients, families and front-line health care workers. It's a tax on our sickest citizens, their families and those who care for them.

On May 1, Nova Scotia's PC government eliminated hospital parking fees. It's time for Ontario to do the same. Let's do it in this week's budget. The people of Ontario will be watching.

NATIONAL POLICE WEEK

Mrs. Karen McCrimmon: It's so very important to recognize the role our police services play in the safety and security of our communities. They do a difficult job, and we owe them our thanks and our commitment to support them as they fulfill their functions, which are so very important to Ontarians. Police in Canada are a proud and independent institution that work without fear or favour to fairly and diligently protect the rule of law. This independence, competence and resilience needs our loud and proud support.

This week is National Police Week, and I wanted to acknowledge the difference our police services make. I thank our police services for their timeless and constant contributions to our country and communities. Your examples of service and integrity matter greatly.

ÉVÉNEMENTS DIVERS À GLENGARRY–PRESCOTT–RUSSELL

M. Stéphane Sarrazin: Je prends la parole aujourd'hui avec beaucoup de joie et de reconnaissance puisqu'il s'agit de ma première déclaration depuis ma réélection en tant que député de Glengarry–Prescott–Russell. J'aimerais remercier sincèrement les citoyens de notre belle circonscription pour la confiance qu'ils m'ont renouvelée. C'est un privilège de continuer à représenter nos communautés dynamiques, de Cumberland à Hawkesbury, en passant par Casselman, Embrun et tous les villages entre les deux.

Depuis mon retour, j'ai repris la route pour rencontrer les familles, les agriculteurs, les entrepreneurs et les organismes communautaires de chez nous. Rien que vendredi dernier, j'ai eu le plaisir de participer à sept rencontres, juste pour vous dire à quel point notre région est active, engagée et inspirante. Au cours des dernières semaines, j'ai aussi pu annoncer plusieurs subventions provinciales pour soutenir des projets locaux importants, et ce n'est pas fini. D'autres belles annonces s'en viennent très bientôt. J'invite les gens à visiter mon site Web, stephanesarrazinmpp.ca, pour rester à l'affût.

Je profite aussi de l'occasion pour souhaiter une bonne fête des Mères, un petit peu en retard, à toutes les mamans de notre circonscription. Merci pour votre amour, votre patience et votre contribution inestimable à nos familles et nos collectivités.

Et alors qu'arrive le long week-end de la fête de la Reine, je souhaite à tout le monde du repos, du bon temps en famille et surtout une fin de semaine en sécurité.

WATERLOO REGION ECONOMY

Ms. Catherine Fife: On March 6, 2025, the University of Waterloo, with support from NorthGuide and the Balsillie school, invited 200 community leaders to come together for the community economic offence challenge. I quote: "In the face of this uncertainty, Waterloo region has a choice: react to change or lead the response. Business, academic and community leaders must come together to proactively shape our region's economic and policy response." Their goal was to ensure that Waterloo region remains a leader in innovation and industry.

Through their discussions, five key themes emerged: regulatory barriers, investment challenges, talent development and retention, IP and innovation, and regional development and infrastructure. Their goal: To find solutions to these challenges.

In this time of uncertainty, Ontario can and should refocus our investment challenges. Proposals included pilot programs with tax benefits for local investors, creating tax incentives for businesses to remain in or relocate to Waterloo, or utilizing government procurement as a strategic tool to benefit the domestic economy. The best solutions for our local communities come directly from those leaders, so let's listen to them.

I look forward to sharing the report with colleagues here at Queen's Park, and I want to thank the University of Waterloo for their deep leadership and commitment to the province of Ontario.

CANADIAN CADET PROGRAM
VOLUNTEER SERVICE AWARDS

Mr. Brian Saunderson: This morning, I want to recognize and salute the many hard-working cadet corps that serve my riding of Simcoe–Grey. The Canadian cadet program, whose origins go back to 1862, is a youth-development program offering various activities for young Canadians. Cadets can join at the age of 12 years and age out at 19. They participate in sea, army or air elements, gaining skills and experiences in areas like seamanship, outdoor expeditions and aerospace studies.

This month, I had the honour of attending and being part of the reviewing party at the 40th Ceremonial Review of the 1944 RCEME Royal Canadian Army Cadet Corps in the village of Creemore. I was proud to represent the government of Ontario and present the inaugural Murray Whetung Community Service Award for cadets to Sergeant Hunter Banks, recognizing his extensive volunteer work in his community.

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Murray Whetung, from Curve Lake First Nation, was a World War II veteran who served with the Royal Canadian Corps of Signals. Murray, like many Indigenous soldiers, lost his Indian status because he was away from his reserve for more than four years fighting for Canada during the war. Despite this injustice, Murray Whetung came home and continued to serve his community selflessly for the duration of his life. This award, bearing his name, is to

honour Murray and those like him who demonstrated exceptional citizenship, dedicated volunteerism and selfless service.

I want to thank my colleague, MPP Smith from Peterborough, who tabled a private member's bill to create this award in honour of Murray Whetung, and congratulate and thank the cadets in my riding and across this great province who participate in the cadets program.

SERVICES FOR PERSONS WITH DISABILITIES

M^me^ France Gélinas: Last week, Tina Senior called my office in crisis. Her family receives funding to help cover the cost of hiring professionals to support her child who has severe disabilities. But suddenly, without any warning, she did not receive the funds, so she called the CCN. Tina learned that the money would be delayed until the end of May, or possibly longer. She was told to pay for the services upfront in the meantime.

Speaker, Tina cannot afford to pay out of pocket. She does not have the money to wait for reimbursement. So she's left with two options: to not provide her child with the disability services that he needs, or to spend money she doesn't have for care that her son absolutely needs.

There has been zero communication from the government to explain what is going on and why the program is being changed. In fact, right now, the program is such a mess that special agreement officers who work there are telling people to stop calling, because they are overwhelmed with questions that they cannot answer.

We saw this in home care, Speaker, when the government changed something that worked, simply to give Bayshore access to more government revenues.

I urge the government to address this so that parents like Tina Senior can take care of their loved ones and support their children with disabilities. When will this be fixed? Children's lives and children's health are in the balance.

CONSTRUCTION WORKERS

MPP Paul Vickers: Madam Speaker, every single day, thousands of workers in Bruce–Grey–Owen Sound wake up and go to work in civil construction. Whether it's on road crews, in residential construction and renovation, or with electricity contractors, these workers make our community the great place it is. If you drove somewhere this morning, woke up with a roof over your head or sat in a well-lit room, well, you have Ontario's civil construction workers to thank for that.

In March of 2025, these workers became heroes. When an ice storm struck, which devastated many parts of this province, Bruce–Grey–Owen Sound was not immune. These professionals worked tirelessly. They restored the electricity, cleared roads of debris and fixed damage to homes, properties and businesses. On behalf of the communities across Bruce–Grey–Owen Sound, I wish to thank these workers. Thank you for your courageous work during these difficult times.

KING CHARLES III CORONATION MEDAL

Mr. Dave Smith: To mark the coronation of His Majesty King Charles III on May 6, 2023, the King's coronation medal was created. In order to be eligible for this honour, a person must have made a significant contribution to Canada; or to a particular province, territory, region or community in Canada; or attained an outstanding achievement abroad that brings credit to Canada. With that as the backdrop, the federal government offered many organizations the ability to nominate someone.

The central Ontario chapter of Canadian peacekeepers is not a formal chapter, but it is a recognized organization for Canadian veterans who have served in peacekeeping operations. Because of this bureaucratic anomaly, UN peacekeepers in Ontario were not given the opportunity to honour their own for this award.

When I brought this oversight to Premier Ford's attention, he felt that Ontario needed to do the right thing and offer the peacekeepers the opportunity to nominate 10 deserving members for this award.

Speaker, today we're joined in the gallery by veterans of missions in Rwanda, Somalia, Afghanistan, to name but a few. All will be receiving the King's coronation medals at a ceremony here at Queen's Park later today. All will be formally introduced by the Minister of Citizenship and Multiculturalism.

We also have Bill Steedman, the retired peacekeeper who brought this oversight to my attention. Bill will be accepting the medals on behalf of Gordon Jenkins, Greg Palmer and Harold James.

Speaker, I present to you the King's coronation medal recipients from the Ontario chapter of the UN Peacekeepers, and I respectfully ask that all members here in the chamber rise from their seats and say thank you to these heroic individuals who have given so much to our country and made the world a better place through their service and sacrifice.

Applause.

INTRODUCTION OF VISITORS

The Speaker (Hon. Donna Skelly): We're going to move on now to introduction of visitors, but before I acknowledge anyone, I would like to acknowledge Daniela Turcios Regalado. Her father, Jay Turcios Rodriguez, is here today, and Daniela is our page captain. Welcome to Queen's Park.

Hon. Graydon Smith: Not a visitor here today but someone I definitely need to give a shout-out to: It's the 18th anniversary for my beautiful wife, Melissa, and I today, and I just want to tell her how much I love her.

Happy anniversary, darling.

Hon. Graham McGregor: Supplementary to the great member's statement by the member of Peterborough–Kawartha, it's my honour to welcome a group of retired

veterans and members of the central Ontario chapter of UN peacekeepers, many of whom we will be awarding the King Charles III Coronation Medal later this afternoon. Please join me in welcoming Gary Miner, Kevin Wadden, Kerry Mould, Tom Aldred, Ronald Graves, David Raths, their family and other guests and—forgive me, Madam Speaker—as well as Robert Manns, who is here as well.

Thank you, Madam Speaker, for opening up room 340. After question period, I encourage all members to attend the medal ceremony.

M. Guy Bourgouin: J'ai mon assistante législative, Astrid Krueger, qui est dans la Chambre, mais je voulais aussi lui souhaiter une bonne fête pour ses 25 ans d'anniversaire.

Hon. Sam Oosterhoff: I have a couple of introductions today. First, we have Jon Downing, who is coming to us from Niagara College. He's visiting Queen's Park today.

I also do want to acknowledge Kevin Wadden, who comes from Beamsville, I believe. Thank you for your service, sir. Welcome to Queen's Park.

Mr. Sol Mamakwa: ᒥᐢ, Speaker. ᒥᓂᑫᔦᐊᕽ

Good morning. I'd like to welcome to Queen's Park Councillor Alizabeth George-Antone, from Oneida Nation of the Thames; councillor and chair of Grey-Bruce Board of Health, Nick Saunders, Chippewas of Nawash Unceded First Nation.

But also, I'm happy to welcome Sergeant Jamie Doxtator, Oneida Nation of the Thames; Sergeant and Supervisor Natasha Maxwell from Neyaashiinigmiing; and Constable John Sahanatien, Hiawatha First Nation, but also, the representatives of Chiefs of Ontario, Jackie Lombardi and Kent Elson.

Finally, welcome to the representatives of Blackbird Strategies, Travis Boissoneau and Erica Wallis.

Thank you for being here.

Hon. Trevor Jones: Good morning, Madam Speaker. I wanted to welcome members of the Ontario Dairy Council here today. I remind all my colleagues to attend the chocolate milk social at lunchtime today, rooms 228 and 230.

1030

Mr. Anthony Leardi: I want to recognize a constituent from my riding who's here today. Her name is Carmen, she's a member of the Leardi family and she's my daughter.

Hon. Doug Downey: I looked up in the gallery and I see my old friend Fern Taillefer who's here. He's part of Legion Branch 147.

Mr. Mike Schreiner: I'm honoured to introduce Guelph residents Sanpreet Sihota and Sukhvinder Singh to Queen's Park today. Welcome to your House.

HOUSE SITTINGS

Mr. Steve Clark: I just want to advise the House that the night sitting scheduled for this evening has been cancelled.

QUESTION PERIOD

HEALTH CARE

Ms. Marit Stiles: This question is for the Premier. A new study from the Canadian Centre for Policy Alternatives found that private staffing agencies have cost Ontario hospitals more than $9 billion over the last decade. Hospitals, as we all know, were already overstretched after their budgets were frozen under the previous Liberal government, but now we know that they're struggling even more with unconstitutional wage freezes that this Conservative government brought in. The result is underpaid, overworked nurses fleeing the system and an overreliance on these private nursing agencies.

To the Premier: Why is the government funnelling billions into private staffing agencies at the expense of patients and health care workers?

The Speaker (Hon. Donna Skelly): Response? I recognize the Minister of Health.

Hon. Sylvia Jones: I think some facts on the table would be helpful. In fact, we have registered over 100,000 new nurses in the province of Ontario. We have 30,000 nurses currently training in our post-secondary institutions. Why? Because we have programs in place that are ensuring, like Learn and Stay, that individuals who want to train and practise in the province of Ontario get to do so, free for tuition and books. Why? Because we know that there are opportunities in Ontario and we are making sure that they have those pathways, not only to upskill, but also to train and stay in the province of Ontario.

The Speaker (Hon. Donna Skelly): Question?

Ms. Marit Stiles: Speaker, let's talk facts, shall we—back to the Premier—because last year alone, hospitals and long-term-care homes spent almost $1 billion on private nursing agencies, private staffing. Under this government, hospital spending increased by a little bit—about 6%—but private staffing agency spending—98%.

Something is really wrong here and not only is this costing the system more, but it is also resulting in worse outcomes for patients. I can't tell you how many times I've spoken with nurses who talk to me about the moral distress of not being able to do the work that they are trained to do, to care for patients, while billions of dollars are going into the coffers of private nursing agencies.

Will the Premier put an end to this two-tiered system and pay nurses fairly for the work that they do?

Hon. Sylvia Jones: We know that staffing agencies are a tool used primarily in rural and northern hospitals to avoid service disruptions. In fact, it is a tool that they have been using for decades, so to suggest that a registered nurse who has oversight and has the same oversight that any other nurse practising in the province of Ontario, is in some way providing less service in their role, is frankly a grave disservice to those regulated health professionals. Our government will not take away this important tool.

However, we are also doing so much with Learn and Stay, with upskilling, with directing the College of Nurses of Ontario to quickly assess and review and, when

appropriate, license internationally educated nurses who want to be in Ontario.

The Speaker (Hon. Donna Skelly): Supplementary?

Ms. Marit Stiles: Speaker, it's not only the private nursing agencies where we're seeing these public dollars—billions of them—funnelled into the corporate pockets of those providers, but the government is also handing more than a billion dollars a year to private staffing agencies but then another $62 million to Shoppers Drug Mart for exploiting the system for unnecessary MedsChecks. If you want to talk about moral distress, listen to some of the pharmacists, who will tell you how they are forced to meet quotas by Shoppers Drug Mart, by Galen Weston, not to serve patients but to meet their bottom line—millions coming out of the Ontario drug benefit and going straight into the pockets of folks like Galen Weston instead of better care for patients.

Why does this government continue to sell out Ontarians to private companies that just gouge our health care system?

Hon. Sylvia Jones: Speaker, I would appreciate your direction, because I'm not sure how this question is in connection to the first two that were raised in her lead-offs.

HOSPITAL FUNDING

Ms. Marit Stiles: Wow, I can't believe that the Minister of Health can't make the connect between billions of dollars leaving our health care system to private nursing agencies and billions of health care dollars leaving because of this MedsCheck scheme that they've set up that's going into the pockets of Galen Weston. I mean, we see this pattern of privatization in our health care system, and the minister knows quite well what she's doing here.

Speaker, I want to talk a little bit more about that public health care system, because our nation was built on world-class public health care, on health care that is there when and where you need it, no matter where you live or regardless of how you can pay, and on emergency rooms that are open, as well, by the way, when you need them. But the Premier's list of nation-building projects that he put forward to the federal Prime Minister didn't include any hospitals, not one.

Does the Premier consider building hospitals to be a nation-building project?

The Speaker (Hon. Donna Skelly): The Minister of Health.

Hon. Sylvia Jones: We never have and we will never wait for the federal government to suddenly come to the table and talk about capital hospital builds. They have never been our partner. We have made the commitment—$50 billion in 50 different capital projects across Ontario, whether you're talking about Windsor, Ottawa, London, Toronto—

Hon. Sam Oosterhoff: Niagara.

Hon. Sylvia Jones: Niagara South, of course—and Mississauga; I can't forget Trillium in Mississauga.

The number of capital projects that we have done, respectfully, without the help of the federal government, we will continue to do, because we know, for Ontario residents, that's what they expect of their provincial government.

We're playing catch-up because of the Liberal neglect, but we'll get it done.

The Speaker (Hon. Donna Skelly): Supplementary?

Ms. Marit Stiles: Well, Speaker, they seem willing to go to the federal government for support for the ridiculous tunnel under the 401, but hospitals, no.

Durham, Brampton, Brantford: Delay after delay after delay, and the costs just keep going up, and every year the government says this is going to be the year. But those communities are still waiting, right? And do you know who else is waiting? Construction workers, skilled trades workers in those same communities who are not working right now.

This moment we are in is an opportunity. It is an opportunity for all levels of government to agree that we need to invest in nation-building projects and get people working, instead of a ridiculous tunnel under the 401.

Will you add building hospitals to your list of nation-building priorities?

Hon. Sylvia Jones: If the member is suggesting that a hospital redevelopment that is happening in the city of Guelph to ensure that their emergency department can appropriately deal with individuals coming in, with emergency departments—the answer is we're not waiting. If the member opposite is suggesting that we should pause actually building a Mississauga hospital that is going to serve Mississauga, Etobicoke, north Toronto and the surrounding communities and wait for the federal government to do something, I would respectfully say we will not wait. We will get the job done with or without you.

1040

The Speaker (Hon. Donna Skelly): Supplementary?

Ms. Marit Stiles: Speaker, if only they were actually getting the job done, right? You can't pause projects that never got started in the first place.

This afternoon we're going to help them out. We're going to bring forward a motion calling on the government to commit to prioritizing hospitals as part of these nation-building projects. This is our priority, to build care and strengthen Ontario. We can save rural emergency rooms. We can build new hospitals in growing communities, and we can do that all at the same time that we get construction and skilled trade workers back to work.

Back to the Premier: This afternoon, will the Premier commit to adding hospitals and prioritizing them as nation-building projects?

The Speaker (Hon. Donna Skelly): Back to the Minister of Health.

Hon. Sylvia Jones: We'll continue to make those investments. We'll continue to build. Perhaps the member opposite should take the May long weekend and actually visit South Niagara and you will see a hospital that is doing excellent work getting those projects done.

I have to respectfully say, turn around and speak to your member from Waterloo: "This new, state-of-the-art facility will serve our growing population, and it will also

act as a beacon to attract more health care professionals to our community, including physicians, nurses and family doctors. It's an exciting day for the region," says the MPP from Waterloo.

GOVERNMENT ACCOUNTABILITY

Mr. John Fraser: In March 2024, just before a by-election in Lambton–Kent–Middlesex, the Premier and his government promised a comprehensive environmental assessment on a dump that was being proposed in Dresden, a dump that had been dormant for—wait for it—30 years. Now the Premier is using Bill 5 to renege on that promise.

So Speaker, my question is quite simple: Why is the Premier breaking his promise to the people of Lambton–Kent–Middlesex?

The Speaker (Hon. Donna Skelly): I recognize the Minister of the Environment, Conservation and Parks.

Hon. Todd J. McCarthy: Madam Speaker, I thank the member opposite for the question. What the member needs to know is that the Dresden project, if approved, would be subject to the same environmental approval processes that were in place last year and that would be in place if this were new. It's not a new project. We're building on what's already been approved as a waste management site.

Now, the position that we're in, Madam Speaker, is a crisis of landfill capacity. That was created by the previous Liberal government's inaction, propped up by the NDP.

And now, in the face of the trade and tariff wars with Mr. Trump, we have that challenge. We cannot afford to transport over our border 40% of the waste in this province. We're not going to stand for that. We're taking decisive action with strong environmental oversight.

The Speaker (Hon. Donna Skelly): Back to the leader of the third party.

Mr. John Fraser: So your defence for breaking your promise is, "The devil made me do it." That's what I hear you saying: "The devil made me do it."

The reality is this dump has been dormant for 30 years—actually longer than some members in here have been alive.

Speaker, in 2022, a group of wealthy, well-connected insiders purchased this dormant dump, among them, the Guizzetti brothers, Andrew and Daniel, and their business partner Brian Brunetti. Records show that since 2018 they've donated, along with executives and members of their family, hundreds of thousands of dollars to the Premier's party.

So, back to the Premier: Simple question, why did the Premier break his promise to the people of Lambton–Kent–Middlesex?

Hon. Todd J. McCarthy: Speaker, this question raises the important balance that we are proposing in Bill 5, building the Ontario of tomorrow, being resilient, being self-sufficient while ensuring strong environmental oversight. That is the key.

Now, a comprehensive environmental assessment process would not, under current regulations, be required for this site. Nevertheless, like every project that is built in this province, we have strong environmental oversight. That, in this case, includes an environmental compliance approval under the environmental permissions act. That, I will stand behind, and I can assure the residents of Dresden and I can assure all Ontarians and all members of this House that Ontario has the strongest environmental protections in the world and we are very proud of that. We will continue it.

The Speaker (Hon. Donna Skelly): Back to the leader of the third party.

Mr. John Fraser: You made a promise. We're asking you to keep that promise. It's very straightforward. We all know that wealthy, well-connected insiders in this province always get a leg up. It's a pattern. It's like an MO. It's just like the greenbelt, just like Therme, just like MZOs, just like urban boundaries; now it's the Dresden dump.

Speaker, I'm just going to ask once again: How is it that the Premier thinks he can break his promise to the people of Lambton–Kent–Middlesex?

Hon. Todd J. McCarthy: This government was elected on a renewed mandate—a historic third consecutive majority government with a quarter-million more votes than even the previous two elections. That's what I call a strong mandate. And that mandate means that we make and keep our promise to the people of this province to build the Ontario of tomorrow, to be resilient and self-sufficient but maintain strong environmental oversight and protections. That's what we're doing.

Speaking of donations that the member mentioned, I understand many donations were made to the Liberal Party from some of these same individuals. That's democracy. People are allowed to express themselves with their vote, with what they say and how they donate. But of course, the Liberals—

Interjection.

The Speaker (Hon. Donna Skelly): The member for Beaches–East York will come to order.

Hon. Todd J. McCarthy: —and they blew it.

Mr. John Fraser: I know the Premier doesn't like hearing this, but he broke his promise, and it's not the first time: It happens again and again and again. Right now, the people of Lambton–Kent–Middlesex are getting it. The Dresden dump has its own special section in Bill 5, so I think the people of Lambton–Kent–Middlesex and Ontarians have a right to be concerned about it.

Bill 5 is starting to look like a get-out-of-jail-free card for the Ford government, where they can do whatever they want: break a promise and use words like "trusted partner," "special economic zone" and legislation to legitimize breaking a promise to the people of Ontario.

Will the Premier just keep his promise?

Hon. Todd J. McCarthy: Speaker, despite the Liberal inaction, despite that inaction being supported by the NDP and the previous government, we are making sure that reliance and exporting our waste to the United States ends now. We cannot afford to be anything but self-sufficient and self-reliant on all fronts.

This site was already approved for waste management. It will be subject to the same environmental oversight, the same environmental compliance approval under the environmental permissions act as it would have been last year, as it would be if this was a new project. I make no apologies for the fact that I will stand for strong environmental oversight in Dresden. I can assure the residents of that; I can assure Ontarians of that. But we must address our landfill capacity challenges. We will be out of landfill within a decade if we do nothing. We are taking action, unlike the Liberals, who have no plan.

GOVERNMENT ACCOUNTABILITY

Mr. John Fraser: Maybe somebody over there can stand up and apologize for breaking a promise to the people of Lambton–Kent–Middlesex?

We all know this thing doesn't pass the sniff test. Just ask the member from Lambton–Kent–Middlesex. He knows it stinks. He knows it's not right. And just like with Therme and Ontario Place, the owners of the Dresden dump—guess what? They won a prize, Premier. They won a prize.

Speaker, does the Premier really think that rewarding wealthy, well-connected insiders and leaving the people of Lambton–Kent–Middlesex to hold the bag is the right thing to do?

Hon. Todd J. McCarthy: I wonder if the member opposite understands that their old, tired narrative just doesn't work. It didn't work in the last three campaigns. They have still finished third in seat count because the people of Ontario reject their inaction, reject their lack of any plans and have embraced our plan to build the Ontario of tomorrow, to protect Ontario, while ensuring strong environmental oversights.

That will continue—that balance is important. The same old ways of doing business under the Liberals have been rejected thrice, and we stand for Ontario, we stand for protecting Ontario and we stand for strong environmental oversight.

The Speaker (Hon. Donna Skelly): Supplementary?

Mr. John Fraser: Speaker, I have tongue twister for the folks on the other side, and it goes like this: Doug's dormant dump in Dresden. Now, try to say that five times fast. I couldn't even get through it once.

1050

The reality is—and the Premier really hasn't looked up yet, Speaker—he's turning his back on his own member from Lambton–Kent–Middlesex, turning his back on the people of Lambton–Kent–Middlesex. And his excuse, his reason is, "The devil made me do it. Trump made me do it." It's pathetic.

So Speaker, I'm going to ask one last time: Is the Premier going to actually take this out of Bill 5 and keep the promise that he made to the people of Lambton–Kent–Middlesex?

Hon. Todd J. McCarthy: One of the important things about being legislators is to look at current laws and regulations, look at what we're proposing to replace. Under current regulations, the member should know that this project would not typically require a comprehensive environmental assessment. That's a fact. Nevertheless, it is still going to be subject to an environmental approval process, and that is clear under the environmental permissions act.

This proposed bill is about achieving the balance of being self-sufficient and self-reliant, ending the reliance on exporting 40% of our waste to the United States. When the 25% tariffs came, our waste diversion was affected. So it's already happened, and it could happen again. We're going to be ready. We're going to be ready to stand up and protect Ontario.

FIRST NATIONS POLICE SERVICES

Mr. Sol Mamakwa: A study published today shows us the stark reality of the mental health of police officers serving under the Ontario First Nations Policing Agreement: officers patrolling an entire region or community by themselves with no backup, police chiefs treated differently because they are Indigenous, officers in dangerous situations without the needed resources.

To the Premier: Do you find this reality acceptable?

The Speaker (Hon. Donna Skelly): I recognize the Minister of Health.

Hon. Sylvia Jones: The member opposite raises a really important issue and something that Premier Ford has, since 2018, been very focused on, to ensure that individuals who protect our communities 24/7 also have that protection from their governments. It is critical.

We know that when we have strong police services and police forces, we have strong and safe communities, which is why we, of course, have added over the last three years support for mental health for our first responders, specifically early intervention, upstream care for first responders before they experience crisis—trauma-informed care, programming that builds on resiliency skills, training for management and office staff to help support their front-line colleagues.

Look, I know that we can do more. We will continue to support our front-line officers wherever they serve in the province of Ontario, because it is the right thing to do.

The Speaker (Hon. Donna Skelly): Supplementary?

Mr. Sol Mamakwa: The Deputy Premier—the programs and the funding that she's talking about do not reach the First Nations officers on reserve. The results of this unequal treatment are heightened levels of stress, longer leaves of absences and PTSD.

First Nations leadership and officers under the First Nations policing agreement travelled to Queen's Park today. They are actually here to hear the answer to this question: Will you commit now to provide funding needed to fully resource First Nations officers' mental health services?

Hon. Sylvia Jones: Again, I will say, I don't think we are in misalignment. I know that you and I and our government believe very strongly that our first responders—whether they are police officers, corrections

officers, ambulance drivers, communications officers—all need the support when something happens.

Which is why, again, under Premier Ford's leadership—the first PTSI rehabilitation centre in Canada: Runnymede Healthcare Centre's first responders PTSI centre—we did that. We are working towards that centre because we know that there are unique challenges when you are a first responder, which is why we are putting the funds and the commitment for all police officers serving in Ontario to have access to that Runnymede centre when it is operationalized.

GOVERNMENT ACCOUNTABILITY

Mr. Ted Hsu: I want to know if public policy in Ontario is for sale.

The problem in the Dresden landfill matter is the sequence of events. First, there's public opposition to the expansion. An environmental assessment is promised in March 2024. Then donations by executives connected to landfill owners are made at big-ticket PC party fundraisers and during a by-election. No environmental assessment takes place, and now, in Bill 5, the government does a U-turn and cancels it.

People across Ontario want to know: Is the way to get ahead by making the right political donations?

The Speaker (Hon. Donna Skelly): I will caution the member on his questions and the wording of his questions.

I recognize the Minister of the Environment, Conservation and Parks.

Hon. Todd J. McCarthy: As the member may well know, I am a bit of a historian, and I like talking about sequences of events.

Speaking of sequences of events, in 2018, the former Liberal government was thrown out of office and reduced to third place by the people of Ontario. That status was repeated in 2022, and again, still stuck in third place—although those members can fill two minivans now, so congratulations on that. But the people of Ontario have three times in a row rejected the negativity and poor track record, sour track record, of this Liberal Party.

We stand for optimism and hope. We stand for balance in this Progressive Conservative government. We stand, under the leadership of Premier Ford, with strong environmental oversight while building the Ontario of tomorrow and being self-sufficient and protecting Ontario, and leading Canada in the fight against the trade wars and the tariff threats. We're proud of that track record and we—

The Speaker (Hon. Donna Skelly): Supplementary?

Mr. Ted Hsu: I have asked the Integrity Commissioner for her opinion on the Dresden landfill matter.

My immigrant parents raised me to believe in hard work and in following the rules. Even if it looks like people get ahead by donating to the powerful, we must investigate. Otherwise, the perception is that working hard doesn't matter, that following rules puts you at a disadvantage. That perception drains public trust. It saps the will to strive for the common good and it leaves behind a hollow cynicism.

Will the Premier simply pull the Dresden landfill from Bill 5 and keep his promise?

Hon. Todd J. McCarthy: The member opposite and his party failed to recognize what the realities of the mandate of February 27 for this government represent. President Trump's threats and this trade war and the border disruptions associated with it have created an urgent situation. This is why the party opposite is not in office and is not trusted by the people.

Our province is rapidly running out of landfill capacity. We will be out of landfill capacity even sooner than the next 10 years if these threats come to reality—

Interjections.

The Speaker (Hon. Donna Skelly): I apologize to the minister.

The Liberals will come to order.

Back to the minister.

Hon. Todd J. McCarthy: The status quo cannot continue, Madam Speaker, because 40% of our waste is exported to Michigan and New York. That must end now, and it will end now. We must enhance our—

The Speaker (Hon. Donna Skelly): Question?

