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Standing Committee on Finance and Economic Affairs

Comité permanent des finances et des affaires économiques

Pre-budget consultations

Consultations prébudgétaires

1st Session
43rd Parliament
Tuesday 7 February 2023

1re session
43e législature
Mardi 7 février 2023

Chair: Ernie Hardeman
Clerk: Vanessa Kattar

Président : Ernie Hardeman
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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON FINANCE AND ECONOMIC AFFAIRS

COMITÉ PERMANENT DES FINANCES ET DES AFFAIRES ÉCONOMIQUES

Tuesday 7 February 2023

Mardi 7 février 2023

The committee met at 1000 in the Holiday Inn Kingston-Waterfront, Kingston.

PRE-BUDGET CONSULTATIONS

The Chair (Mr. Ernie Hardeman): I call this meeting of the Standing Committee on Finance and Economic Affairs to order. We're meeting today to continue public hearings on pre-budget consultation 2023.

As a reminder, I ask that everyone speak slowly and clearly. Please wait until I recognize you before you start to speak.

Any questions?

Each presenter will have seven minutes to make an opening statement, and after we have heard from all of the presenters, there will be 39 minutes for questions from members of the committee. This time for questions will be divided into two rounds of seven and a half minutes for the government members, two rounds of seven and a half minutes for the official opposition members, and two rounds of four and a half minutes for the independent members as a group.

SEXUAL ASSAULT CENTRE KINGSTON INC.

PROVIDENCE CENTRE FOR JUSTICE, PEACE AND INTEGRITY OF CREATION

CITY OF KINGSTON

The Chair (Mr. Ernie Hardeman): The first panel members will be Sexual Assault Centre Kingston Inc.; Providence Centre for Justice, Peace and Integrity of Creation; and the mayor of the city of Kingston.

I ask each person, as you speak, to introduce yourself—and if you have anyone else who will be speaking and answering the questions, to also introduce themselves before they start.

I also want to say that for the first presentation, I believe we have two people who will be joining us virtually.

With that, Sexual Assault Centre Kingston Inc., the floor is yours.

Ms. Beth Lafay: Good morning. My name is Beth Lafay. I'm the executive director at the sexual assault centre here in Kingston. I just started a month ago. I've got two board members here with me today, Yvonne and Tryphena.

As I said, I'm the executive director at the sexual assault centre here in Kingston. I just got started in the role about a month ago, but I've been working in the sector for just about 10 years. The staff at the sexual assault centre in Kingston are exceptional. There are about 15 staff who provide professional, trauma-informed care in the city of Kingston, Frontenac, Lennox and Addington, for about 45 years now.

Our last increase in core funding came from the Ministry of the Attorney General, MAG, before the recent change to MCCSS, the Ministry of Child, Community and Social Services. This last increase came from Kathleen Wynne's Liberal government in the 2015-16 fiscal year, and it was approximately $23,000. This is despite the drastic rise in the cost of living in Canada, as seen looking at stats on the consumer price index, increasing about 9% in the past two years.

The cost of benefits for our full-time permanent staff increases yearly, and this leads SACK to find ways to manage these increases, to support staff wellness in a field in which vicarious trauma and burnout are widespread—not to mention how half of my staff are contract. This also leads us to spend time applying for grant money, which is challenging in terms of starting programs, and precarious because generally we only have one to five years, maximum, as these programs gain momentum and build awareness and community funding. That ends, and we lose access to these underserved communities that we're working with. This puts an increased amount of pressure on the need to constantly apply for grants, and this takes time away from actually working on our programming. The use of our funding is that about 70% of our budget goes to staff.

SACK is seen as a lead in the field in regard to our crisis line. We have about 140 volunteers who work on that crisis line, and we manage and cover about seven jurisdictions between the KFL&A area, Ottawa, Cornwall, Niagara, Quinte, North Bay and Renfrew. Our volunteers supported 4,976 individuals in crisis from April 2020 to March 2021. However, we are currently at capacity, as our tech is out of date; it cannot support multiple callers at once. We are working with a tech company that specifically designs software for crisis lines, and the cost of this software is $2,000 as a start-up fee, $1,250 a month, and about $15,000 a year to operate. This was presented to the MCCSS for a funding increase, and we were denied.

