Legislative Assembly of Ontario

Assemblée législative de l'Ontario

Official Report of Debates (Hansard)

M-15

Standing Committee on the Legislative Assembly

Connecting People to Home and Community Care Act, 2020

1st Session
42nd Parliament

Monday 22 June 2020

Chair: Kaleed Rasheed
Clerk: Valerie Quioc Lim

Journal des débats (Hansard)

M-15

Comité permanent de l'Assemblée législative

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

1re session
42e législature

Lundi 22 juin 2020

Président : Kaleed Rasheed
Greffière : Valerie Quioc Lim

Hansard on the Internet

Hansard and other documents of the Legislative Assembly can be on your personal computer within hours after each sitting. The address is:

Le Journal des débats sur Internet

L'adresse pour faire paraître sur votre ordinateur personnel le Journal et d'autres documents de l'Assemblée législative en quelques heures seulement après la séance est :

https://www.ola.org/

Index inquiries

Reference to a cumulative index of previous issues may be obtained by calling the Hansard Reporting Service indexing staff at 416-325-7400.

Renseignements sur l'index

Adressez vos questions portant sur des numéros précédents du Journal des débats au personnel de l'index, qui vous fourniront des références aux pages dans l'index cumulatif, en composant le 416-325-7400.

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

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

ISSN 1180-436X

CONTENTS

Monday 22 June 2020

LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON THE LEGISLATIVE ASSEMBLY

COMITÉ PERMANENT DE L'ASSEMBLÉE LÉGISLATIVE

Monday 22 June 2020

Lundi 22 juin 2020

The committee met at 1004 in committee room 1 and by video conference.

CONNECTING PEOPLE TO HOME AND COMMUNITY CARE ACT, 2020

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

Consideration of the following bill:

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

The Chair (Mr. Kaleed Rasheed): Good morning, everyone. The Standing Committee on the Legislative Assembly will now come to order. We are here for clause-by-clause consideration of Bill 175, An Act to amend and repeal various Acts respecting home care and community services.

We have the following members in the room: MPP Teresa Armstrong, MPP France Gélinas, MPP Robin Martin. The following members are participating remotely: MPP Logan Kanapathi, MPP Jim McDonell, MPP Christina Mitas, MPP Joel Harden, MPP Sam Oosterhoff, MPP Lorne Coe, MPP John Fraser.

We are joined by Ralph Armstrong from legislative counsel, as well as staff from Hansard and broadcast and recording.

To make sure that everyone can follow along, it is important that all participants speak slowly and clearly. Please wait until I recognize you before starting to speak. Since it could take a little time for your audio and video to come up after I recognize you, please take a brief pause before beginning. As always, all comments by members and witnesses should go through the Chair.

Before we begin, I propose that consecutive sections with no amendments or notices be grouped together unless any members would like to vote on a section separately. Do all members agree? MPP Gélinas.

M^me^ France Gélinas: You can group together.

The Chair (Mr. Kaleed Rasheed): Thank you very much. Are there any brief comments on the bill as a whole before we proceed? MPP Armstrong.

Ms. Teresa J. Armstrong: I first want to thank all the staff here for putting this together. I know these are very unusual times, and I appreciate the patience that you've all had with our members.

With respect to Bill 175, when we heard the presenters at committee, there was very much a common consensus that we should be not looking to rush this bill around the COVID-19 pandemic. Those concerns were made very clearly, and they articulated their concerns very seriously. We're in an outbreak, and health care is one of the most important pieces, a foundation in our society. If we don't have our health, then many other parts of our lives fall apart.

So having this bill come forward right now is really not advisable. I understand that the government wants to get their business accomplished, but under COVID-19—I think we have a lot of lessons that we could have learned and strengthened this bill going forward, so that 20, 25 years from now, we learned the lessons of PPEs, we learned the lessons of members who received care, and what could be improved. Passing this bill and pushing this bill so fast through the Legislature—I think the government needs to understand and listen to voices that are being very reasonable.

These are, like I mentioned earlier, very unprecedented times. If this is not an opportunity that we take to hear each other out and understand fully the consequences of what other people might be saying, I think it's a missed opportunity for everyone.

As an NDP member, I'm a little bit dismayed that we are pushing this bill through without first understanding and analyzing and consulting with people who are experts, who have lived experiences around the pandemic that could make this bill so much better.

So I just wanted to put that on record—that during the pandemic, I think this is not the best move forward, to be pushing the bill.

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

M^me^ France Gélinas: Everybody agrees that we have serious issues with our home and community care sector, issues that need to be fixed. But is the bill going to fix this? No. The bill concentrates on the administration and doesn't look at hands-on care. It doesn't look at things like the shortage of PSWs. It doesn't look at the problem we have with labour. It doesn't look at conflict of interest. To make matters worse, the bill actually opens the door to further privatization through the opening-up of more

contracting out, with no regulation whatsoever to say that the contracting out will be done to the not-for-profit sector.

1010

Not only is the bill coming at a wrong time, I would like to put on the record that the Advocacy Centre for the Elderly; the Chatham-Kent Health Alliance; the Canadian Union of Public Employees; the Ontario Council of Hospital Unions; Mrs. Grist; the Interfaith Social Assistance Reform Coalition; the Kingston Health Coalition; the Ontario Federation of Labour; the Ontario Health Coalition, as well as the Ontario Health Coalition Guelph Wellington chapter; Mrs. Swirsky—I hope I pronounced her name right—Mr. Tucker and the United Food and Commercial Workers, and the list goes on, all asked us to withdraw the bill. They all asked us to look at the evidence that now is not the right the time.

The home and community care sector is working flat out right now to keep people safe at home during the COVID pandemic. Many of them, who would have liked to be heard, who would have liked to present, simply could not find the time in their schedules to do so. The fact that not one single group from the francophone community was able to come forward shows you that we've missed some big segments of our population that never had a chance to be heard.

There are many, many groups that want this to be withdrawn, that see these changes coming at a bad time, plus, that pinpoint that if we're going to change home and community care, first of all, we should have legislation in Ontario that focuses on that. Once we pass this bill, there will not be a home and community care bill in Ontario anymore; it will be part and parcel of a number of other bills, with no home of its own, when really, home and community care is where people want to be. It is where a lot of our focus and attention should be, and none of that is being done. The bill is taking away, not adding anything, and is problematic for a number of people who were able to take time out of their busy schedules to come to see us.

I have a lot of problems with this bill. You will see that the NDP is putting many amendments forward. I have been an MPP long enough to know that not every government is willing to listen to the other side, so we will end up with no legislation focusing on home and community care and a huge gap in contracting out to for-profit, which so many people have said they oppose, as well as giving the government extraordinary powers for cabinet to make regulations. Those powers never existed before. We are giving them the power to do this, which means that nobody—not MPPs, not people who work flat out in home and community care—no Ontarians will have an opportunity to see this, to talk to this, until it is done. It will all be done behind closed doors, in cabinet.

This is not how you build confidence. This is not how you build a robust home and community care system; much to the opposite. It's very, very problematic, and I'm very disappointed that the government is moving ahead with such a bill at this point.

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

Mr. John Fraser: I agree with my colleagues. We shouldn't be debating this bill at this time and trying to pass this piece of legislation. It's not the right time. The home and community support sector, right now, is just trying to manage through some very difficult times and challenges, especially around the availability of labour and a shift in the work that they're doing. It's just the wrong time to be asking them to support us in doing this legislation.

The legislation is exceptionally permissive. It relies a lot on creating regulations, and creating regulations for things that really essentially should be in this bill, like a bill of rights, the right of appeal, provisions around abuse. Not having those pieces in the legislation, I think, is a critical error. I think we need to take the time to get it right. There's no rush to do this. We can do it right.

So I'm disappointed that the government is continuing on with this bill. It's not the right thing to do. Looking at the package of amendments, I'm very disappointed that the government did not do their own amendments with regard to the bill of rights or appeals or abuse provisions. I think that's wrong. I think it's in all of our interests to ensure that basic fundamental principles are included in the legislation, and that we do that to protect the people we serve.

I thank you for your time, Mr. Chair.

The Chair (Mr. Kaleed Rasheed): I'm now going to move to MPP Joel Harden.

Mr. Joel Harden: I want to echo what all of my colleagues have already said. I really benefited from the opportunity to hear deputations, and I thank the committee for organizing that. I thank the government for allowing that to happen. I agree with my colleague MPP Gélinas: I think we could have had many more, particularly from francophone communities and Indigenous communities; we had some, but even more.

I'm mindful that what isn't in this bill troubles me most. My colleagues may notice that I put a particular emphasis, when I was listening to people and asking questions, on finding out how concerned they were about administrative costs in the home care sector. I asked that because in 2015, the Auditor General told the government of Ontario and the people of Ontario that only 61% of what got publicly funded into home care was actually reaching the front line, that an enormous amount of money was being used up in administrative costs.

When I look at the nursing home sector, which is a related sector to the one we're discussing with this legislation, we have seen examples of incredible waste in executive compensation and in administration. I know this is something that my Conservative colleagues have made a point of disagreeing with in the past. For example, in the last Parliament, when we had the discussion about the decision to take the energy sector in this province—which had been, from a Conservative government, left in public hands—and privatized it, the process by which that happened and the way in which so many consultants dug deeply into the pockets of the people of Ontario with crazy administrative costs, my friends who are currently in

government, and were then in opposition, yelled loudly for transparency.

What I'm asking today is that we make sure—I would love to see this legislation taken off the table, as my colleagues have said, because I don't think any government with a shred of accountability, with a shred of credibility with the Ontario taxpayer, with the Ontario people, can allow a piece of legislation like this to continue the status quo of organizations taking four out of every 10 cents that we fund into this sector to themselves. I just think it's egregious, particularly when—speaking as Ontario's critic for people with disabilities and seniors—the needs are so high. The care needs are so high.

I'm thinking also, Chair, about what we heard particularly from the personal support workers who deputed to this committee. I'm thinking in particular of stories we heard about violence that people often had to encounter because of lack of support and not knowing what you were going into, whether it be from somebody who was consuming the service, or from a partner or family member of that service—or from others who were talking about the reality in this sector of having to stitch together small amounts of time over a day, not being paid for your transportation from one consumer to the next.

I just find the fact that we would allow an opportunity to reform the home care sector pass without directly addressing, as some of my colleagues have said, the working conditions of people on the front lines—of course, there are many occupations on the front lines in this sector, but I'm speaking in particular about personal support workers. As I understand it, from what we heard at deputations, 70% of the front-line work being done in home care is done by personal support workers.

1020

When I heard from the Ontario Health Coalition that it is very common for a personal support worker to be earning a salary of between $16 to $19 an hour but for the often private organization billing the Ontario government for that service—the bill they charge us is between $29 to $49 an hour. I find that egregious, that we would use public money to make organizations who are extremely profitable—in some cases, multinational—even richer.

What I did see in recent weeks was that Extendicare, one of the largest operators in nursing care, and through their subsidiary ParaMed in this sector, recently issued a potential opportunity to issue dividends of over $10 million to shareholders. At a time of COVID-19, Chair, when we see the need to be so pronounced among people with disabilities and seniors to get the services in their own home so they can safely live there, to know that some organizations that almost entirely exist thanks to public contracts are benefiting themselves to that extent, I find absolutely galling.

It is something that normally when I listen—and I do listen intently—to my Conservative friends talk about the need to use the public's money wisely, I can't imagine how we would let a piece of legislation be passed, debated in clause-by-clause today, without ensuring full, transparent financial disclosure for how every single red cent is used, which the people of Ontario work very hard for and then share with government to make sure that we can deliver fairness in our services.

I just want to end also by mentioning something that we heard from people with disabilities in this hearing: We also have to be mindful of the language that we use. I want to make sure that the government embraces a disability-rights perspective. They want to be known as consumers of services, not patients. They want to be able to live with attendant care services, with personal support worker services, and not be thought of as being readmitted into institutional care or being patients. There's nothing wrong with having a disability. What we do as a society is make sure that everybody has the services they need to have an equal opportunity.

I am going to end by reading that into the record and thanking Wendy Porch, John Mossa and others who took the time to re-educate me and re-educate our committee and our Legislature about how we don't want to revert back to old stereotypes. When people with disabilities need home care services, it's because they need to be their fullest selves.

Again, I want to encourage the government to take this bill off the table, but if you let this pass today, please—absolutely, please—make sure that we know how every single cent in this sector is used and that it's used for care, not for profit.

The Chair (Mr. Kaleed Rasheed): I recognize MPP Martin. Please go ahead.

Mrs. Robin Martin: I just want to respond on behalf of the government. We all know that the current home care framework is not serving patients well and that COVID-19, frankly, has made the issue all the more urgent. We feel we need a strong and effective home care and community care system now that is properly linked and integrated with other aspects of our health care system. We feel the time for action is now, and we look forward to going through this bill clause by clause.

The Chair (Mr. Kaleed Rasheed): Are there any other comments before we move on? Seeing none—

Interjection.

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

M^me^ France Gélinas: Is this the right time to ask that all of the votes on the motions be recorded as a recorded vote?

The Chair (Mr. Kaleed Rasheed): Yes. Now, the question is, only on the amendments, right?

M^me^ France Gélinas: Correct, only on the amendments.

The Chair (Mr. Kaleed Rasheed): Awesome. Perfect, yes. Thank you very much. We'll make sure we do that.

M^me^ France Gélinas: Thank you, Chair.

The Chair (Mr. Kaleed Rasheed): Can we stand down sections 1 to 3 to deal with the schedules first? Okay, so we're going to do that. We're going to go with the schedules first.

Now we are going to move to schedule 1, section 1, NDP motion number 1: Madame Gélinas.

M^me^ France Gélinas: I move that section 1 of schedule 1 to the bill be amended by adding the following subsection:

"(9) Section 1 of the act is amended by adding the following subsection:

"'Guide to interpretation, equitable health outcomes

"'(5) This act and the regulations shall be interpreted so as to advance the objective of promoting equitable health outcomes in home and community care.'"

The Chair (Mr. Kaleed Rasheed): Further debate? Madame Gélinas.

M^me^ France Gélinas: This is something that many of the presenters asked for: the Interfaith Social Assistance Reform Coalition, ARCH disability law, the Ontario Community Support Association, the Ontario Federation of Indigenous Friendship Centres, the Ontario Health Coalition, the Ontario Health Coalition, Guelph Wellington chapter, the Ontario Nurses' Association, the Toronto Seniors' Forum, the Ontario Medical Association, the Alliance for Healthier Communities. They all asked us to put in the bill an objective for equitable outcomes.

We know that there is systemic racism. We know that there is discrimination. Unfortunately, those are present in our health care system, including in our home and community care system. They are asking that we put in the bill equitable access so that we measure outcomes, so that we do collect race-based data, LGBTQ data, ages—because there is ageism even in our home and community care system—to make sure that everybody gets the expected outcome. If you don't measure it, if you don't look at it, the system that we have in place will continue.

There are places within our province—I can use northern Ontario, because this is the one that I know the best. For us, to qualify for home care you need on the scale to rate at least as an 18. It doesn't matter if your needs are 13, 14, 15 on the scale; if you don't rate 18, you get zero home care. Yet, in Ottawa, everybody starts at 13. Why? Because there are more resources in Ottawa. No offence to the people of Ottawa, I'm really happy that they get the care that they deserve, but the people I represent in northeastern Ontario don't. So unless you look at promoting equitable health outcomes, unless you look at how do people who come into home and community care—how do they do?

A big part of the people that are referred to home and community care are post-op. All the hips and knees, they all get home care upon discharge. Many other surgical procedures get home and community care upon discharge. It is part of the package. You go home, you get the physiotherapist coming to see you at home—how to transfer in and out of your house, if you have stairs etc. But the outcomes are really different depending on who they are, depending on if they are racialized, if they are Black, if they are LGBTQ, if they are elderly, if they live in a remote First Nations community. All of this means that we don't have equitable health outcomes. As Ontarians, we want this. As Ontarians, we believe that our health care system is equitable to all. Let's make this belief a reality. Let's make sure that no matter who you are, no matter where you come from, no matter the colour of your skin, your social orientation, your race, that we look at it and you will all get the care you need that is culturally appropriate to who you are to be able to get better.

This is an opportunity. This bill is open right now. We know that our system is not equitable. Let's listen to all of the people who came to talk to us and asked us to make it equitable and put it in the bill.

The Chair (Mr. Kaleed Rasheed): Further debate? MPP Armstrong.

Ms. Teresa J. Armstrong: I wasn't sure if we were doing rotations on debates.

The Chair (Mr. Kaleed Rasheed): Just raise your hands.

Ms. Teresa J. Armstrong: I wasn't sure.

This is a huge piece, I think, when we talk about access to service. Equitable outcomes, making sure there is equity around health care. It's a fundamental piece that, when we talk about equity, we know that there are populations in our society that don't have the same opportunities to access health care. And when they do access health care, there are lot of barriers to it. Language is a barrier. As we talked about, culturally appropriate care is a barrier. Geography is barrier. Ageism is very real; that is a barrier.

1030

There are so many discussions and reports about these inequities in our health care system, and this bill doesn't address those inequities. To not have those outcomes when people access health care—it doesn't improve it. It doesn't strengthen the equity piece that we are striving for. If we're all able to access health care and get the health care that we need, we actually will have prevention of more expensive health care going forward.

When we looked at one presenter who talked about disabilities and how they want to make sure that we refer to people as consumers of services, that's respectful. We have to listen to those voices because, again, it's about feeling like you can ask for something, but it's not carved into a box or a label.

We know right now what's happening with Black Lives Matter and Indigenous rights. These are things that aren't equitable in our health care, and we do have to acknowledge them. Does this bill promote equitable outcomes or equitable health care? No. It needs to be strengthened. It needs to be addressed. It needs to have report and database information so that we know how we're doing: Are we doing well? Are we serving all populations equitably?

I had a story from one of my constituents who got a knee operation in December 2018. What had happened was, when she was home, someone came out, assessed her, helped her. She had the home care she needed. She had a nurse come and take out her stitches. In December 2019, she got the second knee done—a year later. The difference in services that she experienced was so opposite. She said she was sent home and told that there will not be a nurse or health care provider coming to help her. No one would be there to take out her stitches. She would have to contact her surgeon to get an appointment through her doctor.

The situation she had with regard to transportation was she had stairs going down her first floor at the front door.

It was winter, in the middle of December. She felt very, very vulnerable that using those stairs, she could actually reinjure herself and cost the health care system even more. The option that was given to her was, "Well, you can call Paratransit." Paratransit, however, was not covered under that service. So she would have to take Paratransit—that, I believe, was $274—just to get to her doctor, who could take out the stitches. She opted not to do that and she got a friend, who is a retired PSW, to come into her home and remove the staples and stitches.

Here we are changing our health care system without delivering on the needs of what people require. We are putting them at risk in different degrees of situations for further complicated health care issues. In this constituent's case, there could have been infection, there could have been ripping of the wound, and she had no means to pay the Paratransit fee to get to the doctor's office to have her stitches removed.

A few years ago, I brought a bill forward with a five-day home care guarantee. What that meant was that you would be assessed and there would be an actual person to visit you within five days. That could have been a measure for equitable outcomes. People who went home and they didn't have a caregiver or care provider in the five days, that's when they became susceptible to infection and reoccurring health issues. They actually cost the system more. They went back to the hospital, to the emergency room, because no one was there to calm their anxiety or fears around what their medical issues were.

Post-op, when you go home—everybody wants to recover at home, but you need to have the supports in order to make sure that you recover properly and that you're not going back to the emergency room and clogging up the emergency room where you shouldn't be. You should be in your home, in community care.

A lot of times, what governments fail to do when they're making these changes and they say, "Hospitals, you are in the business of acute care," is they don't transform, they don't put the resources back into community and home care. I believe that what we're seeing when you talk about emergency room overpopulations, long wait times, people basically not being able to get the help they need is because when we make changes to legislation, and particularly health care bills or home care bills, we are not putting the money and the funding—which this bill doesn't address, any funding into the resources of home care and community care—in order to support the ideas that we bring forward so that we can prevent the costs of people going to the hospital, where really they don't belong. They should be getting the health care in their community.

This amendment is very important. I hope this government will support it. It does say "equitable health outcomes," and that means collecting race-based data, as the member from Nickel Belt described. There are many ways to collect that data: with regard to LGBTQ, with regard to ageism, all ethnicities. There are outcomes that we need to understand so we can actually address the problems that we keep talking about over and over again.

When we create legislation, let's put those levers in so we don't have to keep coming back and correcting it. Yes, we should be coming back to legislation and making sure it works properly, but not always undoing and redoing. There's a system in place. Let's strengthen it by having an amendment that provides a guide to interpretation for equitable outcomes.

I hope that this government will understand the reasoning behind it, understand the long-term planning as to why it's needed for the immediate inequities that people face, but also the future issues when it comes to inequity in health care. I leave that with them, and I appreciate the time to have my thoughts put on this amendment.

The Chair (Mr. Kaleed Rasheed): MPP Fraser, followed by MPP Harden.

Mr. John Fraser: I want to just begin by thanking my colleagues for bringing this amendment forward. This just underscores the fact that we're in a rush to do this bill, and when the government presented this bill, they didn't include something as critical as this. We can tell, or we know, I should say, right now, with what has happened in the pandemic, how unequal health outcomes are in different neighbourhoods, different professions, different ethnicities.

We don't collect enough data, but what we see in front of us is that there are some basic inequities in our health care system that need to be addressed. I think we all agree they need to be addressed. That's why this amendment is important. I'll be supporting this amendment, and I would encourage my colleagues on the government side to include it in this bill going forward.

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

Mr. Joel Harden: I wanted to add a couple of comments to what my colleagues have said. I want to hearken back to what Tracy Odell told us, from Citizens with Disabilities – Ontario. She told us a story that I think directly illustrates what having equity inscribed into the values of home care and how it operates in a province means.

What Tracy talked about, if we recall, was her experience growing up as someone with a developmental disability, and the way in which, if you can imagine—I think an appropriate metaphor is the current of the river. The way in which her life was going was very much along the lines of finding her way into a nursing home, finding her way into a form of institutional care after she was discharged from the youth institutional care she was in. Her family didn't have the means to look after her so she was in institutional care, and she was going to transition very clearly into some sort of a nursing home or extended home situation. It's not what she wanted.

1040

In Ontario, we've gone through the experience where we have made a shift, telling people with disabilities, their caregivers and their families that they can have the ability to live on their own, to avail themselves of the same services as everybody else in this province, but a real critical part of that is effective home care and attendant care services. Tracy talked about it at length. She said, "If

I didn't have access to those sorts of supports so I could access post-secondary training, so I could access the various help I needed around my home to make my life worthwhile," then she wouldn't be where she is today, which is a leader—a warrior, I don't mind saying—for justice for people with disabilities, and a shining example to every single other person with a disability in this province who wants to resist this constant push to medicalize and institutionalize people with disabilities. The antidote to that is effective well-funded home care.

In order to know how this is impacting all kinds of people with disabilities, as my colleague from Nickel Belt mentioned, we have to map this, we have to track this across the province, across so many different demographic points of calculation. We have to understand how every single person with a disability is able to access well-funded, proper home care and attendant care services, because what it will do—as Mr. Onley has said in his report to the current government and to the previous government, we are sitting on a huge reservoir of under-utilized talent in this province: people with disabilities who want a decent opportunity to offer their talents and their skills to their employers, to their communities, to what they can do.

I think it's very, very important that we inscribe the principle of equity into the way in which home care works in this province, particularly because what I've seen in learning, as I have done, from disability rights organizations, is that it has taken a concerted effort, decades of work to push people like us, to push legislators into a perspective where we understand that our goal is to enable and empower people, not to hold them back, not to medicalize them, not to put people into boxes and say what they can or cannot do. I'm thinking of Tracy when I think about how important and how worthwhile this amendment will be.

In ending, Chair, I want to remind all of my colleagues that we have obligations in this province under the Accessibility for Ontarians with Disabilities Act. By 2025, we should be, as a province, moving towards creating a barrier-free province that is fully accessible, and it is 2020. What I learned, certainly, from deputations in this committee from the home care sector is we have a lot of work to do to make sure we get there. We have that responsibility provincially, under statute, to the AODA.

We also are signatory to the UN Convention on the Rights of Persons with Disabilities, which says very clearly that we are not allowed, as signatories to that global covenant, to do anything that would roll back the living conditions of persons with disabilities. The only allowable progress is helping ameliorate the living conditions, the equal-opportunity-seeking chances for people with disabilities.

So we have those two obligations, and what I think this amendment would do is to signal very clearly to people of Ontario that we take those obligations seriously. We're going to make sure that equity and equitable outcomes are written right into the DNA of the way home care works in this province.

The Chair (Mr. Kaleed Rasheed): MPP Harden. I'm now going to move to MPP Martin. Please, go ahead.

Mrs. Robin Martin: I recommend voting against this motion, because the preamble to the Connecting Care Act, 2019, already includes a commitment to equity and the promotion of equitable health outcomes, something this government believes in. The preamble guides interpretation and decision-making. Referencing home and community care specifically is not consistent with an act which is focused on an integrated health care system and bringing home and community care into the rest of the system.

The Ontario health team model is designed to drive key goals: Improving access, better efficiency and effectiveness, and improving equity. Ontario health teams would have flexibility in how they spend their budget to advance those goals tied to quality and outcome objectives.

The Chair (Mr. Kaleed Rasheed): Further debate? I recognize MPP Fraser.

Mr. John Fraser: Preambles are just that—they're before the legislation. They don't, in fact, do what the member says. They really don't have very much force in law. I just want to put that out there to make sure the member knows that. I've been through that a couple of times on a few bills.

I'll still be supporting this motion.

The Chair (Mr. Kaleed Rasheed): I recognize MPP Gélinas.

M^me^ France Gélinas: MPP Martin will remember that when we debated Bill 74, where this preamble comes from, people asked for the exact same thing. They asked to take it out of the preamble and put it in the bill. To put it in the bill means that it is in legislation. I remember the Alliance for Healthier Communities asked for it to be there, the Ontario Medical Association asked, ONA, RNAO—I'm going by memory, so I'll stop now. There was a long list of people who asked us. It's not enough to put it in the preamble. It has to be in the law.

We have an opportunity now to do good. We have an opportunity to make sure that we will be promoting equitable outcomes. This is what people expect of us. To say that because it is in the preamble, it will happen—it will not happen. Trust me, this is not how you make things happen. You make things happen by putting it in legislation. It is here now. Let's not waste this opportunity to do good for so many people who face barriers to equitable access all the time. We see, here in Toronto and—in my community, on Friday, hundreds of people came out for Black Lives Matter. The people who spoke at the microphone shared stories of racism in our health care system that brought me and hundreds of people to tears. We know that we are not reaching equitable outcomes. We know that we are not promoting equitable outcomes. We have a chance to change this. We have a chance to tell all those people who support Black Lives Matter, all of the people who support anti-racism against First Nations and Indigenous people, against LGBTQ people, "We heard you. We will do better. We've learned. We will put it in legislation." As legislators, this is what we can do to tell them that we care.

The Chair (Mr. Kaleed Rasheed): Further debate? Seeing none, we are now going to vote on the first motion moved by the NDP. A recorded vote has been requested.

Ayes

Armstrong, Fraser, Gélinas, Harden.

Nays

Coe, Kanapathi, Martin, McDonell, Mitas, Oosterhoff.

The Chair (Mr. Kaleed Rasheed): This motion is lost.

Now we are going to move to NDP motion number 2. MPP Armstrong.

Ms. Teresa J. Armstrong: I move that section 1 of schedule 1 to the bill be amended by adding the following subsection:

"(10) Section 1 of the act is amended by adding the following subsection:

"'Guide to interpretation, removing profit-making

"'(6) This act and the regulations shall be interpreted so as to advance the objective of removing profit-making from the delivery of health care services.'"

1050

The Chair (Mr. Kaleed Rasheed): Further debate?

Ms. Teresa J. Armstrong: This, I think, was one of the main themes that presenters brought forward of concerns. Our health care system, both home and community care, over the years, has been deteriorating into a privatization, for-profit system, and we know that for health outcomes, better quality of care under a not-for-profit system in health care is more successful.

There was presenter after presenter, as we know—and in particular the Ontario Health Coalition, and ONA, as well, talked about, "Do not expand services to private, for-profit hospitals. This would not be in the best interest of the public interest." Another one, CUPE and OCHU, also said, "Do not proceed with amendments to the Private Hospitals Act which would allow private hospitals to expand home and community care beds by excluding such beds from the definition of a 'private hospital.'" Many, many people were concerned that this bill leaves the privatization and the for-profit sector as an open playing field to come in and take over our community and home care services without public, transparent accountability.