ENERGY POLICIES

Mr. Billy Pang: My question is for the Minister of Energy and Mines. Ontario needs strong, reliable energy to power our homes, businesses and factories. But the world is changing fast. Energy security is more important than ever, and we cannot rely on others to meet our needs. That's why our government is investing in Ontario's energy future.

We are building the first small modular reactor in the G7 right here at home. It will help secure our energy supply, protect us from outside threats and keep Ontario competitive. We're also making major investments to make our energy grid stronger and more efficient. This will reduce our dependence on foreign sources as we protect Ontario's energy grid.

1100

Can the minister please explain how our government is securing Ontario's energy future and protecting our province from outside risks?

The Speaker (Hon. Donna Skelly): Response? I recognize the member from Mississauga–Lakeshore.

Mr. Rudy Cuzzetto: The member is absolutely correct. We can never return to the short-sighted policies of the Liberals. Independent experts confirm that under our government, hydro rates will be 23% lower by 2030 than they would be under the Liberals.

Electricity demand in Ontario is expected to increase by 75% by 2050. To address this, we're introducing the largest energy-efficiency program in Canadian history: an $11-billion initiative to reduce peak demand by 3,000 megawatts.

Last week, we broke new ground on construction of the first small modular reactor in the G7. This is a transform-

ative project, creating 18,000 jobs during construction and 3,700 jobs for the next 65 years. It will add over $500 million to our economy each year. Thanks to our government's negotiation, 80% of the project spending will stay right here in Ontario. This is a nationally built project—

The Speaker (Hon. Donna Skelly): Supplementary?

Mr. Billy Pang: Thank you for the parliamentary assistant reminding us that Liberals are short-sighted.

Ontario's energy network is critical to our economy and our security. We can't afford to rely on foreign sources for the power and resources we need. That's why our government is taking action. We are cutting red tape and speeding up projects that unlock Ontario's vast natural resources. This means more jobs, stronger industries and a secure energy supply. It's not just about keeping the lights on; it's about protecting Ontario from outside threats and making sure our province leads in the industry of the future.

Can the parliamentary assistant share how these steps are helping Ontario lead the world in energy production and protect our province from global risks?

Mr. Rudy Cuzzetto: I'd like to thank the member for this question.

While we cut costs for Ontarians at home, we're also strengthening our economic independence by ensuring our province is a global leader in energy and critical minerals. Europe and the Asia-Pacific are looking at us at this time to strengthen and approve. We're unlocking Ontario's incredible mineral potential, creating thousands of jobs. Ontario's one of the richest mineral regions in the world, with critical resources like nickel, titanium, cobalt and lithium—essential to produce products like cellular phones, medical devices, electric vehicles and clean energy storage. We're the only western country with all the raw materials needed to make a lithium-ion battery, and northern Ontario is already a key producer of these resources.

This is how we create jobs, secure our economic independence and continue to lead the world in clean energy innovation, because Ontario is a clean energy superpower.

HEALTH CARE FUNDING

Ms. Chandra Pasma: The Queensway Carleton Hospital has one of the biggest emergency departments in Ontario. It was built to serve 100,000 people, but now it serves 500,000. This means incredibly long wait times in the ER for people who are seriously ill, in pain and anxious about their health.

The Queensway Carleton has a plan to double the size of the hospital, ready to go as soon as the funding is there. Will the Premier commit today that the funding to right-size the Queensway Carleton Hospital will be in his government's budget?

The Speaker (Hon. Donna Skelly): I recognize the Minister of Health.

Hon. Sylvia Jones: Of course, I hope that the member opposite is in her seat in the chamber Thursday at 4 o'clock when the Minister of Finance is going to introduce and table his next Premier Ford budget. When that budget is announced, you will see the investments that we are making and continue to make across Ontario. Specifically, as it relates to the Queensway Carleton Hospital, I'm sure the member opposite knows that they are actually in phase 3 of a mental health project to expand and renovate the space for their mental health services.

There are ongoing projects across almost every hospital, it seems, in the province of Ontario because of that $50 billion in 50 projects that we have committed to, and of course, on Thursday, we will learn more.

The Speaker (Hon. Donna Skelly): Back to the member for Ottawa West–Nepean.

Ms. Chandra Pasma: The government might have difficulty remembering that Ottawa is in Ontario, Speaker, but the people of Ottawa deserve timely access to health care nonetheless.

The Queensway Carleton serves twice the population with half the beds of the Ottawa Civic. I spoke to an elderly woman during the election who has been told she won't have surgery for an incredibly painful condition until 2027. We urgently need to expand the Queensway Carleton to be able to meet the needs of the population of the whole western half of Ottawa.

Will the Premier commit to doing that today? Yes or no?

Hon. Sylvia Jones: As the member continues to rightfully advocate for the hospitals in her community, we will ensure that across the region, whether it is at Ottawa, Carleton, in Almonte, in Perth, in Carleton Place, we are making those investments.

We do that in a way that ensures that whether it is an improved emergency department, whether it is increased access to long-term-care homes, whether it is, in fact, increasing the number of acute care beds—something that we have already increased by over 3,000 beds since we were in government with plans to do an additional 3,500—we are making those investments across Ontario, and we will continue to do that in Ottawa and beyond.

JOB CREATION

Ms. Stephanie Bowman: As you know, it's budget week, and this government really has its work cut out for it. In their seven years in power, Ontario's economy has taken some really big hits. One of the biggest? Unemployment, now at 7.8%. When this government came to power, we had the second-lowest unemployment rate in the country. Under them, it's now the second-highest.

Stats Canada's April Labour Force Survey shows that 691,000 Ontarians are out of work, a number not seen since the financial crisis. In just one month, 24,000 more people are without a job, worrying about how to pay their bills. I know the Premier will blame US tariffs, but the number of people without jobs has been getting worse since June 2022.

So my question to the Premier: When will he admit that he isn't protecting jobs, he's losing them?

The Speaker (Hon. Donna Skelly): I recognize the Minister of Labour, Immigration, Training and Skills Development.

Hon. David Piccini: The only state-sponsored loss of jobs occurred when that party had the balance of power in this place, when manufacturing jobs fled Ontario. In fact, that's one of the reasons I signed up to run.

Interjection.

The Speaker (Hon. Donna Skelly): The member for Ottawa South will come to order.

Hon. David Piccini: This Premier decided to turn it around when no automotive jobs were slated for this province and actually get in the game and dress a player to play. That's what we did: $14 million in payroll—I keep saying this because it bears repeating—a week in Windsor. That's pretty impressive.

We're not immune from global trade winds, but what workers know is that we'll protect them. We'll back them up with a historic investment in the Skills Development Fund. We'll support our automotive workers, like the Premier reiterated with me at GM, speaking with workers at Local 222.

They know that when it comes to dressing to play and to bring those jobs and foreign direct investment, there's only one leader they can count on, and that's Premier Doug Ford.

The Speaker (Hon. Donna Skelly): The member for Don Valley West.

Ms. Stephanie Bowman: The minister can spin it however he wants, but the reality is the previous Liberal government created more construction jobs and more manufacturing jobs: 17,000 compared to their 7,000—

Interjections.

The Speaker (Hon. Donna Skelly): The government side will come to order.

Ms. Stephanie Bowman: Stats Canada's numbers don't lie.

Interjection.

The Speaker (Hon. Donna Skelly): The Minister of Natural Resources will come to order.

Ms. Stephanie Bowman: The reality is, this government isn't protecting jobs, it's losing them.

Look at the manufacturing sector. Seven years ago, yes, the Premier promised he'd bring 300,000 manufacturing jobs to Ontario. Well, consider that another broken promise. He's only delivered 7,000, and 33,000 of those jobs were lost last month alone. Those 300,000 jobs have not reappeared under this Premier.

So my question to the Premier: When will he admit that his plan for manufacturing jobs has failed?

1110

Hon. David Piccini: If there's one thing that question got right, it was that 300,000 jobs did flee. In fact, over a million have come back thanks to the leadership of this Premier.

Speaker, if the member wants to confront the cold, hard facts, it's that almost every single building trade union abandoned them to back this Premier because they know that, when it comes to building hospitals, this Premier is going to get it done. When it comes to building subways, this Premier is going to get it done. In fact, the Ontario Line right now is sending thousands of men and women in the trades to work. When it comes to building roads and highways—something that they don't even want to build; we know their friends don't even want to build roads at all—it's this Premier who's going to get the job done.

And when it comes to supporting men and women in the trades and entering a meaningful job as an apprentice, we've increased that by 30,000 more people in apprenticeships today because we know Premier Wynne—a view still held by the members opposite is that they wanted us to be a service economy. They don't want to build things—

The Speaker (Hon. Donna Skelly): Question?

ENERGY POLICIES

Mr. Robert Bailey: My question is to the Associate Minister of Energy-Intensive Industries. Ontario's economy depends on energy. It powers our factories, keeps our lights on and heats our homes. It supports good jobs in towns from Windsor and Sarnia to Thunder Bay. It also drives exports and keeps Ontario's economy strong. But demand for electricity is set to rise by at least 75% by 2050. We can't afford to ignore that.

Our government has a plan. The integrated energy plan will make sure Ontario has that power it needs. It covers electricity, natural gas and fuels. It will cut delays, reduce costs and support jobs our families rely on.

Madam Speaker, can the associate minister tell this House how this plan will build a stronger, more reliable energy network for Ontario's future?

Hon. Sam Oosterhoff: I want to thank the member for Sarnia–Lambton for his strong advocacy and for bringing me through so many of the industries in Sarnia last week. We had the opportunity to tour Imperial Oil, Arlanxeo, TransAlta. These are industries that are seeking to grow here in Ontario, and they need certainty about the cost of power, the reliability of power, and the fact that they're going to have reliable power for decades to come.

That's exactly what the integrated energy plan does. It builds out an energy approach that brings all the fragmented sources of energy, whether it's electricity, natural gas or fuels, into one coordinated strategy, which means a better alignment between infrastructure and demand, fewer delays and ultimately a stronger investment climate.

We're doing this because we know, under Premier Ford and Minister Lecce, our focus is on building affordable and reliable energy that supports industry, creates jobs and strengthens Ontario's economy for decades to come.

The Speaker (Hon. Donna Skelly): The member for Sarnia–Lambton.

Mr. Robert Bailey: I want to thank the associate minister for that great response and for his visit to Sarnia–Lambton.

Energy costs matter. They impact the jobs in our factories, the costs for small businesses and the bills for families. They make the difference between companies choosing to invest here or somewhere else. Under this last Liberal regime, rates soared, and the jobs left.

But our government is taking action. We have cut energy costs, signed better contracts and brought those jobs back, but we know there's more to do. That's why the integrated energy plan is so important. It brings all our energy sources under one plan. It means lower costs, fewer delays and more jobs.

Madam Speaker, can the associate minister please share more about how this plan will keep our costs down and support jobs in Ontario for the years to come?

Hon. Sam Oosterhoff: The member for Sarnia–Lambton is absolutely right. Under the previous Liberal government, we saw political ideologies drive energy planning in this province, and the result was a 300% increase in energy costs for hard-working families.

As a result of our actions, we've actually seen a reduction by renegotiating contracts at a 30% discount compared to where those contracts were with the Liberals. In fact, we've seen independent analysts saying that, by the end of this decade, we will have energy prices that are 23% lower than they would have been under the previous Liberal plan. That's because we're taking an integrated approach that listens to what industries need, that listens to what families need and says we need to stay competitive. When we're competitive, we're able to attract more jobs, build our economy and grow—as our plan for the future is.

Now, I'll say, Speaker, when I was out in Sarnia, we heard so much from those industries about their plans to grow as a result of the changes. They were leaving this province; now they're coming back. We're going to have their backs as they had the backs of workers in this province.

PUBLIC TRANSIT

Mrs. Jennifer (Jennie) Stevens: My question is to the Premier. The Ontario government's recent announcement of GO service expansion to West Harbour touts improved service for Niagara commuters, yet omits any mention of direct benefits for St. Catharines residents. Why is this government neglecting the long-standing demand for all-day, two-way GO train service in St. Catharines, and what concrete steps are being taken to address this glaring oversight?

The Speaker (Hon. Donna Skelly): The Minister of Transportation.

Hon. Prabmeet Singh Sarkaria: Madam Speaker, here are the facts: Since 2019, this government has increased service on the Niagara line by over 200%. That's passengers, people taking that GO train almost every single day, Madam Speaker.

And we've made historic investments. Just last month, we made an announcement which is going to save almost 15 to 20 minutes per round trip for those commuters on that line. We will continue to work tirelessly to improve changes, and I ask that member to please support and vote as this government puts more funding toward not only the stations and the service in St. Catharines and Niagara across that line—because to date, the NDP have opposed every single one of those investments into the Niagara line by refusing to support this government's investments and budgets and fall economic statements when they are put forward in this House.

We will continue to invest in public transit, and we will get it done.

The Speaker (Hon. Donna Skelly): Supplementary?

Mrs. Jennifer (Jennie) Stevens: To the minister: I have to let the minister know that Niagara goes all the way to Niagara Falls and passes Hamilton.

I also want to know, back to the minister: Any plan to expand GO service in Niagara must include the region's largest city, which is St. Catharines. With every new announcement, residents hope and pray they don't have to wake up at 4 a.m. just to catch the only few trains that leave St. Catharines each morning. What concrete actions are this government taking to ensure St. Catharines is finally included in the next phase of expansion, and bring two-way, all-day GO, after years and years of this Ford government's broken promises to the area?

Hon. Prabmeet Singh Sarkaria: Madam Speaker, the member knows construction is well under way on many of those projects that are happening right now.

But you want to know the facts? When it comes to St. Catharines, that member voted against one of the largest infrastructure projects, the Garden City Skyway, that which help her own commuters and residents and businesses across not only St. Catharines, but across the Niagara region.

When it comes to GO Transit, that member has voted against every single one of the investments that we have made, including the latest investment on that line, which reduces the time for those commuters by over 20 minutes per round trip. We have increased service on that line by over 200% for residents who are using it. We will continue to invest in GO Transit. I hope that member opposite and the members from Niagara region and others support this government's investments.

I want to thank the member—

The Speaker (Hon. Donna Skelly): Question?

ONTARIO DISABILITY SUPPORT PROGRAM

MPP Stephanie Smyth: Good morning, Madam Speaker. I have spoken with community leaders at food banks, housing shelters and support organizations who all say the same thing: Doubling ODSP is the most immediate and effective way to fight homelessness in our communities.

To the Minister of Finance: How does this government expect people with disabilities to survive, let alone live with dignity, on rates that fall so far below the cost of living? Will the minister commit today to doubling ODSP in the upcoming budget?

The Speaker (Hon. Donna Skelly): The Minister of Children, Community and Social Services.

Hon. Michael Parsa: I thank my honourable colleague for the important question, Madam Speaker. It's this government that has taken charge in the face of unaffordability and has made it a priority for us to make life more affordable for all Ontarians, including those on social assistance.

Madam Speaker, the member is talking about ODSP. We have raised ODSP rates by 17% in less than two years, and we've done more. We tied rates to inflation so that it could keep up with the cost of living every single year, and as a result of our decision in July, you will see a new adjustment, Madam Speaker.

More than that, for those who can and are able to work, we increased the earned-income threshold from $200 monthly to $1,000, so that those who can earn and work can keep more money in their pockets.

1120

Madam Speaker, when it comes to making life more affordable for Ontarians, we will continue working, and we hope the opposition will support us in our efforts at making life more affordable for all.

The Speaker (Hon. Donna Skelly): Supplementary?

MPP Stephanie Smyth: The Ford government's 4.5% increase to ODSP last year amounts to just a few extra dollars—hardly enough to cover rising rent, as we all know, let alone the soaring cost of groceries and transportation.

Community leaders are really clear about this: Without a bold step like doubling the ODSP, we are going to see more people forced onto the streets. When will this government stop making people with disabilities wait, and commit to an income that actually meets their basic needs?

Hon. Michael Parsa: I do want to remind my honourable colleagues: The decisions that we've made to make life more affordable for Ontarians, including those on ODSP—regrettably, your party and the NDP have systematically voted against every single initiative, so it's very rich when it comes from the two opposition parties on the floor of the Legislature lobbying for supports while we're providing that. But when it comes to voting, they vote against every single initiative.

But that's okay. That's okay. People of Ontario know that they have a government that will stand up for them. They know that they have a government, a Premier, that will not stop fighting for them, which is why I alluded to some of the measures that we put in place. The increases that I mentioned earlier, Madam Speaker, are the largest increases in the program's history in decades. The Liberals didn't do it. The NDP never did it. In fact, they oppose it. It's this government, it's this Premier, that will continue to stand up for all Ontarians.

SENIORS' SERVICES

Mrs. Michelle Cooper: My question is to the Minister for Seniors and Accessibility. We know that seniors have given so much to build our province. They should be able to live safely, stay active and feel connected. But for too many seniors, social isolation is a real challenge. It can affect their health and well-being. That is why it is so important to keep seniors connected to their communities.

Our government has invested in seniors active living centres to do just that. These centres are about more than just programs: They're about keeping seniors connected to their networks and support systems. They offer a safe place to share experiences, build friendships and stay physically and mentally healthy.

Speaker, can the minister please explain how these centres are keeping seniors safe, healthy and connected?

Hon. Raymond Sung Joon Cho: Thank you for the great question from the excellent new MPP from Eglinton–Lawrence. We know that social isolation is public enemy number one for seniors. This is why our seniors active living centres are so important to help our seniors stay active, healthy and connected in our communities.

We increased the base funding for seniors active living centres by nearly 30% in the last few years, raising support for this program to over $20 million every year. We are helping to protect our seniors and keep them active, healthy and safe.

The Speaker (Hon. Donna Skelly): Back to the member for Eglinton–Lawrence for supplementary.

Mrs. Michelle Cooper: Thank you, Minister, for your never-ending energy and leadership. It is clear that supporting our seniors is a top priority for our government. We know that staying connected and active is key to keeping seniors healthy and strong. That is why we need to keep building on this progress.

These centres are more than just buildings: They are places where our seniors can connect, share their stories and stay engaged with their communities. Our government is supporting our seniors by investing in the programs that matter most to them. By expanding support for seniors, we are ensuring they have the resources and the connections they need to stay healthy, active and engaged in their communities.

Speaker, can the minister share more about how these new centres are helping protect seniors from isolation and support their mental and physical well-being?

Hon. Raymond Sung Joon Cho: Under the leadership of Premier Ford, our government has not only increased the base funding by nearly 30%; we have also had a historic increase in the number of seniors active living centres. We have added nearly 117 more centres all across Ontario, helping to ensure that every senior who wants to can access these marvellous programs. This is protecting our seniors from isolation and improving their physical and mental health. It is helping them live with the dignity they deserve.

NURSES

M^me^ France Gélinas: I hope everybody will join me in wishing the hard-working 180,000 nurses a happy Nursing Week.

Do you know what the wish of all those nurses is for this year and what they are saying? They want to be heard. They want a workload that a human being can handle. They want a safe workplace. Violence in health care is directly linked to a workload being too heavy, to not being able to meet your patients' needs.

I ask the Minister of Health: Will she listen to nurses and adopt a nurse-to-patient ratio?

Hon. Sylvia Jones: Of course, it is always a pleasure and opportunity to say thank you to our front-line nurses and other health care allied professionals because of the work that they do 24/7.

It is incredible that we have been able to support them with some very innovative programs, whether it is offering new opportunities for young people who want to become nurses with the Learn and Stay program that we have since been able to expand to other necessary areas like lab techs and paramedics, or whether it is upskilling that we are providing so that individuals who are working in our hospitals have an opportunity to train in different specialties and be able to move through their workforce.

I am very pleased that we continue to invest in our health care system and, particularly, in our people.

The Speaker (Hon. Donna Skelly): Back to the member for Nickel Belt.

M^me^ France Gélinas: There are so many nurses right here, right now in Ontario who are burnt out. They are leaving their profession because they know that they cannot provide quality care to their patients with the assigned workload.

I ask the minister: Does she think that a patient in ICU on a respirator does not need 1-to-1? Does she think that patients in palliative care at the end of lives do not need 1-to-4? Other jurisdictions have proven that nursing ratios help recruit and retain nurses, and it also encourages many experienced nurses to come back to the profession to care for us.

Will the minister support my bill to legislate nurse-to-patient ratios?

Hon. Sylvia Jones: Well, I look at the numbers, and the number of licensed nurses who have now got a licence in the province of Ontario is over 100,000 now. Why is that? Because they want to practise, they want to train in the province of Ontario. We have 30,000 nursing students who are in our post-secondary institutions today, training to become a nurse. Why? Because we have opportunities.

Whether that is in our communities, whether that is in our long-term care homes, whether that is in our hospitals and the expanded primary care multidisciplinary teams that we have announced and are rolling out now, those are the investments and the impacts to our communities, but also the opportunities that we have available for our allied health professionals.

Whether you are a nurse, a lab tech, a paramedic, a physician or a midwife, there is an opportunity for you in the province of Ontario.

TRANSPORTATION INFRASTRUCTURE

Mr. Stephen Blais: My question is for the Premier.

Mr. Premier, during the election, you came to Ottawa to great fanfare to promise the upload of Ottawa's LRT. Now, when asked about it last week, the Minister of Transportation's office said, "I don't want to say it's not a priority, but basically we're focused on building infrastructure in Toronto instead of addressing Ottawa's transportation needs."

The Speaker (Hon. Donna Skelly): Through the chair.

Mr. Stephen Blais: So, Mr. Premier, through the Speaker, when will you actually make good on your promise to Ottawa and upload the LRT?

The Speaker (Hon. Donna Skelly): The Minister of Transportation.

Hon. Prabmeet Singh Sarkaria: Here are the facts, Madam Speaker: We struck an historic deal with the city of Ottawa for close to $543 million of support, and guess what? That member over there voted against it. In fact, a part of that deal is to upload Highway 174, which unfortunately that member from Orléans has asked and advocated to toll, which is absolutely not going to happen under this government's watch.

We have put forward legislation that will prevent tolling across Ontario and that member, who advocated to toll Highway 174, will be uploading to the government in the province as well.

We will continue to be there to support the city of Ottawa and make those investments and upload the LRT.

The Speaker (Hon. Donna Skelly): Back to the member for Orléans for a supplementary.

Mr. Stephen Blais: Speaker, through you, just last week the minister's office said that the LRT upload isn't a priority, that they're focused on building infrastructure—great. We know they're not building infrastructure in Ottawa. They're not building any highways in Ottawa, they're not building any roads in Ottawa and they're not building any transit in Ottawa. They just lost the ambassador that the Premier dispatched to the city of Ottawa. They're not building anything in Ottawa and they're making no progress in uploading the LRT.

So when there is no cabinet minister from Ottawa, when the Premier continues to break his promises to Ottawa, when can the residents of Ottawa actually expect some success and some results from this government?

Hon. Prabmeet Singh Sarkaria: Here are a list of initiatives that member from Ottawa has voted against: $180 million in transportation infrastructure—that includes Highway 416 and the Barnsdale Road interchange, Madam Speaker. When it comes to the Kanata North Transitway, every one of the members from the city of Ottawa have voted against that crucial investment. When it comes to $47 million in improvements for Highway 174, every single one of the Liberal members from Ottawa have voted against it.

Interjection.

The Speaker (Hon. Donna Skelly): The member for Orléans will come to order.

Hon. Prabmeet Singh Sarkaria: In fact, the member for Orléans not only voted against it but has advocated for tolling Highway 174, which will never happen under this government's watch.

NOTICE OF DISSATISFACTION

The Speaker (Hon. Donna Skelly): Pursuant to standing order 36(a), the member for Kingston and the Islands has given his notice of dissatisfaction with the answer to his question given by the Minister of the Environment, Conservation and Parks regarding Dresden landfill. This matter will be debated tomorrow at 6 p.m.

DEFERRED VOTES

THRONE SPEECH DEBATE

The Speaker (Hon. Donna Skelly): We have a deferred vote on government order number 1 on the motion for an address in reply to the speech of Her Honour the Lieutenant Governor at the opening of the session.

Call in the members. This is a five-minute bell.

The division bells rang from 1133 to 1138.

The Speaker (Hon. Donna Skelly): The members will please take their seats. A reminder: If you're not in your seat, you cannot vote.

On April 16, 2025, Mr. Clark moved, seconded by Mr. Leardi, that an humble address be presented to Her Honour the Lieutenant Governor as follows:

"To the Honourable Edith Dumont, Lieutenant Governor of Ontario:

"We, His Majesty's most dutiful and loyal subjects, the Legislative Assembly of the province of Ontario, now assembled, beg leave to thank Your Honour for the gracious speech Your Honour has been pleased to address to us at the opening of the present session."

All those in favour of the motion will please rise one at a time and be recognized by the Clerk.

Ayes

Allsopp, Tyler	Gualtieri, Silvia	Rae, Matthew
Anand, Deepak	Hamid, Zee	Riddell, Brian
Babikian, Aris	Hardeman, Ernie	Rosenberg, Bill
Bailey, Robert	Harris, Mike	Sabawy, Sheref
Bouma, Will	Holland, Kevin	Sandhu, Amarjot
Calandra, Paul	Jones, Sylvia	Sarkaria, Prabmeet Singh
Cho, Raymond Sung Joon	Jones, Trevor	Sarrazin, Stéphane
Cho, Stan	Jordan, John	Saunderson, Brian
Ciriello, Monica	Kanapathi, Logan	Scott, Chris
Clark, Steve	Khanjin, Andrea	Scott, Laurie
Coe, Lorne	Leardi, Anthony	Smith, Dave
Cooper, Michelle	Lecce, Stephen	Smith, David
Crawford, Stephen	Lumsden, Neil	Smith, Graydon
Cuzzetto, Rudy	McCarthy, Todd J.	Smith, Laura
Darouze, George	McGregor, Graham	Surma, Kinga
Denault, Billy	Mulroney, Caroline	Tangri, Nina
Dixon, Jess	Oosterhoff, Sam	Thanigasalam, Vijay
Dowie, Andrew	Pang, Billy	Thompson, Lisa M.
Downey, Doug	Parsa, Michael	Triantafilopoulos, Effie J.
Dunlop, Jill	Piccini, David	Vickers, Paul
Firin, Mohamed	Pinsonneault, Steve	Wai, Daisy
Flack, Rob	Pirie, George	Williams, Charmaine A.
Gallagher Murphy, Dawn	Quinn, Nolan	
Grewal, Hardeep Singh	Racinsky, Joseph	

The Speaker (Hon. Donna Skelly): All those opposed to the motion will please rise one at a time and be recognized by the Clerk.

Nays

Armstrong, Teresa J.	Gilmour, Alexa	Shamji, Adil
Begum, Doly	Glover, Chris	Shaw, Sandy
Blais, Stephen	Hazell, Andrea	Smyth, Stephanie
Bourgouin, Guy	Hsu, Ted	Stevens, Jennifer (Jennie)
Brady, Bobbi Ann	Kernaghan, Terence	Stiles, Marit
Burch, Jeff	Lennox, Robin	Tabuns, Peter
Cerjanec, Rob	Mamakwa, Sol	Tsao, Jonathan
Clancy, Aislinn	McCrimmon, Karen	Vanthof, John
Collard, Lucille	McKenney, Catherine	Vaugeois, Lise
Fairclough, Lee	McMahon, Mary-Margaret	Watt, Tyler
Fraser, John	Pasma, Chandra	West, Jamie
French, Jennifer K.	Rakocevic, Tom	Wong-Tam, Kristyn
Gates, Wayne	Sattler, Peggy	
Gélinas, France	Schreiner, Mike	

The Clerk of the Assembly (Mr. Trevor Day): The ayes are 70; the nays are 40.

The Speaker (Hon. Donna Skelly): I declare the motion carried.

Motion agreed to.

The Speaker (Hon. Donna Skelly): It is therefore resolved that a humble address be presented to Her Honour the Lieutenant Governor as follows:

"To the Honourable Edith Dumont, Lieutenant Governor of Ontario:

"We, His Majesty's most dutiful and loyal subjects, the Legislative Assembly of the province of Ontario, now assembled, beg leave to thank Your Honour for the gracious speech Your Honour has been pleased to address to us at the opening of the present session."

NOTICE OF DISSATISFACTION

The Speaker (Hon. Donna Skelly): Pursuant to standing order 36(a), the member for Orléans has given his notice of dissatisfaction with the answer to his question given by the Minister of Transportation regarding support for the Ottawa LRT. This matter will be debated Tuesday at 6 p.m.

MEMBER'S BIRTHDAY

The Speaker (Hon. Donna Skelly): I recognize the member for Mississauga–Streetsville.

Hon. Nina Tangri: I just want to say a very happy birthday to my colleague Deepak Anand from Mississauga–Malton.

The Speaker (Hon. Donna Skelly): Happy birthday.

This House stands in recess until 1 o'clock.

The House recessed from 1143 to 1300.

INTRODUCTION OF VISITORS

The Speaker (Hon. Donna Skelly): I recognize the member from Mississauga–Malton.

Interjection.

Mr. Deepak Anand: Not singing the birthday song, but what I am doing is I actually am taking a moment to thank the Ontario Dairy Council for hosting the chocolate milk social with lunch today. Thank you to Christina Lewis, the president; Gilles Froment, the chair of ODC; and in fact, my friend Kiran Mann from Brar's. W,elcome to Queen's Park.

INTRODUCTION OF GOVERNMENT BILLS

PROTECT ONTARIO BY BUILDING FASTER AND SMARTER ACT, 2025

LOI DE 2025 POUR PROTÉGER L'ONTARIO EN CONSTRUISANT PLUS RAPIDEMENT ET PLUS EFFICACEMENT

Mr. Flack moved first reading of the following bill:

Bill 17, An Act to amend various Acts with respect to infrastructure, housing and transit and to revoke a regulation / Projet de loi 17, Loi modifiant diverses lois en ce qui concerne l'infrastructure, le logement et le transport en commun et abrogeant un règlement.

The Speaker (Hon. Donna Skelly): Is it the pleasure of the House that the motion carry? Carried.

First reading agreed to.

The Speaker (Hon. Donna Skelly): Would the member briefly explain the bill?

Hon. Rob Flack: The proposed legislation, the Protect Ontario by Building Faster and Smarter Act, if passed, will support the development of housing and infrastructure delivery across Ontario. The legislation updates rules related to building, planning, transportation and development charges, to reduce delays and improve consistency. These changes will help enable faster construction of housing, critical infrastructure and transit, while supporting and streamlining provincial and municipal planning.

