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Consultations prébudgétaires

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43rd Parliament

Thursday 25 January 2024

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Jeudi 25 janvier 2024

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON FINANCE AND ECONOMIC AFFAIRS

COMITÉ PERMANENT DES FINANCES ET DES AFFAIRES ÉCONOMIQUES

Thursday 25 January 2024

Jeudi 25 janvier 2024

The committee met at 1000 in the Cornwall Golf and Country Club, Cornwall.

PRE-BUDGET CONSULTATIONS

The Chair (Mr. Ernie Hardeman): Good morning, everyone. Welcome to Cornwall. I call this meeting of the Standing Committee on Finance and Economic Affairs to order. We are meeting here today to resume public hearings on pre-budget consultations 2024.

The Clerk of the Committee has distributed committee documents, including written submissions, via SharePoint. As a reminder, each presenter will have seven minutes for their presentation, and after we've heard from all the presenters, the remaining 39 minutes of the time slot will be for questions from the members of the committee. This time for the questions will be divided into two rounds of seven and a half minutes for the government members, two rounds of seven and a half minutes for the official opposition members and two rounds of four and a half minutes for the independent members as a group.

CORNWALL AND DISTRICT REAL ESTATE BOARD

MS. NINA DEEB

ONTARIO COUNCIL OF HOSPITAL UNIONS/CUPE

The Chair (Mr. Ernie Hardeman): With that, our first panel today is the Cornwall and District Real Estate Board, Nina Deeb and the Ontario Council of Hospital Unions/CUPE. I believe we're all at the table ready to go, so just a couple of comments: In your seven-minute presentation, at six minutes, I will say, "One minute." Don't stop, but when I say, "Thank you," stop, because it's all over.

I also want to remind you that the microphones are automatically activated by—well, it's not quite automatic—by the good folks that we have at the back. Don't sit too close to the mike, and don't fuss with the buttons.

We now will start the presentations. First we'll hear from the Cornwall and District Real Estate Board. Please start the presentation with introducing yourself for Hansard.

Mr. Lyle Warden: My name is Lyle Warden. I'm a realtor here in SD&G. We're actually sitting in South Glengarry, just on the east side of Cornwall.

Members of the committee, thank you very much for taking the time to hear from us today. As I said, my name is Lyle Warden. I am representing the Cornwall and District Real Estate Board's 200 members. I want to express my gratitude to all of you for your unwavering dedication to addressing the housing needs in Cornwall, our surrounding region and throughout the province.

It comes as no surprise to anyone present that the housing affordability crisis remains a significant concern for residents from Brockville to Cornwall to Hawkesbury and beyond. We can all think of someone in our own community, maybe even our family, who is diligently following the right steps, securing well-paying jobs, working hard, saving responsibly and making sound financial decisions, yet the dream of home ownership remains elusive for many. As realtors, we witness this situation first-hand on a daily basis and understand the urgency of implementing effective solutions to alleviate the housing crisis we currently face.

Home ownership plays a pivotal role in fostering prosperous communities. Beyond encouraging retirement savings and improving children's performance in schools, it supports families and contributes to the development of stronger communities. Additionally, the housing and real estate sectors generate billions of dollars in economic growth and support tens of thousands of jobs across this province.

Unfortunately, there has been a gradual decline in home ownership across the province in recent years, exacerbated by economic factors such as unprecedented inflation and multiple interest rate hikes. Despite these challenges, household incomes have not kept pace, resulting in a staggering 180% increase in housing costs over the last decade. While Ontario strives to be an excellent place to live, conduct business and raise a family, the rising cost of housing and its lack of affordability are prompting many families to consider leaving the province in search of more affordable housing elsewhere.

To address this crisis, we believe the 2024 budget must bring a change in outlook and instill hope among Ontario families. Today we present three key solutions to tackle the current housing affordability crisis. In various municipalities within eastern Ontario, numerous development units face prolonged delays due to a continuous stream of objections. Despite receiving approval from the municipal council, the projects are subject to repeated objections, causing significant delays lasting for months or even years.

To address this issue, we propose a comprehensive approach.

(1) Reform the Ontario Land Tribunal: Prevent abuse of the system, eliminate the backlog through efficient processing and allow fines for unwarranted delays to expedite the development timeline.

This exact scenario happened here in South Glengarry while I was mayor. There was a proposed project 20 minutes down the highway. It fit all the criteria—zoning and everything—and some NIMBYs just decided to hold it up and delayed it by almost three years. I bet it cost the developer over $1 million, and for what? They had no legitimate reason other than they didn't want it, so a huge problem.

(2) Implement land use changes to eliminate exclusionary zoning: Introduce modifications to land use policies to put an end to exclusionary zoning practices. By understanding these reforms, we aim to streamline the development process, ensuring that approved projects move forward without unnecessary hindrances, fostering timely and effective growth throughout Ontario.

Exclusionary zoning practices are prevalent in various regions across Ontario, restricting the types of housing permitted in designated areas. Transforming a single-family home into a low-rise apartment within such zones involves navigating a protracted and intricate approval process.

While the introduction of Bill 23, the More Homes Built Faster Act, in 2022 marked a significant step in curbing exclusionary zoning, further action is imperative to effectively address the ongoing crisis. We urge the Ontario government to embrace as-of-right zoning, enabling the unimpeded development of missing middle housing throughout the province, devoid of bureaucratic hurdles and prolonged approval procedures.

Recognizing that thriving communities necessitate a diverse housing mix encompassing low-rise apartments, duplexes, townhouses and single-family homes, we advocate for a comprehensive approach. This broad spectrum of housing options empowers families to discover residences that align with their needs at affordable price points. Challenge exclusionary zoning by allowing as-of-right zoning to facilitate the development of missing middle housing without bureaucratic obstacles. Support the full spectrum of housing, including low-rise apartments, duplexes, townhouses and single-family homes to meet diverse needs at affordable prices.

The Chair (Mr. Ernie Hardeman): One minute.

Mr. Lyle Warden: In a 2023 CIBC report released last year, one fifth of Canada's construction workforce is nearing retirement, 300,000 workers are projected to retire in the coming decade. There are currently over 80,000 vacancies in the skilled trades labour force.

Ontarians are depending on their government to increase funding for skilled trades to meet the goal of building 1.5 million homes over the next decade. We encourage the Ontario government to increase funding for skilled trade programs in colleges, trade schools and apprenticeship programs.

In conclusion, Ontario's housing crisis is reaching historic levels, but we believe that implementing the discussed changes will bring us closer to a solution. Thank you for your time, and I'm available to address any of your questions.

The Chair (Mr. Ernie Hardeman): Thank you very much for the presentation.

We'll now hear from Nina Deeb.

Ms. Nina Deeb: Good morning, Chair and committee members. My name is Nina Deeb. I am a full-time real estate broker since 1996.

The government has an opportunity to address the concerns of the people of Ontario through funding. The federal government has allocated $117.5 billion specifically for housing. Housing is provincial jurisdiction. Ontario must ensure this funding is being downloaded to those that have the responsibility to build, retain and repair Ontario's deeply affordable housing stock. The recipients of this funding must only be the people of Ontario or municipalities. This taxpayer funding is being captured by pension funds, financial landlords and real estate investment trusts.

Municipalities are seeking financial relief from the province. Some of the financial shortfalls they're experiencing are a direct result of provincial legislation.

1010

Nutrition for Learning experienced food cost increases of 90% last year. Canada is a wealthy country. Food insecurity is due to corporate misconduct and taxation inequality. It is a result of rents, utilities, interest rates and home costs having tripled. Household incomes have not kept up. Some households are spending 100% of their incomes on their housing.

In 1996, there were 13 competing grocers in Canada. This has been reduced to five: Loblaws, Sobeys, Metro, Walmart and Costco. The Affordable Housing and Groceries Act will do the exact opposite of its title. It will concentrate the powers and increase the profits of the corporations at the top even more. The legislation makes housing and groceries more expensive.

Overpriced food has led to hunger and waste. Corporations are destroying food in their compactors. Corporations are creating serious food insecurity for Canadians, while operating as real estate investment trusts. REITs and pension funds are operating as asset managers of real estate. They do not pay taxes in Canada. This has a corrosive effect on what remains in our local markets to circulate. This money leaves the area it is generated in and reduces the prosperity of the local population, sending their labour to other countries through rent collection.

Wealthy corporations are destroying the food that humans need to live. These corporations are being rewarded with tax exemptions and sole-sourced contracts. The favouritism of corporations over people must end. Corporations do not live. They do not need houses. They do not need food. Humans must have housing and food in order to live. Corporations cannot be trusted with Ontario's housing or food supplies.

Ontario has a growing new field of colleges, councils and associations that claim to be protecting the interest of the public. These organizations do not pay taxes. Some are

collecting $1 million per employee, while claiming to be not-for-profit. These organizations are being carried by the taxpayers of Ontario and Canada. These non-government organizations are a shadow government that we did not elect.

Delegation to private corporations must be rescinded. These capitalist enterprises only take. They bring nothing to the table. These corporations are capitalist entities that employ the politicians that created them when they were elected members of Parliament. They must be abolished.

Revenue: Some corporations are paying reduced taxes, some pay no taxes and some are reaching into the collection basket to cover their own operations. With self-regulation, my organized industry severed itself into two and transformed itself from a trade organization grossing $3 million a year to a profit powerhouse that is grossing over $70 million annually. It only has 70 employees. This is the size of a Tim Hortons grossing $70 million a year and not paying taxes.

The regulator also does not pay taxes and their landlord does not pay taxes. Their landlord is Starlight real estate investment trust, which is otherwise known as Blackstone. The spinoff business ideas don't pay taxes. The idea to exempt one corporation from taxation has been extended and has grown into 108 corporations that do not contribute anything to the budget that we're trying to make stretch today. Their network of businesses have surpassed $1 billion a year. They are local organizations with transnational interests. They lobby to defund Ontario, Canada, municipalities and taxpayers. They are transferring their tax responsibilities to the people of Ontario.

The travel authority must reimburse the people of Ontario $10.1 million and repay the compensation fund the $30 million they have spent. This delegated authority does not have the authority to spend the consumers' compensation fund.

The 407 operators owe the people of Ontario $1 billion.

I would like to ask you to support the public libraries in their request. They have been asking for many years for increases. They haven't had increases in 25 years. The budget request for the provincial library grant is supported. The request for an Ontario digital library is supported. This will increase library services to all of Ontario, expanding access to rural areas that do not have this benefit now, or any library benefits now. An annual First Nations library grant is also supported. Library investments complement the education investments that Ontario makes. Ontario uploaded education, and libraries were left behind, which is fine, but they need funding.

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Nina Deeb: This is a very small request.

A request for budget allocation for $60 billion to be downloaded to the 444 municipalities. This funding is required to set up acquisition funds to build social and co-operative housing. Ontario needs deeply affordable housing. When the federal government and the province retreated from home building, 17,000 approved homes were not built in Ontario. The housing deficit continues to grow.

Please keep the municipalities' delivery of social service supports, health care and libraries at the top of your budget considerations. We're a wealthy province and we can't afford all the programs that we have. We need tax reform to capture the corporate malfeasance that is pushing up the cost of housing and groceries. Ontario can remove the tax incentives that encourage this conduct. These players must contribute to the pot. We need more money. Corporations must be banned from real estate ownership—

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time.

We'll now go to the Ontario Council of Hospital Unions/CUPE.

Mr. Doug Allan: Great, thank you. My name is Doug Allan. I'm a research representative with CUPE. Regrets from Michael Hurley, our president, who can't be here today. You're stuck with me, unfortunately.

OCHU represents 40,000 hospital workers in Ontario. We're currently in central bargaining, closely collaborating with the Service Employees International Union and Unifor. In total, it will be well over 70,000 hospital workers at hospitals and some long-term-care workers that will be affected. Today, I'd like to talk about the staffing capacity crisis in our hospitals, the causes and consequences, what is needed to resolve this both in terms of improved staffing and improved capacity in the hospital system for workers and for patients and families.

Inadequate staffing: Currently, Ontario, compared to the rest of Canada has—well, the other provinces have 18% more hospital staff per capita than Ontario. To put a number to that, 33,778 more full-time equivalent positions—huge. The biggest chunk of that is for nursing and in-patient services at about 16,000; also support workers, about 8,000 missing. On page 2 of the brief, you will see the various categories that occurred. This occurs despite the fact that we're actually high in a couple of areas in terms of research—not surprising.

There has been a long-term decline in spending on compensation and workers in the hospital system in Ontario. This has gone on from at least 2005-06. We went from 64% of total hospital spending down to 59%. This isn't something intrinsic to hospitals. The very opposite trend is happening in the rest of the country, where it's been going up from 65% to 67%. This is unique to Ontario and is part of the problem. You'll see that those charts are set out in page 3 of the brief.

The staffing crisis has been worsened by the fact that hospital and health care workers have not kept pace with other wages. On the bottom of page 5, you'll see the chart where health care and social assistance wages, the category Stats Canada has, started out at 65 cents per hour more than the average industrial wage in 2017 and are now $2.12 less—a big change in their relative position from where they were. Averagely hourly increase for all industries: 27.5%; for health and social assistance workers, 16.9%. The general wage increase for hospital workers that's been negotiated is much less: 12%. It's been very harsh austerity, very hard bargaining from this government over that period—far behind.

We have had some other changes. Because of the staffing crisis that we had, the government was forced to introduce a $2 PSW wage increase. We bargained a $2 increase for RPNs. There is more RPN usage. That's driven up wages overall. The hospitals tell us it's actually gone up about the same as health and social assistance wages, about 17%. That's still 10% behind the increase that we've seen for all industries.

Hospital work has become much less attractive—much less attractive—over a very, very short period of time. We're now $4.41 behind the average industrial wage for the average service worker in Ontario. We were 59 cents above; now, just six years later, $4.41 less.

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The results? A huge increase in job vacancies in hospitals. We've gone from—you will see the chart on page 4—actually being below the all-industry average to being way above the all-industry average in terms of job vacancies. We've gone from 4,000 job vacancies in hospitals to now 21,885 job vacancies in Ontario hospitals. The labour market is destroyed—totally destroyed.

The consequences of the staffing and capacity crisis—you guys hear about it almost every day in the news: ER closures, hundreds—totally unprecedented. The number of people being treated in hallways in hospitals has exploded. Since 2018—a key year, obviously—we have gone from 1,289 patients in hallways to now 1,374 patients in hallways, a significant, significant increase.

We've got other developments: 4,500 fewer surgeries per month than existed in 2019. Wait times are 49% longer than in 2019—this is all according to the Financial Accountability Office—and 107,000 patients are waiting longer than the maximum clinical guidelines. And 7.7% fewer beds than exist, per capita, in the rest of Canada.

And it's going to get worse. We're already being driven by respiratory illnesses in our hospitals right now. We have 1,400 patients in hospitals with COVID.

The Chair (Mr. Ernie Hardeman): One minute

Mr. Doug Allan: We've returned to the regular COVID era. We're going to have a huge population growth increase over the next little while. That, we believe, will drive, with the aging that is going on in the population, about a 2.18% increase in need over the next little while.

We need to address this. We need to address it through better wages for hospital workers. We're in bargaining right now. We believe we need a pattern towards the top end of the bargaining pattern right now. And we need to deal with increasing the staff and the capacity of the hospital system. We think we can achieve a 5% increase in capacity per year that would help to both deal with the growth in demand that is driven by the aging of the population and begin to address the capacity crisis that we currently have—

The Chair (Mr. Ernie Hardeman): That concludes the time.

We now will start with questions with the official opposition. MPP Pasma.

Ms. Chandra Pasma: Thank you very much to all the witnesses for being here. We really appreciate you taking the time to come and share your insights with the committee.

I'm going to be spending most of my time on the hospital crisis, not because the crisis in housing and groceries is not also very important—we have many crises in the province right now. But, Doug, was there anything else you wanted to share with committee since you got cut off there?

Mr. Doug Allan: Okay, thank you. Our estimate of staff needed, given what we say is resolving the crisis and dealing with the push from population and aging—aging is growing at about twice the rate of population. Population is actually growing much faster than projected by the government, although, even with the government's estimates, it's growing at a very significant pace.

Our estimate of the actual staff needed is about 60,000 staff in hospitals over the next four years: 14,500 per year in the first year and a little bit more in each year after that. That would begin to address the vacancies that we have in our hospital system and begin to address the capacity crunch that we have in the hospital system. There's no easy way out of this system.

We have seen some significant efforts to increase other parts of the health care system, but those won't keep up. The government, under pressure, I would submit, from CUPE and others in the health coalition and many others, has agreed to increase staffing in long-term care to four hours, something we'd like to see in hospitals, something we'd like to negotiate and discuss with the government—improving those staffing levels, achieving those staffing levels so that people feel they can have a decent job where there's not violence in the workplace. We have the highest violence level of any industry in the hospital sector, a female-dominant industry. It's not police, it's not fire, it's not paramedics—it's hospital workers who get that terrible incidence of violence and the terrible workload that comes with this, where people's morale is terrible and people leave the industry.

We are looking at sort of a twofold solution: both increase capacity—make the jobs more attractive again—but also reverse the policy of wage suppression and make the jobs more attractive to people, so we can actually fill those job vacancies once again. Those would be key things.

I would just say, on long-term care and home care improvements in capacity that have been brought, that because of the aging and population growth that we see, it won't actually improve the bed capacity in long-term care or the hour capacity in home care. In home care, even with the $1 billion that the government has promised over three years, according to the FAO, that will actually lead to a 1% reduction in capacity per year relative to the 65-plus population. That population is exploding and the oldest part of that population is exploding even quicker. Those guys drive the need for health care. Some 60% of our hospital beds are used by people 65 and older. It's even greater for the 75-plus and 90-plus population, which is growing much more rapidly. We are dealing with a wartime situation and we need a wartime response in order to improve the capacity and make the hospitals a better place to live.

Just to give an example: I don't want to belabour this, Chandra, but even where there has been a significant promise

to increase long-term-care capacity by, I think, 31,000 beds, according to the FAO, the Financial Accountability Office, that will actually not improve the number of beds relative to the 75-plus population. The beds are totally driven by the number of people who are 75 and older. That actually increases it, I think, by 0.1% per year by the time we're at the end.

We're not going to get any relief from home care. We're going to get more pressure from home care under the current plans. Plans can be improved on, and I encourage them to be improved. We are actually going to have just a tiny, tiny improvement of capacity in long-term care. It won't address the 40,000-person wait-list.

Anyway, I don't want to hog all of the time. Sorry.

Ms. Chandra Pasma: No, no. We certainly appreciate your insights. You've painted a very stark picture for us this morning. You've painted a very stark picture of the current vacancies and the trends we are facing now, but CUPE also just did some recent polling of your workforce that really suggests if we don't do something, we are in very deep trouble. Do you want to talk about that?

Mr. Doug Allan: That was very interesting. It was a poll, a fairly simple poll, and it really did catch the zeitgeist. I think we got 1,000 media stories out of that simple poll; it's not often we do research that gets that sort of attention. But what it showed is that people are dreading work in a very significant way. Many are thinking of leaving their jobs. People are sleepless at night. They go to work with churning in their stomach, because people are working short-staffed.

If somebody doesn't show up because they just can't take it or whatever, they work short-staffed. Their patients are unhappy. The families are very unhappy, and crazy sometimes. It creates this system where we do have this almost unknown fact that it's the female hospital workers who are bearing the biggest share of violence in their workplace. It ain't the police. It ain't the firefighters. It isn't even the paramedics. It's the hospital and long-term-care workers who are really getting beat up on the job, if you look at the WSIB stats on that.

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Chandra Pasma: Well, first of all, we're at risk of losing another half of our workforce, our exiting workforce, if we don't do anything. We're also asking individuals to pay an incredible price every day for refusing to address wages and the staffing vacancies. But also, when you're listing longer wait times, the number of patients whose wait times are exceeding clinical guidelines and patients in hallways, we're actually pushing people to a point where they're going to need more extensive medical interventions, more health care. As a witness said the other day in Brockville, this is waste through poor planning. We're actually ending up spending more by not spending upfront and making sure people are getting timely health care.

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Mr. Doug Allan: Exactly, 100%. It's a two-sided crisis. There's the workplace crisis that we've tried to talk about, but also, and very greatly, there is this patient crisis. I think there is a sense right now that things have never been this bad.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time.

The independents? MPP Collard.

M^me^ Lucille Collard: I also want to extend my warm appreciation for you coming here. We always learn a lot from presentations from people who are in the sector and living the experience that we need to take into consideration when the government is making decisions.

Just to continue a little bit on the trend of the health care crisis, and the staffing capacity crisis in particular, which you very well explained, I think it's very clear that it's a question of attracting more people in the sector but also the retention. I believe, because I know some nurses and people who are in the sector, that the working conditions are a big part of that problem, of the challenge that we have. Can you speak more about what we need to do to improve the working conditions of those workers so that they are motivated to stay and that we can attract more people?

Mr. Doug Allan: Excellent question. We have raised this in bargaining with the Ontario Hospital Association, and our sister unions, Unifor and the service employees, likewise, have raised this. What we have called for is staffing ratios not unlike what the government has already agreed to in long-term care. It would very obviously, by the different nature of the patient—we've made a proposal on this, and we've also invited the government to meet with us to discuss this issue in a way that we can work on it together with the government and, of course, with the opposition parties to help resolve that issue. Unfortunately, to date, we have heard nothing back from that letter that was sent from the three unions that are in bargaining.

We hope to make progress on this in this round of bargaining that would begin to address that staffing and capacity issue and develop a system where people felt that when they went to work, it wasn't a crisis every day, that they actually had the staff necessary to deal with this. We understand we're not going to solve the problem overnight. We hope we're not making unrealistic or just ideal solutions, but we do want to make progress. We hope to make progress in this round.

It was done in long-term care when there was significant concern about what was happening in long-term care. That became very evident. We had campaigned with the community for about 10 or 15 years to get the four hours of care per resident per day. We were heartened when the government did move on that and introduced it. We haven't yet seen that in the actual staffing hours. The actual staffing hours of RNs and RPNs have actually decreased in long-term care, which is kind of shocking because the industry has gotten a lot more money. That's a concern, but it's not the first time that employers call for more money in the guise of, "It's going to go to the workers," and in fact it doesn't work out that way. That's something we—

The Chair (Mr. Ernie Hardeman): One minute.

Mr. Doug Allan: —want to work on with the government.

Sorry, I'll turn it back to you, in case you—

M^me^ Lucille Collard: Yes, I'll ask a quick question, and maybe you can answer in other questions.

We're seeing a privatization of part of our health care system. Maybe you can think about explaining what the impact is on the staffing capacity crisis in our hospitals.

Mr. Doug Allan: It's a major concern. Budgeted funding for the for-profit industries, the independent health facilities and so forth, went up 212% in the last budget—212%. It's not going to make a difference because that part of the industry is so small. It's just a tiny little fraction of hospitals. It can't resolve the capacity crisis in the short or medium term. But hospital budget funding went up 0.5%—

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time.

MPP Jordan.

Mr. John Jordan: Thank you all for your presentations.

I want to direct my question to Lyle. Thanks very much. Your presentation seemed to echo a lot of what the government has focused on and has prioritized.

I've actually been in this area four times now, cutting ribbons on new long-term-care homes as the PA to long-term care and breaking ground on others and priority funding announcements so it's a great time for long-term care and moving those homes, and there is a housing component to that as you know and it will free up other homes.

My question is around the tribunal—part of your presentation. So the Attorney General has added about 40 new adjudicators and he streamlined an electronic system and there has been a significant improvement in the wait times for people getting through the tribunal. So I'm wondering, here in the Cornwall area, if you've experienced improvements in that process?

Mr. Lyle Warden: Thank you for the question. I haven't, first-hand, heard of any improvements but we were aware of the investments that were made. I think the problem is there has been just such a long backlog that I think it's going to take a little more for the results to be seen in this area.

I can only refer to that one instance that I referred to in my speech where it was, again, during the pandemic and it was very painful. But we are happy with the investments that the government has been making and we just hope that it's continued and we will see the improvements.

Mr. John Jordan: Thanks.

The Chair (Mr. Ernie Hardeman): MPP Hogarth.

Ms. Christine Hogarth: I just want to thank everyone for being here today and for your presentations.

Nina, I have some good news for you: The city of Toronto is actually opening up more libraries on Sundays. I know you mentioned that's in our municipal budget but it also comes at a 17%—almost 17%—property tax hike, but we are going to have more libraries open on Sunday.

My question is for Lyle as well. As a realtor—the market has been tough lately over the last little bit—can you just explain, in your professional opinion, just a little bit about how realtors can help with the housing crisis?

Mr. Lyle Warden: I advocate on behalf of my clients every day. The biggest hurdle lately has been the interest rate. It has just gutted the market. It has allowed for prices to come down and it's been a more balanced market, where buyers are allowed to do their due diligence, they don't have to put in a cash offer, but we're still seeing multiple offers and I think the biggest hurdle is the interest rate, at this time. Peoples' buying power is just eroded.

Two years ago, a $100,000 income, whatever that netted them—buying powers have been dropped significantly. So they are just not able to afford what they could have two years ago and the market still has a lot of buyers that were not successful throughout the pandemic. I would say as realtors—I work hard every day for my clients, but there's no magic solution. I feel that if the interest rates were lowered, I think it would certainly help more folks get into homes.

Ms. Christine Hogarth: We also agree. And it's an affordability crisis on various fronts, as we mentioned, food and purchasing homes. So what we're working on at the government is we have a couple of pieces of legislation. One was the Building Faster Fund. Have you heard of that fund that was introduced in the fall?

Mr. Lyle Warden: I didn't, sorry.

Ms. Christine Hogarth: Okay. So there's the Building Faster Fund and we're also removing the HST on new purpose-built rentals for housing. Can you tell us a little bit about how that will help with the housing crisis and what kind of effect will that have?

Mr. Lyle Warden: I think that along with the exclusionary zoning being a thing, you're going to see more purpose-built homes, more multi-unit developments happening. I think if you can increase the housing on an existing sewer line, where a single-family home was, and you could put up to a fourplex, it's not costing the municipalities any more money for infrastructure, because it's so darn expensive to replace and to build. I think that, and also the removal of the HST and the PST off of that, is going to encourage that type of development and it's what we need.

1040

We need diversified development. All around us here in this municipality, there's very, very little mixed development. They're all single-family homes, and it can't continue that way. It needs to be mixed, where you have sixplexes, townhouses, single family—it just needs to be mixed to get the densification up.

Ms. Christine Hogarth: That's a great answer.

My final question is around property taxes—though, obviously, those are municipal. What type of effect will that have—when you're a renter, you're not technically paying property tax, but what effect do you think that would have, a double-digit—it's like almost 17% if the feds don't come to the table—property tax? How will that affect renters? Or do you think it will affect renters?

Mr. Lyle Warden: Absolutely, it will. The taxes have to get paid somehow. That's a whole other subject, per se. There's problems with the landlord tribunal that would make it worse.

The renters, at the end of the day, will pay the taxes. Landlords are finding ways—not all of them are maybe above board and following the rules exactly. But a lot of them—at the end of the day, the tenants will pay the taxes in some way, shape or form.

Ms. Christine Hogarth: It falls on their shoulders.

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Christine Hogarth: Did you have anything else you wanted to add?

Mr. Lyle Warden: I do want to say that I feel that this government has done a great job of putting legislation in and putting it out there, like with Bill 23, I think it was—last year, building more homes faster. It's a great first step, and I think addressing the exclusionary zoning is going to do wonders for getting densified development.

Ms. Christine Hogarth: Well, we all know there is a housing crisis, and it takes three levels of government to make that happen. We need partners like yourself to make that happen for our citizens, so thank you. Thank you all for being here.

The Chair (Mr. Ernie Hardeman): We will now go to the official opposition. MPP Harden.