We know that the Ontario health teams have that provision where they don't have access to public participation. We don't have access to their meetings. That isn't going to create confidence in a situation where people—right now is a turning point in health care; we know, we've talked about this—are on wait-lists for long-term care for years. People can't get into the hospital emergency rooms because of the wait times, because the services just aren't there. People are looking to rely on home and community care, and the way we can deliver it makes a huge difference to outcomes, to health quality.

It also makes a massive impact on workers who deliver that health care. We heard from PSWs that the working conditions were not optimal for delivering health care. They will go into someone's home and they won't know what to expect. They will be doing the best they can. They will be going from home to home without being reimbursed for travel time.

For-profit is exactly what it means: It's private health care service providers squeezing profits out of public dollars. We can do so much better and increase the kind of health care and quality care that people receive if we take all that public funding and put it into a not-for-profit health care system. That means that all that money gets put into front-line care. That means that we're going to have PSWs, who we're calling "health care heroes" during a pandemic, being paid properly. That means that we're going to have patients who are going to have continuity of care.

People will want to enter into a health care system, home and community care, and make a career out of it. Right now we know that people are leaving because of wages, because of time scheduling, and we know that—I'm going to say "consumers," because I want to change that language—consumers are telling us that PSWs are not showing up, that when they do come the visit is too short, and there are reasons behind that.

There is a high percentage of for-profit injection into our community and home care system. We heard a presenter talk about how it has increased. Originally it was 18% in private home and health care, and now it has increased exponentially, so we see the trend that is happening, the trajectory that we're on. We can change it. We can stop increasing privatization. We know it's not the right way forward when it comes to health care. When we look at our system that we have now in health care, where people don't have to pull out their credit card to pay for services, that is something that we can be proud of. I think when you look at home care and community care, it has been left out of the picture. There were discussions with presenters talking about copayments and how that is restrictive to accessing health care services in the home care sector and the community care sector.

I'll go into another story that I had. Again, I'm sure all MPPs around this table and the Legislature have heard from constituents during COVID-19 and what they've experienced in home care. We had a constituent who had a brain injury, and they went to the Dale Brain Injury centre in my riding for programming. It's community care programming, and they go out and they do all kinds of activities. It's a wonderful service. It's a wonderful facility. But during COVID-19, they were not in operation. Now, that health outcome for that person was not going to be good. Fortunately for them, they were able to pay out of pocket to bring home care into their home so that they wouldn't regress in their progress around their health care needs. But not everyone had those resources.

That is why it's important that we keep home and community care not-for-profit, that we don't have a different level of access. Somebody who can pay gets better service than the one who can't pay. That's not how we want to see Ontario move forward. That isn't equitable,

as we talked about in the last amendment. That also disadvantages people who are racialized, people who are minorities. We know that that's the case. They're telling us now that there is racism. There are inequitable pieces in the justice system. There are inequitable pieces in the health care system, in the education system.

We can do so much better. We have all the tools to make those changes in order to ensure that all dollars that are put into health care are put into front-line care, are put into quality care, are put into the consumer care, accessing that health care.

Again, I know we had a bit of a talk back and forth about how this is not about for-profit and not-for-profit, but really it is. When you're talking about spending money on health care, the primary goal should be not-for-profit. That money should be used, first and foremost, for front-line care. No one should be profiting on the backs of the most vulnerable people when they're seeking care.

I strongly believe that that should be something—I can tell you, listening to the government, there wasn't a will to do that. I'm not sure why. It makes sense. If there are best practices that can be followed in all areas of home and community care, we can certainly share those, but they need to be not-for-profit. We've seen the results of what the Canadian military report brought forward when it came to the care that was happening in for-profit facilities. It's heartbreaking, but we have to do something about it. It's not just a matter of empathizing, it's a matter of taking action when we know these things have happened.

We know that the for-profit sector—it doesn't have to be that way. It can be a not-for-profit sector. People believe that when money is going into the health care system, it's going to be used for them. It's not going to be used to pad the pockets of shareholders. It's not going to be used to invest and make money off of those public dollars. I'm not even sure a lot of citizens understand that there is a two-tiered system in our home and community care. If they really knew that, I think they'd be appalled that we are giving public money so that people can profit from health care for home and community care.

Again, most likely, I would expect the government to oppose this, but it is a discussion that needs to be had. It needs to stop. It needs to stop: Privatization can't continue under health care. It's a recipe—and we've seen it—for disaster. We can do so much better. We can show the people of Ontario that we are willing to turn this ship around if we're serious about making changes to home and community care. This is a huge step—a huge step—that can happen to show that community care and health care is just not going to be the status quo.

1100

The Chair (Mr. Kaleed Rasheed): MPP Oosterhoff, followed by MPP Harden.

Mr. Sam Oosterhoff: I recommend voting against this motion because the preamble to the Connecting Care Act, 2019, does include a commitment to publicly funded health care services, which is something our government believes in. Bill 175 enables the existing home and community care model, where home care services are provided through a contracted model with third-party service provider organizations delivering home care and community not-for-profits delivering community support services.

The government can already restrict specifically how health service providers deliver home and community care services through terms and conditions of funding, either by regulation or policy. We don't want to destabilize the provision of home care services to the hundreds of thousands of Ontarians who depend on them.

This legislation ensures that service delivery models can respond to evidence and can change over time as services and client needs and preferences evolve. This may include learning from the COVID-19 response. Any changes to the home care delivery model need to be carefully implemented to ensure there is no disruption to the continuity of client care.

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

Mr. Joel Harden: I think this is such an important discussion. I take my colleague MPP Oosterhoff's point about language about this being in the preamble, but as many MPPs have already said in this conversation at this committee—certainly, I've been privy to the same point being made in other committees on other pieces of legislation—the legislative impact of including words in the preamble does not have the force of writing a commitment like this into the body of the legislation. That's just a fact. So what I'm taking from my friend MPP Oosterhoff is that, while it's in the preamble and it's something his government supports, they are not prepared, at this point, anyway, to support writing it into the body of the legislation.

And what I think is clear is that while we can all, in Canada, agree that public medicare is part of being Canadian—it's something that is a badge of honour for us—for decades we have let that badge of honour slip because we've entertained the fallacy that we can reduce taxes on the very affluent and maintain our public services. Governments all over our country have maintained this fallacy, and the people who are paying the price are the consumers—in this particular bill, the consumers of home care services—and the people whose families surround those who use those consumer services, and people working on the front line. So it's inconsistent, I would submit, Chair, to say that we support the objective of non-profit delivery of services while purposefully, over decades, starving the system of necessary funding.

And to pick up on something that MPP Oosterhoff said, we did introduce the managed competition model under the Conservative government led by then-Premier Mike Harris, and we can see the impacts of it. I've talked to small service providers in the home care sector who deliver services privately, and they've confided that they got out of public funding and operating in large organizations specifically because they were very upset with the quality of services being delivered, because what large, for-profit organizations did from the time that managed competition model was introduced is compete on the costs

of labour, the most expensive part in home care. They consistently pushed out non-profit operators by underbidding, because governments of the day want to be able to minimize the impact of services on the balance sheets of the province.

What we did is compete on labour to the extent that last year, in 2019, one of the largest operators in the sector, CarePartners, and its CEO, Linda Knight, told PSWs in this province, Chair, that they are not entitled to sick days. Think about that. These are the very people right now we are calling "health care heroes," going into the front line, often without adequate supports, often without adequate protective equipment. And a major operator, gaining many public contracts to deliver home care services in this province, is telling workers for that organization that they are not allowed sick days—an organization, CarePartners, that gets $140 million worth of home care a year, at the same time telling its workers, "I'm sorry, I'm not prepared to pay you sick days." We should really think about that for a moment. For me, what it represents is the attitude of the for-profit industry descending into a public service.

Now, that's not to say that every for-profit operator in this province, particularly the small-scale ones I've had the privilege to talk to, are not doing as well as they can with the services that they provide to their clients. But the clients who can pay for those services are the ones with the means. I thought the fork in the road we took in this country after the Second World War, when a generation of Canadians made incredible sacrifices, was to create an equal-opportunity province and country where it didn't matter how much money you had in your bank account. If you needed health care services, if you needed attendant care services so you had an equal opportunity to succeed and to thrive, we would make sure you had that opportunity. That's what I thought my grandparents taught me.

While I take my friend MPP Oosterhoff's point that his government supports non-profit care, I would challenge him and I would challenge the government: If that is what you believe, pass this amendment, write it into the bill, and say very clearly in this sector that the era of starving this sector of funding, of allowing large, for-profit operators into this sector who will systematically and have systematically shortchanged front-line care workers and consumers of these services is not the model we want to follow.

I want to end by remembering one particular anecdote, Chair, from the deputations we heard. Mr. Stuart Cottrelle, the president of Bayshore HealthCare Ltd., said, when I was asking him what can we learn from the use of administration costs in this sector and what can we learn of the need to make sure that the people of Ontario are getting value for money, what transparency can we offer because of how common it is for people who are doing care work, PSWs in this sector, to be working tiny shifts, not paid for travel between shifts, paid very low—what can we do to do better? Mr. Cottrelle said in his answer to my question—and I have no evidence by which I can back up the veracity of these claims; I await it coming from Bayshore. But what he said was that actually the average amounts of hours worked by people from his company is 37 hours a week, which is actually probably too much and we should trim it back because it gets into overtime.

After I read the transcript of our hearings, I sat and thought. At that moment, I was very focused on the issue around transparency, but I also thought about what that statement actually meant. What Mr. Cottrelle was telling us, as a major operator in the sector, is that it's not appropriate for us to be looking towards full-time weekly hours for the care sector. I don't think there's an MPP on this committee who would say that there isn't a huge need for home care that would allow people to work full-time shifts on a salary basis where their travel was properly compensated, where they had the gear they needed to do the job well. I was stunned, to be honest with you, Chair, by that admission.

I think what this amendment does is call us out on our own principles. We are saying, as Canadians, we love public health care. It's part of our legacy. It's a part of something we're proud of. If that's the case, take it out of the preamble, my colleagues who are in government. Show us with action, not words, that you support non-profit provision of services in this sector and render judgment on the for-profit operators in this industry, the large ones who have been chewing up PSWs and spitting them out, who have not been providing the quality services that consumers of home care deserve. Take a stand today. If you've got a memo to vote one way on this amendment, show us your courage by voting for something that I think will salute the best values of this province and this country. Show us that you support non-profit delivery of home care services.

The Chair (Mr. Kaleed Rasheed): Further debate? Madame Gélinas.

M^me^ France Gélinas: The issue of privatization was raised by most—I think 35 of the 42 presenters who came last week talked about opposition to privatization, to the point where it became an irritant for MPP Mitas and MPP Oosterhoff and MPP Martin, when they went on and asked yes-or-no questions: "Where in the bill do you see privatization? Yes or no, is privatization in the bill?" That tells me that this is not something they are proud of, this is not something that they want to promote. They do not want to promote privatization, but it is in the bill. Contracting out of services is unrestricted in the bill. Enabling the new care setting, called the "residential congregate care model," which is not legally defined and has no oversight—it could also all be privatized and, although the bill does say that it will be not-for-profit, there is nothing in the bill that prevents not-for-profits from contracting out services. This is what everybody is talking about. At the end of the day, it is not the management who comes to your house to give you a bath; it is a PSW who works for a for-profit company.

1110

You will remember when SEIU Healthcare brought us Jodi Verburg and Gloria Turney. Gloria told us that she had been working in home care for the last eight years as a PSW. All she has as her contract is 10 hours of guaranteed of work. That's it, that's all. She had no paid

sick leave, she has no hope of a pension and she went on to say that the company takes everything and leaves nothing for the PSW.

Jodi Verburg has 10 years as a PSW working for home care. She basically said the same thing: No paid sick leave; no hope of a pension. When I asked her, "How much do you make after working for 10 years for the same company in home care?", she was quite open and told us that she was making $17 an hour.

They all oppose privatization, because they know what it means. It means that you don't have enough time to provide the care that the person needs and you don't have good jobs. I'm on record many times: How do you solve the problems? You make PSW jobs good jobs. Pay them a decent wage. Pay them a little bit of benefits, a pension. Give them full-time hours. They said it even better. They said the job is required to change, to go from a job to a career. Make PSW a career and you will have solved many of the problems, but none of that can happen if we continue with privatization because, as MPP Harden just said, privatization means the contract goes to the lowest bidder.

In home care, you don't build anything. You provide a service. A service is provided by people who need to be paid. So how do you win contracts? You win contracts by being the lowest bidder. How do you get to be the lowest bidder? By not paying your employees, most of them being PSWs. The whole thing has to change.

I know that the PC members are not proud of privatization. They try to steer away from it. They get very angry and aggressive when people tell them, "Hey, it's in the bill. We don't like it. We want it changed." You have an opportunity to do this. You have an opportunity to say, "As legislators, our way of putting action behind our words is to put in legislation that they will not be for-profit."

How do you transition? Have no worries. You guys have all the regulations and the policy-making. You will make it happen at a pace that makes sense to the patients who receive the care and to the businesses that are within the sector. But you have to take a stand. You have to say, "As a legislator, my one action to show that I oppose privatization is to put it in legislation," and this is what this will do.

The contracting-out model: To hear MPP Oosterhoff say, "We can restrict privatizations through regulations and policies"—I'm sorry. If it's not in the bill, MPP Oosterhoff, it's not going to happen. Our system is already 65% of the contracts in home care are to for-profit delivery. Just leaving it to regulations and policy is not going to make any difference. We are legislators. We have an opportunity to put it in legislation. Let's not let that opportunity go by.

When you see your grandparents, when you see your parents and the poor home care that they will receive, it will be on you to say, "I had an opportunity to change this. I had an opportunity to make sure that we turned the corner toward a home care system that meets the needs of the people I love and the people I care about." That opportunity is here this morning, by voting for this and removing the for-profit in this bill.

The Chair (Mr. Kaleed Rasheed): Further debate? Seeing none, we are ready to vote.

Ayes

Armstrong, Gélinas, Harden.

Nays

Coe, Kanapathi, Martin, McDonell, Mitas, Oosterhoff.

The Chair (Mr. Kaleed Rasheed): This motion is lost.

Ms. Teresa J. Armstrong: That was recorded, as well?

The Chair (Mr. Kaleed Rasheed): Yes, it was recorded. Next time, I'll make sure I say that it's recorded. But we already passed that one. Thank you.

NDP motion number 3: MPP Harden, please go ahead.

Mr. Joel Harden: I move that section 1 of schedule 1 to the bill be amended by adding the following subsection:

"(11) Section 1 of the act is amended by adding the following subsection:

"'Guide to interpretation, recognizing role of Indigenous peoples

"'(7) This act and the regulations shall be interpreted so as to advance the objective of recognizing the role of Indigenous peoples in the planning, design, delivery and evaluation of health services in their communities.'"

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

Mr. Joel Harden: What I will just acknowledge for the benefit of the committee is that yesterday was National Indigenous Peoples Day in our country, in our province, and many of us had the occasion to reflect on what that means for all of us, as treaty people, in doing our very best to improve, frankly, on the legacy of this country. There are many moments—I'm sure I'm not the only one on this committee—where it has been very difficult to learn about what generations of legislators have done to rebuke and repudiate the friendship that Indigenous peoples have shown us. My ancestors here date back for many generations, and they would never have been able to make it in this often godforsaken, cold climate without, at that time, central air, transportation networks that were immediate, refrigeration for food. Generations of Canadians absolutely benefited from the friendship of the Indigenous peoples of this land. Unfortunately, for decades, the history of our province and of our country is that we returned that generosity with extreme colonial prejudice. I think it behooves all of us—and I know I've heard every single person who is part of this committee, at one moment or another during this Parliament, say that they want to turn the page.

One of the moments—I'm sure members of this committee remember it—that was shocking to me, as we listened to deputations, was when we heard a story about an Indigenous senior who had been in home care leaving her apartment and freezing to death outside. It really makes you wonder where we live. I often talk to our children in our home about what the objectives are for our

society, why Dad does the work he does, why I'm proud to work with the people I work with—and that includes not just my own caucus, but all caucuses in the Legislature—the idea of creating a better society. But sometimes when I hear stories like that, it really impresses upon me the fact that there are many Ontarios, there are many Canadas, and the one in which Indigenous peoples live hasn't ever, in many meaningful ways, progressed beyond the colonial relationship where people are told and rationed about services they get.

1120

If I've learned anything as a treaty person, it has been that we do our best in walking the real path of reconciliation if we see our Indigenous friends in the driver's seat of the change their communities want, their communities need. My friend Sol Mamakwa, the NDP member for Kiiwetinoong, often says that the system isn't broken, it was built this way. It's working precisely as it was intended to by people who carried awful prejudice, hard-wired into the laws of this land decades ago. If we want to actually rewire those laws so they're affirming and moving in the good way, we have to make sure that it's actually Indigenous peoples who are in the driver's seat.

So I really welcomed the deputations from the Indigenous friendship centres and others who impressed upon us the need that they have to be the ones steering the change, and that's how I see this amendment. Offering a real opportunity for us as a committee, in voting for this, to make sure this bill, if it in fact is passed, is passed with those priorities in mind.

The Chair (Mr. Kaleed Rasheed): MPP John Fraser, followed by MPP Lorne Coe.

Mr. John Fraser: I'd like to thank my colleagues for bringing this amendment forward. I'll be supporting this amendment. We heard in testimony how important the role of Indigenous people, and the nation-to-nation relationship that we have, is in the delivery of probably the most important service: health care. I think the inclusion of this in the act is a recognition of that importance, and I would encourage the members of the government to accept this amendment.

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

Mr. Lorne Coe: Thank you, Chair. Through you, I recommend voting against this motion because improving the health of First Nations, Inuit, Métis and urban Indigenous people is important.

The preamble to the Connecting Care Act, 2019, already includes a recognition of the role of Indigenous peoples in the planning, design, delivery and evaluation of health services in their communities, something our government believes in. The Connecting Care Act, 2019, also requires Ontario Health to engage with Indigenous health-planning entities to support the planning and delivery of health services in their communities.

With the proposed legislative framework, we have an opportunity to work with First Nations, Métis, Inuit and urban Indigenous communities to co-develop services that meet the unique needs of these communities. The Ministry of Health and Ontario Health will continue working with First Nations, Métis, Inuit and urban Indigenous community partners to ensure the needs of all populations are ensured equitably, their preferred approaches to care are respected, and patients, families and communities are engaged in their care journey.

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

M^me^ France Gélinas: I just want to give an example. You've all said that the Connecting Care Act, in its preamble, talks about the need to connect and the need to consult with Indigenous people, yet when the Chiefs of Ontario came, both Carmen Jones, their executive director, and Chief Donald Maracle, chief for 27 years, were asked, "Were you consulted before Bill 175 came out?" They said no. Same thing when the Ontario Federation of Indigenous Friendship Centres, their vice-president Ms. Jennifer Dockstader came and was asked by my colleague, "Were you consulted before Bill 175 came out?" She said no.

Can you see that putting good intentions in a preamble of a bill that is your bill—the Connecting Care Act is your bill. You've put this in the preamble of the bill, yet on something as important as home and community care, those two organizations were not contacted at all. They did not have a chance to have a say. They did not have a chance to be consulted. None of that happened. That's why you have to put it in law. Once it is in law, you give them rights.

Both of them talk about wanting this in the bill. They want the interpretation, recognition of the role of Indigenous people to be in the bill. They came; they testified. They showed us that having it in the preamble doesn't work, because here you are making changes that will affect both on-reserve and off-reserve Indigenous people, and they were not consulted. They were not talked to at all. The bill came and it was a surprise to all.

To me, you can see that it needs to be in. Reconciliation means that we need to listen to them. Reconciliation means nothing about them without them. They say it way better than I do. She said, "Nothing about us without us." I'm not Indigenous, but Jennifer Dockstader is, and she is the one who used that quote. Yet, here we go again: A new piece of legislation that is apparently part of the Connecting Care Act, an act that has in its preamble that you will consult with First Nations on anything about them. This bill is about them, because they, right now, have really poor access to home and community care, and yet you never phoned them, emailed them, talked to them, consulted them, heard from them.

It needs to go in the bill. Let's do that one little step as legislators to show that we care about our Indigenous partners, that we care about our Indigenous friends. They came and talked to us and asked us to do that. It's the least we can do, to listen to them and put it in legislation, so that next time there is legislation or changes or new regulations or new policies about home and community care that will affect them, we will have a law that says that we have to connect with them. Nothing about them without them. This is what this motion tries to do.

The Chair (Mr. Kaleed Rasheed): Further debate? MPP Armstrong.

Ms. Teresa J. Armstrong: I think this is a glaring example of how things can fall through the cracks when things are not in legislation and are a requirement for us to act upon. The comments from the Ontario friendship centres—they said, "Engage urban Indigenous communities and organizations as partners in developing, implementing and evaluating any home and community care legislation, regulations, policies and programs."

For them to have to come to the committee and actually say, "You need to include us" when the rationale that the government gave was, "Don't worry. We'll include you. We have it in our preamble under Bill 74, the Connecting Care Act, so that ensures that we will consult you. That ensures that we will hear you and engage you"—but it didn't in this case. It didn't include it in Bill 74. So where are the assurances in this preamble that the government is going to take action on what they said they're going to do?

Many people have said that a lot of words don't mean things are going to change. Putting them on paper in a preamble, in this example, had no effect on change. Let's support this legislation so that people actually believe the words that you're saying when it comes to Indigenous peoples and wanting reconciliation and wanting their input and wanting their engagement and understanding what their traditions and cultures are, so they do have appropriate care for home and community care.

This amendment is just a logical amendment. This amendment is prescribing what the government is saying, that we're going to do this and we want to do this. Then solidify it. Enshrine it so that you are held accountable to do it, not just in a preamble—watered-down words that don't mean you take action on these things.

I hope that we're not going to hear about the preamble. It has failed. In this case, your intent in this preamble failed. You failed the Indigenous voices in Bill 74—terrible. I was shocked, I think when I asked that question, they said neither one of those organizations was consulted. I was just shocked. And now we're going to discuss whether or not it's in the preamble under a different bill that we had the intent to do that? You failed on your intent, so make it right, correct it and vote for this motion, and enshrine it so that we don't leave people behind who need their voices heard, like the Indigenous communities.

The Chair (Mr. Kaleed Rasheed): Further debate? Seeing none, we are now going to vote on this motion.

Ayes

Armstrong, Fraser, Gélinas, Harden.

Nays

Coe, Kanapathi, Martin, McDonell, Mitas, Oosterhoff.

The Chair (Mr. Kaleed Rasheed): This motion is lost.

We are now going to move to, I believe, NDP motion number 4. Madame Gélinas, please go ahead.

M^me^ France Gélinas: I move that section 1 of schedule 1 to the bill be amended by adding the following subsection:

"(12) Section 1 of the act is amended by adding the following subsection:

"'Guide to interpretation, recognizing role of francophones

"'(8) This act and the regulations shall be interpreted so as to advance the objective of recognizing the role of francophones in the planning, design, delivery and evaluation of health services in their communities.'"

The Chair (Mr. Kaleed Rasheed): Further debate? MPP Gélinas, please go ahead.

M^me^ France Gélinas: Je commence par dire que c'est une vraie honte que les—

The Chair (Mr. Kaleed Rasheed): My apologies. If you would like to speak in French, then we need to get an interpreter for this one, and we have to recess until they come down.

M^me^ France Gélinas: Yes, please.

The Chair (Mr. Kaleed Rasheed): Okay, so since there is a request for the interpreter, we have to take a brief recess for 10 minutes, please. Thank you.

The committee recessed from 1133 to 1146.

The Chair (Mr. Kaleed Rasheed): Thank you, everyone, and welcome back. Thank you for your patience during this time. Now, members, we do have the interpretation individual here, so we have the interpreter in the room. As you know, on Zoom, there is an option, if you would like—I think it's called—

Interjection.

The Chair (Mr. Kaleed Rasheed): There's an interpretation option, so you can select the English or French option from there.

Before we went on break, I believe Madame Gélinas was debating on the motion. Please go ahead.

M^me^ France Gélinas: Le changement à la loi veut que les règlements soient interprétés pour faire avancer l'objectif de reconnaître le rôle que les francophones jouent, autant dans la mise en oeuvre que la livraison ou l'évaluation des services dans la communauté.

Je vais vous dire, monsieur le Président, que j'étais vraiment désolée. C'est quasiment une honte de voir qu'il n'y a aucun organisme francophone qui a pu se libérer à temps pour participer aux audiences publiques. Je ne les blâme pas. Je sais que c'est la COVID. Ça fait que bien des gens sont bien occupés.

Mais en même temps, avec les rapports du commissaire aux services en français, M. Boileau, on sait très bien que les soins à domicile, les soins communautaires—ces deux aspects du système de soins de santé ne servent pas bien la population francophone. M. Boileau, dans ses rapports antérieurs, parle spécifiquement d'exemples où des familles francophones qui avaient demandé des services en français ne les ont pas reçus.

Je peux donner un exemple dans mon comté de Nickel Belt. J'ai plusieurs familles francophones. On est 40 %—38 % maintenant de francophones dans le Nickel Belt. Au fur et à mesure que les gens vieillissent, surtout les femmes

de 90 ans et plus—beaucoup d'entre elles n'ont jamais appris à parler l'anglais. Dans le temps, leurs maris travaillaient, et eux, ils ont appris à parler l'anglais. Mais elles, elles sont demeurées à la maison. Elles ont élevé leurs six, sept, 12, ou 14 enfants, et elles n'ont jamais appris à parler l'anglais. Ça parle français dans la maison chez eux.

Maintenant qu'elles ont besoin d'aide, c'est important que cette aide-là soit en français. Je peux vous donner l'exemple où la travailleuse qui s'en venait—c'était M^me^ Leblanc, la préposée aux soins, mais lorsque M^me^ Leblanc s'est présentée, oui, elle avait un nom français, mais elle ne parlait pas un mot de français puis n'était pas capable de répondre aux besoins.

Le problème, c'est que la Loi sur les services en français ne s'applique pas, donc les gens n'ont pas un droit aux services en français dans leur maison. Ce qui finit par arriver, c'est que les gens francophones disent : « Non, je ne veux pas qu'une anglophone rentre dans ma maison. Je ne sais pas ce qu'elle dit. Je ne comprends pas ce qu'elle fait. Je n'en veux pas. » Mais elles ont quand même besoin d'aide. Elles ont quand même besoin d'aide pour prendre leur bain. Passer une semaine, deux semaines, trois semaines, un mois sans un bain, ce n'est pas « cool » avec personne, ça. Il faut que ça change.

`La raison pourquoi on a mis cette motion au projet de loi 175, c'est vraiment pour s'assurer que la Loi sur les services en français va s'appliquer non seulement à ceux qui ont le contrat, mais à tous les sous-contrats—parce que c'est comme ça que notre service de soins à domicile fonctionne—et que la Loi sur les services en français va continuer de s'appliquer. Comme ça, si vous êtes une personne francophone qui recevait des soins à domicile, vous allez pouvoir demander que les personnes que l'on envoie chez vous soient des personnes avec lesquelles vous êtes capables de dialoguer, avec lesquelles vous êtes capables de parler.

Donc, pour que ça arrive, il faut que la planification soit faite en français, parce qu'une fois que la personne se qualifie pour les soins—habituellement, le contrat est donné pour une région géographique. Dans cette région-là, on va dire que c'est Bayshore qui a le contrat, il faut que—dans cette région où il y a des francophones—la planification ait été faite pour qu'il y ait au moins une des agences qui ont le contrat qui soit capable d'offrir des services en français.

Même chose dans le design : souvent, plutôt que de demander à tous ceux qui ont des contrats d'être capables d'offrir des services en français, c'est plus facile d'avoir un organisme francophone qui va desservir les francophones partout. Comme ça, tu peux garantir le service en français.

Même chose du côté de la livraison : oui, il y a des changements culturels. Oui, les francophones, comme tous les autres Ontariens et Ontariennes, ont des tendances culturelles qui sont propres à eux. Je peux vous dire que ce mercredi sera la Saint-Jean-Baptiste. Peu importe où tu es en Ontario, si tu es francophone, mercredi va être une journée de fête. Je peux vous garantir que les francophones vont porter le vert et blanc, qu'il va y avoir des repas spéciaux. Ils vont se faire bien des tartes au sucre, puis ils vont se faire bien d'autres recettes typiquement franco-ontariennes, parce que mercredi est la Saint-Jean-Baptiste. C'est une journée que l'on fête.