PETITIONS

EDUCATION FUNDING

Mr. Peter Tabuns: Speaker, I present a petition for the funding of Ontario public schools.

It has been made clear by the Minister of Education that he's investigating a number of school boards and is concerned about their finances. The fundamental problem is that education is not properly funded; that, in fact, we've had substantial reduction in funds available per student since this government came to power. People in my riding are asking that, in fact, that funding be restored and that the integrity of those school boards be respected and preserved.

I agree with this petition. I submit it to the table and give it to Isabelle to take over there.

MEDICAL ASSISTANCE IN DYING

Ms. Bobbi Ann Brady: I have a petition here entitled "Petition Regarding Conscience Protection for Medical Professionals."

The petition states that medical assistance in dying, MAID, is increasingly controversial as it expands to more Canadians.

The petition goes on to read that medical professionals in Ontario have conscientious objections to providing MAID, yet the College of Physicians and Surgeons of Ontario forces medical professionals to provide referrals even in cases of conscientious objection.

It reads, "Therefore we, the undersigned, petition the Legislative Assembly of Ontario" to legislate conscience protection for objecting medical professionals.

I fully support this petition, will affix my signature to the bottom and send it to the Clerks' table with page Ivan.

VISITOR PARKING FEES

Mrs. Jennifer (Jennie) Stevens: I am presenting this petition on behalf of Judith Brooks of St. Catharines. She has affixed her name to this petition to ban paid visitors' parking at multi-unit residential apartment buildings throughout Ontario. She, as well as all who have signed this, are saying that parking meters are being installed at multi-unit rental apartment buildings across St. Catharines by corporate landlords. Visitors to these buildings often include personal support workers, who are being charged heavy parking fees.

St. Catharines city council actually passed a motion in November 2023 asking that the province of Ontario ban paid visitors' parking at multi-building units. Residents of the residential multi-unit rental buildings reflect all demographics.

They're asking and petitioning the Legislative Assembly of Ontario to direct the Minister of Housing to issue an order that states that owners of residential multi-unit apartment complex buildings are banned from installing parking meters and charging visitors to park at the buildings when they're spending time with seniors and residents in these buildings.

I fully support this petition. I'll affix my name to it and send it down to the table with Emily.

EDUCATION FUNDING

Ms. Chandra Pasma: I'm pleased to rise to table a petition entitled "Fund Ontario Public Schools."

The government has cut $1,500 per student since they came into power in 2018. This has left our children without the supports and the resources that they need, in much larger class sizes, in schools that are not safe and

healthy. The provincial government could choose at any time to reverse those cuts and make sure that they properly fund schools so that our kids receive the supports that they need. The petitioners are calling on the provincial government to do that, rather than attacking local democracy.

I'm happy to table this petition. I wholeheartedly endorse it, will sign my name to it and send it to the table with page Massimo.

AFFORDABLE HOUSING

MPP Kristyn Wong-Tam: I'm very proud to rise in this House to present this petition calling on the Legislative Assembly of Ontario to do the following: reverse the recent rent control protections that were eliminated for new rental units; end vacancy decontrol—landlords should not be allowed to increase rents whenever they want, especially when a tenant just moves out; end the above-the-guideline rent increases; have the landlords repair and maintain the units—and that they should not be paying extra for that; and strengthen the Residential Tenancies Act to protect the tenants from renovictions, demovictions and illegal evictions.

I'll be proud to sign this petition and send it back to the centre table with page Hayden.

EDUCATION FUNDING

Ms. Peggy Sattler: I have a petition calling on the Ontario government to properly fund public schools in this province. The petition notes that several school boards in Ontario are currently under investigation by the Ministry of Education.

One school board, Thames Valley District School Board, is actually under supervision right now.

A lot of the financial pressures that school boards are facing are a result of the $1,500 cut to education funding that this government has implemented since they were elected in 2018. The issues that school boards are experiencing right now could easily be addressed if the provincial government restored that funding and gave our school boards the revenues that they need to provide supports for kids in our classrooms.

The petition calls on the government to ensure that the coming provincial budget allocates funds to avoid any cuts—further cuts—to education funding, that classroom funding that has been lost since 2018 be restored, and that the government move to bring stability to our public education system.

I fully support this petition. I will affix my signature and send it to the table with page Henry.

HEALTH CARE

Ms. Bobbi Ann Brady: I have a petition here asking the government to prohibit medical and surgical transitioning for minors. The petition explains that children with gender dysphoria require time, rather than medical or surgical transition. Those who have signed the petition are concerned that children as young as eight or nine are receiving puberty blockers and teenagers are receiving irreversible procedures.

1310

The petition reads, "We, the undersigned, petition the Legislative Assembly of Ontario to prohibit regulated health professionals in Ontario from providing puberty blockers, cross-sex hormones, and transitional surgeries for minors under the age of 18."

I support this petition. I will affix my signature to the bottom and send it to the table with page Ivan.

EDUCATION FUNDING

MPP Jamie West: This petition is to help fund Ontario's public schools. This has to do with the people of my riding and of Ontario wanting the provincial government, the Conservative government, to fund public schools properly.

We know that since 2018 there has been a cut of $1,500 per student. Right now, the Minister of Education is talking about doing audits and maybe taking the boards under direct provincial control so you can facilitate cutting services in the school boards.

People who have signed these petitions are concerned that there have been cuts already that have led to children, especially those with special needs and autism, not getting the services they should be required to have and those children being sent home without education.

I fully support this petition. They're asking for the government to fund the schools properly and stop the panic that they're creating with the families and businesses and workers across our province.

I support this petition. I think that we need to fund our schools efficiently if we want our kids to get the jobs of tomorrow and the proper education that they require. I'll affix my signature. I'll provide it to page Aashman for the table.

OPPOSITION DAY

HOSPITAL FUNDING

FINANCEMENT DES HÔPITAUX

Ms. Marit Stiles: I move the following motion:

Whereas hospital infrastructure is vital to protecting the health of the public and in strengthening Ontario in the face of economic uncertainty; and

Whereas the government has identified priority nation-building infrastructure projects, but failed to include any health care infrastructure; and

Whereas there are significant hospital infrastructure projects which have experienced long delays and funding cuts under Liberal and Conservative governments; and

Whereas hospital infrastructure improvements create good union jobs for construction tradespeople; and

Whereas hospital expansions create good union jobs for health care workers;

Therefore, in the opinion of the House, the government must designate critical hospital infrastructure as nation-building projects and fund them in the 2025 budget, including specific commitments to new hospitals for Durham region, Brantford, Kitchener-Waterloo and Brampton; reopening the Minden hospital; expanding the Windsor-Essex regional hospital, Queensway Carleton Hospital, Arnprior regional hospital and Hamilton Health Sciences; redeveloping the Weeneebayko General Hospital and Health Sciences North; renovating the Thessalon Hospital, Matthews Memorial Hospital, Manitoulin Health Centre and Red Lake Margaret Cochenour Memorial Hospital; and restoring 24/7 emergency services and urgent care to Welland Hospital, Douglas Memorial and Port Colborne.

The Speaker (Hon. Donna Skelly): MPP Stiles has moved opposition day motion number 3.

I recognize the leader of His Majesty's official opposition.

Ms. Marit Stiles: Across Ontario, people are doing their part. They're showing up for each other. They're working hard to build a strong future here in our beautiful province. But when they walk into an emergency room, they're told to wait. When they need surgery, they're told they have to leave town. When they ask for help, they're told, "Not yet."

Hospitals are crumbling. Urgent care and emergency rooms are closing. Communities have been waiting for too long.

That's why today we are putting forward a motion to build care and strengthen Ontario. We are making hospital projects across the province nation-building projects:

—new hospitals for Brampton, Durham, Kitchener-Waterloo and Brantford;

—reopening the Minden ER;

—expanding care in Windsor, Hamilton, Niagara, and all across the north;

—renovating hospitals in Red Lake, Manitoulin, Thessalon, and more; and

—restoring 24/7 urgent care in Welland, Port Colborne and Fort Erie.

These are life-saving, job-creating, shovel-ready investments.

Speaker, let's build care and strengthen Ontario.

Interjections.

Ms. Marit Stiles: You know what, sit down.

There's a very tall member across the way who likes to stand in the camera when I'm speaking. I've noticed it a number of times.

I would appreciate it if you didn't do that anymore, okay?

Speaker, last week we learned that Ontario's manufacturing sector is facing the sharpest decline in the country. That's now 33,000 manufacturing jobs that have been lost under this government. In Windsor, unemployment is spiking. In Oshawa, GM is cutting shifts. In Thunder Bay, Alstom workers are facing layoffs again. And the Premier's response? "Wait and see."

Ontario workers don't need a Premier who crosses his fingers and then just waits to see what's coming. They need a plan, they need a path forward, and they need a government that actually shows up. That's what it means to strengthen Ontario. As the official opposition, that's our focus every single day.

A few months ago, the Premier pulled US-made alcohol from LCBO shelves. It was to send a message, and I supported that. But now? Bacardi is back, with no explanation.

If you want to show strength, act like it. The Premier needs to pick a lane, because mixed signals are not sending the right message; they're weakening it.

If this government wants to send a message, here's another one that they could use to get started with—they could get people vaccinated. It's 2025, and we are in the middle of a measles outbreak. Over 1,300 confirmed cases—the worst we have seen in decades. We're now outpacing the United States in a disease that we know how to prevent.

Dr. Robin Lennox, our MPP for Hamilton Centre, has been raising the alarm from day one, calling for clear public communication, a province-wide education campaign about the free MMR vaccine, and a coordinated strategy with public health units.

We have seen how fast misinformation can spread. We need to meet it with urgency, clarity and fast action, because when public health is at risk, there is no time for "wait and see."

So let's work together, and let's protect our communities. That's how we are going to strengthen Ontario.

This government says it wants to invest in nation-building infrastructure. But here's the reality: They're pushing forward with a $100-billion tunnel, while hospitals across Ontario are stuck waiting. You want to build something that strengthens Ontario? Then build hospitals. Build urgent care centres. Build the infrastructure that people are counting on, from Brampton to Ottawa to Windsor to the north. Don't chase vanity projects. Fund the services that actually save the lives of people right here in the province of Ontario.

This motion, although it lists a lot of projects, isn't just about a list of projects; it is a blueprint for a stronger Ontario. These hospitals have been studied. They have been planned. They have been promised. Some are shovel-ready right now. Some are long overdue. All of them are needed right now.

When you build care, you don't just shorten wait times; you give people peace of mind, you create good union jobs, you strengthen local economies. And that is how we build a province that's ready for whatever is coming next.

This motion is a test of our priorities. If you believe that a sick child in Brampton deserves a hospital bed, support this motion. If you believe a laid-off worker deserves a job building care, support this motion. If you believe Ontarians deserve a government that meets the moment, support this motion.

Let's build care. Let's strengthen Ontario. And let's get the job done, together.

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): Further debate?

1320

Ms. Lee Fairclough: I'm pleased to speak this motion today, as hospitals are an essential part of our public health care system.

I've worked in health care for 27 years, at Princess Margaret Hospital, which is part of the University Health Network, and most recently at CAMH.

I also had the privilege of serving as the president of St. Mary's hospital in Kitchener—a job I started in January 2020, just nine weeks before our world changed as we experienced the global pandemic and lockdowns to protect lives and our hospitals from becoming overwhelmed with severely ill and infectious patients. St. Mary's hospital's infrastructure dates back about 100 years, and it showed. Throughout my tenure, I worked with our board of directors and community leaders, including local members here, to advocate for funding to build a new, modern, larger hospital, combining the programs of St. Mary's hospital and Grand River Hospital. It was the last announcement made under my tenure—just before leaving to run for office—and we had made a clear case for change.

There's actually very good data available to inform choice on hospital redevelopments and communities most in need—where there's population growth; where repairs are too costly or the buildings are getting beyond the ability to repair; where there are still tiny, four-bed rooms with shared bathrooms that you can't even fit a walker through the door of. The government's job is to be systematic in picking hospitals based on objective criteria, and I think it's important that the current government should take that very seriously too. I know, for example, that the redevelopment of Grand River Hospital and St. Mary's hospital, as a large joint project, met these criteria, and it was well recognized that it was needed.

Trillium Health Partners, a big redevelopment, was a project started under the previous Liberal government and now continued by this one. It's another example of a community in desperate need of expanded hospital services.

I recall that in one of my previous roles, I visited many hospitals back in 2019 to look at the state of hallway health care. I recall one hospital that was in a community that so desperately needed more capacity, so, appropriately, it was funded and moved forward.

Given the population growth and the long capital project wait-lists, it's important that these hospitals, like the one in Kitchener-Waterloo, move forward and the work gets under way. Whether a nation-building project or not, these investments are needed. I appreciate this bill comes forward to signal it's an opportunity to ensure that these projects progress at pace.

But the reason I ran for public office was not because we had an old hospital; it was because under this government, I saw a loss of transparency and accountability, and our public health system weakened. We lost a view as to how our system was performing and where attention needed to be paid, while I saw our public resources redirected to private benefit that cost our public payers more without accountability on outcomes.

One example of this was Bill 124. Today is the first day of nurses' week. Nurses get into nursing because they care. They want to make it better. This bill, now deemed by the courts as a violation of charter rights, tied the hands of every hospital in Ontario to be able to appropriately reward nurses during that period. To no one's surprise, nurses capped at a 1% wage increase felt disrespected and unvalued. Too many left when we needed them most—and some to private nursing agencies. Like most hospitals, we had no choice but to fill that gap with private agencies that cost significantly more, who were happy to make a profit from public dollars at a time when we were the most in need. It was almost as if it was all by design. The government decided to only provide funding for about 75% of those wage settlements. Meanwhile, our public hospitals are now expected to find a way to fill that gap. Many had no choice but to make cuts in services, including emergency departments, that rarely happened before 2018. These closures come at a time of crisis in primary care. With record numbers of people without primary care, more are forced to turn to emergency departments.

Even on primary care, we're seeing announcements this week—but in 2018, we had over 90% attachment, which means that people had access to primary care. And that has significantly dropped off.

The nation-building project that started six decades ago is public health care, and that is the project I believe most Canadians and most Ontarians support. It is what I heard on the doorsteps thousands of times this past election. Yes, we need hospitals, and we need stable funding to run them. We need our workforce to be valued and respected, and we need the other parts of the system—primary care, home care, long-term care, mental health care, and prevention—to be properly resourced. We need it to be strategic. These are not insurmountable challenges, and they require a government to make deliberate choices to support them.

Our public health care system isn't just a collection of policies and buildings; it's a profound expression of Canadian values. We value fairness, compassion and the dignity of every person. The people of Ontario deserve nothing less than a health care system that honours these fundamental Canadian values, and I urge this government to respect those values.

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): Further debate?

MPP Robin Lennox: I would like to start today by recognizing that this motion is meant to support our publicly funded health care system, the thing that, in Ontario, we should all be wanting to reinforce and to strengthen, because it serves all Ontarians.

Just the weekend before last, I was doing a shift in hospital covering for a colleague, and as I walked by the emergency department to see my patient, I walked by a hallway in the emergency department that was stretcher

and stretcher and stretcher and stretcher—so many that we now know exactly how those stretchers are labelled in the hallway so that we can find our patients. We also now have terminology for our patients—"SR" for "sunroom," because we always have patients sitting in our sunrooms to be seen, trying to sleep even though the windows are blaring.

We also now know what it is to often see patients with cognitive impairment having to sit permanently by the nursing station because there's no quiet room for them to be in to get the attention they need. So they're sitting in the nursing station among all of us doing our charting because that is the only place for them to be. This has become normal, but it shouldn't be. It is extremely abnormal, and it is different than how it was when I was practising seven years ago.

We know that in Ontario, our health care system has been intentionally strained and intentionally underfunded; that despite hearing that ending hallway health care is a priority, there has been no meaningful change under this Conservative government; and that, despite health care being our largest budget item, we in Ontario still spend the least per capita on health care of any other province. In addition to that, we know that we have less than half the hospital beds that we had 30 years ago, but that doesn't mean that less people are ending up in hospital.

I commend the effort of our caucus to try to promote the need for increased hospital investment, increased hospital infrastructure and reopening services that have been closed, because we know that people turn to hospitals in their time of greatest need. The worst thing that can happen to someone is to show up at a hospital door, see a "closed" sign and be told to keep driving to try to find help somewhere down the road, and that has become our new normal.

I look forward to hearing more about this motion.

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): Further debate?

MPP Tyler Watt: Let me begin by saying this: I wholeheartedly agree with the spirit of this motion. Ontario must treat hospital infrastructure as a priority. Our province is growing, our population is aging, and the wear and tear on our health care facilities is undeniable.

As a front-line nurse at the Queensway Carleton Hospital in Nepean, I see every single day the human cost of our crumbling hospital infrastructure.

We are past the point of asking whether hospital infrastructure is vital. That's a settled question. Hospitals are where life begins and, too often, where it ends. They are where Ontarians go in moments of crisis and vulnerability, trusting that help will be there. But increasingly, we are pushing our hospitals to their limits and the people who work inside them to a breaking point.

We've seen this government roll out a list of their priority projects, like a fantasy tunnel in Toronto or a luxury spa at Ontario Place. I'm not fully understanding why this is the focus for this government while our hospitals are overcrowded, our ERs are literally shutting down, and our aging facilities aren't able to keep up with increased demand.

1330

At Queensway Carleton Hospital, which serves one of the fastest-growing populations in the city of Ottawa, we are well beyond capacity on a daily basis. Our emergency department was built to handle about 60,000 patient visits a year; last year, we saw nearly twice that number. Patients are being treated in hallways. Stretchers are lined up in waiting rooms. And we, the nurses, doctors and staff, are expected to make it all work in the same space, with the same aging infrastructure and fewer resources. Let me be clear: I am proud of what we do for our patients at the Queensway Carleton Hospital. Our resilience speaks volumes. But it shouldn't be that way.

The current conditions of hospitals throughout Ontario are unsustainable. And they're, frankly, unsafe. Hospitals across this province are literally falling apart, and yet this government doesn't seem to care.

Last week, I asked the health minister if she would commit to investing in and funding the much-needed expansion of the Queensway Carleton Hospital emergency room—a simple yes or no question, which she refused to answer. What message does that send? It tells Ontarians that our health doesn't matter, that access to emergency care doesn't matter, that the dignity of patients and the well-being of front-line workers doesn't matter. But we know that this isn't true, because hospital infrastructure does matter, not only to health care delivery but to our economy. Investing in hospital expansions creates good, family-sustaining union jobs for construction workers, for tradespeople and for the next generation of skilled health care professionals. Every crane in the air is a signal of hope. Every new bed opened is a promise fulfilled.

We have shovel-ready projects ready to go. We have aging facilities desperate for renewal. We have communities in crisis. What we don't have is the political will.

This motion calls for long-overdue action in places like Durham region, Brantford, Kitchener-Waterloo, and Brampton. It calls for expanding the Windsor-Essex regional hospital and Queensway Carleton Hospital, my hospital, where every additional square foot means better care, faster treatment and safer working conditions for staff.

As I said, I'm supportive of this motion, and I'm thrilled to see the Queensway Carleton in the list. I do wonder, though, why certain hospitals were left out. For example, where is the Kingston General Hospital listed—a hospital that serves not just Kingston, but the entire southeastern Ontario region. Its aging infrastructure requires modernization to meet today's demands, and yet it wasn't mentioned—so I'm just curious why. It's not enough just to name some hospitals in some regions.

If we're serious about building a strong health care system, we need a framework that prioritizes need, capacity and regional equity. This isn't just a to-do list; it's a moral obligation, one that we owe to every patient who waits too long for care, to every family who drives hours

for a hospital bed, and to every nurse or doctor who burns out trying to do more with less.

Let me tell you what not investing looks like. It looks like nurses leaving the profession. It looks like hallway medicine becoming the norm. It looks like delayed surgeries, cancelled appointments, and patients dying from preventable deaths.

As a nurse, I can tell you this: No amount of training can make up for a system that's physically broken.

I urge every member in this House, regardless of party affiliation, to seriously consider this motion. It is a question of what kind of province we want to live in—one where your postal code determines your access to care, or one where every Ontarian, north or south, urban or rural, can count on a strong, modern, well-staffed hospital when they need it.

We can't fix hallway medicine without fixing the physical capacity issues. We can't recruit and retain health care workers without giving them the facilities they need to do their jobs safely. And we can't call ourselves a strong, prosperous, nation-building province while our hospitals fall into despair. So let's stop pretending that the only infrastructure that matters is roads and bridges. It means hospitals and hospital beds. It means MRI machines. It means emergency departments that stay open.

It's time we invest in hospital infrastructure and show the people of Ontario that their public health care system is not negotiable.

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): Further debate?

Mr. Tyler Allsopp: Before I begin today, I just want to say to my colleagues on the other side of the House, if any of you for any reason need to stand up, stretch your legs, visit a neighbour, feel free.

It is an honour to speak about a topic that is crucial to the well-being of our communities and the future of our province: hospital infrastructure. As we navigate the complexities of modern health care, it is imperative that we invest in and enhance our hospital infrastructure to meet the growing needs of our population.

Under the leadership of Premier Ford and Minister Jones, our government is making capital investments across the province so we can sustainably support the health care needs of Ontario—just like in my home riding of Bay of Quinte, with our new Prince Edward County Memorial Hospital state-of-the-art, $200-million mass timber build. We cannot wait for that hospital to be completed.

Interjection.

Mr. Tyler Allsopp: Thank you very much.

These investments mean more hospital beds in communities, more diagnostic testing like MRIs and CTs closer to home, and more skilled health care workers to provide care.

Our government is building a convenient and connected health care system that puts people first. That is why Ontario is delivering on the most ambitious plan for hospital expansion in the province's history. Ontario's plan will lead to investments of nearly $50 billion over the next 10 years in health infrastructure, including close to $36 billion in capital grants. This includes supporting more than 50 hospital projects that would add approximately 3,000 new beds over 10 years to improve access to reliable, high-quality care.

For example, Durham region is experiencing significant population growth, with a rising level of alternative-level-of-care, or ALC, rate. Addressing these pressures is essential to ensure that residents receive timely and effective health care services.

Among our approved projects is the hospital redevelopment project at Lakeridge Health's Bowmanville site. Planning and design work is currently under way for the Bowmanville redevelopment, and in summer 2024, Infrastructure Ontario initiated the process to select a team that will be delivering this project. The Ministry of Health continues to work closely with Lakeridge Health and other partners, such as Ontario Health, to determine how the hospital's short-term and long-term program and service needs can be met in alignment with capital planning needs. To date, our government has provided more than $12 million in capital planning grants to support Lakeridge Health's master planning, including the Bowmanville redevelopment project.

It is important to note that planning for major capital projects like Lakeridge Health's proposed new hospital is a complex process to address the health service needs within that community.

Our government is supportive of Lakeridge Health's plan for the future, involving a multi-phase redevelopment that will ensure families across the Durham region can access the care they need when they need it. The plan includes redevelopment of hospital campuses across the region, as well as a new hospital site in Whitby that will expand services and add more beds to connect more patients and their families to convenient care closer to home. Ontario will continue to work with Lakeridge Health as it moves forward with its plan and continues planning for the site of its proposed new Whitby hospital. To support the early planning work for its master plan, a total of $2.25 million was approved as a planning grant by the ministry.

Lakeridge Health is planning expansion of its services and hospital campuses to add new hospital beds and enhance services throughout the region, including:

—redeveloping the Bowmanville Hospital by adding up to 32 new beds and building new facilities to expand in-patient and ambulatory care services and the emergency department;

—planning for a new post-acute-care centre in Pickering; and

—creating space for acute-care capacity at the Oshawa site by relocating some services to a new post-acute-care centre in Pickering.

Later phases of the redevelopment plan under consideration include expanding the Ajax Pickering Hospital to connect more people to clinical and support services.

Earlier this month, our government broke ground on an expanded emergency department in Renfrew county. The

largest redevelopment in St. Francis Memorial Hospital's history, in Barry's Bay, will connect more people to quality emergency care close to home. Once opened, the new, state-of-the-art emergency department will accommodate an estimated 11,900 visits each year and will include a dedicated isolation room equipped with negative air pressure to keep patients safe by preventing the spread of airborne infectious diseases; a new entrance for ambulances to use, improving patient flow; quiet room space for mental health patients and families; an upgraded trauma area to ensure timely responses to emergencies; and improved infection prevention and control measures, because our government understands that when someone experiences a medical emergency, it is vital that they get the urgent attention they need quickly.

1340

That is why we're investing an additional $44 million this year in 165 high-volume and smaller emergency departments to reduce wait times and provide people with faster and easier access to timely care close to home. This funding is in addition to the $90 million that our government invests each year to reward emergency departments that put in place innovative solutions to reduce emergency department wait times, including hiring additional health care staff, accessing more transportation to help transfer medically stable patients out of emergency departments, and creating new beds.

We know that emergency departments have faced capacity pressures. That is why our government has offered a range of initiatives to support rural and northern hospitals. The Northern Ontario Resident Streamlined Training and Reimbursement program, or NORSTAR, enables medical students to provide immediate and longer-term physician support to northern Ontario communities.

The Ontario Health emergency department staffing stabilization strategy is a joint Ministry of Health and Ontario Health nursing action plan to stabilize emergency department nursing coverage by investing $4.7 million to bolster and stabilize the emergency department nursing workforce through emergency department training initiatives and the establishment of clinical leadership and support by hiring regional emergency department educators for on-site nursing education in hospitals.

The community commitment for nurses program offers nurses a $25,000 incentive in return for a two-year commitment in areas that need nurses most.

The Supervised Practice Experience Partnership offers internationally educated nurses the opportunity to meet their evidence of practice and language proficiency requirements to achieve their nursing licence.

The Enhanced Extern Program also offers employment opportunities in hospitals to clinical learners such as nursing and medical students to work in an unregulated capacity as externs.

The Nursing Graduate Guarantee funds employers to provide new nurses, including those who studied out-of-province and abroad, with temporary full-time employment above employers' staffing complement. Over $76 million has been funded to nearly 60 health care organizations and has employed up to 2,200 new nurses in 2023-24.

The Temporary Fee Reimbursement Program reduces financial barriers to registration for internationally trained and retired nurses by covering application, examination and registration fees.

The Emergency Department Peer-to-Peer Program supports emergency department physicians through access to immediate, on-demand coaching, mentoring and support from a credentialed peer emergency department physician via virtual channels. The program initially launched as a pilot in October 2022 across six emergency department sites and completed its pilot phase in December 2022. Following this, the program was expanded to 27 emergency department sites and then to every emergency department in the province by June 2023.

The emergency department Pay-for-Results Program supports emergency departments that provide emergency care to fewer than 30,000 patients a year so they can hire and retain the staff they need to keep their emergency departments open.

And the Clinical Scholar Program was launched in June 2023 and supports both recruitment and retention by creating mentorship opportunities. Through this program, experienced front-line nurses provide at-the-bedside mentorship and support to new graduate, internationally educated or upskilling nurses to confidently transition into new health care working environments and nursing practice. This includes emergency department settings.

In Orangeville, we are building new emergency and diagnostic imaging departments that will increase patient capacity and ensure the hospital is better equipped to deliver state-of-the-art care for patients and families, now and in the future. Kim Delahunt, the president and CEO of Headwaters Health Care Centre, said, "We are deeply grateful for the investment being made to renovate and expand our emergency and diagnostic imaging departments. This will transform patient care and experience at Headwaters and support the teams that work in these departments. It will enable us to continue to provide excellent care, close to home, for the rapidly growing population and patient volumes that we see in Dufferin-Caledon."

And we recently broke ground on a new emergency mental health and addictions services unit in Guelph, Ontario. Once opened, Guelph General Hospital's new mental health and addiction services unit will include:

—expanding capacity in the short-stay assessment unit from four to eight beds, to monitor and treat more adult patients experiencing psychiatric emergencies;

—a new emergency follow-up service that will increase individual and group counselling services by 14%, to help more than 2,200 patients stabilize before being discharged and reduce readmissions;

—a new walk-in patient intake zone;

—additional ambulance capacity, from two to three, by building a new three-bay ambulance garage with a dedicated off-load area, reducing off-load wait times in the emergency department; and

—a brand new reception area in the emergency department, including a new waiting room and triage area.

Earlier this year, we celebrated the completion of a historic Cambridge Memorial Hospital expansion. The hospital's largest redevelopment project will connect more people to an expanded emergency department, surgical suites, and an intensive care unit. Our government invested over $220 million to support the project, which renovated and redeveloped over 400,000 square feet of hospital space to build a new in-patient care tower. This new, state-of-the-art facility will increase the hospital's ability to care for more people by over 30% and improve care for patients undergoing life-saving surgery or requiring emergency care.

By expanding access to hospital care in Hamilton, Juravinski Hospital will become the largest in-patient facility in south-central Ontario, with more than 500 in-patient beds, and will help the region meet the needs of its growing population, making it faster and easier for people to connect to a range of specialized adult care and services.

Tracey MacArthur, president and CEO of Hamilton Health Sciences, said, "The Juravinski Hospital will bring the hospital's nearly 100-year-old spaces into the 21st century. Our patients and teams expect and deserve nothing less than access to modern, accessible health care facilities to support world-class care. We are grateful for the provincial government's ongoing partnership and investment in this vital community health project."

In November, our government announced that we are making it faster and easier for people living in Burlington, Ontario to connect to high-quality, comprehensive mental health and addiction support services closer to home by building a new health unit at Joseph Brant Hospital. Our government's investment will build and create a larger state-of-the-art space for in-patient and outpatient services, to ensure the hospital is better equipped to deliver timely and high-quality mental health and addictions care for more patients and their families in a safe and comfortable setting.

In Kawartha Lakes, we are building an expanded emergency department at Ross Memorial Hospital that will include the creation of a new, state-of-the-art mental health emergency services unit. This expansion will improve patient safety and ensure the hospital is better equipped to provide timely care for mental health patients. This expansion will also include a new trauma room with improved infection-control measures to provide emergency department staff with additional space to treat patients requiring life-saving care.

At St. Joseph's Healthcare Hamilton, our government is connecting more newborns and their families to better, more convenient, specialized neonatal intensive care and birthing support through the redevelopment of the special care nursery. Through this redevelopment, the current special care nursery will be renovated to create a larger and more comfortable space to ensure that newborns and their families have better access to specialized neonatal intensive care and family-centred birthing supports, including:

—enhanced infection prevention and control measures, to ensure the health and safety of critically ill newborns;

—more private rooms, to address privacy concerns and create lower-stimulus environments for newborn patients;

—capacity to accommodate state-of-the-art design standards which provide more space for specialized care;

—a designated room to store pumped or donated milk; and

—other supports tailored to the early developmental needs of infants, including respiratory treatments, lactation and nutrition supports.