Mr. Joel Harden: Good morning, everybody. As we get started, can I just quickly offer a public thanks to all the MTO workers out there salting the roadways that made sure our buses and our cars could get here. We had an occasion to talk to one of those folks who work in security in Brockville, I know, but thank you to all those families and thank you to all those workers.

Okay, let's get started, Ms. Deeb, talking a little bit about the housing crisis and some of the information you've presented this morning. I've been at committee before and I've heard you talk about worries with respect to real estate investment trusts. When we met in Brockville, we had occasion to hear from an organization representing asset managers, hedge funds, private equity firms managing allocations of less than $1 billion, and their worry was that, if there's not a focused attempt to understand how massive capital managers are entering into the Canadian space, we are not going to be in control of important sectors of our economy. This is advice coming to us from Bay Street, to be clear.

One of the things I noticed—and it's a company you've mentioned in the past—Blackstone has made a big buy in Toronto, taking a $3.5-billion play in Tricon, which, as was pointed out when we brought this up in Brockville, has a significant imprint in American housing, but it also has significant ownership in Toronto real estate and housing, in particular modest-income and low-income rental.

What we heard yesterday from the Alliance to End Homelessness Ottawa is that for every one unit of affordable housing we're building in our economy, we are losing seven just because of the nature of housing, the cost of rent. At the moment, it's $2,000 a month in our city, in Ottawa; it's even higher in places like Toronto. I would be interested to know, in this area, what rent looks like now compared to four or five years ago. The cost of a house has doubled since this government came to power first in 2018 to now.

So I am worried about the activity of real estate investment trusts, because I'm aware of the fact that one country, Denmark, had to pass a specific law, which lawmakers in that country called the Blackstone law, that was basically targeted towards huge acquisitions of multiple apartment buildings that forbade rent increases for five years when big acquisitions like that happened, so rents weren't driven up. In some cases in that country, rents went up 250%, so long-serving tenants were pushed out, modest changes were made and rents were jacked up.

As you are looking at the information you presented to the committee this morning, are you still worried about the activities of real estate investment trusts and what it will do to make the housing crisis worse?

Ms. Nina Deeb: Thank you for the question. I am worried enough about the activity of real estate investment trusts and pension funds in Canada that I have, in my 14 recommendations to government on making housing affordable, recommended for probably about three years now to ban them. I think that real estate investment trusts should be banned in Canada. Blackstone is banned in other countries, as well; they brought in legislation in Europe. I think it was the Netherlands.

It's important to realize that there are different names they are operating under within the different countries. Sometimes it feels or looks like it's a repatriation between the local corporation and Blackstone when they come in and take over. Quite often, they are taking over 30,000 or 60,000 units at a time. They bought, in one lump block purchase, I think it was 1,600 units in my region. The top real estate landlord in Waterloo region is Blackstone and I have taken inventory of every high-rise building in Waterloo region.

Mr. Joel Harden: Okay.

Moving, Mr. Warden, over to you: First of all, thank you for representing realtors this morning. I can totally sympathize with what you're talking about and how difficult it is in the current environment.

But I was also intrigued by what you said about the Landlord and Tenant Board. I'm hearing it from renters, I'm hearing it from small landlords and it seems to be the only people who are happy with the status quo are the large real estate investment trusts, which are very happy if there are long delays, because tenants won't file complaints and they'll simply move out if they're incentivized to do so with a cash payout or if they just give up.

We literally have a case that we're working on right now in our office where elderly tenants of an apartment building that was recently bought by a REIT have had their power shut off. We've had to call Ottawa by-law into the site to make sure the power was restored. It's just aggressive tactics to incentivize people who won't move out if they're given financial incentives to do so, and I believe they're unlawful situations.

Could you, for the benefit of the committee, explain: The goal that I understand the landlord and tenant tribunal set in 2022-23 is to have a hearing within 50 days. The goal two years previous to that was 25 days. From the standpoint of a realtor, whether one is in the ownership market or the rental market or you're a small landlord trying to operate a successful rental property, how important is it to make sure that people can get ready access to a complaint, be they a landlord or a tenant?

Mr. Lyle Warden: Thank you for the question. I couldn't agree with you more. There are cases of bad actors on both

sides. I think it's having access to a situation where, in a timely fashion, it has to happen.

I will give you a specific example: I sold a house with the tenant inside of it. The purchaser is buying the house for their son, so it's a legitimate N12 eviction notice. The tenant hasn't moved out yet and refuses to move out, so it is holding up the deal. It's a legitimate situation where this is something that happened. Stay tuned, as it hasn't closed yet, but we are hearing up to six months at the tribunal right now, so it's not fair for the seller, who legitimately has a right to sell their home, and it's not fair to the buyer. I sympathize and empathize with the tenant, but they don't own the property.

And I think another issue that needs to be addressed is the fact that at some point, there needs to be a reset—

The Chair (Mr. Ernie Hardeman): One minute.

Mr. Lyle Warden: —of the rents. If a tenant lives at a place for 20 years, the provincial yearly whatever they allow it to go up by is not enough. I'm a landlord; I own, I think, eight doors. It's not enough to increase to keep up with the actual cost of living. Right now, I've got a couple mortgages that are coming due and the interest rates are going to be double. I can't double the rent. I'm not saying that I should double the rent, but I think there needs to be a more realistic and balanced approach to—

Mr. Joel Harden: In my last 30 seconds, sir, if you don't mind just a wrap-up, because we'll have another opportunity to discuss this and I hope we can exchange cards to talk about it afterwards—

Mr. Lyle Warden: Absolutely.

Mr. Joel Harden: But we certainly do need more due process, don't we to make sure that if it's a landlord, if it's a tenant, they shouldn't be waiting for six months. That makes zero sense.

1050

So 40 adjudicators is great. It would be great, Chair, just for the record, if it couldn't only be online, because people for whom the Internet is not their strategy, they need an in-person hearing to have access to justice, whether they're a landlord or a tenant. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much.

We'll now go to the independents. MPP Collard.

M^me^ Lucille Collard: I'll continue with you, Mr. Warden, because you did speak about the need to reform the Ontario Land Tribunal, and I totally agree. Most of our tribunals have backlogs that have negative impacts on the lives of everybody. It's costing the system money. It's costing people a lot of anguish, and mental health issues arise from that.

I'm just wondering, and it's maybe something I missed, but while I agree that we need to improve the Ontario Land Tribunal process, how do you see that would impact the price of housing? Do you see a link, or are you just talking about the need to do that?

Mr. Lyle Warden: I think there's two sides to that. I think it would prevent the large corporations that are buying these big buildings and doing these mass evictions. I think eventually it will get to less of that, because if it's reformed and there's a more reasonable approach to how the rents are able to be increased over time, I think it will that slow down. It probably will put the rents up higher, but the fact of the matter is it's costing everybody more to live, including landlords.

M^me^ Lucille Collard: Ms. Deeb, did you want to react to that? I saw you taking notes.

Ms. Nina Deeb: About the OLT?

M^me^ Lucille Collard: Yes.

Ms. Nina Deeb: Well, we would have quicker builds, and we would have less time. Time is money, so if we could have some reform to the Ontario Land Tribunal, one of the best things we could do is—we need more adjudicators. The Ontario tribunal watch has been publishing for about six years now that the adjudicator positions are being left open, and it was taking eight months for a landlord-and-tenant hearing. The last number I got from my client, it took them eight months to get a hearing.

M^me^ Lucille Collard: Right. And while the digitization process can save some time, would you agree that it's not for everybody and that there still needs to be capacity for people to appear before the board itself?

Ms. Nina Deeb: Absolutely. In-person hearings must always exist. It's fantastic that we have the privilege of having digital, electronic, but in-person is always more effective. I drove here five and a half hours today, all night, so that I could appear in person. There's a reason I do that. It's definitely more effective. I've proven that point I think.

M^me^ Lucille Collard: Thank you so much.

How much time, Chair?

The Chair (Mr. Ernie Hardeman): One point three.

M^me^ Lucille Collard: Maybe a last question for you, Mr. Allan. The pandemic, as you know, increased tremendously the challenges that we see in the health care system. Based on the bills and the decisions, the policies the government has made, do you feel that we've learned from the pandemic and that we're doing things differently based on those lessons?

The Chair (Mr. Ernie Hardeman): One minute.

Mr. Doug Allan: No, I don't think I do. The capacity problems that have been brought so much to the fore previously got significantly worse in the last few years. The plan that exists to improve capacity falls far, far short of what is actually needed, given both the increased incidence of respiratory illnesses and the growing and aging population. I think the promise is 3,000 beds over 10 years. That's an 8.4% increase in capacity. Population itself will be double that almost, and then there's a whole other increase that is due to aging. So we need to rethink the whole capacity issue. We need to recognize that there's a crisis existent now that has to be resolved, that we need extra capacity to deal with that, and we also—

The Chair (Mr. Ernie Hardeman): Thank you very much.

We'll now go to MPP Bresee.

Mr. Ric Bresee: I greatly appreciate all of you being here today.

Mr. Warden, you and I have something in common: We are both former municipal heads. I know that that brings a different perspective, and I greatly appreciate the idea that

in your presentation you brought forward suggestions, proposals. It's always better to come with ideas, and I do appreciate that.

One of the things that I was thinking about—and again, we often end up talking about very large corporations and very large apartment owners and things of that nature, but you and I live in a different world than that. We live in the rural space or the small community space, where there are not a lot of large corporate landlords in the residential sector, certainly.

One of the things that I'm seeing in my area that has created a fairly significant change to our real estate market is, in my community, there are a whole bunch of those 1970s and 1980s 2,000-square-foot bungalows. They are incredibly common across Ontario, especially in the smaller communities that—a lot of them were bought into by people in their twenties and thirties. They are now in their seventies or eighties and they're moving out of them because there's a lot of maintenance etc. that is required for that. That housing market—those houses becoming available to the market—we are seeing a tremendous number of them being picked up by local people and being converted into a couple or three apartment units in that rental market. In most cases, again, these are not large corporations that are doing this. These are, quite often, local tradespeople who are investing in themselves, investing in the community and providing that extra rental space.

One of the tools, and you mentioned it before—Bill 23 and the availability for three units as-of-right in those spaces—has certainly enhanced that capability. But one of the questions that I've been presented with is that while that is providing more apartments, more purpose-built rental capacity, is it also providing, from the real estate sales perspective, a challenge to those people who are looking to buy that first home, those looking to move into those in the ownership market?

Mr. Lyle Warden: That's a fair question. It's a free market. If a house gets put up for sale, the seller has the right to choose whichever offer comes in, and most times they don't know what the next purchaser is going to do. But I think, on the whole, it's positive for the housing sector, period. Yes, it may be difficult for some folks to be able to get into their first home, but the developers are creating, potentially, three residences, right? If it's done properly and if the zoning permits it, they can potentially be three separate parcels of land. It could be put into a condo or it could be—if it's developed as a rowhouse, instead of having one house, you could potentially have three houses that could be put for sale in the future.

I think it's positive. Again, it's a free market, so it's tough to—I think it's a very valid question, but I do believe that it's positive more than negative.

Mr. Ric Bresee: Thank you. And a follow-up to that: In your presentation, you actually specifically mentioned the development of fourplexes and sixplexes, which actually takes a step beyond the current new legislation, and that comes back to that municipal zoning and the requirements under that. In your area, are you seeing a lot of that size of development or are you seeing more of the ones and twos?

Mr. Lyle Warden: More the ones and twos. For some reason, there's not a lot of that type of development yet. You drive 25 minutes to the east, you cross the border into Quebec, it's sixplexes, fourplexes—it's unbelievable. I can't emphasize enough how different it is. As soon as you cross the border, driving on old Highway 2, it's fourplexes and up almost from the border.

Mr. Ric Bresee: I actually very much agree. I was in that area recently, but I'm also noticing very similar developments happening in I'll call it the greater GTA, into the spaces being developed just outside, on the fringes of the GTA. There's a lot of that small, but multi-residential development going on. So thank you very much.

Mr. Lyle Warden: Thank you.

The Chair (Mr. Ernie Hardeman): MPP Dowie.

Mr. Andrew Dowie: I want to thank all the presenters for being here.

I'd like to inquire with Mr. Allan. Over the last couple of months, I've met with many health care providers in my community. All are saying the attraction of staff has been a real issue and that the remaining staff are experiencing burnout. I believe your presentation mentions that.

1100

But when it comes to the primary care providers, they keep on saying universally they're losing their nursing staff to hospitals, that it's a more attractive position, the wages are higher and there are benefits. There's just a greater compensation package. It doesn't matter whether it's the endoscopy centre, an urgent care centre, a family health team or a community health clinic, they all say the hospitals are attracting their workforce and that they can't compete with hospitals.

And so, I guess I'm trying to digest: If the hospital compensation package is not sufficient for hospital workers, perhaps that's what's creating these vacancies where the primary care workers are moving up into those vacated positions. Is that what's happening?

Mr. Doug Allan: Yes.

Mr. Andrew Dowie: That is what's happening?

Mr. Doug Allan: Well, there's a crisis right throughout. It's even worse on the community health centre side. I almost wish I could have talked about that today. We have a demonstration right now from home and community care workers out in front of the treasury board over this sort of issue. Watch Global at noon.

That is a big problem on the community health side that even despite—

The Chair (Mr. Ernie Hardeman): One minute.

Mr. Doug Allan: —how we've lost so much in terms of wages to inflation on the hospital side and to other industries, it's even worse on the community health centre side and the home care side, and primary care.

Mr. Andrew Dowie: Now, everyone involved in the management from the hospital side usually tells me we need to bolster our primary care, and you echo those comments—

Mr. Doug Allan: We need to bolster every part of health care, including primary care, yes.

Mr. Andrew Dowie: But would primary care not be a better priority to bolster versus the hospital side to reduce the burnout for the hospital workers?

Mr. Doug Allan: I would say we need a full side—a way to deal with the health care crisis. We need to bolster—on bad news I have for government today, is we need money and funding, and it's right throughout that system. That's just the reality that we're in of a population growing and aging. It won't always be this way. At a certain point, the aging dynamic will die off. We may not always have population growth like we have right now—

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes that question. It also concludes the time for this panel, so we want to thank all the presenters in this panel for the time you took to prepare and the great way you presented it to us. Thank you very much. I'm sure it will be of great assistance.

SEAWAY VALLEY COMMUNITY HEALTH CENTRE
ONTARIO ASSOCIATION OF CARDIOLOGISTS
CHAMPLAIN REGION FAMILY COUNCIL NETWORK

The Chair (Mr. Ernie Hardeman): We will now hear from the Seaway Valley Community Health Centre, the Ontario Association of Cardiologists and the Champlain Region Family Council Network.

As the presenters are preparing themselves, again, we will have seven minutes to make your presentation. I will give a warning at one minute. Don't stop then because at seven minutes I will stop it with a "Thank you."

We also ask that all the presenters make sure that you introduce yourself as you start your presentation. If there is anyone else involved in answering in the questions, make sure we have them introduce themselves before they speak to make sure we have the names in Hansard properly.

Oh, I also want to add, don't push the buttons on the speaker. That's all done automatically when you start to speak. And don't sit too close to the mike so it goes through clearer.

With that, we will hear from the Seaway Valley Community Health Centre.

Ms. Penelope Smith: Good morning. Bonjour tout le monde.

My name is Penelope Smith. I'm representing the Glengarry Nurse Practitioner-Led Clinic. I'm here in conjunction with Erin Killoran, who is the executive director of the Seaway Valley Community Health Centre. Of course, I am here also representing our local collaborative of primary health care organizations that includes, again, the Glengarry Nurse Practitioner-Led Clinic, Seaway Valley Community Health Centre, le Centre de santé communautaire de l'Estrie and the Rideau St. Lawrence Family Health Team.

Ontario's health care system is in crisis. We have heard or perhaps experienced the following:

—waiting in a crowded, noisy emergency room for more than four hours with a feverish, crying and inconsolable six-month-old;

—perhaps you've learned that your family physician has retired and now your only source for your prescription renewals is to wait in the emergency department, and you wait for hours;

—having to wait 12 hours to simply have a finger bandage changed or sutures removed; or

—perhaps you know of someone who had to wait for five hours in an emergency department to simply have a tick removed on their back in a spot that they could not reach.

These stories are all too common: people attending the emergency room when emergency services aren't needed. They're experiencing undue distress and at a higher cost to the health care system, when in fact they could and should have received care from a community-based primary team-based model of care.

ERs are for emergency care. Regionally, we only have one walk-in clinic and hospitals are for the most unwell. Comprehensive primary health care happens in the community. For Ontario to move out of this current crisis of overwhelmed emergency departments and hundreds of thousands of Ontarians without access to comprehensive health care, one needs to look to the primary care sector and make needed, sustainable, adequate funding investments to interprofessional team-based models of care such as nurse practitioner-led clinics, community health centres and family health teams.

Researchers and clinicians will confirm that an efficient, client-centred, quality-based health care system requires community-based primary care to be its foundation. Ontario's own publication, Your Health: A Plan for Connected and Convenient Care, actually states the same. Nurse practitioner-led clinics, community health centres and family health teams are community team care models that connect people to the right level of care by the appropriate provider in a timely manner, yielding positive health outcomes. These are innovative, responsive, efficient models of primary care that can certainly help solve the current health care crisis.

Did you know Ontarians served by nurse practitioner-led clinics, community health centres and family health teams tend to be 68% more medically complex, meaning they have higher rates of hypertension, diabetes, mental health concerns and other chronic conditions compared to the average Ontarian? Yet despite this medical complexity, clients attached to these types of primary care models tend to go to the emergency department far less often, and certainly less than expected. This saves the health care system and taxpayers roughly $27 million every year according to research conducted by the Institute for Clinical Evaluative Sciences.

How is this possible, you might ask. Community-based primary care organizations are salary-based models of care. They are not OHIP-billing-based models of care. They enable clients to access care from a unified team of health care workers such as nurse practitioners, physicians, social workers, nurses, registered dietitians, physiotherapists, pharmacists and chiropractors who work collectively to serve clients' health care needs. They assess, diagnose, treat and provide preventative care, chronic disease management, supportive education, health teaching and care coordination as a unified team.

By ensuring people have access to comprehensive primary health care in a team-based setting, we can keep people out of the hospital, in the community, save money and help reduce hallway health care. Community-based primary care teams can be a solution to the current health care crisis. These models are innovative, responsive, client-centred and lean. But we need your help.

We propose that the Ontario budget invest in two key areas. First, we ask that you invest in the people doing the work. Staff in community-based interprofessional primary health care teams are paid at or under the 2017 salary rates. This sector is losing staff to the private and hospital sectors due to wage disparity. The cost of living has skyrocketed, and because investments have been made to hospital wages, for example, 11%—

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Penelope Smith: —for hospital nursing staff and others, no wage increases have occurred in the primary care sector, and we cannot compete.

1110

The second ask is to invest in enhancements to the community primary care sector's base budget funding of 5%. Operational costs continue to rise, and if you can imagine—did you know that community primary care organizations have not had a base budget funding increase for over 15 years?

If primary care is the foundation to a strong and responsive health care system, Ontarians want access to comprehensive, team-based care. We call upon the Ontario government to make needed, sustainable and adequate funding investments to address the salary wage gap and operational or base funding lags.

The Chair (Mr. Ernie Hardeman): We'll now hear from the Ontario Association of Cardiologists.

Dr. Richard Davies: Yes, hello. Good morning. I'm Dr. Richard Davies, here with my colleague Dr. Robert Wald. We've both been cardiologists in Ontario for approximately 40 years. I'm currently retired in Ontario and see patients in Nunavut. Dr. Walsh could retire but hasn't because, like me, he loves what he does. We both see cardiology as a calling as well as a profession and are here because, in Ontario, our profession is in trouble and needs your help.

To explain, I'll describe to you Dr. A, who's real but whom I won't identify, except to say that his or her initial is not actually "A." Dr. A is about the same age as Dr. Wald and I, loves seeing patients and is very good at it. Dr. A retired from practice and started seeing patients full-time for an academic cardiology group, first in consult and then in follow-up, helping them with their problems and arranging for their care. The group made an arrangement in which Dr. A kept everything. They billed OHIP, and with this arrangement, Dr. A was able to take home an income that was comfortable but not excessive, keeping in mind that Dr. A also has to purchase benefits, receives no pension and has to plan for retirement, which has become a real challenge.

With this arrangement, Dr. A saw as many patients as any six other cardiologists in the group and single-handedly kept the group's waiting list for an office visit under some semblance of control—meaning months rather than years. For Dr. A to do this, the group provided Dr. A with a small but fully equipped office, two full-time admin assistants to handle patient calls and bookings, a fully staffed clinic with a reception area and receptionist, two clinic rooms and a fully functioning and maintained electronic medical record, all of which was paid for by the group and not Dr. A. If Dr. A wanted to see patients full-time on their own without this support, it would not have been possible.

Dr. A is very good, fast and efficient, but OHIP's fees for cardiology visits are simply too low for a physician like Dr. A to cover overhead and still make a living. This, writ large, is the problem Ontario faces. With the added stress of COVID over the past several years, it has reached a crisis point.

Let me give you a few statistics. In fiscal year 2019, fee-for-service cardiology clinics provided over 466,000 outpatient services in Ontario. This included 54% of outpatient cardiology consults and 72% of cardiology follow-up visits done in the province. These clinics have long been a critical part of Ontario's health care infrastructure, and they are now at risk. Their loss would manifest itself as even longer waiting times for specialist care and emergency rooms being even more crowded because of patients these clinics could have and should have cared for.

OHIP fees for cardiology clinic visits are currently only 37% of what the OMA recommends and, as a result, they are two- to threefold less than what you would pay a lawyer or a dentist or other professional in the office for the same amount of time. Prior to 2023, OHIP fees for cardiology visits were last increased in 2011. If you use this as a benchmark and adjust for inflation, you'll find that in 2023, consult fees have fallen by 27% and follow-up fees by 32%. In addition, because of COVID and other factors, the cost of maintaining a clinic has spiralled far above published inflation rates, while at the same time clinic incomes have plummeted.

To illustrate the impact of this, I'd like to read you two things. The first is the title of a paper published in the Lancet in 2020: COVID-19's Crushing Effects on Medical Practices, Some of Which Might Not Survive. The second is a sentence from an article published in the New England Journal of Medicine in 2020: "For the first time since the Great Depression, crippling financial losses threaten the viability of substantial numbers of hospitals and office practices...."

The data I've just outlined for you indicates that the potential loss of fee-for-service cardiology clinics is a looming crisis for Ontario. To begin to address this, the OAC and the OMA section of cardiology proposed as their only priority to the OMA's Physician Payment Committee that a new fee code be put in place that would cover the overhead cost of seeing patients in clinic in order to avert this crisis. The PPC's response to this was as follows: "This request represents a system-wide issue. The item is extremely complex, involves the entire profession and potentially significantly rewriting the schedule," meaning the schedule of benefits. "As a result, this committee has

decided it is not feasible for them to deliberate on this request and it is therefore declined."

The academic group I described for you supported Dr. A and made it possible for he or she to do what they love: see patients. This had a tremendous positive impact on waiting lists and patient care. Ontario needs an army of physicians like Dr. A seeing patients, off-loading emergency rooms, reducing waiting times and preventing hospitalizations. They're out there, but they need to be able to make a living doing what they love, and they need support.

On behalf of the OAC and the OMA section of cardiology, Dr. Wald and I came here today to ask for your help in providing this support.

The Chair (Mr. Ernie Hardeman): The next presenter is the Champlain Region Family Council Network. The floor is yours.

Ms. Grace Welch: My name is Grace Welch, and I'm the chair of the Champlain Region Family Council Network. Thank you for the opportunity to speak to you today about the issues facing long-term care in our region and across Ontario. I've been an essential caregiver and volunteer in long-term care since 2008. I was also a member of the advisory panel on the 2020 Ontario ministry staffing study.

Our network is a volunteer group that supports the family councils in the 59 long-term-care homes in the Champlain region through information-sharing, education and advocacy. It's a voice for concerned families. We also bring issues forward to all levels of government, with the goal of improving the quality of life and the quality of care for residents in long-term care. If you'd like to learn more about our work, I invite you to visit our website champlainfamilycouncils.ca.

My focus today is on long-term care, but I also want to recognize that we also need an expanded, robust home care system and innovative housing solutions for seniors, such as NORC-SSPs, to promote healthy aging in place.

We are very pleased that after decades of neglect, we are finally seeing much-needed investment in long-term care by the provincial government: in construction and renovation of long-term-care homes, training and recruitment and especially the long-awaited commitment to a minimum care standard of four hours of care per resident per day by 2024-25. For this, we are grateful. But there's still much work to be done to "make long-term care a better place to live, and a better place to work," and that's a quote from the 2020 Long-Term Care Staffing Study.

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In our written submission, which we'll be sending later, we've grouped our recommendations under five broad categories. First is staffing. It's the number one concern of family members. Recruitment and retention remain critical challenges in the sector, I think as you well know. The increased reliance on costly agency staff because of staff vacancies means that homes are paying two and three times the hourly rate of their own employees. But more importantly, residents are put at risk on a daily basis because agency staff do not know the specific needs of residents or the routine of a home. How can you have quality care when there is a revolving door of staff? And we hear that the staffing situation is particularly dire in rural areas and in the north.

The Auditor General's report, which was released just last month, notes that homes are still struggling to maintain sufficient staff to meet the needs of their residents, a quarter of the homes in the province still provide fewer hours of direct care than the provincial targets and half of the homes were unable to meet the legislated standard for allied health professionals.

We recommend that the government invest in improved compensation, wage parity, benefits and working conditions to ensure staff are attracted and retained in the long-term-care sector, and we ask that the government put into place a robust human health resource plan that will focus on recruiting the right people in order to create a stable, consistent workforce that will reduce onboarding and training costs and improve job satisfaction and staff retention. The need for this plan is urgent, not just for today but for the new homes that will be opening in the next few years.

Secondly, person-centred care: We need a fundamental shift away from the institutional task-oriented model to one that puts the needs and preferences of residents as the focus of care. We believe that, given the will, our government is in a unique position to transform and rebuild our long-term-care sector on the tenets outlined in the preamble to the new Fixing Long-Term Care Act. I encourage you all to read that preamble because it's all laid out there. That is on a person-centred model of care that promotes quality of life and quality of care for the residents and attracts, supports and retains all levels of staff. Widespread implementation of person-centred care, however, will require resolution of the staffing crisis and investments in training, as well as the sharing and promotion of best practices. The dividends, however, will be big—a more dignified life for residents, better health outcomes and a work environment and culture that attracts and keeps staff.

We recommend that the ministry and long-term-care leadership embrace, fund and make real progress on implementing a person-centred model of care that is built on respect, kindness, compassion and dignity for the resident—not in the years to come, but now.

Thirdly, building standards: We do not need any more large, sterile institutions with shared rooms and bathrooms that don't feel anything like a home. Adopting person-centred care as a model of care requires modifications to the existing outdated building standards for long-term-care homes in order to create smaller, homelike environments that provide resident privacy, foster a sense of community, include space for indoor and outdoor activities and which are also more functional for staff to provide care. Many of the new long-term-care homes honestly look more like prisons than homes. If BC can build a publicly funded long-term-care home based on the concepts of a dementia village, why can't Ontario?

We recommend that the current building standards be revised to create smaller homelike environments that promote person-centred care. We also want to see homes

constructed within the context of a provincial plan based on needs and community profiles, especially the needs of underserved populations such as the LGBTQ+ and Indigenous communities. And we want to see non-profit ownership favoured when awarding licences and construction funding.

Fourthly, quality control accountability and transparencies: Families want a robust inspection regime that ensures that every long-term-care home is fully inspected on an annual basis with regular oversight and impactful enforcement consequences. We also want transparency and meaningful performance measures.