Bien, ça veut dire que pour les gens qui reçoivent des soins à domicile, du côté francophone, ils vont s'attendre à ce que les travailleurs respectent ça. Ça fait partie de la culture de la communauté francophone, et bien entendu, l'évaluation, parce que c'est avec l'évaluation qu'on peut vérifier s'il y a des barrières à l'accès, si l'accès est juste et équitable et si les services qui sont rendus sont de bonne qualité. S'il y a un endroit où c'est important, c'est dans les soins à domicile et les soins communautaires, parce que quand tu es à domicile—ce n'est pas comme dans un hôpital où il y a peut-être d'autres infirmières autour qui peuvent vous aider. Dans les soins à domicile, c'est une travailleuse—la plupart sont des femmes—avec un patient ou une patiente, et les deux doivent être capables de communiquer.

Donc, c'est ce que l'on demande comme modification à la loi. Je sais que ça n'a pas été demandé pendant les audiences publiques, tout simplement parce que la communauté francophone n'a pas été capable de se libérer, en temps de COVID, pour être disponible pour venir nous en parler. Mais je peux vous assurer que si vous regardez le livre blanc de l'AFO, l'association francophone de l'Ontario, si vous regardez les directives qu'elle a données et si vous regardez les cinq nouvelles priorités qui sont sorties de leur grand exercice de priorités à la grandeur de la province, vous allez voir que cette demande est là.

Je vous remercie, monsieur le Président.

The Chair (Mr. Kaleed Rasheed): Thank you very much, Madame Gélinas. Merci beaucoup.

We are now going to further debate: MPP Harden, followed by MPP Armstrong.

M. Joel Harden: C'est vraiment un honneur de donner, un peu, des mots en français, parce que la langue française est importante pour notre région ici à l'est de l'Ontario, la ville d'Ottawa et la région sud-est. Il y a un réseau ici qui s'appelle le Réseau des services de santé en français de l'Est de l'Ontario, y compris 260 000 personnes ici dans l'est de l'Ontario—c'est presque la moitié des personnes francophones partout dans la province de l'Ontario. Il y a plus de 600 000 personnes ici en Ontario qui parlent le français. Donc, c'est 5 % de notre population, pour les Ontariens et les Ontariennes.

Il faut que, avec ces détails-là—on a un patrimoine, comme mon amie la députée de Nickel Belt disait. On a un patrimoine franco-ontarien. On a une obligation de créer des services qui sont accessibles pour tous et toutes ici qui parlent la langue française. Et, désolé, on a eu l'expérience ici dans l'est de l'Ontario—on a beaucoup de travail, beaucoup de travail à faire, particulièrement pour les personnes qui sont vulnérables, les personnes handicapées, les personnes âgées, qui ont des besoins énormes. Pour eux, les services de santé à la maison sont absolument importants pour corriger leurs problèmes. Je pense beaucoup aux aînés qui vivent ici, particulièrement des femmes qui sont absolument vulnérables s'il n'y a pas de services en français pour elles.

Donc, notre amendement dit que c'est important. C'est une pièce de notre histoire. C'est une opportunité pour nous de construire un Ontario avec des services de santé à lamaison qui sont accessibles pour les francophones. Je suis heureux de donner mon appui à cet amendement aujourd'hui, et je souhaite que tous mes amis de ce comité vont faire la même chose. Merci.

The Chair (Mr. Kaleed Rasheed): Merci beaucoup. Further debate? MPP Armstrong.

Ms. Teresa J. Armstrong: I certainly am not fluent in French. I just want to add my thoughts to this amendment and, again, how important it is that we look at culturally appropriate, equitable services when it comes to home care and community care. This is a very important motion.

Like many populations, we have different groups. The francophone community is very populated, as expressed by MPP Harden and MPP Gélinas. This is just something that we want to make sure isn't left out, isn't left behind. It's sometimes—like many things, many minority issues, many equitability issues—an afterthought when we're talking about legislation and services in this province, so I echo the comments that have been made.

Speaking from a community in London, we do have a very strong, robust, vibrant francophone community. This would be something that would be very much welcomed and needed. So with that, Chair, I thank you for allowing me the time for comments. Thank you.

The Chair (Mr. Kaleed Rasheed): Further debate? MPP Jim McDonell. You need to unmute yourself, please—perfect.

And I do recognize MPP Coe and MPP Fraser. MPP Coe, you will follow after MPP McDonell, and then MPP Fraser will follow after MPP Coe.

Just to let you know, MPP McDonell—my apologies—you have one minute before we go on a recess.

Mr. Jim McDonell: I recommend voting against this motion, because we acknowledge the importance of continued engagement with Ontario's francophone communities to improve home and community care. The preamble to the Connecting Care Act, 2019, already acknowledges that the public health system should recognize the diversity within all of Ontario's communities and respect the requirements of the French Language Services Act in the planning, design, delivery and evaluation of the health care services for Ontario's French-speaking communities.

The Connecting Care Act, 2019, requires Ontario Health, Ontario health teams and health service providers to establish mechanisms for engaging with patients, families, caregivers, health sector employees and others as part of their operational planning process. In fulfilling its community engagement duties, Ontario Health is already required to engage with French-language health planning entities that the minister designates by regulation to design services that directly meet the needs of the francophone communities.

The Chair (Mr. Kaleed Rasheed): It's 12 noon, so we are going to recess. We will reconvene at 1 p.m. Thank you very much.

The committee recessed from 1200 to 1300.

The Chair (Mr. Kaleed Rasheed): Welcome back, everyone. We are here to do clause-by-clause for Bill 175, An Act to amend and repeal various Acts respecting home care and community services.

Just before we went on break, MPP Fraser, you were next in the queue to speak, so the floor is all yours. We are discussing NDP motion number 4.

M. John Fraser: Je remercie mes collègues d'avoir proposé cet amendement. J'appuierai cette modification. Le rôle des Franco-Ontariens dans la planification et la conception des services de santé dans leur communauté doit être reconnu dans cette loi. Un préambule n'est pas l'endroit idéal ou suffisant. J'encourage mes collègues du côté du gouvernement d'appuyer cette modification.

Chair, I think this amendment is in keeping with a number of amendments that have come before. It's clearly underscoring the need to establish certain principles inside legislation. A preamble does not have the same weight as actually putting measures like this and the ones that have come before inside legislation.

I think it would be the best approach for government to accept this amendment, because we do have a law in Ontario, the French Language Services Act, which protects the linguistic rights of Franco-Ontarians, and we need to respect that. We need to reflect that in the legislation that we put forward—not just in health care, but in other fields, as well.

So I really encourage our colleagues on the government side to take a look at this amendment and support it when we come to a vote.

The Chair (Mr. Kaleed Rasheed): Further debate? Seeing none, we are now going to move to the voting.

Ayes

Armstrong, Fraser, Gélinas, Harden.

Nays

Coe, Kanapathi, Martin, McDonell, Mitas, Oosterhoff.

The Chair (Mr. Kaleed Rasheed): The motion is lost.

We are now going to move to NDP motion number 5. MPP Armstrong.

Ms. Teresa J. Armstrong: I move that section 1 of schedule 1 to the bill be amended by adding the following subsection:

"(13) Section 1 of the act is amended by adding the following subsection:

"'Guide to interpretation, building and developing relationships

"'(9) This act and the regulations shall be interpreted so as to advance the objective of building and further developing relationships with Indigenous communities through meaningful consultation and engagement.'"

The Chair (Mr. Kaleed Rasheed): Further debate? MPP Armstrong.

Ms. Teresa J. Armstrong: We briefly touched on this earlier, but this is specifically directing the government or

whoever is the government at the time to make sure that they are actually engaging and advancing the objectives and building those relationships with the Indigenous communities. It's a fact that it has been overlooked. We heard from the two presenters last week, whom I was available to listen to, and they were clear about not being consulted. That, in a lot of ways, is not very good, quite frankly.

The government says that many other things are in the preamble, and there's the intent to do it, and, "Don't worry. Trust us. It's going to happen," but there are many times where there have been examples—and this is one such time—where the Ontario Federation of Indigenous Friendship Centres was not consulted on this bill. The Chiefs of Ontario were not consulted on this bill.

I can speak to the friendship centres. We have the N'Amerind Friendship Centre in London, and it does wonderful work. It's such a part of educating people in London, and the initiatives that they take to engage us. We should, as legislators, be taking those initiatives, to include them, to engage them, to understand and interpret what they need when it comes to community and home care.

Their needs are unique, in a good way. They need to make sure that the people who receive home and community care who are Indigenous people are respected and are treated with dignity when it comes to home care. Their culture is different, so if we don't acknowledge that in legislation and have those obligations where you have to act upon them, we're not treating them in a way that they're asking to be treated. I think it's not a large undertaking to put this in legislation to assure Indigenous populations that we will, and we are obligated, and we won't forget and it won't be an oversight the next time around when we have legislation.

There should be, quite frankly, no next time around. This shouldn't be a mistake that should be happening over and over again when it comes to pieces of legislation. All governments can learn from this exercise, that not including these things in legislation, where we are obligated, where we are forced—we're supposed to do our job, do our due diligence and consult the Indigenous communities. They have such a perspective, really, to bring to the table, and I think we can learn from them on a lot of things. They have such knowledge.

Our MPP Sol Mamakwa teaches us things every day that we should be aware of and should have known, and we don't. An opportunity like this just shows members like MPP Mamakwa that we are here to honour and listen to their teachings, and we are willing to openly do it, not just with words, but with actual commitment. We've heard that a lot in the last recent couple of weeks that people want action and they want solid change. I think putting this, again, in legislation and not deferring to a preamble strengthens that engagement piece and the development of a relationship piece.

I'm not sure what the harm would be in putting it in legislation, because I can see only a benefit to both parties for this to be enshrined, so I urge the government to seriously consider taking their preamble and solidifying it in a piece of legislation.

The Chair (Mr. Kaleed Rasheed): Further debate? Madame Gélinas.

M^me^ France Gélinas: I want to bring us back to the deputations that we heard from the Ontario Federation of Indigenous Friendship Centres on Wednesday morning. Ms. Jennifer Dockstader, the vice-president, was there, and she talked to us about the 375,395 First Nations people—that's 85% of the self-identified First Nations people in Ontario—who live off-reserve. When she was asked by MPP Martin if she had been briefed, she said yes; she agreed that she had been briefed after the fact with a non-disclosure agreement. For a First Nation, this does not in any way, shape or form resemble consultation.

We have a duty to develop better relationships with our First Nations people. We have a responsibility to develop better relationships with the First Nations, Métis and Inuit people of Ontario. This is what this amendment to the bill talks to.

1310

Home care, community care, is very, very personal. You're talking about a stranger, a care provider, coming into your home, coming into your safe place. Often, for a First Nations person, there are very few safe places; home is one of them. It would have been very important to talk to them—"This is what we are putting into the bill"—further developing a relationship. Don't wait until the bill is drafted and then say, "Well, you've been briefed." "Yes, and the Toronto Star briefed us, because they managed to have a copy of the bill before MPPs got a copy of the bill."

We have to do better. There has to be an ongoing effort to develop those relationships with First Nations, with Métis, with Inuit ahead of time. This is what we want put in legislation. If we are serious about reconciliation, if we are serious about the requests that have been made both by the Chiefs of Ontario and by the Ontario Federation of Indigenous Friendship Centres, then we will put it upon ourselves, as legislators, to make sure that developing relationships is in the bill, so that we hold ourselves responsible for doing that—not for offering a briefing once the bill is already drafted.

The Chair (Mr. Kaleed Rasheed): Further debate? MPP Mitas.

Miss Christina Maria Mitas: I recommend voting against this motion, because improving the health of First Nations, Inuit, Métis and urban Indigenous people is important, but the preamble to the Connecting Care Act, 2019, already includes a recognition of the role of Indigenous peoples in the planning, design, delivery and evaluation of health services in their communities—something our government firmly believes in. The Connecting Care Act, 2019, already requires Ontario Health to engage with Indigenous health-planning entities that the minister specifies in regulation in a manner that recognizes the role of Indigenous peoples in the planning and delivery of health services in their communities.

With the proposed legislative framework, we have an opportunity to work with First Nations, Métis, Inuit and urban Indigenous communities to co-design services that meet the unique needs of these communities.

The ministry and Ontario Health will continue working with First Nations, Métis, Inuit and urban Indigenous community partners to ensure that the needs of all populations are served equitably, and that preferred approaches to care are respected, and that patients, families and communities are engaged in their care journey.

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

Mr. Joel Harden: I want to speak to supporting this amendment. As I mentioned earlier, I think all the time, in the work that we do, about our treaty responsibilities. While I acknowledge the point that MPP Mitas and other colleagues have made in previous amendment debates, I think it's disappointing that we're satisfied with relegating these integral commitments that we're supposed to make as treaty people to the preamble of the legislation, because it doesn't offer the force that we require.

I want to, in illustrating this point, illustrate an Ottawa story that will make the case for supporting this amendment. A very good friend of mine here in our city is Candyrose Freeman, an Indigenous woman who has taught me a lot with respect to her own struggles with public services, one of which was around home care for her ailing mother. I had the honour to attend the celebration of life for her mom two years ago at the Wabano centre, which is one of the amazing Indigenous friendship centres here in our city, on Montreal Road, in the east end. It was disappointing to hear Candyrose and many of her friends reflect on the struggles they had for appropriate care, until they were able to get what they were able to get at the Wabano centre. I just want to, on the record, give my thanks for the work that the Wabano centre does for Indigenous peoples in our community—not only for Indigenous peoples, but as a place of reconciliation for all treaty peoples.

I think if we require our friends in government to build these relationships in legislation, what you will be saying is that Indigenous peoples and the treaty responsibilities we have as a province are more important than window-dressing to legislation; they are woven into the act. As you have heard time and again, and you will continue to hear this afternoon, we want you to take this act off the order paper and we want you to give it a substantial rethink. That is the advice we got from almost all deputations, and our Indigenous friends were among those asking you to do that.

So if you are not going to listen to that, please, at least listen to the notion that this particular amendment needs to be put into the body of your bill. At least do that, because if you don't, you're going to be sending a message to our Indigenous friends that, as has happened through our province's history, window-dressing and rhetorical statements are going to be what we do, instead of making clear legislated commitments.

The Chair (Mr. Kaleed Rasheed): MPP Harden. I recognize MPP Fraser. Please go ahead.

Mr. John Fraser: Again, I'd like to thank my colleagues for bringing this amendment forward.

Here's the thing: We keep talking about a preamble and how this is in the preamble. Well, actually, what's in the preamble needs to be reflected in the bill, and it's not. That's the problem here. On things like our nation-to-nation relationship with our Indigenous partners and the rights of francophones, it baffles me as to why you think it's not good to put that in legislation, why you can't reflect that preamble in the legislation and give it the kind of force and strength that it deserves. I urge my colleagues on the government side to reflect on this and support this amendment.

The Chair (Mr. Kaleed Rasheed): Further debate? Seeing none, we are now going to vote.

Ayes

Armstrong, Fraser, Gélinas, Harden.

Nays

Coe, Kanapathi, Martin, McDonell, Mitas, Oosterhoff.

The Chair (Mr. Kaleed Rasheed): This motion is lost. Shall schedule 1, section 1 carry?

Ayes

Coe, Kanapathi, Martin, McDonell, Mitas, Oosterhoff.

Nays

Armstrong, Fraser, Gélinas, Harden.

The Chair (Mr. Kaleed Rasheed): Schedule 1, section 1 carries.

Now we are going to move to independent Liberal member motion number 6. MPP Fraser, please go ahead.

Mr. John Fraser: I move that section 1.1 be added to schedule 1 to the bill:

"1.1 The act is amended by adding the following part:

"'Part I.1

"'Bill of Rights

"'Bill of Rights

"'2.1(1) A health service provider shall ensure that the following rights of persons receiving care from the health service provider are fully respected and promoted:

"'1. A person receiving a health service has the right to be dealt with by the health service provider in a courteous and respectful manner and to be free from mental, physical and financial abuse by the health service provider.

"'2. A person receiving a health service has the right to be dealt with by the health service provider in a manner that respects the person's dignity and privacy, that promotes the person's autonomy and that recognizes the person as a member of their own care team.

1320

"'3. A person receiving a health service has the right to be dealt with by the health service provider in a manner that recognizes the person's individuality and that is

sensitive to and responds to the person's needs and preferences, including preferences based on ethnic, spiritual, linguistic, familial and cultural factors.

"'4. A person receiving a health service has the right to information about the health services provided to him or her and to be told who will be providing the health services.

"'5. A person applying for a health service has the right to participate in the health service provider's assessment of his or her requirements and a person who is determined to be eligible for a health service has the right to participate in the health service provider's development of the person's plan of service, the health service provider's review of the person's requirements and the health service provider's evaluation and revision of the person's plan of service.

"'6. A person has the right to give or refuse consent to the provision of any health service.

"'7. A person who is incapable of making their own decisions with respect to the provision of any health service has the right to a substitute decision-maker in any health care setting at any time.

"'8. A person receiving a health service has the right to raise concerns or recommend changes in connection with the health service provided to him or her and in connection with policies and decisions that affect his or her interests, to the health service provider, government officials or any other person, without fear of interference, coercion, discrimination or reprisal.

"'9. A person receiving a health service has the right to be informed of the laws, rules and policies affecting the operation of the health service provider and to be informed in writing of the procedures for initiating complaints about the health service provider.

"'10. A person receiving a health service has the right to have his or her records kept confidential in accordance with the law and to know to whom his or her personal health information has been disclosed.

"'11. A person receiving a health service has the right to a complete, accessible personal health record that is available without delays or unreasonable cost.

"'12. A person receiving a health service has the right to designate another person as their essential caregiver, to have access to that essential caregiver in any health care setting at any time, and to have that essential caregiver treated with respect as a valuable contributor to the care team.

"'Guide to interpretation

"'(2) This act and the regulations shall be interpreted so as to advance the objective that the rights set out in subsection (1) be respected.

"'Deemed contract

"'(3) A health service provider shall be deemed to have entered into a contract with each person receiving a health service from the health service provider, agreeing to respect and promote the rights set out in subsection (l).'"

The Chair (Mr. Kaleed Rasheed): Further debate? MPP Fraser.

Mr. John Fraser: I'm glad I made it through that. This is something that we heard consistently in committee, over the hearings from the deputants, the people who came to present to us. This bill, Bill 175, removes the current bill of rights from the home and community care act, and the government has signalled its intention to put this bill of rights into regulations.

What the government is actually doing is they're putting something, a bill of rights, that is in the legislation to inform regulations into the regulations. Secondarily, regulations are not a very democratic process. They're, of course, done as a decision of cabinet. They're not debated in the Legislature. A bill of rights, which is essential to everyone in this province to know what their rights are in probably the thing that's most important to us and that we put the most resources into, deserves debate through their elected officials. That's why I put this forward right now. I'm really disappointed that the government hasn't included the bill of rights in their package. It was an opportunity. They've heard it consistently throughout the hearings.

As you'll see in this motion that I've put forward, I've somewhat updated the bill of rights to reflect some things that are, I think, important additions to a bill of rights. They're by no means complete or exhaustive, but I wanted to do that to underscore the point that we actually need to put this forward and debate it.

Some of the things that were added that I think are of significance that I'd like to highlight for my colleagues are, in number 2, it recognizes the person's autonomy, and also recognizes that the person is a member of their own care team. When we're talking about client-centred or patient-centred health care, that's a critical piece. That's not something that is reflected very clearly in the legislation anywhere. It needs to be. I think anyone who's had to experience a serious care plan or a serious health situation, whether it be for themselves or a family member, would recognize the importance of that person being included in their care, not only from the point of making decisions but understanding the differences, understanding what's happening to them and being informed. It's a really important principle.

Number 7 is something that I believe is also important: "A person who is incapable of making their own decisions with respect to the provision of any health service has the right to a substitute decision-maker in any health care setting at any time." That's a very important principle. We can see through this pandemic a number of things that have happened with people's power of attorney, with people's essential caregivers. We can understand the pressures that are on right now because of COVID-19, but this is just a reflection of things that happen in health care settings every day across the province.

I'd also like to highlight number 10: "A person receiving a health service has the right to have his or her records kept confidential in accordance with the law and to know to whom his or her personal health information has been disclosed." That's, again, a really critical piece.

Number 11: "A person receiving a health service has the right to a complete, accessible personal health record

that is available without delays or unreasonable cost." We know that this has been a challenge for many people for a number of years. We have to put that as a principle inside our legislation so that we can ensure that when we make the regulations and the rules and the policies, that principle is reflected.

1330

Now I'd like to speak a little bit about number 12. It's something that's new in this bill of rights that doesn't attach itself to anything else that was previously in the bill of rights in the Home and Community Care Services Act. Number 12: "A person receiving a health service has the right to designate another person as their essential caregiver, to have access to that essential caregiver in any health care setting at any time, and to have that essential caregiver treated with respect as a valuable contributor to the care team."

We've seen with COVID-19, not just in long-term care and retirement homes, but in hospitals and other health care settings, that family who are essential caregivers, partners who are essential caregivers, or friends who are essential caregivers, who are advocates—they are caregivers in the sense that they make sure that a person's daily needs are met. They're protectors. They're an extra set of eyes and ears that watch over and listen to the one they're giving care to. Very often, they're marginalized or excluded in many health care settings, and COVID-19 has revealed that, but it's not something new.

It's not just about COVID-19 and the fact that we have to practise some isolation, but there's a real challenge with people who take the responsibility of essential care for another being ignored and neglected in our health care system. It really affects the outcomes for the patient, and not in a positive way. We need to begin addressing that, and not just because of what we've seen in COVID-19 and how these essential caregivers have been treated and how long it's taking to get them back to the person that they're caring for, but because it has been a problem for as long as I can remember.

It's something that needs to be addressed. That's why I included it in this bill of rights. I would urge my colleagues to support this bill of rights. If you want to amend this in any way and change it and put it forward, I'm open to that. It needs to be in there. I'm asking that you support it.

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

Mr. Joel Harden: I want to thank my colleague MPP Fraser for putting this forward. As committee members will know, we'll have a similar amendment on this issue later on in the day. In any event, it would be great to codify and have it remain codified—this bill of rights—in the legislation impacting home care, for all the reasons that MPP Fraser just mentioned.

In addition to that, I have already spoken about remarks made by Tracy Odell and folks from ARCH Disability Law Centre. From a disability rights perspective, it is deeply problematic to move this particular bill of rights into regulation. What I actually think it does is it abrogates our provincial responsibilities under the Accessibility for Ontarians with Disabilities Act and the global responsibilities Canada and Ontario have taken in signing on to the UN Convention on the Rights of People with Disabilities, where we have agreed to never diminish the rights or living standards of people with disabilities.

Inasmuch as my friends in government may have the best intentions, under regulation, to do the best things possible, we now have a situation in which this bill of rights is codified in law, and if it is moved to regulation, it is then left to the interpretation of the government of the day.

I would impress upon my friends in government to realize that you inherited a government, and those previous Parliaments created statutes, created precedents, that you have to live up to.

Certainly, given the overwhelming consensus I always hear from all members of all parties and all Ontarians of all persuasions around the rights for people with disabilities and seniors, I think it's incumbent upon us to not issue our talking points today. If you've been given the directive to vote against this particular amendment or the amendment we are going to be serving later on this afternoon to have this particular bill of rights remain codified under the law—it's your opportunity as members of the government caucus to say that people with disabilities, seniors and vulnerable people in our province matter to you. By voting for this amendment, you are saying, as a member of provincial Parliament, that you will make sure their living conditions—their rights—are not diminished, because it's our obligation regardless of political perspective, regardless of where we live in this province, to make sure that never happens. I encourage you to vote in favour.

The Chair (Mr. Kaleed Rasheed): Further debate? I believe MPP Fraser had his hand up. Please go ahead, MPP Fraser. I recognize you.

Mr. John Fraser: I want to put this out here to the government because my colleague Mr. Harden reminded me of something, and why it will be good for the government to support this. I'm really pleased that the government appointed a Patient Ombudsman, albeit almost two years late. I also wanted to make the government members aware that the Patient and Family Advisory Council, which is mandated under law, has not functioned since last August, when the people who were part of that council, who provided some very important input that the ministry is currently using on their website, were all told that their services were no longer required—last August—a committee that's mandated under legislation. You can go and check the public appointments website. Positions are totally vacant. I can't find anything advertised; I don't know if you can.

Here's my point: If you're serious about patient and family rights then we need to do something about it. I would suggest that you start by voting for this amendment, or at the very least, one of the two that are going to be in front of you.

The Chair (Mr. Kaleed Rasheed): I recognize Madame Gélinas, followed by MPP Kanapathi.

M^me^ France Gélinas: I too will speak in support of this amendment, basically, to have a bill of rights in law. If you look at the lawyers who came before us, either the ARCH

Disability Law Centre or the lawyers who work with ACE, the centre for the elderly, they all spoke about the importance of having the patient bill of rights in the legislation. They were not the only ones. The Interfaith Social Assistance Reform Coalition asked for it. The Ontario Community Support Association, Ms. Deborah Simon—one of the main points that she made was the importance of having this in the law. Same thing with Toronto Seniors' Forum—that was one of the main points that they made. They wanted the patient bill of rights to be in the legislation. And the list goes on: The Ontario Federation of Indigenous Friendship Centres asked for it; the Ontario Federation of Labour; the Ontario Health Coalition, the branch from Guelph Wellington; the Ontario Nurses' Association; RNAO; the Alzheimer Society—they all talked about the importance of having the bill of rights in legislation. Why? Because they all know that, in the home and community care sector, there is a huge power imbalance. The provider, physician, nurses and physiotherapists have all the rights. They have all the knowledge, and the client has needs. There is a huge power imbalance. As long as everything goes right, all is good. But the minute that things derail, the minute that the care is not provided in the way that it should be, it is really, really difficult for the person in need to go against the providers of care. The way to level off this power imbalance is to make sure that you have a patient bill of rights.

I would say that Jane Meadus from the centre for the elderly put it very eloquently—way more eloquently than I will ever be able to—that this is something they use all the time. They get hundreds of elderly people complaining about their care. And how do they rectify this? By using the patient bill of rights. Once the patient bill of rights is not in legislation anymore, every lawyer has told us that this power imbalance will be a whole lot more difficult to deal with.

1340

I will point to paragraph 3, où on dit que les préférences des personnes, c'est-à-dire des patients et patientes qui reçoivent le service—qu'on doit tenir compte de leur préférence linguistique.

This is the one place in the bill where we talk about the linguistic preferences that have to be respected. Remember, the majority government voted down the part about francophones wanting and being allowed to have guaranteed services in French, when it comes to home and community care services. We have this in section 3, which basically says that a person receiving a health service has the right to be dealt with by the health service provider in a manner that recognizes the person's individuality and that is sensitive to and responds to the person's needs and preferences, including preferences based on ethnic, spiritual, linguistic, familial and cultural factors.

I could go on and on. Every single one of the paragraphs in the patient bill of rights is important. You have to make sure that you don't set up patients to fail. I have nothing against the Patient Ombudsman, but the Patient Ombudsman comes after many, many steps, and a patient bill of rights is at the forefront. This is how you protect people. You give them rights so that the providers know that those people have rights, and that if they don't respect those rights, they will be held to account. If you take away the patient bill of rights from legislation and put it in regulation, you've just given the already very powerful group, the providers, even more power over the people who need services and who have very little power.

The Chair (Mr. Kaleed Rasheed): I recognize MPP Kanapathi.

Mr. Logan Kanapathi: I recommend voting against this motion. The government recognizes the importance of maintaining and protecting patients' rights. Introducing a bill of rights into legislation without a consultation process leaves key partners, including patients, out of the process. That's why we began consulting on an update to the bill of rights through the proposed [*inaudible*]. The government has laid out a broader approach for the expression of patient [*inaudible*]—

The Chair (Mr. Kaleed Rasheed): Sorry; MPP Kanapathi, we are having difficulty hearing you. Is there a possibility that you can repeat what you have said?

Mr. Logan Kanapathi: Can you hear me now? I can repeat some of the statement.

The Chair (Mr. Kaleed Rasheed): Go ahead. We were just losing you here and there, so that's why—

Mr. Logan Kanapathi: It's the WiFi. I'm sorry about that.

The government has laid out a broader approach for the expression of patient values in the health system through the patient declaration of values for Ontario.