Those projects are just some of the many examples of the bold action that our government is taking to invest in our hospital infrastructure, supporting world-class health care facilities for patients, families, health care professionals and communities.

In conclusion, investing in hospital infrastructure is essential for the health and the well-being of our communities. It ensures that patients receive the best possible care in a safe and modern environment. Our government's dedication to investing nearly $50 billion over the next 10 years in health infrastructure is a significant step in the right direction. However, it is up to all of us to support these efforts and work together to build a healthier future for Ontario.

Thank you for your attention. I look forward to working with all of you to achieve our shared goal of a world-class health care system.

1350

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): I'd like to recognize the member for Niagara Falls.

MPP Wayne Gates: I obviously support the motion, but I want to talk about Fort Erie and talk about Douglas Memorial Hospital. It used to be a 24/7 urgent care centre, but this Premier and Niagara Health decided to cut the hours down to 10 hours a day. It made absolutely no sense then, and it makes no sense today. Speaker, 38,000 people live in Fort Erie. They rely on that urgent care centre. Think about this: 12,000 of those residents don't have a family doctor. Where are they going to go? They can't go to the family doctor. And now they're cutting the hours in urgent care centres so there's no overnight—so they have to go to the emergency room either in St. Catharines or in Niagara Falls. Our emergency rooms today have 12- to 19-hour wait times just to get in. It makes no sense.

The Auditor General's report was very clear, and these guys over here should listen. It said that if you want to improve wait times in your emergency rooms, invest in urgent care centres—not cut them and close them. It makes no sense to me.

Then I take a look at Fort Erie—I kind of break it down into families. You know that 60% of the people who live in Fort Erie are over 55 years old. A lot of them don't drive. There's no reliable transit.

It makes no sense, what this government is doing. So when they talk about investing in health care—that's not happening in Niagara.

I want to talk about what happens at an urgent care centre. I'll give two examples. There's a gentleman who

had a heart attack—he wouldn't have made it to Niagara Falls; he wouldn't have made it to St. Catharines. He made it to the urgent care centre, and those doctors and those nurses saved his life. And they came and thanked that hospital for doing that. But he would have been dead.

There's a young kid, 11 years old, who had an appendix attack. And guess what happened? He wouldn't have made it to Niagara Falls. He wouldn't have made it to St. Catharines. But he made it to that urgent care centre, and it saved his life.

That's the difference, when you have an urgent care centre 24/7. It saves lives. Why do I have to, every single day, worry that if I'm not going to get into an urgent care centre because it's closed, I may die? Nobody should die in the province of Ontario—one of the richest provinces in this country, quite frankly—because they're not getting health care when they need it, where they need it and why they need it. It makes no sense.

I'm going to finish by saying this: We heard today during question period, very clearly, that they spend $1 billion on agency nurses, and they tried to defend that. They said, "Oh, that's good. These are good nurses." We're not talking about the nurses. We're talking about the $500,000 to $600,000 of that money that went to a corporation or private company that's run by the Harris family. That's what we're talking about. And then we heard about Shoppers Drug Mart—$62 million. So I say to them: Take that $1 billion, take that $62 million, and put it into urgent care centres, put it into the community of Fort Erie. That's what should be happening in health care today.

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): I recognize the member for Ottawa South.

Mr. John Fraser: I just want to preface this by saying that I'm going to support this motion, but I want to express some concerns about the motion—because I do understand that the Prime Minister has indicated that it could be a priority. To be honest, right now, I'm not sure that we have a problem with building hospitals in Ontario as much as we have as to what's happening in hospitals here in Ontario. I don't want to complain, but I would have rather seen that in the motion.

The second thing is, we're kind of picking winners and losers here.

Bruyère Continuing Care, which is in Ottawa–Vanier and in Ottawa Centre, is not included in it. It has one building that's over 100 years old and another building that's approaching it. They have a project. They've been skipped. They've been missed for years and years and years.

So while I support what's behind the motion, I'm concerned, number one, that we've picked winners and losers and we've excluded institutions—in Kingston as well. I think it's a valid concern. And the second thing is, the problem that we have right now is not building hospitals. These guys—it's easy; they like to build. That's what they do. They just can't get what happens inside right, and that's bad for people.

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): Further debate?

MPP Alexa Gilmour: In 2023, just a few months before she died, I memorized my grandmother's hands—102-year-old hands. So fragile, so petite, bony and curled in—the way all of our hands might go if we are lucky enough to live to be 102. I had hours and hours to study them after the ambulance delivered her to the hospital. St. Joe's emergency was full. We had to go to a new hospital, and we were placed—you won't be surprised—in a hallway to wait. As she tried to get comfortable on a gurney, the sympathetic looks from the health care workers as they went by gave us some comfort, as they moved away from her to serve or save some other life. These elderly hands, I thought—these hands that served as a bomb girl in World War II; these hands that helped to build a shelter for unwed mothers in Orillia decades and decades ago; these hands that nurtured four children and nine grandchildren and seven great-grandchildren—deserved more dignity, more compassion and more care than a public hallway in a hospital could give.

As we contemplate nation-building projects and what is primary to Canada, I can tell you that it is not tunnels under the highway. Think Tommy Douglas and health care—building up our public health care system, providing good union jobs to construction workers and to health care providers that will lead to caring for our loved ones when they are most in need.

From the premature babies to our elders, this government is failing our families. That is why it's time to include hospital infrastructure in the nation-building projects of this government.

So, in remembrance of my nana and for the people of Parkdale–High Park and St. Joseph's Health Centre, I'm going to vote in favour of this motion. I'm going to invite and urge my colleagues across the aisle to think of whom they would like to dedicate their votes to.

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): Further debate?

Mr. Chris Glover: It's a real pleasure to be able to stand up and speak in favour of this NDP motion to reopen the Minden emergency room; to restore emergency room services in Welland, Port Colborne and Chesley; to rebuild and build new hospitals and renovate the hospitals that we have across this province; and to do this as part of a nation-building exercise that we need to undertake because we are under economic threat from the United States.

One of our biggest competitive advantages in Canada is our public health care system. In the United States, they spend $12,000 per person on health care; we spend half of that, yet we live longer lives and our babies are born healthier. Our public health care system is the thing that defines us as Canadians.

When businesses are deciding whether they're going to locate in Canada or the United States, one of the things they look at is the employer premiums, health care premiums—much, much more affordable here in Canada.

This government is playing games with numbers. They continue to say, "Oh, we're investing a million dollars

here, a million dollars there." But the fact is that they announced in the budget $7 billion in health care that they did not actually invest in our health care services last year. We have the lowest per capita spending on health care of any province in the country. We would have to invest another $12 billion just to reach the provincial average.

And what happens is that people are not getting the services they need because this government is under an ideological campaign to privatize and Americanize our public health care system. They are wasting our money. Today, the CCPA put out a report that they are spending $9.2 billion on private, for-profit nursing agencies. There are private, for-profit corporations performing surgeries at three times the rate in our public hospitals.

So I'm asking the government to change course—to look at public health care as a competitive advantage, as a way to build our nation; to stop using our health care system as a cash cow for private corporations; to stop treating our Ontario patients as sacrificial lambs for corporate profits—and instead to rebuild public health care and our competitive advantage in this province.

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The Deputy Speaker (Ms. Effie J. Triantafilopoulos): Further debate?

Mr. Rob Cerjanec: I appreciate the opposition day motion today from the NDP, as it talks about hospitals and health care as nation-building exercises. I agree. They absolutely can be nation-building exercises. Just because someone lives in Ontario, sometimes they may need to go somewhere else to get care in the country, or vice versa. We know that between different provinces, that does happen from time to time—so, 110%, I do think it can be nation-building.

I appreciate that the NDP has identified health care issues, but in areas that are primarily where we tend to see NDP representatives, instead of other places in the province as well—when I look at York region, for example, or as the member from Ottawa South said, other areas of the province. While it's a good motion, a good start, I think it's important that we're also looking at the entire province.

We've seen, over the last seven years—and this is a Conservative government that ran on ending hallway health care; in fact, it has doubled, and that is a really, really big challenge for people in my riding. It's something that I'm hearing about from constituents in my riding—not only on the campaign trail, but afterwards as well.

The emergency room department at Ajax Pickering Hospital is struggling under the pressure that our health care system is facing, not just in Ajax and Durham region, but, really, all across Ontario. Right now, it's seeing about 15,000 additional visits per year more than it was designed to handle. When that hospital was originally built, it was built to handle about 20,000 visits a year. In 2009, under a previous Liberal government—I know members on the other side sometimes talk about, "Oh, Liberals didn't do this or that." Under a previous Liberal government, it was renovated to handle about 60,000 folks. And right now, the hospital in my riding of Ajax is seeing 75,000 visits per year. I hear stories of my constituents waiting more than 12 hours to be seen, or even longer—folks who are coming in with chest pains, folks who are coming in with other medical problems and issues that they're facing. That's something that I hear quite frequently in my community when I'm out and about.

Our health care workers are doing their best. In my view, they are doing their best under what is a really, really challenging situation.

My constituents are worried about what's going to happen to them if they need emergency care.

Ironically, on the day of the federal election, I was in my constituency office—a woman came in to see me because she was dealing with a situation that involved her mother, who's 94 years old. Her mother had been waiting in the emergency room department for over three days, set aside over in a hallway, but kind of at the end of the hallway, where, she described to me, many other elderly patients are just kind of parked until a room is available, until something opens up. She came into my constituency office, understandably upset, understandably concerned about the well-being and the health of her mother. She went on to tell me, "We've been taking shifts, sitting by her, helping her in the hospital, helping her with feeding"—helping her in this situation that her mother is dealing with.

But not every person who's in the hospital has a family support system, who can be there in shifts, helping feed their parent, their loved one, the person who raised them. That's something that I hear quite frequently.

It just so happened, on that day I was in the constituency office, and she came in and needed somebody to talk to. So we've been helping her and working with her. But I had to be honest. The current situation, frankly, is not good enough. It's not good enough for my constituent who came in to see me, or her mother, 94 years old, out in the hallway.

I followed up with my constituent, and I asked her what has happened since. After a lot of pushing, after three days and six hours—what they did in the hospital is, they had to open up a different, extra little room that wasn't really equipped as a room where you would have patients, typically. They transferred her into there—in a gym, essentially, with four beds. There are no call buttons. I was told, a little bell—"Oh, you need help?" A little bell, like you would see in probably 1900—but this is today.

This is 2025, and this is the state of our health care system in Ontario, because more funding is needed in our health care system.

I heard the member opposite speak about Durham region. That's an actual story from Durham region. That's taking place right now.

I'll say this: We have not seen specific commitments on improving the Ajax Pickering Hospital emergency department capacity.

More recently, we saw how this government ended up fighting with the mayor of Whitby—ended up fighting with folks in Whitby who were advocating and standing up to get a new hospital there. It was only after public

pressure, it was only after community pressure of more than 4,000 people signing petitions, advocating—that pushed this government to say, "Oh, a little bit more." But what we've seen time and time again—it's a day late and a dollar short.

So my belief is that this government should be doing a lot more right now. I think the opposition day motion helps move it in that direction, but, in my view, quite frankly, not far enough. So we need to see action taking place.

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): Further debate?

M^me^ France Gélinas: I'd like to talk a little bit about Health Sciences North, which is the name of the hospital in Sudbury. It's a hospital that we call the heartbeat of regional health care. It serves more than 569,000 people over 300,000 square kilometres. It is a lifeline for 23 small health care facilities in our region that all refer to Health Sciences North for secondary and tertiary care. They have a lot of learners—2,900 learners every year. They were named the best cancer treatment centre out of the 14 cancer treatment centres in Ontario.

Interjection.

M^me^ France Gélinas: Yes, for sure, for sure.

Many in northern and rural Ontario have unique health care challenges. People in northern Ontario have poorer health outcomes. The rate of addiction and related death is way higher than anywhere else in our province. We have a lot of underserved children and youth population.

Did you know, Speaker, that on an average day, the hospital will have 130 patients in what they call "unconventional bed space"? When you go to Health Sciences North, there isn't a corner that hasn't got a bed and somebody admitted into it. Think about it: You are sick enough to be admitted in a hospital, and 130 of those people sick enough to be in the hospital will be in a hallway, in a TV hall. Some of them are even downstairs, very close to the morgue. It just grosses me out.

The hospital needs expansion. We had four hospitals in Sudbury. You remember Mike Harris—the health restructuring? We went down to one. It was too small. They have been waiting for money for expansions for decades.

Apparently, it takes 15 years to build a mine. It takes over 20 years to build an addition to an existing hospital.

Health Sciences North cannot wait any longer. Let's make sure that we get the number of beds that are needed to care for the people of the north. That means funding Health Sciences North.

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): Further debate? I recognize the member from Beaches–East York.

Ms. Mary-Margaret McMahon: Beautiful Beaches–East York, yes. I'm happy to be here to represent my glorious riding.

Good afternoon, everyone, and thank you to my colleagues for bringing forth this opposition day motion.

Today, I'll be taking my time to showcase magnificent Michael Garron Hospital in beautiful Beaches–East York.

For over 90 years, Michael Garron Hospital has delivered quality and crucial care to more than 400,000 people from over 20 distinct neighbourhoods. From a hard-working and determined emergency department; to specialized cardiology and neurology services; to youth mental health treatment; to innovative research projects focused on improving health care and access for community members; to its exemplary response to COVID-19, which ended up being a role model for community outreach city-wide, and, actually, right across the province, Michael Garron Hospital is a staple institution in our tapestry of communities.

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Michael Garron Hospital is responsible for one of the fastest-growing emergency departments in the greater Toronto region, constituting the second-highest growth rate among hospitals in the region. Despite being designed to see only 60,000 people per year, its emergency department volume has exceeded 100,000 patients annually. Consequently, Michael Garron's emergency department operates in surge capacity for nearly three quarters of the year—can you imagine—ensuring almost double the amount of planned patients are provided with excellent care for nearly nine months. Think about the nurses and health care workers who are already underpaid, overworked and neglected having to work in unsafe conditions every day because they are answering their community's calls for help. And this figure is slated to only get worse, with major residential densification projects estimating a more-than-135,000 influx of residents to east Toronto over the course of the next five years.

This government has not listened to the calls for investing in Michael Garron Hospital—the calls from constituents, community organizations and politicians alike, including yours truly. I have asked about this support in both verbal and written questions in this chamber and have only received weak—weaker than weak—responses from the Minister of Health.

The first phase of Michael Garron's redevelopment, the new Thomson Centre, opened in 2023. It is glorious, but in-patient capacity did not increase.

Michael Garron Hospital requires approval of phase 2 of its hospital campus redevelopment. This project encompasses the replacement of critical acute-care services, including operating rooms, adult and newborn critical care units, birthing units, cardiac in-patient units, and the emergency department. They are once again being innovative by operating the hospital while growing and redeveloping its footprint all on its current location, but they are in desperate need of sign-off by this government, as phase 2 will take years and years to build, and we have no time to wait.

I'm happy to support this opposition day motion. I'd love for Michael Garron to be added to the list.

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): Further debate?

Mr. Jeff Burch: In my riding, the Welland Hospital is in urgent need of modernization, and a rebuild is part of the current hospital plan, but to even begin this process, Niagara Health requires a planning grant. Despite repeated requests for this pre-capital grant, final approval has not

been given, and this has created anxiety in our community about the future of the Welland Hospital—a hospital my predecessor Cindy Forster had to fight to keep open at all under a previous Liberal government. This motion is an opportunity to get this project moving forward. From 2020 to 2024, Welland's population grew from 57,000 to 64,000, and the hospital's full catchment area is growing just as quickly as the population ages.

Given the growth and Niagara's aging population—one of the highest concentrations of seniors in the entire country—it's imperative that we rebuild a full-service hospital in Welland and prevent the closure of the urgent care centre in Port Colborne.

Residents in south Niagara deserve equitable access to health care and hospital care, including emergency services. Using the name "South Niagara" to describe a hospital in Niagara Falls does nothing for the people of south Niagara who want health care services close to home.

Speaker, we all know that investing in hospital infrastructure at this uncertain time will mean good-paying jobs in the skilled trades for carpenters, electricians and many others, as well as economic spinoff effects for communities like Niagara all across Ontario.

We need a new, modern, full-service hospital in the city of Welland.

I urge the government to get on board with this important motion so that my constituents can have confidence in the future of health care in Niagara and across Ontario.

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): I recognize the member from Kingston and the Islands.

Mr. Ted Hsu: Hospital infrastructure is vital infrastructure.

I'm disappointed that there's a long list of hospitals in this opposition day motion from the NDP but that Kingston is not mentioned in the motion.

Kingston General Hospital—the main building—is 190 years old. The Kingston Health Sciences Centre has been planning what they call the "phase 2 redevelopment" since 2015. The first plan, which involved building a new tower, was stopped by Infrastructure Ontario in December 2023. They're working on a different plan now for vital renovations and modernizations.

Kingston Health Sciences Centre is a tertiary care academic health sciences centre. It's critical hospital infrastructure for southeastern Ontario. So I'm disappointed that it's not part of this long list on the NDP opposition day motion.

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): Further debate?

Mr. Sol Mamakwa: Meegwetch, Speaker. When we talk about hospital infrastructure, I think one of the things that we need to understand and talk about is the social determinants of health.

In Kiiwetinoong, the current approach to hospital infrastructure perpetuates a sickness system in the north. It only reacts to the health of the people living in the north when we are sick, instead of preventing health care crises in the first place. I know that in Kiiwetinoong, First Nations communities are directly impacted by the social determinants of health, including Indigenous determinants of health—to name a few, it would be colonialism, racism, poor housing conditions, experiencing disability, gender-based violence, and the lack of clean drinking water. There are so many examples that we can share, in the north—Sioux Lookout Meno Ya Win Health Centre long-term-care facility, Wiigwas elder centre in Kenora. Those are some of the issues that we face.

Again, if the government wants to move from a sickness system to a health care system for all of Ontario, they must start investing in health care infrastructure with the social determinants of health in mind. Meegwetch.

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): Further debate?

M. Stephen Blais: Cette motion semble énumérer tous les hôpitaux que le NPD veut améliorer et/ou agrandir. Il est certain que l'infrastructure hospitalière est importante pour bâtir une nation, pour bâtir un Canada plus fort.

Malheureusement, mais peut-être pas très choquant, le NPD, comme le gouvernement, ignore les besoins de l'est de l'Ontario et ceux de la communauté franco-ontarienne. Nos communautés franco-ontariennes ont également besoin des infrastructures médicales. Comme plusieurs communautés en Ontario, elles sont mal desservies, avec de longs délais d'attente dans les salles d'urgence.

Comment le NPD peut-il parler d'infrastructure ou de construction nationale tout en excluant les soins de santé et l'infrastructure pour nos communautés franco-ontariennes? Comment? Aucune mention de la communauté franco-ontarienne dans votre motion.

Renouveler la fierté des Canadiens et la valeur de notre système de santé universel d'un océan à l'autre contribuerait grandement à bâtir un Canada plus fort, mais cela ne peut pas être réalisé si le NPD ou même le gouvernement oublient nos communautés franco-ontariennes. Reconnaître la valeur et l'importance de nos communautés franco-ontariennes est essentiel pour bâtir la fierté nationale et un Canada plus fort.

Madam Speaker, how can the NDP expect to build nation-building health care from one part of Ontario to the next—from one part of Canada to the next—if they ignore Franco-Ontario communities in eastern Ontario. These communities are under-serviced by health care services at the moment. They see enormous delays in emergency rooms. It seems to me that the NDP have gone out of their way to ignore mentioning Franco-Ontarian communities in eastern Ontario.

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The Deputy Speaker (Ms. Effie J. Triantafilopoulos): The member for Ottawa West–Nepean.

Ms. Chandra Pasma: The Queensway Carleton Hospital is a jewel of Ottawa West–Nepean, and I know the residents are incredibly proud of the high-quality health care that we receive, the excellent doctors, nurses and health care workers that work there every day, but the hospital is just not the right size for the population that it serves. I regularly hear heart-wrenching stories about the kinds of waits that people endure, particularly in the

emergency department. I spoke with one person whose mother had a pulmonary embolism, and they waited 13 hours in the Queensway Carleton. A pulmonary embolism is not only very dangerous, it's very painful. Imagine sitting there in that kind of pain, knowing that you are waiting because there are other people who have more urgent problems than a pulmonary embolism. It's incredible that this is happening, Speaker. I also spoke to someone who thought they were having a heart attack—10 hours before they were seen by a doctor. This shouldn't be happening in Ontario.

The Queensway Carleton has a plan to double the size of the hospital, double the size of the emergency room. They're ready to put shovels in the ground now if the government would just commit the funding.

The people in Ottawa do not need a $100-billion fantasy tunnel under the city of Toronto; they need timely access to health care in their own community.

I urge government members to vote for this motion to support the rights of people in Ottawa to access timely health care, and I especially encourage the members from Carleton and Renfrew–Nipissing–Pembroke, whose constituents use this hospital all the time, to support this motion.

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): I recognize the member from Mushkegowuk–James Bay.

M. Guy Bourgouin: C'est drôle quand j'entendais le député d'Ottawa qui essayait de nous faire la morale sur les services en français quand ils ont été plus de 15 ans au pouvoir, et ça fait combien d'années, là, qu'ils sont—

Interjection.

M. Guy Bourgouin: Deux gouvernements consécutifs qu'ils n'ont même pas été un parti reconnu, puis là, maintenant qu'ils sont reconnus, ils se pètent les bretelles. On n'a pas de leçon à apprendre de vous, messieurs les libéraux.

Mais, ceci dit, ça me donne la chance de parler de notre système d'obstétrique dans le Nord, parce que notre motion en parle et on veut défendre les droits. Mais il y a une réalité que le gouvernement doit voir quand on parle d'obstétrique dans le Nord. En 2023 à Hearst, le département d'obstétrique est fermé. Ça veut dire que les femmes qui vont avoir des bébés, qui attendent des bébés doivent aller soit à Thunder Bay, soit à Sudbury ou à Ottawa—ou où est-ce qu'il y a de la famille. Elles sont obligées de se déplacer à 37 semaines.

Moi, à Noël, je viens d'apprendre que ma fille va avoir un bébé, notre premier petit-bébé. Je vais être grand-père pour la première fois. Mais, je suis chanceux; même à travers ça, je suis chanceux. Parce que moi, ma fille, vu qu'elle reste à Val Côté, qui est à peut-être 20 minutes de Hearst, elle peut venir à Kap. À Kap, il y a un système d'obstétrique, mais notre système d'obstétrique est financé pas tout à fait comme il devrait l'être, ce qui le met souvent en danger.

Fait que, je pense que c'est important. On doit faire beaucoup mieux. On doit financer nos systèmes d'obstétrique, nos hôpitaux, dans le Nord pour ne pas mettre la vie des enfants en danger—surtout avec nos routes, comme on connaît, dans le Nord.

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): I recognize the member from Don Valley East.

Mr. Adil Shamji: I'm pleased to rise in this chamber to address the opposition day motion before us which, very briefly, seeks to urge the government to designate hospital infrastructure projects as nation-building projects and therefore fast-track us for federal funding.

I must admit that this motion and this call for action couldn't come at a more important time: at a time when our health care system under this government faces its worst performance in Ontario history. We're seeing ER closures that now number in the thousands. We're seeing code zeros, a phenomenon during which patients call 911 but there is no ambulance available to meet them. Ambulance off-load times—the amount of time it takes for the transfer of care from a paramedic crew to an emergency department—are higher than it has ever been before. Alternate-level-of-care rates in our hospitals—higher than it has ever been before.

We have more people who are paying for health care than ever before. We've just learned that recently $62 million has been spent for MedsCheck through Shoppers Drug Mart—considered to be an abuse of our public health care system. We're seeing $9 billion spent on temporary, for-profit nursing agencies. We're seeing home care falling apart. We're seeing hallway health care at absolutely astronomical levels.

I was just working in the emergency department in my hospital yesterday, and believe it or not, our medical short-stay unit is now in a public lobby. That wasn't the case in 2018—nothing even close to that, seven years ago. But under this government, all we have seen is our health care system deteriorate.

And so, in the wake of all of these failures under the current government, of course I would support a motion such as this one—one that seeks to increase funding associated with our health care system and specifically with our hospitals. But I will argue that this is actually a bit of a wasted opportunity and that there are certain premises in this motion that I find difficult to agree with, the first of which is that we are in this situation because of a past Liberal government. I would point out that, under the previous government, we built hospitals, redeveloped hospitals, invented the first nurse practitioner-led clinics, the first family health teams, had the lowest ER wait times in the province's history—and then this government came along. So I have difficulty accepting that premise of this motion.

I will also say that this motion misses important opportunities to fight for the right thing in our health care system. Now, what I'm going to say, I say in the spirit of trying to improve our health care system and make this motion as strong as we actually can make it: One of the biases that I find this motion perpetuates is this preoccupation that our health care system equates to our hospitals and our acute care. That is the most expensive form of health care—the kind of health care that people resort to

when they have no choice because they are already experiencing severe illness.

A proper health care system is founded upon primary care, home care, long-term care, community care, none of which are mentioned here. A proper health care system doesn't just preoccupy itself with bricks and mortar, unless it is a health care plan that is put together by this government.

This government consistently focuses on concrete and beds without focusing on the workers and the staff that are necessary in order to make those hospitals and beds actually work for the people of Ontario. And so, I worry that the foundation of our health care system, the most important part of our health care system, is left completely unaddressed.

And finally, I will reiterate what my colleague just mentioned, which is, while no one can disagree with the fact that our hospitals do need more funding, I worry that I see no mention of our francophone hospitals and the elements of our health care system that serve our francophone community.

One additional point that I will make is that, while you could make the argument—and it's hard to find it offensive—that hospitals should be a nation-building priority of this government, I will point out that Prime Minister Carney has already designated at least $4 billion for the construction of hospitals. This is an opportunity not just to call for funding for hospitals, which is already being promised, but to fight for the other things that we desperately need in our health care system here in Ontario: to fight for funding for primary care, home care, community care, long-term care, and support for our health care workers—none of which, regrettably, is mentioned in this legislation.

That being said, I will return to a point that I made at the beginning of my remarks, which is that, of course, hospitals could use more funding.

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I'll point to one of the big hospitals that serves my riding in Don Valley East and that would be Michael Garron Hospital. I have heard, repeatedly, during question period, the Minister of Infrastructure comment on the funding that this government purports to have provided to this hospital serving my community. And yet what she chooses to ignore and to gloss over is every request for phase 2 funding for Project Imagine—which would actually be a project that increases the number of beds, because any projects up to now have not resulted in any net new beds. Our funding requests to actually create net new beds through the phase 2 Project Imagine proposal have been rejected by this government.

It's hard for me, though I will, to support this motion without pointing out the fact that one of the fastest-growing ridings in the province does not have its major hospital mentioned in it, and I would call for that if we ever had an opportunity for amendments.

I've seen first-hand the challenges that our hospitals face. Michael Garron Hospital, I mentioned already: The medical short-stay unit is now in a public lobby; the emergency department, built for 60,000 people, now serves over 100,000 people.

I've worked at Weeneebayko General Hospital in Mushkegowuk–James Bay, an old, old hospital in desperate need of replacement urgently—and not just in desperate need of funding for replacing that hospital, but for the training of its health care workers, for the hiring of its health care workers and for the support of all of the nursing stations that feed patients into the central location.

Of course, I support the reopening of the Minden emergency department. I have been there at least on three separate occasions. I understand how the people of the Minden community and surrounding area are being robbed of the vital—what we call the golden hour in emergency medicine and critical care; the golden hour during which the right intervention and the right treatment with the right people in the right place can mean the difference between life and death. For those people who reside in and around Minden who will no longer be able to access emergency and specifically critical care within that golden hour, those all-important 60 minutes, I cannot speak to the importance of them having their emergency department restored—not just restored, but restored to 24-hour, seven-days-a-week service, not just bankers' hours.

Just last week during question period, we heard my amazing colleague from Nepean speak to the challenges that are being faced at Queensway Carleton. He's a nurse. He's there propping up the health care system and that hospital against the odds. We had the Minister of Health have the audacity to attack a health care worker and say that he was denigrating his own hospital that he works at. We need a culture of respect, of listening to experts and not just of building hospitals, but supporting our health care workers, like the one behind me who is trying to fight for his community and was talked down to by the Minister of Health.

In closing, Madam Speaker, the current situation in Ontario is untenable. The government's mismanagement of health care in Ontario is untenable. More funds are required, more hospitals and infrastructure are required, but more support for health care workers is required. The preoccupation with health care worker recruitment has to be balanced with an equal preoccupation with health care worker retention.

Only if we can address all of these things, which are not fully captured in this motion—only if we can capture all of these things can we build and strive towards the health care system that all Ontarians deserve.

I will support this motion, though I point out that there are many missed opportunities to make it as strong as our province deserves.

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): The member for Scarborough Southwest.

Ms. Doly Begum: We know too well the pain of visiting an ER room, waiting for hours and hours, or worse, taking a loved one who's in excruciating pain and waiting for hours.

I visited hospitals with portable clinics in the driveway of the hospital, and we heard about Michael Garron Hos-

pital. We have also seen staff use storage rooms just so they can make space for beds in hospitals as well. We also know the shortage of staff in hospitals where ER rooms had to be closed down during the crisis. Imagine shutting the doors to a patient—hours of wait, months and months or years waiting for surgeries or appointments, all of which are costing this province money, but also costing lives, Speaker.

Meanwhile, Ontario actually spends the lowest per capita funding when it comes to our health care. And this is a legacy that the Conservative government actually carried on from the Liberals. In 2015, 2016 and 2017, we saw some of the lowest per capita funding to health care in the province—in this country, actually—that this province had. And so it's the years and years of neglect to our health care system that has cost us where we are right now, the health care crisis that we're facing: the aging buildings, the shortage in staff—

Interjections.

Ms. Doly Begum: I know the truth hurts—the truth hurts for both sides.

Speaker, this morning the CCPA revealed that over $9 billion of taxpayers' funding were actually going to private nursing agencies, private agencies for profit—not to the nurses; to the agencies, Speaker. That's what's happening right now. That's not nation building, especially at a time when we're facing an economic crisis, when we should be strengthening our province.