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Grace Welch: We recommend that the inspection regime and inspection program strike a balance between a strong inspection regime that allows homes to innovate and try new approaches to improve the lives of their residents; have, at its core, coaching for compliance and sharing of best practices to help poorly performing homes; develop and report performance measures related to resident quality of life and working environment for staff; and we really want to see public reporting of direct hours of care by each home currently hidden in the average taken across all provinces.

Lastly, we recommend that the province adopt the national long-term-care standard. We want to see the province work with the federal government on the implementation of the recently published standards. The roadmap for long-term care reform—

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time for the presentation. Hopefully the rest of it will come out in the question period.

We'll start this round of questioning with the independents. MPP Collard.

M^me^ Lucille Collard: Thank you to all the presenters. We were able to capture most of what you say and it's very charged. You've got a lot of information you want to convey, and so hopefully through the questions we're going to get a little bit more into details.

Je vais commencer avec Penelope. Je vais poser ma question en anglais. Je sais que vous êtes francophone ou que vous comprenez le français, mais pour le bénéfice de mes collègues.

The health service and the community program is so important. I come from Vanier, where there is a void of community health services, so everybody needs to go to the hospital if they want services. So I totally can relate to the challenges you've explained.

The government has come up with a new formula with the Ontario health teams which decentralizes services under a bigger umbrella. I would just like to have your opinion on that, if you see that that would improve community health care services or if there are some concerns around this new formula that would centralize the access to service.

Ms. Penelope Smith: It's a very key question that you pose. Again, I'm here representing the primary care community-based collective, which is the nurse practitioner-led clinic within our region, the Centre de santé, which is a francophone CHC and a family health team as well. As a collective, we are very much immersed in Ontario health teams and that planning and certainly appreciate the government's direction to move towards a more regional-based planning approach. All of the community-based primary care organizations are very much an integral part of the OHT and its planning processes, but we are also non-profit organizations who are very much dependent on funding from Ontario Health and the Ministry of Health, and so that is where we receive the majority of our funding in order to operate.

M^me^ Lucille Collard: That's helpful. But do you think this is a good direction to take in the long term that will improve community health care services?

Ms. Penelope Smith: I would say that for the sector, yes, this is a positive step forward, because it's creating an environment for all health care organizations and providers to actually work together to collaborate, to develop innovations and to plan to respond to the broad health care needs for our entire region and community.

M^me^ Lucille Collard: Great. I'm really pleased to hear your answer.

I'm going to turn to Grace. Talking about long-term care, the idea of person-centred care, is really great, and it's what we've been hearing from the beneficiaries, but also the families, who really want more of a personal environment for their loved ones. Can you explain a little bit more what's needed from the government to make that happen and what that would look like on the ground?

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Grace Welch: We're very fortunate here in Ottawa. In this region, we have a community of practice that's working together to share best practices. So I think one of the things that is very important, and I think the ministry could do this, is to set up a quality centre that would help homes, coach homes and share best practices for person-centred care.

There's going to have to be some investment in more training, certainly. But I think the best part is having that encouragement and promoting it, helping to coach homes on how they can implement it within their own environment. Certainly even starting with person-centred care language—CLRI, the Centres for Learning, Research and Innovation in Long-Term Care has a tool kit on changing the way that you talk about residents. You don't talk about bibs; you don't talk about feeding residents, you talk about assisting them. There's a whole different mindset. So there's work to be done, but it's quite achievable and it does pay real benefits.

M^me^ Lucille Collard: Thank you very much.

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The Chair (Mr. Ernie Hardeman): We now go to MPP Jordan.

Mr. John Jordan: Thanks, Penelope, for your presentation, and Grace. I'm familiar with the community health centre model, Seaway Valley in particular. Debbie St. John-de Wit and I worked closely in my previous role as CEO of ConnectWell Community Health. Interdisciplinary

care, I think, is very important and a big part of the solution to our health care challenges at this time.

I'm also very optimistic for the Ontario health teams and bringing that collaboration that you referred to together. I wonder if you can speak a little bit, now that we have home and community care moving through there: How do you feel this will help or how do you feel this will impact the effectiveness of our home and community care program?

Ms. Penelope Smith: I'm actually not here to speak on the home and community care program. I think there are other presenters who are much more versed in that sector.

I guess I'd like to take the opportunity just to reiterate that Ontario health teams certainly are a foundational driving force, moving forward, for coordinated care. However, when you look at primary team-based care models, we are still facing some significant challenges, and those challenges will only be transferred over to Ontario health teams, perhaps as they progress, and the two issues relate to funding.

There's a significant wage disparity between the community health care sector and the hospital health care sector, and the other issue has to do with funding needs in terms of base funding needs. So as non-profit organizations within the community-based primary care sector, we're calling on the province to make needed significant investments in those two main areas.

Mr. John Jordan: Just as a follow-up then, I'm familiar with the Hay report, Korn Ferry report and now your new funding report. Can you speak, just briefly—I know when I left the CHC model in 2021, we were about 80% of the 2017 report. Just to give us a sense about where you are, where the sector is now relative to that compensation.

Ms. Penelope Smith: In terms of the Eckler report?

Mr. John Jordan: Well, the Eckler one if you want to speak to that, or even the 2017 one, the previous one.

Ms. Penelope Smith: Right. The most recent report is the Eckler report, which was a pan-association—there were 10 associations, if I recall, that collaboratively worked together to commission the report. The findings were just recently released in the fall. With that, it made very clear that there is need for significant investment just to meet standard industry wages.

As I presented earlier and in the information I had circulated to everyone here today, those in the community primary team-based care sector—so nurse practitioner-led clinics, community health centres and family health teams—as well as extending beyond just the primary care sector, their wages have not increased since 2017. This is rather significant for our sector, because we know people want to work in a team-based care environment, but there are some economic pressures they encounter given the current climate.

So we're asking the Ontario government to make those needed, sustainable investments to bring wage parity. There have been significant investments in the hospital care sector and their wages, and the community-based sector is asking for comparable investment.

Mr. John Jordan: Thanks, Penelope. Just lastly on that, I never had a problem with recruitment and retention despite those disparities, and it's because of the work environment that you have spoken to and CUPE spoke to as well, previously. So I'm just wondering how the recruitment and retention is in your sector.

And just before I let you go on that one, Nolan Quinn wanted to do a shout-out for the great service and filling those gaps we have right now in health care.

Ms. Penelope Smith: Excellent. Yes, with regard to recruitment and retention within the organizations, again, we know from clinicians, and research certainly does show, health care providers, particularly in the primary care sector, want to work in a team-based care environment. I would think the last thing that we need in our health care sector is more solo practitioners. People want to work in a team-based environment where they can draw upon the skills of various professionals and work in a coordinated, client-centred fashion.

Yes, culture is essential, and certainly primary team-based care models are very nimble and responsive. They're smaller organizations that are able to really optimize a positive team-based culture. This is where people want to invest their time and energy, and exercise their professional skills. But wages are important as well.

The Chair (Mr. Ernie Hardeman): MPP Byers.

Mr. Rick Byers: Thank you very much to the presenters for joining us here in lovely Cornwall today. Maybe I'll carry on with Erin and Penelope. I don't have MPP Jordan's expertise of the CHC world, but I was on the board of a CHC for three years before my current occupation, so I know the model and love the model. It was in South East Grey, serving Markdale and Dundalk, two very well-known communities in Ontario.

Anyway, can you give me a sense of how long Seaway Valley has been in the community here? Has it been quite a while? Just give me a sense of the team-based care in this part of the province?

Ms. Penelope Smith: Perhaps we could direct that question to Erin, who is the executive director of the Seaway Valley Community Health Centre.

Ms. Erin Killoran: Good morning, everyone. Thanks, Penelope. We've been here since 2009 in our community.

Mr. Rick Byers: And very well-established now, it sounds like, in the community with your care model?

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Erin Killoran: Yes, very established and quickly outgrowing our space. I think the building was originally built for 16 staff, and now we're edging close to 50.

Mr. Rick Byers: And how many staff, how many NPs and physicians, have you got in the clinic, just out of curiosity?

Ms. Erin Killoran: We're funded for two full-time physicians—which is actually shared amongst three physicians, two part-time and one full-time—and we have seven nurse practitioners.

Mr. Rick Byers: Got it. And then how many PSWs and nurses have you got?

Ms. Erin Killoran: We have PSWs, RPNs and RNs. In total, we would have 10.

Mr. Rick Byers: Good. Well, thank you very much. It's much appreciated.

Ms. Erin Killoran: You're welcome.

Mr. Rick Byers: Maybe over to you, Penelope, on nurse practitioners: In meetings I've had over the last number of months—

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time.

We'll go to the official opposition. MPP Harden.

Mr. Joel Harden: I think I'm going to be carrying on very much in the vein that MPP Byers was on. I'm very appreciative of the presentations this morning. It's a theme, just as MPP Pasma and I have been going to the eastern Ontario hearings, about how much work the community health centre movement is doing for the investment that you've been given, and I think you've made a very compelling case this morning, as your colleagues have done elsewhere, that a base budget increase is absolutely warranted. There hasn't been one in 15 years.

So if I'm understanding from what MPP Byers was asking you, you started in 2009. You have three folks working through a two-FTE component on the physician side; you've got 7 RPNs and a team of other allied health professionals. How many patients are you rostering with that amount of folks?

Ms. Penelope Smith: What's interesting is that our models of care are somewhat different, right? We're a collective in terms of representing the community-based primary care models, but nurse practitioner-led clinics in fact are very forward-thinking, a very innovative model of care—actually first introduced in Ontario and, as far as I'm concerned, the best-kept secret in Ontario.

There are only 25 NPLCs in the province of Ontario. Rather than physicians leading primary care within those models, it's actually very skilled, trained nurse practitioners who function at full scope. They work in conjunction, very similar to CHCs, with a team of inter-professionals. That might include nurses, mental health workers, social workers, physiotherapists, chiropractors, pharmacists and what have you, really providing comprehensive team-based care to the population.

Mr. Joel Harden: That's terrific. Then maybe just to the ED of the community health centre: Do you have an idea of your catchment, just to follow on the vein of the questions from before? How many patients?

Ms. Erin Killoran: If we're looking strictly at rostered patients, rostered clients to nurse practitioners and physicians would be about 3,500. And if you take into account the numbers who see our dietitians, our lung health program, cardiac rehab, that number would actually double.

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Mr. Joel Harden: Wow. That's terrific. That's terrific work. I think you made a very good case for funding this. Thank you very much for being with us this morning.

Moving on to Drs. Davies and Wald—full disclosure—I'm married to a physician myself and have heard the complaints about the headaches of administration and planning for one's own retirement.

Often what we're hearing at this committee are some very difficult challenges that people are facing, but I'm wondering if we could blue-sky for a moment, given that you folks are at a moment in your career where you can reflect backward as well as forward. If you were to have that time back and the province of Ontario came to your profession with an opportunity to not have to worry about your retirement, as many municipal and provincial employees have—we invest in their retirement, so they don't have to worry about them; it's collectively bargained for them. If you had that same opportunity for your own benefits for your staff, if you had those obligations taken off your plates and you could focus 100% on providing the crucial care that you provide for heart health to patients, is that something an earlier version of yourself in your profession would have liked? What do you hear from colleagues? I'm just curious to know.

Dr. Richard Davies: I can speak to that. Basically, before I retired, I was also the managing partner of a large group of cardiologists, and many spoke to me about that. Even some of what you would call, if you like—they did a lot of procedures—the higher earners, and they routinely would come to me and say, "If we didn't have to worry about this, it would be a real blessing because we would likely be able to focus more on patient care and less worrying about these things."

Mr. Joel Harden: I can definitely say from the standpoint of our own household, it is interesting to have to do your own personal financial research of all the mutual funds to which you're connected and to realize that 15% to 20% to 25% of your retirement savings could be bled out in fees because you're not in a competitive enough arrangement to get what you can.

We're asking people on the administrative side, for their staff members, to put a lot of effort into something when we've trained you—the province has trained you, the country has trained you—to play a critical role in health care. So that's affirming to know. That's a good note for us as the entire committee, that perhaps we can look forward, inspired by collaborative health care models, to offer people that retirement security, that benefit security and to the allied health professionals.

Chair, where am I at in my time?

The Chair (Mr. Ernie Hardeman): Two point five.

Mr. Joel Harden: Grace, really nice to see you this morning. I really loved your idea about a best practices approach for the whole province and it's one more feather in our cap in Ottawa that that seems to be the standard that people take. There's a very collaborative approach between institutions who are innovating. I'm very familiar with the Glebe Centre and what they do for Chinese Canadian seniors, what they do in particular for embracing the butterfly approach of person-centred delivery.

Would you mind just elaborating on some anecdotes and information you have around best practices to make that case for a centre of excellence that you were making earlier?

Ms. Grace Welch: I think there's a lot of information for homes to process and there's different approaches to the person-centred care.

One of the things that has come out is that every home has to modify the person-centred care to suit their environment, so I think that's where having that centre would come in, so that if somebody is saying, "Well, we're thinking the Eden model"—I mean, there's the Eden, the greenhouse,

the butterfly—is just one of them, and that they could go and learn quickly and easily. "Well, you know, this works really well in this environment, but not so well in this environment"—that kind of thing.

And also, connecting homes to one another I think is also very important. It's sort of that mentoring, like, "Here is what we learned." For instance, the city of Ottawa has two homes that are doing a pilot now on person-centred care, and we're looking forward to hearing what they have learned. And I think sometimes homes are surprised, they think this is going to work and it doesn't, or vice versa.

In fact, one of the things I heard is that the city is seeing some efficiencies. It's still in the pilot stage and I think that's surprised them. So people think, "Oh, it's going to cost more," but you gain other efficiencies and if you have happy staff—

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Grace Welch: —there's big dividends, as I mentioned, and also improved staff retention.

Mr. Joel Harden: Absolutely. So I want to end—the Chair warned me, so it will be more of a comment. I'm not going to ask a question. I'm going to follow the direction you gave me before, Chair—with just a comment inspired by what you said. You were saying in your comments about moving towards a less institutional feeling in long-term-care homes. When I look at the role of Scandinavian examples—great researchers we have in our city have been bringing this message to bear that we should be putting life into years and not years into life, the idea that folks who are aging in a multi-care facility deserve the right to have a homey home and that it should feel that way when you walk through it. So, Grace, I do want to thank you on the record for all of the urging you do within the Ottawa network of homes, and to think that there is a positive that we could focus—

The Chair (Mr. Ernie Hardeman): Thank you very much.

We'll now go to the independents. MPP Collard.

M^me^ Lucille Collard: I will continue with Grace for another question about long-term care. You mentioned the aspect of having a balanced approach to inspections so that the well-being of patients can be educated by a different role for inspections. Can you explain what is envisaged and what you mean by that?

Ms. Grace Welch: There's a lot of time spent on inspections and a lot of reports written. One of the things that we have not seen necessarily is the follow-up action. The inspectors don't always go back or it's just a written notification. So it's making sure. And if a home is consistently performing poorly, again it comes back to this coaching: going back and seeing what's preventing them from making the corrective action. First of all, making sure the corrective action has been done and if it hasn't been done, why not? What do they need? Do they need different tools? And this is one of the gaps that's been missing.

The Concerned Friends actually did an analysis of inspection reports and how many gaps there are. There are still many homes that are not getting an annual inspection, which I think is important. But I think there's a lot more scope, again, for coaching for compliance, working with the homes and doing that follow-up, because there's homes that are consistently cited. But why, you know? So that's one of the things that we would really like to see.

M^me^ Lucille Collard: Thank you very much, Grace.

I'm just going to turn to the cardiologists probably for a last question. I would like you to elaborate a little bit on the virtual care options, what needs to be available to make sure that patients receive the best care. I know that there's been some limit, maybe, about the billing for phone calls versus video. What is your message to the government in that regard?

Dr. Richard Davies: Robert, I'll let you take this.

Dr. Robert Wald: This is a very important subject that you bring up and I don't think that some of the policies that have been put in place in terms of how to pay for these services have really tried to advance the cause of providing the best care to the largest number of people, who are mostly—and certainly in our practices—very old. It's very, very difficult for them to travel to our clinics. It's a massive impact.

If there's anything good about COVID, it certainly accelerated a lot of developments that were about to happen probably over the next 10 years, and they just happened in two years or one year. And I think that one of the things is virtual care, for sure. It's a tremendous help. You can imagine if a patient's family has to give up a day of their job to bring their elderly parent to a clinic, the miles that are used, the CO_2 emissions, the parking—I mean, it's a tremendous problem and burden. I think that—

The Chair (Mr. Ernie Hardeman): One minute.

Dr. Robert Wald: —this particular way of providing care should be completely opened up, made much more flexible and available and should not be put into a straitjacket by restrictions as to where you can or cannot use it and how you use it. I think we're not doing a service to our patients by doing that.

M^me^ Lucille Collard: I am living this situation with my mother right now, so I totally relate to what you just said. Thank you for your answer.

Dr. Richard Davies: May I add to that? I think care is something that has to be flexible and you deliver it to the patient and you have to give them what they need. Often, you can do it by telephone and maybe patients don't have access to video facilities. So I think if we were going to do one thing, I would say: Make it the care that's important, not the technology that underlies it—

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time.

We'll now go to MPP Byers.

Mr. Rick Byers: Thank you again, presenters. I just want to carry on with Penelope and Erin for a minute. Talking about nurse practitioner availability, we hear a lot about health care human resource challenges, particularly with positions like nurses, PSWs etc. Is it the same with nurse practitioners or are they a little bit more available in the market, in your view?

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Ms. Erin Killoran: I can start off, maybe. What I can say is from two recent experiences. The last two nurse practitioner postings that we've had available—the first

one was just over a year ago; it took us at least three or four months to fill that role, and that role became vacant because of a retirement.

We've just recently posted within the last month for a nurse practitioner. We received one applicant. Fortunately, she was excellent and wanted to move back to our community, where she's from, and we were able to hire her, but we posted that before Christmas and it received one application, so I would say it's definitely an issue.

Ms. Penelope Smith: And for the Glengarry nurse practitioner-led clinic, historically we have had far more staff interested in joining our team, but have not had the funding capacity to actually hire them. This, again, very much aligns with the request that was brought forward today.

We have members who are nurse practitioners, registered nurses, mental health workers, nursing staff and other professionals who would like to join an NPLC and/or a team-based care model, but our funding is capped. So if we are only funded for two NPs, that's all that we can hire; we can't hire any more because we have no funds to pay them. And, so, certainly within our model we've seen that there is a significant demand for people to join a team-based organization, but we require more funding to be able to recruit more.

Mr. Rick Byers: Okay, good. Thank you.

Maybe, Penelope, to you: You made a comment in your presentation about the salary model that you use. Could you expand a little bit on why you feel that seems to make sense for your model and what the benefits are?

Ms. Penelope Smith: The salary-based model exists for family health teams, nurse practitioner-led clinics and CHCs alike. Rather than being an OHIP billing model, for example, which is what the traditional health care/primary care system was based on, a salary-based model implies that there is more of an emphasis, if you will, on quality of services, perhaps rather than the quantity of services, because there is not a tie-in in terms of how many people you can see in a day.

Yes, there are metrics that we have to respond to and ensure that we meet certain quality standards, client experience and access expectations, but a salary-based model really is a model where providers are paid an annual salary and expected to deliver quality-based client-centred health care services which are measured.

I'm not sure if Erin would like to elaborate on that.

Ms. Erin Killoran: One thing I'd like to elaborate on with the salaried model is physicians. We constantly have a list of physicians who want to come and work at our CHC because of the salaried model, the balance, being able to focus their team on seeing clients and providing care, versus other administrative tasks that are associated with other models, especially newer, younger physicians who are coming out of school.

Mr. Rick Byers: Excellent. Thank you so much.

Mr. Chair, I'll pass it over to MPP MacLeod.

The Chair (Mr. Ernie Hardeman): MPP MacLeod.

Ms. Lisa MacLeod: I really just wanted to make a couple of comments. I'm going to start with the Seaway Valley Community Health Centre, and I want to speak to Erin, but Penelope, you're right in front of me so I'll say it to you as well. I'm in for Nolan today. He can't be here, but he really wanted to say, as my colleague MPP Jordan said, how critical your services are in managing a gap, especially with mental health and addictions. I think it speaks overwhelmingly to what we're all facing in this region, in eastern Ontario, which is the need for more nurse practitioner-led clinics. So I wanted to say thank you for being here today and making the case, on behalf of him and of course all of our colleagues.

Of course, I also wanted to take the opportunity to say hello to Grace, who I have had the opportunity to work with for many years, both in opposition and in government. To see that you're still active and bringing that passion that you've had over all these years to the floor here today is something that's really special. You provided a great deal of insights to me personally and to governments of various stripes over the years, and I really took to heart the fact that you looked at the investments that we were making, because one of the things you and I have always talked about is the need for more care in our community. And we're building that capacity, but as you say, inspections and compliance, still, are the name of the game.

You could have a number of beautiful, new, big buildings, but it is the care and the support that's within that that is critical. I've got the PA to long-term care here, and they're working very hard and diligently. I know we've just broken ground in Barrhaven on a new facility that is going to contain a new health clinic, as well, within it.

I'm just wondering, of all the years that you've been going through this, Grace, have you decided that there have been things that we've done extremely well, regardless of government, and things that just never seem to get done, regardless of government, that are sort of just part of the bureaucratic standards of the day, that we should know about?

Ms. Grace Welch: There has been a huge waiting list, and we used to have that as one of our talking points, but of course, we've seen incredible investment in new buildings and the fact that we got four hours of care.

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Grace Welch: Lisa, you remember, you presented our petition to the House way back, and that's a huge step forward. Although what we need to focus on now is the way in which that care is delivered, and we have to really, really address the staffing crisis.

So if we can find ways to attract and retain people in long-term care and then start to introduce that model of care that actually gives staff satisfaction, it makes the residents' lives so much better. So that's where we really want the focus to be, is on implementing that person-centred model of care. I think some of the staff problems will dissipate as you improve retention. So I think there have been a lot of positive steps, but I think more it's now on the softer stuff—

The Chair (Mr. Ernie Hardeman): Thank you very much.

We'll now go to the official opposition. MPP Pasma.

Ms. Chandra Pasma: Thank you to all of our witnesses for being here today. I really appreciate you sharing your insights with the committee.

Grace, I really appreciated your comment about how so many long-term-care facilities today look like prisons. Sadly, I had a constituent in Ottawa West–Nepean come in and share with me some of the materials being used to provide care for her mother. One of them was her pillow, and honestly, I was shocked that that was a pillow that was being used for a human being, let alone in a care facility. I would certainly feel like I was sleeping in a prison, if I was forced to sleep on a pillow like that. She also last had some other things, including a chipped cup that was being used. For my constituent, it was her beloved mother, for us, it's a member of our community who helped to build our society for years, and this is the level of care that we're providing in their senior years. I think that's incredibly unfortunate.

And, sadly, in Ottawa, as we are replacing some of our long-term-care facilities, many of them are moving to an even bigger model, with multiple floors and multiple wings. But you mentioned that alternatives are possible. They're doing things differently in other jurisdictions. You made a brief reference to the BC government building a publicly funded long-term-care facility modelled on a dementia village, and I was hoping you could describe that a bit more to us, what that looks like and what that means for the residents.

Ms. Grace Welch: Again, it's very, very homelike, and it's smaller homes grouped around a space. It's called Providence. It's based on a model out of Holland, and anyone that's ever been there, it's like people living in a village. They can go to different buildings. It feels just like they were living in their neighbourhood.

But I also wanted to mention, even though this is what we'd love to see, even within the bigger buildings—and I know there are economies of scale etc. Right now, we have a 32-bed unit. That's the basis of all the planning. But you can create more homelike environments in those homes by making the home units eight to 12 people, so it's not this overwhelming 32 people or sometimes 60 people in the dining room. So there's things that can be done, but I think actually that's one model to look at. And the home that I always say that I really like is Sherwood in Saskatchewan. That is an amazing home. They have a grade 6 classroom. They have a daycare centre there. We're lucky in Ottawa; we're going to have a daycare at the Perley Health, which is great. So, yes, I'd love to see a pilot in Ontario to show what can be done.

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Ms. Chandra Pasma: Absolutely. I would love to see that happen in Ottawa. As you mentioned earlier, it just reinforces the importance of having that staff continuity. If you're going to try to create an eight-person home unit within a 32-person floor, you have to have the same staff there every day consistently in order to make that happen.

Turning to Richard and Robert, I was shocked to hear that the fees haven't increased since 2011, and I'm wondering if that's typical. Is this unique to the cardiology sector? Is this happening in other health care sectors?

Dr. Richard Davies: It's particularly bad in the cardiology sector, but I don't think it's unique at all. We described it with cardiology because that's our mandate, but I think what we're describing also really covers across the health care sector.

Ms. Chandra Pasma: Right. There's been a lot of inflation over the past 13 years, especially in the past few years, so not increasing fees over 13 years is actually a cut.

From what I understand, you're saying this is primarily impacting the delivery of outpatient services because cardiologists simply can't afford to deliver those anymore. If those aren't being delivered as outpatient services anymore, the alternative is, because people still need to see a cardiologist, that service is being delivered in a hospital where it's far more expensive. Is that correct?

Dr. Richard Davies: Yes. You got it exactly right.

Ms. Chandra Pasma: So this is a case where we're being penny-wise and pound foolish?

Dr. Richard Davies: Yes. Robert?

Dr. Robert Wald: If I may, just for a second: The old model of physicians working in the community was that it was a small business, really, and they would have to cover their overhead. That model is not working now, and you can't find any young doctors trying to do that just by themselves obviously.

The family care people have been really good at going forward, progressing, and they left the specialists behind. I would challenge this committee to think about ways in which they can actually apply the same kind of advantages and big progress that they have done in primary care. There's a huge specialist group out there that could really use the same models. They just have not been developed, and they're not looked at by the OMA. I think this is a really big problem, because we're going to have to do something, because the fee-for-service model of a small business—even judging from the interest in this panel—really is something of the past I think. But you can't sunset it before you replace it with something else.

Ms. Chandra Pasma: Right. Well, and it's been interesting having you on the same panel as family health team-provided models of care, and it's also been interesting in the past three days just hearing from people in various sectors of our health care system sharing very similar themes about the crisis in health care but also some opportunities for common solutions. I really take Doug Allan's point this morning that we need to invest across the system and embrace these solutions across the system. It's not a question of picking winners or losers among providers or sectors, we really need to shore up our entire health care system.

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Chandra Pasma: Similarly for the family health teams, the community health care centres, if you didn't get an increase in base funding in 15 years, that's not just not an increase, that's actually a cut, because of inflation. Meanwhile we're sitting on $5.4 billion in contingency funding that could be allocated to any program the government chose today—you don't even need to wait for the budget in March.

So my question, in the 30 seconds remaining, to Erin and Penelope is, with the government not investing these funds, who is paying instead and how are they paying for that decision?

Ms. Penelope Smith: The residents of Ontario are paying. They are not having access to timely needed primary health care services that are comprehensive. Unfortunately, they might become ill, maybe experience a chronic disease that's not properly managed and require to visit their local ER department, for example. And so—

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time, not only for this question, it also concludes the time for this panel.

I want to thank each and every one—the virtual ones on the screen and here at the table—for the time you took to prepare and the great job of handling the questions from the committee. We very much appreciate it and wish you well.

With that, we now are recessed until 1 p.m.

The committee recessed from 1205 to 1300.

The Chair (Mr. Ernie Hardeman): Welcome back. We will now resume consideration of public hearings on pre-budget consultation 2024.

As a reminder, each presenter will have seven minutes for their presentation. After we've heard from all the presenters, the remaining 39 minutes of the time slot will be for questions from the members of the committee. This time for questions will be divided into two rounds of seven and a half minutes for the government members, two rounds of seven and a half minutes for the official opposition members and two rounds of four and a half minutes for the independent members as a group.