Moreover, the Patient Ombudsman will continue to champion fairness in Ontario's health sector organizations, defined as public hospitals, long-term-care homes and prescribed aspects of home and community care services.

As we communicated publicly and indicated during the public hearings, the government will maintain a home and community care patient bill of rights in regulation, and it's engaging the partners to update this 25-year-old bill of rights.

The Chair (Mr. Kaleed Rasheed): We're going to move to MPP Armstrong, followed by MPP Fraser.

Ms. Teresa J. Armstrong: I have to say during the presentations—all of them were very compelling. There were a lot of personal experiences that were very moving. But one recurring theme that was in the presentations, very strongly, over and over again, was that the bill of rights being moved from legislation to regulation is a detriment to the home and community care sector and a detriment to the people who are receiving care.

When I was looking through my notes, everywhere in the presentations of people I had highlighted: bill of rights, bill of rights, bill of rights. This is something that is so fundamentally basic to have in legislation that I don't understand the rationale of it going into regs. If you want to develop something, as the MPP just said, you can certainly consult prior to, get it right and then put it in legislation. It doesn't have to be in regulation in order for it to be flexible. You can do your homework, consult and make sure that those things are enshrined in legislation.

I reflect back to the presenter, Lin Grist, where she commented—of course, she said she's very concerned that the bill of rights was moved out of legislation to regs. In one of her comments, she said she was terrified of becoming sick and having to rely on this bill. Lin Grist is a constituent, an Ontarian, lives somewhere in Ontario—it was Guelph, I believe, or the Kitchener area, if I'm not mistaken; somewhere in that part of Ontario—and for her to come forward and express that kind of concern about having to rely on this bill if she becomes sick, it has to send some kind of wake-up call to us as legislators.

She said that she has a partner of 49 years—it was Guelph that she lived in, I see in my notes here. To be terrified when you're getting older in society, where there is ageism, and if we don't have a home and community care system that we can access, that people have faith in, that will actually deliver the services to keep you at home, not-for-profit, knowing that care is going to be dealt with, all the money is going to be going to all that care—her presentation really spoke to me, along with many, many others.

The bill of rights is just something that has to continue to be enshrined in legislation. We cannot compromise and default to the good will of the government, the good intentions of any government, that this will be respected and this will actually be written in a way that's strong enough to protect people who receive care at home and in the community.

So I urge this government—I'm saddened to hear that they would not be supporting this in legislation. It's so fundamentally basic that, as Lin, I would be quite concerned if that's not even in Bill 175. If that's something that this government can't compromise on, then I'm very concerned about the trajectory that this bill has been written in and the way it's going when it comes to community and home care.

The Chair (Mr. Kaleed Rasheed): I recognize MPP Fraser. Please, go ahead.

Mr. John Fraser: I'll try to be brief. I just want to highlight something that France said. For as long as I can remember, I've seen the power imbalances that exist in health care. I can remember it from the time I was 17 or 18 years old my father trying to solve my grandmother's care. It took him six years. I won't go into the story right now, but it was evident that what was happening there was not in the best interest of the patient.

I know that my colleague, who I respect a lot, said the bill is open—it's 25 years old. But for 25 years, that bill of rights has been used to interpret law and protect, I would argue, thousands and thousands of people. What you're proposing is to take that out of the law right now, leave it vacant for a while and replace it with something that could be changed by the power of the cabinet, that you won't have an opportunity to debate, that your successor in your seat, my successor, all of our successors won't have an opportunity to debate.

1350

I'd like you to think about it this way: If we look at other rights that we have that exist in law, like the freedom of speech, the freedom of expression, the freedom of religion, the rights to person, would any of us on this committee be comfortable putting forward something that said, "We're going to make it so these laws can be changed without having to go back to the government, without having to go back to the people"? That's why this thing stood for 25 years. It needs to be updated; I've done some updating. It's not perfect. But it needs to be there, just like those other laws that protect us around our rights to person, speech, freedom of religion, freedom of expression. They're not written in regulation. That's because they need to have some permanency, and putting them in regulations just is not good enough.

I urge you to support this amendment. If you can't support this amendment and you would simply like to accept my colleagues in the NDP's amendment, that will be a big step forward.

Thank you for the time, Chair.

The Chair (Mr. Kaleed Rasheed): Further debate? Seeing none, we are now going to move to the vote for independent motion number 6.

Ayes

Armstrong, Fraser, Gélinas, Harden.

Nays

Coe, Kanapathi, Martin, McDonell, Mitas, Oosterhoff.

The Chair (Mr. Kaleed Rasheed): Motion lost.

Shall schedule 1, section 2 carry?

Ayes

Coe, Kanapathi, Martin, McDonell, Mitas, Oosterhoff.

Nays

Armstrong, Fraser, Gélinas, Harden.

The Chair (Mr. Kaleed Rasheed): Carried.

Now we are going to move to NDP motion number 7. MPP Harden.

Mr. Joel Harden: I move that section 2.1 be added to schedule 1 to the bill:

"2.1 The act is amended by adding the following section:

"'Meetings open to public

"'9.1 All meetings of the board of directors of the agency and any of its committees must be open to the public.'"

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

Mr. Joel Harden: I would say we heard on several occasions how important it was for the new Ontario health teams model that my friends in government are encouraging for the province in health care to embrace the same degree of public accountability that the local health integration networks model had. There were many

criticisms that I certainly have heard as an MPP of the old LHIN model, but certainly one strength of that model was the fact that all of its deliberations were open to the public. We have worked here in Ottawa Centre with a number of people and families who took the opportunity to sit in and watch those discussions happen in real time, and I think it's important and incumbent upon the government to make sure that issues around home care, these deliberations are open and available to the public for public scrutiny. I'm sure my other NDP colleagues and independent member colleagues would have other comments in this regard. Thank you.

The Chair (Mr. Kaleed Rasheed): I recognize MPP Martin, followed by Madame Gélinas.

M^me^ Robin Martin: Je suggère que l'on vote contre cette motion, parce que les modifications de la législation ne sont pas nécessaires pour permettre à Ontario Health d'avoir les réunions du conseil en public.

The proposed amendment would not enable the board of directors to conduct meetings or portions of meetings in camera under circumstances where that would be appropriate and necessary. While the government supports openness and transparency in health care decision-making, establishing a prescriptive requirement in legislation can limit the ability of the board to adapt its decision-making processes to the needs of the system.

While we do not recommend establishing the "how" in legislation, we are committed to ensuring that Ontario Health's board meetings are transparent to the public. Our government is working with Ontario Health to provide further openness and transparency in decision-making without compromising sensitive information. This includes public board meetings while using discretion to exclude the public in circumstances where a public meeting would be inappropriate or prejudicial to a public or private interest, for example, where personnel matters, personal health information, matters of public security, matters subject to solicitor-client privilege are being discussed.

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

M^me^ France Gélinas: This is something of grave importance. Right now, Ontario Health has been formed, the people who sit on Ontario Health have been identified. Most of them are from around the GTA, with one man with a financial background who comes from North Bay. For me, who represents people in the north, there is a huge distrust from everybody that I represent that a group of people from the GTA will understand the needs of the people of Gogama when they can't even point to it on a map. If I asked them, "Where is Biscotasing?" I bet you none of them are able to identify it on a map, but they are responsible for the health of those people, nevertheless.

Right now, with Ontario Health, none of their meetings have been open to the public. Let me tell you, I have FOIed, I have asked gently, I have asked the MPP liaison, I have begged, I have danced, I have done anything, but I have yet to see—I'm not even sure they take minutes, for all I know, because they are no minutes that can be shared with anybody, and none of their meetings have ever been open to the public. Yet they are responsible for hospitals, for long-term care, for primary care, for palliative care, for home and community care, and for mental health and addictions. They're responsible for all of this; yet none of the decisions they make are available to any of us, and it's not because I didn't try, I can guarantee you. I have been around here long enough to know how to find my way around, and if I cannot get through, I'm guessing most people can't. I'm no better, no worse, but nobody can. This is wrong; it has to change.

Right now, through COVID, Ontario Health has set up a number of tables. With all of those tables, we can't even find out who the people on those tables are, never mind what they discuss, never mind what's on the agenda and never mind the decisions that they have made. All of this undermines the confidence in our health care system.

1400

Health care is something that happens between two people. In order for quality of care to happen, you have to have confidence, and all of this, behind closed doors, undermines the confidence that people have in our health care system, and once you've lost confidence, you cannot have quality care. It is so important that those meetings be open. It is so important that their agenda be shared, that the minutes be available. Are there things that have to go in camera? There could very well be items that are in camera regarding a particular employee; we have no problem with that. But there's no reason why their agenda is not available. There is no reason why the rest of the meeting is not available. There is no reason why the minutes of their meetings are not available. None of this is available right now.

Let's face it: Ontario Health has been making some pretty important decisions with COVID-19, such as shutting down the entire economy of Ontario, and all of this is done behind closed doors. All of the recommendations that Ontario Health has done are done behind closed doors. We see what Dr. Williams and what public health are doing, because public health is not under Ontario Health. But everything else is behind closed doors. That cannot continue. It has to change.

We have to have transparency, and it starts by making sure that the meetings of the board of directors of the agency—which is the way that the law describes Ontario Health—and any of its committees are open to the public.

The Chair (Mr. Kaleed Rasheed): Further debate? MPP Fraser.

Mr. John Fraser: I will be supporting this motion.

It's interesting; In the last couple of weeks I've been thinking a lot about The Wizard of Oz and how it relates to this government and the things that they're doing. Today, I'm reminded of that scene in the movie where the Great Oz is telling Dorothy and the little dog, "Don't worry about what's going on behind the curtain. There's nothing to see." That's what I'm reminded of with the government's reluctance to have these meetings be public or the minutes be public.

Coming back to what France mentioned earlier on with regard to a power imbalance: This is a real power

imbalance. We've given a lot of power to a small number of people and the minister, with negligible public oversight. We went from a system where the governance of local health care, community care, was accessible—there were public meetings, and people could connect to the people who were making decisions about the services in their communities. That's all gone.

As people who represent communities, I think all of us should be very, very concerned that what we've done is removed local governance and given, for example, the power to a minister to amalgamate and change in any way services in our community—30 days, no right of appeal, no public input, no public board meetings.

What I tried to describe to my colleague from Brockville one day was, "How would you like it if one day, the minister of the day—maybe not the minister right now—and the board of health said, 'In Brockville, no more maternity. Actually, we're not just going to remove the maternity section; we're going to amalgamate Kingston general hospital and Brockville, and we're going to take these services out.' You just find out about that. You've got 30 days. There's nothing you can do because you didn't know that was going to happen, because you weren't informed of what was going on at the board meetings."

The transparency of Ontario Health is critical. It's critical for the people of this province and for us, as representatives, to have access to that information so we can have input into the decisions before they're made, and in the way the government has gone about this, they have just eroded that even further. This is a reasonable amendment. If you believe in transparency and accountability and you're worried about in camera, amend the amendment. Put your own amendment in.

Ten years from now, if this kind of stuff doesn't change, members on all sides are going to be really unhappy with the outcome—really unhappy with the outcome. So I hope my colleagues on the government side will support this amendment.

The Chair (Mr. Kaleed Rasheed): Further debate? I recognize MPP Armstrong.

Ms. Teresa J. Armstrong: Chair, I have to say again, there are some shocking pieces in this legislation, and this is another one, where government has a majority and decides to take away public oversight on Ontario health teams. It's transforming all of health care and it doesn't have the foresight to understand that public participation in a board of directors meeting that controls the health care system, the funding, who gets it, decisions like amalgamation—I'm just strangely in awe that that's okay.

When we're looking at privatization in this bill, this is just another form of keeping things out of the public so the public doesn't understand. Ultimately, it's affecting the people that are looking for care, the most vulnerable. It's lopsided when it comes to—what is the fear or the worry or the concern around public participation in a board meeting, a directors' board meeting, when it comes to community care or delivering home care? I have to ask this government if they could please explain the rationale, because it doesn't make any sense to have all this secrecy and expect people not to be upset, patients not wonder what it is they're hiding. That's not good form.

If you want people to trust and have faith in a system, you would open up the doors and welcome them to come and understand where money is spent, how much is spent, the decisions that are being made. Ultimately, you have the power to make those decisions, but at least you're informing people of what those things are rather than behind closed doors at every turn.

Many participants, all participants worried about conflict of interest, lack of public participation—it does not bode well. It does not give confidence to people who are going to receive that care. Honestly, in this atmosphere, it makes us very concerned. It doesn't give us confidence, the way these things are written, that there is going to be accountability and transparency when this government or any government makes a huge mistake. There are many pieces of legislation where they have decided they're immune to lawsuits, they're immune to their decision process.

Thanks, Chair. I think I'm done talking about this.

The Chair (Mr. Kaleed Rasheed): Further debate? Seeing none, we are now going to move to the vote.

Ayes

Armstrong, Fraser, Gélinas, Harden.

Nays

Coe, Kanapathi, Martin, McDonell, Mitas, Oosterhoff.

The Chair (Mr. Kaleed Rasheed): Motion lost.

We are now going to move to independent member motion number 8. MPP Fraser, please go ahead.

1410

Mr. John Fraser: I move that section 2.1 be added to schedule 1 to the bill:

"2.1 The act is amended by adding the following section:

"'Board meetings open to public

"'9.1 Any meeting of the board of directors of the agency at which matters relating to the funding of home and community care services are discussed shall be open to the public.'"

The Chair (Mr. Kaleed Rasheed): Further debate? Please go ahead, MPP Fraser. The floor is all yours.

Mr. John Fraser: This is obviously a very similar amendment to the previous amendment, but what I wanted to underscore here was that essentially, in taking apart or ending the home and community care act, first of all, we're taking out a bill of rights, but we're removing the rights of people to know things about their care and for communities to know things about how the care is going to be delivered there.

I don't want to belabour the point and repeat everything that I said in the last amendment. What I will say again is I think, as legislators, it is our responsibility to ensure that

the thing people probably depend most on, especially when they're sick or when they need it, and the thing that we invest the most in, has the kind of scrutiny, transparency and community input as is reasonable.

I think this is a reasonable amendment, I encourage my colleagues to support it, and I'll leave it at that.

The Chair (Mr. Kaleed Rasheed): I recognize MPP Oosterhoff.

Mr. Sam Oosterhoff: I recommend voting against this motion because legislation amendments are not required to enable Ontario Health to hold public board meetings. Ce n'est pas nécessaire pour Santé Ontario d'avoir les rencontres publiques, en législation.

The proposed amendment would not enable the board of directors to conduct meetings or portions of meetings in camera under circumstances where it would be appropriate and necessary. So while we do support openness and transparency in health care decision-making, we also recognize that establishing a prescriptive requirement in legislation can, in fact, limit the ability of the board to adapt its decision-making processes to the needs of the system, and I think that, of course, is important.

We are committed, however, to ensuring that Ontario Health's board meetings are transparent to the public, and we will be working with Ontario Health to provide further openness and transparency in decision-making without compromising any sensitive information. This will include public board meetings while using discretion, of course, to exclude the public in circumstances where a public meeting would be inappropriate or prejudicial to a public or private interest, such as personnel matters or personal health information, matters of public security, matters related to solicitor-client privilege and the like. I think that explains our reasoning for opposing this motion.

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

M^me^ France Gélinas: We will be supporting this motion. Although it limits how much of the meetings of Ontario Health would be available to the public, it is a step in the right direction, as in when they talk about funding to home and community care—which is actually a very important part.

When you look at what is under the responsibility of Ontario Health against our hospitals, our long-term care, community mental health, primary care, palliative care and home and community care, they are the ones that are most at risk, as in it is easy for the big players—hospitals, long-term care—to have access to the people of Ontario Health. It is a whole lot more difficult for a small home or community care service agency to have access to those people.

Just look right now at the issues with PPE, the personal protective equipment. The big players were able to talk to the people at Ontario Health, and they had it figured out. But you go to the little community-based services, if you go to the little Meals on Wheels, if you go to the little community-based agencies, they are still having a very tough time. I'm giving this as an example to show that home and community care services are most at risk to be gobbled up by the big giant, who won't even realize they have eaten them alive, and so home and community services will have disappeared. So to make sure that it becomes public when the board of directors of Ontario Health talks about this is important.

And with all due respect to MPP Oosterhoff, who says, "We're going to work on this," Ontario Health has been meeting for the last year. Why is it that a year down the road nobody has thought about, "Oh, look at all the requests for freedom of access of information we are getting, to get access to the agenda and the minutes at the boards. Maybe we should make those boards' minutes and agendas available to the public." None of this has come to you for the last year. Those people have been in place. They have held meetings. We know that meetings have taken place, and yet, not a peep has come out of those boardrooms, and you are telling us now, "Oh, we will work on it." You'll work on it in your third term in office, if you get there. Like, how long does it take for you to say, "Hey, there's a lot of people who would like to know what's going on at Ontario Health. Maybe we should make their agenda available. Maybe we should make their minutes available. Hey, maybe we should make those meetings public"? You know, Zoom works in Toronto just as poorly as it works in Nickel Belt.

Anyway, you get the idea. Once it's in legislation, it becomes done. Once it is the very truthful wish of an MPP, it is just this: the wish of an MPP. Legislation gets action—an MPP's wish, not always.

The Chair (Mr. Kaleed Rasheed): MPP Fraser, I recognize you. Please go ahead.

Mr. John Fraser: I just want to respond to Sam, Mr. Oosterhoff. I just want to remind you that you have taken all the power and decision-making and firmly ensconced it in downtown Toronto. There's no provision for any governance for any of the Ontario health teams. There's no discussion about it in the legislation. There's no framework. There is no clear right of local appeal. There is no appeal to a minister's decision any longer, and it could be implemented in 30 days. That is a tremendous amount of power. What I'm trying to say is, if we don't keep a check and an eye on that power, we're not going to be very satisfied with the results, whatever side we're on, because someone is going to come in and there is going to be a decision that's going to be made that nobody is going to see coming in your community or my community or some other member's community, and people won't have the opportunity to have input into that decision and, even more importantly, to actually accept it, promote it or fight against it. That's why these amendments are here, and there are about four of them in a row.

I just wanted to say that I hope the members can support the amendment, and I'll leave it at that.

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

Mr. Joel Harden: As I was listening to the debate this afternoon on this particular amendment, I very much enjoyed the anecdote MPP Fraser made to The Wizard of Oz. It is interesting for me when I've tried in the two years

that I've been elected to understand various ways in which colleagues who are not part of my caucus, members of the government caucus, have understood legislation. A recurring theme I'm always hearing is the need for entrepreneurialism, the need to unleash the power of the individual, the need to get government "out of the way of people." I guess I'm wondering about the antagonism between that objective, which is a Libertarian objective with which I'm very familiar, and bodies like Ontario Health which, as my colleague MPP Gélinas said very clearly, is meeting in secret, is meeting in secret despite the best efforts of people to understand what's going on. I guess I'm wondering what it must be like to be a Libertarian in this government that is occupying secrecy around these major decisions.

1420

If the goal is to actually unleash, as I've often heard Minister Elliott say, innovation and transformation in the health care sector, whatever those buzzwords might actually mean—and you know, buzzwords are buzzwords; they're good objectives. But if the goal is to protect the people from the central decision-making, which—I take MPP Fraser's point: On the surface, it appears to be happening in downtown Toronto, something that certainly concerns a lot of people up here in Ottawa and the outlying regions around Ottawa.

If we can't compel ourselves as a province to ensure disclosure—any board I've ever sat on has always had a capacity to ensure that the public needed to sit aside when matters that are confidential with staff or various other measures needed to be private. We were always able to figure out a way in which the public could still be apprised of what was going on, whether I was sitting as a trustee on a pension board or a board of directors of a child care centre, or other duties I've exercised in the past in public life. What I find really surprising—and I'm saying this earnestly, from a standpoint of individual liberty and individual disclosure, which I would like to think is a sacrosanct thing; we all support it. If that in fact is the case, then why can't we make sure it actually is in the bill? Why can't we make sure it's actually there before us?

MPP Fraser mentioned The Wizard of Oz. Immediately, as I've been hearing this debate, I think of the great playwright Bertolt Brecht, who, through a character, once said the following, which is reminiscent of this debate:

> Some party hack decreed that the people
> Had lost the government's confidence
> And could only regain it by redoubled effort.
> If that is the case, would it not be simpler,
> If the government simply dissolved the people
> And elected another?

He's sardonically joking about the awful nature of the Stalinist empire and its intrusions into eastern Europe, but in this example can we not also detect a little of that same reliance upon authoritarianism? It's really too bad if, as governments, we believe that in order to move things quickly, they have to be kept out of public scrutiny.

I would submit to you that whether it's the amendment that we put forward or this amendment that MPP Fraser is putting forward, that is the implicit message that the people of Ontario are hearing: "We care a lot about making change now, and we don't have time to consult you. We're actually going to dissolve the electorate and elect our own. We are going to decide what you think and the care that you need."

I just want to impress upon my colleagues who are participating in this debate this afternoon that that is a very serious, serious mistake. If that's the trajectory you want, all hope to the contrary, all wonderful intentions to the contrary—if what we're actually doing is ensuring that Ontario Health is going to be debating issues of home care, shepherded, from what I can tell, with the list of people who are currently populated on the central organizing and executive committee of the Ontario health teams—I don't see many health care practitioners there. I see many health care administrators—clearly knowledgeable people—and many people from the financial world—I'm sure also very knowledgeable people. I don't see a single personal support worker on that board, certainly none from the Ottawa region.

If we can't bring these meetings out into the light of day by legislation and compel it to happen, the only conclusion reasonable people can draw is that decisions that are being made by smart people with very little front-line expertise at delivering home care are going to be kept from the public.

I'm just wondering, Chair, if any of my colleagues in government are troubled by that example, and if they want to break ranks this afternoon and say, "Do you know what? Let's make sure that if we want this legislation to pass, it's going to see the light of day. The Ontario health team deliberations on home care and all of their other deliberations are going to see the light of day. The people of Ontario will get the opportunity to find out what's going on in these meetings which impact their family, their health needs and the province we're working so hard to build."

The Chair (Mr. Kaleed Rasheed): Further debate? Seeing none, we're going to vote on independent motion number 8.

Ayes

Armstrong, Fraser, Gélinas, Harden.

Nays

Coe, Kanapathi, Martin, McDonell, Mitas, Oosterhoff.

The Chair (Mr. Kaleed Rasheed): Motion lost.

Next, we are going to move to independent motion number 9. MPP Fraser, go ahead please.

Mr. John Fraser: I move that section 2.2 be added to schedule 1 to the bill:

"2.2 The act is amended by adding the following section:

"'Public Meetings

"'Public meetings

"'17.1(1) The agency shall hold at least four public meetings in each calendar year.

"'Content of meetings

"'(2) Each public meeting shall include an opportunity for public input on the agency's funding of health service providers and Ontario health teams for the purpose of the provider or team providing funding to or on behalf of an individual to purchase home and community care services.'"

The Chair (Mr. Kaleed Rasheed): Further debate? MPP Fraser, go ahead.

Mr. John Fraser: One more kick at the can to get some transparency and openness—

The Chair (Mr. Kaleed Rasheed): Sorry, I do recognize MPP Lorne Coe, following MPP Fraser.

Mr. John Fraser: Okay. Thank you, Chair. Just one more kick at the can to try to get some openness and transparency at the agency. What this amendment has done is, again, ask for four public meetings. We're not asking for all of them to be public, but perhaps the members of the government can find their way to get the agency to hold at least four public meetings in each calendar year.

I just want to remind everybody, again, that we've taken all the local governance out of health care, save and except for hospital boards. So the connection between communities and the people who are making decisions about the health care delivered in that community have been broken. They've all been brought to downtown Toronto. There are no provisions for governance or public transparency around Ontario health teams. I can't find any statements of principle or regulations.

I think all this secrecy is not good for health care in this province. That's why I put this amendment forward, and I would encourage my colleagues to support it.

The Chair (Mr. Kaleed Rasheed): Further debate? I recognize MPP Coe, followed by Madame Gélinas.

Mr. Lorne Coe: I recommend voting against this motion because legislation amendments are not required to enable Ontario Health to hold public board meetings. The proposed amendment would not enable the board of directors to conduct meetings or portions of meetings in camera under circumstances where it would be appropriate and necessary.

While the government supports openness and transparency in health care decision-making, establishing a prescriptive requirement in legislation can limit the ability of the board to adapt its decision-making processes to the needs of the system.

While we do not recommend establishing the "how" in legislation, we are committed to ensuring that Ontario Health's board meetings are transparent to the public. Our government is working with Ontario Health to provide further openness and transparency in decision-making without compromising any sensitive information. This includes public board meetings by using discretion to exclude the public in circumstances where a public meeting would be inappropriate or prejudicial to a public or private interest, e.g., where personnel matters, personal health information, matters of public security, matters subject to solicitor-client privilege etc. are being discussed.

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

1430

M^me^ France Gélinas: I respect my colleague MPP Coe when he says that his government is committed to transparency of Ontario Health, that they are working with Ontario Health to make board members available to the public, but there is nothing to support this. All we can see is that Ontario Health has been there for a year. The people who were appointed, we have no idea how those people were chosen to sit on the board of Ontario Health, but for some reason, they're all from southern Ontario, except for this one man from North Bay. There is no opportunity to see, to hear what those people are doing, and it has been a year.

How much working do you have to do to convince them to put their agenda online? How much working does it—you are the government. You have a majority government. You fund Ontario Health 100%. You selected each and every one of the people on Ontario Health's board. And you cannot get them to hold an open meeting? Like, how much work did you really put into this in the last year, that you are a year down the road, you're a majority government, you appointed everybody there, you fund all of this, and you cannot get them to hold one open meeting yet, you cannot get them to share one agenda, and you cannot get them to share minutes of meetings?

I want to believe in the good words that you say, but putting it in legislation is the way that legislators make sure that things happen. As an MPP, I am there to make laws. This is what we're doing right now. I guarantee you, I don't know how much time, effort and energy you have put in convincing Ontario Health to be committed to transparency and to be committed to open meetings, but if we put it in law, you don't have to put in time, effort and energy anymore; it will be done—end of story.

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

Ms. Teresa J. Armstrong: So when we're talking about Ontario health teams and the fact that the transparency isn't there—people have been trying to do FOIs. They can't get a response. They can't find their way around the system to get information. Then you've got us trying to negotiate public interest here at this table. We've got the amendment here saying to at least provide with us four meetings in a calendar year.

To have to ask a government to negotiate public interest and public transparency just seems wrong. Health care is public, it's publicly funded, and the decisions that are made with the Ontario health team should be accessible, even with an FOI. I would think all MPPs in this Legislature would be concerned. If you're trying to get information from a system that's supposed to give you information through freedom of information and you can't access that,

that would be something you'd want to question. So questioning today why we can't put in amendments to make these board meetings public is very valid.

I think back to Ornge, when we were in the Legislature, and the kind of structure and set-up that was put in place. Finally, after some time, it all blew up. Again, it had to be through FOIs and things like that that this information was found, that the dealings with the financing—how egregious it was.

I go back to that this bill also protects conflict of interest. There is no conflict of interest in here. So when you have an Ontario Health board dealing with funds that no one has access to their agenda or their minutes or the money that's been put out, and there's no public accountability, it really breeds another Ornge.

I remember when we were talking about these things in the Legislature—again, justifications for why a structure was set up that did not serve the public, that did not serve the health care system. It just feels like governments don't learn from mistakes of the past—whoever the government is.

It's very sad that we're repeating this when it's very clear that it doesn't have to be this way. This board can continue to do its work, but it needs to be responsible to the people who fund it, and that is the public, Ontarians.

Negotiating here what public accountability looks like and what public participation should be in a public health care system seems counterproductive for why we're supposed to be here. We are MPPs. We represent the public. We serve our constituents. We are servants of the public. We are to give them information and be transparent and open.

Yes, there are times when you talk about HR, and we all know that those things are kept in camera. That is nothing new. Patient confidentiality is nothing new. But when you're talking about finances and decisions of a board around a health care system that provides services to the public, that needs to be publicly open, with participation.

I highly doubt that this government will look at reasonableness if we're negotiating how much transparency we have under Ontario health teams and these boards, but I implore you to pay attention. This is not just you being in power now; this is about the future of what power looks like if somebody else comes into power. You may think, "We're responsible. We're never going to be doing it so that it turns into an Ornge." But you are giving that power to other people in the future and taking away that responsibility from yourselves to be held accountable to the people who elected you in this Legislature.