Today we have a solution. We have a solution to build this province, build this country. That's the nation-building plan: to make sure that we are building hospitals, that we're providing the support they need and making sure that we actually have the people in those hospitals as well. That's our plan, Speaker—and we're creating jobs.

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): Further debate?

Mrs. Jennifer (Jennie) Stevens: I rise today on behalf of the residents of St. Catharines to address the urgent issue of hospital infrastructure and the state of our health care system.

The Marotta Family Hospital in St. Catharines is at a breaking point. Residents are waiting up to 18 hours in the ER department. When this hospital was built, residents were promised a mental health wing, staffed and open 24/7. The reality is we lack the staffing infrastructure to open this wing. People in crisis are being directed to the emergency room instead of having dedicated support in place. Hospital infrastructure is not a luxury; it's a lifeline.

In St. Catharines, we are seeing first-hand the consequences of years of neglect, of funding shortfalls: overcrowded emergency rooms, aging buildings and staff stretched to the max. Yet infrastructure proposals that would provide relief and modernization have been stalled or shelved under successive Liberal and Conservative governments. Investing in hospitals means investing in people, Speaker. It creates space to retain and recruit desperately needed health care workers, from nurses and PSWs to specialists, who form the backbone of our public system and make it easier for residents to get the care they need.

We are in a health care crisis. If we want to build a stronger, more resilient system, our hospitals must be a top priority, not next year, not this year, now—right now. From hospital parking fees to MRI wait-lists, Ontarians are being forced to pay the price. That's why I'm calling on this government to designate critical hospital infrastructure as a priority in the 2025 budget. Show our front-line workers in Ontario that their health and safety come first, that our aging population in St. Catharines and across Niagara can access the quality care they've paid into for decades.

People deserve a government that puts health care first, not one that pushes off their responsibility while patting themselves on the back for other infrastructure priorities. You have an opportunity to get this right and support this critical, common-sense motion.

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): Further debate?

MPP Catherine McKenney: I'd like to just point out that the redevelopment of the Ottawa Hospital's Civic Campus was meant to be a transformative project, a long overdue investment to replace an aging facility and improve health care for residents from across the region. However, this project has become a textbook example of mismanagement, misguided priorities and the downsides, again, of privatization. The decision to use a P3 model has already led to significant delays and escalating costs. Originally projected to cost $2.8 billion with construction set to begin in 2024, the project is now delayed until at least the end of 2025, with costs now under review. This P3 model has failed to deliver on its promises.

Instead of investing in the hospital itself, the government has pushed the costs of infrastructure onto local municipalities, asking the city of Ottawa to contribute $150 million of the $700-million local share, while the rest is expected to come from fundraising. But as construction costs rise and projects like a parking garage swallow more of the budget, we have to ask, where is the money for patient care? Every dollar spent on P3 delays is a dollar not being used for front-line staff, specialized equipment, expanded emergency services, and the 641 single-patient rooms this hospital was supposed to deliver.

1440

Ontarians deserve a government that listens to people, invests in public services, and makes decisions that benefit everyone, not just the bottom line.

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): I recognize the member for Sudbury.

MPP Jamie West: I want to start by thanking the nurses. It is Nursing Week, after all.

Interjections.

MPP Jamie West: Absolutely.

As we know, nurses have been short-staffed—affected by Bill 124. They're subject to workplace violence. And a lot of that would be alleviated with funding.

Getting to the motion, though, on infrastructure and extending infrastructure in hospitals: Health Sciences

North in Sudbury was amalgamated by the Harris government and was built too small. So now we have dozens of off-site places for a one-site hospital which is broken. The investment into this organization would mean that we would put good tradespeople to work, we'd drive the economy, and we'd have a hospital large enough to accommodate people.

Sadly, I was elected in 2018 because the Liberal government had created Health Sciences North as the foundation, and the boilerplate of hallway medicine is now spread across the province. The Conservatives have failed to address this, but they could if they would invest in our hospitals, our nurses and our health care.

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): Further debate?

Ms. Catherine Fife: I just came from the Empire Club, where the finance minister was talking about how we need bold projects, nation-building projects, to stabilize the economy as we move through this, really, economic uncertainty as a province and also as a nation.

We think, though, on this side of the House, that being bold means having safe hospitals, having accessible hospitals, having well-resourced and well-staffed hospitals. In our mind, that is a very bold plan.

The list of hospitals that are contained within the motion would also stimulate those local economies for the skilled trades. You can't outsource those jobs when you're building to protect Ontario.

Finally on this point is that when investors, when capital is looking to go someplace and move into another jurisdiction, they are looking for that social infrastructure, they are looking for the strong schools.

But health care is the number one issue that attracts people into the province of Ontario, and they are not impressed with what they're seeing.

I just had surgery last Monday. I got great care in the hospital, but the hospital itself, the infrastructure, is failing people, and the people who work within that system feel it too.

So let's support those good people who are doing strong health care practices across our communities. Let's support the innovation in those communities by investing strategically, by ensuring that every community has access to health care and that we as legislators are supporting those good people. This is smart investment. It is, in fact, very bold.

I encourage everybody to support this.

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): Further debate?

Mr. Anthony Leardi: We in the government benches have grown so accustomed to the NDP being opposed to building things in Ontario that it was a breath of fresh air when I read this motion—that the NDP finally decided to build one thing in Ontario, because they're so against building everything else. They're against building highways. That's why they're against building Highway 413. They're against building tunnels. That's why they don't want a tunnel under the 401. They're against building mines. That's why they voted against the Building More Mines Act. They're against building signature provincial recreation projects. That's why they don't want to redevelop Ontario Place. They're against building roads. That's why they love bike lanes. And they're against building homes—because they want the government to put everybody else out of business and have the government build homes. But finally, the NDP have decided that they're in favour of building one thing: They're in favour of building hospitals, and that's a breath of fresh air, I think. I think we can all agree with that.

Of course, they probably don't want to move too fast on building those hospitals. First, they will want to do 15 years of environmental studies and then another 15 years of consultation. And then, 30 years from now, they might eventually get around to maybe tendering one of those hospitals. You can't expect the NDP to move too fast.

Well, we've got the jump on them, because while they were deciding whether or not they wanted to actually build anything in Ontario, we have 17 major capital hospital projects already under construction in the province of Ontario, while the NDP were asleep at the switch. Here are some of those capital projects:

—in Brantford, the emergency department expansion project for Brant Community Healthcare System;

—in Cambridge, the main capital redevelopment project at Cambridge Memorial Hospital;

—in Toronto, the redevelopment of the Centre for Addiction and Mental Health;

—in Grimsby, under construction, the West Lincoln Memorial Hospital redevelopment project, through the Hamilton Health Sciences Corp.;

—in Toronto, phase 1 of a new patient care tower for the Michael Garron Hospital;

—in Niagara Falls, the new South Niagara hospital capital project, through the Niagara Health system;

—in Picton, the Prince Edward County Memorial Hospital redevelopment for Quinte Health;

—at the Scarborough Centenary site, a new dialysis unit for the Scarborough Health Network;

—also in Scarborough, a diagnostic imaging fit-up for the diagnostic imaging/concourse at the Scarborough Health Network;

—also in Scarborough, at the General site, a hemodialysis isolation unit, through the Scarborough Health Network;

—in Toronto, an off-site and on-site dialysis centre, through Sunnybrook Health Sciences Centre;

—also in Toronto, provincial mental health and addictions capacity brain sciences centre project, through Sunnybrook Health Sciences Centre;

—in Thunder Bay, the cardiovascular surgery program, through the Thunder Bay Regional Health Sciences Centre;

—in Toronto, a patient care tower, through Unity Health Toronto, St. Michael's Hospital;

—also in Toronto, stem cell transplant phase 2 expansion head start project, through the University Health Network;

—also in Toronto, the new Toronto Western Hospital tower, through University Health Network;

—and in Moose Factory/Moosonee, a new replacement hospital at the Weeneebayko Area Health Authority.

Speaker, 17 capital projects currently under way—and those are just the ones that are under way. I haven't included any of the ones that are in the planning stage or in the tendering stage or in the land acquisition stage. Those are just the ones that are currently under construction. I could go on and list a whole lot of other projects that are in the planning stage and in the tendering stage, but the list would be so long that I think a lot of members of the Liberal Party would reach retirement age before I got to the end of the list.

Remember, it was the Liberal government that promised to build a new hospital in the greater Essex region. It was the Liberal government that promised to do that, and then they reneged on that promise. It was the current Premier who picked up that promise, and now that project is in phase 3. We've already gone through the first phase. There was the land acquisition phase—we acquired the land. Then there was the second phase, which was the design phase. That's done. Now we're in phase 3, the tendering of the project for the new regional hospital in the greater Essex region—a project that was promised by the Liberals. They reneged, and this government had to fulfill that promise.

So this motion, by the way, is far too late.

If you want to hear more about that project that I just talked about, in the greater Essex region, you should buy the member from Windsor–Tecumseh a coffee because he has a lot more to tell you. He could tell you, for example, how there were certain activists—locally known NDP and Liberal activists—who actively campaigned to block that hospital. He will tell you all the details. He's intimately informed about that, and he'd be happy to tell you all about it for the price of a coffee.

This motion—although it's a pleasant motion to build something in Ontario—comes far too late. The NDP should have brought this motion 15 years ago, to get the Liberal government of the day moving to build something, because if they had built something in Ontario, then we wouldn't have so many capital projects that have fallen so far behind in the province of Ontario, that the present Premier now has to make up ground for. Also, the NDP should have brought this far earlier than now because we already have 50 capital projects under way in the province of Ontario, many of which are already under construction. But it's nice to see that the NDP have finally decided that there is just one thing they want to build in the province of Ontario.

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): Further debate? Further debate?

The leader of His Majesty's loyal opposition.

Ms. Marit Stiles: I was listening very carefully to some of the comments made by others, and it sounded to me like we might have the support of all parties here. I certainly hope so, as so many of you spoke in such glowing terms about the motion and everything that we could be doing together here.

At the end of the day, this motion is about delivering health care and a health care system that people were promised—making sure that it's actually funded in the 2025 budget. I know that's what we're all looking for. It's about getting shovels in the ground, creating good union jobs, and giving families all across this beautiful province the peace of mind that care will be there when and where they need it. Those are not far-off dreams. These are shovel-ready projects, some of them. Some of them have been long planned, long promised and, of course, in many cases, long overdue. People in Brampton shouldn't have to be kept waiting. Families in Welland, in Windsor and in the north have been more than patient—and as you see, Speaker, we've included a lot of projects in the language of the motion. But, yes, hey, let's build more. Let's get it done. But they need a government that works and a government that delivers.

This is a test of priorities. If the Premier wants to invest in nation-building infrastructure, as he says he does, he should start here—build hospitals, expand urgent care, reopen our emergency rooms. If this government is serious about strengthening Ontario, then these projects must be funded in this year's budget. And that's what we're going to be looking for. Whether this government decides to support this motion—and I can't see why they wouldn't, but if they decide not to, then we want to see it in the budget. Let's wait and see what they're going to do in the budget.

Let's go. Let's stop delaying. Let's stop pretending that these are not urgent issues and urgent projects. Let's build care. Let's strengthen Ontario. Let's get the job finally done.

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): Ms. Stiles has moved opposition day motion number 3. Is it the pleasure of the House that the motion carry?

All those in favour of the motion will please say "aye."

All those opposed to the motion will please say "nay."

In my opinion, the nays have it.

Call in the members. There will be a 10-minute bell.

The division bells rang from 1454 to 1504.

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): Ms. Stiles moved opposition day motion number 3. All those in favour of the motion will please rise one at a time and be recognized by the Clerk.

Ayes

Armstrong, Teresa J.	Gates, Wayne	Shamji, Adil
Begum, Doly	Gélinas, France	Shaw, Sandy
Bell, Jessica	Gilmour, Alexa	Smyth, Stephanie
Blais, Stephen	Glover, Chris	Stevens, Jennifer (Jennie)
Bourgouin, Guy	Hazell, Andrea	Stiles, Marit
Bowman, Stephanie	Kernaghan, Terence	Tabuns, Peter
Burch, Jeff	Lennox, Robin	Tsao, Jonathan
Cerjanec, Rob	Mamakwa, Sol	Vanthof, John
Clancy, Aislinn	McCrimmon, Karen	Vaugeois, Lise
Collard, Lucille	McKenney, Catherine	Watt, Tyler
Fairclough, Lee	McMahon, Mary-Margaret	West, Jamie
Fife, Catherine	Pasma, Chandra	Wong-Tam, Kristyn
Fraser, John	Rakocevic, Tom	
French, Jennifer K.	Sattler, Peggy	

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): All those opposed to the motion will please rise one at a time and be recognized by the Clerk.

Nays

Allsopp, Tyler	Grewal, Hardeep Singh	Pirie, George
Anand, Deepak	Gualtieri, Silvia	Quinn, Nolan
Babikian, Aris	Hamid, Zee	Racinsky, Joseph
Bailey, Robert	Hardeman, Ernie	Rae, Matthew
Bethlenfalvy, Peter	Harris, Mike	Riddell, Brian
Bouma, Will	Holland, Kevin	Rosenberg, Bill
Calandra, Paul	Hsu, Ted	Sabawy, Sheref
Cho, Raymond Sung Joon	Jones, Trevor	Sandhu, Amarjot
Cho, Stan	Jordan, John	Sarkaria, Prabmeet Singh
Ciriello, Monica	Kanapathi, Logan	Sarrazin, Stéphane
Clark, Steve	Kerzner, Michael S.	Saunderson, Brian
Coe, Lorne	Khanjin, Andrea	Scott, Chris
Cooper, Michelle	Leardi, Anthony	Smith, Dave
Darouze, George	Lecce, Stephen	Smith, David
Denault, Billy	Lumsden, Neil	Smith, Graydon
Dixon, Jess	McCarthy, Todd J.	Smith, Laura
Dowie, Andrew	McGregor, Graham	Surma, Kinga
Downey, Doug	Mulroney, Caroline	Tangri, Nina
Dunlop, Jill	Oosterhoff, Sam	Thanigasalam, Vijay
Firin, Mohamed	Pang, Billy	Thompson, Lisa M.
Flack, Rob	Parsa, Michael	Vickers, Paul
Ford, Doug	Piccini, David	Wai, Daisy
Gallagher Murphy, Dawn	Pinsonneault, Steve	Williams, Charmaine A.

The Clerk of the Assembly (Mr. Trevor Day): The ayes are 40; the nays are 69.

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): I declare the motion lost.

Motion negatived.

ORDERS OF THE DAY

MORE CONVENIENT CARE ACT, 2025
LOI DE 2025
POUR PLUS DE SOINS COMMODES

Resuming the debate adjourned on May 8, 2025, on the motion for second reading of the following bill:

Bill 11, An Act to enact or amend various Acts related to health care / Projet de loi 11, Loi visant à édicter ou à modifier diverses lois en ce qui concerne les soins de santé.

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): Further debate?

M^me^ France Gélinas: I'm happy to have an opportunity to talk about what is now called Bill 11—that was Bill 231 before Christmas, but we've had an election; all of the bills got put aside, and they're coming back one by one—An Act to enact or amend various Acts related to health care. Let me start by saying, we have more and more people coming to Queen's Park—RNAO, the registered nurses' association, was in the media studio this morning with a call to action as to, our health care system is in crisis. It's in crisis like we have never seen before. Things have to change. They came to Queen's Park. There were over a dozen—I don't know, 20 of them—who came to Queen's Park to really send a strong message. They have a new call to action for nurses—this is also the start of National Nursing Week. That started today. And their highly anticipated, evidence-based recommendations to transform the health care system for the benefit of all Ontarians—their new ECCO report, number 4, Enhancing Community Care for Ontarians. They released one in 2012, one in 2014, one in 2020. And now they've just released a new one centred on strengthening community care, which is pretty much in line with what this bill intends to do, but I would tell you that they come from a very different direction.

1510

OCHU, the Ontario Council of Hospital Unions, was also in the media studio this morning, pressing the government to take the crisis in our health care system seriously.

What we are facing we have never faced before, but there are solutions out there, from communities, from volunteer organizations, from health care professionals, that the government needs to listen to.

If you are expecting those solutions in Bill 11, one of the first health care bills to be tabled in this new Parliament, I want to tell you right now, Speaker, you would be sadly disappointed. This bill is not going to fix the crisis in our health care system. This bill is not going to tackle some of the, I would say, areas of health care where everybody agrees things need to change, everybody agrees as to how it should change, but yet, nothing is done and nothing is moving forward. The bill itself has six schedules. Some of them, I would say, are more important than others, but none of them are directed at solving the problem.

I would like to thank Dr. Claudette Holloway, who is the past president of the Registered Nurses' Association of Ontario, RNAO, as well as NP Lhamo Dolkar, who is the present president of RNAO, as well as their CEO, Dr. Doris Grinspun—Doris has been there, I think, for over 30 years—for their comments this morning.

Nurses are asking to be heard. Nurses are asking to be taken seriously. They are on the front line. They know how many patients are being failed by the crisis in our health care system right now, and they would love nothing more than for the government to listen to nurses and see how to improve.

I can tell you that they're not advocating for nurses in their paper; they're advocating for a strong and robust, publicly funded and publicly delivered health care system. Although they thank the government for many steps that they have taken, they draw a line in the sand when it comes to privately delivered, for-profit health care. RNAO doesn't want anything to do with this; neither do most Ontarians—if they had a chance to be heard.

We will start with schedule 1. Schedule 1 is called the City of Hamilton Act, 1999. "Section 11 of the City of Hamilton Act, 1999 is re-enacted to establish a board of health for the city. Currently the city itself has the powers, rights and duties of a board of health under the Health Protection and Promotion Act."

For reasons that I don't really remember, about 30 years ago, things changed for public health in the city of Hamilton. We have 34 public health units. They cover all of our province. They basically all run the same way, except for Hamilton, and that comes from many decades ago—something that I don't fully understand had happened.

What will happen now is that the board of health in the city of Hamilton will be basically dealt with the same way that Toronto or Ottawa or any other exist. The city of Hamilton is ready to change to basically go in line with the type of governance that all 34 boards of health have in Ontario. They will have important responsibility. They will have a board of governance. Now the board of governance of Hamilton will be similar to the board of governance of the other 33 health units. The board will have responsibility for things like dental care. They have public health employees who go into the different schools to do screenings of children, to identify kids who would benefit from accessing dental services. We do have a program in Ontario to help pay for dental services for kids under 18 years of age—to gain access to a dentist through public health.

They have public health inspectors who are also part of public health. They do inspections to make sure the water that we drink is safe to drink, the food that we eat in a restaurant is in compliance with the health regulations, and to prevent hazards, so we don't get sick from the food that we eat etc. They also promote hygiene and safety and handle emergency preparedness.

The board of health will also be responsible for Smoke-Free Ontario. Smoke-Free Ontario requires inspectors from Smoke-free Ontario, from the board of health, to go into pretty well everywhere we sell tobacco and cigarettes, to make sure that they don't sell to minors and to make sure that they respect all the laws we have in place regarding advertising, regarding who can sell tobacco products and to who you can sell it.

There are also many public health nurses. Most people now know about public health nurses because they were the people who were giving out the COVID immunizations, but they also do school immunizations. They continue to be very busy—although nobody wants to talk about COVID anymore, and I'm one of those. The pandemic is behind us, and please don't bring it back. There are still many cases of COVID going.

There are still many cases of measles—we are over 1,440, I think, cases right now that have been diagnosed in Ontario. We all know that all this is preventable. We have the MMR vaccine that has been available, free of charge, to Ontarians. During COVID, when schools were closed and public health could not gain access to the children in school, many children fell behind, either because they got their first dose but then the school was closed and they never got their second dose; or they were due for their first dose, but the school was closed—you get the idea, Speaker. So public health has a lot of catching up to do. Unfortunately, they have not received the resources to do that catching up. The budget for public health only increased by 1% for the next three years, at a time when Ontario and Canada are about to lose—we had eradicated measles in Ontario. I remember, in the 1990s, everybody was so proud that we achieved close to a 93% to 95% vaccination rate. Measles was eradicated in Ontario. We were able to protect vulnerable populations, whether it be the Mennonites or children or people who have low immune systems, because of the herd immunity that we had built in Ontario. All of this is at risk. We know how to fix this: Give public health the resources they need to do advertising, to do education, to reach out, to do vaccination clinics etc. They need resources to do that, and the government is not giving them their resources.

Public health also deals with Healthy Babies Healthy Children. Anybody who's had a child, and there's a few of them in this house that have brand new babies, you think you know it all till you bring your baby home and realize that there's a lot of questions you didn't think about asking. Well, you can ask all of those to Healthy Babies Healthy Children at public health. They help every new parent with any kind of question that you have and they're very helpful. I would say you could always call your grandmother—I'm a grandmother—but it's also good to call Healthy Babies Healthy Children, and they do follow up.

1520

Public health also has epidemiologists who investigate outbreaks of diseases, identify the risk factors, inform the public on health interventions, look at patterns, cause and effect etc.

Public health also has health educators and health promoters who develop programs and materials to teach communities about health topics and promote healthy behaviours. Health promotion and disease prevention go a long, long way towards keeping people healthy. Let's face it, Speaker: We all want to be healthy. Nobody will say, "Oh, I can't wait to be sick." No. We all want to be healthy, and we want to stay healthy. One of the best ways to do this is for government to invest in health promotion. And if you are sick, your diabetes or asthma—disease prevention. How do you make sure that you can control your chronic diseases so that it doesn't get worse?

I don't think I have heard anyone on the government side talk about health promotion and talk about disease prevention. We talk about primary care, we talk about hospital care and we talk about long-term care and home care, but health promotion and disease prevention are an integral part of our health care system. Lots of it is offered through public health.

This is what we have in schedule 1 of the bill, with the City of Hamilton Act. I wanted to give a little bit of background as to what public health does, because now, through schedule 1, the city of Hamilton will have a board of health very similar to the other 33. It is a step in the right direction. This is something that the city of Hamilton has been ready for. They wanted to do the change, and now they will be able to do that change. So it's a step in the right direction—no problem with schedule 1.

Schedule 2, Connecting Care Act, 2019: The schedule amends the Connecting Care Act, 2019, to provide for the application of the French Language Services Act to the service organization. You won't be surprised that this is something I have been pushing for, for a long time, as 40% of the people that I represent are French-speaking. Many of them are elderly; many of them are receiving home care. When everybody in your house speaks French, when your grandmother is receiving home care and the home care provider coming to the house does not speak French, believe me, they will pick up the phone and they will phone their MPP because they're not happy about that.

Unfortunately, when the government did changes to—I don't know if you remember, but they used to be called CCACs, community care access centres. They were the ones who managed home care. It used to be called home care. Then it became CCACs. Then it changed names and became the LHINs, local health integration networks. Then it changed, and it's become community care—something else. Now it's called Ontario Health atHome.

Nothing has changed. We still have a whole bunch of for-profits, mainly Bayshore and the kind that provide the home care. But the structure at the government level has changed through many, many changes, and through those changes, they dropped the obligations to follow the French Language Services Act.

When Ontario Health atHome was brought, I was the one doing the clause-by-clause. I brought forward an amendment and said, "Hey, when it was the CCACs, you had to provide services in French in home care. When it was the LHINs, you had to provide services in French in home care. When it was the home and community, you had to provide services in French in home care. Now you're changing it to Ontario Health atHome, and it's not covered by the French Language Services Act. It must have been just a mistake. Let's pass this amendment to make sure that home care continues to be covered by the French Language Services Act." Much to my surprise, they voted against it. They, as in members of the Conservative Party, voted against that amendment. I was not happy. They did not explain why they would vote against such an amendment. It had been there all along. Come on, you've changed the name, but home care is still the same thing; it's a PSW or a nurse who comes to your house. No.

But now, they are bringing it in schedule 2. So, what I could not get through an amendment, I am now getting through schedule 2 of Bill 11. It's good news.

Je peux vous dire que pour les gens que je représente, les services en français, surtout les services à domicile en français, c'est quelque chose de très important. La grande majorité des gens qui reçoivent des soins à domicile sont des gens âgés, et dans mon comté, beaucoup des maris, les hommes, sont décédés—travailler dans les mines en 1950, 1940, 1960, ce n'était pas facile—mais la femme, la veuve, est encore là. Elle a besoin de soutien à domicile. C'est une femme de son temps qui n'est pas nécessairement allée travailler, qui est toujours restée à la maison, a élevé ses 14 enfants et a pris soin de sa famille. Maintenant, elle a besoin de soins à la maison. Elle ne parle pas l'anglais et Bayshore lui envoie une préposée qui parle seulement en anglais.

Les soins à domicile sont souvent des soins très, très personnels. On parle, là, de prendre un bain. On parle d'aller à la toilette. On parle de s'habiller. On parle des soins personnels, et quand tu dois faire affaire avec une personne qui ne parle pas ta langue, ce n'est pas évident d'avoir des soins de qualité.

Donc, je vous dirais que la deuxième—je ne me souviens plus comment on dit « schedule » en français; laissez-moi vérifier—annexe, c'est quelque chose qu'on appuie et c'est un pas dans la bonne direction. J'aurais aimé que ça ait été fait quand le projet de loi pour changer les soins à domicile avait été mis de l'avant. Je peux vous dire que j'avais mis une motion pour faire un amendement pour s'assurer que la Loi sur les services en français était pour être là. Ça n'a pas passé, mais là, ça passe avec « schedule 2 ».

I would tell you that I'm happy with schedule 2 and I'm happy that people who want services in French will be able to have them, but I don't want to give anybody false hope. Our home care system was privatized under the Mike Harris government. People who are as old as me will remember that he was going to make home care "better, faster, cheaper." Well, none of that happened. The only thing that happened is that now the for-profit company that provides home care services—they have the contract to provide home care services—cannot recruit and retain a stable workforce. Why can they not recruit and retain a stable workforce? Because what people want is a permanent full-time job, well-paid, with benefits, sick days, vacation days, and maybe the dream of a pension plan.

What they get when they go work for home care is you sit by the phone to hope that you get a shift. You're not paid to go between clients, so just imagine: I'm in northern rural Ontario, 33 little communities, 600 kilometres from north to south. They will come to me and show me, "I drove 731 kilometres last week." They get 36 cents a kilometre as reimbursement, but they don't get paid for the time it takes to go from one client to the next. Think about it, Speaker. In the middle of the winter, in a northern rural area, how long do you figure it takes to drive 731 kilometres in northern Ontario? It takes hours and hours. What other workers would be asked to work for 10 hours a week not paid? The people who work for Bayshore, for home care. This is not acceptable.

Although schedule 2 talks about bringing French services to home care, and I'm all for it, I don't want to give anybody false hope that this will fix our home care system. Our home care system is privatized. Bayshore continues to make hundreds of millions of dollars in profit. How do they do this? By not paying their staff a fair wage, by not giving them permanent full-time, by not giving them benefits or sick days or holidays or a pension plan or anything else. So, what happens? They cannot recruit and retain a stable workforce.

Quality of care is based on continuity of care. When you have a different person coming every second day to give you your bath, it doesn't take long that you don't want to strip naked in front of a different stranger every week and you say, "I don't want this anymore." Then you end up in trouble, and then you end up at the hospital, and then you end up on the ALC list because it's not safe to send you back home, because home care doesn't meet your needs. This is just one example.

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I'm happy with schedule 2, which brings the French Language Services Act under Ontario Health atHome, but there are many, many other steps that need to be done to fix our home care system. If you go into any seniors' club and ask, "Who is looking forward to going to a long-term-care home," I guarantee you nobody raises their hand. People want to stay at home, and this is what home care does.

When you have a robust home care system, people are able to stay home safely and respectfully. It is cheaper. It is what people want. It is better for the taxpayers. It has nothing but good things. But our home care system has been privatized, and what we have is private delivery who puts profit ahead of quality care, so they cannot recruit and retain a stable workforce. When Health Sciences North—that's the name of the hospital in Sudbury—puts an ad for one PSW, they will have 500 applicants apply for one job. If Bayshore tries to recruit, they can't. We get a busload of people every Saturday that come from down south, through agency nursing, to come and fill up shifts.

Every day, I will have either a message on the voice mail or people who call the office to say the PSW didn't show. What often happens is that if you're in a wheelchair, or you need help to get out of bed, get dressed, go to the bathroom, get into your chair—but once you're there, you're good for half the day—Bayshore will call you at about 10 o'clock and say, "Oh, I'm sorry we missed your 7:30 appointment. We will be there at 3 p.m." Be there at 3 p.m. to get me out of bed? Nobody wants to get out of bed at 3 o'clock in the afternoon. Everybody needs to go to the bathroom, maybe. Everybody wants to live a regular life. But if you refuse what Bayshore is offering you, Bayshore gets paid for the visit, you get no visit, the PSW doesn't get a cent, and they increase profit. I'm tired of this, Speaker. I'm tired of this. Home care should exist to support people to the best of their ability, not to make private investors rich.

So that's basically what's in schedule 2: We will now have services in French for a broken home care system.

Then, schedule 3: Schedule 3 talks about the Health Care Staffing Agency Reporting Act. Basically, the schedule enacts the Health Care Staffing Agency Reporting Act. It "requires health care facility staffing agencies to submit reports to the minister containing aggregate administrative, billing or pay rate information for health care facilities to which the agency assigns prescribed" workers. They require "health care facility staffing agencies to comply with specified record maintenance requirements." They authorize "the Minister of Health to publish certain information contained in the reports submitted." They "describe elements of the crown's liability and state that no person is entitled to compensation as a result of the enactment of the act," and there are other regulations that "prevail over any agreement to the contrary."

Basically, what schedule 3 does is it tells us that the staffing agency will have to give a report to the ministry. It could be every three months, six months, two years—it doesn't say. The report could be made public or maybe won't be made public.

Speaker, we have a crisis in health care. The use of agency nursing has exploded. The last stats that were shared with us, which go until 2023, show that $9.2 billion—not million; $9.2 billion—was spent on agency staffing by our hospitals in Ontario. This is really hard to wrap your head around—that of this billions of dollars, a small part of that money goes to the workers, but a big part of it goes to the agency who owns those workers.

One of them came to me as a whistle-blower. They basically showed that they were able—the word that he used—to poach 500 nurses from the Toronto and area health care system. They basically go at shift change and look at the nurses crying in their car. Because the nurse, after their shift, if they know that they have failed their patient, if they know that the workload was not sustainable and they are burnt-out, they finish their shift and they go to their car and they start crying. They will go talk to that nurse and say, "You don't have to work at that hospital anymore. Come and work for us. We will give you more money. You can pick your shift. You don't have to do afternoons anymore. You don't have to do night shifts. You don't have to do weekends if you don't want to. You don't have to do statutory holidays. Come and work for us. You can pick your shift. You will work when you want to and you will make more money."