CANADIAN MENTAL HEALTH ASSOCIATION CHAMPLAIN EAST

ROTHMANS, BENSON AND HEDGES INC.

GOOD ROADS

The Chair (Mr. Ernie Hardeman): The first panel are anxious and ready to go at the table: Canadian Mental Health Association Champlain East; Rothmans, Benson and Hedges Inc.; and Good Roads, eastern region of Ontario.

With that, you just heard the instructions about your seven minutes each. At six minutes, I will say, "One minute." Don't stop because at seven minutes I'm going to say, "Thank you," and you're going to stop dead. And so—

Mr. Joel Harden: Stop dead?

The Chair (Mr. Ernie Hardeman): I'm getting tougher.

With that, we also ask each one of you, as you make your presentation, to start off by introducing yourself for Hansard to make sure that we get the right name to the great presentation you're going to make.

We will start with the Canadian Mental Health Association Champlain East.

Ms. Joanne Ledoux-Moshonas: Good afternoon. My name is Joanne Ledoux-Moshonas. Thank you for allowing the Canadian Mental Health Association Champlain East the opportunity to address this committee.

I know that this committee has already heard from my colleagues at other CMHA branches, but I wanted to begin by adding our thanks to the provincial government for demonstrating their commitment to the community mental health and addictions sector by providing a 5% base budget increase. As we work to provide the highest quality of care, this infusion of infrastructure funding, the first in more than a decade, helped keep our lights on.

But as more people need our services and require more complex care than ever before, the wage gap between our sector and other health sectors continues to grow. We urge the government to maintain momentum this year by providing another round of stabilization funding for the community mental health and addictions sector.

Like many municipalities across the province, our region is facing a health and homelessness crisis. In Cornwall and SD&G counties and the United Counties of Prescott and Russell, 298 individuals reported as homeless in 2023. Of those, 88 are actively homeless. This issue has become more visible in our community since the pandemic, with encampments taking root in multiple sites.

Our municipal partners are working on a response which includes connecting individuals and families seeking shelter with services and supports. But individuals who are homeless are often the most complex to serve. While it's important to recognize that not every unhoused individual struggles with a mental illness, people without stable housing are at heightened risk of mental health issues. It's difficult to fully support our municipal partners with homelessness initiatives when we have such limited resources and are struggling with a health human resources crisis.

I appreciate that this committee may have already heard from my colleagues in the community health sector about the challenges to retain our dedicated staff. But we share the same challenges in competing with hospitals and other health care organizations, resulting in turnover and inefficiencies. My colleagues are often paid 20% to 30% less when compared to others doing the same job in other health sectors. It's a challenge for us to compete given that we are already managing staffing and operating costs with limited resources.

Take, for example, our resource centres. Situated at three different locations in our community, these centres help prevent rehospitalization. They provide support to adults who are living with a severe mental health issue by providing social, educational and recreational activities. However, the funding for these centres does not cover operational or administrative costs. We supplement the difference with our current budget allocations to assure quality of care for our clients, but many of our programs face the same issue. They are dependent on grants, donations and in-kind gifts to sustain optimal service delivery.

The lack of secure funding makes these programs vulnerable and unable to engage in long-term planning and commitments. This means that we're continuing to lose people to hospitals, public health and other areas of health care that pay more and offer more resources.

To put numbers to our story, this past year, our branch managed a staff vacancy rate of 24%. Of the 12 employees

having left our branch between September 2022 and December 2023, they all cited leaving their employment for better pay elsewhere. Across our sector, these are intensive case managers, crisis counsellors, social workers, nurse practitioners and those who help some of the most marginalized people in our community, yet are not paid an equitable wage. This needs to change.

With these challenges in mind, the community mental health and addictions sector needs a 7% increase in funding, equal to $143 million annually, to ensure we are resourced appropriately. This includes 5% in stabilization funding to help us bolster services while managing the health human resource crisis. The remaining 2% of our ask, $33 million, comes in the form of a new provincial three-year community supportive housing innovation fund—more on that in a moment.

We appreciate the government is focused on more affordable housing across the province, but this needs to include more supportive housing. Supportive housing helps reduce homelessness and connects service users with wraparound mental health and substance use supports. Evidence shows that supportive housing models can help a person's journey to recover from even a severe mental health issue, and it's also a fraction of the cost compared to stays in hospital or correctional facilities. The latest data indicates that the average wait time for supportive housing across the province is 300 days. Here in our own community, the average wait time is 70 days and growing.

The new community supportive housing innovation fund would provide capital and operating dollars for the development of innovative and evidence-based models of housing with supports. This fund would be available for initiatives led by the community mental health and addictions sector, who are experts in this space and have many collaborative partnerships in place with municipalities and other social service providers. It would complement the Ministry of Municipal Affairs and Housing's Homelessness Prevention Program, which our municipal partners have indicated is appreciated, but not enough support is in place to support those in need.

The community supportive housing innovation fund and the Homelessness Prevention Program would work in tandem to get more people housed and ensure they have the mental health support they need.

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Joanne Ledoux-Moshonas: Our sector is proud of the work that we do to provide appropriate community care pathways for clients and help reduce the strain on our colleagues in the hospital settings. As you can see, our work helps support many areas in our community.

With stabilization funding and more commitment to supportive housing, our sector can support the government in addressing key issues that are impacting our partners within municipalities, hospitals and first responders.

In closing, I'd like to thank the committee for making the time to hear from the Canadian Mental Health Association Champlain East and other stakeholders in our community. I'll be happy to take questions.

The Chair (Mr. Ernie Hardeman): Thank you very much.

We'll now hear from Rothmans, Benson and Hedges, Inc.

Ms. Kory McDonald: Certainly. My name is Kory McDonald and I'm the head of external affairs for Rothmans, Benson and Hedges. Good afternoon, Mr. Chairman, committee members and guests. On behalf of our whole team at RBH, I want to extend my sincere thanks for the opportunity to speak with you here today.

With over 100 years of history in Canada, RBH is a proud leader in the tobacco industry, with strong roots in and around Ontario. We have our national headquarters in Toronto, which houses 50% of our Canadian workforce, partnerships with 67 tobacco farmers in southwestern Ontario and a factory in Quebec City.

Over the past 100 years, we've seen a tremendous evolution of the tobacco industry. Most recently, RBH has made a distinct shift towards embracing harm reduction, with the goal of creating a smoke-free Canada. But we can't do it alone, and we need government to take action to help move Ontario's tobacco industry into the future.

Today, we're putting forward two recommendations to this committee for consideration in the upcoming budget:

(1) We ask that the government take steps to stop the continued growth of the contraband tobacco market, to keep Ontarians safe.

(2) We ask that the government acknowledge harm-reduced product categories within the Tobacco Tax Act to encourage consumers to switch to potentially less harmful alternatives to cigarettes.

Without action, Ontario's 1.5 million adult smokers will continue to face barriers to accessing potentially less harmful alternatives. The province will lose hundreds of millions in lost tax revenues each year due to the contraband industry and organized crime will continue to thrive, putting Ontarians at risk. A recent report from Ernst and Young and the Convenience Industry Council of Canada estimated that in Ontario, contraband tobacco sales could represent anywhere from 39% to 50% of the total tobacco market, meaning that potentially one out of every two cigarettes sold in Ontario are illegal.

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Aside from the estimated $990 million to $1.7 billion in lost tobacco tax revenues between 2019 and 2022, and the well-documented reality that organized crime is heavily involved in the industry, Ontario's contraband tobacco industry also increases the risk of youth access, with little incentive for sellers of contraband tobacco to ID young customers.

We're asking the government to take action against contraband and to stop the growth of the contraband market by increasing penalties under the Tobacco Tax Act, maintaining appropriate taxation levels on cigarettes to avoid pricing people out of the legal framework and launching an education campaign around the realities of the contraband industry and the rules around purchasing tobacco products. While none of these actions alone will rid Ontario of the growing contraband industry and its associated challenges, I believe they are important steps that can make a real difference and move us forward in this ongoing battle.

The government's Smoke-Free Ontario Strategy sought to reduce smoking rates in the province to 10% by 2023.

Today, Public Health Ontario suggests that smoking rates in the province hover around that 10% mark, which amounts to roughly 1.5 million Ontarians. Looking ahead, however, the federal government is seeking to further reduce smoking rates across Canada to 5% by 2023. To close this gap, more needs to be done to drive smokers away from cigarettes. At RBH, we have a saying: If you don't smoke, don't start. If you smoke, quit. If you don't quit, change.

But right now, in Ontario, the ability to change—that is, to make the shift away from cigarettes to a less harmful alternative—is limited by a lack of knowledge about the existence of less harmful alternatives. Smoke-free products, such as heated tobacco, which eliminates the combustion in the nicotine delivery process, drastically reduce the user's exposure to harmful and potentially harmful chemicals.

We're asking the government to take action, acknowledge the existence of less harmful alternatives and encourage consumers to switch to less harmful alternatives by creating a non-combusted alternatives product category in the Tobacco Tax Act that is taxed at a lower rate compared to combusted products.

With strict rules around communications to consumers, there are limited avenues through which consumers can make informed purchasing decisions. A responsible tax-based approach would send a clear message to consumers that switching to potentially less harmful alternatives is a better choice when compared to cigarettes.

In summary, on behalf of RBH, I'm respectfully inviting the Ontario government to consider these two recommendations that will help move Ontario's tobacco industry into the future. First, we ask that the government take steps to stop the continued growth of the contraband market to keep Ontarians safe. Second, we ask that the government acknowledge our harm-reduced product categories within the Tobacco Tax Act to encourage consumers to switch to potentially less harmful alternatives to cigarettes.

I and the rest of the team at RBH are excited to continue working with the Ontario government on these important issues. I know that with a clear commitment to act, Ontario can be a leader in achieving a smoke-free future. I'd like to thank the committee for your time and attention today. I look forward to your questions and continuing this important discussion.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation.

We now will go to Good Roads, eastern region of Ontario.

Mr. Justin Towndale: Good afternoon, Mr. Chair, members of the committee. I'd like to thank you for the opportunity to present today on behalf of Good Roads. My name is Justin Towndale. I'm a director with Good Roads for the southeast zone. I'm also the mayor of the city of Cornwall. You'll be hearing from me on that a little later this afternoon. I'd like to welcome you to the Cornwall area. I say "area" because we're actually in South Glengarry right now, but I'm glad you've come out here. I've had the opportunity of meet with a few of you over this term—

Interjection.

Mr. Justin Towndale: Yes, keep coming, please.

A little bit on Good Roads: I know you've heard from some of my colleagues across the province, but Good Roads has represented the transportation infrastructure interests of municipalities since 1894, which is 129 years, and 426 municipalities and 19 First Nations are Good Roads members.

So, today, I'm going to be seeking a partnership between the Ontario government, Good Roads and its municipal and First Nation members to proactively address preventable accidents on rural and northern Ontario roads. Looking at some of the statistics of rural roads and rural road safety, 55% of fatalities in Ontario occurred on rural and northern roads. This number is from 2020. This has a disproportionate impact despite only 17% of the population residing in these areas. For a number of you, you may have taken Highway 138 to this area today or previously. It's a good example of a road where these statistics would apply.

So what's the impact on society? Well, these collisions resulted in 4,200 hospitalizations—again, a number from 2022—and almost 43,000 days of hospital stays. Rural roads are inherently more dangerous. When we look at other jurisdictions that prioritize road safety—we can look at the United States, Australia, New Zealand, Germany, United Kingdom and Ireland—they are looking at cost-effective solutions: guide rails, crash cushions, lighting and signage.

The current approach that is under way is something that Good Roads had taken a strong stance against. It's somewhat of a thoughts and prayers approach. We hope that nothing will happen, but when it does, we'll look to fix it. But, realistically, it doesn't need to be that way.

Our proposal is for an $168-million program, which is $33.6 million over five years for effective solutions. This works out to approximately $400,000 per rural municipality. We see the role of the government as addressing some of the priorities, including municipal insurance premiums, joint and several liability reform and health care costs, and this will all result in saving lives.

On the Good Roads side, we've invested in Ontario's first road safety auditing guideline, and we trained the first 50 road safety auditors in Ontario. We feel there's an urgent need for provincial assistance to treat and diagnose road safety issues.

There can be two aspects here: saving lives and significant cost savings. Good Roads is committed to moving forward. We're ready to impartially administer a program, leveraging 130 years of experience working with the municipalities and the industry.

Thank you very much for your time today. I look forward to answering any questions you may have.

The Chair (Mr. Ernie Hardeman): Thank you very much for that presentation. That concludes the presentations.

We'll start the first round of questioning with the government. MPP MacLeod.

Ms. Lisa MacLeod: Thank you all for your deputations. Your Worship, I know that some of my colleagues are

going to talk to you about Good Roads, and I'll let them do that.

I just wanted to say, Ms. McDonald, I am so glad that you brought forward the notion that we need to get control of contraband tobacco. In 2011, I was a critic in the opposition and the estimate at the time was that it was costing Canadian society $1 billion, not only of lost revenue but, as importantly, people getting the right type of help that they need. I believe those numbers at the time were outside of British Columbia, so I do support you. I'm in that call.

But I did want to talk a little bit about the Canadian Mental Health Association's proposal today. I wanted to first start off by just acknowledging my gratitude for the work that you do. I know that you've acknowledged our funding that came after a decade, where there hadn't been increases. But you also rightly point out that our demographics have shifted in the country. Our population is bursting through the seams and there's new pressures that we're dealing with.

I can imagine because we are on the 401 here, you're dealing with everything from sex trafficking on the route, on the 401, and into the rural communities, you're dealing with a lot of farmers. I've just started to see and have conversations about the impacts that a number of different government policies have on them at the federal level. And I know—and the mayor probably could speak about this a little bit—that Cornwall has dealt with an increase of refugees and immigrants and maybe haven't had the opportunity to fully build the right type of infrastructure, whether that is roads or whether that is homes or whether that is the soft infrastructure when we're trying to support people who are integrating into society.

I know that you're dealing with those challenges, and yesterday we had the opportunity to speak to the Mission in Ottawa as well as the Alliance to End Homelessness in the city of Ottawa. You mentioned that as well because those are new pressures, the lack of affordable housing and the lack of housing, in particular. Both of them mention the fact that we need to have a larger conversation with the federal government about how we are settling folks and making sure that we're—how do you say this? The best way is, letting people know what to expect when they come here and making sure that they're—because many of them were saying that we've just been telling them to go right to the Mission without providing them with any type of support, whereas years ago, we would have done something like that to make it much easier for a newcomer to come to our country and settle, making sure that there was culturally appropriate types of services for them.

Also, we need municipalities to start saying yes to building houses. I think there was the issue yesterday of zoning and saying, "Yes, we need these homes," and not being so set in our ways with NIMBYism.

I'm just wondering, as we talk about these changes, things that we would not probably have been talking about in 2018, they've now been saddled on your lap, in addition to the high rate of inflation and people all asking for increases to do the work that they're doing because they're competing with others. What kinds of changes and challenges have you seen since 2018 that you didn't see previous to that and that have put more pressure on the work that you and your colleagues are doing?

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Ms. Joanne Ledoux-Moshonas: One of the major pressures that we're facing currently right now is supporting our municipalities with the homelessness challenges that we're facing. We're there at the planning tables with them. We're working with them collaboratively to come up with some solutions, but we are still limited in our ability to go beyond that in providing some wraparound supports and services like supportive housing to individuals who will need them to help them stay well and be able to maintain their housing situation.

Ms. Lisa MacLeod: A lot of this does, at the end of the day, come down to families that are secure in their own environment, taking that pressure off mom and dad and the anxiety off of the children and being able to do that, whether you're a newcomer or you've lived here. That's putting the pressure on the city, and I understand now it is putting it on our rural community.

I just wanted to say thank you for all the work that you're doing, the three of you. I'm going to pass it over to my colleague from Windsor, Andrew Dowie.

The Chair (Mr. Ernie Hardeman): MPP Dowie.

Mr. Andrew Dowie: Thank you to all the presenters today.

I wanted to first ask Ms. McDonald: I just wanted to get a sense of the severity of the issue of contraband. I am aware of—certainly, in my region anyway, there are many convenience stores that have noticed a dramatic drop in tobacco sales, and the theory is that it is as a result of the increasing availability of contraband tobacco. I'm wondering if you might be able to share if that might be a reasonable proposition or if you feel there's just a general drop in consumption that may affect the viability of these stores, which is what they're sharing with me.

Ms. Kory McDonald: Yes, certainly, great question. Thank you very much. I'd be pleased to share afterward the report that the Convenience Industry Council of Canada had done with Ernst and Young where they looked at exactly that question. In that report, I recall they looked at about a 20% drop in legal sales between 2019 to 2022, which far outstrips what we look for when we see some of the surveys that are done on smoking rates in Canada.

Just a few other stats from that report that I personally found interesting when I was looking over it: Not only are contraband cigarettes typically at least 40% cheaper—just to give you an example in Ontario, an average carton of cigarettes would be around $125 from the legal market. The report found, depending on whether they're bought on-reserve or off-reserve, you're looking at between $30 to $50 a carton, so it's a massive, massive cost differential.

Don't forget that besides the tax, these are being sold without plain packaging. They're being sold without health warnings. They're being sold likely without ID checks. So a lot of the checks and balances and the things that we've

done to try to reduce smoking rates in Canada from a regulatory perspective don't apply to these products.

The other stat that I found really interesting from the report was that in terms of organized crime, it's eight times more profitable for them to sell contraband cigarettes than cocaine. So it's highly, highly profitable for organized crime to get involved.

The Chair (Mr. Ernie Hardeman): One minute.

Mr. Andrew Dowie: Thank you for that. Just to conclude that thought, what is the risk that you see to local businesses that are currently selling your products? Is their viability truly at stake?

Ms. Kory McDonald: Certainly. It's a great question for the convenience store folks, but we've heard from them that there's a massive impact. It's a huge, huge hit to their business, so it's not something that's a theoretical problem; it's actually affecting small businesses and communities, 100%.

The Chair (Mr. Ernie Hardeman): We'll now go to the official opposition. MPP Pasma.

Ms. Chandra Pasma: Thank you to witnesses for being here this afternoon.

I'm going to begin with the Canadian Mental Health Association, Ms. Ledoux-Moshonas. You mentioned that you're seeing an increase in demand for care and that the people needing care are having more complex needs. I'm wondering if you can talk about what that increase in demand looks like, what the wait-lists for care are in this region and what's driving that demand and need for services right now.

Ms. Joanne Ledoux-Moshonas: Our wait-list in our community can range from anywhere between eight months to a year, depending on the type of service and depending in which region. We service a large geographical area. The greatest areas of our complex needs are really around different challenges, both from a financial perspective, and there are often clients who need more of that intensive case management support to help them be able to better manage their mental health. Certainly, the feelings of loneliness and isolation, and programs like CMHA and our resource centre do help to address those. The complexity and the intensity—we also have people who deal with opioid dependencies. That has also created a different set of challenges in supporting members of our community.

Ms. Chandra Pasma: And do you support children as well or just adults?

Ms. Joanne Ledoux-Moshonas: No, our organization is 16 years of age and older.

Ms. Chandra Pasma: Okay. So when you're seeing the increased complexity and urgency, what does it mean to an individual to have to wait eight months or 12 months in order to be able to receive care?

Ms. Joanne Ledoux-Moshonas: Good question. What ends up happening is, their mental health needs aren't addressed and they end up going to emergency services, where the supports—that is not where they should be receiving that care. We would want to support individuals as a preventative and having those community services in place to divert them from going to the emergency departments, where our partners are already strapped with some of that care. Investing in the community mental health support services really saves the government millions of dollars in hospital visits.

Ms. Chandra Pasma: Absolutely. I certainly hear you on the economic savings and the savings for our health care system. Does it have impact on someone's care and prognosis if they are being first shuttled though the emergency system and then, finally, eight months or 12 months later, able to have a dedicated care path in the community?

Ms. Joanne Ledoux-Moshonas: Yes. If we were able to do it earlier on, it would certainly have a better projection for someone, for sure, but our system is not designed in that way. Right now, it's more in terms of the crisis. So we want to continue developing that infrastructure in our communities to be able to better manage those wait-lists and having those right supports at the right time for when the individuals need them.

Ms. Chandra Pasma: Right. And in terms of the cost to the system, which you've noted, and the cost to the individuals, the $143 million that the sector as a whole is asking for, for the entire province, is only 2.6% of the government's $5.4-billion contingency fund that they could put towards these programs today—they don't even need to wait for the budget in March. So it's a decision to be paying more money to address these challenges through the health care system rather than addressing them now through community programs.

I was also struck by what you said in your presentation about the resource centres not receiving operational or administrative support. I'm wondering if you can tell us a bit more about the resource centres, how they work and why is it that they're not getting operational or administrative support. How are you keeping them going right now?

Ms. Joanne Ledoux-Moshonas: Our three resource centres are there to support people in their recovery with a mental illness. It's a social/recreational centre. We receive some funding from the ministry, but it's not enough, as I mentioned, in terms of keeping the doors open. So it really leaves a lot of pressure to do some of that fundraising, where it's not a good use of our time. It's not a sustainable model to be able to do that.

When you take into account that 90% of our budget is in wages, it doesn't leave a lot of wiggle room to be able to address some of the growing needs and pressures that an organization like ours faces to be able to keep the lights on, deal with increased rents, IT infrastructure—all of those important things that are very much needed to run an organization that will help give better outcomes for our clients as well.

Ms. Chandra Pasma: Right. And what's fundraising like in the middle of an affordability crisis?

Ms. Joanne Ledoux-Moshonas: Very challenging—not enough to be able to even fund a position.

Ms. Chandra Pasma: Right, which is certainly a shame right now, and ends up creating costs for government in other areas, as we've already heard. So thanks for helping us understand that better.

Mayor Towndale, I had a lot of sympathy hearing your presentation. I grew up in a rural area. That's where I learned

to drive. Given that many of the suggestions you put forward are coming from other jurisdictions, do you have an idea of what kinds of costs we would be looking at to put these mitigation measures in place?

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Mr. Justin Towndale: I think, looking at what we're proposing, it would be the $33.6 million over five years. That would start to really address the problem. Some of the measures that I mentioned—guard rails, padding, that sort of thing—they are low-cost solutions. Some of them are $150 a piece for each solution. So when we look at things like that, it's a big number upfront—the larger envelope of funding—but it really breaks down. It actually can have a further impact as it goes.

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Chandra Pasma: Yes, absolutely. I didn't have the time to do the math just now, but I know that the price for a hospital stay for one day in Ontario is $722, and I believe you said it's 43,000 hospital days?

Mr. Justin Towndale: Yes.

Ms. Chandra Pasma: That's annually in the province?

Mr. Justin Towndale: Yes.

Ms. Chandra Pasma: And the outlay is significantly less than to implement these changes one time rather than paying this price annually to hospitalized people for preventable accidents, not even considering the financial cost to the families and the individuals of time in hospital, time off work, losing your family's provider because of a preventable accident.

Mr. Justin Towndale: I would agree. Thank you.

Ms. Chandra Pasma: Thank you very much.

The Chair (Mr. Ernie Hardeman): MPP Collard.

M^me^ Lucille Collard: I will continue with Mr. Towndale about road safety. I would like to hear a little bit more about the unique challenges that are associated with road safety in the rural, northern and remote areas. How is that different and how are the costs different from urban areas?

Mr. Justin Towndale: I think the challenge with rural roads—it's the funding model, but it's also just the availability of funds. It becomes a challenge where, in an urban setting, you have greater resources and the roads that are travelled are different.

There's a lot of factors that tie into road safety. Our own municipality is looking at this. While it may not be rural, it does affect us. I mentioned Highway 138 earlier; that is a major connecting link for us to go to Ottawa, for example. When you talk about speeds, the condition of the roadway itself, investments in infrastructure—I think one thing that Good Roads likes to comment on, and it's correct: that sometimes it can be politically beneficial to not invest in infrastructure when we're looking at keeping tax rates down. That is always a challenge. There's always a pressure for municipalities in terms of where the monies go. We draw the majority of our funding from taxes and then we have to allocate them accordingly.

So we do find that it's challenging. And while I do represent an urban municipality, the impacts in rural Ontario are not foreign to me. We see the same struggles, but I think it's amplified in rural communities, where there's a smaller tax base to draw on and the needs are greater.

M^me^ Lucille Collard: Okay, thank you. And can you speak more about the proposed partnership that you would like to see with the government of Ontario, the private sector and Aboriginal people? What would that look like?

Mr. Justin Towndale: Yes, I think the partnership that Good Roads would look to explore would be to express confidence that our road safety program should work. Given positive outcomes in other jurisdictions, based on their investments, we would see Good Roads be the administrator of the proposed fund that I brought up today. It would be administered in collaboration with the Ministry of Transportation. This isn't a foreign concept. Some of our colleague organizations administer funds on behalf of the government.

We have an existing relationship. Good Roads has existed for almost 130 years, so there is a proven track record there. As I mentioned, Good Roads has been an advocate for safety for that time, has trained the first safety auditors in the province when it comes to work safety, so I think that's part of the collaboration. Good Roads' reputation and foundation is one that can be built on.

M^me^ Lucille Collard: Thank you.

How much time?

The Chair (Mr. Ernie Hardeman): One point five.

M^me^ Lucille Collard: Then I'll ask a question to Joanne regarding the impact of homelessness on mental health. You've alluded to that to some extent. I think we can understand that not all people with mental health issues have addiction problems, but would you agree to say that people with addictions could be helped with mental health support, from your experience on the ground?

Ms. Joanne Ledoux-Moshonas: Absolutely, they could. That's the grassroots programs that would reach those individuals, and we need that support to be able to do that.

The Chair (Mr. Ernie Hardeman): One minute.

M^me^ Lucille Collard: Right. So if we would have community supportive housing programs, we would be able to help a lot more people and lower the cost for the system. Can you speak to the economies we would make necessarily with our health care system if we would have those supportive programs in place?

Ms. Joanne Ledoux-Moshonas: For the housing?

M^me^ Lucille Collard: Yes, for the housing.

Ms. Joanne Ledoux-Moshonas: Yes, we would see more—community supportive housing would help individuals stay housed and prevent them from rehospitalizations when they're attached to an intensive case manager to support them in addressing their mental health and addiction needs.

M^me^ Lucille Collard: Thanks. I'm good.

The Chair (Mr. Ernie Hardeman): We'll go to MPP Bresee.

Mr. Ric Bresee: To all three of you, thank you for your presentations. I've actually got questions for all of you, but I'm not sure I'll get through all three of them.

I will start on the mental health side. I greatly appreciated your presentation. We've discussed that there have

been some tremendous new innovative processes and funding into the mental health services in the area, but as a community, we all recognize that there is still more to do, certainly.

I appreciate that all mental health services face a particular challenge in the rural and the very small, low-density population areas. How to deliver those services becomes incredibly challenging, especially when there is no transit, there is no availability to get out to these. Over the last 10 years, we've actually seen, I'll say, some newer trends in the small communities of homelessness appearing on the streets in our very small communities, which we simply didn't see previous to that. It was a big city problem, but we know that it is now a small-town problem as well.

Can you speak to the efforts that your organization has taken—I'm hoping to get both the pros and the cons. What have you guys done that has worked successfully in your smaller communities and what have you tried that maybe hasn't been so successful in those processes?

Ms. Joanne Ledoux-Moshonas: We collaborate with our municipalities, and that's first. As you know, municipalities receive the housing funding and they decide how those funds will be carried out in partnerships with the communities.

For the Cornwall area, we've collaborated with them for the CHPI fund, and that was definitely of great support. But unfortunately, that agreement is coming to an end this fiscal period because they needed to redirect those funds to the encampments and to some of the other infrastructure. But they're still looking for us to provide them some support and some solutions around that. We're prepared to do that, but we would need the additional funding to do that.