We also struggle with a lack of competitive employment within our sector. The general cost of a psychotherapist at AMHS pays anywhere between $36 to $42 an hour, which is $10 higher than what we're able to pay our staff. The psychotherapists at SACK are working with the same level of complexity regarding the clinical population as psychotherapists at AMHS. In fact, AMHS often refers complex cases to SACK specifically for our expertise. Staff need to take on jobs or leave SACK to make a better living or wage elsewhere, because we can't match the rates that psychotherapists are usually paid. Client wait-lists can be very long as a result, with demand for services increasing year after year.

As I mentioned before, half of our staff are contract, which means our pub ed assistant and advocacy and outreach coordinator are all on contract. These folks do very important work in the community educating different groups on things related to the prevention of gender-based violence and sexual violence in Kingston. Our contract staff also don't receive benefits, so we need to pay them higher rates. This kind of precarious employment has a huge impact on staff wellness. My management team spends a lot of time coming up with creative approaches to make sure our staff are well.

At the heart of SACK's work is supporting survivors. SACK's programming has a deep impact on the community, especially from an equity perspective, in supporting equity-seeking communities. We have a program called the Diverse Communities Project—

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

Ms. Beth Lafay: —where we employ a counsellor so that equity-deserving groups can see themselves within our agency, and encourage them to access services. We also run an Intersectionality Project that is funded for approximately two years. The community feedback we received doing projects like this emphasizes the importance of sustainability and putting words into actions. How do we do this if we only have a limited amount of time and money?

Last year, you heard from the OCRCC, the Ontario Coalition of Rape Crisis Centres, about the increase of service requests since 2014 and again in 2021, during the height of the COVID-19 pandemic.

In September 2019, Statistics Canada released its findings of incident-based crime statistics in Canada. There was an increase in 2016 and 2018, with a year-over-year increase of almost 19%—

The Chair (Mr. Ernie Hardeman): That concludes the time. We very much appreciate that.

I just want to say that I forgot to mention that I would notify the speakers at one minute.

With that, we thank you very much. Maybe we can get the rest of your presentation in during the question period.

We'll now hear from Providence Centre for Justice, Peace and Integrity of Creation.

Mr. Jeremy Milloy: Thank you very much. My name is Jeremy Milloy, and I'm here via Zoom with my colleague Sayyida Jaffer. We are the leads on poverty, housing, climate change and the environment at the Providence Centre for Justice, Peace and Integrity of Creation, which is a Catholic social justice office that carries on the legacy of the Sisters of Providence of St. Vincent de Paul, an order of nuns who have served this community since 1861. We are working for a world in which all experience compassion, justice and peace in solidarity with creation. In 2022, our office joined the Catholic Health Sponsors of Ontario, reflecting our capacity to address the social determinants of health in our community and also at provincial and national levels. So we come before you today as experts in hearing and responding to the needs of our community.

1010

The government's priorities and spending plans currently do not meet the needs of Kingston or, we think, the province of Ontario. We're going to be specific about a few areas here. Our city is facing an affordable housing crisis, a drug poisoning epidemic and a climate emergency. We do not feel that current policies meet these vital needs. We will provide comments and suggestions about how we feel that our government could do better for Kingstonians and for all Ontarians.

First, on housing: The housing strategy specifically fails to provide the type of affordable housing Kingstonians and Ontarians need. We recommend that the province allocate money to build and retain affordable housing through giving municipalities funding to build municipally owned, mixed-income housing. Grants could cover the rent-geared-to-income and below-market units, and this could help reduce our social housing wait-lists and set up buildings with a self-sustaining income stream. Developers have not built and will not build housing that people living on low and fixed incomes can afford, so we need the province to be a funding partner here. We would like to see a province-wide program based on Toronto's Multi-Unit Residential Acquisition program, or the MURA program, where non-profit housing providers can access funds for down payments and other supports to buy affordable rental units and keep them affordable. This helps protect our existing rental housing stock. Each year in Ontario, we're losing about 20,000 existing affordable rental units. We would also like to see the province provide funding to renovate and improve the quality of existing social housing, especially to reduce energy consumption. Much of this housing was built between 1945 and 1990 and therefore requires a lot of maintenance and renewal to keep these units in the system.

We talk a lot about building housing, but we need to focus more on not losing more housing.