I don't blame nurses for accepting to go work for a staffing agency. Think about it: You are burnt-out. You know that on the unit you were on, there should have been five nurses but there were only three of you. You know that the client you were looking after, you transferred her to the bathroom and she sat there for an hour and twenty minutes because you were too busy looking after other people. She was really angry when you got back, and very angry patients tend to be very violent—can be violent; not all people are. But think about it: Now you can go work for a staffing agency. You will make more money. You will get to pick where you go, when you go, and they are going in droves.

But that means that of that $9.2 billion, the max is close to $4.65 billion—anyway, half of it went to profit. This is billions of dollars that had been transferred to our hospitals to care for people that never reached the bedside. They go into investors' pockets. We can do a lot, Speaker, with $4.65 billion. We could do a lot of good change to our health care system if we had this. But all that schedule 3 does is it talks about how we'll have a report that will come telling us how much staff they have provided. The report may be there every three months, six months, 12 months, two years—we don't know; it may be made public or not.

Those are very, very tiny steps. They're tiny steps in the right direction, but the end goal is a whole lot further.

The Premier of Ontario is also the lead for all of the provincial Premier get-togethers. Did you know, Speaker, that all of the provincial Premiers talked about agency nursing, because it's not only happening in Ontario, it's happening in all of the provinces? Every single other province has put in place ways to limit the use of agency nursing except Ontario. And now that Ontario is putting a step forward—there's no limit in there. There's no change in there. There's nothing.

I have put forward a private member's bill to limit the use of agency nursing, to limit how much profit they can do, to put them under the Auditor General so that we know exactly how much profit goes out of those agencies and into investors' pockets. At the bottom of it, it's the harm that it does. Because a nurse that has never been—you have been a nurse for seven years working in, we'll say, the medical surgery floor. Now you're an agency nurse and they need a nurse on Monday morning in, we will say, obstetrics. You've never worked in obstetrics before. The other nurses that are there, who know the floor, who know how things work, are being paid less than the agency nurse and they have to teach the agency nurse how to do the work.

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Same thing: You may have been an orthopedic surgical nurse for many, many years, you're really good at what you do, but the shift that they call you in for is for psychiatry, in which you know nothing, but you will be there with the rest of the staff that is there. The rest of the staff know full well that you're making 10%, 20%, double the salary that they're making, but yet they have to help you do the work. This is not good for good relations between co-workers. Nothing good comes from the use of agency nursing.

And before anybody comes at me: Yes, I come from northern Ontario. Yes, we have used agency nursing in northern Ontario forever on end. But we use agencies that used to cost—I don't know—8%, 10% more than what you pay your regular staff.

I can talk about Manitoulin Island. Manitoulin Island is beautiful. Everybody should come and have a look. There are 50,000 people that come out there in the summer to visit, so you go from an island of 3,000 people to 50,000. Yes, you will need a little bit more stuff. I don't wish harm upon anybody, but somebody will sprain their ankle having a look at the beautiful waterfalls and somebody else will fall or whatever; the hospital gets a whole lot busier. So, yes, a few nurses come during the summer, all the way to hunting season, and then they go back home. It's the same nurse that has been coming for the last 10 years. They don't cost $200 an hour or anything like this. It is very different to say, "Oh, this exists in northern Ontario." What existed in northern Ontario and what is going on now is on two different planets. What is going on now is a whole bunch of investors saw a way to make a ton of money off of the back of a health care system that is in crisis. And they are making billions of dollars, according to the last report, at the expense of quality care.

So, schedule 3, Health Care Staffing Agency Reporting Act: Why do we have to take such small steps when the crisis is so big? Last time I talked about this bill, I said it's important to water your flowers. Everybody knows if you want your flowers to bloom, you need to water them. But when your house is on fire, maybe it would be good to put a hose onto that house rather than go water the flowers. So we are watering the flowers—nothing wrong with watering the flowers—but the house is on fire. Maybe it would be good to have a little bit of water going that way—apparently not. That was schedule 3. I think that's all I'm going to say about schedule 3.

As I mentioned, most other provinces have changed. If you look at Quebec—not that far away from Ontario, not that different from us—they have passed a law that basically gives big municipalities—so they started with Montreal, Quebec, Trois-Rivières—all the big centres have to have a staffing plan, and they limit how much money they can use for agency nursing. They have given the big hospitals two years to do this. In the medium-sized cities, they have three years to do that, and in the smaller-sized cities, they have even a little bit more time, but all of them have to submit a staffing plan that shows how they're going to limit and get rid of agency nurses.

I can tell you, Speaker, that I kind of copy-and-pasted that bill from Quebec, and I brought it here in Ontario, to limit the use of agency nursing in—I started with hospitals and long-term care. It is feasible. Every other province is doing it. What is Ontario waiting for? This tiny wee step is not going to change anything. Many hospitals are facing, basically, big deficits in their budget. Every hospital is supposed to have a balanced budget. Many of them won't be having a balanced budget, and in huge part, it's because of the high, high cost of agency nursing. This has to change.

Schedule 3 is not going to change anything. It's going to have them report at some point something that may become accessible to all or not. We just don't know. I will be re-tabling the agency nursing bill at the end of the month, and I sure hope that the government will be willing to support that.

Next is schedule 4, Health Protection and Promotion Act: "The Health Protection and Promotion Act is amended to require medical officers of health to notify the Chief Medical Officer of Health and to receive the Chief Medical Officer of Health's written approval before issuing a class order."

This is another one of those where I don't know what they have against public health, but, yes, it's kind of weird. The class order is something that is used very, very rarely. It's when a medical officer of health issues a directive regarding a communicable disease. Most people will have become aware that such things as class orders exist through COVID, when one medical officer of health—"medical officer of health" is the name of the physician in charge of a health unit. We have 34 in Ontario, and then we have the Chief Medical Officer of Health, who, for

reasons unknown in Ontario, is an employee of the Ministry of Health, as opposed to other provinces where they are an independent officer of the Legislature. They have the right to issue a directive regarding communicable diseases, and that would include mandatory compliance for individual entities. They can include isolations, quarantine or other health care measures—

Ms. Teresa J. Armstrong: Measles.

M^me^ France Gélinas: Yes, my colleague talks about measles.

What the class order does is that it gives it legal force. This is a power that the medical officer of health of every public health unit already has but very, very seldom uses. But now, if they need to use the class order to order isolation, quarantine or other health measures, they will have to have the blessing of the Chief Medical Officer of Health.

We have a Conservative government here that talks about red tape all the time. Why do we have all of those rules and why do we have all of those sign-offs and all of this? Well, if this is not red tape, I don't know what red tape looks like. You already have a medical officer of health of one of the health units that will use any power that they have to try to control an outbreak, to try to control a communicable disease. They come to the conclusion that a class order is needed for isolation, quarantine or other health measures. Usually, once they make that kind of decision, it's because there's an urgency to it because you're afraid the disease is about to spread to a whole bunch of other people and you want to protect your community. But now it doesn't matter that you have the knowledge, the skills and you very seldom use this; you will have to do the second step of making sure that the Chief Medical Officer of Health agrees with you.

I have nothing but good things to say about Dr. Moore, our Chief Medical Officer of Health here in Ontario. I have nothing against this doctor. What I have a problem with, though, is that, as I said, in Ontario, the Chief Medical Officer of Health is an employee of the Ministry of Health, of the Minister of Health. In other provinces, they are an independent officer. They don't take the political side into decision-making. They decide for themselves, based on medical evidence, what are the best decisions for their province—but not in Ontario.

You will remember, Speaker, that I have tabled a bill to change this so that the Chief Medical Officer of Health of Ontario would be an independent officer. Right now, it has the role of an independent officer, but it is an employee of the minister. Let's finish that; let's make sure that they continue. I would feel more comfortable if the Chief Medical Officer of Health was an independent officer of the Legislative Assembly because I would know for a fact that the decision-making is based on medical evidence, on what is best for the community. I still don't think it's a good idea to add a step, but I would feel more comfortable. What we have in Ontario, where the Minister of Health can say, "No, we don't want you to do this"—and he won't be allowed to do this and keep his job, I have a problem with that.

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So schedule 4 is red tape—it's not a reduction, it's a red tape addition that is not needed, that is not going to keep people healthier, that is not going to do any of that. Public health does not issue class orders very often. When they do, most of the time it is a very timely, urgent situation, and now we're asking them to go through more steps. This is not a step in the right direction.

Schedule 5 talks about the Mandatory Blood Testing Act: "The Mandatory Blood Testing Act … is amended to allow nurse practitioners to perform many of the functions in the act that must currently be performed by physicians." We have this all over the health care acts in Ontario where we limit practitioners to do certain things.

What this is all about is that it has to do mainly with EMS—emergency medical people, so think about paramedics, firefighters, police officers. If, during their work in the line of duty, or call it whatever, they come in contact with bodily fluids—think about spit, think about blood, think about anything else; any bodily fluid that they come in contact with—they will be tested to see if they came in contact with communicable diseases. So you're talking HIV/AIDS, you're talking hepatitis A, hepatitis B, hepatitis C etc.

Right now, if you are a paramedic, a firefighter, a police officer, you're at the scene of an accident, there's blood all over the place, the person is stuck in the car, you do what you do with the jaws of life to get the car apart, to get the person out of this, they all come out of there covered in blood—not that they wanted to, but they did what they had to do to help the person in their time of crisis. They have to be tested.

Now, in my riding, where out of 90,000 people, 40,000 of us do not have a family physician, you have to find a family physician who will do a requisition for you to be tested because you have been in contact with blood; now with schedule 5, nurse practitioners will be able to do this. Why nurse practitioners were not able to do this all along—this is not a change to the scope of practice; nurse practitioners are allowed to order blood tests, they are allowed to order tests for HIV, for hep C, for all this, but the law said that they were not able to do that, so now we're changing the law to take out the fact that they were not allowed to do this—they are.

But there's all sorts of stuff like this. Did you know, Speaker, that if you went into a nurse practitioner-led clinic, they all have an AED—a defibrillator—but they were not allowed to use them? So if you had a heart attack in the nurse practitioner-led clinic, they would get the secretary to apply the AED because a nurse practitioner was not allowed to apply an AED.

It's not only that—pregnancy tests. Nurse practitioners were not allowed to dip a stick to see if you were pregnant. So what did the nurse practitioner do? They would ask the secretary or anybody else that happened to be in the waiting room, "Could you dip that for me, please? Because I'm not allowed to do that." Then they could read it and say, "Yes, you're pregnant" or "You are not"—whatever. There are all sorts of really archaic limitations on different

health professionals. I could go on with what physiotherapists are not allowed to do. Anyway, there's all sorts of stuff.

This is one little step in the right direction. When EMS, police officers, firefighters are in contact with blood, it is not them who get tested, it's the person who had the accidents who we test. If the person who had the accidents, the person whose blood was all over the place, is HIV-positive or hep C-positive or whatever, you can initiate treatments on the first responders and you can initiate a follow-up with the first responders that had contact with the bodily fluid to make sure that we keep them safe, we keep them healthy and we treat them if they were in contact.

That we now remove this limitation on nurse practitioners is absolutely a step in the right direction, but I could give you a long list of other things, other limitations to the scope of practice of health professionals that make absolutely no sense but are there in the laws and in the regulations in Ontario. We're taking one away—yay. There are about 500 more that need to be looked at, and I hope that, eventually, we will look at the other ones, but one little step in the right direction so that we can keep our first responders as safe as we can.

I'll go to schedule 6. Schedule 6 is called the Personal Health Information Protection Act. The schedule amends the personal health information—basically, to make amendments. "The act currently provides for an organization to be prescribed as a 'prescribed organization' for the purposes of ... the act." A prescribed organization is basically who is allowed to have access to your health care information.

In health care, it's a relationship between two people most of the time: the one who provides the care and the one who receives the care. In order to achieve quality care, there has to be a high level of confidence between the two. There has to be a high level of trust. You have to be able to tell your health care provider things that you probably would have never told anyone before, things that you really want to keep private, but you have to share those with your health care providers in order to get the right diagnosis, in order to get the right plan of care. This can only happen when there is a really high level of trust between the two.

I will start with the problems with schedule 6. The number one problem is that the Information and Privacy Commissioner—who's just been renamed, Patricia Kosseim—she recommended removing schedule 6 from the bill, and she issued a recommendation to strengthen transparency and ensure equitable access to health information.

The Information and Privacy Commissioner "issued recommendations on how the policy objectives underlying the bill could provide more meaningful access rights, while also being clearer and more practical to implement and enforce." She also expressed concern over the lack of clarity regarding the scope of personal health information to be collected, used and disclosed. Under the new system, the absence of defined limitations could lead to over-collection and misuse of sensitive information. The Information and Privacy Commissioner noted potential conflict arising from Ontario Health's dual role as both a health data repository and the administrator of digital health ID. This overlap could compromise the impartiality and integrity of data and governance.

I wanted to read that into the record. I'm not opposed to electronic health information. Other provinces have done this, and it is successful and it's a way to identify yourself. But you have to bring those kinds of changes in a way where the public is fully informed and, certainly, the Information and Privacy Commissioner supports you because, as I said, your health care information is very personal. It has information in there that only health care providers that are there to help you should have access to. People know this. People know that when you go see your doctor, your nurse practitioner, your physio, your dentist, you know that the information that they collect, nobody will have access to.

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But now that we are going to this online, the language in the bill makes many people uncomfortable as to how much information will the minister have access to. How much information will the Ministry of Health have access to? How much information will the people working for Ontario Health have access to? As I say, going to an electronic health card, electronic health records, are all things that are the way of the future; it is the way that people want to go. But you have to go there in a way that—I call it do your homework. Make sure that you have connected with patients, with hospitals, with health care providers, with the Integrity Commissioner to make sure that everybody is online, that this is the way to move forward. And then it becomes a whole lot faster to put anything like this in place.

I think Ontario has the know-how, they have the technology, they have the goodwill to do this. Schedule 6, the Personal Health Information Protection Act, speaks to this. They want to protect your health information. That's the name of the act: the Personal Health Information Protection Act. It wants to do the right thing, but when you come out with an act and you have the Information and Privacy Commissioner asking you to remove that schedule from the bill, that's kind of a big setback. How come you did not collaborate with the Information and Privacy Commissioner ahead of time? Did you do your homework? Did you talk to hospitals? Did you talk to providers? Did you talk to lawyers? Did you talk to Ontarians in general as to what they would like to do?

To say that your information will only be shared if there is agreement—we all know, Speaker, that when the agreement is three pages long and then you have to agree in order to be able to see a doctor, everybody will say, "I've waited in the waiting room for"—I don't know; in my neck of the woods, we don't measure wait time in minutes or hours anymore, it's in days. You could be a day and a half in the emergency room waiting area of Health Sciences North before you are seen. If they ask you, "You have to agree to an electronic medical record in order to

be seen," everybody will agree to this because you want to be seen by a doctor, because you're in pain, because you're in need of care. Then it falls apart, because then there's mistrust in the system because people want their personal health information.

Personal health information is something very important. If you work in a hospital and you access a client's health record that is not your client, you lose your job. It doesn't matter if you are unionized, it doesn't matter if you're the chief executive officer; you are not allowed to do this. There will be very serious consequences if you go and access a health record of someone who's not your own patient, that you didn't need to go see. It has happened in the past. Everybody who works in health care knows full well you are not allowed. Nobody does it. There is a very good process in place to see who has access, what record, at what time, and for how long and all of this. They keep track. They check. If somebody is found to have accessed a record that they were not allowed to—if they're not your patient, you're not allowed to have access to those records—they lose their job. There are really, really severe consequences.

But then the Personal Health Information Protection Act says that Ontario Health would have access to your record. Who is Ontario Health and who works there? The Ministry of Health would have access to your record—hmm. Does the Minister of Health really need access to a health record? How much of that in the record will be shared? It has not been defined. It is not clear, so it leaves a lot of people uncomfortable. As I say, the end goal is good; how we get there, not always as good.

Je viens de voir qu'il reste seulement que quelques minutes. J'aimerais vous parler du projet de loi 11, qui était un projet de loi qu'on avait déjà discuté avant Noël : la Loi visant à édicter ou à modifier diverses lois en ce qui concerne les soins de santé. Le projet de loi a six annexes. La première nous parle de la loi sur la ville de Hamilton, pour s'assurer que Hamilton crée un conseil de santé pour la ville. C'est quelque chose que Hamilton veut depuis longtemps et c'est quelque chose qui devrait être en place, pour a).

L'annexe numéro 2 nous dit que les soins à domicile seront couverts par la Loi sur les services en français. Les services à domicile—s'il y a une place dans le système où les gens insistent qu'ils veulent être traités dans leur langue, c'est dans les soins à domicile. Il y a une grosse partie de la population qui reçoit des soins à domicile qui sont des personnes ainées, qui n'ont pas toujours autant de facilité en anglais, qui vont demander—ou leurs familles vont demander pour elles—l'accès à des services de soins à domicile en français. Pour une raison qu'on ne sait pas, la Loi sur les services en français ne s'appliquait pas et maintenant elle va s'appliquer. C'est un gros pas dans la bonne direction.

La prochaine, l'annexe 3, c'est par rapport aux agences de placement de personnel de soins de santé. L'annexe en elle-même dit que les agences de placement qui sont à profit vont devoir donner certaines informations à certains laps de temps, et que cette information-là peut devenir disponible au public ou pas. Les données sur les agences de placement de personnel nous disent que 9,2 milliards de dollars ont été dépensés par les hôpitaux de l'Ontario pour des agences de placement de personnel en soins de santé. De ça, près de la moitié n'a jamais été pour les soins; a été pour les profits.

Toutes les autres provinces au Canada ont des lois pour limiter l'utilisation, pour limiter les coûts afférents que les agences de placement de personnel demandent, sauf l'Ontario. Là, l'Ontario va avoir une loi sur les agences de placement de personnel, mais qui en fait très peu. Tout ce qu'on leur demande, c'est de soumettre un rapport de temps en temps et peut-être que le rapport va devenir public. On a besoin de beaucoup plus que ça. J'ai un projet de loi pour limiter l'utilisation des agences de placement de personnel. J'espère que le gouvernement va être prêt à faire un plus grand pas.

La prochaine, l'annexe 4, c'est la Loi sur la protection et la promotion de la santé, qui limite les pouvoirs des médecins-hygiénistes, qui doivent demander une approbation écrite du médecin-hygiéniste en chef pour mettre en place certains changements. On ne sait pas pourquoi on ajoute cette étape-là. Ce n'est pas nécessaire, mais ils l'ont mise quand même.

L'annexe 5, c'est le dépistage obligatoire par test sanguin. Les infirmières praticiennes vont maintenant avoir le droit de faire ça. Elles ont toujours eu le droit depuis longtemps, longtemps, de faire des prescriptions pour des tests sanguins, mais n'avaient pas le droit de le faire lorsque c'était du personnel pompier, policier ou paramédic qui en avait besoin.

Le dernier, c'est la Loi sur la protection des renseignements personnels sur la santé, qui veut amener les dossiers et la carte Santé vers les ordinateurs vers l'année 2025—un pas dans la bonne direction, mais qui doit être fait avec l'appui des gens qui sont un peu nerveux face à ça.

Merci beaucoup, madame la Présidente. Thank you, Speaker.

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): Questions?

Mr. Lorne Coe: I wanted to thank the member for Nickel Belt for her presentation. It's tough to talk that long, for an hour, right?

I want to circle back, Speaker, through you, on mandatory blood testing. As you would expect, there are regular conversations that we have with the police services in our ridings—for me, it's the Durham Regional Police Association, and Andrew Tummonds is the president. We talked a little bit about this bill recently, and he talked about the current process being—I want to make sure I get it right—slow and cumbersome, which can hinder timely investigations and the administration of justice. They're pleased that they have the ability now, through this proposed legislation, to enhance public safety in my riding and other ridings in the region of Durham.

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Given the importance of these reforms, does the member from Nickel Belt stand with the police officers in Ontario in supporting this bill?

M^me^ France Gélinas: I'm always happy to stand with police officers, firefighters and paramedics. Basically, the people they've helped are the ones who will have their blood tested—not the paramedics or the police officers—to make sure that the people that they've helped—usually in a time of crisis, in an accident, where there is blood all over the place. Sometimes, people are vindictive and will spit on them and that kind of stuff. That person will need to be tested. If the firefighter, the police officer or the EMS had been in contact with bodily fluids from that person, it used to be that you had to find a physician who would write a requisition for the blood test to be done. Now you can ask a nurse practitioner to do the exact same thing. She or he has the power and knows how to do this. It will make things faster and less cumbersome—absolutely, a good step in the right direction. I support it 100%.

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): I recognize the member for Niagara Falls.

MPP Wayne Gates: I want to congratulate my colleague—an hour, to stand up here and talk. That's not easy to do, and as you get older, you'll find out why.

The Conservatives are spending $9.2 billion on agency nurses. It makes absolutely no sense.

I want to read the bill—More Convenient Care Act, 2025.

I'm going to ask you a question that I think is fair and reasonable: How is this bill going to help people who don't have a family doctor? We have 2.3 million people in the province who don't have a family doctor today. What care are they supposed to get that's going to be more convenient?

M^me^ France Gélinas: The member is absolutely right; we have a crisis in Ontario. I've compared it with—is it important to water your flowers? Yes. But when your house is on fire, this is where the water should go. The house on fire is the 2.3 million Ontarians who don't have access to primary care; it is the 122 patients at Health Sciences North who are sick enough to be admitted into a hospital but are in a hallway or in a TV room or anywhere but a room, because our hospital is too small. All of this is a crisis.

The government brought forward their first health care bill after an election. You figure that they would put all of their energy towards solving a crisis and put a bill forward that would really give hope. None of that is in the bill. You're without a family physician, and this bill passes—you will be without a family physician.

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): Question?

Ms. Lee Fairclough: Congratulations on a one-hour debate. I think that is quite impressive. I didn't see all of it, because I was in public accounts, but I was trying to watch a little bit on the TV behind—what you were saying, as well.

I want to ask you about the section on agency nursing. I don't know about you, but I got a little bit hopeful that we might have some increased accountability around it, until I read the bill. I'm interested in you expanding a little further on your thoughts on the schedule related to agency nursing.

M^me^ France Gélinas: Agency nursing: It asks the agencies to give some information at some time frame not defined, that could or could not be shared publicly. That's all it does.

We have a crisis. We're talking about $9.2 billion spent by our hospitals, not for care—half of this went to profit, because they had to use agency nurses.

Every other province in Canada has put forward legislation to limit the use of agency nurses—the last one was Quebec, who is already moving forward in their big centres. We have a law in Ontario—I brought forward a bill that would do just this, to make sure that the billions of dollars that our hospitals spend on agency nurses could be put toward good, permanent jobs. We can do this, but it's not in the bill.

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): Question?

MPP Paul Vickers: This bill aims to make it easier for Ontarians to access their health information online. By implementing this measure, we are ensuring that individuals can conveniently view their medical records, test results, and other important health data through secure online platforms. This increased accessibility empowers patients to take a more active role in managing their health, facilitates better communication between patients and health care providers, and enhances the overall efficiencies of the health care system. It also helps in reducing administrative burdens and wait times for accessing health information. Given these benefits, why does the member disagree with this initiative?

Specifically, do you not agree that in our modern world we should be making health information more accessible online to Ontarians, and will you agree that the status quo is not good enough for patients to access their own health data?

M^me^ France Gélinas: I absolutely want health information to be available to patients. I absolutely want to live in 2025 and not in—whatever. But it has to be done in a way that maintains the trust between what I'll call the "patient" and the "health providers." If you don't have a trusting relationship between the patient and the health provider, you cannot have quality care. And when you have the Information and Privacy Commissioner, who asks you to withdraw schedule 6—then it makes me nervous. If people don't trust it, then you will do more damage to our health care system than good. Do I want this to happen? Yes, absolutely. Other provinces are doing it, and they're doing it in a way that is supported by their agencies, by their privacy commissioners. I want us to get there. I want it to be accessible. It will help manage—it will bring efficiency. This is 2025. We should have it already—but do it in a way that where the Information and Privacy Commissioner gives you a check mark, "You're doing good," not a "Withdraw this."

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): The member for Mushkegowuk–James Bay.

M. Guy Bourgouin: J'aimerais te parler de l'annexe 2, parce qu'on sait comment les services en français sont importants, puis encore plus quand ce sont les services à domicile. On sait aussi que le gros enjeu, c'est de les garder. J'aimerais vous entendre sur ce point-là, parce que vous en avez parlé un petit peu, mais je veux vous donner l'opportunité d'en parler plus profondément.

M^me^ France Gélinas: Merci. Absolument, dans les soins à domicile, le plus gros problème, c'est que les cliniques privées, les Bayshores ne sont pas capables de recruter et de retenir le personnel. Pourquoi? Parce qu'ils n'offrent pas de bons emplois permanents, bien payés avec des vacances, des avantages sociaux et des journées de maladie. Peut-être qu'on pourrait rêver d'avoir un plan de pension.

Qu'ils traitent leurs employés comme avant que Mike Harris ait fait la privatisation du système de soins à domicile, où est-ce que c'étaient des bons emplois—il y avait des infirmières qui travaillaient là toute leur carrière dans les soins à domicile. C'est ce que les gens veulent. Ils veulent demeurer chez eux. Ils veulent être soutenus de façon respectueuse, à la maison, chez eux, et ça, ça se fait au travers des soins à domicile. Mais les soins à domicile qui, à toutes les semaines, appellent pour dire : « Oh, on ne sera pas capable d'y aller; même si tu as besoin d'aide pour te transférer de ton lit à la toilette, pour t'habiller, tout ce qu'on te donne, c'est deux bains par semaine », ce n'est pas suffisant. Les soins à domicile ont besoin d'aide et ce n'est pas dans le projet de loi que tu vas trouver ça.

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): Further debate? I recognize the—

Mr. Anthony Leardi: Point of order.

The Deputy Speaker (Ms. Effie J. Triantafilopoulos): The member for Essex.

Mr. Anthony Leardi: I just want to take this opportunity to remind everybody that there is a Beer Canada reception commencing at 5. Thank you very much.

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The Deputy Speaker (Ms. Effie J. Triantafilopoulos): I'd like to recognize the member for Don Valley East.

Mr. Adil Shamji: Good afternoon, Madam Speaker. Thank you for allowing me this opportunity to speak to one of the government's latest health care bills, Bill 11.

I'd like to begin by stating that I'll be sharing my time with the member from Etobicoke–Lakeshore this afternoon.

At first glance, the More Convenient Care Act, 2025, appears to be a tidy bill that patches a few regulatory holes and modernizes a few existing statutes. But look closer, and I suspect that you'll see something far more familiar and far more disappointing. This is a bill that in many ways is made to look as though it will help—but actually won't, and in some cases, it may make the situation worse. It reflects this government's ongoing pattern of over-promising, under-delivering and avoiding the structural reforms that our health system truly needs. To be clear, there are certainly elements of this legislation that can and should be supported, but I must admit that I have major reservations with other parts of it. Those parts are woefully incomplete and, without significant amendment, cannot achieve what they set out to attempt.

In many cases, this bill pretends at progress while bypassing the actual work. Nowhere is this clearer than in the shadow of Bill 135. And I think Bill 135, the Convenient Care at Home Act, is illuminating—to see what the consequences are of legislation that this government introduces that has the words "convenient care" in it. Bill 135, the Convenient Care at Home Act, passed just last year. It was pitched as a transformational reform to improve access and efficiency in home and community care. What it delivered, instead, was chaos. That legislation dismantled the 14 local health integration networks and replaced them with a single centralized entity, Ontario Health atHome, a subsidiary of Ontario Health and a crown agency. Critics, including myself, warned at the outset that this centralization would lead to more bureaucracy, less flexibility and slower responses to community needs. We were right.

In less than a year, Ontario Health atHome has become synonymous with disorder. The new system has failed to deliver basic care to patients across the province. Reports have emerged of homebound patients missing medication deliveries, not getting access to the equipment and supplies that they require, being denied access to palliative care, or being sent to emergency rooms in their final days because the system couldn't provide them with the bandages or pain relief that they required. One might call that a crisis, but typically crises are natural disasters. This is a government-made disaster, the result of hasty restructuring with no regard for front-line realities.

Under Bill 135, legislation enacted to ostensibly make care more convenient, we've seen a procurement and distribution system so overwhelmed that it has led one official to describe these as catastrophic shortages. Health professionals have flagged that contracts were awarded with minimal transparency. Even the Minister of Health of herself has called the outcome "completely unacceptable."

In the wake of a past bill that promised more convenient care in its title and yet failed so dramatically, I hope that I can be forgiven for being terrified at the prospect of a new More Convenient Care Act or to feel as though the title, if anything, just sounds like a threat. For those of us who watched the last reform unravel, convenient care under this government is now synonymous with delays, uncertainty and abandonment.

This government continues to legislate as though the biggest problems in our health care system are technical or bureaucratic, as though we can fix systemic underfunding and workforce burnout with a few data reports, a new central authority or a clever new name. But until we address the real issues—the staffing crisis, the erosion of local autonomy, and the chronic underinvestment in public care—these bills will keep piling up and the problems will only get worse.

My analysis of this legislation will focus on schedules 2, 3, 4 and 5, with my colleague the member for Etobicoke–Lakeshore also commenting on some of these schedules and elaborating on the rest.

I'll begin by focusing on schedule 2, which amends the Connecting Care Act, 2019, to make that new service organization, now known as Ontario Health atHome, subject to the French Language Services Act. On its face, this is uncontroversial and entirely supportable. Of course, French-language services should be protected under the law. Of course, Ontario Health atHome, just like any other government agency, should uphold the rights of francophone Ontarians. But we must not mistake this symbolic compliance for meaningful respect or implementation. In fact, this government's track record with French-language services has been defined by neglect, broken trust and outright disrespect.

For example, the last report by the French Language Services Commissioner revealed serious shortcomings in the province's offerings of services in French—some examples now: Many francophones report having to switch to English in order to receive government services, and many government websites are not equally available in French. For unilingual francophones, this can result in not receiving urgently needed government supports, and even bilingual Franco-Ontarians often feel more comfortable in their own language and are left behind by widespread difficulty because they're unable to do so, and the reason is that in many cases they're being forced to explain their situation in English, resulting in a less clear communication of facts. As it relates specifically to health care, if someone is not fully comfortable in English and does not have access to health care in French, important and life-altering miscommunications can happen, and I've seen that in my own clinical practice.