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

Mr. Joel Harden: I want to thank all my other colleagues for their contributions to this debate.

The only reasonable conclusion I think people can draw if amendments like these get defeated for the reasons that MPP Coe and MPP Oosterhoff and others have articulated is that we just have to trust that these meetings that are happening behind closed doors, without public scrutiny, are going to be in the best interest of Ontarians.

As another attempt to reach my colleagues in the government caucus, I would ask them if they would be satisfied—this is what they're proposing for health care and home care, in particular, which this legislation addresses—with that method of decision-making in their own political party, in their own caucus? I can tell you, I wouldn't. If the members of my caucus, of the leadership team, said, "We're going to figure this out. We have eight people, and we think we know how to run our party very well. We'll keep you in the loop. We're going to be letting you know down the road how we intend the party to go"—if we didn't have regular caucusing, if we didn't have regular input from grassroots members of our political party from across the province and provincial councils, if we didn't have that kind of scrutiny, nobody would be satisfied with the way we were trying to take perspectives forward at the Legislature. I can only assume that that's true for you, too. So if that's the standard you hold for your own political party—that you deserve, as a member of provincial Parliament, disclosure, input, the ability to shape and influence the direction of the policy of your own party, of the government of Ontario—then why do you have a different standard for the people's health care? That's my question. Why would you not agree to a minimum of four meetings a year, with regular public input from the people of Ontario, who could only strengthen the decisions that are being taken?

Whether you hear my colleague MPP Gélinas, who talks about how health care needs to be delivered in northeastern Ontario, or our colleague MPP Mamakwa, who can tell you exactly how you could serve the health care needs of 28 different fly-in communities in what we think of as northwestern Ontario—or here in Ottawa, where people here could ably tell you how you could work with a very diverse city with many different needs. Why wouldn't you, if that is your standard—again, I'm making assumptions. If other government caucus members want to continue this debate this afternoon—and correct me if I'm assuming wrong. I'm making the assumption that as an MPP in your caucus you would demand scrutiny, demand accountability and demand to play a role, because the people who sent you to the Legislature sent you to hold forward on their behalf and to listen to them.

1440

If we have one standard for our job, and I'm not only speaking for you—that's the standard I hold myself to, and I think I can speak for other colleagues from our caucus and MPP Fraser from his caucus. Why do we have a different standard for the people's health care? Why do we feel it's necessary to insulate it from public scrutiny if, in fact, you're telling us that we don't have to codify this kind of public transparency in law? I don't get it.

I have, at moments, heard fragments, I have to say in the course of our interactions with deputants on this bill, I remember at one point MPP McKenna mentioned something that we in the opposition caucuses didn't understand, which was that a very important part of health care and home care in Ontario, and our health care in general, was the role of private businesses. She referred to doctors, physicians as operating small businesses.

I've heard this from the government before, and I wouldn't deny there may be physicians out there who think that way. But myself, I can tell you explicitly from the standpoint in our own home, I happen to be married to a health care professional and that is not how she thinks of her role. She thinks of her role as providing care and provision of services, and she thinks her remuneration is coming through the people of Ontario, thanks to the billing scheme that we have.

What worries me, Chair, is that if we are actually saying that these decisions, this process by which policy is developed for health care is happening behind closed doors, and if I get little fragments of discussions from colleagues like MPP McKenna who say, "Well, you know, we just need to be realizing that small business or a business-oriented mindset, a profit-oriented mindset is how we deliver health care services in the province of Ontario"—if I'm not seeing what's going on behind the curtain, I'm worried that's the perspective that's going to continue in Ontario health care. I'm worried that the Bayshores of the world, the CarePartners of the world, the ParaMeds of the world, who have been absolutely making a mess of our home care system, are going to be continuing to dominate the sector.

We have a 60% turnover rate here in the city of Ottawa for personal support workers because people enter the profession and they leave, but any time any one of our major health care institutions offers up a health care attendant position, which is the commensurate position in the institutional tertiary sector to what PSWs do in home care, there are hundreds of applications because there are decent salaries, decent benefits, predictable hours. There's a process by which those jobs that are created in those tertiary institutions are good jobs, but as my colleague MPP Gélinas said, we do not have that standard. We don't have that attachment to regulation. We have let this sector fester and go the direction of where large operators have wanted it to go.

So if that is the hint that I'm hearing from colleagues like MPP McKenna that we have to realize the role of for-profit thinking and business-oriented delivery of services in health care and the role placed on our health care system—if that is the hint that I'm hearing, I'm worried, Chair. I'm worried about what is going to be happening at these large tables, dominated by folks from the financial services industry, from health care administration without the grassroots health care worker provision perspective that I think is absolutely needed, and you only get that if you build it in.

Getting back to my analogy earlier, if we as a caucus didn't allow the membership of the NDP to have some scrutiny to what we do at Queen's Park, we would not be doing anywhere near as good a job as we've tried to do in any one of our portfolios. You need that public scrutiny to make the right decisions, and when you refuse it by saying, "Oh, well, we can say in the preamble that it's important to us," or "This is too onerous for us. Democracy is somehow inconvenient to us," I think you're sending a chilling message. You're sending an absolutely chilling message that you in fact yourself lack confidence in the efficacy of your own ideas to carry it forward in the light of day, under public scrutiny. So if you vote against this amendment, I fear that's the message you're sending.

The Chair (Mr. Kaleed Rasheed): Further debate? Seeing none, we are now going to vote on independent motion number 9.

Ayes

Armstrong, Fraser, Gélinas, Harden.

Nays

Coe, Kanapathi, Martin, McDonell, Mitas, Oosterhoff.

The Chair (Mr. Kaleed Rasheed): The motion is lost.

We are now going to move to NDP motion number 10. Madame Gélinas.

M^me^ France Gélinas: I move that section 2.2 be added to schedule 1 to the bill:

"2.2 The act is amended by adding the following section:

"'Bill of rights

"'20.1(1) A health service provider or Ontario health team that provides a home and community care service shall ensure that the following rights of persons receiving home and community care services are fully respected and promoted:

"'1. A person receiving a home and community care service has the right to be dealt with by the health service provider or Ontario health team in a courteous and respectful manner and to be free from mental, physical and financial abuse.

"'2. A person receiving a home and community care service has the right to be dealt with by the health service provider or Ontario health team in a manner that respects the person's dignity and privacy and that promotes the person's autonomy.

"'3. A person receiving a home and community care service has the right to be dealt with by the health service provider or Ontario health team in a manner that recognizes the person's individuality and that is sensitive to and responds to the person's needs and preferences, including preferences based on ethnic, spiritual, linguistic, familial and cultural factors.

"4. A person receiving a home and community care service has the right to information about the home and community care services provided to him or her and to be told who will be providing the home and community care services.

"'5. A person applying for a home and community care service has the right to participate in the health service provider's or Ontario health team's assessment of his or her requirements and a person who is determined under this act to be eligible for a home and community care service has the right to participate in the health service provider's or Ontario health team's development of the person's plan of service, the review of the person's

requirements and the evaluation and revision of the person's plan of service.

"'6. A person has the right to give or refuse consent to the provision of any home and community care service.

"'7. A person receiving a home and community care service has the right to raise concerns or recommend changes in connection with the home and community care service provided to him or her, and in connection with policies and decisions that affect his or her interests, to the health service provider or Ontario health team, government officials or any other person, without fear of interference, coercion, discrimination or reprisal.

"'8. A person receiving a home and community care service has the right to be informed of the laws, rules and policies affecting the operation of the health service provider or Ontario health team and to be informed in writing of the procedures for initiating complaints about the health service provider or Ontario health team.

"'9. A person receiving a home and community care service has the right to have his or her records kept confidential in accordance with the law.

"'Guide to interpretation

"'(2) This act and the regulations shall be interpreted so as to advance the objective that the rights set out in subsection (1) be respected.

"'Deemed contract

"'(3) A health service provider or Ontario health team shall be deemed to have entered into a contract with each person receiving a home and community care service from the health service provider or Ontario health team, agreeing to respect and promote the rights set out in subsection (1).'"

The Chair (Mr. Kaleed Rasheed): Further debate? I recognize Madame Gélinas, followed by MPP McDonell.

1450

M^me^ France Gélinas: This is really to try to keep the patient bill of rights inside legislation. The previous home and communities act had the bill of rights inside legislation. It was used many times by different lawyers working with patients' groups to try to bring justice. As I have mentioned before, there is a huge power imbalance in health care between the people who provide the care and the people who need the care. In order to balance this power imbalance, you have to rely on legislation. This is what the lawyers from the Advocacy Centre for the Elderly, from ARCH Disability Law Centre, from the Alzheimer Society, from the community care services association—they all use the law to protect the patients.

As I said, when everything goes well, you don't need a law; it doesn't matter where it is. But when things derail, the fact that the patient bill of rights would be in legislation rather than anywhere else gives power. This power not only helps when things derail, but this power sets the tone to improve this power imbalance. It sets the tone for providers that they are going to be held to the rule of law when it comes to the patient bill of rights, because it is in legislation. If it needs to be modified, if it needs to be updated, if it needs any changes—that is not a reason to take the basic parameters that have served us well over the last 25 years out of the law.

Let's keep what we had. Let's add to it, let's modify it, but not at the expense of taking it out of the bill.

The Chair (Mr. Kaleed Rasheed): I recognize MPP McDonell.

Mr. Jim McDonell: I recommend voting against this motion. The government recognizes the importance of maintaining and protecting patients' rights. Introducing a bill of rights into legislation without a consultation process leaves key partners, including patients, out of the process. That is why we began consulting on an update to the bill of rights through a posting in February on Ontario's Regulatory Registry. The government has laid out a broader approach for the expression of patient values in the health system.

Moreover, the Patient Ombudsman will continue to champion fairness in Ontario's health sector organizations, defined as public hospitals, long-term-care homes and prescribed aspects of home and community care services.

As we communicated publicly and indicated during the public hearings, the government will maintain a home and community care patient bill of rights in regulation, and we are engaging with partners to update this 25-year-old bill of rights.

The Chair (Mr. Kaleed Rasheed): Further debate? I recognize MPP Fraser.

Mr. John Fraser: First of all, I want to thank my colleagues for bringing this forward.

As I've said before, this is a really important piece of current legislation that has protected thousands and thousands of people over 25 years, and it is still applicable today. It is in no way wrong in the principles that it has in there; it needs some more. If the government was serious with regard to wanting to consult on the bill of rights and serious about the importance, they would have done that, and they would have done that in a way that they could have put it into legislation.

Here's why we need a patient bill of rights: The government hit the pause button on the Patient Ombudsman.

Interruption.

Mr. John Fraser: Excuse me, everybody, for my dog barking in the background. I can't do anything about that.

For two years we've been without a Patient Ombudsman. Last August, the Patient and Family Advisory Council mandated by legislation was disbanded and hasn't been replaced. That does not really show a true commitment to patients and families.

Now, I believe my colleagues on this committee think that's important. I know they believe that's important, making sure that patients and families are at the centre, or I believe that's what they want. But your government's own record with regard to this bill of rights, with regard to patients and families, doesn't give anyone on this committee or anyone observing this committee or looking at this piece of legislation any confidence.

With all due respect to the members on the government side, I really urge you to consider putting this into the

legislation as it is, as it stands, without many changes—not as many changes as were made earlier in my amendment. It's the principle. It's an important principle, and it's going to demonstrate that you have a commitment to patients and their families. You need to do that because over the last two years, the signals that are being sent are not that. I'll leave it at that.

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

Ms. Teresa J. Armstrong: The whole process of us creating legislation is to have, of course, the committee piece and having presenters come and give us their perspective on the legislation. It's supposed to help you change your mind. It's supposed to help you open up your ideas that maybe what you've put in here isn't serving the public or there needs to be some changes because it's not going to work the way you intended to help people.

Obviously this government wants to improve home and community care, but taking the bill of rights out of legislation and putting it into regulation—the public has told you, has spoken to you and said that it's not the right way; it's not going to help. Your legislation is making it more precarious for vulnerable people. It's leaving more questions unanswered.

We've said that when there are changes in regulations, they don't come back to the Legislature for people to give input, give you a different insight. I think you're doing a disservice to yourselves when you don't have different ideas and insights into what you're proposing. Being one narrow-minded focus and truly not listening to other people's perspectives and how it's going to affect them gravely—I mean, we're talking about a bill of rights. That in itself is a title that's very crucial to a service: bill of rights.

This government is saying that yes, they're going to create it. They're going to consult. It needs changes. You can still do that when you have these consultations through legislation with people and then come up with something that's stronger. I'm sure people are wondering, when we're talking about the Ontario health teams not meeting for a year and we don't know what's going on, how is it that we believe that this government will actually do the hard work that it takes to create a stronger bill of rights in the face of the reality that we have today.

There are many things that people can contribute to strengthen the bill of rights. This is a wonderful starting point and it should be enshrined, absolutely. It talks about the familial and the linguistic and all those things. We talked about that when we heard from the Indigenous community. That's in the bill of rights. When you take that away, how are you going to guarantee that someone can't use that and say, "You know what? I want that in my health care. It's my right. It's in the bill of rights that I get that. I get to decide those things for myself."

1500

Chair, again, I'm not hearing much from the government on the rationale. We heard the Ontario health team part about the HR pieces, the security pieces. We get all that. There are already provisions in the law for those things when you're operating. But what rationale, what reasoning does the government have for taking out the bill of rights? It's not a privacy piece; I can't see why that would be a concern for them. It's really a power imbalance—that phrase has come up. You're creating a power imbalance when you're taking someone's rights out of legislation, when it comes to health care.

The Chair (Mr. Kaleed Rasheed): Further debate? I recognize MPP Joel Harden.

Mr. Joel Harden: There are two things I wanted to say just by way of adding a little bit more debate—because to some extent, given MPP Fraser's earlier amendment, which was analogous to this, we've had this discussion—but to add some new content to this debate, just in case anybody thought I was regurgitating things or getting something to read off of from somebody else all afternoon. That's not what I'm doing. I'm actually very interested in this debate from the standpoint of being the critic for people with disabilities for our caucus.

What I would invite my friends in government to consider is—you didn't take MPP Fraser's amendment, but you can take this amendment. It could accomplish, basically, the same thing, and you can even improve upon it. We can keep the bill of rights that we already have, codified under law, for people who avail themselves of home care services, and we even think you could one-up us and say, "You know what? We heard from Wendy Porch, we heard from John Mossa and we heard from the ACE legal centre. All those folks said, 'Let's even redefine this further to talk about not a patient bill of rights, but a consumer bill of rights.'" If you remember what we were told, also, by Tracy Odell, we were told, "Look, let's evolve our thinking around attendant care, around home care so it's not seen from a purely medical model," so it's not seen that if you live with a disability for your entire life, you're not any less of a person. What you are is someone who needs an equal opportunity to succeed, like everybody else; and to do that, you need access to well-funded, well-regulated, present home care. Take that as something I'm offering to my colleagues in government as an opportunity. Vote in favour of this, and then help us, under the law, perhaps improve it by the time it gets to third reading. I think that would be a huge step forward that we could take on a multi-partisan front.

The other thing I want to point you to under item 6 of the bill of rights that we have here, which we want to see codified in law, is the notion that "a person has the right to give or refuse consent to the provision of any" home and community care service. I want you to think from the standpoint of a consumer of home care. I want you to think about it from the standpoint of an elderly woman who's living in her apartment—I'm not going to talk about specificities of people we have helped through our office here in Ottawa Centre, but this is something that we've worked with before—who is very uncomfortable with the way in which home care is being provided.

Imagine for a moment a care worker presents themselves to a consumer's apartment, an elderly woman's apartment, and their job is to help that particular consumer have a bath. The amount of time they're given to transact

that task is 15 minutes. I want you to think about it from the standpoint of the person on the receiving end of that service telling the worker—and later, telling our office—this was an inappropriate amount of time to transact a reasonable service. Then what our home care system said back to the consumer and to the worker was, "Well, what can you accomplish? What can you accomplish in 15 minutes"—fully aware of the fact that this person hadn't been bathed in a week, and it might be two weeks.

It really makes me wonder, from the standpoint of being Ontario's critic for people with disabilities, what the values are that we are soldiering on with in our system. What I have been told by advocates with legal experience in this particular area is that this part of the bill of rights is actually integral for that constituent who lives here in Ottawa Centre to defend herself and what she's entitled to, irrespective of what the local LHIN decision-makers may say, irrespective of what the organization who employs that care worker may say. It gives the consumer an opportunity to push back, to assert their rights.

If we lift that out of the legislation, what we will do, I submit to you, is make consumers like the person I've described much more vulnerable in a society where we are going to have more and more people who are elderly, more and more people who are disabled, more and more people who need our help, more care workers who will need to help those folks. Every single one of us from all of our parties are saying that this will be the sector of growth—the attendant care sector, the personal support worker sector—because people want to age in place, they want to stay in their homes, they don't want to be defaulted into a tertiary institution or a nursing home institution—certainly not three to a room with 300 people in the building, if we've learned anything from COVID-19.

The focus is community care in the home. What I will say absolutely definitely is that this particular section of the bill of rights empowers consumers and safeguards their rights, so that when they disagree with the care, it ensures there's no retribution and there's no "Oh, you've said no to your worker in that instance so, therefore, we're just going to change up your care."

As my colleague MPP Gélinas mentioned, we have a much better standard here in Ottawa in being able to access home care services; imagine what that must look like if you're in northeastern Ontario or if you're in another part of the province that is not as well-serviced, whose needs are not seen with the level of intensity that we have here in Ottawa.

I want my colleagues in government to understand that this bill of rights exists for a reason. We can work together to actually improve it, instead of shifting it into regulations where folks with legal experience who have deputed to our committee have told us that you will diminish the rights of consumers, you will diminish the rights of care providers. I'm just going to make the assumption that none of us want to do that. So let's vote in favour of this and let's work together to improve it.

The Chair (Mr. Kaleed Rasheed): Further debate? Seeing none, we are going to vote now on NDP amendment number 10.

Ayes

Armstrong, Fraser, Gélinas, Harden.

Nays

Coe, Kanapathi, Martin, McDonell, Mitas, Oosterhoff.

The Chair (Mr. Kaleed Rasheed): The motion is lost.

We are now going to move to independent member motion number 11. MPP Fraser, please go ahead.

Mr. John Fraser: I move that section 2.3 be added to schedule 1 to the bill:

"2.3 The act is amended by adding the following section:

"'Plans respecting abuse – obligation of agency

"'21.1(1) The agency shall ensure that any health service provider to which the agency proposes to provide funding has in place a plan for preventing, recognizing and addressing physical, mental and financial abuse of persons who receive health services from the health service provider.

"'Same

"'(2) The plans mentioned in subsection (1) shall provide, among other things, for the education and training of the health service provider's employees and volunteers in methods of preventing, recognizing and addressing physical, mental and financial abuse.'"

The Chair (Mr. Kaleed Rasheed): Further debate? MPP Fraser, please go ahead, followed by MPP Mitas.

Mr. John Fraser: This is, I think, very straightforward. Again, it's something that we lost in the translation of this new legislation. Mental, physical and financial abuse is of great concern to us. There are many, many vulnerable people—vulnerable seniors, vulnerable people with disabilities—and we have established over a period of time that that's something that our health care system needs to be vigilant of and have a plan for. Having that in legislation will protect those vulnerable people and keep us vigilant to ensure that everyone is safe from any form of abuse. I would ask my colleagues to support this motion.

1510

The Chair (Mr. Kaleed Rasheed): Further debate? MPP Mitas, please go ahead.

Miss Christina Maria Mitas: I agree with MPP Fraser that this is straightforward, but I will recommend voting against this motion because of the fact that the government is committed, of course, to protecting patients from abuse when receiving health care services and the government can make regulations setting out requirements for abuse prevention plans and related training.

The government intends to continue, in regulation, the patient bill of rights outlined in the Home Care and Community Services Act, 1994, with minor modernization updates. The bill of rights will, of course, include a right to be free of various forms of abuse by whoever is providing services to the patient. A person would be able to make a complaint about a violation of this or any other right with the health service provider or Ontario health

team. These rights and related measures to support the safe delivery of care will, of course, be reinforced through accountability agreements and contracts, as they are now.

The Chair (Mr. Kaleed Rasheed): Further debate? Madame Gélinas.

M^me^ France Gélinas: I'm happy to hear that the intent to make regulations regarding abuse—that they intend to do it, that they intend to put it in accountability agreements, that they intend to put it into policy. But we are legislators. If you really want it to happen, you have the opportunity—right here, right now—this afternoon to make it happen. You put it in law, and then you know that forever on end, it will happen.

You don't know who will be in government. You don't know if you're still going to be there as an MPP. But you know one thing for sure, is if it's in legislation, the protection from abuse for very vulnerable residents of Ontario will be there. Leaving it to regulation: There are lots of regulations that never got made. Leaving it to policy: even more iffy. And leaving it to actual accountability agreements becomes even iffier. There's only one way to guarantee that it is done, and it is done for the next 25 years: Put it in law. This is what we could do today.

The Chair (Mr. Kaleed Rasheed): Further debate? I recognize MPP Fraser.

Mr. John Fraser: I want to go back just to comment: I believe and understand the government's commitment to putting the bill of rights into regulation, but what I just heard was "with minor changes." I'm getting a little bit of whiplash here, because there's talking about consulting on a new bill of rights and how that's important, and now I'm hearing that "We're going to make minor changes."

Look, we have a Patient Ombudsman now. It has taken two years to get there. I don't question anybody's intent, but it took two years. We have a body, the Patient and Family Advisory Council mandated by legislation, that brought forward a statement of values that's actually on the website and was touted by a release of the government. You can check it out. I think it was last March or May. But they're very important values that actually did inform the work we did on our previous amendment on the bill of rights.

There's not a shortage of information here and not a shortage of knowledge of what it is we need to do. The Patient and Family Advisory Council gave us those things. I really, really don't understand the government's reluctance to put this into law and, then, not to put this provision into law. It baffles me as to why they think that's not important. We can literally write every piece of legislation and say, "Well, we're going to leave it all up to regulation because it's easier to do and faster." That's not always good, anyhow, and often not good.

I just wanted to highlight that, and I want to ask my colleagues again to support this motion.

The Chair (Mr. Kaleed Rasheed): I recognize MPP Armstrong, followed by MPP Harden.

Ms. Teresa J. Armstrong: Once again, I think the bill of rights and this is just an addition to what is required of us as legislators to make sure that people are protected when they access health care. Putting it in legislation ensures that future governments can't tinker around with these things. They have to come back to the Legislative Assembly. We have to debate them. We have to have consultations from the public, as long as the government, of course, doesn't kybosh that as well.

We're talking about abuse. There are so many scenarios that can occur when someone comes to your home to provide health care. First of all, there's always a power imbalance. You're the one receiving that care, and someone providing that care has that power imbalance over you.

Basically, we're saying we're going to leave it up to regulation. We don't think it's important enough to solidify it in legislation to protect you. Putting it in regulation—I mean, a year down the road something could change and unless you look at the Gazette every day or when it's published, you won't know that that regulation has been changed and then, at that point, it's already been changed. It's not like there have been discussions about it. It's already a done deal.

Again, for this government to justify why you wouldn't have a plan for respecting abuse when it comes to health care, the bill we're talking about is quite concerning and has not articulated properly their reasoning for it, and it's really sad.

Abuse in any situation needs to be clearly defined in legislation so that the people who experience that have the levers to protect themselves, and this is not allowing people who are being abused to protect themselves. It's very shallow and it's watered down. As well as with the bill of rights, I think that this is not the right way to go.

The Chair (Mr. Kaleed Rasheed): Further debate? MPP Harden, please go ahead.

Mr. Joel Harden: I'm very glad we're talking about this. I have to be candid with my colleagues as part of this committee. This subject has been one of the most disturbing aspects I've had occasion to learn about in my critic work for disabilities and seniors. I find it deeply troubling—I'll share this, just so people know the gravity of the matter.

According to Elder Abuse Prevention Ontario, there are between—and this is all based on reporting, which is a tricky exercise—40,000 to 200,000 seniors every year in the province of Ontario who experience some kind of abuse. According to disability rights organizations, again the numbers vary widely. People with disabilities as well are disproportionately subject to abuse.

So when I heard MPP Mitas talk about minor modernization updates to the bill of rights, it makes my hair stand on end because if those minor modernization updates are not available for public scrutiny now, and we're going to find out about them later, in regulation, what will that do to stem the awful tide of the problem of abuse, which is happening right now? Literally right now, somewhere in this province, there is a senior who is being taken advantage of; there is someone with a disability who is having the same experience.

1520

So if we choose to believe the Advocacy Centre for the Elderly, Elder Abuse Prevention Ontario, the Office of the Public Guardian—people whose job it is to safeguard the interests of people who are disproportionately susceptible or vulnerable to abuse—I think we have to absolutely codify it in law, and if we don't, if we say, "Don't worry, trust us," we are not making serious inroads into these problems.

I could get into details that I've been privy to, but I have no interest in slamming the members of the committee with awful stories. I can assume that, from your offices, you know the sorts of stories that I would draw upon.

We have an obligation to make sure that home care and attendant care is safe—safe for the consumer, safe for the worker—and what I'm led to believe is, disturbingly, that is not the case for an alarming amount of people in our province.

So please don't tell me about minor modernization updates to come later under regulation. Tell me about what we can do with this amendment to codify rights under the law for people who deserve them. And if you say no, what you're implicitly telling people I'm accountable to is that their rights don't matter enough to be codified in legislation. Let's take a step back and think about what that actually means.

Mr. Onley has produced a report to this government—the third review of the Accessibility for Ontarians with Disabilities Act—which is very clear, talking about tragically acceptable prejudices people with disabilities face every day in this province.

If we can't take the word of Mr. Onley and of organizations out there on the front line working with vulnerable populations, and be inspired by that to put this into law, I think we really have to ask ourselves, what's the purpose of this committee's work? What's the purpose of what we're doing? I would think the most important purpose is for us to look after the most vulnerable and the most marginalized folks, at a minimum. If we aren't doing that, then we aren't doing our job.

I think leaving it up to regulations, with minor modernization updates, without disclosing those to the public, disclosing that to us right now so we can make informed decisions on this particular piece of legislation, is shameful. I'm going to be very clear, MPP Mitas. That is shameful. People with disabilities and seniors deserve to know what those minor modernization updates will be, given what they've experienced in the home care sector for decades.

Your government has to do better. By voting in favour of this amendment, you will send a signal to us that you have an intention to do better.

The Chair (Mr. Kaleed Rasheed): Further debate? Seeing none, we are now going to vote on independent motion number 11.

Ayes

Armstrong, Fraser, Gélinas, Harden.

Nays

Coe, Kanapathi, Martin, McDonell, Mitas, Oosterhoff.

The Chair (Mr. Kaleed Rasheed): This motion is lost.

What I'm proposing is a five-minute health break. It's 3:24. We will start at 3:30 on the dot. Now I have to make sure I'm back.

The committee recessed from 1524 to 1531.

The Chair (Mr. Kaleed Rasheed): Thank you all. I appreciate the much-needed break. We are now going to move to NDP motion number 12. MPP Armstrong, please go ahead.

Ms. Teresa J. Armstrong: I move that section 3 of schedule 1 to the bill be struck out and the following substituted:

"3. Section 21 of the act is amended by adding the following subsections:

"'Home and community care services

"'(1.1) The agency may provide funding to a health service provider or Ontario health team for the purpose of the provider or team providing funding to or on behalf of an individual to purchase home and community care services.

"'No funding to for-profit entities

"'(1.2) The agency shall not provide funding under subsection (1.1),

"'(a) to a for-profit entity; or

"'(b) for the purpose of having funding provided to or on behalf of an individual to purchase home and community care services from a for-profit entity.'"

The Chair (Mr. Kaleed Rasheed): Further debate? I recognize MPP Armstrong.

Ms. Teresa J. Armstrong: I think with this amendment, it's very clear: It requires that Ontario Health cannot provide funding for home or community care services to a for-profit entity. We've talked about this because we think that the funding that happens in home and community care should be specifically designated for care and not to private providers that squeeze profits out of the delivery.

It's something that I think we need to really re-evaluate. We've gone in the wrong direction. I know I mentioned earlier that back 25 years ago, there was only 18% privatization in health care. Now, we're at more than half. That trend—I think if you were able to keep reports and track these things, we'd see that the deterioration of health care has happened, the quality of health care has happened in community and home care because we are privatizing and we aren't showing transparency and accountability.