Mr. Ric Bresee: To that end—and forgive me, Mayor, but Cornwall is actually a big city compared to many of the small towns and small communities around the area—have you had much luck or much programming that you are able to deliver out into the very small—the 200, the 500 population—villages?

Ms. Joanne Ledoux-Moshonas: Yes. We also collaborate with the other aligning counties, particularly the United Counties of Prescott and Russell. We also have a lot of our services that are in those communities, so we have intensive case managers. We service a large geographical area. We have a main site here in Cornwall, another subsite in Hawkesbury and then other satellite point centres to be able to meet the clients. And our case managers meet our clients in those communities, in their homes or elsewhere.

Mr. Ric Bresee: Excellent. Thank you very much.

I will move on, because, as I say, I've got questions for everybody. I'm going to go to you now, Mayor, if I may, in your role representing OGRA. You and I have met before. I wanted to mention the fact of the long-standing history that OGRA has with this province. In fact, my office is in the Whitney building, which all of you know in Toronto, and there is a plaque on the first floor that is dedicated, I believe, to the 50th anniversary of OGRA, about the time of the opening of that building. The plaque on the first floor is still there and it still represents OGRA, and we thank you for your very long term in supporting this province and the municipalities in the province in building our better road systems.

You mentioned a number of things in your presentation. One of the ones that has been outstanding as long as I've been involved in municipal and provincial politics is that whole joint and several liability issue, which has been a long-term challenge, and we're still working towards that.

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But you came to the road safety auditor process, and I'd like to know more about how you envision that rolling out. As you've noted, there are 444 municipalities and a whole lot of back roads and, I'll say, empty spaces that we need to get to be able to do that type of audit work. I think you mentioned the number of auditors involved in that process, and I'm thinking that the program you're mentioning with the dollars you're mentioning would actually absorb a lot of that just in the auditing process. Can you speak more to that side of it versus the actual implementation of the solutions you're suggesting?

Mr. Justin Towndale: Yes. I will try my best. I'm not an expert in auditing per se, but I do recall our meeting and you showing us the plaque. I do appreciate that, and it certainly reinforces our long history of working together collaboratively.

I think, when it comes to the auditing, we need to take a look at the diagnostic framework for auditing the roads. We have to identify the problems that are contained within these roads, whatever those problems may be. When we're looking at road condition ratings and we're looking at priorities, when we're looking at, "What are the functions of these roads," part of it is the challenge I mentioned earlier when it comes to road safety. For example, in my municipality, we have road condition assessments for asphalt, for sidewalks, for concrete—for all infrastructure. But then it comes down to, sometimes, it's the politics that prevents the road safety from happening.

I know that that responsibility can lie with individual communities, but I think giving them the tools could help remove some of the politics from that. It would make the decisions easier in some respects. So a fund, like mentioned earlier—if every rural municipality had an extra $400,000 that they could put specifically towards road safety and infrastructure related to rural roads, I think that could have a huge impact and is a good starting point to move forward from there.

The Chair (Mr. Ernie Hardeman): One minute.

Mr. Ric Bresee: Of course. More money would be helpful, but I want to focus in on that. We already have the minimum maintenance standards approach within the province. All of the municipalities are subject to that and follow that guideline. Most have engineers or engineers on contract who do that work to ensure those rating systems that you made reference to. How would this be significantly different than that?

Mr. Justin Towndale: I think it's a good point. I think part of it may tie into the follow-up. We get these condition assessments, and decisions are made whether the roads are repaired or whatnot. But sometimes they're not, and that's when we see bridge collapses, road collapses and whatnot.

There are tools in place that say, "Yes, this should be done." But then is the work getting done? Is it prioritized? Is it happening? I think that's where a look can be taken to say—because it's always after the fact, like I was saying. When there's an issue, when an accident happens or a major incident happens, then we go back and review what led us to this part, but we never should have gotten to that part. We never should have gotten to that place. It should have been prevented ahead of time, because when lives are at stake it can be too late after the fact.

Mr. Ric Bresee: Understood. And I think I'm out of time?

The Chair (Mr. Ernie Hardeman): You're right.

MPP Harden.

Mr. Joel Harden: Thank you to all our presenters this afternoon.

Mayor Towndale, I want to continue, because I have a lot of respect for the work that Good Roads does. I had a great collaboration opportunity recently on a piece of legislation about vulnerable road users, and I'd just note for the committee's benefit that 18% of road fatalities do not involve people who are driving cars. They're involving pedestrians. They're involving cyclists, motorcyclists, road workers, first responders responding to scenes often of incidents—accidents made worse in the course of a response to an incident.

So, I'm just wondering, as you make the case for safer rural roads, how much vulnerable road users are also on your mind.

Mr. Justin Towndale: Absolutely. Thank you for the question.

I would say that it's part and parcel. You can't really separate one from the other when we're talking about this. That is an impact, and that's where we look at the road infrastructure itself. You mentioned, for example, the safety of pedestrians, cyclists and, say, first responders or construction workers working on the side of the road. That can tie into the actual roadway and the width of the roadway, the width of the shoulder, everything that contributes to that—the number of lanes that are part of that roadway. There's a lot of factors that tie into that, and I think it's one of those factors that contributes.

When we're looking at road construction and maintenance, is it simply replacing the asphalt, or is it looking at the asset as a whole and a full reconstruction that's related to that? That's something I can draw on my own experience within my municipality when we look at that and when we're looking at repaving. Are we just throwing down a top layer of asphalt, or are we doing more? Are we adding sidewalks, curbing? Are we widening lanes? Are we adding better signage? It's that sort of thing.

But it ties into it as well, I think more especially in rural areas because they don't have the benefit of street lighting—blind corners and whatnot. If you travel here within SD&G, you'll see plenty of that, frankly.

I will always fall back to the 138 because it is a major connecting link for us. While it is a two-lane highway, the traffic density on there has increased in recent years and a lot of what you're raising in terms of pedestrians—because there are people who walk alongside it; there are people who cycle on it. There are communities that are on the 138, and that all plays into it.

It is part and parcel with the bigger picture, I would say.

Mr. Joel Harden: I appreciate those comments. And as someone who grew up in rural eastern Ontario—Vankleek Hill, specifically, in Prescott—I can confirm that I have never ridden my bicycle on Highway 138. I wouldn't advise anybody to do so.

Ms. Lisa MacLeod: Especially not today.

Mr. Joel Harden: Especially today, indeed.

But here's the question again, then, Mayor Towndale: You're proposing a $36-million investment, which, it would seem, would make a lot of sense from a preventive standpoint to help make sure that we don't have the kinds of tragedies that we're seeing on an increasing basis. We're following the data that's coming in from emergency rooms. They are telling us that 20 people a day—20 people a day in Ontario—are admitted for serious, or in some cases, fatal interactions as vulnerable road users.

My question, I guess, for the benefit of our work here at the committee informing the budget and what you're asking: Where should we set the target insofar as road safety? Because I think, to some extent, if I'm trying to be fair to the MTO, in that debate I mentioned on another piece of legislation, it seemed that the ministry was saying, "Well, if you look at the amount of overall people using the roads, it's a marginal percentage of people that are seriously hurt or killed." But other jurisdictions—I'm thinking about Scandinavian jurisdictions, in particular—have set the target at zero. Vision Zero: The notion that we should strive to make sure everybody gets home safe regardless of whether they're using a car, a bicycle, a scooter, a motorcycle, if they're responding to an incident on the road or if they're working on the road as construction workers.

I guess that's my question for you, sir: Where should we set the target in rolling out the investment you're talking about?

Mr. Justin Towndale: If we're talking about a target in terms of dollar figures, it's difficult to say because obviously more is better. There is a need. We're looking at a $42-billion backlog in roads and bridges in the entire province. That may not just be rolled, but that just sets the tone for what we're looking at.

I think, from a Good Roads perspective, if we're proposing a $168-million program, that can assist. That's a good starting point, I think, because the reality is, and I will say this as a mayor, frankly, if I had unlimited money, everything would get fixed, right? But unfortunately—and you all know this very well—that can't be the case and we have to prioritize. It's a difficult ask because there are always competing interests. We're hearing about mental health and housing, and I don't want to lead into my next presentation a little bit early, but those are serious issues that our municipality is facing too.

But on the topic of infrastructure, it's one of those things where that backlog is something I'm going to have to pull back on because that is a very, very large number. And every year it gets worse because, as assets age, they

reach their end of life and there are sometimes unforeseen circumstances where that end of life and that deterioration accelerates. I would argue in this case that we feel that $168 million is a reasonable ask—

Mr. Joel Harden: It's a reasonable ask—if you don't mind me interrupting. I'm sorry.

How much time do we have, Chair?

The Chair (Mr. Ernie Hardeman): Just over two minutes.

Mr. Joel Harden: Okay. I'm sorry to interrupt, Mayor. I just wanted to make sure I also get to the mental health point. But if I understand you correctly, it's a modest ask in a difficult environment, but we're going to try to strive towards the goal of everybody getting home safe, not accepting that 4% or 5% or 3% of road users could be critically injured or—

Mr. Justin Towndale: Absolutely. Road safety is for everyone.

Mr. Joel Harden: I totally agree.

Now, moving on to the mental health front, I'm just wondering if you could explain, just for the benefit of the committee—because I'm well aware that in places like Hawkesbury, which was down the road from where I grew up, there are unique needs in the sense that you will find in that part of this beautiful province unilingual francophone speakers who are having difficult times adjusting to late-in-career new employment opportunities, if indeed there are. I've heard person after person in the city where I'm proud to serve—a big part of mental health work is about restoring people's connection to their family and to their self, whatever has happened to them.

Could you just describe for us, given the unique needs in eastern Ontario, your work in trying to help people connect back to their sense of well-being, their sense of loss, their trauma?

Ms. Joanne Ledoux-Moshonas: That's a lot. Well, certainly through our intensive case managers, we work with them in supporting them through those needs.

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Joanne Ledoux-Moshonas: And, certainly, if there is that sense of belonging, there will be better outcomes for them and their ability to be productive members of the community. If you feel connected and well supported, then your overall mental health is better improved.

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Mr. Joel Harden: In this part of Ontario, it's not an option to be bilingual, one must be bilingual. So from a staff recruitment standpoint—

Ms. Joanne Ledoux-Moshonas: That has been a challenge for our community, recruiting francophones. I spoke earlier in terms of our vacancy rate. It was definitely a challenge, and hiring bilingual individuals was part of that. Certainly, retaining the qualified—

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time.

MPP Collard.

M^me^ Lucille Collard: Maybe we'll get back if I have any time left.

I just wanted to ask a question to Ms. McDonald regarding the shift of the corporation. You've stated that there has been a shift for the corporation for a commitment to smoking harm reduction, but also with a bigger goal of a smoke-free future. It just strikes me as being really odd because your corporation's business is to sell tobacco. Can you explain to me: If the corporation is really serious about moving to a smoke-free future, what is the future of Benson and Hedges if that is going to happen?

Ms. Kory McDonald: Yes, another great question. I know it's something that people are very surprised to hear from a tobacco company. I can tell you, myself, I've been with the company a little over a year. I come from over 16 years with a pharmaceutical company, and it was a question I had myself when I first looked at joining the company: Are they serious about this? Is this really something that the company is committed to doing? I can tell you, it's a very, very serious transformation. We really do believe that the future—I think the best thing for Canadians but also for the company is to move away from cigarettes and to move toward smoke-free products. So we're very serious about it. A lot of the time that we spent looking at how can we look at product innovation is really all around how do we get to a future where people are moving away from cigarettes and to better alternatives.

M^me^ Lucille Collard: So we're talking about alternatives, but still selling products that are not good for your health.

Ms. Kory McDonald: Nicotine is clearly addictive. I think what we're focusing on is the fact that cigarettes burning tobacco is where so much of the harmful chemicals come from. While nicotine is addictive, the real danger is cigarettes. Even Health Canada's website talks about comparing cigarettes to vaping products. For people that smoke, if they can quit smoking—and we've said that that's certainly the best option. But if they're going to continue to use nicotine, other products—heated tobacco is one we've talked about; vaping; there are other products—products other than cigarettes are a better alternative, so we fully support that.

M^me^ Lucille Collard: Right, but vaping is still harmful. A lot of the focus of your strategy is to lure younger people, because you've come up with flavoured vaping solutions that are attractive to younger people—

Ms. Kory McDonald: I want to be very, very clear: Our company does not believe that young people should be vaping, that minors should be vaping, that people who are not already smokers should be adopting vaping products. We've been very clear, even when we've talked about flavours—not supporting flavours that appeal to young people. We've testified and given submissions supporting flavours like mint for adults, tobacco flavours for adults, but not other flavours. We're very clear that we don't believe that products should appeal to youth and that there should be strategies in place to make sure that there's not youth appeal to these products.

M^me^ Lucille Collard: All right. But the intent of the corporation is to remain in that field of selling tobacco products.

Ms. Kory McDonald: Certainly selling—it's a nicotine company at this point. I know the company, on a broader range, is looking beyond nicotine. But at this point, it's really: How do we get away from cigarettes and how do we get to less harmful alternatives?

M^me^ Lucille Collard: Thank you.

I'm good. Thank you.

The Chair (Mr. Ernie Hardeman): Thank you.

With that, that concludes this panel. We thank the presenters for presenting today and taking all the time to prepare to come here and sharing your wealth of information with the committee.

CITY OF CORNWALL
TOWN OF MOOSONEE
CANADIANS FOR PROPERLY BUILT HOMES

The Chair (Mr. Ernie Hardeman): With that, as we're changing tables here, the next panel will be the city of Cornwall—we don't have to do a lot of changing for that one—the town of Moosonee and Canadians for Properly Built Homes.

I do ask the committee—I need unanimous consent. I believe that the city of Cornwall would like to have three delegates sitting at the table, and we need unanimous consent to do that. Okay, very good.

So as we're gathering, I believe that the town of Moosonee will be virtual. So now that we're all gathered, as for the previous delegations, you will have seven minutes to make your presentation. At six minutes, I will say, "One minute." At seven minutes, I will say, "Thank you." We ask each presenter to make sure to state their name at the start of their presentation, and if anyone else wants to speak during that, to make sure they introduce themselves before they make the comments.

So with that, the floor is yours, starting with the city of Cornwall.

Mr. Justin Towndale: Thank you. It's very nice to see you all again so soon. Once again, I'd like to thank the committee for taking the time to hear our delegation. I'm putting on my other hat for this role, but once again, I'm Justin Towndale, mayor of the city of Cornwall. With me, on my right is Katherine Wells, director of government relations and corporate priorities for the city of Cornwall, and Mathieu Fleury, our chief administrative officer for the city of Cornwall.

So as you're keenly aware, governments, especially municipalities, are enduring many financial challenges across the board. Inflation accounts for much of this, but other factors such as rising insurance rates, aging and inadequate infrastructure and additional costs play into this as well. Most of our revenue is derived from property taxes, which is limited in nature, especially when considering that our properties are being assessed to 2016 assessment levels.

So the first item I want to touch on today is a crucial piece of infrastructure in the city of Cornwall: our secondary water intake and the project. The city of Cornwall owns and operates one water purification plant, which is the single source of potable water to our community. The existing intake to convey raw water by gravity from Lake St. Lawrence to the plant is 3.7 kilometres long, which is unusual, and it is a 1,050-millimetre diameter pipe that was constructed in 1955. It is reaching the end of its expected service life. The intake pipe has had blockage threats due to zebra mussels and frazil ice. In the late 1980s, a full water stoppage for the city did take place.

In 2022, we undertook an environmental assessment which resulted in a recommendation for the construction of a new water intake that would be closer to our water purification plant and reduce that distance. The recommendation includes a new intake pipe, low-lift pumping station, zebra mussel facility and transmission piping. Now, should a failure occur on the single water intake, the consequence would be environmentally, socially and economically catastrophic. With no water intake redundancy, a pipe blockage or infrastructure failure would leave the city of Cornwall with no incoming raw water.

The city's reservoirs contain enough water for approximately four hours of redundancy for the entire municipality. Afterwards, critical services, such as hospitals and fire protection as well as all residents, would be without water. We recently conducted an emergency planning exercise with the failure of the water intake as the main event. Based on estimates, it would take about four days to fully restore water to our municipality. Through this exercise, we also determined that our back-up course of action, which would involve bringing in piping to connect directly to the St. Lawrence, would also require about the same amount of time to implement as a fix. This renders that plan ineffective. So, of course, we are exploring other courses of action, but the need for a secondary water intake remains. We are already currently looking at requests from our neighbouring municipalities, such as South Glengarry, to provide water and waste water to their communities as well.

The current cost estimate for construction in 2027, which allows us to acquire land and conduct all necessary studies, is $51.6 million. Now, the province has recently supported large infrastructure in other municipalities, like the Gardiner Expressway. We hope to see financial support for this project. You could consider this our Gardiner Expressway for water. The city of Cornwall is seeking financial support from the Ministry of the Environment, Conservation and Parks to assist in expediting the design and construction of this critical infrastructure project.

The second topic I want to move to is one that you're all very familiar with: housing. The province devolved housing to municipalities in early 2000s. Since then, provincial support of housing has dropped significantly. Municipalities have aging community housing, which puts housing at risk. Capital investment in the repair and maintenance of community housing stock is necessary.

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Increasing the allocation communities receive for the Homelessness Prevention Program is necessary. Previous increases have been very helpful, but in a worsening housing

and affordability crisis, our homelessness numbers are increasing. Municipalities need support to manage encampments and pressures on our services.

Costs to build have grown exponentially over the last number of years, on average about 20% per year, and this started prior to the pandemic. Communities are having great difficulty keeping up with housing demand. These costs don't factor in the cost for the purchase of the land if the municipality does not own anything suitable. As an example, we recently opened a new 77 one-bedroom-unit building, which was originally approved at a cost of approximately $9 million to $10 million. The final cost, post-inflation and post-construction, was approximately $250,000 per door, which brings us closer to $19 million in total, and in this instance the cost for the land was separate.

We are currently planning another set of 69 multi-bedroom units for 2024. Our region is looking at costs above and beyond the same amount that I just quoted you, but realistically, we don't know what to expect.

We recognize the recent investments of the province in housing initiatives located in larger urban centres—for example, in Toronto—and we hope that the investments that will be made in urban and small communities that face equally significant housing pressures per capita will also be looked at.

As part of the eastern Ontario region, we have a unique economic and housing landscape, and we feel our community is well positioned for pilots and strengthened partnership with the province. As we were considering several options and pilots, we have reached out to the Ministry of Municipal Affairs and Housing and engaged with Assistant Deputy Minister Cooke on a proposal which would see our community housing buildings exempted from property taxes. This is a practice in some other municipalities.

The challenge with this strategy is that we would see a loss of $2.4 million in property tax revenue. As a result, we are looking at a five-year phased-in-approach model whereby the Ministry of Municipal Affairs and Housing would offset the loss of revenue from those taxes over the five-year period. We propose $500,000 a year over five years. These funds would then be captured for direct investment in new affordable housing projects.

Again, I want to thank the committee for their time today. I look forward to answering your questions.

The Chair (Mr. Ernie Hardeman): Thank you very much for the presentation.

Our next presentation will be the town of Moosonee. I believe this is a virtual one. I see we're up on the screen. Mr. Mayor, the floor is yours.

Mr. Wayne Taipale: Good afternoon. Thank you for taking the time to meet with us. The town of Moosonee is a unique town. We're situated on the tip of James Bay. We are isolated, only accessible by rail, air and, in the wintertime, we have a couple of ice roads.

The town of Moosonee is a hub for the whole north. We service five First Nations communities along James Bay and Hudson Bay. We also service the MoCreebec Eeyoud and the local service board at Moose Factory. We are the transportation hub. Be it freight or passenger, everything has to come to Moosonee and then be distributed from here to the remote communities and Moose Factory Island.

We have major construction going on here right now with the new health campus in Moosonee, which is going to put a real additional load on our financial situation to upgrade our infrastructure to meet these requirements. It is a campus that will service the whole northern community here.

We also are looking at the impacts that are going to come from this on our infrastructure, be it fire halls, airport terminal buildings and a transportation system that will be requiring additional funding. The town of Moosonee has a very low tax base here. We have approximately 2,500 people in Moosonee, but we service over 10,000 people from this community.

We are the only provincial municipality surrounded by all First Nations, which are federal. We are looking to speak with you guys about trying to see if there is any way of getting more funding for the northern communities and the Far North communities.

The Moosonee health campus is going to consist of a hospital, 36 in-patient beds, 15 semi-detached units for staff, plus a hostel for the people who come from the north to seek treatment and an elder centre as well. This puts a big load on our infrastructure and it's going to be a major cost. We are working with them. We believe growth pays for growth, so we are working with the Weeneebayko health authority and Infrastructure Ontario to try to come up with more funding on this.

Over the past few years, we've done major improvements to our water and sewer infrastructure, and we plan on looking for more funding. We appreciate the ICIP funding and the grants. That is how we can move forward here in Moosonee. We could not afford to do it without these in place. We were looking at possibly a new fire hall and emergency preparedness centre that we'd have to upgrade, because what we have right now is not sufficient. With the hospital and the additional growth in the town, we're going to have to upgrade that. We have done a study and plan. We're looking at approximately $10 million for the fire hall up in Moosonee.

We looked at a new terminal building for the airport because of the increased traffic at the airport, and we have come up with an estimate of $12 million for that. We also have docking facilities that are used by all in the area for the water marine docks and we are looking for additional funding for that.

The Ontario Northland train that comes to Moosonee that brings the freight and the passenger—the passenger operates Monday, Tuesday, Thursday and Friday, which is not enough days for us to transport everybody in and out and with the medical appointments and that. Also, the freight train brings freight in twice a week, which is not sufficient, and with this growth it's going to need to be more. We have met with the Ontario Northland—again, it's due to funding, so we would urge that if there's any possibility to have more funding put to the Ontario Northland railway to service our community.

Again, when we are speaking for the town of Moosonee, we are really speaking for seven different municipalities

or First Nations because they're all involved with us. There's going to be an increase in tourism as well in Moosonee.

With that, I would like to thank everybody for listening to us, and if you have any questions, we would like to take them. Also, we are looking forward to the committee coming to Moosonee so we could meet with them in person and show them our unique community.

The Chair (Mr. Ernie Hardeman): Thank you very much, Mr. Mayor.

Our next presenter is Canadians for Properly Built Homes. Karen, the floor is yours.

Dr. Karen Somerville: Good afternoon. Thank you. My name is Karen Somerville. I'm the president of Canadians for Properly Built Homes. It's my pleasure to be with you here today.

I'm going to start off by asking you to imagine for a moment: Imagine saving up to purchase a newly built home in Ontario, moving in and, a year later, finding yourself living in your vehicle, as that home is making you sick due to code violations and mould. This is happening today in Ontario to the purchaser of a newly built home, living in their vehicle in the winter. I spoke with this homeowner as recently as last week. Tragically, this is not the first time that this has happened in Ontario. It could be you, it could be your mother, it could be your father, it could be your child next.

Our organization, CPBH, has been operating for 20 years now, entirely with volunteers. No one is a paid a cent. We do this because of the need. We know that organizations charged with consumer protection responsibilities in Ontario often do not adequately protect consumers when it comes to newly built homes, the largest purchase that most people make.

I'm going to summarize five points that comprise the reality for far too many people in Ontario today. Number 1, the Ontario building code is often not enforced during construction, and many agree that the Canadian government's "build faster" movement is going to result in even greater number of homes with code violations.

To begin to understand the depth of this serious problem, just look at the city of Toronto's 2023 audit report related to Toronto's building inspections group. The audit findings show that the city of Toronto's building inspection group's performance is very weak and that many weaknesses are not new, often persisting from the 2013 audit 10 years before. The auditors found that "construction is proceeding without inspections," "deficiencies are not always well documented, communicated or followed-up" and inspectors are "not always issuing orders to enforce compliance."

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The picture that emerges in this audit report is one of a fundamentally important public function that is in chaos and not working. We've provided you with a link to our two-page statement, and I've also included it with your package today.

Number 2 is that Tarion continues to fail many purchasers of newly built homes. As one example, often homeowners have to wait for years for code violations to be assessed by Tarion and then repaired, if they're ever able to convince Tarion at all. This delay threatens the health and safety of the occupants.

Number 3: Now we have the Home Construction Regulatory Authority, HCRA, failing many purchasers of newly built homes. As one example, consider the Ontario builder directory that continues to mislead potential purchasers for many builders. I've got an appendix for you with that, as well.

Number 4: The administrative authority model used in Ontario often does not provide adequate consumer protection. The problems with Tarion and HCRA provide specific examples.

Finally, number 5: A newly built home with code violations typically takes a tremendous toll on Ontario families—financially, physical health, mental health and/or family breakdowns. In extreme cases, people consider declaring bankruptcy or suicide, just because they purchased a newly built home in Ontario with code violations.

We understand that the Ontario government is currently not interested in addressing the decades-old problem of the lack of enforcement of the code during construction, or the decades-old issues with Tarion, or the decades-old issues with the administrative authority model or the serious shortcomings of the relatively new HCRA. So what is CPBH recommending this year for Ontario's budget? We're recommending that you provide the resources to effectively operate a consumer watchdog office, which is proposed in Bill 122, the Ontario Consumer Watchdog Act, 2023.

In the recent hearings related to Bill 142, Ontario's consumer protection act, most, if not all, presenters expressed their support for a consumer watchdog related to newly built homes and many other serious consumer protection issues in Ontario. One way to fund the consumer watchdog office is to divert some of the millions of dollars administrative authorities are forced to pay annually to the Ministry of Public and Business Service Delivery for oversight fees.

As I close today, please know that the suffering by so many Ontarians just because they purchased a newly built home with code violations and inadequate consumer protection is great. It's unbearable for some. We are gravely concerned that it is getting worse with the government's movement to build faster. Please don't look away. Please help us fix this.

Thank you. I'll be happy to address your questions.

The Chair (Mr. Ernie Hardeman): Thank you very much for the presentation. That concludes the presentations.

We'll start the questions with the official opposition. MPP Harden.

Mr. Joel Harden: Thank you to all the presenters for coming this afternoon.

Karen, I want you to pick up where you just left off, if it's okay. I've had the benefit to read your research. I've had the benefit to attend community meetings you've hosted with entire places of our city—Cardinal Creek in Orléans, for example. I've walked through some of the

homes you've talked about, with radon contaminating brand newly built buildings. I've seen homeowners poke X-acto knives through foundations that were so shoddily built.

So you've mentioned there's not alignment right now on some of your key asks, because I know you're constantly engaging all members of the Legislature. But if you were to point out a specific ask for the consumer watchdog, where would it begin to at least, as I understand from your research, identify the problem? Where would it begin?

Dr. Karen Somerville: Thank you for that question. It's a good one. This is a complex area, just as we look at newly built homes. I have given you an example in your package today of the Ontario builder directory. If I had one place to start, it would be there. Why? Because that is what tells potential purchasers very important information about a particular builder. Currently, unfortunately for many builders it's misleading. So that would be the place when it comes to newly built homes that we would like to see the watchdog start.

Mr. Joel Harden: So it's almost like a Better Business Bureau approach to awareness of the prospective homebuyer?

Dr. Karen Somerville: Correct.

Mr. Joel Harden: Okay.

Dr. Karen Somerville: And if I could add one other thing: In 2013—this is not a new issue—the Toronto Star did an exposé, an investigative report on this builder directory. The government at the time said it had to be fixed, given what the Toronto Star exposed. Many agree that it's worse now than it was in 2013.

Mr. Joel Harden: So, as that old adage goes, the best disinfectant is sunlight, right?

Dr. Karen Somerville: Absolutely.

Mr. Joel Harden: People need to understand where there are repeated bad actors.

Dr. Karen Somerville: Correct.