Other examples of disrespect for francophone rights and services include the government's choice to slash and burn funding for francophone rights in their first year in office—cuts that have never been undone. And we're still suffering from the decisions this Premier made seven years ago.

Some of the most devastating impacts have been on our francophone post-secondary institutions. Funding francophone colleges and universities is the only way to make sure that Franco-Ontarians don't have to abandon their language to succeed in their careers. We need to be training and educating the next generation of francophone nurses, teachers, optometrists, dental hygienists, paralegals, police officers—and other in-demand jobs—to ensure a vibrant future for Ontario francophones. Merely amending legislation in this superficial way, as we're seeing in Bill 11, is not adequate. Unfortunately, universities like University of Ottawa and colleges like La Cité are experiencing extreme budgetary difficulties, and the government is refusing to provide basic levels of support—in the same way that I am deeply concerned the basic levels of support to implement the French Language Services Act within the Connecting Care Act will not be present.

In the past, government funding has resulted in colleges and universities relying on francophone international students to balance the books. Now with federal restrictions on the number of international students, those universities and colleges are left without funding. The simple solution is that the province must fulfill its basic obligations and ensure that universities and colleges are able to offer a diversity of programs at affordable tuition rates. To do otherwise sets the future of Ontario up to be less-skilled and less-educated, especially for francophones—which brings me back to the current legislation, which finally purports to do something after treating francophone communities as an afterthought and leaving them out in the first place. Even within the bill, where the application of the French Language Services Act is finally extended to Ontario Health atHome, it is telling that this provision is buried in schedule 2 with no fanfare and no resources attached. It reads more like a legal patch to meet minimum obligations than a real investment in linguistic equity.

So, yes, I support this change, but we can't congratulate this government for doing the bare minimum, especially when so much damage has already been done. Franco-Ontarians deserve more than basic minimum legal compliance. They deserve confidence that their language rights will be upheld—not only on paper, but in practice. Nothing in any of the examples that I've given earlier in my remarks has inspired confidence that they will.

I would next like to turn to schedule 3, which focuses on the creation of a new statute: the Health Care Staffing Agency Reporting Act, 2025. At long last, this government is acknowledging the unregulated explosion of temporary health care staffing agencies in our system. That alone is a step forward. But let's be clear: This schedule is a shadow of what is actually needed.

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Ontario's hospitals, long-term-care homes and home care providers have been pushed to the brink. COVID-19 exposed the deep fractures in our workforce: wage suppression, exhaustion, moral injury—wounds that were exacerbated by policies like Bill 124, which capped compensation at levels below inflation and drove nurses out of the health care system. Into that vacuum stepped temporary staffing agencies, filling shifts with short-term, high-cost personnel—and their growth has been nothing short of staggering. For example, hospitals in northern Ontario now routinely pay, easily, $160 an hour for agency nurses—nearly quadruple what they may pay their permanent staff—plus accommodation, travel and onboarding costs. Some hospitals have even been forced to buy houses just to host agency nurses because housing markets are so tight. That's public money being siphoned away from patient care into private contracts.

But cost is only part of the problem. Agency nurses often arrive unfamiliar with hospital systems, requiring weeks of onboarding. They rotate quickly. Continuity of care suffers. Perhaps most gallingly, many of these agencies actively poach public nurses out of our system, only to send them back into those same hospitals at triple or quadruple the cost as agency nurses. Some agencies even hire out of hospital parking lots.

Through all of this, these agencies have operated with no regulation whatsoever—no credential-verifying requirements, no licensing, no controls on pricing, no

oversight on recruitment practices. It has been, as one commentator described, the Wild West of health care staffing.

Now this government has introduced a bill. What does it do? It asks for data. It requires agencies to submit reports on billing rates and administrative fees, and it empowers the minister to publish those figures if the minister wants to. That's it—no licensing, no restrictions on predatory contracts, no enforcement of fair pricing, no safeguards for patient safety. Transparency, especially voluntary transparency, is not regulation. And schedule 3, as written, is essentially toothless.

Contrast it with Bill 67, the private member's bill that I introduced, which laid out a robust yet minimally invasive licensing regime. Bill 67 would have accomplished the following: It would have prohibited dynamic pricing—just like we see with Ubers during rush hour—that exploits short-term desperation; it would have banned non-compete clauses that lock nurses out of underserved communities; it would have prevented agencies from placing nurses in hospitals they just left as full-time staff; it would have required credential verification and liability coverage; it would have ensured transparent reporting of expenses, revenue and contracts; and it would have empowered inspectors to monitor compliance and issue fines that would deter, without bankrupting operators. That bill was supported by front-line workers, hospitals and the public, but this government regrettably did not adopt it. Instead, this government has come forward with schedule 3, a watered-down version that asks bad actors to essentially voluntarily disclose their prices, with no mechanism to actually stop exploitative behaviour.

The stakes are high. Recent reports indicate that temporary nursing agencies have charged hospitals nearly $9 billion in recent history. That's money that could go towards stabilizing our public workforce, improving wages, or reopening shuttered emergency departments.

Let's also remember, temporary staffing agencies are not the problem; they are a symptom, a desperate solution for a system in crisis. We can't fix the underlying problem if we let those agencies operate unchecked, and the fundamental strategy needs to be to overcome this preoccupation with health care worker recruitment, which is one part of the solution, but to rebalance so that we are also focused on health care worker retention, making sure that our workplaces are safe places to work, making sure that people are paid fairly, making sure that there is stability in scheduling, ensuring that health care workers get the respect and dignity that they require.

This bill doesn't offer any of those things. If this government is serious about addressing agency reliance, then schedule 3 must be amended to include a licensing regime, enforceable standards and basic protections for the public interest. Anything less, I would argue, is not a solution but just a spreadsheet.

Next, I would like to turn my attention to schedule 4, which focuses on the Health Protection and Promotion Act. Now, what schedule 4 proposes is a deceptively simple change to that Health Protection and Promotion Act. It would require medical officers of health to obtain written approval from the Chief Medical Officer of Health before issuing any class order. A class order is an instruction or directive affecting a broad group of people in response to a public health threat. This could be, for example, an order implementing a quarantine or lockdown—a decision that can never be taken lightly and that almost always is implemented in the wake of an emergency.

We certainly saw the regrettable but necessary use of class orders during the pandemic with COVID-19. If there's one thing that that underscores, it is that when class orders are implemented under emergency circumstances, the emergency element of that indicates we don't have the luxury of time. Apparently, this government would think that we do.

This change would essentially mean in practice that no local medical officer of health would be able to act independently in a public health emergency. Their authority, once grounded in science, local knowledge and immediate responsiveness, will now be conditional on approval from Queen's Park. That conditional approval that lacks a local context should concern every Ontarian, because we have seen time and time again that when public health is centralized, it becomes slower, more political and less responsive.

Let us take a moment to consider the Ford government's track record as it relates to public health. In 2019, for example, this government announced sweeping cuts to public health funding, slashing the provincial share and pushing costs onto municipalities. Programs that were once 100% provincially funded dropped to 70% or even 60% funded, forcing local units to reduce essential services. The government has also tried, and continues to try, to consolidate our local public health units, ignoring regional differences, undermining local accountability and risking rural and underserved communities falling through the cracks.

During the COVID-19 pandemic, we saw what happens when provincial approval becomes a bottleneck. When local officials in Toronto and Peel called for stronger restrictions in the face of rising cases, the province dragged its feet and that cost us lives.

Now, we've also seen the impact of centralization in public health units and concentration of power play out in other crises. In Thunder Bay, public health officials overwhelmed by the opioid crisis find themselves underfunded and undermined. During migrant worker outbreaks, local health units have lacked the authority and resources to intervene quickly. And we see inconsistent school responses and vaccine rollouts, all symptoms of a public health system where local expertise is stifled and provincial control is overreaching.

Nowhere is this more true than what we are seeing unfolding as we speak with our measles outbreak here in Ontario, where we have the most number of cases compared to any other jurisdiction in North America and on this continent. As we have seen the number of cases rise and, frankly, accelerate over the past five months, at

the same time, we have seen local public health units—I believe we're at 10 now; nine or 10—forced to consolidate. And in the midst of a public health emergency—a catastrophe, the worst measles outbreak our country has seen in three decades—can you imagine local public health units, essentially independent organizations unto themselves, being forced to amalgamate, find new processes, create new organizational structures, align new budgets and having to do so while trying to simultaneously respond to an emergency? No doubt it is a critical factor, one of many critical factors, explaining why the measles response in our province has been so terrible.

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For a government that speaks about cutting red tape and being preoccupied with slashing paperwork, all this schedule does is create more paperwork, but public health threats don't wait for that. Whether it's measles, opioids or a food-borne outbreak, we need our local public health officers to act quickly, independently and based on the realities of their communities. Yet schedule 4 moves us further in the opposite direction. It puts politics over public health. It makes decisive action slower. It removes local accountability and replaces it with bureaucratic gatekeeping.

In the current system, I will say, there may be circumstances in which the Chief Medical Officer of Health may disagree with a local medical officer of health. This is a very rare circumstance. I can really think of, at best, only one circumstance in recent memory in which that may have happened. In such a situation, there is no reason that a Chief Medical Officer of Health cannot overrule a local medical officer of health.

Conversely, if a local medical officer of health needs to respond quickly, they are now forced to go through additional bureaucratic steps in order to get approval for the urgent emergency response that they are asking for. How can you provide a local, timely, contextually sensitive public health response when you've got to report to Queen's Park every time you need to?

So this is not coordination; this is control, and it comes in a context where public health in Ontario has been chronically underfunded, repeatedly reorganized and left dangerously fragile. If the government wants to improve public health response, it should start by restoring funding, respecting local expertise and depoliticizing the system. Requiring permission slips from Queen's Park during a crisis is not reform; it is merely sabotage.

I will now touch on schedule 5, the amendments to the Mandatory Blood Testing Act, 2006. Under these amendments, the proposed legislation, if passed, will allow nurse practitioners to carry out several key functions that were previously restricted to physicians, including making reports, collecting blood samples and receiving lab results under the act. The need for obtaining these blood samples can occur in a variety of circumstances, oftentimes after exposure to bodily fluids in performance of emergency services. A common scenario would be a needle-stick injury in a health care setting.

I can speak from personal experience that this has happened to me. In fact, many people would say you haven't practised in a clinical setting or in health care for long enough unless you've had a needle-stick injury. I can reflect on how terrifying that is: having a patient whose blood-borne pathogen status is unknown and getting poked with a needle that is contaminated with their bodily fluids. On the occasion that it happened to me, my patient had a degree of cognitive impairment, so I couldn't get permission from the patient themself to get a blood sample, but I was able to communicate with the family. But if I hadn't been able to, the Mandatory Blood Testing Act would provide an avenue for me to be able to obtain a blood sample and determine my risk for a blood-borne pathogen such as HIV or hepatitis C.

As we face a crisis in our health care system, with more people than ever before not having access to a family doctor, with rampant emergency department closures across our province, it is entirely foreseeable that a situation may arise in the future where a first responder is exposed to blood or a bodily fluid and would require a court order for mandatory blood testing.

If a physician is not available, it is absolutely appropriate, in my opinion, for a nurse practitioner to be able to step in. They're qualified and are well trained to make the order and interpret the results. This reflects the reality of modern health care delivery, particularly in long-term-care homes, rural and northern communities and other settings where nurse practitioners often may be the only available clinician to deliver health care. This step of expanding their authority is not just reasonable, I would argue it is overdue. But it also raises an important and uncomfortable truth: This government has spent seven years undermining, sidelining and under-supporting Ontario's nurse practitioners, and no amendment tucked into schedule 5 can erase that track record.

Let us recall that Bill 124 kept public sector wage increases, including for nurse practitioners, at 1% annually, far below the rate of inflation. It suppressed their wages, sapped their morale and drove practitioners away from the public system. When the court struck it down as unconstitutional, the Ford government appealed. The government also rejected efforts to allow nurse practitioners to be fully integrated into Ontario's public health care system. When I introduced private member's legislation called the Keeping Primary Care Fair Act, there was a proposal to bring nurse practitioners and clinics that they work in under the Commitment to the Future of Medicare Act. It would have allowed nurse practitioners to be publicly funded like physicians and community health centres, using models that reflect their real-world work. This government voted that down. As a result, nurse practitioners are still forced to operate on the margins of our system, often billing privately, cobbling together grants and working through administrative loopholes just to serve their communities, sadly all too often leaving patients with no choice but to use their credit cards instead of their OHIP cards.

So, I do support this schedule, but let's not pretend that expanding scope of practice in this narrow context makes up for years of exclusion. If this government truly values nurse practitioners, it will take bold action to support their work—not just grant them authority under a single act, but provide them with stable funding, equitable compensation and full integration into our public system. Until that happens, gestures like this, however welcome, will be seen for what they are: too little, too late.

Madam Speaker, the More Convenient Care Act tries to present itself as a pragmatic bundle of modest reforms—a little more data here, a little more oversight there—but as we have seen, that modesty is its greatest failing. This bill does not meet the moment. It does not confront the depth of the crises we are facing in staffing, in public health or in equitable access to care. It gestures at solutions while avoiding the structural changes that are urgently needed. In doing so, in some cases, it risks entrenching the very problems that it claims to address. It centralizes authority at the expense of local decision-making. It collects data without correcting abuse. It makes symbolic gestures towards inclusion—of French-language services, of nurse practitioners—while failing to fund or empower those commitments in practice.

We must remember that legislation does not exist in a vacuum; it lands on the fractured ground this government has created through Bill 125, Bill 124 and years of disinvestment and erosion. On that ground, the foundations laid by this bill are not strong enough to carry real reform. This is why I am calling for significant amendments. I am not here to tear it down without offering a path forward. With significant amendments, this bill could become part of a meaningful step towards repairing our health care system.

Schedule 3, for example, must be reworked to create a licensing and enforcement regime for staffing agencies based on the principles laid out in my Bill 67. Schedule 4 must be amended to preserve and respect the autonomy of local medical officers of health, allowing rapid, independent responses to public health emergencies. The changes in schedule 2 and schedule 5 must be matched with real investments in French-language services and the full public integration of nurse practitioners.

Madam Speaker, this legislation has the opportunity and the obligation to do better than symbolic action. If the government truly wants to build a more convenient system, then it must be one that is more accessible, more accountable and more equitable, not just more centralized. So today, this afternoon, I am calling on all members of the House to work together, to work with me, so that we can amend this bill, so that we can fix what is broken, and so that we can deliver the health care that Ontarians actually need.

I thank you and yield the rest of my time to the member for Etobicoke–Lakeshore.

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The Deputy Speaker (Ms. Effie J. Triantafilopoulos): I recognize the member for Etobicoke–Lakeshore.

Ms. Lee Fairclough: Thank you, Speaker, for the opportunity to address Bill 11, with the short name of More Convenient Care Act, 2025. The bill, as the longer name implies, addresses a hodgepodge of very important issues related to health care, public health and personal health information.

Our health care system is something, as Canadians, we take pride in. For those like myself that have spent many years working in that system, we see daily how important it is to have timely access to care and to seek care when you're sick, knowing that you will not be required to mortgage your home or use all your savings to pay for your care. This principle is at the core of who we are and what we believe in as Canadians.

Improving timely access to health care is vitally important, and I very much support the policy directions in this bill, especially vis-à-vis schedule 6. But it is essential that we get things right. There are several aspects of this bill that are very important, and following the remarks from my colleagues, the member for Don Valley East, I will discuss three of them in more detail: schedule 2, schedule 4 and schedule 6.

Schedule 6 makes amendments to the Personal Health Information Protection Act of 2004. It makes related amendments to the Health Information Protection Act of 2016. The changes hinge on the issues of who is a prescribed organization, and the duties and powers provided to those organizations. These are really important concepts about how our personal information can be used and who will have the authority to use it. It also spells out the role of the minister in making decisions and providing directives to organizations about digital health identifiers and activities.

At the highest level, I want to start by saying we need to properly implement electronic health records and patient portals. Patients need to be able to have a complete picture of their health care as they journey from an emergency department, have had to follow up with a specialist like an oncologist specializing in cancer treatment at a different hospital or a cardiac surgeon following a heart episode. As they return, then, back to their family physician, and they have had blood work done at a local lab or gone for imaging at another hospital, they have to have access to this information to be empowered in their care. That, I believe, is critical.

We've also been studying this for years, to be sure that as we develop patient portals and access to their information and provided people with direct access to their electronic health records, that it was done in a way that was useful and empowering and, importantly, with all the appropriate checks and balances to protect their privacy.

For example, I remember close to 20 years ago, when I was working at Princess Margaret hospital, we wanted to provide the very basic ability for patients to have their lab tests done close to home and then be able to see the result before they travelled down to Princess Margaret for their care. These were patients that were undergoing treatment for leukemia. If their blood counts were too low, treatment might need to be delayed. People were spending hours

travelling to the hospital for this highly specialized care, only to turn around and go home. This was accomplished by working with a prominent lab provider and the IT team at UHN to solve the problem. This is one of the very early test cases of how we could share information between health service providers and the patient that enabled better coordination of care.

A few years later, we started discussing patient portals and whether it was even appropriate to provide people with access to test results and clinical notes before they had had a chance to discuss them with their doctor. This was a big debate in the health care community. An important study was released at that time that demonstrated that patient access to records improved their ability to be prepared for questions of their provider, to organize aspects of their care, including prescription renewals, and understand the care that was planned for them.

It was important research to move ahead on patient portals and access at the time. We're now 25 years later. It's been slow progress, and we still don't have a complete picture readily available to patients. At an individual provider level, the information is available. I have the ability to access my clinical records at UHN, St. Michael's and St. Joseph's hospital, all hospitals where I have received care at various points over the last years. However, for the most part, it requires patients to access each hospital system separately. Digital solutions like ConnectingOntario enable clinicians that have consent from a patient to be able to at least see their test results and clinical notes between different providers to piece together a story. However, there's no ability for the clinician or a patient to holistically see the big picture, see trends, analyze what those results mean. Patient portals that give access to their own test results, appointments and clinical notes are really great; however, each hospital has to have their own, and many of them do not apply to family physicians.

As an example, I was trying to help a close family member navigate their care. Their care included a full assessment for severe swelling in their lower limbs, diagnosis and surgery for lung cancer, assessment for rapid and severe hearing loss, and early-stage dementia. For him, this meant multiple ways to access his records, access to separate systems for his labs and imaging results, when they weren't done at the hospital, and clinical notes. There were so many clinicians involved in his care: the family doctor, respirologist, surgical oncologist, radiologist, geriatric psychiatrist—the list went on. But what was evident to all of them involved in his complex care is that they needed to be empowered with access to their information.

It is time we help turn this into a reality for patients, families and clinicians. The idea of a single digital ID that links this information is exactly the right solution: a single portal for patients to see their results in an integrated way; a single place for clinicians who have patient consent to see the full picture. We need this service in Ontario and we're actually now really lagging behind many other jurisdictions.

Speaker, we do need this service, which is why I'm actually so concerned about the Information and Privacy Commissioner's assessment of this bill tabled under the last Parliament as Bill 231. She said, "Rather than confer individuals access rights to their health records in the EHR, Schedule 6 actually diminishes those rights." That is a very stark and sobering statement and that cannot be the outcome of this bill, actually. The changes that are proposed in this legislation are designed to confer the capacity of a third-party organization to provide clinician and patient access to all records. In Ontario, given the disparate and independent governance models of organizations, of hospitals, of community providers, each a prescribed entity unto themselves, to manage personal health information, we don't have an organization that is able to hold information at the system level and make it available. Each hospital and community organization has its own boards and requirements to maintain privacy.

Ontario Health is the massive agency that the government has created through the amalgamation of 20 agencies. Its authorities and roles are highly varied as a result of this amalgamation. They do have the ability to collect information for the purposes of managing the system and, in some, authority for some other programs. They are the natural organization to enable a strategy like this.

Where I get concerned is this: The government has now tried to move this issue ahead multiple times, the first through regulation last summer and now through two bills, Bill 231 in 2024 and now Bill 11. Each of those times, the Information and Privacy Commissioner of Ontario provided a detailed letter of concerns and recommendations to resolve, and I looked closely at all those versions to see if anything had changed, and little had changed.

Yet the Minister of Health said in her opening debate, "First of all, we have been working very closely with the Information and Privacy Commissioner to ensure that the protection is there. As much as we are keen to push forward on this very quickly, we also need to be very careful to make sure that we have the protections in place, because I think most of us will agree that our personal health information is probably the thing that is most needed to be secure. So we have been working with the Information and Privacy Commissioner's office all through the preparing of this legislation and, ultimately, regulation."

Really. Did you really work with them? Because I don't see the evidence of it. How is not making a single change in response to the feedback from the privacy commissioner working with them?

In this session of Parliament, the government has introduced bill after bill that reduces or eliminates legislative oversight, consolidates ministerial/executive power at the expense of individual rights.

According to the IPC, this bill repeals Ontarians' already established right of access to their records, and it only contemplates restoring them at a later date—it authorizes the government, at a later date, to narrow those rights through rule-making authority.

1700

And she continues, to say that the bill "further confuses the many roles of Ontario Health and challenges my office's ability to oversee and enforce the law."

Much is being deferred to ministerial direction and/or future regulation, and while there is a provision for consultation, there's no requirement for the minister to take the received advice.

Ontario Health will have new authorities through this legislation, and we can't forget that this legislation involves unnamed third parties as agents to facilitate digital ID. There's no requirement that this company is Canadian-based or where they'll store that information. And because the legislation references regulation—regulation that will specify the type of information that will be made available and other important details—it leaves it wide open to how the government could interpret this. If what we need to do is to be more specific about the organization we're working to enable in this third-party relationship, I believe we should put the effort in and adjust the legislation as such.

So here's my offer to the current government: I want to see the ability for patients to access their information in a consolidated way to be more empowered in their care. I want to see doctors and those provided permission able to access medical information they need from across the health system to provide the best care. Countries around the world, and here in Canada, and others have this ability. We need to enable this in Ontario, and I think, though, we should be working to incorporate some of the feedback from the privacy commissioner. My offer to the government is to make the time to work those into the system, and with the privacy commissioner, to make the adjustments to the legislation through the committee process. I'll do the work to do that, because as she has recommended, I don't want to see this schedule removed, as this is an urgent issue that needs to be solved to enable better care. We need to provide confidence to people that their health care data is protected, and we have work to do on this schedule. That's my offer, and hopefully you may accept that working support.

Schedule 3 attempts to bring some increased accountability around health care staffing agency use in Ontario. This is something that my colleague spoke to very eloquently earlier and has been calling for action on for many, many years.

As a hospital president during the pandemic, I saw the egregious hikes in rates by staffing agencies, while I operated under Bill 124 with one arm tied behind my back on the way to fairly compensate people for the work they were doing in one of the hardest times I've ever worked through in the health system. Staff found themselves literally working beside their same colleagues who had made the choice to go and work for agencies because of higher salaries. But let's face it, it wasn't that they were seeing the markup that we were receiving—those were going to profits. Also, many travelled out of Canada with those same agencies. It was completely inappropriate, and it was allowed to continue for years under this government, with no restrictions, like the entire public sector in that period.

There are times when hospitals need to rely very temporarily on agency nursing. All hospitals manage it closely. It's a metric we look at very regularly, and we work to minimize it, knowing that continuity of care of a team of nurses and others is always what needs to be our goal. When I read this bill, I actually felt some hope that maybe it was an effort to bring it under control finally. But, as usual, it doesn't go far enough. In fact, it actually feels a little bit like adding red tape without any real potential for accountability. That's how I saw it. That's it.

The bill requires agencies to twice a year submit what they charged hospitals to get the staff, and fines them if they don't submit. That's it—just submit. As my colleague said, it creates an Excel spreadsheet. However, it doesn't suggest any plan to set a cap on the premiums charged, whether what has been invoiced is actually appropriate, or to even publicly report this—it gives the option to, but it actually doesn't make any commitment to. Will we really see anything change with that adjustment to the act? I doubt it. And I know my colleagues in the health care system will continue to do their part, managing agency use every day, but after so unfairly disadvantaging our public system for years—time when those rates were set—we are once again faced with inaction. I would actually support this minuscule step, yes, but I will never forget the situation this government put us in. Front-line workers will never forget either, and I know it because, time and time again on the doorsteps of health care workers in my community, I still hear it.

The next schedule that I'd like to speak to relates to health protection: schedule 4, the Health Protection and Promotion Act. This schedule is the usual power grab that we've learned to expect from this government. Public health officers and local communities need to be responsive when local issues requiring a class order need to be implemented. I've seen it time and time again in the course of my work. Time is often of the essence to protect the people impacted. I also know many of these public health officers. They are experienced professionals with an immense sense of accountability to the population they serve. They're appointed by local boards with the CMOH and, if hired, should have the trust of the CMOH to make the right decisions. So why this additional clampdown on control? Do I have confidence in local medical officers of health to manage appropriately? I do. I think the question is, why does this government not trust?

I'm not sure I trust that evidence will guide our choices on medical issues that are designed to protect the public—that arm's length will be maintained, giving room for Chief Medical Officers of Health to respond to issues appropriately. I would argue that the response to measles that we've been witnessing suggests this isn't the case.

In terms of the other schedules, my colleagues have spoken to these in more detail.

I'm definitely in favour of nurse practitioners working to their full scope, which is what has been described. Of course, I'm supportive of ensuring that French-language

service is available through Home Care Ontario—and introducing some consistency for the broader participation on the boards of public health units in municipalities such as Hamilton. All of these changes make sense. The question is, really, when it comes time to implement them, will they be implemented fully? And will people requiring French-language service actually be able to access it?

In my concluding remarks, I just want to say that Ontarians want faster, more convenient care, and we support that. But modernizing care doesn't mean weakening transparency or privacy. There's much in Bill 11 that we can support, from reporting transparency for staffing agencies to improvements in the scope of practice for nurses. But schedule 6, dealing with digital health identifiers and data handling, raises concerns about privacy, accountability and consent. I'm not being dramatic in this. I'm actually being really pragmatic. We just need to get to the table and redraft this in a way that we can actually put it into use and that addresses the various serious concerns that we've heard from the privacy commissioner. It will be really important to do that work at the committee and examine the input from stakeholders, including her. And then we need to do the work to adjust, to ensure the best outcome to ensure individuals' health information is accessible to them. Again, the studies have been done—when patients are empowered, they actually can have better outcomes.

I made a commitment today to bring forward those suggested revisions so we can finally, after decades, catch up with the rest of the world on enabling care with digital information. It can be solved; it just takes some additional lifting and some heavy work. I'll look forward to working with the committee on how we can do that.

Thank you very much, and we'll open it up now for questions.

The Acting Speaker (Mr. Lorne Coe): Questions?

Ms. Laura Smith: I want to thank the member opposite from Etobicoke–Lakeshore for her comments.

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I think we're all in agreement that providing good health care is a good thing. The reforms are intended to provide police officers with the tools they need to perform their duties, and this technology would facilitate that. I think the member is in agreement that if it's a holistic approach, it's good for the entire community.

Given the importance of these reforms—and I think I've heard some real positivity, which I am very encouraged by, and I appreciate that—do you think you have an issue with this, specifically having to deal with first responders?

I wondered if she would comment on the first responders and the importance of them having—

The Acting Speaker (Mr. Lorne Coe): Thank you for the question.

Response, please.

Ms. Lee Fairclough: Thank you very much for your question. I think that your question relates primarily to the schedule around the mandatory blood testing, if I'm not mistaken, and enabling nurse practitioners and others in those circumstances to be sure that we can respond quickly and order them. So I am definitely supportive of us moving ahead on that bill.

In terms of the digital ID, though, I think that extends much more broadly. I think the idea on the digital ID is that we're enabling patients. We're basically creating the ability to connect health records for use by those who work in the system and for use by patients being able to access them as well. Again, I actually believe we have to do this. We can't let time pass any longer, so I am very much in favour of working with the government—

The Acting Speaker (Mr. Lorne Coe): Thank you for that response.

We have a new question, from the member for London–Fanshawe.

Ms. Teresa J. Armstrong: Speaker, I really have to talk a little bit about the history of the Liberals when it comes to electronic records. There was a debacle called eHealth, if we all recall that. The Auditor General, in 2009, actually said that in this eHealth scandal, $1 billion was wasted, of taxpayers. So I don't want to see that repeating itself. You talked about assisting the government in making sure those things are done right.

One of the things I do want to quickly wrap up with: One of my constituents went to the hospital and asked for MRI results, a copy of the report, and they were directed to what's called PocketHealth. They accessed it, and they tried to download the MRI test that happened in 2022. They were charged $59.

Can you speak to whether or not fees should be applied to this new—

The Acting Speaker (Mr. Lorne Coe): I need to hear a question, please.

Response?

Ms. Lee Fairclough: Thank you for the question, which I think is whether or not fees should be applied in these circumstances to access the records.

I think that, first of all, what we should be moving towards is a method of being able to provide this through some of the electronic health records that we've already invested in. That is what is being contemplated here with the digital ID.

In terms of some of these other apps, I've certainly encountered them at hospitals and other places—radiology departments. They really are making choices to use those, because we don't have this ability across the system.

I know there's lots of history around electronic health records in this province, but, boy, it's time to act. We need to move, and we need to do it right—as I say, that's why I'm quite willing to invest the time to make sure we do.

The Acting Speaker (Mr. Lorne Coe): I have the member from Beaches–East York.

Ms. Mary-Margaret McMahon: Thank you to my capable and competent and clever colleague from Etobicoke–Lakeshore. You bring a wealth of information and experience and knowledge and credibility, quite frankly, to your role and to especially anything covering health care in this chamber. You have some great ideas and great experience, as I mentioned.

How hopeful are you that the government will work with you at the committee to actually pass your thoughtful amendments that I know that you'll have there to improve our health care system in Ontario?

Ms. Lee Fairclough: I have to have hope. I have to have hope in our democracy. We've got committees with mixed expertise. There have been three letters submitted to that committee, and hopefully the committee will take them to heart.

I feel encouraged by some of the questions from my colleagues. Let's get to work and make this happen.

The Acting Speaker (Mr. Lorne Coe): I have the member from Sarnia–Lambton with a question, please.