Yes, there are, as MPP Harden mentioned, some good private providers, for-profit providers, but that isn't the norm. Normally, reports have come out that when you have public not-for-profit services, health care specifically, the outcomes are much better, the quality of care is much better when they are not-for-profit. There are reports for that on child care, there are reports on that for long-term care, so it's not something that we can ignore. I think going forward, we can start changing the way our health

care system is delivered and make sure that for-profits aren't benefiting from public dollars.

We are saying here, if someone is contracting out, that Ontario health teams don't provide that funding to those for-profit homes. I think that's something we need to look at in today's world. It's forever changing what we're doing in this Legislature. With COVID-19, here we are in a committee room—some of us are here in person, others are on Zoom or technology—and there is a perfectly good example as how the world is forever changing. We can't just stick to the way we've done things. I think if we move forward and actually stop putting privatization and for-profit into health care, we're going to make a better system. It was a wonderful system when we had the not-for-profit.

Some 18% privatization 25 years ago; over half now privatization in health care. That says that we need to fix something. It's the same thing with long-term care when you look at the percentages of privatization creeping up over the last 25 years. It's something we need to fix.

I point back to the Canadian Armed Forces, who exposed that. But it has been exposed. Everybody knew about these things in long-term care and nobody took the steps to do anything about it. We don't need that to be something that happens in home care, when we're taking out the bill of rights, when we're taking out prevention of abuse. We're now setting ourselves up for a horrible situation in the future.

I have to say, again, I hope this government, when they say, "We're open to listening. We're open to hearing people that we represent. We're here for the people," but when you're not listening to what's being presented and you're not making it easy for democracy to happen and people to come forward—we had two PSWs in this committee to talk about their experiences. Some individuals that gave us their life experiences around health care—but you really need to listen to all kinds of different voices. From my perspective, a couple of days of presentations wasn't sufficient. If you're going to understand as a legislator, as an MPP, the gravity of how your decisions impact people, then you need to hear it.

I'll point to an example: The all-party Select Committee on Mental Health and Addictions. It was a non-party select committee that happened in 2010 where they got together and they listened, and they went throughout Ontario. I think it was for—was it, France, for 16 months? Something like that?

M^me^ France Gélinas: Eighteen months.

Ms. Teresa J. Armstrong: Eighteen months. Eighteen months that this Legislature decided this is an important topic where we need to consult. If you think about 2010 and where we are today when it comes to mental health and addictions, they were watching what was going on, but we acted too slowly. Now we're doing something here; we're saying, "Let's not keep privatization creeping into this," because as time goes on, we're going to develop models that aren't going to work for the people we serve.

Again, it's such a serious issue, it truly is. Every one of us at one point in our lives is going to access health care or know people that do access health care, and if we don't stop the train to privatization, we are going to pay for it dearly. Like I said, not having a bill of rights to be in legislation to have that protection and prevention for abuse, not having in that legislation protection of the patient, of the person receiving that care, is only going to cause a lot of pain for a lot of people. I don't know why this government can't acknowledge that and see that that's going to happen. But we're only here trying to be the voices of, maybe, their conscience; I'm trying to get them to change their minds. I hope they will support this.

The Chair (Mr. Kaleed Rasheed): Further debate? I recognize MPP Gélinas, followed by MPP Kanapathi.

M^me^ France Gélinas: I am grateful that the government allowed for 18 hours of deputations on that bill. During that time, 42 groups were invited. One didn't show, so 41 people and agencies came and talked to us.

We live in a democracy. Out of the 41 people and groups that came to talk to us, 36 of them spoke either against privatization or for not-for-profit.

1540

Whether you look at the Advocacy Centre for the Elderly; the Adult Enrichment Center; the Alliance for Healthier Communities; the ARCH Disability Law Centre; the Alzheimer Society; the Centre for Independent Living in Toronto; the Chatham Kent Health Alliance; the Canadian Mental Health Association; the Chiefs of Ontario; the Communist Party of Canada; the Canadian Union of Public Employees; the Ontario Council of Hospital Unions; the Citizens with Disabilities; Mrs. Lin Grist; the Hamilton and District Labour Council; Innis Ingram; the Interfaith Social Assistance Reform Coalition; the Kingston Health Coalition; the Ontario Community Support Association; the Ontario Federation of Indigenous Friendship Centres; the Ontario Federation of Labour; the Ontario Hospital Association; the Ontario Health Coalition; the Ontario Health Coalition, Guelph Wellington chapter; the Ontario Medical Association; the Ontario Nurses' Association; VON, the Victorian Order of Nurses; Unifor 1451, the retiree chapter, as well as the Unifor national office; the United Food and Commercial Workers, Locals 175 and 633; Jules Tupker; the Toronto Seniors' Forum; Hilda Swirsky; SEIU Healthcare, Mervyn Russell; the Registered Nurses' Association of Ontario; or Michael Rachlis, they all spoke either against privatization or for not-for profit delivery. We live in a democracy. When so many people who took the time to come to us, took the time to talk about this topic, they cannot all be brushed away and ignored. This is not how democracy works.

The legislation is open to privatization. There's a not-for-profit loophole, more or less, where it allows for the subcontracting of the delivery of care, home and community care delivery, to for-profit agencies. As MPP Teresa Armstrong was saying before me, way back, before Mike Harris made the first round of changes, only 18% of the care delivered in home and community was by for-profit. When the bidding contracts started, the competitive bidding—I'm still saddened to this day to say that VON

Sudbury went bankrupt. They lost the contract to—at the time it was Bayshore who underbid them. All of the nurses who had built a career in providing home care were out of a job. They were made to reapply for their job with the new health care provider, except that the job came with no benefits, no pension plan and a cut in pay.

What do you figure happened? Most of those nurses found jobs elsewhere, and it has been the same thing for the last 20 years. Home care is not able to recruit and retain a stable workforce. If you don't have continuity of caregivers, you don't have continuity of care. You don't have quality care. All of this is all linked to privatization, with a competitive bidding system that basically gives contracts to the lowest bidder. And how do you have a low bid? By not paying your employees a living wage.

This has to be addressed. It is your opportunity to do this. I hope you'll seize the opportunity.

The Chair (Mr. Kaleed Rasheed): Further debate? I recognize MPP Kanapathi, followed by MPP Harden.

Mr. Logan Kanapathi: I recommend voting against this motion, because the government's priority is to strengthen the publicly funded health care system, making it better for patients, families and their caregivers. This motion would only apply to a self-directed care program, a home care program designed to maximize the family's choice of qualified care providers. For home and community care more broadly, including self-directed care, Bill 175 supports the current delivery model for home and community care, which is outlined in the Home Care and Community Services Act, 1994. Any changes to the delivery model would need to be carefully implemented to ensure no disruption of the continuity of patient care.

Similarly, Bill 175 would support the current model for self-directed care, where home care patients may purchase services in accordance with their care plan from a qualified provider of their choice. This model maximizes the patient's choice in their selection of qualified providers, which puts people at the centre of their care.

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

Mr. Joel Harden: I want to echo what my colleagues have said—MPP Armstrong and MPP Gélinas—about what we appear to not have learned about the impacts of privatization in the sector.

I just want to note, for the record, that the managed competition model, which began under then-Premier Mike Harris's government, has been implemented, and we can see the effects. Research has been done. We can see the effects of lost service, with PSW visits not taking place. We can see the effects on the working conditions of PSWs. We heard from two PSWs provided to us by their union, SEIU Healthcare, who talked about what work is like. That's on us. It's on no one else. It's on Legislatures that decided, "We're going to go with this managed competition model because getting the lowest price is what's good for the industry." We have allowed for-profit organizations, which are not required to disclose any aspect of their business to the wider public, to take a larger and larger role in our home care services.

I'm going to make a guess here that, in the next provincial election, nobody taking part in this committee is going to be campaigning on the basis of extending for-profit health care with user fees attached to it. Nobody could get re-elected anywhere in Ontario with that as a platform. That was something that Dr. Rachlis said to us in his deputation. No one could get re-elected on that basis.

And yet, here we are with a home care system that is delivered more and more by for-profit organizations that are not compelled to disclose any of their administrative costs and any of the ways in which their executives are compensated. Let's just think about that for a second.

We've heard about what life is like for personal support workers working directly with people who are consumers of home care services. We've heard from the Advocacy Centre for the Elderly and from ARCH Disability Law Centre. We've heard from Wendy Porch and John Mossa, from the Centre for Independent Living in Toronto, about what life is often like for people who are trying to access decent attendant care and decent care work.

The for-profit industry has had a major leg up, and the only conclusion that I can draw is that that industry has had great access to government in recent decades.

I want to caution my friends in government that if you move forward with permissive legislation, which is what this is—I take the point that MPP Oosterhoff and MPP Mitas and MPP Martin have mentioned, about, "Well, there's nowhere in this bill that is explicitly saying we will be moving forward with the private delivery of home care services." That was never our point when this was being debated at committee. Our point, as members of the opposition caucus, was to remind our friends in government that this is permissive legislation. There's nothing in this legislation to stop us from furthering the creep of large, for-profit industries that, frankly, act as creeps, that act as awful employers to their members.

I'm thinking about how all of us, so many times in the Legislature, stood united, thanking our health care heroes, thanking those who had the courage to go into the apartment buildings, into people's homes, to help people get tested for COVID-19, to help people get the support and the care they need. We all stood on our feet and we applauded those care workers.

And yet, in this legislation, we are implicitly, permissively encouraging the growth of a for-profit industry, with absolutely nothing by way of oversight. That really should make us think about where the country and where the province is going.

I know that former Premier Harris, not long after he left political life, found himself on executive governing structures of for-profit nursing homes, as the chair of Chartwell. He earns a tidy benefit for that. I also know that former Premier Harris started up a franchise of Nurse Next Door, which is a for-profit organization delivering home care services.

1550

So I'm impressing upon my Conservative colleagues and members of this committee: Do you want to be associated with that legacy of your party? Do you want to

be associated with that legacy of your party that has said, "Okay, we can't afford to invest more public funds in public and not-for-profit delivery of home care, so we're going to set up a managed competition model," which, as my colleague MPP Gélinas said very well, advantages people who compete on the costs of labour? And we heard it from Bayshore executives who deputed to us who said that 37 hours a week is too many hours. "We have to worry about overtime in that context. We have to ration their hours."

Think about the mentality of that. That is absolutely obscene. In this day and age, we have a huge opportunity—to young people, to people who are retraining who may have had training from other parts of the world and have come to Ontario to make a better life. We have a huge opportunity to offer great employment and necessary services in home care, but we have to make sure we are attentive to the working conditions and the consumption conditions for the consumer in this industry, and we haven't been. We have not been.

If you vote for this particular amendment, Chair, I will say through you to my colleagues on this committee, that we will commit to turning over a new leaf. We will say, "Okay, medicare, a legacy of public medicare which the veterans insisted we put in place, so everybody could get the benefits they needed to make sure they can live safely and can contribute to our society, that celebrated public aspect of our society, that is going to continue." If you vote for this amendment, that tradition is going to continue.

If we say no because we are going to have faith that the government, in the preamble to this legislation, agrees with public medicare, we are not putting ourselves, as a Legislature, right there on the line, showing them clearly that we agree with those community values of making sure that medicare is public and that we increase the scope of the public medicare system so it can get people the care they need when they need it. So the care-working conditions for those wonderful heroes who deliver those services to people who need them, work in decent conditions. They can feed their families, they can rely on predictable hours, they can have benefits for when they need them. That's the kind of care system we could build.

But if we have permissive legislation that allows what exists to keep going forward, what we're going to have, I fear, are larger and larger monopolies operating on public dollars at benefit to those organizations delivering 61 cents, as the Auditor General said in 2015—61 cents of every public dollar invested in private home care was going to the front line, and 39 cents was being hived off somewhere else. Many of my Conservative colleagues who are part of this committee have history in business. I ask you: Could you foreseeably run a business with that kind of mission, with that much money being hived off for administration? It's obscene, absolutely obscene.

So let's make sure we pass this amendment so we can actually say, "This is what we've committed to. We've committed to a standard of care, a delivery of service model that we're very familiar with in the tertiary sector where we have to grow it in the community care sector."

The Chair (Mr. Kaleed Rasheed): Further debate? Seeing none, we are going to move to the vote.

Ayes

Armstrong, Gélinas, Harden.

Nays

Coe, Kanapathi, Martin, McDonell, Mitas, Oosterhoff.

The Chair (Mr. Kaleed Rasheed): Motion lost.

Now we are going to move to an NDP motion, number 13. MPP Harden, please go ahead.

Mr. Joel Harden: I would like to move the following amendment: I move that section 3 of schedule 1 to the bill be amended by adding the following subsection:

"(2) Section 21 of the act is amended by adding the following subsection:

"'Assessment

"'(1.3) Funding may only be provided under subsection (1.1) if the health service provider or Ontario health team ensures that the home and community care services needs of the individuals who will be purchasing the home and community care services are assessed by a person with expertise in primary care assessment who is unrelated to the entity that will provide the home and community care service.'"

The Chair (Mr. Kaleed Rasheed): This amendment makes reference to a subsection that does not exist. I therefore rule this amendment out of order.

Shall schedule 1, section 3 carry?

Ayes

Coe, Kanapathi, Martin, McDonell, Mitas, Oosterhoff.

Nays

Armstrong, Fraser, Gélinas, Harden.

The Chair (Mr. Kaleed Rasheed): Carried.

Shall schedule 1, section 4 carry?

Ayes

Coe, Kanapathi, Martin, McDonell, Mitas, Oosterhoff.

Nays

Armstrong, Fraser, Gélinas, Harden.

The Chair (Mr. Kaleed Rasheed): Carried.

Now we are going to move to NDP motion number 14. Madame Gélinas, please go ahead.

M^me^ France Gélinas: I move that section 4.1 be added to schedule 1 to the bill:

"4.1 The act is amended by adding the following section:

"'No delivery of home care and community services by for-profit entity

"'23.0.1(1) For-profit entities shall not provide home and community care services.

"'Offence

"'(2) Every person or entity who contravenes subsection (1) is guilty of an offence.'"

The Chair (Mr. Kaleed Rasheed): Further debate? I recognize Madame Gélinas.

M^me^ France Gélinas: We fully understand that since the Mike Harris years, we went from 18% for-profit delivery to 65% for-profit delivery in our home care system. In the meantime, our home care system has gotten worse, not better. We fail more people than we help pretty much every day in home and community care. To put this in legislation sets the path toward recovery, sets the path to make sure that every dollar invested in our home and community care system goes to care, not to profit.

We're in the middle of COVID-19. We see the lack of preparation with the catastrophic outcomes of for-profit long-term-care homes on the lives of our elderly. We are at 2,657 residents of our long-term-care homes who have died from COVID, the majority of them from for-profit long-term-care homes. We know that we can do better. We know that there will be lessons to be learned from COVID. Some of them will apply to the home and community care sector. We all know this. We have an opportunity as legislators today to set that path into motion to make sure that care is delivered by not-for-profit entities, that every penny that is invested into care goes into care, not into the profit-making of for-profit companies.

The second thing that happens with for-profit is that because they have to compete for contracts, they hide their best practices. In health care, when a best practice becomes available, it will be shared. It doesn't matter which annual conference you go to; there is always a big part of those conferences in health care that is on best practice. You've identified a new best practice for cataract surgery, for hip replacement, for dealing with people with mental health and addiction; you share those best practices. Not in home care. In home care, a best practice is seen as a competitive advantage to get the contract, not the way to bring our home and community care system forward toward best possible quality.

You have an opportunity to put this in the law; don't let it go by.

1600

The Chair (Mr. Kaleed Rasheed): I recognize MPP Fraser, followed by MPP Martin. MPP Fraser, go ahead, please.

Mr. John Fraser: No, I'm good, Chair.

The Chair (Mr. Kaleed Rasheed): Oh, okay. MPP Martin, I recognize you.

Mrs. Robin Martin: I would recommend voting against this motion, because the government's priority is to strengthen the publicly funded health care system and make it better for patients, families and their caregivers. Bill 175 actually supports the current delivery model for home and community care. This model requires organizations approved to deliver home and community care services to be non-profit, and enables them to contract for-profit and not-for-profit organizations for the delivery of home care services.

If the government wants to make changes to the current delivery model, it can do so through regulation. Changes would not be made without comprehensive engagement with patients and health system partners. In addition, any changes to the delivery model would need to be very carefully implemented, to ensure that there are no disruptions in the continuity of patient care, which after all, should be of primary importance to all of us.

The Chair (Mr. Kaleed Rasheed): Further debate? I recognize MPP Harden. Go ahead, please.

Mr. Joel Harden: I want to continue in the vein that my colleague MPP Gélinas mentioned about this particular bill and react to what MPP Martin just said, which are words we've heard already this afternoon.

I think it's really important to remember that publicly funded care is not the same as publicly delivered care. That is the lesson, I think, for the home care sector. We can publicly fund things, but we could also, in the end, deliver it through an insufficient mechanism. Those insufficient mechanisms, for me, have names like Bayshore, CarePartners and ParaMed. In my opinion—and I will edify that opinion further when I get further disclosure and I can investigate some of these organizations more closely—every bit of evidence I've had reason to accumulate today leads me to believe that these organizations have been competing on the well-being of workers who happen to work for them and create all the value for them, and customers who require their services to lead meaningful and fulfilling lives. That is an important distinction. When I hear MPP Martin say that the government will consult and the government will ensure that publicly funded medicare continues, first of all, MPP Martin is not drawing the causation link between publicly funding something and publicly delivering something. That's the first point.

The second point is that I fear, given what we see in the long-term-care sector, that some of the partnerships that had been evident between the private long-term-care industry and this government may begin to repeat themselves in the home care industry. That's, frankly, what I'm worried about in the absence of more disclosure. For example, Mr. Patrick Tuns was the manager for Premier Ford's 2018 election campaign, and now he is a lobbyist for Caressant Care, which is a major for-profit long-term-care organization in the province of Ontario.

My question, Chair, through you to my colleagues, is: What will we find out when you decide to pass these apparent protections for public health care later about their impact upon home care, about the relationships you may or may not have with private home care operators? I think you as a government, colleagues, need to make these links clear right now, because as of right now, June 1, Ontario's Patient Ombudsman has started an inquiry into your handling of the long-term-care situation under COVID-19, where so many of our loved ones have lost their lives. So

many care workers have also lost their lives, or felt terribly insecure, in the course of doing their duties in the long-term-care system. What will we find out if we don't get this right, if we don't make sure we stop the hemorrhaging of public dollars into private hands through private delivery of home care services in the province of Ontario?

We need only look west of Kenora into the province of Manitoba to see a different way in which home care is being delivered, Chair. There, they do have a robust system that is very popular with voters of all stripes in that province, I'll have you know, because I had occasion to talk to folks out there in the course of doing research for our committee work, they support their public home care system there. When previous governments have attempted to change it and allow for a role for the private, for-profit delivery of home care with public dollars, the people of Manitoba have spoken up and said no.

We have a choice here, as their neighbours in the province of Ontario, to learn from the Manitoba experience and say, "Actually, it's important for us to make sure that public health care dollars are administered and delivered through public, non-profit entities, because we want every single cent that people pay in their taxes to the province of Ontario to be brought right to the front lines of the services that people need."

I'm not mollified by what MPP Martin has said about robust consultation and commitments to public health care in the abstract, and I'm surprised that someone as intellectually deep and clever as MPP Martin would offer that excuse to us this afternoon. If you believe those things, MPP Martin, why don't you, in voting for this amendment, offer a message to your party and say that it's time for us to look out for the greater good?

MPP Martin and I are both fans of Professor Charles Taylor. I understand in deputations she acknowledged, in her conversation with Dr. Rachlis, having studied with Professor Taylor. Think about the legacy that Professor Taylor often talks about, MPP Martin, in thinking about the politics of redistribution in this country, the politics of recognition, the politics of understanding how we give people, through positive liberty, an equal opportunity at a decent life. Do we do that if we hemorrhage 39 cents of every public dollar to greedy for-profit operators, who are competing on the basis of home care workers who make a pittance, who don't get paid travelling between working with different consumers of services, who aren't given sick days? Is that a fitting legacy for what Professor Taylor has imparted to our country, that you and I have both had the benefit to learn from? I'm shocked, to be honest.

I think it would be a great moment if all of us participating in this committee's business could say it's time for us to reverse the legacy—reverse the legacy of private operators hiving off public dollars for private benefit. It's time for us to put all of those resources into the front lines, and this is an important way in which we can communicate that interest to the public.

The Chair (Mr. Kaleed Rasheed): Further debate? I recognize MPP Armstrong.

Ms. Teresa J. Armstrong: I also noticed the explanation about having more public consultation. I think the word was "comprehensive" consultation. If we think about that, what has been said is we haven't had comprehensive consultation. When we look at the presenters last week, when they said that they weren't consulted, those would be the two that we've discussed today: the Chiefs of Ontario and the Ontario Federation of Indigenous Friendship Centres. If we are talking about how comprehensive consultation in the preamble under the Indigenous portions about how they're going to include them in health bills hasn't actually come to fruition, it's hard to believe that that will be the case.

I'm very proud that we're bringing up this issue about for-profit and not-for-profit, because it needs to be. It's long overdue. When we say that our system is publicly funded, we also have to have it publicly delivered. Just to say that a system is publicly funded does not guarantee that you will have it publicly delivered. Those are two crucial differences. Making the for-profits have no delivery of home care under this amendment to community services is something we should do.

I have to tell you, when we created this amendment—and reading it over even now, it says,

"Offence

"(2) Every person or entity who contravenes subsection (l) is guilty of an offence."

That's pretty strong. Those are pretty strong ideas about how we should not have our public dollars given out for delivery to for-profit entities. When we were in our committee, we heard that people were concerned about that model: publicly funded for-profit delivery. And we heard about the transparency and accountability of those pieces.

1610

This is, again, another motion talking about strengthening the accountability and responsibility of us as legislators, of people who are delivering that home care. If we've taken things out into regulation left, right and centre when it comes to people who are receiving their home care, let's at least make the companies accountable for the care that they deliver. That's another piece that's missing if we don't stop the further privatization.

Presenters were asked to drill down those details where it is. Well, we know where it is. It's the overall bill. When you don't have declarations of conflict of interest, when you don't have public involvement in board of health meetings, when you take out things that protect patients—those make it weaker. It weakens legislation when things are in regulation.

Again, I say to this government that these conversations need to be had. I was hoping that if we did have comprehensive consultation on this bill, there could be very strong arguments and examples brought forward around those things as to why we need to stop the privatization of for-profit health care and change the direction that we're going—going back, like we said, 25 years ago, 18%, and now over half. We know that there are players in home care and long-term care that have had a stake in this legislation and are benefiting from that.

I was listening to a CBC news media report on the weekend, and they talked about how people get ahead by pedigree. When we're talking about benefiting and taking away conflicts of interest and family members—how do you know that these contracts won't be given to people who have conflicts of interest? We don't. There's no transparency around that.

I know this government will vote against it. This is probably not a government that's going to look at not-for-profit home care and make sure that it stays that way going forward. But I do look to the future of health care, and this is opening the doors for further governments to hack away at this even further when there's not legislation protecting it.

The Chair (Mr. Kaleed Rasheed): Further debate? Seeing none, we're going to move to vote.

Ayes

Armstrong, Gélinas, Harden.

Nays

Coe, Kanapathi, Martin, McDonell, Mitas, Oosterhoff.

The Chair (Mr. Kaleed Rasheed): Motion lost.

Shall schedule 1, section 5 carry?

Ayes

Coe, Kanapathi, Martin, McDonell, Mitas, Oosterhoff.

Nays

Armstrong, Fraser, Gélinas, Harden.

The Chair (Mr. Kaleed Rasheed): Carried.

Now we are going to move to NDP motion number 15. MPP Harden.

Mr. Joel Harden: I move that section 5.1 be added to schedule 1 to the bill:

"5.1 The act is amended by adding the following section:

"'Annual financial report

"'25.1(1) Every health service provider and Ontario health team that receives funding from the agency shall provide an annual financial report to the minister on or before June 30 of each year including,

"'(a) the most recent financial statement of the health service provider or Ontario health team; and

"'(b) the total annual compensation of each executive employed by the health service provider or Ontario health team.

"'Publication of report

"'(2) The minister shall publish the report on a government of Ontario website as soon as possible after receiving it.

"'Definition

"'(3) In this section,

"'"executive" means an employee of a health service provider or Ontario health team who,

"'(a) is the head of the health service provider or Ontario health team, regardless of whether the title of the position or office is chief executive officer, president or something else,

"'(b) is a vice-president, chief administrative officer, chief operating officer, chief financial officer or chief information officer of the health service provider or Ontario health team, or

"'(c) holds any other executive position or office with the health service provider or Ontario health team, regardless of the title of the position or office.'"

The Chair (Mr. Kaleed Rasheed): Further debate? I recognize MPP Harden, followed by MPP Oosterhoff.

Mr. Joel Harden: I will just submit, because I've mentioned it many times in the course of our discussions and listening to deputations, that I find it rather alarming that we don't have this disclosure today. This is a multi-billion dollar sector that is publicly funded, and the people of Ontario deserve to know how public dollars are being used in the provision of home care services that, while publicly funded, are not necessarily publicly delivered.

What we've learned in revelations about the long-term care industry, allied industry and industry that exists in the caring professions is that many of the executive compensation levels are absolutely obscene, where executives in the private long-term-care industry, who are largely publicly funded in many cases, are drawing salaries that, in a day, are more than many personal support workers make in an entire year.

As a legislator, I would like to have the information to make informed decisions about how our money is being used. In the course of deputations, I asked the CEO of Home Care Ontario, Sue VanderBent, this particular question. I asked Stuart Cottrelle, president of Bayshore Ltd. if they would agree to the notion of full public disclosure.

From Ms. VanderBent, I did not get a commitment. I was told it was going to open up "another conversation." I'm not entirely sure what that other conversation that was being referred to was. But from Mr. Cottrelle, I heard that they had a big interest in getting more public contracts and, in doing so, transparency was really important. But I didn't get a commitment from either of those representatives of the private home care industry to submit to the people of Ontario, to the taxpayers of Ontario, to the people whose funds we use to redistribute into public services to meet human needs—I did not get any inkling from them about whether it was incumbent upon them to share with the people of Ontario how they utilize public dollars in the delivery of home care services.

This amendment would change that. I understand from what Mr. Cottrelle told us is that they are already required to deliver some of these documents to the Ministry of Health. Believe me, we will be making every effort to try to access those documents, as people have done in the past, but what we don't have now, which I think we ought to all be able to agree on, is enough information to make

decisions. The 2015 report of the Auditor General was cause enough for me to be deeply concerned about how we need to be making sure that we are getting the most out of the public funding that we have.

Chair, I hope this is something that is just automatic. What I hope to hear from my colleague MPP Oosterhoff is that the government is prepared to require operators who are providing home care services to disclose what they spend on administration, what they spend on executive compensation. I should hope at a bare minimum that we could agree that the public deserves to know this information. Thank you.

The Chair (Mr. Kaleed Rasheed): Further debate? MPP Oosterhoff.

Mr. Sam Oosterhoff: I do appreciate my colleague's comments, but I do recommend voting against this motion because the Connecting Care Act already includes provisions that require Ontario health teams and health service providers to provide their plans, reports and financial statements, including audited financial statements, to Ontario Health, and Ontario Health must, in turn, provide this information to the minister within the time frame in the form that the minister specifies.

1620

The government typically implements reporting requirements through accountability agreements and contracts, and we do provide oversight of executive compensation for Ontario health teams and public service providers. Then the other requirements related to the disclosure of compensation would be best addressed through other legislation such as the Broader Public Sector Executive Compensation Act, 2014.

The Chair (Mr. Kaleed Rasheed): Further debate? I see MPP Harden, followed by Madame Gélinas.

Mr. Joel Harden: Thank you, Chair. I'd prefer to go after Madame Gélinas, having had the benefit to speak already, but please put me on the list.

The Chair (Mr. Kaleed Rasheed): Sure. Madame Gélinas, I recognize you.

M^me^ France Gélinas: I understand that MPP Oosterhoff shared with us what the intents of the government are. You have to realize that, right now, public hospitals are all publicly funded and publicly delivered, except for the four private hospitals that predate medicare. All already share that information. The way the bill has it now, under the Connecting Care Act, is that this information will be contained in accountability agreements that will be shared with Ontario Health and that will be shared with the government, but none of us will ever see it.