Mr. Joel Harden: Okay. Thank you so much for that. I want to make sure I spread my time as much as I can.

But moving to our friends from Moosonee, I just want to offer some regrets today from your wonderful member of provincial Parliament, Mr. Guy Bourgouin, from Mushkegowuk–James Bay. He wishes he could be here to join us today.

If you could elaborate about the unique affordability challenges faced in the Far North as you are. Beyond what you've already mentioned with the new health facility that you're accommodating, when I've heard from Guy and other members in the Far North, I don't know that a lot of us way down south here have a sense of affordability crises in your moment and why you have a unique case for more funding.

Mr. Wayne Taipale: Thank you. We'll use some examples. To bring in the proper aggregate in to make cement, it would have to come in on an Ontario Northland railway train. To do any construction, I think it's about three times the cost of what it would be were we connected to Highway 11. Another example is, our gas up here, right now we are paying $2.60 a litre for our gas. So the cost to do business in the far remote area is about three times what it would be if linked to Highway 11. That was just some examples I have.

Mr. Joel Harden: Okay. Lastly, sir, if you were to talk about what Moosonee returns to the south. I mean, some of the critical industries based around you are important for Ontario's economy. If you could, for our benefit again, just talk about what gets sent back down south, thanks to you?

Mr. Wayne Taipale: In the area here, there's mining. The OPG hydro projects are in our backyard. You know, with tourism and the construction people, there's a lot of stuff like that that takes place.

Trevor, did you have anything you want to add to that? Trevor's our acting CAO, sir.

Mr. Trevor Keefe: I'm public works manager. Trevor Keefe, acting CAO. The only thing I'd like to add is that there are a lot of young candidates freshly leaving school, whether it's nurses, OPP officers and those in critical services and trades—paramedics—that come up to the community, put a few years of service in and tend to travel down south. So we are a hub that is quite transient right now. The CAO position is open, and the economic development officer. So we do have difficulty filling some of those positions and wear multiple hats. But we would also like to look at ourselves as a hub where people come to gain experience, and to do that, there is sometimes a need to pay more for northern living and travel, because our accommodations and grocery bills are substantial compared to some of the southern areas. But like Mayor Taipale mentioned, definitely mobilization to the community is very expensive, travel to the community, receiving supplies, the high cost and fuel costs.

Mr. Joel Harden: Mayor Taipale and Mr. Keefe, thank you for that.

Chair, how much time do we have left?

The Chair (Mr. Ernie Hardeman): Two point one.

Mr. Joel Harden: Turning to our friends from Cornwall, thank you again. You made the case for some pretty major infrastructure improvements, and some of what you were talking about with water was particularly concerning. Are you in conversations with other eastern Ontario municipalities, be it Hawkesbury or others, that are facing significant—like, some of this infrastructure hasn't been in decades, but it's presenting immediate public health questions for you right now. I'm just wondering about, to your knowledge, the degree to which this extends beyond your unique situation.

Mr. Justin Towndale: Hawkesbury for us would truthfully be a little far, to be honest with you. We're in South Glengarry today. We've been in discussions with South Glengarry because they have asked for us for water and waste water provision—and South Stormont as well. We do provide some water outside our boundaries to certain neighbourhoods within South Stormont.

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Certainly, moving forward, we know that it's not necessarily beneficial to have multiple water purification

and waste water plants all across the St. Lawrence. Consolidation of those efforts within fewer plants makes a lot of sense, and that's something that this ties into as well. When it comes to the area, we're the hub in the area, and none of our neighbours would be able to support us.

The Chair (Mr. Ernie Hardeman): One minute.

Mr. Justin Towndale: It's more the other way around, but certainly, we are seeing that. There are infrastructure needs in the city. Our city is 240 years old and we do find pipes that are—sometimes we find wood and other factors, so that ties into this. The pipe we're talking about here is from 1955, but it's indicative of the infrastructure in the area.

Mr. Joel Harden: You mentioned, as others have to us, that in this new environment we're in now, you're discovering the homelessness problem being much more prevalent in your community. You're discovering the mental health and addictions issues being much more prevalent in your community than before.

Can you talk a little bit about, were you to receive some more support from the province, who are some of the folks you rely on locally to help you in that work?

Mr. Justin Towndale: We have a number of partners. The United Way of SD&G has stepped up in a big way and we are operating what we're calling our Stepping Stone Project with them, which is housing people throughout the winter. Right now, our encampments are empty as a result, but we know that's not a permanent solution.

We are working with the Canadian Mental Health Association and the Agapè Centre, which is a local food bank. We have a partnership with the Mohawk Council of Akwesasne, and there are many, many organizations—

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time.

MPP Collard.

M^me^ Lucille Collard: We can continue on because that was the kind of line of questioning I was hoping to pursue anyway. Can you give us an idea of what's the status of Cornwall in terms of homelessness, mental health and addictions issues? What are you dealing with right now? What's the amplitude of it? What kind of help do you need?

Mr. Justin Towndale: It's serious in our community. We are not untouched by the opioid crisis. There are some statistics saying, when it's per capita, we are in the top 10 for overdoses. It's not something that's lost on us.

Mental health has been an ongoing issue. We did just hear from the Canadian Mental Health Association, the local chapter. Coming out of the pandemic, it is a serious issue.

When we look at the root causes of homelessness, these are factors that play into that. Homelessness has always existed in Cornwall. However, it wasn't so visible until recently, and especially coming out of the pandemic is when we started to see encampments forming on our waterfront. Mostly people from the area—that includes Cornwall, that includes Akwesasne, that includes SD&G, but we know there are people who are a bit more transient in that regard as well. But it's certainly something that is somewhat of a newer challenge for us in the sense that a lot of communities that are larger in nature—major urban centres—will have shelters established, although "shelter" is becoming a four-letter word, frankly. So we are looking to the future of what housing solutions look like, and I would highlight our Stepping Stone program in that regard.

But certainly, we face the same challenges anywhere. As MPP MacLeod alluded to earlier, the arrival of asylum claimants in our city has contributed to this. I'm not saying it's a negative thing; don't get me wrong. We welcome anyone who needs a safe place to live and we're happy to step up in those efforts, but there are a lot of housing pressures and the need for housing in Cornwall that are certainly contributing to this.

M^me^ Lucille Collard: As a follow-up to that question: What is your city's long-term vision for housing? What kind of mix of housing do you need to respond to the demand? And are there specific policy changes that you would like to see the government adopt?

Mr. Justin Towndale: I'm going to refer to the CAO, Mathieu Fleury.

Mr. Mathieu Fleury: Thank you for your question. We're a bit unique and the mayor has highlighted that we're a hub city. So we have shared services for our affordable housing portfolio that goes beyond the city of Cornwall. We work closely with our SD&G county partners to develop those housing needs in the counties as well. The mayor is working closely with the wardens of eastern Ontario for that housing strategy.

Our biggest challenge locally is no different than in large urban centres, which is that we have about 1,200 units on our existing social housing portfolio, which we have to maintain and repair. At the same time, we have a lot of pressure, as the mayor described, to build new. How we manoeuvre through the various programs to ensure that we can be a good landlord but also meet today's needs in housing is the biggest challenge.

We could share with you our 10-year housing plan, which I believe is close to 700 units in this area. But I think the challenge we face is with our financial abilities, with our debt levels, and with those two pressures, we have limited tools at hand to really try and meet those goals.

The Chair (Mr. Ernie Hardeman): One minute.

M^me^ Lucille Collard: So, quickly, then, talking about tools: Is there any policy change that the government could adopt that would help you in unfolding your plan for housing more quickly and more effectively?

Mr. Justin Towndale: I think our ask today reflecting the exemption of taxing for our affordable housing portfolio, but then also assisting us with a contribution of $500,000 a year for five years to help offset that loss, would enable us to have capital funds and invest in housing directly. That's an immediate change that could take place that is, I think, a reasonable ask overall that would have an immediate impact.

M^me^ Lucille Collard: Thank you.

The Chair (Mr. Ernie Hardeman): MPP Bresee.

Mr. Ric Bresee: Once again, I'd like to thank all of our presenters today for their input to this process. It is both very valuable and very interesting.

Again, I'll lean back to my municipal background. I want to start by congratulating the city of Cornwall. You had mentioned $250,000 per unit in your presentation. That's actually an excellent number. We're seeing much higher numbers in my own municipality. We recently did an eight-unit build that ended up at $400,000 per unit, and that's not extreme by any stretch, so your $250,000 is actually a really positive number.

Both to yourselves and to the folks from Moosonee, one of the historical tools that you—and formerly me, as a municipal rep—had access to was the infrastructure programs that provided federal, provincial and municipal dollars all into a common pot. It was extremely valuable to us and, of course, I'm sure you've heard from our government that we were rather frustrated that the feds have not come to the table with that partnership for this coming year. We have put in some monies, but as you've highlighted, a $200-million water and sewer infrastructure program from the province is wonderful, but you're looking at a $55-million project just for Cornwall, certainly. So, again, these numbers, with the construction inflation rate the way it is, have been incredibly challenging over the years.

One of the things that I picked up on through your presentation is that you have been actually very successful with your growth. You've built housing; you have some social housing builds, certainly. I'm wondering, with the idea around the second intake pipe: Is it fully just for redundancy or will it also give you added capacity, therefore coming under the growth category and therefore subject to development charges and availability for long-term funding from that side of it?

Mr. Justin Towndale: Thank you for the question. It's part and parcel in this case, I think, because it's a redundancy, but it does allow for a level of growth. Quite frankly, it's more water intake, but at the same time, while the initial intake is nearing its end of life, with the establishment of the secondary intake, it would allow us to refurbish the primary intake. The plan is not to discontinue use of that intake, but it's to make sure it's repaired and brought up to spec and to modernize it, frankly. It's a project that will provide us security for future growth, but also current needs at the same time.

Mr. Mathieu Fleury: If I may just add one element to respond to your question, one of the conversations the province is having is with one of the partners we're excited about in Cornwall, the Great Wolf Lodge. As part of those potential investments, we've done our due diligence at our water plant and absolutely can meet our growth, can meet those investments. So from a plant perspective, we have capacity, and as the mayor highlighted, we are in discussions with multiple counties in the region to be able to see what the relationship is. But we're holding off on solidifying those agreements until we can solidify our own risk management for the intake.

Mr. Ric Bresee: Yes, so this ends up being about some growth, but a lot more about stability and that long-term view on that. It's wonderful to hear. I was actually thinking: Water intake is great, but you then also have to have the plant capacity to be able to handle that water, especially if you're doing technically double the volume or whatever that may be. So it's great to hear, and great to hear that you do have that long-term vision on this.

Listening to the other presentations, I actually want to tie in your municipal lens to the presentation from Ms. Somerville from Canadians for Properly Built Homes. There were some statements in there that, again, as former municipal rep, I would have had some trouble with, in the idea that we're not necessarily doing the proper building code inspections and management from that side of it. You, as municipal leaders, are in charge of that particular portion within your municipality. Certainly, we've got 444 of them across the province that are doing the same, and the province has certainly a vested interest in that.

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So can I get your comments to the statements that are being made that there are challenges around building inspections, and whether they're being done in winter or if they're being challenged by the sped-up process that we're encouraging as a province?

Mr. Justin Towndale: Yes, I think there certainly are challenges. Part of it is also the resources that every municipality has. Right now, the municipal sector is having difficulty, like many other sectors, in terms of recruitment and retention. In our case, we require people with very specific skill sets, and that includes building inspectors. What we've seen in our building department, unfortunately, is somewhat of a high turnover. When that happens, we see the need for new training, and then we have to maintain consistency among multiple inspectors, and that's a challenge.

Moving aside from that too, one thing that I heard from the construction industry in our community: We had a round table, and whenever regulations are changed—and change is good, don't get me wrong; there have to be updates to the building code—it can create confusion at times, depending on when they're implemented and the amount that are being implemented at the same time. There can be inconsistencies just in terms of the understanding of what is required. That's something where sometimes the law will provide guidance or the building code will provide guidance, but it may not be an absolute. There may be a bit of a grey area up to the interpretation of the building code inspector. That's where maybe some of the difficulty is being seen.

But, certainly, we do see challenges in terms of staffing issues, training and retention issues. That's something we are working on, but I know that we're not alone in that. We're not immune to that, but municipalities across the board are struggling in that regard.

The Chair (Mr. Ernie Hardeman): One minute.

Mr. Ric Bresee: Following that line—again, I've got that experience where two neighbouring municipalities interpret sections of the building code slightly differently, depending on what that particular conversation is. At times, there were some larger regional efforts to have those conversations amongst the different municipal building departments to ensure that there was a level of consistency, which then promotes the developers in the area, the builders

in the area, to know how the cold will be interpreted in that region.

Do you see that as an effective tool? Or would you see the development—forgive me; I just want to get the term right. The development of a consumer watchdog—no, that wasn't it; the new board that's being referenced. Which would you see as a more effective tool?

Mr. Justin Towndale: I think, without having seen that, frankly, and having had the time to study it, it's hard for me to comment on it, I'll be honest. But I know that clearer standards would certainly play a role. That would help us in our staff's effort. I think there is some value in potentially looking to collaborate with our partners in that regard. That's also a thing that I—

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time for that question.

We'll go to the official opposition. MPP Pasma.

Ms. Chandra Pasma: Thank you so much to all the witnesses for being here.

I am going to start with you, Karen. First of all, it's very nice to see you here. You've been a great help to me in the past. I have a development in Ottawa West–Nepean where constituents have laid down tens of thousands of dollars. Some of them are still waiting, five years after paying those deposits, to actually have a home built, with no transparency and inaccurate information coming from the developer. Those who were actually lucky enough to get their home built have seen many challenges with the construction of their homes, those homes not being up to the standard that they expect. Complaints have been filed with the Home Construction Regulatory Authority, and then a whole lot of nothing.

When I reached out to the HCRA to advocate on behalf of my constituents, I was told that they prioritize ones where they have a sense that there's financial wrongdoing or some sense that the company's financials might not be on solid footing, and that they had just received information that suggested that that was the case with this developer, so this file was now going to be prioritized. That conversation was about eight months ago. Nothing has happened.

My constituents who don't have a home still don't have a home. The constituents who had their homes built still haven't gotten any kind of justice for the state that their homes are in. So, my question to you, as someone who is an advocate, somebody who has helped many people in Ontario who are dealing with these challenges: Whose side would you say Tarion and the HCRA are on?

Dr. Karen Somerville: Whose side are they on? Unfortunately, the feedback that we get regularly—and we talk to hundreds of homeowners a month—the feeling is that they are on the builders' side, that they are there to protect builders and not homeowners. I'm sorry to say that. When you hear that, hundreds of times a month, and you see evidence of that being presented, that's also the conclusion that we draw at this point.

We believe it stems from the governance. You take a look at the board of directors, for example. There have been changes in the board of Tarion, for example, but there is still lots of concern about the builders' influence—whether it be through the board of directors or other ways of influence—that the builders still are being protected by these administrative authorities.

Ms. Chandra Pasma: Is that why we need a consumer watchdog? And how is the consumer watchdog different?

Dr. Karen Somerville: Ideally, we would like to see the problems with Tarion and with HCRA and with code enforcement sorted out. That is definitely our first preference and I think that of most people who are in this situation. But, as I mentioned in my presentation, there doesn't seem to be an appetite for that right now, so the backup plan that we are advocating for is the consumer watchdog. It would be better than what we have now.

In an ideal world, we need to address the enforcement of the building code during construction. If we had that properly done, then we wouldn't need to worry so much about Tarion or HCRA. Get it right to start with and take the pressure off of those other organizations. Build it right to start with is really what we're saying, but we don't see much evidence of that improvement.

I also don't want to paint all municipalities with the same brush, nor all builders with the same brush. There are municipalities that, we understand, do a good job, but then, when you see the city of Toronto—and I am going to speak to them, and, Chair, you may recall me sitting in your office many years ago and you asking for evidence. The best evidence we've got so far is this audit from 2023 and 2013 regarding the city of Toronto.

Let's get it right to start with. Let's get those municipal inspections properly done so that, when someone assumes and moves into their newly built home, all happy, they know that at least the code has been met.

Ms. Chandra Pasma: To MPP Bresee's question earlier: What's the provincial role in making sure that these inspections are happening correctly across the province, especially having heard some of the challenges faced by a municipality like Cornwall?

Dr. Karen Somerville: As the Chair heard from me, probably 10 years ago now, sir, the way that it's being handled, with offloading these responsibilities to municipalities, is problematic. No one is holding them accountable. We have written to every councillor in the city of Toronto when this 2023 report came out. We wrote to the chief building official of the city of Toronto. We wrote to the new mayor. No one has responded at all in a year to any of this.

The audit report, we believe, was quietly released. We can find no mainstream media reporting on it. It seems to be buried. But many of the problems raised in 2023 by the auditors were also raised in 2013. In 2013, they said that they would take those auditors' recommendations and address them. They haven't.

If there's an appetite for this, there's got to be some accountability coming from the province to municipalities to make sure that these homes are properly built, at least to code.

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Chandra Pasma: Thank you, Karen. I certainly agree with your comment that if we are going to empha-

size building homes faster and we have a housing crisis, we certainly want people to have quality homes that they are able to live in, instead of being homeless when they actually own a home.

Turning quickly to Mayor Taipale, you've mentioned the much higher cost of living in the north. You've mentioned the challenges of providing infrastructure and the construction costs of building that infrastructure, and how you provide those services to the region. My question is, what if the province doesn't step up with assistance in building that infrastructure? Do you have the capacity to build that infrastructure with the revenue you can raise from your ratepayers in the region? Or, given the very high cost of living that you cited, is that simply not an option in the north?

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Mr. Wayne Taipale: That is not an option in the north. Another thing that they have to take into consideration is the province has been helping us out with the funding and the grants and that, but being a municipality, we have five First Nations around us that we service. We service five First Nations plus the two other organizations, and our tax base is really, really low. We're expected to provide all these services and that, and we just would not be able to do it—

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time on that question.

We now will go to the independents. MPP Collard.

M^me^ Lucille Collard: Mayor Towndale, you came here today with your biggest ask being for very important—I would say critical—infrastructure for the government to provide funding for. If you don't get the money from the government, what kind of alternative will you be forced to consider?

Mr. Justin Towndale: I think, at the end of day, the project has to get completed. But what happens in the case of if we are not successful in getting the funding is that it could potentially take away from other projects that are competing interests in our community. We are prioritizing the water intake because of the importance it plays. But we do feel we need assistance in this regard and it also plays into a number of priorities that align with the government in terms of providing safe drinking water and providing water to our neighbours and emergency preparedness and planning in that regard.

M^me^ Lucille Collard: Thank you.

I'll turn to Karen for a question, because the example you gave at the beginning of your presentation of somebody having to live in their car after moving into a new house that's making them sick, I thought that would be an isolated event. But you seem to say that you are seeing more of that and that it's happening more and more. So how broad is the issue? How many cases are we seeing of that kind of situation?

Dr. Karen Somerville: CPBH is 20 years old this year. I personally have been doing this for 24 years as a volunteer. We're a national organization; we have seen this happen across the country. But we're seeing it now and we're hearing about it more now. A lot of it is related to mould. I can't give you any study, per se. I can only tell you about the people we're hearing from and we are hearing from a number of people right now who are out of their home. This is an extreme case of living in their car in the driveway beside a 3,400 square-foot home, okay? But we know of many others who are out of their home, living in motels, living in hotels. Tarion has a lot of that data because Tarion is, in fact, financially supporting many of those people at $150 a night.

So I can't give you an exact answer, but I can tell you that there are a number of cases right now.

M^me^ Lucille Collard: Is it possible that some of the problems associated with the consequences of building could be attributed to maybe the building code not being adapted to the changing of our climate? I'm thinking about that because you spoke of mould, so do you think we need to have a look at our building code and make sure that we build more efficient housing, or do you think it's really a problem of constructors not following the building code?

Dr. Karen Somerville: The latter, at this point. We are always looking and hoping to see more advancement in building methodologies, but we're talking about the basic building code not being met as it stands today.

M^me^ Lucille Collard: Okay. And I agree with you that definitely there needs to be an inspection process during the construction to prevent that from happening in the first place.

How much is Tarion responsible for the anguish of those homeowners? Because I've heard a lot of complaints about Tarion.

The Chair (Mr. Ernie Hardeman): One minute.

Dr. Karen Somerville: The people we hear from are people who are very unhappy. Tarion probably has people who are happy with them. We do not hear from those people. And what homeowners are coming to us about is they are not getting support from Tarion; it's taking far too long; they have multiple peer review processes; multiple engineers coming in at numerous times. Meanwhile, they're living in homes that don't meet code, which means their health and safety are impacted. So there are lots of concerns around Tarion and Tarion's consumer service standards.

The Chair (Mr. Ernie Hardeman): Now we'll go to MPP Dowie.

Mr. Andrew Dowie: Thank you to all the presenters. I'd like to start with Moosonee. I was intrigued by your presentation. Actually, just as a committee member, I was very much looking forward to our visit, because I think your part of Ontario is something that is poorly understood by those of us from the south.

The existence of the saltwater port is something that is pretty unique to your community. I'm wondering if you have any thoughts for us about how we might be able to better leverage the assets that you have to help with your prosperity, particularly on the marine side. The province unveiled the marine transportation strategy a few months ago, and the hope is that communities like yours might be able to better leverage some of the economic power that Ontario has.

Mr. Wayne Taipale: Thank you. Again, with the marine, we have to look at the four-season transportation in this area, because the marine is only approximately three months out of the year due to the ice conditions. The other means of transportation would be air and then the winter road. Everything comes into Moosonee by train, and then it is distributed from here up north. But due to the ice conditions and that, the marine transportation would be three months a year. We do have barging organizations here that do take stuff up to the communities. Actually, they go right up to the Belcher Islands sometimes.

I'll let Trevor add to that a little bit as well, if he would.

Mr. Trevor Keefe: Yes, just to elaborate on that a little further: Like the mayor mentioned, the marine travel is only capable a few months of the year. The Hudson Bay travel route, and James Bay, have quite the ice cover until into the summer months, and freeze-up begins around maybe mid-to-late October with the last trips on the barge. It depends also on the tidal influence. Every 12 hours, we have a tidal impact from the Hudson Bay, which brings up our water level up and down about four or five feet during that duration, so travel is limited based on those tidal influences as well.

But like His Worship mentioned here, all of our supply services, goods, come up on the ONR and ONTC, through rail; further north in the winter months on the road; and, like you mentioned, through the saltwater channel up James Bay to the First Nation communities.

Mr. Andrew Dowie: Thank you for that. And understanding the necessity for winter roads in your community, I believe it was last year that $6 million was invested to bring forward those winter roads. I'm wondering: How is this amount relative to the need that is out there? At $6 million, I believe that is for 3,200 kilometres of road. Are we in the ballpark of what is needed to provide safe access, or what kind of investment level would better help the people of the community?

Mr. Wayne Taipale: A permanent road would also help us. The ballpark figure would have be discussed with the First Nations, because they look after the funding. The town of Moosonee does not look after the funding for the winter roads. They do help our economy by linking the three First Nations—Kashechewan, Attawapiskat and Fort Albany—to come to Moosonee for supplies and also, on the winter road, the building materials that are taken up on the ice road. It wouldn't be practical to fly it up there, and the barge only operates for so many months out of the year.

Then there is a winter road called the Wetum Road South that goes from Moose Factory Island to the south, which some of the local people use for shopping, for the economy, but there's no freight that comes on that at all. The roads are not built for freight on that one. And then there's the road connecting Moose Factory Island to the town of Moosonee, but we have very little input on that.

I'll turn it back to Trevor as well.

Mr. Trevor Keefe: I'll just comment a little further on that. The current support of the road is not sufficient for safe and long-term travel throughout the winter months. The road heading north is not open yet, and when it is open, which will be shortly, it is open until about the end of March break, so mid-March.

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Previously the De Beers Victor diamond mine supported the winter road. When that support is not there, the quality of the road and the conditions of the road drop significantly. I hear that conversation through the contractors who work on the road, that the funds just aren't there to create a good, strong, durable ice-capped road when there's not the support from that mining agent.

The road is in a similar condition to the road that goes south from Moose Factory down to Smooth Rock Falls, which is the Wetum Road, that ties in at the OPG site. It's just a residential road for recreational travel.

Mr. Andrew Dowie: Thank you very much.

Chair, how much time is left?

The Chair (Mr. Ernie Hardeman): One point five.

Mr. Andrew Dowie: Maybe I'll close it out and I'll ask Cornwall: Just recently the province unveiled the infrastructure bank, which is intended to leverage investment so that we can help find the capital funds for larger infrastructure projects. You mentioned the water component. I know waste water is also big for many communities, or interchanges on the highway etc. What are your thoughts on this as a potential funding source so that you could pay for growth in advance and pay it back over time and have growth pay for growth?

Mr. Justin Towndale: I'm in favour of any supports that can be provided to municipalities. I think there's a lot of promise with the infrastructure bank. That's something that, in my other role as well, we are aware of, so we're certainly pursuing that.

I'm going to hand it over quickly to Katie Wells.

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Katherine Wells: Just further to the mayor's comments, we are always looking into alternative sources of funding, including the Ontario Infrastructure Bank. We've recently had a lot of conversations with other agencies, like FCM and other groups, for funding sources. Certainly that's something we are very supportive of, and very much we look into these opportunities.

Mr. Andrew Dowie: Thanks very much.

The Chair (Mr. Ernie Hardeman): Thank you very much. With that, that concludes the time for the questions and the time for this panel.

We thank all the panellists for taking the time to prepare and bringing us your thoughts. It's going to be very helpful as we move forward on the budget.

ALS SOCIETY OF CANADA, CHAMPLAIN
YMCA OF THE NATIONAL CAPITAL REGION
PALLIUM CANADA

The Chair (Mr. Ernie Hardeman): As we're changing here, we introduce the next panel. It's the ALS Society of Canada, Champlain, the YMCA of the National Capital Region and Pallium Canada. If the panel will come

to the table, and if the committee members will get away from the end of the table.

As we give instructions, again, each panellist will have seven minutes to make a presentation. At six minutes I will notify you that there's one minute left. At seven minutes, we'll end that one and go on to the next one. We do ask each panellist as they start their presentation to introduce themselves to make sure we have your name properly in Hansard for the presentations you are about to make.

With that, the first one is the ALS Society of Canada, Champlain.

Ms. Krishna Sagoo: Thank you. My name is Krishna Sagoo and I am from the ALS Society of Canada today. Thank you all for this opportunity to share with you the urgent needs of the ALS community and a solution to address the issues. This investment will not only save the health care system significant costs, but it will also improve the lives and health outcomes of almost 8,000 Ontarians each year.

As I said, my name is Krishna Sagoo and I'm here on behalf of the ALS Society of Canada and the five multidisciplinary ALS clinics in Ontario. Today I am representing over 1,300 Ontarians and families living with ALS. In my role at the ALS Society of Canada I work directly with over 100 people and their families living with ALS in the Champlain region to provide resources and support.

For those of you lucky enough not to know what ALS is, I am going to ask you kindly to sit absolutely still and not move a muscle for the reminder of my remarks. That is the reality someone with ALS faces, except they don't have a choice that their muscles don't move.

ALS is a terminal disease that gradually paralyzes a person. They will lose the ability to move, to speak and to swallow, and eventually to breathe. With no cure, 80% of people living with ALS will die within three to five years. This is a disease that does not discriminate based on age, gender, race or social economic status. Each one of us has a one in 300 chance of receiving this diagnosis in our lifetime, unless you have the hereditary form, and then it will be every person in your family.

The progressive nature of ALS is relentless and results in substantial care needs that increase over time. It has profound impact on the individual and residual trauma for the family. Today, Ontario's health care system is not meeting these needs, leaving people living with ALS unable to access the critical care and support they urgently require. This issue extends beyond immediate health care concerns. It impacts our families, our communities and the very fabric of Ontario. Without dedicated and sustainable funding for ALS care and support, people living with ALS face greater risks, leading to increased strains on our health care resources.