A specific need in our city, which has recently declared an addictions and mental health crisis, is that we need help building and operating supportive and transitional housing for different needs for our community members, such as people who use substances, people with disabilities and other needs. Some members of our community need more than just rent-geared-to-income or below-market units; they need supports to stay in those units and to thrive. This is a critical piece to addressing the housing crisis. We need funding for construction, operating costs and staff, for good services.

In our community right now, many people are camping outside, even in the winter, because they cannot find housing or even shelter that meets their needs.

The recent Ontario Superior Court ruling from Justice Valente ruled that the region of Waterloo cannot evict an encampment of people who are unhoused, because the region does not have enough beds to meet their needs and the shelter spaces do not meet the needs of people who are unhoused.

Municipalities need the province to help pay for services that meet current needs in order to not provide an undue obligation on our municipalities.

We need to invest in safer supply and safe injection sites across Ontario. People die every day in this province due to the drug poisoning crisis and due to needless delays in the providing of approved services. Providing access to pharmaceutical-grade drugs is saving lives and could save more. Everyone's life, in our community and our province, is important.

Another note on poverty: The government's decision to raise the minimum wage to $15.50 last year was a positive step. However, it only partially mitigated the damage done when the government froze the minimum wage and scrapped many positive changes to the Employment Standards Act. The Ontario Living Wage Network has calculated a living wage for eastern Ontario to be $19.05. Addressing this gap between the current minimum wage and a living wage would be enormously beneficial for our community, for our health, for people's ability to access and stay in housing and to boost our local economies.

On climate: Kingston was the first city in Ontario to declare a climate emergency. The government's budget and policies are failing to support us in our climate ambitions now and in the future, and in the energy transition required to meet our goals. For example, we have a massive program to retrofit homes, Better Homes Kingston, in order to tackle our climate emissions. This program is—good news—so popular that it is now currently oversubscribed and not taking new members. So it needs additional funding to support its growth.

We are facing a massive electrification challenge in this city as we shift away from a fossil fuel economy. More people are driving EVs, using electric heat pumps etc. We need funding for electrical infrastructure that will support our electrical needs in the future, including this increase in electrical demand and the ability to do distributed energy generation.

However, instead of investing in our future, the government seems bent on spending on the past. We apparently are going to massively expand gas plants to meet our future energy needs. I believe this is incredibly wrong-headed. Our city, along with dozens of other Ontario municipalities, passed a council resolution two years ago asking the province to phase out gas-fired power plants by 2030; instead, we are moving ahead with them. Not only are the carbon emissions of a gas plant worse, threatening to wipe out the progress we made phasing out coal, they also—along with new nuclear plants—will cost a lot more than new wind and solar.

Instead, we would like to see further investments in renewable production, energy efficiency and energy storage.

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

Mr. Jeremy Milloy: In terms of piloting energy storage, this could mean piloting vehicle-to-grid technology that could better make use of electrical vehicle batteries as a storage resource for our electrical grid; piloting advanced demand-shifting, i.e., through using smart water heaters as dispatchable resources, which lets them be essentially thermal batteries within Ontario homes; and we could move ahead with investments in research and development for energy storage over the long term, shifting energy gained in summer to energy that could be used in the winter.

While the energy transition is necessary, it must be done in a just way, so that lower-income Ontarians and rural Ontarians are not left further behind. In this respect, there should be provincial incentives and requirements for our largest landowners in the province to enhance energy efficiency and retrofits in rental buildings.

We also need more options to respond to our housing transition. City council here, responding to the desires of residents, recently stalled building new gas infrastructure for a new residential project. Unfortunately, the will of the people and council was blocked by archaic provincial regulations that require Utilities Kingston—

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

We will now go to the city of Kingston. Your Worship.

Mr. Bryan Paterson: Thank you very much. My name is Bryan Paterson. I am the mayor of Kingston. I am joined this morning by our chief administrative officer, Lanie Hurdle, who is available virtually to answer questions as well.

Let me begin my comments by welcoming all of you here to Kingston. We really appreciate that you've come to listen to me and to some of our other stakeholders and local community organizations. I'm sure that these few weeks are very busy for all of you, so thank you for taking that time.