I can tell you that just the fact that compensation of hospital executives is now available on their website has changed things for the better. I can tell you that the outliers that were there before are not there anymore. Once the boards of the 152 hospital corporations in this province looked at how much the other hospitals were paying their executives, they all looked at this and, surprisingly enough, the total package did not go up, it went down. All of the outliers who were making $1-million salaries, those executives are not there anymore, and the new executives who have been recruited are more in line with everybody else. This is happening right here, right now in Ontario, and I think it is something that we will all agree was good.

The problem with the way the bill is now is that, although this information will be reported for the not-for-profit deliverer, it will never be available. The positive that came out of making compensation of hospital executives public is that it had an element of pushing everybody's wages down to more or less a range, depending on the size of your hospital and the size of your budget—of course, a little hospital in Espanola does not make the same salary as UHN. We all understand why not: One has 56 beds; the other one has thousands. But if you look in the categories of hospitals, given a few years, they all came in line.

This is what we're asking. This is the opportunity that we have now to put into the bill the same thing. Don't keep it a secret. Keeping it a secret does not help the taxpayers, does not help the people on the board—if there is ever a board assigned to this down the road, which still needs to be seen. Transparency leads to good things for the public purse. Don't let it go by.

The language that we use in this particular motion is the language that comes from the broader public sector act, and it's an opportunity, because this bill is open right now, to bring this and to extend it to the for-profit, because although the not-for-profit long-term-care homes have to disclose their salaries, the for-profit do not. In our hospital system, as I said, 152 of them are not-for-profit deliverers, we know, but for the four for-profit hospitals, they are not covered. This bill would cover them all. I think we would see the same end result that we saw when this was rolled out to our hospitals, and it helps the public purse. Why not take advantage of it?

The Chair (Mr. Kaleed Rasheed): I recognize MPP Harden, followed by MPP Fraser.

Mr. Joel Harden: Chair, I'm happy to go after MPP Fraser; he hasn't spoken yet. But I'd like to go after him.

The Chair (Mr. Kaleed Rasheed): Sure. MPP Fraser?

Mr. John Fraser: Thanks very much, MPP Harden. I'll be supporting this amendment. It's very reasonable and in line with what we want to be doing here in Ontario with regard to value for money in our health care system, and the inclusion of people who aren't currently reporting financial salaries and other financial details around their operation needs to happen.

The Chair (Mr. Kaleed Rasheed): I recognize MPP Harden for further debate.

Mr. Joel Harden: I just want to respond to some of what I've heard in the debate so far. One of the reasons I think it's really important to require disclosure is, frankly, to surface some of the assumptions that I think are being made by successive governments in Ontario, as they made the assumption that it's important to create a managed competition model in which we are awarding home care contracts on the basis of who can deliver the most service for the lowest possible price.

One of the revelations that has come out since in the allied sector of home care and long-term care is the fact that 90% of corporate directors at some of Canada's

biggest for-profit nursing homes have actually no medical qualifications. The people sitting on the boards of these large entities that have a huge impact into nursing homes have actually never themselves undertaken any medical training of any kind. By and large, the people making the board decisions have substantial, I'm sure, knowledge of business and economic factors in running an organization, but they don't have medical knowledge. A stark example for me, and I was surprised to read this, is Chartwell, whose board right now has not a single health care provider—not one. It has a Premier who is chair of the board, but it has not one health care provider.

So that makes me curious, Chair, I have to tell you. When I'm asking for this information about administrative costs and executive compensation, I want to know—because the people of Ontario are investing in these organizations—how they run. I want to know what their priorities are. I want to know what their values are, because the decisions they make have a huge impact on the livelihoods and well-being of people with disabilities and seniors in this province.

What I heard MPP Oosterhoff say is that he's comfortable, that regulation and other statutes around executive compensation are suitable enough to surface the information for people like us to make informed decisions about how the sector is being run. What I would submit to my colleague in response is to say, has that happened to date? Do we know how much is actually earned by executives at Bayshore or ParaMed—actually, ParaMed would be easier to find out, because it's part of the publicly registered company Extendicare. But organizations that have a huge role—CarePartners. Do we know how much money they're specifically spending on executive compensation?

All I know, what I'm basing my decisions upon as we deliberate here in this committee, is what the Auditor General reported in 2015 and what I've heard anecdotally from care workers in the sector and care consumers—be they people with a disability or seniors—who routinely are telling me the same thing: We are not getting value for money. We're having too much money lost in administrative costs. In fact, I recall—MPP Gélinas will remember the proprietor's information—the two women who presented to us, MPP Gélinas, from your area, from Nickel Belt and Sudbury, explicitly saying that they were absolutely disgusted by the amount of money that was lost in administration to some of the larger operators with whom they had participated earlier in their career. So they decided they were going to create a private, local home care service—which I can only assume is wonderful; they were so passionate about their work—for people who can afford those services.

But what I'm saying in the course of our deliberations here is that this amendment will give us the information to dive down that rabbit hole a little bit to figure out if we're actually getting value for money. With all due respect, MPP Oosterhoff, I am not confident that the statutes that we have have helped us do that, and I think we get elected to these positions, we serve on these committees, we do our parliamentary work with the intent of getting the best information to make the best possible decision.

1630

So I will be candid: I will be stunned if this amendment doesn't pass. What it will tell me is that I'm going to be relying upon the wiles of our own office here in Ottawa Centre, the work of MPP Gélinas's office, the work of MPP Armstrong's office, who is our lead on home care. I will be relying on wonderful investigative reporters like Zaid Noorsumar, who has been doing some fantastic reporting in this area. But we could do a lot better. I think we should be compelling disclosure when we give people public funds to offer public services to Ontarians. I would hope that that could be a multi-partisan consensus, that that information—it shouldn't be debatable, whether we get that information or not. Because it's being channelled through this particular ministry, I think this particular piece of legislation is an appropriate place to ask for disclosure. Thank you.

The Chair (Mr. Kaleed Rasheed): Further debate? MPP Armstrong.

Ms. Teresa J. Armstrong: It's a great motion, and it highlights the contradiction in rules between one agency or service provider and the other. Why is one open and transparent of what their executives get paid and the other one isn't? I don't understand those differences. What's good for one should be good for the other when it comes to publicly funded or privately delivered or publicly delivered. This motion just really sets the record straight that we need to know what people are getting paid when they're accessing public money when they're delivering health care. If we've decided that for not-for-profit we can find that information out, why is the for-profit not under the same rule? What is so special about the for-profit, privatized corporations or care providers that they don't provide that information? We're asking that the not-for-profits do that. Why are the rules different in the same health care realm? This amendment corrects that, and it only, as members have said, will help to shed a light on what's really going on when it comes to compensation.

We know that that has happened with the long-term-care file—what the compensation, what the profits have been in long-term-care for-profit agencies recently. It's in the billions of dollars, and people are shocked when they hear that, that people are profiting from our long-term-care system, but that shouldn't be a surprise, because we've never had access to these figures. Now, we have—I'm going to tie it in—the fact that the government is looking for immunity for the situation that happened under COVID, and the majority of them are for-profit.

I ask why the rules are different. In not-for-profit, there's full transparency around funds and where they go and who gets paid and how much they're paid, whereas in the for-profit private sector, the rules are different. That does not make sense, and it needs to come to light.

I fully agree with this amendment and hope that people will understand the reasoning behind it. You can't make rules for one sector and the other sector, but they're both health care providers. That is government wheeling and dealing that we don't want to see happening. It would be a step in the right direction, at least to say, "If we're going

to accept the privatization that's there now—this government accepts it—we're at least going to be open and honest about what people are paid in that sector." Thank you.

The Chair (Mr. Kaleed Rasheed): Further debate? Seeing none, we are going to vote now.

Ayes

Armstrong, Fraser, Gélinas, Harden.

Nays

Coe, Kanapathi, Martin, McDonell, Mitas, Oosterhoff.

The Chair (Mr. Kaleed Rasheed): Motion lost.

We are now going to move to NDP motion number 16. I recognize MPP Armstrong.

Ms. Teresa J. Armstrong: I move that section 5.2 be added to schedule 1 to the bill:

"5.2 The act is amended by adding the following section:

"'Annual report assessing home and community care service needs

"'25.2(1) The minister shall, in consultation with the agency, prepare an annual report that assesses Ontario's need for home and community care services.

"'Publication of report

"'(2) The minister shall publish the report on a government of Ontario website on or before December 31 in each year.

"'Tabling

"'(3) The minister shall table the annual report in the Legislative Assembly as soon as possible after it is published.'"

The Chair (Mr. Kaleed Rasheed): Further debate? MPP Armstrong.

Ms. Teresa J. Armstrong: Again, this is a very important amendment because we are, first of all, looking at a report assessing home and community care services. This is an opportunity we can take so that we can actually analyze and review what's happening currently, so we can predict and project for the future needs of people as they age.

We're all asking to age in place. That's where people want to be as they get older. So to know what's going on now and using those as stepping stones to the future so that we can create proper legislation to assess people's needs, and provide those services as we go along rather than causing long wait-lists and a shortage of workers, these are ways we can encompass better legislation going forward—and being prepared, quite frankly. Being prepared for the workforce that we need. Again, this legislation doesn't address the HR commitment that should be in here, when it comes to good-paying jobs with benefits and sick days and health and safety for workers.

Having this actual annual report makes the government follow this file on a regular basis annually so that it can continually tweak and make the changes that are needed to ensure that we do have quality health care, to ensure that patients are getting the health care that they've been promised, quite frankly.

The publication of the report is very important. Again, we say that it needs to be public. People need to see what the results are. We need to see how good we're doing under this file. If there are problems, we need to see those problems and fix them now—not wait 10 years, 15 years down the road, when they explode.

Lastly, tabling it in the Legislature: Again, that is something that we should all, as legislators, be responsible to our constituents and have access to this report and make sure that we give feedback on it, because just publishing it and not making it accessible to everyone—"everyone" meaning on the government website. It will encourage people to let us know what is working and what's not, and then we can actually take steps to do it.

I think if we're going to be looking to the future, we need to make sure that we have good health outcomes. This report would be an annual piece that would come to the Legislature and help us accomplish that.

Earlier, we had amendments about equitable outcomes. Well, this can somewhat facilitate some of those. If you voted against that, maybe this is a way we can talk about how reports and what's in those reports can help us frame those things.

I urge the government—again, this is something that is a tool they can use to monitor this bill as to how it's moving forward in the Legislature and how people are receiving the care that they claim is going to improve. It would be nice to see what these reports actually come back with, with the results of their claims about this being the way to move forward and it's going to make things better. We need to have measures of what that looks like, and this would be a way to have one of those measurable outcomes.

The Chair (Mr. Kaleed Rasheed): Further debate? I recognize MPP Coe, followed by Madame Gélinas. MPP Coe, go ahead please.

Mr. Lorne Coe: I'd like to begin by saying that Health Quality Ontario already publishes reports on this. I recommend, Chair, voting against this motion because the government's priority is to strengthen the publicly funded health care system and making it better for patients, families and their caregivers. The government is committed to ensuring appropriate oversight and accountability in the health system. That's why Ontario Health undertakes a range of annual public reports on health system performance, including the Measuring Up report that includes home and community care.

1640

The Canadian Institute for Health Information also provides a range of public data and reports on home care, including as part of the federal/provincial/territorial shared priorities agreement.

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

M^me^ France Gélinas: Thank you. I would like to start by saying that yes, every now and again Health Quality Ontario looks at the home and community care sector, but

not every year and not on an ongoing basis, and they do not exist anymore. They have been rolled under Ontario Health. What will they do in the future? Whatever Ontario Health tells them to do, which may not be to do a yearly report on home and community care services.

There are things in the bill like lifting the maximum amount of care, which was a limit that was put in by the last Conservative government that is now being taken away by the new Conservative government. I'm all for it, but really, it's all for none, because if you look at the resources that we allocate to the home and community care sector versus the needs, there's a huge, huge difference between the two. If you look at patients who come in in February and March, it doesn't matter their level of need; they will have way less services than people who come in in April and May because, by February and March, the old CCACs, now the LHINs, just don't have the money to meet the needs.

The system that was put in place was a system that was based—home care is there to help the family. It has never been funded in a way that it will meet patients' needs. Apparently you have this family that has nothing better to do than to transfer you from your bed to your wheelchair in the morning, help you shower and eat, and transfer to work or whatever you want to do. It's the same thing with people who are being discharged after an acute episode into the hospital. Our home care system has never been able to meet the needs. It meets part of the needs part of the time, and it has huge regional differences. In the northeast we are the big losers in those regional differences, so I would very much like to have those fixed.

To say that Health Quality Ontario, every now and again, will publish a report on home and community care is very different. Just look at what happened when we started to measure wait times for hips and knees. All of a sudden we measure them province-wide and we see the difference. We see where people wait for over a year in the northeast for hips and knees versus three weeks in Toronto, and then we started to say, "Oh, maybe there's an allocation problem. Maybe the northeast is not getting equitable access because they don't have equitable funding."

The same thing will happen with home and community care if you start to measure it. Once you measure it, it matters. You can make arguments, you can make decisions based on facts, to start to improve things. This is what this motion tries to do. This is what this amendment will do, by forcing in the law the gathering of a report, so that we assess the needs.

We all know that as the population is aging—don't get me wrong, Chair; aging is not a disease, but as the population ages, there's a good chance that if we want them to stay in their homes like they want to do for as long as possible, they will need a little bit of home care and community care. This is all fine, this is all good, but it has to be measured. We have to know what the needs will be, so that we can look at how we can best meet those needs. What are the best practices? Can home and community care change? Yes, absolutely. There are some best practices out there that could be implemented province-wide, but none of them will happen if you don't know and start to assess and report on it on an annual basis directly to the government, not leave it to whatever is left out of Health Quality Ontario and whatever is decided at Ontario Health. Remember, nobody knows the decisions made at Ontario Health, because we cannot find out what's going out. This, as legislators, will make sure that this is an important part of our health care system. It will be assessed, it will be measured and it will be acted upon.

The Chair (Mr. Kaleed Rasheed): Further debate? I recognize MPP Harden.

Mr. Joel Harden: I want to amplify what my colleagues MPPs Armstrong and Gélinas have said about this. I take MPP Coe's point, but I would welcome a response from him about MPP Gélinas's point about the Health Quality Ontario office being subsumed under the Ontario health teams, and whether he would be comfortable with that level of oversight for anything else, particularly under his own purview. I know he can be a very serious parliamentarian.

What level of oversight is satisfactory for MPP Coe, for the government? Is it one where there is no disclosure, where there's no compulsion to disclose, where there's no compulsion to report? That doesn't fit the pedigree of the MPP I've seen in action in the chamber. I actually would hope—I would hope—that we would want that mandatory reporting to be baked into this legislation.

Again, my friends in government could do us a big favour by just taking this off the agenda for the committee for now and reworking this, so we didn't have to have this particular debate deficiency by deficiency. We had the benefit of so many great deputations to inform a completely different approach to this project of work, this project of law, but again, here we have another problem.

One can have many suppositions, Chair, but one supposition would be that the government has ill intent. I actually want to hope that the government doesn't have ill intent. What I've heard from my colleagues in government is that they have a real interest in moving quickly: They see a huge need; they see an absolutely flawed sector in the home care sector, and they want to fix it. Terrific. They're coming at it from a different political perspective than I do, but I take the sincerity of that point.

But if we rush the transformational agenda in home care, and we forget to oblige organizations to report and disclose, and organizations that have had that responsibility episodically—we subsume them under a new entity, and that entity has no compulsion to disclose to the public what's going on, to the point where someone like MPP Gélinas, with all her experience, has no idea what's going on in the top decision-making tables in the sector—that should be a cause for concern, not just for our caucus, but for the entire province.

I would like to think that every MPP participating in this deliberation this afternoon, today, wants to make sure that this transformational agenda that you have is done with the best possible information. Unfortunately, as we saw in the debate over the last amendment—I fear we lost a real opportunity there; I fear that might happen again.

Again, colleagues, we do have an opportunity here to pull against the leash, to say to the folks who are telling you what to do at this committee that you heard reasoned debate that led you to believe that it was important for us to have this kind of reporting in the legislation, or you couldn't, given your convictions as a parliamentarian, support it. I urge you to support this amendment. I think it's well reasoned. I think it's something we could all agree on.

The Chair (Mr. Kaleed Rasheed): Further debate? MPP Armstrong?

Ms. Teresa J. Armstrong: I think I'd like to add that the purpose of this amendment is really to show that Ontario needs to assess the current home and community care needs. Has it been assessed properly? Is it being underserved? We have to do that, and this report will actually factor those things in.

Then, of course, we could look at that to ensure that the government is aware and can plan for the needs that are prioritized in health care and fund those needs. That's something that we also need to talk about: As that report information comes out, you can see where those priority places could be and we can, again, prepare better and not underestimate the current need for home and community care. We see now that there is a huge need, but going forward, let's deal with it and address it.

The Chair (Mr. Kaleed Rasheed): Further debate? Seeing none, I'm going to go ahead and request a vote.

Ayes

Armstrong, Fraser, Gélinas, Harden.

Nays

Coe, Kanapathi, Martin, McDonell, Mitas, Oosterhoff.

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

Schedule 1, section 6, section 7 and section 8: We're going to bundle them up. Shall schedule 1, sections 6 through 8, inclusive, carry?

1650

Ayes

Coe, Kanapathi, Martin, McDonell, Mitas, Oosterhoff.

Nays

Armstrong, Fraser, Gélinas, Harden.

The Chair (Mr. Kaleed Rasheed): Sections 6 to 8, inclusive, carried.

Now we are going to move to NDP motion 17. Madame Gélinas.

M^me^ France Gélinas: I move that section 8.1 be added to schedule 1 to the bill:

"8.1 The act is amended by adding the following part:

"'Part III.1

"'Residential Congregate Care

"'Residential congregate care licensing

"'27.1(1) Subject to subsection (2), no person shall operate a residential congregate care facility.

"'(2) A not-for-profit entity may operate a residential congregate care facility if it has a licence issued in accordance with the regulations.

"'Regulations

"'(3) The Lieutenant Governor in Council may make regulations,

"'(a) clarifying or defining the meaning of "residential congregate care facility" for the purposes of this section;

"'(b) establishing and governing a licensing scheme for residential congregate care facilities, including by authorizing persons to issue licences, set conditions on licences or revoke licences.'"

The Chair (Mr. Kaleed Rasheed): Further debate? Madame Gélinas.

M^me^ France Gélinas: A number of deputants who came last week talked about either being excited or being a little bit scared of residential congregate care. I will start with the exciting part.

You remember Dr. Michael Rachlis, who came and talked to us about the BEST program, where people can be maintained in the community in a way that is respectful as well as in a way that is a whole lot more cheerful than a long-term-care facility. They are people who meet the assessment for long-term care, so they have needs for the activities of daily living 24/7, but they are supported in the community. They could be supported through residential congregate care, but on a much smaller scale than what we see in long-term care. You're talking about a home with four, five, maybe six people who would live together. They would have access to adult day programs for socialization, for a little bit of care, getting their meals, getting to go out—maybe see the nurses, physicians and physiotherapists in those adult day programs. They do this once or twice a week, and then they go back to their residence and live in a home that looks like a home, smells like a home, feels like a home—not 128 beds divided into 32-bed wings. That doesn't look, feel or smell like a home. But four or five people under the same roof? Yes, that looks and feels like a home.

The residential congregate care has possibilities and got quite a few people excited about this, but a whole lot more people had worries. They had worries because there is nothing in the bill that describes that those are going to be not-for-profit, that would ensure that—if you qualify for long-term care, there's a good chance you're a frail, elderly person who may not be able to advocate for themself that much. If you look at the population that lives in the long-term-care home right now, 90% of them have cognitive impairments. Two thirds have a diagnosis of dementia and one third with Alzheimer. Those are the people who would qualify for residential congregate care, so the last thing you want is people with high levels of need being put in a setting that has no licensing, no oversight, no requirement, just—and people called it the

way it was—a way to empty our overcrowded hospitals that have all of those alternate-level-of-care patients who are waiting for long-term care, and transfer them into what we would call the new residential congregate care facility, which has nothing to protect them.

We all know that they are a group of people who deserve provincial oversight and who deserve our protection. None of that is in the bill. So this is what this section of the bill sets out to do. It sets out to say what is the minimum that needs to be in place for the residential congregate care setting to be safe. That's all that does, but it's important to keep that in mind, because they are very vulnerable people who would qualify for that type of residential setting.

The Chair (Mr. Kaleed Rasheed): We are now going to move to MPP McDonell.

Mr. Jim McDonell: I recommend voting against this motion because the government is introducing an oversight framework for residential congregate care in Bill 175. The ministry is taking the first step toward development of future options for care outside of hospitals and long-term-care homes. The bill outlines an appropriate legislative oversight has accountability framework, including powers of investigation, that will support high-quality standards of care. The next step would be to engage with partners to define residential congregate care models in regulations.

The government will consider the lessons learned during the COVID-19 pandemic and the findings of the independent commission into long-term care to inform the regulations.

The bill also allows the government to determine, in regulation, which organizations can operate residential congregate care facilities.

The safety of residents and care providers, and the quality of care, are our top priority. Thank you, Chair.

The Chair (Mr. Kaleed Rasheed): Thank you, MPP McDonell. Next, MPP Harden.

Mr. Joel Harden: I think this is a really interesting part of our work today. What this amendment is putting forward, as MPP Gélinas mentioned—there is a positive and a concerning way to look at the requirement for an amendment like this. What I want to also do is focus on the positive element of what an amendment like this could present for the people of Ontario.

All too often, when we talk about services at home, attendant care, personal support worker care and the links between those kinds of care and residential congregate care, what we'll conjure for a lot of people in Ontario who have been paying attention to the news under COVID-19 and those who have suffered the most, are the horror stories of what's happened in large congregate facilities. I can tell you, Chair, here in Ottawa, there are four for-profit operators whose homes resemble the very stereotypes where many people are very upset to have seen the spread of the virus take its worst impact. We have 200, 300 seniors living in a facility, three or four to a room. When I've spoken to seniors and people with disabilities in their homes, they've referred to these sorts of facilities as prisons. They've been so utterly candid with me. They've said, "Joel, I'm doing everything I can to make sure I don't get discharged into that kind of an incarcerated context." That's what they've told me.

1700

What I think this amendment allows us to do is imagine, with some minimal standards, as Dr. Rachlis said in his deputation to us, what an exciting, enabling, vibrant form of residential care connected to home care could look like.

What I can tell you—we have a fantastic scholar here in Ottawa Centre, Susan Braedley, who's affiliated with Carleton University, who has done work with the great Dr. Pat Armstrong, who is one of the foremost researchers on age, aging and care in Canada. What they have said recently in a seven-country comparative study is that we do not have to default to this assumption of warehousing being the best cost-efficient model for congregate care for people with special needs. In fact, it would seem that most other countries, except for us, when you think of western democracies with not-so-vibrant economic potential now but normally vibrant economic potential, are going in the opposite direction of these large congregate care facilities towards more decentralized care.

I will note that earlier in this legislative session, it was actually, if I recall correctly, MPP Lindsey Park who put forward the Golden Girls private member's bill, celebrating these more decentralized, familiar, affirming home environments where seniors and people with disabilities could share homes together and could share care services together so as to reduce the costs of those sorts of arrangements. That was a really interesting piece of legislation.

What this particular amendment could purport to do is scale that up. The best model that Dr. Rachlis talked about, the other not-for-profit decentralized models that Dr. Braedley and Dr. Armstrong talk about—we should be aiming much, much higher than we do currently in the province of Ontario. I say that because it's not only dollars on the balance sheet for the province, I would say. I would think the living conditions of seniors and people with disabilities, folks with special needs in congregate care and with home care playing a role in that, have a multiplier effect.

As we heard the deputation of Deborah Simon from the non-profit home care sector say to us explicitly, there's a huge economic footprint for home care in the economy, and if workers and consumers are availed of a great sector with robust funding, with appropriate protections for workers, with appropriate services and retraining opportunities for care workers, that has a multiplier effect. That can really help us grow good jobs for young people, which is certainly something that a lot of young people I speak to here and around the province are looking for, and we can start to imagine what would the minimum standards be like for residential congregate care that was connected to home care. I think this is a much more positive discussion than things I'm used to hearing. Often when I hear people talking about home care and the need for aging in place, it's prefaced with the context of the grey tsunami, of a huge demographic explosion of seniors.

There's this kind of apocalyptic feel to the discussion, and I don't think that's very useful.

I think it's better for us to say, we have an aging society. People are living longer because we have the technology to help people live longer. We know more about healthy diet; we know more about the benefit of exercise—maybe today not so much about how bad sitting is, but nonetheless. We have the information in our hands to lead better lives, and that then allows people to live longer.

In the context where people are living longer and we are seeing a cohort move demographically through our society who are going to be seniors or who already are seniors, let's plan for that, let's look after that, and let's do it in a way where people aren't fearing discharge from their home into an incarceration situation, where they're actually seeing a nice, even line between all the contributions they've done in their lives in the community to what the French call "the third age," or "le troisième âge"—the notion that your first age is your learning, the second age is your employment and career, and the third age is your retirement and opportunity to give back to our society, which so many seniors do already. But if we created through really effectively funded home care, perhaps with links to residential congregate care, some ways in which that could do well, I think that would be great.

The other model I'll point to, which one operator here, a non-profit operator that does long-term care and some allied home care, the Glebe Centre—they're experimenting with the butterfly model, and that model is really testing people to think about what kind of familiar living environments could help seniors and people with disabilities feel an attachment to home in a congregate setting. They've done things like introduce knitted shawls that people will create themselves in workshops. They'll be draped over the sofas, which can sometimes look a little industrial because they're built so that they can be cleaned well, but there's a homier feel to the place. The residents help design the curriculum and the planning of services at the Glebe Centre. There is a celebration of residents being involved, including residents with dementia, in the planning of care. If we look positively to the challenges before us with an aging society and think about what the minimum standards are so that we do not repeat that kind of big box warehousing model we've done in the past, home care can play a really, really important role.

So I welcome colleagues voting in favour of this amendment, and I think it will be very clear that if we're leaning towards home care and a link between residential congregate care, we'd be doing it with the best interests at heart.

The Chair (Mr. Kaleed Rasheed): Further debate? MPP Armstrong, I recognize you. Please go ahead.

Ms. Teresa J. Armstrong: This is a very important turning point, I think, when we're looking at congregate care centres, residential congregate care. In the bill right now, again, there's no definition of what that looks like, there's no framework around it. It's in regulations and it's going to be developed as we go.

It's a very important amendment, because I really urge the government, as they're going forward, to look at non-profit residential congregate care places. I'll give you an example in my riding: There are people who have disabilities, they're on ODSP and OW, they deal with mental health or addictions, and they're all in this one particular building. This building used to be a long-term-care/retirement centre, that no longer is operating, so it was taken over by someone and then people who are vulnerable moved in. It's run by someone specifically who gives them their meals, provides security and oversees their care. But it's not regulated and there's no oversight. And we've heard from a couple of people who are there. They're room-and-board, and it's not a good situation. Now, under COVID, it has gotten even worse.

The other example that I want to bring up is a few years ago, the same kind of scenario, bigger scale. So the one I just spoke about is a smaller scale for people living there. But again, the intent is good, but it can be abused. The second building is literally an apartment building. Tenants there who have room and board are people who have mental health and addiction issues, on ODSP and OW. What happened was there was someone who was smoking and there was a fire, and then it turned out that there was a death; he died. It all came to light that there were ACT teams involved, their bylaw officers were in that other building that I'm speaking about right now; there were fire infractions, health and safety infractions. There were actually even co-op students going into this building and doing their experiential learning for social work and that kind of thing. There was no oversight. Everybody knew that there was a problem with that building on Oxford Street, and nothing could be done.

When I think about these residential congregate care centres, the way France is describing them, as smaller scale, there are bigger scales of people living in congregate care facilities, and there is no oversight. So when the government is planning to put this in place, I hope that there's going to be a non-profit element in there and that we're going to be able to get the definitions down accurately so that people aren't being taken advantage of. When the prevention of abuse isn't in legislation, when the bill of rights isn't in legislation, it's concerning that if you can set these places up without oversight or not-for-profit providers, it can again lead to precarious situations.

1710

I'm going to support this motion—of course; we put it forward—but I'm hoping that as we go forward, the government will agree to some of these legislative pieces that will protect people who are receiving care and make this bill stronger for them.

The Chair (Mr. Kaleed Rasheed): Further debate? Seeing none, we are going to vote now.

Ayes

Armstrong, Fraser, Gélinas, Harden.

Nays

Coe, Kanapathi, Martin, McDonell, Mitas, Oosterhoff.