ALS Canada is a charity that has been addressing the gaps in critical equipment and community support services by providing over 40 different types of equipment in a timely manner and direct psychosocial support in the communities throughout this province. Our services not only support the individuals with this disease but also their caregivers and their families, ultimately impacting more than 8,000 Ontarians affected by this disease.

These vital services should not be funded by donor dollars. This is inappropriate and unsustainable. The five multidisciplinary ALS clinics in Ontario are beyond capacity and under-resourced, unable to meet the unique levels of complex care patients require as identified by the Canadian best practice recommendations for the management of ALS. Ontarians living with ALS and their families are in an increasingly vulnerable position, where we are seeing one out of four people dying of ALS choosing to access medical assistance in dying.

However, between these challenges, there is hope and an opportunity for change. To respond to this urgent need, ALS Canada, in collaboration with the five multidisciplinary ALS clinics, developed the Ontario Provincial ALS Program, which represents a comprehensive solution to a complex issue. For budget 2024, we are asking the provincial government to implement the recommendations outlined in the Ontario Provincial ALS Program:

—investments in ALS clinics to ensure the clinical care needs of the community are met;

—that full staffing of an ALS neurologist, respirologist, occupational therapist, physiotherapist, social worker and a dietitian be provided, with regular visits with the full team as the disease progresses;

—sustainable funding for ALS Canada's equipment program and community services so people with ALS in Ontario can maximize their quality of life and minimize additional cost to the health care system due to emergency interventions for the individual or their caregiver, who may be injured in trying to provide care;

—formation of a secretariat to ensure the program's effectiveness and ability to adapt and the value for money; and

—development of a regional strategy for people living in northern and rural Ontario to get the care they need.

The initial investment required for this transformative program is estimated at $6.6 million, which is a modest figure in comparison to the program's profound impact that it promises. If we consider the "if not, then what?" scenario, the immediate funding of $6.6 million equates to approximately $5,000 for each person living with ALS. In contrast, the average cost for a person with ALS who is admitted to hospital in a crisis state is almost over $30,000.

At Sunnybrook alone in the past year, 46 patients were admitted, with an average length of stay of over 16 days, and the cost per patient was over $29,000. Sunnybrook is caring for the largest number of people in our province, with over 700 ALS patients and only 20% coming from within their catchment area. If Sunnybrook restricts access to their catchment area, we will push people back to the other clinics who lack capacity, causing further disparity, and some people will simply not have access to a multidisciplinary clinic.

ALS Canada is efficient and cost-effective, but it cannot continue to fill the gaps and meet the demands going forward. Providing core services and equipment is inappropriate

and unsustainable using donor funds. We will need to start to restrict the services and equipment we can provide.

1500

As the care needs increase, so does the burden on the caregiver, psychologically, financially and physically. You can only imagine yourself caring for a parent, a spouse or a child, trying to care for them or transfer from a hospital bed to a powered wheelchair without the equipment or a ceiling lift

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Krishna Sagoo: The risk to the caregiver is dramatically increased without these basic pieces of medical equipment that ALS Canada is providing. The caregiver is also likely to need health care resources if not appropriately supported. One in four people dying of ALS are choosing MAID, increasingly citing a lack of access to care and resources. We are concerned this will significantly grow if care, services and equipment are further restricted.

As you consider the Ontario budget for 2024, please know that together with the Ontario government, we can ease the burden of ALS and ensure Ontarians living with ALS and their loved ones receive the care and support they rightly deserve. In doing the right thing, we can also save the health care system significant cost.

Thank you so much for listening.

The Chair (Mr. Ernie Hardeman): Thank you so much for the presentation.

Now, we'll hear from the YMCA of the National Capital Region.

Mr. Morgan Bello: Good afternoon, everyone. My name is Morgan Bello. I'm the vice-president of people and culture for YMCA. Today, I want to thank you for the opportunity. I stand before you as a community member, also as an immigrant and father in Ottawa, invested in seeing our community grow and succeed.

The impact of the Y goes beyond its walls. The Y has been a centre of the community for 157 years in the National Capital Region. The YMCA, just last year, touched 90,000 lives. Many of those lives cannot be here today to speak to you, so I have the duty to talk about them, about their journey, about their dreams, about their hopes and the transformative power of the YMCA.

The YMCA has been described for many as the heartbeat of the community. I say this because we have programs going from youth to senior, and our goal is fostering healthier communities.

I'm here today to talk about something that is probably something that you have seen across the province. In Ottawa, we are facing that reality: housing. Each night, in the heart of the National Capital Region, we have 280 individuals who find themselves without a place to call home. These are not just numbers for you—and I hope they're not; these are members of our community, our neighbours, our families who are facing the harsh reality of homelessness.

The Y is one of the biggest transitional houses in the National Capital Region. Each night, we provide housing for 269 individuals. From women's to men's to family and youth transitional housing, the Y is a home for many of those who cannot afford one. But we are facing challenges with aging facilities that often need extensive repairs. Operators like the Y are at a crossroads to decide what to do with the facility: to invest in repairs or face the risk of selling the facilities.

Last year alone, the YMCA of the National Capital Region invested from their budget $2.5 million in essential and maintenance repairs. This is no longer sustainable for our charity. That is why, as part of the budget, we are asking to consider funding to renovate or retrofit existing infrastructure.

I want to talk to you also about employment and newcomer services. With the rapid change in demographics in Ottawa, we have witnessed incredible success stories with programs that we offer. Programs like Power of Trades have not only helped to secure employment but have also become contributors of economic vitality in our community.

Last year alone, our Y provided help to 60,000 individuals to find employment—when I say "employment," it's meaningful employment—and helped 11,400 newcomers to settle in Canada. We have received financial support to do this, but it's only temporary. We are asking for, in the budget 2024, a multi-year agreement with organizations like the Y that can develop programs to be flexible and emergent to the needs of our community.

Finally, I want to talk to you about child care. With the historic Canada-wide child care program rolled out in Ontario, we are seeing a lot of excitement in families who now can see affordability as no longer an issue. The demand for child care has been exceeding any expectation, and I want to give you an example. Our YMCA provides each day—annually—service to 450 children in the National Capital Region. Our waiting list is made of 676 families in Ottawa hoping to have space in our program.

Now that operators can no longer increase their fees, we rely on government funding to maintain our programs. Many Ys across Ontario, including Ottawa, are finding the current funding approach insufficient and not covering the true cost of program delivery, leaving us with shortfalls and uncertainty if we can stay here in the future.

We are also seeing a significant change in the dramatic—as probably you are hearing today about the workforce. The YMCA has spent thousands of dollars in trying to retain qualified staff who work in child care. Although we appreciate the efforts that have been made, it's not sufficient. That is why we ask for budget 2024 to deliver on their commitment to a better formula that builds true cost recovery to ensure our funding for 2024 can guarantee a success for an organization like the Y.

Finally, I want to close by saying, humbly, that the support in these three areas—housing, child care and employment and newcomer services—is an investment in the future and the well-being of the community. With your support, organizations like the Y, which has been around for 157 years, probably can be there for 157 years more. I ask for you today to consider the investment in the well-being and the future of the community and their well-being.

The Chair (Mr. Ernie Hardeman): Thank you very much for the presentation.

We'll now go to Pallium Canada. I believe they're on the screen. The floor is yours.

Mr. Jeffrey Moat: Hello, good afternoon. I'm sorry I couldn't join you in person. Thank you so much for your time. My name is Jeffrey Moat. I'm the chief executive officer of Pallium Canada, and for those who are not aware of what Pallium Canada is, we're a national non-profit organization. We're based in Ottawa. We focus on building professional and community capacity to help improve the quality and the accessibility of palliative care across Canada. We're a community of clinicians, educators, researchers, Indigenous leaders and citizen advocates, all working together, ultimately, to accelerate the integration of palliative care in communities and health care systems. We were founded about 24 years ago today, and we provide practical and evidence-based training solutions to increase the quality and accessibility of palliative care.

I want to talk to you a little bit about the highlights of our pre-budget submission. Let's face it, we all have our memories of what went down during the COVID-19 pandemic. As we all know, there were many gaps and inefficiencies that emerged across the entire health care system, but the gaps were particularly evident in the long-term-care sector, where almost 70% of Canada's COVID-19-related deaths occurred. In most sectors, palliative care services were either inadequately staffed to respond to patient needs or sidelined as long-term-care homes went into shutdown and imposed restrictions on the movement of health care professionals across care sites and sectors to control the spread of COVID-19.

In many cases, front-line long-term-care staff lacked the necessary core palliative care competencies that we refer to as the "palliative care approach" to provide even the most basic, foundational palliative care. At the very time that strong support of palliative care skills were required, those having to provide it lacked the required knowledge and lacked the skills. This resulted in many residents with severe illness and other diseases, such as cancer and advanced heart disease, neurological diseases or renal diseases, experiencing unnecessary suffering. In recognition of this—and we applaud the Ontario government for passing the Fixing Long-Term Care Act in December 2021 because it enshrined in legislation the commitment of the integration of the palliative care approach, or what you call the palliative care philosophy. That is guaranteed to all residents of Ontario's long-term-care homes.

I'm here to underscore the fact that training and education of staff on the palliative care approach is an essential component of any strategy that aims to improve the provision of palliative care and access to palliative care for citizens living in these long-term-care homes. To this end, we are proposing a proven cost-effective solution that rapidly scales and spreads the palliative care approach in a staged manner to a prioritized number of long-term-care establishments. The solution that we provided in our submission will provide health care workers with the skills and the knowledge to provide earlier, more effective and more compassionate palliative care to residents and their families.

1510

The good news is that evidence-based, trusted solutions already exist to help fulfill the Ontario government's commitment to improving palliative care in long-term-care homes. The good news is that Canadian taxpayers have already paid for the development of these training courses and they could be affordably and efficiently provided to health care workers needing these skills. The courses are referred to as LEAP. It stands for Learning Essential Approaches to Palliative Care. These have been implemented in thousands of homes across the entire country.

There are some 625 long-term-care facilities in the province of Ontario, and our recommendation is for $1 million per year for each of the next three years. Think of that: $3 million total is what we're asking for. We can train 50% of the long-term-care staff—that's about 6,000 health care professionals—to ensure that the palliative care philosophy that's enshrined in this legislation is integrated into our province's long-term-care sector.

I want to leave you with this: Having the right amount of staff and the type of staff being properly trained and supported is one of the most critical components of quality in long-term-care homes. I think the time has come for a system-wide solution and, frankly, strong, decisive leadership that's willing to move past incrementalism and tinkering at the margins to really drive transformative change. Right now, we're rolling out our LEAP programs, our Learning Essential Approaches to Palliative Care programs, in private homes such as through networks like Sienna and Extendicare, but the public homes are not ramping this up. We have this two-tiered system where if you're in the right homes you're going to have staff who are properly trained in palliative care to give the best possible care, and other homes that do not have this. So let's level the playing field. I think $3 million over three years to train 6,000 health care professionals is a very modest ask. I'll leave you with that. Thank you so much for hearing me out.

The Chair (Mr. Ernie Hardeman): Thank you very much for your presentation. That concludes the presentations for this panel.

We'll start the questions with the independents. MPP Collard.

M^me^ Lucille Collard: Thank you to all the presenters. I find it very compelling to just realize that all you're asking today—the three of you representing different sectors—are all essential care services that are based on ensuring that people can live or terminate their life with dignity. I think that's very important in our society. At the same time, I think what you're asking demonstrates clearly that those are cost-saving measures for the taxpayer, so it all makes sense. I'm hoping that the government will take that into consideration when developing the budget.

To Krishna Sagoo regarding ALS: I had the opportunity to know not one but two people that have died of ALS. The first person, it was an acquaintance that was more than 20 years ago. I was told almost on a daily basis about the progress of that illness, and I was crushed every time. It was a person with young children, and the burden on the wife and the family was just so big, so there's no doubt

that the support is required. And the second person was somebody that we probably all know: Mauril Bélanger, who died in 2016. I was also close to him, and I saw him even towards the end. He had access to some kind of technology that helped him communicate, but the suffering was really, really evident.

So I totally agree that there needs to be some more help in that area, especially for the families, but also touching upon the equipment, and the strategy for the north I think is a very sensitive one. Can you give us an idea—because I heard about that disease more than 20 years ago; before that, it was totally unheard of. What is the progress in the numbers of people getting affected by this illness?

Ms. Krishna Sagoo: So, currently, we are seeing over 1,300 people diagnosed every year with ALS. Like you said, core funding is really important because we're at a point where we are unable to provide the services such as the equipment. Equipment costs are very high, so the numbers are increasing, and we do have treatment options, which means that people are living longer, we're finding. So equipment is out with those people for longer, so we're also finding that there's challenges in providing equipment to new patients coming in, to new clients and their families, as the numbers are growing each year.

M^me^ Lucille Collard: So the number is definitely growing?

Ms. Krishna Sagoo: Yes, absolutely.

M^me^ Lucille Collard: And we don't know what it is associated with—like, is there any environmental factor that makes it so?

Ms. Krishna Sagoo: There isn't any cause or cure that suggest any of those things at all. And even to get a diagnosis, it can take up to two to three to five years for that person to get an actual formal diagnosis because it's the elimination of assessments and tests, because there is not an actual test that can determine that this is ALS. One has to go through many assessments and treatments and things like that to—

M^me^ Lucille Collard: And there's no early detection that can help us?

Ms. Krishna Sagoo: No, and this is why we're trying to focus on early interventions with the multidisciplinary teams, so that clients and patients can go to their family doctor to get a referral to a neurologist and be part of that multidisciplinary team from the beginning, to get an early diagnosis and get early interventions and supports and services in place. Time is not on their side because two to five years is not a very long time, and as you mentioned with the person that you knew, ALS progresses very quickly. Things change from Monday to Wednesday. Someone can wait there on Monday; by Wednesday, they're unable to wait there. And then equipment changes, their needs change, adaptations within the home. So there's so many different factors to that that one may need.

M^me^ Lucille Collard: Okay. I think I'm out of time, so thank you.

The Chair (Mr. Ernie Hardeman): MPP MacLeod.

Ms. Lisa MacLeod: I want to say thank you for the three presentations today. These are all three very difficult topics to discuss, but they're topics that we have to learn about, if we don't know them first-hand as legislators, to understand what dollars we're putting out and where they are going in order for the betterment of society, and I fully believe that.

I want to say thanks to you, Morgan. I just want you to know, as your local MPP in Ottawa, I've been working with one of your board members to deal with some of your housing issues. For the members here, they're the only YMCA, I think, in all of Canada that actually offers supportive housing. So keep the work up. I've already texted them. We're going to continue to work together.

Jeffrey, I want to say thank you to you. Palliative care is one of those issues that until you're confronted with the end of life of a loved one, you do not realize how important it is that there is a facility that is there to offer them dignity. But, more importantly, the people who work in palliative care must be sent from God. So I want to say thank you to you. I hope that we have an opportunity to speak. I do a lot of work with Bruyère Continuing Care, but when we get back to Ottawa, please look me up and let's have a conversation.

I do want to talk to you, Krishna. You've mentioned something very profound: One in 300 people can get this diagnosis. And you're looking at a government caucus where two of us out of six have lost very close loved ones to ALS. And make no mistake, colleagues, it is one of the most cruel diseases that was ever invented by the body, because it strikes a body and makes it limp. It turns the body against the entire brain, but the brain is still there. You have a fertile mind that's watching themselves deteriorate in front of their family and their loved ones. It's been a very difficult experience for anybody who has had to see somebody they love wither away, in most cases, in under a year.

So I want to thank you for coming here today, and I think that you add a very important voice. Because sometimes we hear people that want wage parity—fair enough, we do too. They want to build a road. They want to build a bridge. But until you know somebody that you want to save their life—you brought that to us today, and for that, we thank you.

1520

I want to talk a little bit about this because I want my colleagues to get a sense of it. Because when I started listening to you—and of course you answered a lot of the questions—I started thinking about when my grandfather was there and he had to climb up the stairs, and people laughed at him. Then he was into a hospital bed and he needed a wheelchair to go out. Then he needed a breathing tube. I'm thinking, "That's a lot of equipment." A family in need can't pay for that; that's why we've always looked to the ALS Society to provide that little bit of charity. But that's growing, especially as demographics go.

As I ask you these questions just think about this, because I want you to respond to me and to my colleagues so that they understand what the cost of a wheelchair is, what the cost of a hospital bed is and what the cost of a breathing tube is—I know you don't have the dollar figures, probably,

in front of you but you can give a sense—that's above and beyond the nursing care or the PSW that may have to come in and support the spouse that is not dealing with this.

Then we have to talk about research. We have to start talking about research in every single disease that we have, but some—I have mental health issues. Yesterday there was a whole day dedicated to people like me. But there's not a big day any more, really, dedicated to ALS and how important the research is. How much do you guys need in terms of funding, and where do you get it from?

Finally, you talked about regional strategies. I want to know from you—and if you don't have that information, you can provide that to the Chair—where in Canada or in North America right now do we have a really good regional strategy that we can look to and start that groundwork.

Second of all, if you ranked all the provinces in the country or all of the states in the United States, which jurisdiction comes out on top? Which state or province would you look to and say, "Wow, if we had that here we might be able to provide those families with a little bit more hope"? I'll leave you with the rest of my time.

Ms. Krishna Sagoo: Thank you for your questions. I'm sorry for your experience with your losses.

In terms of equipment and the cost, it's through the roof. It feels like our equipment teams are constantly purchasing equipment—power wheelchairs, transport wheelchairs. As I mentioned, things change so quickly. Somebody may be able to use a transport wheelchair one week and the next week not. That's how quickly our equipment team is purchasing these types of equipment pieces.

Ms. Lisa MacLeod: I'm going to interrupt: Sometimes people have one type of wheelchair and then they need to move into a different type?

Ms. Krishna Sagoo: Absolutely, and very quickly. It could be days.

Also, you mentioned hospital beds. They are very expensive. And we have specialized air mattresses for people who have bulbar onset or they progress to have breathing issues. They have to have adaptive mattresses to help support their sleeping so they don't choke or have any respirology issues or failures with their breathing when they're on their BiPap machine.

There are various different medical equipment items that we provide which the government should be providing as a core service, as a core piece of equipment. Without all these pieces of equipment, unfortunately, our ALS patients aren't able to manage because they need things so quickly: for example, ramps. There are various different sizes of ramps.

Equipment is very costly. I don't have those actual numbers, but we can get that to you. It ranges from $500 to thousands of dollars. We also provide easy lift chairs for people to help support them in and out of their chair. When they lose their core muscles as the disease progresses, the movement is limited. As I mentioned, 40 different types of equipment pieces.

The Chair (Mr. Ernie Hardeman): One minute.

Ms. Krishna Sagoo: The second question was about—

Ms. Lisa MacLeod: Research.

Ms. Krishna Sagoo: Research, yes. Research is constantly happening. I can absolutely say that, as a community lead at the ALS Society of Canada, we've been to the research lab and I've seen the researchers undertaking some of the research through our clients in the ALS community who have donated their spinal cords or their brains. Researchers are a prime factor of our organization because ultimately we are looking for a cure. Across the globe that is the kind of research that is happening and the researchers are constantly working on that.

You asked, how do we get this money to do that? It comes from our fundraising. Every June is ALS Awareness Month. We're out there—

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time.

We will now go to the official opposition. MPP Pasma.

Ms. Chandra Pasma: Thank you, Ms. Sagoo. I'm going to continue a little bit on this theme. Like many of the committee members, I've also had a close friend lost to ALS, Angela Rickman, who was a long-time NDP staffer who passed away in 2020.

You've spoken very eloquently about the costs to the individual and their family. I want to touch a minute on the public cost, because you mentioned hospitalizations. When we're talking about hospitalizations for people with ALS, you said an average of a 16-day stay? And are we talking about repeat stays?

Ms. Krishna Sagoo: It can be, yes. If their needs aren't met or the progression is occurring more quickly, then yes, they're back into the hospital or in a complex care facility, absolutely. Or if the equipment isn't provided in a timely manner because we can't access that equipment in that region, then they might have to get equipment from somewhere else, or they might end up in hospital because they don't have access to that medical equipment.

Ms. Chandra Pasma: Right, so in some cases, yes, the equipment is expensive, but having the equipment prevents an even more expensive hospitalization and means that is available for another patient.

Ms. Krishna Ragoo: Yes.

Ms. Chandra Pasma: And the $6.6 million you mentioned, that covers the cost of the equipment program plus the development of the strategy that you mention?

Ms. Krishna Sagoo: Absolutely, so it will go to our equipment program to be able to purchase all the different types of equipment in each region of the province and also the community support services.

The emotional support piece is really important for the person that has a diagnosis as well as the family members because it not only affects the person that has a diagnosis, it affects the entire family. So that whole emotional support piece throughout the journey of that diagnosis is really, really important, yes.

Ms. Chandra Pasma: Right. So, I will just observe then that if we're talking about repeat hospitalizations and the average cost of a hospital stay is $722 a day, it doesn't take very many hospital stays to add up to the cost of this fund, which is going to save the province money for the

health care system, and it's going to save these individuals a lot of strain of their personal finances and stress—a time of caregiving at an already stressful time.

Ms. Krishna Sagoo: Absolutely, yes. And as you mentioned, caregivers, they may have to leave work, or the person that has the diagnosis, they may have to leave work, and now that level of employment—the money coming in is eliminated. So now they're wondering how they're going to afford to pay for the equipment, how they're going to pay their bills, and some people have young families and mortgages and all these financial commitments. So they've got that added on a debilitating, life-altering disease, so it's—yes.

Ms. Chandra Pasma: Right. Yes, so this $6.6-million investment is saving a lot of money for individuals, taxpayers, and a lot of stress and worry.

Ms. Krishna Sagoo: Absolutely. And getting them into the clinic with the multidisciplinary team—the money obviously will go towards that too, to get an early diagnosis, to get the support they need, the treatment options. We're very fortunate we have access to therapies now so patients can be put on that treatment option sooner so the progression may be a slower process, so they'll be able to spend more quality time with their families or maybe to do the things that they always wanted to do.

Ms. Chandra Pasma: Right. Thank you for helping us understand that better.

Mr. Moat, I just want to ask, for the patients—say I'm the patient, what's the difference between having access to palliative care options versus not having palliative care options? What does that look like, tangibly?

Mr. Jeffrey Moat: Immense suffering, if I could summarize it.

I'll start by saying that palliative care affects 100% of the population, not 5%, not 10%—all of us will need it at some point in our lives. And if we think that our med students, nursing students, other students coming out of allied schools of health are graduating with these skills, they are not. If you think that the staff working in our long-term-care homes have these skills, most of them do not.

This is why, when they're not equipped with these skills, if they're not provided with proper training, then what happens—to your point—is that the residents receive substandard care. When we have studies coming out of the Canadian Medical Association saying that over 50% of our family docs do not feel comfortable delivering proper palliative care to their patients, that should be alarming to all of us.

I focused my submission on long-term care because we saw what happened during the pandemic when it wasn't properly provided because of that lack of skills—and thank you for your question, by the way.

1530

We're talking about things such as being able to engage in essential conversations. You can imagine how difficult it is for a health care professional to talk about death, dying, bereavement, grief. These are skills that can be taught, but most feel uncomfortable. How do we have conversations around advanced care planning, goals-of-care discussions? How do we train our health care professionals on identifying the signs of the last days or weeks of life? There are so many skills and knowledge that's required, and when we don't have these skills, what happens is, patients and their families are getting substandard care. What I've been saying from the very beginning is that the solutions are actually already there. It's about spreading and scaling them.

Ms. Chandra Pasma: Right. Thank you for painting that picture for us. To me, $1 million a year to avoid that kind of immense suffering is a very, very small price to pay, and one we can certainly afford when we have $5.4 billion in a contingency fund not even being spent in Ontario.

I don't have very much time left, but, Mr. Bello, can you walk me through the situation with the child care funding? Why is the funding that you're receiving for the $10-a-day child care not enough to pay for the child care that the YMCA is providing?

Mr. Morgan Bello: Yes. There are elements that are not being captured. The funding formula is old. It is using data from previous years, before the Canada-wide child care formula was implemented.

The Chair (Mr. Ernie Hardeman): One minute.

Mr. Morgan Bello: That means that many of our Ys are having their fees frozen for over a year because infrastructure or staff are not covered there. So the demand is there, but we're unable to meet that.

When we think about expansion and how we grow, we need to be thinking how we make that list—the waiting list is just growing every day. I talked about 676 families waiting just for an opportunity, and I'm pretty sure across Ontario it's the same reality. It is important to assess that, because it was based on, basically, the minimum, without speaking of the realities of inflation, for instance, how the wages of the workforce are substantial right now.

Ms. Chandra Pasma: And what happens if the funding formula is not addressed?

Mr. Morgan Bello: Well, we are facing what many worldwide are, as you will probably hear in Ontario. They are—

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time.

We'll now go to the independents. MPP Collard.

M^me^ Lucille Collard: I'm going to continue with you, Mr. Bello. Where does your funding come from? You're asking for money from the government. That's definitely fair, but where are other sources of funding coming from for the YMCA?

Mr. Morgan Bello: Our YMCA is a charity, so as a charity that works for the community, we have donors who support the Y, sponsors who support the Y. We have programs and partners who work with the Y. For instance, in the National Capital Region, we are able to do this work thanks to the support of provincial and federal funding. We wouldn't have been able to do it. There is probably some time in understanding that. People believe that the Y—we are a charity, and we are here because of the support. There are many streams of that. All our support is

based on and thanks to federal and provincial and partners and donor support.

M^me^ Lucille Collard: Okay. Thank you. Just a question about the child care: How long is the wait-list to get a child care spot at the YMCA right now?

Mr. Morgan Bello: I can tell you, it can be probably a year to be able to have a spot. That number I presented to you today is from just today. If I told you, for instance, the waiting list to get access to our housing program in our housing building, you would not believe it. It's a registry of 12,000 individuals waiting for support. Our shelter programs, our transitional housing programs, have a waiting registry of 12,000. So we're talking about numbers that are beyond imagination. Families in Ottawa for child care probably have to wait over a year to find a place.

We are hoping to expand our demand, and we are willing to expand to meet that need. It's how we can do it that is operationally possible for us to work.

M^me^ Lucille Collard: Do you have the space available to open more child care?

Mr. Morgan Bello: We have capacity to continue growing, yes. Many of you probably heard through our presentation before, we're unable to do it because the current formula is not meeting the needs. Many of our Ys across Ontario are actually concerned with keeping those child care programs available. So I'm here, truly, to say to you today, this is an important emergency. When you have 600 families just waiting for one spot, many of them think that before even getting to the pregnancy period, they need to already start to register because maybe they are not lucky. I'm talking about an important need. It speaks about equity. It speaks about the support that we need to provide to have accessibility for jobs, for families. It's a reality that we're facing every day.

M^me^ Lucille Collard: Thank you.

Just quickly, with the remaining time, I'm going to turn to Pallium Canada, Mr. Moat. You're asking for money for a training course that is already developed: the LEAP, you said. What will the money do to ensure that the course is being dispensed?

Mr. Jeffrey Moat: Great question. Thank you for that. Yes, you're absolutely right: The courses have already been paid for by taxpayers. The majority of the fees that we collect go to our facilitators who teach the course. These are palliative care specialists, primarily physicians but nurses as well, who we have trained on how to deliver the courses. They go into the long-term-care settings or deliver it online if some of these care facilities are in more rural and remote regions. Their time is compensated. Then the balance, which is a small percentage, goes to just maintaining our systems and maintaining the curriculum and the accreditation, because all of our courses are accredited by both the Royal College of Physicians and Surgeons and the College of Family Physicians.