Mr. Robert Bailey: Thank you, Speaker. It's a pleasure to see you in the chair.

Ontario is emphasizing team-based care, which means patients will have access to many specialists as well as a family doctor. This approach would ensure that patients receive comprehensive care from a team of medical specialists. Can the opposition member please explain why she's opposed to this?

Mr. Adil Shamji: If I heard correctly, the member is wondering if we're opposed to team-based care.

I'd like to be very clear on the record: I fully support team-based care. I have worked in various models of team-based care, and I have seen the benefits that accrue to patients and their families when there is a team of health professionals, including physicians, nurse practitioners, social workers, psychotherapists, and a range of other workers.

Where I hope any members on the opposite side will not be mistaken is if any of us have reservations and criticisms about this government's rollout and implementation of team-based care. I hope that those members will reflect on our collective experience and the amendments we put forward.

When I see things like a primary action team call for proposals that highlights, I think, 100 postal codes, of which only 50 are actually the highest-priority postal codes and the remainder do not rank in the top 100 highest-priority postal codes, it leads me to be concerned that—

The Acting Speaker (Mr. Lorne Coe): Thank you for that response.

I have a question from the Solicitor General of Ontario.

Hon. Michael S. Kerzner: To the member from Etobicoke–Lakeshore: We, as part of this government, stand behind everyone who keeps us safe every day—our police officers, our firefighters, our first responders, and everyone.

What I really believe is so positive in Bill 11 is the expediting of the mandatory blood testing. This is something that the associations have asked for. This is a way that the Liberal Party can support Bill 11—to see if they'll stand with those who keep us safe.

Ms. Lee Fairclough: To the member opposite: As I've said, I'm quite supportive of what we're trying to accomplish in that schedule of this bill. You've very eloquently spoken to that membership, and hopefully we'll see that we'll be able to act on it.

As I said, for the bill to pass, more broadly, the most work is needed on schedule 6, and I look forward to working with the government on that.

The Acting Speaker (Mr. Lorne Coe): I have the member for Ottawa Centre.

MPP Catherine McKenney: I actually was fortunate to sit on the board of health in Ottawa for several years, and I do know how nimble a local board has to be—and looking at unique cases within their own unit.

Just on schedule 4—it does take away the autonomy of local medical officers of health on issues, directives regarding communicable diseases. Do you see any advantage? We know the disadvantages, of course—it's almost fully a disadvantage—but do you see any advantage to that?

Ms. Lee Fairclough: Thank you very much for the thoughtful question.

I do think that there are times when we need to be united in how we respond, mostly so that we can actually really reassure the public. I certainly saw that through the pandemic. We were trying to figure out what the science was telling us, what was the appropriate way—and we learn new things every day. So, in that moment, I think having a concerted effort to give the public some reassurance that we're all moving in the same direction is the advantage.

The Acting Speaker (Mr. Lorne Coe): Member from Kitchener Centre.

Ms. Aislinn Clancy: Recently, I met with a group of family medicine students, and they told me that 50% of the students in our satellite medical school in Kitchener Centre weren't going into family medicine because of the complexity of needs that were there, the compensation they lost when people went to walk-in clinics, the overhead in business.

What do you recommend for improving working conditions for family doctors so that they stay in the field after they graduate?

Mr. Adil Shamji: The top three things I would say that they're looking for: the opportunity to work in team-based environments; cutting red tape and bureaucracy; and then improving their remuneration, especially for administrative paperwork, recognizing that in the current environment, they're spending up to 19 hours per week on paperwork.

Mr. Speaker, I also want to compliment you. I find that you are fair but firm, and I've really enjoyed your leadership today.

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The Acting Speaker (Mr. Lorne Coe): Thank you very much for the compliment. You got 45 more minutes.

Further debate?

M^me^ Dawn Gallagher Murphy: I rise today to speak to our province's plan to provide Ontarians with the publicly funded care that will help build healthier communities and strengthen the province's health care workforce, today and into the future. These are transformative initiatives our government is advancing to

build a system that ensures accessible, high-quality care while modernizing our health care system.

Today's health care priorities are guided by a single principle: creating a patient-centred system that delivers the right care in the right place at the right time. Through bold investments and innovative legislation like the More Convenient Care Act, we are breaking barriers and laying the groundwork for a stronger and more resilient health care system—one that meets the needs of today's Ontarians and prepares us for the challenges of tomorrow.

Other legislative and regulatory changes being proposed in order to connect more people to convenient care close to home include:

—strengthening governance and transparency—and this is specific to schedule 3: creating a transparency framework for staffing agencies that operate in the hospital, long-term-care and community health sectors, to disclose administrative markup rates to the government through the new Health Care Staffing Agency Reporting Act; enhancing hospital governance by working with the sector to define best practices, ensuring providers across the province have access to the tools and resources they need to deliver high-quality care;

—enhancing patient care: modernizing the provincial electronic health record, the EHR, as this is the next step to being able to provide eligible Ontarians with safe, secure and direct access to their personal health information online through Health811—please reference schedule 6, Personal Health Information Protection Act; allowing nurse practitioners to complete and sign mandatory blood testing forms to expand access to care for people submitting applications, including victims of crime, correctional officers, members of the College of Nurses of Ontario or the College of Physicians and Surgeons of Ontario, medical or nursing students or paramedics—this can be referenced in schedule 5, the Mandatory Blood Testing Act; exploring and consulting on options that would support consistent and quality mental health and addiction services by better understanding the variety of services provided by this workforce; reviewing the ambulance vehicle and equipment standards to enhance patient safety and make it faster for paramedics to access the tools they need to deliver emergency care;

—improving service delivery to strengthen the authority of the Chief Medical Officer of Health to promote greater alignment and consistency when issuing orders to local chief medical officers of health across different health regions. This is part of schedule 4 of the Health Protection and Promotion Act;

—also, updating public health regulations for public pools, zoonotic diseases and diseases of public health significance, to reduce burden and align with best evidence.

Speaker, before I get too far into the details of this bill, I would like to speak to the chamber of my recent experiences with our health care system. It was in fact my husband's experience—which ultimately means my experience, as I believe that any time one person interacts with our health care system, there's the loved one who was at their side.

My husband had been in pain for some time. It was his hip. He made the decision to seek out help, finally. From the moment he interacted with our family physician to the moment he walked into the office of the orthopedic surgeon to the time he went to the hospital, our Southlake Health, my husband had nothing but huge accolades for our health care professionals. It is always a bit nerve-racking when you undergo surgery, for the patient and for the loved one, but everyone with whom we interacted were professional, empathetic, patient and always informing of the next steps in the process—and that's what it was about; it was a process.

Of course, I had to send a thank-you note to my husband's surgeon to thank him for helping my husband. What a difference he had made in the quality of my husband's life and our family. Well, I had the great honour of receiving a phone call from Dr. Gamble, who invited me to attend a Christmas function for the orthopedic staff at Southlake. He asked me if I would speak to the team. It would be a great thing for the team, he said, to hear about my husband's experience. What a true honour and privilege it was, to be in a room, to speak with a full room of doctors, nurses, physiotherapists—the entire team. That is what Dr. Gamble said to me: "Dawn, it's not just me; it's the team."

I was able to stand up in front of these amazing professionals and tell them about my husband's experience with the health care system, specifically with the orthopedic team, how he feels better than he did 10 years previous. Boy, did that get an applause. Yes, I was there as the MPP for Newmarket–Aurora, but I was also their voice at Queen's Park, and I was also the voice of a loved one. That was their patient they just cared for. It made all the difference in his life, as well as our family's, and now we can plan for our future family outings, which is wonderful.

However, I have to say once again to all the health care professionals at Southlake Health: Thank you from the bottom of my heart, on behalf of my husband and family. Your expertise, care and professionalism—you're the cream of the crop.

Now, I'd also have to go on to talk about a couple more incidents. I'd like to talk about my current situation. Unfortunately, my husband—once again, we find ourselves in the health care system. I've not spoken about this, probably with less than a handful of my colleagues, so this is new news to everybody. We had a cancer diagnosis—my husband—and this brought us through the health care system once again. I heard from one of the members opposite speaking today about the cancer care system, and this is why I've decided I wanted to speak about this today, to tell you about the experience we had in the health care system, because it's going to lead right into this bill.

Each step of the way, the care has been there for my husband, and for me, as well: nurses, doctors, radiology, chemo. They kept us informed at every single point in the process. They would call me, and my phone would be ringing, and I'd go out—well, it was on silent, and I would

go out. They'd keep me informed or let me know what was going on, both my husband and me. That is the process that our health care system is providing to Ontarians. They didn't know me from whoever; this is down at Southlake, the Odette Cancer Centre. I'm Newmarket–Aurora. They didn't know me from Adam, but they treated us just like everybody else there, and what I heard from other people, just speaking, everybody was thrilled with our health care system.

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Talking about the personal information piece, I noticed all of that, the process, how they have to scan in and how it connected to everything and then how they'd get their report on what happens next over the next week, where they would be, when they had to be there. It all seemed seamless. What I can say is that the process—can it be improved? Yes, just like everything in the world. Every business, every process that you touch, it can always be improved, and that's where More Convenient Care Act also comes in.

I'd like to say that being able to be updated, and especially now, we're at the point—thank the Lord, hallelujah, he had his last treatment last week, and now we are at the point of home care. So we get to experience that part of the health care system as well. And I have to tell you, it's been seamless. I am proud to say that our system is working, but here's where we go to the next phase. I'm happy that I was able to get through that without any tears.

Speaker, I would like to take this opportunity to speak to Ontario's health care workforce, which is at the heart of all of these improvements. Since 2018, our government has added nearly 100,000 new nurses to the system, with another 30,000 currently studying in colleges and universities. In addition, the Learn and Stay grant is helping nearly 3,800 students train for health professions by covering tuition and direct educational costs in exchange for post-graduation service.

I'd like to tell a little story here too: I'm so proud of an intern that I had working in my constituency office. Last summer, she started. She enjoyed it so much, she said, "Can I stay on part-time to support you?" "Yes, by all means." You know what? She was at TMU for nursing. She was just going into her third year. She's been with me for over a year. Now, I have to say, she's gone on to bigger things, and this is where the story comes in. She applied for the extern program, which is an amazing program. They have it at Southlake, but apparently, they also have it at Sunnybrook. They have it at many hospitals. Well, I am proud to say that my intern wasn't only accepted at one; she was accepted into two extern programs, and she is starting this summer as an extern with Southlake Health as well as Sunnybrook. I'm thrilled for her, because she's so excited, because her end goal is to become a nurse practitioner. We've had many conversations about where our health care system is going. Boy, she's just thrilled, and I'm—well, I'm sad too. I'm going to be missing her and her support, but I am so happy for the patients she's going to be able to care for. Here's a prime example of a nursing student going through our system and now going to be going through the extern program, where she can get hands-on experience.

These investments are crucial as we continue to build the health workforce of tomorrow. The expanded scope of practice for nurse practitioners and registered nurses will take effect on July 1, 2025. These changes include:

—allowing nurse practitioners to order and apply defibrillators and pacemakers, enabling faster response times for life-threatening cardiac events;

—enabling both nurse practitioners and registered nurses to certify deaths in more circumstances, expediting end-of-life processes for families and easing administrative burdens during an already difficult time; and

—authorizing nurse practitioners to perform electrocoagulation procedures, which can treat certain skin conditions like skin tags and lesions, ensuring that patients have quicker access to care.

These changes are particularly impactful for rural and Indigenous communities, where access to care can be limited. By empowering nurse practitioners to take on additional responsibilities, we are enhancing the care available to people who may not otherwise have access to specialists. These changes also reflect confidence in our health care professionals' expertise.

Dr. Michelle Acorn of the Nurse Practitioners' Association of Ontario states, "These changes represent a necessary shift to enhance our ability to provide timely and comprehensive care across" Ontario.

Furthermore, by allowing registered nurses and nurse practitioners to perform these procedures and make life-impacting decisions, we reduce pressure on emergency departments and allow physicians to focus on more complex cases, thereby improving the overall efficiency of our health system. This is particularly crucial as Ontario works to meet the health care demands of its growing population.

Residents in Newmarket–Aurora will benefit directly from these initiatives through better access to key services, including mental health and addiction support, as well as secure access to their personal health information through a modernized electronic health record system.

Speaker, I just want to talk a little bit—a side story—on the electronic health record system. My previous life in the private sector was in the secure payments industry. But it also included looking at secure means of handling data—very secure data, like the health care records. I can tell you, this has been looked at since the early 1990s to the late 1990s, and we were still wondering, "Would the governments of the day in the 2000s finally move to a modernized electronic health record system?"

Well, here we are, 2025—so, what, 30 years later? And I am proud to say that we have a government who is taking this extremely seriously and looking at the digital identifiers, and that is a critical part of schedule 6.

I know one of the members opposite was talking about the concerns that that individual felt were in the personal records. Well, having a digital health identifier is going to secure the person's information because you're not going to be dealing with Dawn Gallagher Murphy's information. It's going to be 1-2-8 dash whatever number. That's a

much better way, obviously, of securing our data, but what this bill also calls for is the process on how to deal with those identifiers. It goes into more depth into how the system will work to even protect that identifier.

Speaker, the initiatives I have outlined today are united by a common vision: building a health care system that prioritizes people. As I've talked about in my speech today—I've talked about a real-life experience. I've talked about an individual going through the nursing program and getting that now hands-on experience.

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Speaker, we are addressing long-standing challenges, empowering our health care workforce and investing in innovative solutions to ensure that every Ontarian has access to the care they deserve. Through these efforts, we're not just meeting today's needs but preparing for tomorrow's challenges.

The Acting Speaker (Mr. Lorne Coe): Questions?

MPP Wayne Gates: I'd like to respond to that member. She started by saying we need access to health care when we need it and where we need it. My question is pretty easy: Why isn't this bill doing more to fix the crisis in the ERs and hospitals like Douglas Memorial in Fort Erie? And how can you call this "convenient care" when people in rural towns can't even get emergency care close to home?

M^me^ Dawn Gallagher Murphy: Thank you to the member opposite for the question.

This bill, the More Convenient Care Act, really talks about our action to grow and support our health care workforce through programs like the Learn and Stay grant and investing in upskilling nurses to work in emergency departments.

And we're ensuring that rural and northern hospitals have the support they need. For example, over the last year, we have seen a number of emergency departments' reduced hours drop by 84%.

Speaker, our investments of over $44 million in 2023-24 have—

The Acting Speaker (Mr. Lorne Coe): Thank you for that response.

I have the Associate Minister of Energy-Intensive Industries, please.

Hon. Sam Oosterhoff: I want to just begin by thanking the member for her bravery this afternoon in sharing what her family has gone through and her husband's journey. Thank you. That was powerful and appreciated by all members in this House. Our thoughts and our hearts go out to you.

I do want to ask, though—because I know that that builds, really, just that sense of urgency as to the importance of legislation that continues to believe that better is possible, that we can improve our existing health care system. We've made a lot of investments so far, but this is another step towards delivering better and more convenient care when and where needed. Why does that matter so much to you? I could feel the passion in your voice. I could hear you really express that in a powerful way.

Why does that matter so much to you? Why does it matter to the people of this province? And why is it important that this legislation passes to provide that better future for health care also for future generations?

M^me^ Dawn Gallagher Murphy: Thank you to the minister for the question.

Yes, I would say from personal experience and what we're going through and what I see this bill is offering—number one, I mentioned about the system at the hospital and how they scan, basically, a number. They get information. They get updates. I see our electronic health care record system being able to have that access—not just when you walk in the door, but what we can do to access it from home and having it in a secure manner. That would be so much easier, obviously.

So I think that's where I see the More Convenient Care Act can improve—

The Acting Chair (Mr. Lorne Coe): Thank you for that response.

I have the member from Mushkegowuk–James Bay, please, when you're ready, sir.

M. Guy Bourgouin: Ma question est sur l'annexe 2. Ça dit : « La Loi sur les services en français s'applique à l'organisme de services comme si ce dernier était un organisme gouvernemental visé par cette loi. » Oui, on est d'accord. Oui, c'est la bonne chose à faire.

Mais ma question est plutôt : comment est-ce que votre projet de loi va adresser—parce que, dans les régions éloignées, le problème qu'on a, c'est que les personnes de soutien qui vont à domicile pour les soins de domicile ne restent pas. Soit qu'ils ne sont pas bien rémunérés, soit qu'ils ne sont pas reconnus pour le millage qu'ils doivent voyager, ils ne sont pas financièrement compensés. Fait que, je ne vois pas—c'est correct; je suis pour l'annexe 2, là. Mais je vous demande comment le projet de loi va répondre aux besoins qu'on a avec les soins à domicile, avec des personnes, les soins, pour un service en français quand le monde qui va dans le domaine ne reste pas parce que soit qu'ils n'ont pas de bénéfices ou qu'ils ne sont pas rémunérés ou, encore pire, ils ne sont même pas reconnus pour le millage qu'ils font?

J'aimerais vous entendre à ce sujet-là.

M^me^ Dawn Gallagher Murphy: Merci beaucoup au député pour la question. Dans cette loi à propos des soins plus commodes, si elle est adoptée, elle déploiera la prochaine étape du plan de la province pour prodiguer à un plus grand nombre de personnes les bons soins financés par le public, au bon endroit, en édifiant des collectivités plus saines et en renforçant la main d'oeuvre du secteur de la province aujourd'hui et pour l'avenir. Donc, je pense que dans les endroits du nord de l'Ontario, c'est pour ça qu'on a ces programmes pour les infirmières et aussi pour les docteurs, parce qu'on sait bien que—

Le Président suppléant (M. Lorne Coe): Merci beaucoup.

We're under questions, please. The member for Don Valley East.

Mr. Adil Shamji: To the member for Newmarket–Aurora, thank you very much for your thoughtful comments

and your passion. It's widely reported, if not widely accepted, that our health care system spends about a billion dollars on nursing agencies per year. I'm glad to see that the government has identified this as an issue that needs to be addressed and has introduced schedule 3, which would create a mandatory reporting requirement. In the honourable member's opinion, is this enough to bring our dependence and billion-dollar-a-year spending on nursing agencies down to zero?

M^me^ Dawn Gallagher Murphy: Thank you very much to the member opposite for the question. I believe that you are speaking specifically—schedule 3, if I recall, is the staffing agency, if I recall correctly. Yes—sorry, I don't have them all memorized.

What we're doing is creating legislation to get a framework—a framework for staffing agencies to be able to better report the administrative, the billing, the pay rates. I don't think we're ever going to get rid of agencies because there is a need for agencies, but how we can make the process more transparent with the staffing agencies, I believe that's what we are looking for here, and this is what we're trying to achieve with this framework, is to ensure that we have a transparent framework—

The Acting Speaker (Mr. Lorne Coe): Thank you very much for that response.

I have the member from Mississauga–Malton, please.

Mr. Deepak Anand: Speaker, as you know, in today's world, the digital infrastructure of health care is very important—many residents from Mississauga–Malton and Bay of Quinte have asked us. The question to the member is, how is this bill ensuring the privacy and security of the personal health information through the government's digital health initiatives? Specifically, what measures are being implemented to protect sensitive data as more health information becomes accessible online? That's my question.

M^me^ Dawn Gallagher Murphy: Thank you to the member from Mississauga–Malton for the question. Individuals utilizing the provincial patient viewer will gain access to their health records. They'll be able to see their lab data from the Ontario Laboratories Information System, as well as dispense drug information from the Digital Health Drug Repository division, which currently contains data on public-funded drugs and drugs in the narcotics—

The Acting Speaker (Mr. Lorne Coe): Thank you very much for that response.

I have the member from Sudbury.

1750

MPP Jamie West: At one point during debate, the member opposite said that our system is working, but I know that we've had 1,000 ER closures in the last 12 months. We're spending $9.2 billion on a private staffing agency, which is much more expensive. PSWs and nurses are quitting and leaving the field and hallway medicine is growing. Could you explain how this plan is working?

M^me^ Dawn Gallagher Murphy: Thank you to the member from—

MPP Jamie West: Sudbury.

M^me^ Dawn Gallagher Murphy: Sudbury, thank you. I was thinking Nickel Belt, but that's your neighbour there.

In essence, I believe your question comes down to why aren't we getting rid of the nursing agencies, is basically what I'm hearing. We know, as I've mentioned before, that nursing agencies are a tool, and they are a tool used by both the rural and northern hospitals to avoid service disruptions. We're not going to take away that important tool. This is why this bill is here, so we can build this regulatory transparent framework so we can better understand the billing, the rates etc. through the agency. When we have over 100,000 new nurses—

The Acting Speaker (Mr. Lorne Coe): Thank you very much for that response.

Further debate?

M. Guy Bourgouin: On a vu que pas tout le monde se garrochait à se lever debout pour parler.

Écoute, ça me fait plaisir de me lever et de parler du projet de loi 11, « More Convenient Care ». J'aimerais commencer par l'annexe 2 parce que je pense que c'est important qu'elle soit implémentée.

Quand on parle de l'annexe 2—j'ai posé une question à la députée qui vient juste de parler. « La Loi sur les services en français s'applique à l'organisme de services comme si ce dernier était un organisme gouvernemental visé par cette loi. »

Je pense que le gouvernement fait la bonne chose, de faire certain que les services en français sont protégés, puis que l'agence doit desservir la population franco-ontarienne. C'est un droit qui est acquis et je pense que, dans la moindre des choses, que les personnes à domicile puissent parler dans leur langue natale, parce que je pense—c'est ma collègue de Nickel Belt, qui parle beaucoup mieux que moi; elle use tout le temps de belles paroles pour répondre, de comment le monde se sent. Quand ça vient aux soins à domicile, on oublie que c'est soit pour un bain ou c'est pour d'autres soins personnels. Ça fait que l'intimité puis aussi la dignité, très souvent, il faut la mettre de côté parce que tu as besoin de l'aide de quelqu'un—quelqu'un qui est un étranger qui se présente.

Imaginez-vous, si c'est un étranger qui se présente chez vous et dit : « Hi, madame, I'm here to help you. » Puis la personne ne parle pas l'anglais. Comment est-ce que la personne se sent pour expliquer quels sont ses problèmes et dire comment elle se sent? Aussi, très souvent, tu es obligé de les prendre ou tu es obligé de les déplacer, et des fois, tu leur fais mal. Ça fait que si tu ne parles pas la langue natale ou tu ne parles pas le français et que c'est un anglophone qui se présente—et très souvent, c'est le cas, parce qu'on a de la misère à garder les francophones dans le domaine.

C'est pour ça que j'ai posé la question, tout à l'heure, à la députée du gouvernement qui a fait son allocution. Elle a fait un très bon travail dans son allocution. Elle a parlé d'une expérience personnelle, et si j'ai la chance plus tard—parce que, là, je n'ai pas grand temps, mais j'ai deux bons exemples personnels à vous parler.

C'est quand on parle—pour revenir à la personne qui est à la maison et qui n'est pas capable de s'exprimer dans

sa langue, et c'est un anglophone qui se présente. Même si la personne est très gentille, même si la personne est là de bonne foi et est là pour aider la personne, c'est que tu n'es pas capable de communiquer et tu peux—veut, veut pas—sans le vouloir, faire du mal. Quand je parle du mal, c'est de blesser la personne sans être intentionnel puisque la personne ne peut pas s'exprimer : « Non, prends-moi pas de ce côté-là. » ou « S'il vous plaît, ne prenez pas ce bras-là; c'est mon bras sensible. » Il y a toutes sortes de choses. Mais si la personne de santé qui se présente pour les soins à domicile—la communication ne se fait pas. Je peux vous dire que ça peut causer des lésions, ou le monde peut-être—ça nuit au processus.

Fait que, c'est pour ça que j'étais content de voir ça. J'étais content que la Loi sur les services en français va être respectée sur les soins à domicile. C'est la bonne chose à faire. Comme ma collègue de Nickel Belt a dit dans le dernier projet de loi que le gouvernement avait amené—le dernier gouvernement, ils l'ont ramené, mais elle l'a passé. Il y a eu un vote puis ils ont voté contre. On ne comprenait pas pourquoi. Mais c'est sûr que c'est bienvenu. Je pense que le gouvernement fait la bonne chose en ramenant l'annexe 2 pour la Loi sur les services en français sur les services à domicile, mais on doit faire beaucoup mieux.

C'est aussi de protéger ces travailleurs-là, si on les veut. Parce qu'on le sait : les services à domicile, c'est très important. On veut que le monde reste à la maison le plus longtemps possible. Puis, pour le plus longtemps possible, bien, il faut leur donner les services qui viennent avec. Que ce soit en anglais ou en français, c'est la même chose, parce qu'à la fin de la journée, si on n'est pas capable d'avoir le monde qui travaille dans le domaine, que ce soit en anglais, en français ou dans n'importe quelle langue, si tu n'as pas les services qu'il y a à domicile, bien, où est-ce qu'on s'en va? On s'en va soit à l'hôpital ou bien donc on s'en va dans les soins de longue durée.

Mais, le monde, on le sait : depuis la COVID, le monde veut rester à domicile le plus longtemps possible. Il y en a même qui ne veulent même pas aller dans les soins de longue durée. Parce que ce qu'on a vu dans le temps de la pandémie, c'est qu'on a entendu des horreurs. On a entendu le rapport de l'armée. J'ai eu, moi, dans un soins de longue durée chez nous—durant la COVID, il y a 16 personnes qui sont mortes en dedans d'un mois, en quelques semaines. Tu sais, on a vécu des choses difficiles, puis ça fait peur au monde. Puis, des personnes aînées qui sont à domicile, elles ont peur d'aller dans les soins de longue durée. Il y en a qui n'ont pas le choix; il faut qu'ils y aillent parce qu'ils sont rendus à ce point-là. Mais s'ils sont capables de vivre à la maison, s'ils sont capables d'avoir les services à domicile, comme on le peut si on rémunère le monde, qu'on paye pour quand ils voyagent—parce qu'il ne faut pas oublier, là, que dans les régions éloignées comme les nôtres, les régions rurales, bien, le monde, il faut qu'il se déplace.

Je parlais justement à une préposée, qui me disait : « Guy, réalises-tu que dans une journée, des fois, je vois une patiente? Il faut que je me rende là. Ou je vais voir deux patients parce qu'il faut que j'aille à Hearst puis je suis obligée de me redéplacer, après ça, et aller dans un autre coin, que ce soit Val Côté, que ce soit Mattice ou bien donc que ce soit à Kap ou Smooth Rock Falls, d'un bout à l'autre de la route 11. »

Ça, c'est sans mentionner nos routes : les conditions des routes hivernales que—je sais que le ministre est là et qu'il comprend comment c'est important, les routes hivernales, et comment la route 11 est dangereuse. Imagine-toi : ce monde-là se promène sur nos routes puis il faut qu'ils aillent donner des services à domicile.

On a une responsabilité de faire certain—si on veut les garder puis si on veut développer les soins à domicile, il faut les payer, les rémunérer, reconnaître le travail qu'ils font, puis aussi commencer à les payer pour le voyagement. Très souvent, ils ne sont pas rémunérés pour ça. Ils vont payer, très souvent, pour être capables de se rendre, puis ce n'est pas correct parce qu'ils sont déjà sous-payés pour le travail qu'on leur demande.

Fait que, je peux vous dire que s'il y a de quoi qu'on doit améliorer dans notre système de santé, surtout aux soins à domicile, puis qu'on sait qu'on a une population qui est vieillissante, on doit faire beaucoup mieux pour répondre aux besoins de la communauté—que ce soit anglophone ou francophone—dans des régions comme les nôtre. Je sais que ce n'est pas juste dans le Nord ou dans les rurales—c'est dans les villes, aussi. Parce que veut, veut pas, le monde, il faut qu'il se déplace. On veut rester à la maison puis on veut être dans nos propres loyers ou dans nos propres maisons puis être capables de rester le plus longtemps possible. Je pense que ce n'est pas donné à tout le monde d'aller dans les soins de longue durée ou bien donc d'aller dans un hôpital puis être là parce qu'ils veulent—il y en a beaucoup qui veulent finir leurs jours, aussi, dans leur propre maison. Je pense que s'il y a de quoi qu'on doit faire—

Le Président suppléant (M. Lorne Coe): Asseyez-vous, s'il vous plaît. Oui.

Second reading debate deemed adjourned.

The Acting Speaker (Mr. Lorne Coe): Colleagues, this House stands adjourned until 9 a.m. tomorrow. Thank you.

The House adjourned at 1800.

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Surma, Hon. / L'hon. Kinga (PC)	Etobicoke Centre / Etobicoke-Centre	Minister of Infrastructure / Ministre de l'Infrastructure
Tabuns, Peter (NDP)	Toronto—Danforth	
Tangri, Hon. / L'hon. Nina (PC)	Mississauga—Streetsville	Associate Minister of Small Business / Ministre associée des Petites Entreprises

Member and Party / Député(e) et parti	Constituency / Circonscription	Other responsibilities / Autres responsabilités
Thanigasalam, Hon. / L'hon. Vijay (PC)	Scarborough—Rouge Park	Associate Minister of Mental Health and Addictions / Ministre associé délégué à la Santé mentale et à la Lutte contre les dépendances
Thompson, Hon. / L'hon. Lisa M. (PC)	Huron—Bruce	Minister of Rural Affairs / Ministre des Affaires rurales
Tibollo, Hon. / L'hon. Michael A. (PC)	Vaughan—Woodbridge	Associate Attorney General / Procureur général associé
Triantafilopoulos, Effie J. (PC)	Oakville North—Burlington / Oakville-Nord—Burlington	Deputy Speaker / Vice-Présidente Chair of the Committee of the Whole House / Présidente du Comité plénier de l'Assemblée législative
Tsao, Jonathan (LIB)	Don Valley North / Don Valley-Nord	
Vanthof, John (NDP)	Timiskaming—Cochrane	Opposition House Leader / Leader parlementaire de l'opposition officielle
Vaugeois, Lise (NDP)	Thunder Bay—Superior North / Thunder Bay—Supérieur-Nord	
Vickers, Paul (PC)	Bruce—Grey—Owen Sound	
Wai, Daisy (PC)	Richmond Hill	
Watt, Tyler (LIB)	Nepean	
West, Jamie (NDP)	Sudbury	
Williams, Hon. / L'hon. Charmaine A. (PC)	Brampton Centre / Brampton-Centre	Associate Minister of Women's Social and Economic Opportunity / Ministre associée des Perspectives sociales et économiques pour les femmes
Wong-Tam, Kristyn (NDP)	Toronto Centre / Toronto-Centre	