The Chair (Mr. Kaleed Rasheed): The motion is lost.

We are now going to move to NDP motion 18. MPP Armstrong.

Ms. Teresa J. Armstrong: I move that section 9 of schedule 1 to the bill be amended by adding the following subsection:

"(2) Subsection 29(2) of the act is amended by striking out 'and' at the end of subclause (a)(vii) and by adding the following clauses:

"'(a.1) the governance structures of the person, entity or group of persons or entities includes mechanisms that, in the minister's opinion, sufficiently provide for community participation, community engagement and community decision-making;

"'(a.2) the person, entity or group of persons or entities commits to ensuring that any governance meetings of the integrated care delivery system, including any meetings of a board of directors or of its committees, are open to the public; and'"

The Chair (Mr. Kaleed Rasheed): Further debate? I recognize MPP Armstrong, followed by MPP Christina Mitas.

Ms. Teresa J. Armstrong: This amendment requires that the governance structure of the Ontario health teams be public and, again, allow for community engagement and participation. We can't stress enough how important it is that we open up the Ontario health teams so that people will have confidence and trust that they're being operated and delivering care in a way that they're okay with, really—that they want to have their feedback, they want to make sure that if there's a critique or something positive to comment on, that would happen. It's problematic when this is not something that people can depend on.

When you have a board of directors or committees that are doing things without public awareness, public involvement, public accessibility, the confidence isn't there. And many parts of this bill add to this trepidation as to, "Just trust us. We'll do it by regulation. Just trust us, the closed-door meetings by Ontario health teams. Everything is going to be fine."

We all know that this is not a way going forward that gives people comfort that the government has their best interests in mind. There have been so many examples through history. Why we keep repeating these mistakes—I'm not going to impute motive as to why. But when we look at the amendments that we brought forward for transparency and accountability under the financial piece, under the public participation, under the protection of people with the bill of rights and prevention of abuse, and they're not even considered—everything is in regulation and nothing is debated in the Legislature—it's not serving the people that we represent well. It is not.

I have to say, it's a mistake when—changing the bill is your prerogative, but the process by which it's undertaken is a mistake, and the mistakes that we make here, people pay for out there.

So I would just, again, implore the government to really consider the way they're operating. We are here to give them advice and offer solutions, for the public interest piece that we've talked about. I only hope that some of these amendments—and so far, we've had no luck, but I'm still hopeful that there will be something in here that this government will see their way forward and to strengthen this bill.

The Chair (Mr. Kaleed Rasheed): Further debate? MPP Mitas.

Miss Christina Maria Mitas: I recommend voting against this motion because section 44 of the Connecting Care Act, 2019, already requires that Ontario health teams and health service providers establish mechanisms for engaging with patients, families, caregivers, health sector employees and others as part of their operational planning processes, in accordance with the regulations, if any are made by the minister. The government recognizes the importance of community engagement and can make regulations to further support the development of a model that is grounded in establishing collaborative partnerships, across sectors, that can evolve over time.

Legislation amendments are not required to enable the Ontario health team to hold public governance meetings. The government can make these requirements through accountability agreements. And the proposed amendments would not enable Ontario health teams to conduct governance meetings or portions of meetings in camera under circumstances where it would be appropriate and necessary.

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

Mr. John Fraser: I would recommend supporting this amendment. As I said earlier, the change in health care brought the administration and the governance of almost all health care to downtown Toronto. Community solutions are found just there—in communities. I think it's important for us to ensure that this is put in the legislation, that this is a requirement of health teams, so that the community has some ownership of that, has some connection to that, has some ability to question and scrutinize those decisions, to be able to appeal, to be able to find solutions.

So I strongly recommend that my colleagues on the government side support this motion. I want to thank the member for bringing it forward.

The Acting Chair (Mrs. Robin Martin): Further debate? Madame Gélinas.

M^me^ France Gélinas: I just want to make sure that everybody understands that what's in the Connecting Care Act mandates that the Ontario health teams—not Ontario Health—engage with patients, families etc. for their operational planning. This does not usually get done by the board.

What we are talking about in this motion really has to do with the governance structure. The governance structure is the board of directors of Ontario Health. If we had put other amendments that mandated it, this one really leaves it to the minister's opinion—to make sure that there is sufficient community participation, community engagement and community decision-making—so it's just to make the difference. Yes, in the Connecting Care Act, in

the accountability agreement and in the annual operational plan, they will have to consult with patients and families. But there's nothing in the Connecting Care Act that talks about boards. This is what this motion tries to convey.

I have no problem with having part of a board meeting in camera. We've all been on enough boards to know that if you're going to talk about one specific employee, the law says that you have to go in camera. If you're going to talk about a specific patient and you're part of the care group or whatever, I have no problem.

1720

This allows the minister more flexibility, but it makes it a requirement that the minister look at the governance and look at making sure the governance is diversified, is open, is transparent. That speaks to what we have been speaking about all afternoon: the need to have the agenda available, to have the minutes available once they are approved, to have part of the meeting open to the public and to allow people to present to a part of the meeting, if appropriate etc., so a little bit different from what's in the actual Connecting Care Act.

The Acting Chair (Mrs. Robin Martin): Further debate? MPP Harden.

Mr. Joel Harden: I want to add to what my colleagues have said, and also just impress upon my colleagues to just remark on and reflect on the experience we've had with this bill and hearing deputations. Do you feel, having gone through the experience of listening to those deputations—and I watched not just questions and answers from my colleagues in our caucus, but also from the independent members and from the government caucus. I watched the dialogue that we all had with deputations. My question for us is: Is our consideration of this bill more enriched by having had that engagement? I would make the assumption for all of us that the answer is yes.

I was particularly impressed by the way in which all of us took very seriously the comments made by personal support workers, the two who deputed to our committee. I noted, with every single one of us, that we went to pains to stress upon how impactful those deputations were.

I also remember a deputation given to us by the gentleman who had recently lost his father, who had struggled with home care, and his pointed remarks about the failures of the home care sector for him. I noted how every single caucus representative of this committee—we all found those comments to be very impactful for us.

So if this committee's hearings have been impactful for us in trying to understand this legislation the government has put forward, imagine how impactful it would be to have Ontario health teams and administrative governance structures regularly exposed to public scrutiny. What I will say, from the benefit of the Champlain LHIN's experience, our local LHIN here, because I met with the board members of the LHIN and I've talked to many folks who have simply sat in the gallery and watched the deliberations at the LHIN—they've said that, notwithstanding some tense situations and tense cases, it has been great to be available to the public.

I just want the government to think that consultation doesn't have to be an obstacle. It doesn't have to be a situation in which you have to muddle your way through it or suffer your way through it, because the larger imperative is to make sure change happens and that means we have to move as quickly as possible with people in hospital administrative sectors who are used to high-pressure decision-making and moving files forward quickly. We're going to work with that, because we're so angry that change hasn't happened for X number of years in Ontario's past.

I want to invite you to think that you can actually have a governance structure that is regularly open to the public, that can move quickly if you get the right advice, because, as my father used to say, with the business that he ran—and the business that sent me to school—there is nothing more expensive than a bad decision. There's nothing more expensive than not putting the right inputs in place to make sure people are properly trained and people know what they're doing. It is so much more expensive to rush, sometimes.

There's a hard work ethic amongst every single parliamentarian who walks into that building in Toronto; I take that for granted. But what I don't take for granted, sometimes, is how sometimes we can be motivated by our political persuasions to want to do things quicker because we're so much more enlightened than the previous government. But if we don't bring the public along with us, we make a huge, huge mistake.

I hope that my colleagues in government can reflect upon how useful it was to listen to the people who deputed at this committee, to everything that was said, and why it's important to build that into Ontario Health decisions at the highest levels. That's what I see this amendment doing and I hope you support it.

The Chair (Mr. Kaleed Rasheed): Further debate? Seeing none, we are going to vote now.

Ayes

Armstrong, Fraser, Gélinas, Harden.

Nays

Coe, Kanapathi, Martin, McDonell, Mitas, Oosterhoff.

The Chair (Mr. Kaleed Rasheed): Motion lost.
Shall schedule 1, section 9 carry?

Ayes

Coe, Kanapathi, Martin, McDonell, Mitas, Oosterhoff.

Nays

Armstrong, Fraser, Gélinas, Harden.

The Chair (Mr. Kaleed Rasheed): Carried.

Now, we are going to move to NDP motion number 19. MPP Armstrong.

Ms. Teresa J. Armstrong: I move that section 10 of schedule 1 to the bill be amended by adding the following subsection to section 43.9 of the Connecting Care Act, 2019:

"Mandatory publication

"(1.1) The minister must publish on a website, or otherwise make available to the public, any information the minister receives respecting a complaint or grievance made against an entity that provides a home and community care service within 30 days after receiving the information."

The Chair (Mr. Kaleed Rasheed): Further debate? MPP Armstrong.

Ms. Teresa J. Armstrong: Again, these are measures we're putting in place so that there is some protection to consumers when they receive health care in order that they have a direct pathway to make their concerns known. This amendment makes it mandatory that it should be published, so that if there is a complaint or a grievance made against the home provider—the provider that provides the home care or community care services—the minister receives that complaint and then posts it publicly within 30 days.

These are just things that should be in place in order to ensure that you operate with respect and awareness for people who are using this health care system. Under long-term care, there was an inspection process. We went through a whole time when we had to have them public and what was revealed and this kind of thing, and those served well. Under this government, there have been changes to that inspection where—I understand in the last year, there were only nine inspections out of 636 homes. That, again, is problematic.

When we're setting up a new system, when we're reforming health care, "transformation," all the words; "modernizing," whatever the words the government wants to use, we need to make sure that as we're doing this, when there are problems along the way, we've put in place tools to address those problems, and don't just presume that it's going to run smoothly, that there isn't going to be an issue, and when people have complaints or grievances that they're going to be dealt with. That isn't the way it works when there are problems.

Having it where the minister publishes on a website or otherwise, like we say, makes it available to the public so the information that is received is transparent. It's open. We know what's going on. If there are egregious things happening, it's dealt with early. It isn't compounded so that then, you have things like community care in long-term care when people are having class action lawsuits.

It just makes good public sense. It protects people. It also shows who the good care providers are and where people can feel confident, and when you're looking for health care, this should be something that you're able to access, to see what the problems have been, if the problems have been fixed. Is there something that the consumer is able to access so that they can make informed decisions? Because with this bill, there's a lot of power being taken away from consumers. This is giving power back to some of the consumers, when they know who the players are that there have been complaints and grievances on.

1730

Again, we talk about the sector, and there's the not-for-profit and the for-profit sector. This is a way to ensure the standard is for everyone. We brought amendments about revealing executive salaries and that kind of thing. It seems that there are two playing fields: the for-profit and the not-for-profit.

Having this be public and making sure that the minister is responsible to make this available within 30 days is a reasonable amount of time. I hope it never has to be used, and I hope within the 30 days that the problems are rectified, but unfortunately that isn't always the case, and we can't assume that consumers are going to be protected or providers are going to do the right thing to clear up the situation. It is a stick, and it needs to be there so that people understand that when a mistake happens, when something happens, and you're not fixing it, you're going to be held accountable, and there are going to be people watching. Consumers deserve this information, so that they can make informed decisions on who they allow into their homes, into their lives. I would think the government would welcome this, because, again, it's helping to create better quality. It's helping the government to see where the problems are, and getting those things rectified early.

I go back to long-term care. When inspections are there—and there weren't a lot of teeth behind those inspections. Things lingered, and that shouldn't be happening. Hopefully, if this is something that's approved, the government sees the value in this, that as problems mount, they're not lingering and they're fixed right away, because health care is very precious. People expect no less than to be safe in their homes and have their concerns addressed, and we have to formally give them that opportunity by this amendment.

The Chair (Mr. Kaleed Rasheed): Further debate? I see MPP Logan Kanapathi, followed by MPP Joel Harden.

Mr. Logan Kanapathi: I recommend voting against this motion, because the government recognizes the importance of maintaining the complaints process for home and community care. However, publishing complaints without any sense of their validity raises considerable legal process and policy questions. A complaints process for home care, which we will include in regulation, will provide a clear, concrete process for resolving issues. As outlined in Bill 175, home and community patients will also continue to have the right to appeal certain decisions to the Health Services Appeal and Review Board, and would also continue to have access to the Patient Ombudsman. That's why I'm against this motion.

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

Mr. Joel Harden: Following on what my colleague MPP Armstrong said, I just want to invite us to consider

what happened when we changed the nature of investigations into nursing homes in the long-term-care sector. We went from a situation in which almost 626 facilities were being investigated to some degree of rigour to one in which, last year, nine of 626 were investigated in a serious way.

So my question is: Do we want to repeat that for the home care sector? Given what I've heard MPP Gélinas and MPP Armstrong say and what I heard from deputations, we aren't doing anywhere near enough to ensure that consumers and workers within this important sector are aware of where there are serious problems with certain operators or care providers or residences where there is abuse taking place, where there are serious infractions taking place. I do believe—regardless of what MPP Kanapathi just said, I think the people of Ontario deserve to know. They deserve to know.

MPP Fraser has talked about it before in his family. Any one of us who is put in that position of having to make sure that a loved one is looked after—we want to be making that decision with the greatest possible confidence that our loved ones are safe. I don't think there should be any debate about that.

If those decisions aren't made with the most appropriate and useful information possible, then what are we doing to the people in this province? What are we doing to the mom and dad, the brother or the sister who was put in charge of making that important decision about what to do by way of home care or other forms of care to help the elderly person in their family, the person with a significant disability in their family who needs that extra support? How can we look that person in the eye later if we kept information away from them that would have dramatically changed the choice they made? I personally would have a very hard time ethically talking to that person later, after revelations that there were serious problems.

The debate we've been having in the province of Ontario over Orchard Villa will continue. What will we say to those families now, who have made so many unbelievable sacrifices—so many awful revelations thanks to what the Canadian Armed Forces had the courage to tell us publicly in their reporting to the Premier, in their reporting to public officials. What will we do in the home care sector? Will we make the same mistakes?

I hear what MPP Kanapathi has said as an expression of what his government believes, that they believe that what we have is enough. I take it implicitly from what MPP Kanapathi said that there could be onerous or dangerous consequences, legally, for certain operators if their substantial practices or grievances, critical incidents are made publicly known. I would say the burden of responsibility for us as legislators is much more to ensure that families and people are aware of serious problems. That should be the focus of our concern, not potential legal action or potential reputational harm to operators who are engaging in practices where things have taken place that we wouldn't want any family, any person to have to go through.

I know, frankly, where I stand. I believe that people have the right to know this information, and I would hope that my colleagues in government would think the same.

The Chair (Mr. Kaleed Rasheed): Further debate? I recognize Madame Gélinas.

M^me^ France Gélinas: I have said on the record many times our home care system is broken. It fails more people than it helps pretty much every single day. I have been an MPP for 13 years, and I cannot remember one week when we did not have a complaint against home and community care. In my office, it was Nicole Kivi—she worked in my office for 27 years, longer than I had been there; she used to work for Shelley Martel before me—who handled the health file. When she retired, she basically said that there hadn't been one week since CCAC was there and the home care was changed that we hadn't had a complaint.

Most of them have to do with missed visits—that is, you're supposed to have a home care worker come to your house at a certain time on a certain day and they don't come. But sometimes, those missed visits have very serious impacts on people's lives. I remember a lady who had left a message on our answering machine—we never got it till the Monday because she left it on the Sunday—where she was wheelchair dependent, so she has somebody who helps her get into bed at night and get back into her chair in the morning. It was the baptism of her grandchild. It was the first grandchild. She had booked the Handi-Transit to come and pick her up so they would bring her to the church. Everything had been lined up. The PSW never came that morning, never transferred her into her chair. The Handi-Transit came, but there was no point. She was still in bed, not able to get out, and she missed the baptism of her first grandchild. This is just one example, but every single week, there are people in Nickel Belt who call my office because the PSW, most of the time, did not show up for an appointment.

1740

I thought that with COVID, things would settle down. The types of complaints have changed, but the complaints are still there: the complaint that every Thursday afternoon for the last four years, they get three hours of respite. The LHINs have called them to say, "Is it okay if we cut this back to one hour of respite because of COVID?", and now that things have settled—in the northeast, where I'm from in Sudbury, we're in phase 2—they have a very hard time getting back to two hours, as well.

The number one complaint is missed visits. The number two complaint is the time it takes before home care will start: the example like MPP Armstrong has given, where when we used to do surgeries in hospital—not during COVID, but before this we used to do an awful lot of them—hip and knee surgery requires follow-up by the physiotherapist, requires follow-up by the nurse to take your staples or stitches out, and none of this happened in the amount of time. Your stitches have to be looked upon, have to be taken off between 10 and 14 days—most of the time it's staples, not stitches—and it has been three weeks, and they are still waiting for the first visit to come.

The delay in home care comes in huge part because the contract-holders—most of them for-profit home care companies—cannot recruit and retain a stable workforce. They cannot meet the workloads. The complaints are numerous, but I can tell you something: We would, and we still do, make little lists of all of the complaints that we have. We ask who their care provider is, so they give us the name of the people who actually have the contract, and once a month I go and sit down, and we go through them.

This exercise of taking the time to look at what the complaints are—are they recurrent complaints; are they against the same providers—leads to change, and this is what we want with this amendment. We want that within 30 days of receiving the complaints, they be put out there, so that if it is always the same home care companies which people are complaining about, maybe they will pull up their socks. It is amazing what a little bit of transparency will do. It is amazing what a little bit of accountability will do. This is what this is all about.

Again, to hear the government say, "We will have a complaint mechanism, yet to be defined"—a lot of people who phone our office, and I'm sure it's the same in every MPP office, phone us because they feel safe. They feel like if they phone the care provider, maybe there will be retaliation against them. Maybe their mom won't have any care at all—never mind missing a day or missing a little bit of respite; that they won't have anything at all. There are people who are in very precarious situations, who feel very, very vulnerable, so a good place to make complaints has to be a place that is safe for them. An MPP office is safe. I'm not going to share their names if they don't want me to. I'm not going to identify them if they don't want to be.

This all has to be taken into account with the mandatory publication, so that the agencies that are named as to, "There have been complaints against you," don't go and retaliate against the patients who have put in the complaint or against the family that has put in the complaint. You do this by shining a light on what is going on. It's a great antiseptic. It is a great way to change things, and I encourage us as legislators to put it into the bill. It is not prescribing; there will still be lots of room for regulation changes, but at least the core of it will be there. It will be reported upon. It will be made public. It will be made in a way that is safe for patients to complain.

The Chair (Mr. Kaleed Rasheed): Further debate? Seeing none, we are going to vote.

Ayes

Armstrong, Fraser, Gélinas, Harden.

Nays

Coe, Kanapathi, Martin, McDonell, Mitas, Oosterhoff.

The Chair (Mr. Kaleed Rasheed): Motion is lost.
Shall schedule 1, section 10 carry?

Ayes

Coe, Kanapathi, Martin, McDonell, Mitas, Oosterhoff.

Nays

Armstrong, Fraser, Gélinas, Harden.

The Chair (Mr. Kaleed Rasheed): Carried.
Shall schedule 1, section 11 carry?

Ayes

Coe, Kanapathi, Martin, McDonell, Mitas, Oosterhoff.

Nays

Armstrong, Fraser, Gélinas, Harden.

The Chair (Mr. Kaleed Rasheed): Carried.
Now we are going to move to independent motion number 20. MPP Fraser, please go ahead.

Mr. John Fraser: I move that section 11.1 be added to schedule 1 to the bill:

"11.1 The act is amended by adding the following section:

"'Public Vehicles Act does not apply

"'45.1(1) Subsections 2(1) and sections 23 and 25 of the Public Vehicles Act do not apply to a public vehicle when it,

"'(a) is being operated by, for or on behalf of a health service provider under this act; and

"'(b) is transporting only persons described in subsection (2).

"'Persons transported

"'(2) Clause (1)(b) applies to the following persons:

"'1. A resident of a long-term-care home under the Long-Term Care Homes Act, 2007 who is determined to be eligible for the transportation service being provided.

"'2. A person who is determined by a health service provider to be eligible for the transportation service being provided.

"'3. For a person mentioned in paragraph 1 or 2, one attendant or escort accompanying the person.'"

The Chair (Mr. Kaleed Rasheed): Further debate? I recognize MPP Fraser, followed by MPP Martin.

Mr. John Fraser: This is an amendment that was requested by the Ontario Community Support Association. Of course, they represent community support organizations across Ontario, many of them small, many of them very community-based, many of them leveraging a lot of community support through volunteers and other avenues. They asked us to make this amendment because this exemption existed under the previous legislation, but once we remove that legislation, this exemption no longer exists.

Without this exemption, these services would be subject to the same licensing requirements as taxis and buses and other services governed by the legislation.

Leaving the exemption out of Bill 175 would create an unreasonable administrative burden for providers, who often have volunteers offering services by driving their own vehicles. So the Ontario Community Support Association recommended that this be included in the new legislation.

1750

I'll just finish by saying that I look forward to the government's response. I had anticipated that the government had gotten the same request for an amendment, so I was a bit surprised that they did not put forward an amendment—or even an amendment that was different from the one that was provided to me by the Ontario Community Support Association.

The Chair (Mr. Kaleed Rasheed): Further debate? MPP Martin.

Mrs. Robin Martin: I will recommend voting against this motion. The issue is being addressed through our notice of motion, which is number 23. The government is proposing an amendment to ensure that the government can deal with any technical or transitional items that arise as part of the shift from the Home Care and Community Services Act, 1994, to the Connecting Care Act, 2019. The Ontario Community Support Association, as you mentioned, did request that we maintain the exemption to the Public Vehicles Act, and the government intends to make this amendment by regulation, so that the exemption to that act will be maintained there. That's what our motion 23 is about.

The Chair (Mr. Kaleed Rasheed): Further debate? MPP Gélinas.

M^me^ France Gélinas: Here again, we are left to hoping that the regulations will come, that they will come in time, that it will be in a way that respects all of the different volunteers as well as the different clients who rely on those services to get to wherever they need to go. This is for people whose life is already very stressful because of sickness, because of disability. It is one more stress on their shoulders. We could settle that stress right here to assure them, like the Ontario Community Support Association has asked us to do, that the Public Vehicles Act will not apply and that the different clause—to "Persons transported"—will apply.

The Chair (Mr. Kaleed Rasheed): Further debate? I see none. We are ready to vote.

Ayes

Armstrong, Fraser, Gélinas.

Nays

Coe, Kanapathi, Martin, McDonell, Mitas, Oosterhoff.

The Chair (Mr. Kaleed Rasheed): The motion is lost.

We are now going to move to NDP motion number 21. I recognize MPP Armstrong.

Ms. Teresa J. Armstrong: I move that section 11.1 be added to schedule 1 to the bill:

"11.1 Part VI of the act is amended by adding the following section:

"'COVID-19 committee

"'47.1(1) The minister shall establish a committee composed of,

"'(a) one member of the assembly from each recognized party; and

"'(b) one member of the assembly who is not a member of a recognized party, if the assembly contains such a member.

"'Report

"'(2) Within one year after the day on which section 3 of schedule 1 to the Connecting People to Home and Community Care Act, 2020 comes into force, the committee shall prepare and publish a report reviewing the delivery of home and community care services in Ontario during the COVID-19 pandemic.

"'Tabling

"'(3) The minister shall table the report in the Legislative Assembly as soon as possible after it is published.

"'Definitions

"'(4) In this section, "recognized party" has the same meaning as in subsection 62(5) of the Legislative Assembly Act.'"

The Chair (Mr. Kaleed Rasheed): Further debate? MPP Armstrong.

Ms. Teresa J. Armstrong: We've stressed how important it is that what we're facing right now, the reality of COVID-19, and moving legislation forward specifically on health care—we're not taking the time to understand the lessons of COVID-19 and taking the time to try, again, to make preparations and preventive measures, a way to protect people receiving home care, people delivering home care.

We've heard stories with regard to PSWs who are not getting the PPE they need. I've had somebody contact our office that PSWs in their area get, I think, six or seven masks in a paper bag. They have to go to the depot to pick them up, and that's supposed to last them for the whole week. The gloves are ample so that isn't an issue, but their concern is going from patient to patient—if you're seeing 10 to 20 patients a day, then the high spread of COVID could be much more chronic than having your mask changed and having N95s. By the way, these were not N95 masks.

This amendment speaks to having the Legislative Assembly take into account the lessons learned, and doing it through a non-partisan committee—the minister is actually going to establish it—composed of one member of the assembly from each recognized party and then a member from an independent party, if there should be one. This is a great way to find information. We know it's not partisan if it's an all-party select committee. People all have input and they're working towards, again, finding information to protect consumers, to protect workers and prevent things—the precautionary measures that we learned from SARS. One of the precautionary measures that was taken in place was that if there's an infectious disease outbreak announced, you take those precautionary

measures even if the science isn't there yet. So wear your masks, wear your gloves and take those precautionary measures—at least do that bare minimum.

It would be very educational, I think, and important that we hear from workers as to what the challenges were during COVID-19. Were they protected? How could they protect the people that they served better? So having this is very important legislation. Then, of course, tabling it so that all members have access to it: From this committee, what could happen is recommendations come out of it so that we can strengthen—again, it's all about strengthening and making this product better for health care for people, and this is a tool that we're offering the government to take us up on it.

With that, Chair, I thank you for that time.

The Chair (Mr. Kaleed Rasheed): Further debate? MPP Oosterhoff, I recognize you. Please go ahead.

Mr. Sam Oosterhoff: I do recommend voting against this motion. We take very, very seriously the health and safety of the people of Ontario. It's our number one priority, including the home and community care patients. But we know that although the COVID-19 outbreak has shown us there are gaps in the health care system that need to be fixed—and we're committed to learning the lessons that we've seen through the outbreak; we are committed to putting these lessons learned into action. It's one reason why we are continuing to move this proposed home and community care legislation forward.

Now it's important that we recognize there are multiple approaches that the government should take to reviewing the response to COVID-19 and multiple different approaches we may take. For example, the Emergency Management and Civil Protection Act requires the Premier to table a report to the assembly 120 days after the termination of the emergency declared under the act. We do look forward to working with our colleagues in the assembly, including those in other parties—the Auditor General of Ontario, our health care system partners and the public as a whole—to determine an approach to reviewing our response to the outbreak as a whole. Thank you.

The Chair (Mr. Kaleed Rasheed): Seeing as it's 6 o'clock, this committee is adjourned until tomorrow morning at 9 a.m. If I can just request all members to please start logging in around 8:30 just so that we all are ready for 9 o'clock.

Thank you very much for all your support and cooperation today, and I'm looking forward to more hearings tomorrow. This committee is now adjourned until tomorrow at 9 a.m.

The committee adjourned at 1800.

STANDING COMMITTEE ON THE LEGISLATIVE ASSEMBLY

Chair / Président
Mr. Kaleed Rasheed (Mississauga East–Cooksville / Mississauga-Est–Cooksville PC)

Vice-Chair / Vice-Président
Mr. Vijay Thanigasalam (Scarborough–Rouge Park PC)

Ms. Rima Berns-McGown (Beaches–East York ND)
Mr. Michael Coteau (Don Valley East / Don Valley-Est L)
Mr. Faisal Hassan (York South–Weston / York-Sud–Weston ND)
Mr. Logan Kanapathi (Markham–Thornhill PC)
Mr. Jim McDonell (Stormont–Dundas–South Glengarry PC)
Miss Christina Maria Mitas (Scarborough Centre / Scarborough-Centre PC)
Mr. Sam Oosterhoff (Niagara West / Niagara-Ouest PC)
Mr. Kaleed Rasheed (Mississauga East–Cooksville / Mississauga-Est–Cooksville PC)
Ms. Sara Singh (Brampton Centre / Brampton-Centre ND)
Ms. Donna Skelly (Flamborough–Glanbrook PC)
Mr. Vijay Thanigasalam (Scarborough–Rouge Park PC)

Substitutions / Membres remplaçants
Ms. Teresa J. Armstrong (London–Fanshawe ND)
Mr. Lorne Coe (Whitby PC)
Mr. John Fraser (Ottawa South / Ottawa-Sud L)
M^{me} France Gélinas (Nickel Belt ND)
Mr. Joel Harden (Ottawa Centre / Ottawa-Centre ND)
Mrs. Robin Martin (Eglinton–Lawrence PC)

Clerk pro tem / Greffiere par intérim
Mr. William Short

Staff / Personnel
Mr. Ralph Armstrong, legislative counsel