I will be honest. I would love to be able to come this morning and talk about many different exciting issues that we're working on, whether it's housing, economic development, other community initiatives that are very important to us, but there is one issue that is overwhelming the city above all else, and that is the addictions and mental health crisis that we are seeing right now on the front lines. I'm sure we can all agree that the COVID-19 pandemic really brought to light the seriousness of this issue and has made it much, much worse.

Right now, our downtown is struggling. As you've heard from the previous speaker, we have individuals who are camping out in our downtown, sometimes sleeping in hallways or in foyers—wherever they can get warm. We have individuals in an encampment living in what I consider to be Third World living conditions that are unsafe and unsanitary and a challenge to the surrounding neighbourhood and to the community as a whole. Over the last few years, this city has spent $18 million to try to address this issue, to try to support, obviously, our unhoused individuals, to try to address this giant community need. That

has taken a number of different forms—but to put it in perspective, that's $18 million to support roughly 200 to 250 people. What have we done? We've opened new supportive housing projects, including supportive housing for Indigenous representatives and also for women at risk. We've created new shelter beds. We've opened new warming centres. We've developed an integrated care hub, which is a low-barrier shelter with wraparound supports that also has access to a consumption treatment site. We provided free transit for unhoused individuals to be able to move around the city. Here's a concern—I first want to say that much of that $18 million can be attributed, for example, to the social services relief fund and to targeted provincial funding into the integrated care hub. So I want to be very clear that we appreciate the investments from the province on this; it has been very, very important. If I could express the concern, it's that the social services relief fund is scheduled to end in April, and the issues and challenges that it was designed to meet have not gone away. If I can be frank, we're seeing the issues actually getting worse.

We do want to congratulate the government on the Roadmap to Wellness. This plan that the government introduced back in March 2020, $3.8 billion over 10 years—I think that's absolutely a step in the right direction. As a city, we do have some questions about exactly where that money goes—if it goes directly to large mental health organizations; has that money been earmarked; is there money that is still available that could be mobilized to help address some of the issues we're seeing right now, as a city?

To be clear, right now, as mayor, I feel that we are at a tipping point. At our council meeting last month, we declared unanimously, as council, a mental health and addictions crisis in the city. Basically, this was us waving the white flag and saying, "We cannot manage this anymore. We cannot cope. In spite of all of our investments, the money that we are spending, our staff resources, the problem isn't getting better." I would say that the problem is getting worse. To be clear, this declaration is not about pointing fingers, and it's not about complaining or making sensational statements. It really is a cry for help and an ask for the province to work with us to help to develop more sustainable solutions on this issue.

1020

So there are a few things that, as a city, we are asking for. The first would be more funding for detox and recovery and rehab beds in the city. There are very few of those beds available right now. Many people have to wait months and sometimes even years to be able to get the treatment that they need. In the meantime, they have nowhere to go.

Second, we'd ask the province to develop and fund a health care pathway that would take someone from a situation of mental health and addictions and be able to lead them into detox, recovery and rehab and into supportive housing, and help them to get back on their feet again—provide that sustainable solution, going forward.

Third, we would ask the province to continue to fund the integrated care hub and to fund more low-barrier shelters, which are really important. I'll give you an example. Every week, I get many calls to my office from business owners in our downtown talking about individuals who are camped out in front of their store, wanting me, as mayor, to do something about this. But here's the challenge, and I tell them this: If we have no other place for them to go, there's nothing that I can do. A low-barrier shelter, 24/7, that's open during the daytime would so assist our vulnerable residents, and it would assist our downtown and our community as a whole.

To be clear, there's also a financial benefit to some of the things that I'm proposing. The integrated care hub, in 2021, diverted 777 emergency room visits. In our conversations with the Ministry of Health, they told us that every emergency room visit probably costs about $1,600. If you do the math—777 emergency visits times $1,600—that's a savings to the health care system, at the hospital end, of about $1.24 million.

I know you're the finance committee, and I know you have tough decisions that you need to make in terms of your budget, but I do believe that there can be proactive spending that can help save money elsewhere in the health care system. We are asking the province to lead a working group that the city would be a part of—to be clear, we're not saying that you have to solve this issue; we want to work with you on this issue—to ask other social service agencies and local partners to be able to develop that health care pathway that we think is really important. We're also echoing the call of Ontario's Big City Mayors, asking for an emergency meeting with the province to be able to discuss this, because we know this is an issue across the province. We requested an emergency meeting with the province last June, and we still haven't gotten any information on a date when that actually could take place.