M^me^ Lucille Collard: Thank you.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes that.

MPP Jordan.

Mr. John Jordan: Thank you all for your presentations.

I'm going to direct my question to Pallium Canada. Thanks, Jeffrey, for your comments. I want to recognize your LEAP training. At the CHC model that I worked in previously, we did take advantage of that training with our practitioners—very good feedback. As well as the Fixing Long-Term Care Act that you mentioned, we're making great progress on those initiatives. One of them, as you know, is $4.9 billion to increase staffing and get to our four hours of care. So it's very important that these 27,000 new health care staff and the existing staff are properly trained and have the training that they need to provide the best care possible.

So my question is around the training process. The LEAP is a great initiative, as I've said. But when you look to our colleges and universities, you did mention that our graduates are coming out—these are regulated colleges, and they're coming out without this, one would say, critical training. What do you feel is the barrier to that training being incorporated and added to the required training within our colleges and universities?

Mr. Jeffrey Moat: Great question. I was hoping someone would ask this. Thank you. And thank you first for the feedback.

Let's face it, palliative care has received little to no attention or inclusion in the medical and nursing school curriculum. Even at the postgraduate level, many residency programs, in specialty areas like internal medicine, cardiology, surgery, nephrology, pulmonology and so on, do not require the residents to undertake palliative care training. That's true as well in advanced nursing programs, such as nurse practitioner or programs in other health science professions. They fail to incorporate adequate, if any, palliative care training.

While there has certainly been some improvement over the last decade, many gaps remain. Integrating palliative care in an already full curriculum is a major barrier. There are even more glaring gaps in schools of other professions like social work and pharmacy. Certainly, part of the other barrier is funding. Most universities and colleges have faced significant budgetary constraints in recent times, which reduces, of course, their ability to develop and introduce new programs. And in the case of palliative care, I would say that there's a general shortage of positions, particularly ones with academic affiliations. That, of course, reduces the teacher pool to teach palliative care.

And then the last one I'd mention is just the challenges around the lack of experiential learning opportunities in palliative care available to students, due to lack of settings of care like hospices and palliative care units, as well as palliative care teams in many jurisdictions.

1540

Hopefully that summarizes it. We could have a whole conversation on this, but those are some of the barriers, certainly.

Mr. John Jordan: Okay. Thanks, Jeffrey.

Mr. Jeffrey Moat: You're welcome.

The Chair (Mr. Ernie Hardeman): MPP Byers.

Mr. Rick Byers: Thank you to all the presenters. I wanted to actually continue with our conversation, Jeffrey,

to better understand your role. Can you outline your funding model, the share that you get from governments of different levels and fundraising you may do? Just out of curiosity.

Mr. Jeffrey Moat: Sure, yes. We have three streams of funding that support our organization. One is through the sale of our courseware. We charge learners to take our courses, so that's one stream of revenue.

We have project-based funding, so we would receive funding from, say, the government of Newfoundland and Labrador most recently, to build an Indigenous cultural safety and humility course for people practising palliative care in Indigenous communities. We receive project funding from Health Canada to fund continuous learning through the Palliative Care ECHO Project.

And then the last source is through corporate partners and family foundations. Those are our three main streams of revenue that support our organization.

Mr. Rick Byers: Got it. Thank you very much. I'm curious about your work with—you've described it quite fully—the long-term-care sector. It's very important. I'm curious about your comment about the difference between municipally run homes and private homes. My riding is Bruce–Grey–Owen Sound; Bruce and Grey counties have a large number of municipal long-term-care homes, and I do know the impact that has on their budgets. It's not small. It's a major source, but also a major positive for the region.

But can you deal a little bit with the economics of that? I mean, it sounds like your organization is providing better service to its patients. I thought all types of homes would want to do that. I do know there's a cost, but any more information on that would be very helpful.

Mr. Jeffrey Moat: I mean, to be honest with you, they all want it. There's not one single home we've made outreach to that says they don't want the training. They all certainly do. When we talk about private homes like Sienna and Extendicare, they were very quick to leverage this type of a training opportunity, and the publicly funded ones were a little bit slower; I think that's only because of some of the budget constraints.

What has been happening is that one by one, slowly but surely over the years, we have been training up several of these facilities—budgets permitting, of course. But what happens is that when they come to us as a single home to say, "We would like to train 50 of our staff on your LEAP training course," they don't benefit from the efficiencies of having several hundred of them participating in this. So they're paying a full price of the course for their learners, whereas what we're proposing to the Ontario government is saying, "Let's get away from that." For $3 million over three years, because of the efficiencies, just the cost-effectiveness, I can train so much more for a fraction on a per-leaner basis of what I'm charging each individual home.

Mr. Rick Byers: Very helpful. Thank you.

Morgan, a quick question to you: In Owen Sound, we have a large YMCA, and they've been very involved in ECE training and have a big impact on the community. I'm just curious whether you do that type of service in your facility, and the impact that or other training has on local community health care.

Mr. Morgan Bello: Yes, indeed, we have developed programs for that skills development internally. It has been successful in many other ways. We have the actual developed curriculum that became nationally effective, and we're recognized for that. The same challenge that we are facing is the capacity to run that infrastructure currently—

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time for that.

We'll now go to the official opposition. MPP Harden.

Mr. Joel Harden: Good afternoon, everybody. Thanks again for joining us today. It's interesting, I would say this panel is a mix of the empathy connection and the personal connection for all of us.

Mr. Bello, you're my neighbour. Our community office is at 109 Catherine Street, you're right next door. Many of the families that you work with, that you house, the child care services you provide, we will help those same neighbours with health care and education services and other things. We will miss you if one day the building is, in fact, sold, which is being mooted, for some of the challenges that you are facing. We will miss you greatly.

But for now, I'm wondering if you could just elaborate, for the benefit of this committee—because I don't think it was a story often told and it deserves to be told—on the critical role the YMCA played in the pandemic for some of our neighbours who were greatly at risk. I know of the collaborations you did with the Centretown Community Health Centre. There was a lot of heavy lifting done by the Y then, as there is now, and I think legislators should know about it.

Mr. Morgan Bello: Thank you. Yes, indeed. I think it's very unfortunate news that one of the flagship Ys, which has been there for over 60 years, is actually for sale, due to the financial circumstances I just explained before. They are unable to maintain the cost of the infrastructure to keep that facility there.

But when people reflect on the Y, it is exactly, as I said, that we are the heartbeat of the community, when the community needed one. Reflecting on the pandemic, we didn't just turn our big facilities—health fitness and aquatic facilities—into vaccine centres, but we also opened our doors when they were exploring opportunities to have isolation rooms and spaces for families that they didn't have the capacity to absorb.

Many of our services were mandated as essential. I can tell you today, personally, that many of our workforce, having heard at that time what it means to work from home, working from a distance—they were essential workers, as everyone else, offering, 365 days a year, 24/7, housing services and child care services for our community.

It speaks to the power of a community hub, that it is always there to meet the needs. When we talk about the needs, it's whatever you could probably imagine happening. We are always stepping in and collaborating and supporting in the transformation of what we are. The YMCA in Ottawa, at 157 years—you can imagine, we have changed a lot, and we continue changing. That is why

I am here today, to ask for support to keep all our programs open for more time, for another decade, to support the community as we have done.

So thank you for your question.

Mr. Joel Harden: Bridging upon what you've just said, I want to thank the staff at the downtown YMCA and across the city for the work you did in that moment. It's, I think, analogous to what a first responder does. When a building is on fire, most of us run away; other people run in, creating safe spaces. The staff put themselves—you protected them; don't get me wrong—at risk, and we appreciate it. If a solution could be found from the Ontario government to maintain your downtown footprint, it would be tremendous. It would be absolutely tremendous.

I want to transition, Ms. Sagoo, to you. My family as well has been touched by ALS. The person in my family who saw his life degenerate with it would routinely say to us when we visited him that growing old is not for sissies. This was his mantra. But what he also said was that the rapidity of his decline with that particular condition surprised even him. This was someone who dealt with glaucoma, who dealt with mobility issues—but the rapidity of the decline for someone who led a very active life.

In the interest of not scaring the public but preparing the public, what advice do you have for families whose loved one gets a diagnosis? You're here making the case for more resources, and I think you made a great case, but what advice do you have for people who get that diagnosis and need to move to that preparation/adaptation place?

Ms. Krishna Sagoo: Thank you for your question, and I'm sorry to hear about your personal loss.

I think for each family and for each person who has the diagnosis, it's kind of taking each day as it comes, but also accessing the services and the supports, the resources that are available. Because sometimes there are cultural barriers and language barriers; there are challenges that may be there that prevent them from accessing them—so getting the supports and services in place in order for them to access those services.

1550

And as I mentioned, taking each day as it comes is really important so they don't go away with looking so far into the future of what's to come, but also planning ahead and ensuring that their needs are going to be met in the foreseeable future, like in the next few months—looking at the next few months rather than the next year ahead, so ensuring that they have access to the support and services that they're going to need in the next three months. That will help them not feel so overwhelmed with the system or—there's various different professionals coming in, so understanding what's out there earlier on; trying to also see their family doctor and get a diagnosis sooner; to work with a neurologist to find out what's happening and trying to get a diagnosis or understand the treatment options, the services, what's available right at the beginning, so they know, as the disease progresses, for the person as well as for the rest of the family members, what's out there, what's available. So, when they need it, they know that it's out there, so they don't feel so overwhelmed when they get there, right?

The Chair (Mr. Ernie Hardeman): One minute.

Mr. Joel Harden: It sounds like, from the case you're making today, this is something you're asking for.

It's almost a comment, Mr. Moat—I'm sorry because I have one minute left. I just want to thank you today for coming here to make the case for palliative care and maybe just make a note that I've heard from my friends at the May Court centre, down the street from Sunnyside Avenue in Ottawa, who are part of your network, that we need an allied health approach to palliative care, but even well beyond health care professions. It's been really enlightening to see local artists involved in palliative care, local people in athletics involved in palliative care. Just embracing death as a part of life is a challenging transition mentally for many of us to make.

I'll just say for the record, Chair, because it's promoting an Ottawa person, the singer-songwriter Craig Cardiff has a wonderful song called Smallest Wingless that he did as a meditation on palliative care for infants—infants born stillborn. It's just a way in which parents can deal with that grief and reflect upon it. It's a wonderful resource.

I thank you and all the people you're associated with for your work.

The Chair (Mr. Ernie Hardeman): And I thank you for stopping. That concludes the time for this panel.

We thank you all very much for taking the time to prepare and to come here and delivering such impactful presentations for our committee today.

L'ARCHE OTTAWA

The Chair (Mr. Ernie Hardeman): As we're changing the table here, we only have one more and we only have one presenter for the next one. It's L'Arche Ottawa. They are virtual, so all eyes on the screen.

As the screen comes on, we want to remind you that you will have seven minutes to make your presentation. At six minutes, I will advise you that you have one minute left, and at seven minutes, we will turn it over to questions from the committee. We do also ask you to state your name as you start your presentation, and secondly, if there's more than one speaker, they also need to be introduced as they speak.

With that, we thank you very much again for joining us today, and the floor is yours.

Mr. John Rietschlin: Good afternoon, Mr. Chairman and members of the subcommittee. My name is John Rietschlin. I noticed that my Zoom window there doesn't have my last name or my affiliation. I'm John Rietschlin from L'Arche Ottawa.

And Étienne?

Mr. Étienne Hainzelin: My name is Étienne Hainzelin. I'm the executive director of L'Arche Ottawa.

Mr. John Rietschlin: I'm going to try to share my screen here so that you can see a few slides, and then we'll get on with it.

Mr. Chair and members of the finance budget subcommittee, L'Arche Ottawa is honoured to be here today presenting to you. As one of approximately 300 transfer payment agencies comprising the developmental services sector, we appreciate this opportunity to add our voices to others in the sector who are expressing the importance of an immediate funding increase to the developmental services sector.

The slide you see here provides a brief overview of L'Arche Ottawa. We are one of 30 L'Arche communities in Canada and we're part of the worldwide federation of L'Arche, about 160 communities.

Just to begin and give you a little bit of an impression, L'Arche Ottawa has six homes, and here's a picture of some of the people who live in one of those homes, just to give you a little bit of a bird's-eye view.

A few facts about L'Arche Ottawa: We're one of eight L'Arche communities in Ontario. We're part of the Ottawa Developmental Services Network, comprising 13 transfer payment agencies funded by the Ministry of Children, Community and Social Services. Our budget is $3.5 million. We're officially a bilingual service provider, and our residential services support 26 people with developmental disabilities. We also have four vacancies at the present time, and we have a newly established day activity program currently serving 15 people.

This chart has been prepared by Community Living Ontario and illustrates the funding situation of the developmental services sector. Transfer payment agencies funded under the ministry have not received a sufficient increase to keep up with the rising costs, some programs having been without an increase for decades. Agencies are really struggling to provide services under these conditions.

Some of the impacts of that lack of an increase in funding:

—a risk to staffing levels, a particularly difficult one. We're competing for people with the same skill set with the health and education sectors, where they have a lot more generous levels of funding which have—to some extent, anyway—kept up with inflation;

—a risk to sustainability, because, again, we don't have the funding that we need, and so people are doing things like trying fundraising, looking for one-time grants and so on; and

—ultimately, a risk to vulnerable Ontarians who depend on the sector.

At L'Arche Ottawa, we have difficulty filling key positions because of this. We depend, actually, on temporary foreign workers for much of the staffing that we do have, partly because they're willing to work for lower wages.

We had to close one of our six homes recently because of the lack of funding, and again, because our funding is insufficient, we are constantly looking for other sources of revenue to cover our operating costs.

This is kind of a complicated slide that tries to illustrate for you in a bit more detail the impact of this lack of funding, not only for us, as we're talking about now, but ultimately for every agency. To understand this, you really have to understand our financial cycle. At the beginning of every fiscal year, we spend time developing an expense budget, which itemizes all of the costs that we anticipate incurring to provide the residential and other services that we must provide, and also additional services that we like to do: community building, outreach and so on. We then determine what revenue we will get from MCCSS and the gap that exists, and then we have to basically commit to finding other sources of revenue to cover that difference.

In December of the fiscal year, we submit to our local office a request to cover some of the operating deficit that we knew we would incur from the very outset, and usually we do receive something. We've in fact on average received up to $200,000 a year in each of the years that you see here. However, even so, we've had to cover a deficit. You'll see, for example, that in 2019-20, we had to cover a $257,000 additional deficit. What that means in the end is, we're always on tenterhooks, waiting. And what you see in the last bar on this graph is our current deficit unless we receive precious funding from the ministry. And we're waiting, hoping that that's going to come through.

The Chair (Mr. Ernie Hardeman): One minute.

Mr. John Rietschlin: If we have a few more years like this, it's really going to call into question whether we are financially viable. We are hopeful we're going to get something. We have every year in the past 10 years, as you can see, but never quite enough except in one or two years.

1600

I hope you've already seen this slide. Effectively, these are the recommendations that the developmental services sector has made to Minister Parsa. We're looking for:

—an immediate 5% increase in the developmental service agencies' base budget for 2024-25. That's not just L'Arche Ottawa, that's all 300 agencies in this system;

—a corresponding 5% increase in Passport funding, which is money given to individuals with intellectual disabilities to acquire some of the services that they need; and finally

—to establish an interministerial task force to develop a long-term sustainable funding model for the sector.

L'Arche Ottawa is one of the 300 agencies that certainly supports these recommendations. It is not going to solve all of our problems, obviously, but it is—

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time we have for it. We'll now start the questions, and hopefully the rest of what you were going to tell us will come out in the questions.

With that, the questions go to the government first. MPP Dowie.

Mr. Andrew Dowie: I want to thank John and Étienne for being here. I'm wondering if you might be able to elaborate a bit on workforce challenges. I've been advised by some of my local partners that they just don't have enough options for the workforce; that you could really use those that might be able to be specialists in developmental services coming into the system; and that you really don't have employees to pick from today. They just don't exist, whether it's the specialized education or just a lack of available workforce in general. I'm wondering if you could comment on that.

Mr. John Rietschlin: Étienne?

Mr. Étienne Hainzelin: I don't think we feel it's the lack of skills and people able to take the jobs. It's first, I think, a question of salary and comparative advantage of the sector. The model of L'Arche is extremely less costly than other agencies, and so our salary is lower than other agencies. Our problem of workforce is extremely acute, but I think globally in the sector, the competition with the health system and education system is as favourable in our development system.

Mr. Andrew Dowie: Okay, so I'm hearing you there. If an employee who is skilled and able to work at L'Arche was not working at L'Arche, where would they be working otherwise?

Mr. Étienne Hainzelin: They would first go in the same sector with a better-paid salary—to other agencies that pay better than us. Our model, again, is very original because many of our staff live in the homes with the people with disabilities, so it lowers the cost. So the first option would be to go to another agency. The other option would be to go to the health system, probably, more generally, or to propose services to families directly.

Mr. Andrew Dowie: Could you share an example of your competition for a worker? Who would pay more? What would attract the same type of worker?

Mr. Étienne Hainzelin: For example, we just hired a nurse part-time, for 80% of the time. We managed to hire way below the market price for a nurse. Nurses are extremely expensive. We managed to pay her $70,000 a year compared to $100,000, which would be the normal salary. We attracted her because of, probably, the atmosphere and the mission of L'Arche Ottawa, but it was extraordinary that we had this chance.

At the same time, our core members, our people with disabilities in our homes, need a lot of new—because they're aging, they really take advantage of the presence of this nurse. Without this nurse, a very specific one who wanted to become a part of this community of L'Arche Ottawa, would I be able to hire a nurse? The difference is very important.

Mr. Andrew Dowie: Can you name a specific agency that really attracts your workers, or the workers that would otherwise work for you?

Mr. Étienne Hainzelin: I have in mind the range of salaries in Ottawa that are more competitive, like Tamir, OCL, AISO. They offer better salaries for the basic staff we have in our homes. But they are struggling with a deficit as well.

Mr. Andrew Dowie: Overall, you say this is fundamentally a matter of the value of the salary relative to others in the market. Are there other issues in terms of your work-life balance? If you're living with or working long hours with someone with a developmental disability, is there an ability to have a home life and to spend time with family? Or does it take someone who is incredibly committed to the job to fill a role that you would have?

Mr. Étienne Hainzelin: We feel our model proposed the possibility to have a family life. We have people living in the homes, but you have many people living out of the homes, either as relief assistance—part-time people—or people living out of the homes and coming 40 hours a week to work with us. I think they are happy with the model, but the question of salary and benefits is key.

Mr. Andrew Dowie: Thank you very much.

The Chair (Mr. Ernie Hardeman): MPP Byers.

Mr. Rick Byers: Thank you for the presentation this afternoon. I want to make sure I understand your funding model. You mentioned MCCSS. It sounds like that's a significant portion of your funding. Do you feel you have a good dialogue with the ministry, that they're aware of your services and that you have good access to their team there to follow up?

Mr. Étienne Hainzelin: An excellent relationship, very understanding of our model and very helpful. It's the lack of funding that is key.

Mr. John Rietschlin: Yes, and if I might just supplement that, our local program supervisor—as Étienne says, we have an excellent relationship with this individual, but he has no ability either to alter the initial allocation of budget that comes to us or to make the final decision about whether our budget will be topped up at the end of the year. Those decisions are made by, I suppose, somebody in Queen's Park. I'm not quite sure where they're made, but they're certainly not made at the local level.

Mr. Rick Byers: But that local representative is advocating for you to his or her team. You feel that that information flow is good. Is that fair?

Mr. John Rietschlin: Yes, absolutely.

Mr. Rick Byers: And you do some fundraising yourself? Did I hear you say that? Maybe if you can just expand a little bit on that.

Mr. John Rietschlin: Yes, we do. Of our $3 million budget that I showed you, we typically are successful at fundraising somewhere in the vicinity of $100,000 to $200,000 a year, which is fairly significant, percentage-wise, in this sector.

Mr. Rick Byers: And how is that done? Through individual solicitations, corporate, both? What sources?

Mr. John Rietschlin: It's almost entirely individuals. Our families are certainly generous supporters on behalf of their children who are living with us, of course. But also, we do have a strong friend network in the city—so yes, almost entirely individuals.

Mr. Rick Byers: Well, thank you for the presentation, and more importantly, for all the work you do in the community—very much appreciated.

The Chair (Mr. Ernie Hardeman): We'll now go to the opposition. MPP Pasma.

Ms. Chandra Pasma: Thank you so much, John and Étienne, for being here with us—very happy to welcome you to the committee and very grateful that you have the opportunity to lay your financial situation before the committee. I hope that the government members are taking it to heart.

Yesterday, in Ottawa, we also had the opportunity to hear from the Ottawa-Carleton Association for Persons with Developmental Disabilities and TCE, so many conversations on the impact of underfunding in the develop-

mental disabilities sector and what that's looking like. But I know for L'Arche, you are in a particularly precarious situation compared to those other organizations, already having had to close a home.

Étienne, I'm wondering if you can put up the slide again that shows your budgets versus the CPI. And while you're doing that, can one of you tell me what year was your base funding frozen in? How long has it been since you've had a raise in base funding?

Mr. Étienne Hainzelin: John, can you answer that?

Mr. John Rietschlin: In my awareness, the last time we had an increase in the rate of base funding was, in fact, related to the pay equity increases that happened in the early 2000s.

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Ms. Chandra Pasma: So that's the difference between where your funding level has been versus what is actually happening to the value of money. For over 13 or 14 years now, if I'm seeing those numbers correctly, you haven't gotten any increase in funding, which means your funding is actually being cut every single year while you're trying to deliver the same level of services to people with developmental disabilities at the same time that costs are increasing significantly, particularly for things that have to be provided in a residential setting, like groceries, housing repairs and renovations. You can see how unsustainable it is over time.

Now, the 5% increase that the sector is asking for doesn't even make up for the difference in inflation over the time that the base funding has been frozen, isn't that correct?

Mr. Étienne Hainzelin: That is correct. I just want to mention that this graph is without the pressures. There has been no increase in the base funding, and then every year, we have a rather good surprise of having our deficits partly covered. That's the first point. And the Passport program, that added some money in the system a few years ago.

Ms. Chandra Pasma: Right. If you have to get your deficit covered every year, then it should be apparent to the ministry that the funding they're providing is not sufficient to cover your costs.

Mr. Étienne Hainzelin: That's true.

Ms. Chandra Pasma: Right. So you've mentioned you had to close the home. What has been the impact for your residents and for the services you've been able to provide of having to close a home?

Mr. Étienne Hainzelin: Well, there are two kinds of impacts. First of all, people who live in one of the homes of L'Arche are very attached to their home so they don't like to move easily. People, when they had to move from this home particularly, were kind of upset about moving.

The second thing is that the real impact has been on the vacancy. Some of our members died. Generally, we keep the members and the people with disability until their deaths. What happened is they died, and we're not able to welcome new members. Our 25 members in the homes are aging now. The main impact is that we have three vacancies in the homes to be not filled.

Ms. Chandra Pasma: And does L'Arche have a wait-list of people hoping to get a spot in one of your residences?

Mr. Étienne Hainzelin: Yes, there is a long list, and the mechanism is across agencies. The ministry animated a round table about the urgencies and the needs. Obviously, there are many needs untended.

Ms. Chandra Pasma: We had this conversation when you were in my office. My older sister had severe disabilities and needed to live in residential care, but for committee members who aren't familiar with the situation, can you talk about what leads to the decision on the part of a family that someone with developmental disabilities can no longer be cared for in the home and needs to be placed in a residential care situation?

Mr. John Rietschlin: Yes, so this is always a very difficult situation. Typically, today, families are keeping their person with disabilities in the home as long as they possibly can. Oftentimes, that is not because they necessarily would not like to have the individual move to an agency or care setting, but there simply isn't the capacity of the system to do that. Often what happens is that the move happens at a time of crisis when perhaps the parents become sick or even unfortunately death of the parent. At that point, the individual—it becomes a crisis and the system is forced to respond.

Because we had to close the home, we have very limited capacity to welcome any new people at this point. The only way we'll be able to reopen that home is with an increase in funding as the sector is asking for across the sector.

Ms. Chandra Pasma: And many of these residents need help with daily activities of living in addition to medical care throughout the day.

Mr. John Rietschlin: Absolutely.

Ms. Chandra Pasma: And can you speak to the importance of your day programs? What does that represent in the life of a person with a developmental disability?

Mr. Étienne Hainzelin: That's very important, and we launch our day program—we rejuvenated our day program this month. It's still open. We are welcoming 15 people, and we will be opening probably up to 30 or 40 people across six days of the week for meaningful activities, so it's very significant for families. At the same time, it's respite, but also meaningful activities for people. We have very interesting activities adapted to the needs of the people during the day and it's an extraordinary answer to the needs, but it's still different from the residential needs, obviously.

Ms. Chandra Pasma: And do you have a wait-list for the residential program as well?

Mr. Étienne Hainzelin: There is a common, shared wait-list across agencies. At this point, I've heard about 80 vacancies in the agencies in Ottawa, and we don't have the exact figure of the waiting list of people because there are several categories of people, but I've heard about cases that stay for one year, almost two years in a hospital, waiting for a place in a home.

Ms. Chandra Pasma: Well, thank you very much for helping us understand that better.

I'll just conclude in my final seconds that the ask that this sector is making of $145 million, a 5% increase to both

categories, is less than 3% of the government's $5.4-billion contingency fund, so we certainly have the funds to invest in this sector. I would hope that we would stop making people with disabilities pay the price, but that the government would actually be willing to step up and provide the funding that would make such a huge difference in these lives every day.

The Chair (Mr. Ernie Hardeman): MPP Collard.

M^me^ Lucille Collard: A lot has come out through the questions and answers that I wanted to ask you, but just for precision: How do people find out about your services? I know that you said through agencies, but is that the sole source? Can somebody at home find out about your services? Are you doing any kind of promotion?

Mr. Étienne Hainzelin: There is, for the day program. It's more accessible through our website and through direct contact with families.

For residential services, it has to go through what we call DSO, which is a kind of hub for the needs where families are oriented, the needs are assessed and there is a kind of matching place between vacancies and needs.

M^me^ Lucille Collard: So what are your sources of funding? Is it donation, government, other organizations? And are residents or their families paying for the services?

Mr. John Rietschlin: The main source of funding, by far, is the ministry. As I indicated earlier, we do some fundraising. That would represent less than 5% of our budget, typically.

And the other source of revenue that we have is actually the homes where our residents live, including the staff who live there. They pay rent into those, but it's basically affordable rent, if you will. It's the level of rent that you would pay if you were on a disability pension, so it's not a large amount, but it is something, so that is a source of revenue for us.

M^me^ Lucille Collard: And are you partnering with other organizations?

Mr. John Rietschlin: We do partner, in the sense of—for example, our day program is something that is part of a system of day programs across the city. We offer certain services and other agencies offer complementary services. And there is an agency table, as Étienne pointed out, where agencies try to collaborate and coordinate the services that they're offering, yes.

M^me^ Lucille Collard: All right. I'll just conclude by thanking you for the services you offer. My son happens to work in one of those residences for people with developmental disabilities. It takes special people to do that kind of work and I think they totally deserve good pay if you want to be able to attract the right people, so I want to thank you for what you do, and I certainly hope that you will get the funding that you need to continue expanding on those important services. Thank you for being with us today.

Mr. John Rietschlin: Thank you very much.

The Chair (Mr. Ernie Hardeman): Are there any further questions or comments? If not, I want to thank the presenters for taking the time to prepare and to come and speak to us, and we look forward to very successful process going forward for the budget. Thank you very much for making your presentations.

With that, this concludes our business for today. Again, I want to thank not only the presenters for this one, but all the presenters today. The committee is now adjourned until 10 a.m. on Tuesday, January 30, 2024, when we will resume public hearings in Sudbury, Ontario.

The committee adjourned at 1620.

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