I want to say thank you for taking the time to listen to me today. Thank you for taking the time to come and to hear. We are here to work with you. We are hoping that by working together, we can make real progress on this issue.

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

We'll start this round of questions with the official opposition. MPP Fife.

Ms. Catherine Fife: Thank you very much to all the presenters. I truly appreciate your time and the effort that it takes to come into finance and be so honest with this committee. It's good to hear.

I want to start with Mayor Paterson. You asked a really key question, especially given that the Financial Accountability Officer released his report this morning around the economic state of the province and where they are financially. You asked the question, does the government have the money to support the integrated care hubs, as you recommended, and the social services relief fund, to extend that?

This morning, the FAO released numbers that are shocking. He found that the province has allocated a cumulative $19.7 billion in excess funds to other programs, including a significant contingency fund. These are unallocated dollars that, over the next three years, the government will have at their disposal. They have, right now, almost $6 billion. So they do have the money, and it is this finance

committee's job, I hope, to encourage the government to put that money into play so that you can actually—your example is excellent, Mayor Paterson, around the deferred visits to emergency rooms. That, in and of itself, makes the case for the investment, especially given the state of our emergency rooms in Ontario.

My question to you is, could you prioritize where the greatest return of investment would happen if the government were to actually put these unallocated contingency funds—this is separate from the $1-billion surplus, I just want to be clear, because there are municipalities like yours that have come to the table in good faith. You have come with solutions. Two weeks ago, Peterborough council had to dip into their reserves to top up public health, and that is not sustainable, nor is it fair to the local taxpayers. So I'd like to have three priorities from you right now, so that the government can clearly understand where this money should be spent.

Mr. Bryan Paterson: Thank you very much for the question.

I'd reiterate the three asks that I mentioned in my presentation. The first is more funding for detox and rehab beds. We have individuals who need treatment right now. They need a helping hand, and there are very limited resources available for detox and rehab. We hear that across the community. So being able to fund more beds would be the first piece.

Second is a funded and connected health care pathway that can take somebody from step one, which is living on the street, often with mental health or addiction issues, and being able to have a step-by-step pathway for them with wraparound supports. Initially, it might be just a low-barrier shelter—harm reduction, which we're supportive of—but we also don't want to keep people there. We want to give them hope to be able to recover—so into detox, into rehab, then into supportive housing with wraparound supports, then eventually into independent living. We've seen people who have been able to recover fully from mental health and addictions issues, but they need those supports. So I think that would be number two.

Number three is continued funding in the integrated-care hubs, low-barrier shelters that are helping to take pressures off the hospital system.

And yes, my concern is that if we don't fund these three things, those costs will show up elsewhere in the health care system—

Ms. Catherine Fife: Of course they will, yes.

Mr. Bryan Paterson: —so my hope is that we can be proactive.

Ms. Catherine Fife: Jeremy, you said something powerful in your presentation: that developers are not building affordable housing. The developers are in the business—it is a business, and profit is the goal.

So what are your direct asks for housing? We've heard very loud and clear throughout our delegations that housing is health care—that's just to the mayor's point. Without shelter, without housing, your path to recovery is almost impossible. Do you think the government should be investing in purpose-built, attainable, affordable supportive housing?

Mr. Jeremy Milloy: Thanks for the question.

Let me echo our mayor's welcome. I'm very grateful that you've spent the time here in our community to listen to us. I really appreciate it.

I'm going to answer parts of this question, and then—can we throw it to my colleague on Zoom who is our expert on housing?

Ms. Catherine Fife: Okay, go ahead.

Ms. Sayyida Jaffer: Thanks, everyone, for including me in this meeting.

I think what you just said about the importance of supportive and affordable housing is really important. As the mayor and others have spoken to—and Jeremy—we see that there are lots of people in our community who need more than affordable housing. There is a massive gap in our community for supportive housing in particular communities, particularly for people who use substances, but also for people with disabilities and other kinds of community needs. That requires not only building, but also operating funding. A lot of organizations don't have the operating funding they need to be able to offer supportive services, so it produces a massive gap.

Ms. Catherine Fife: We've also heard loud and clear that when you fund capital or you fund a bed, it's really just furniture unless there's operating funding and human resources to support that.

Beth, congratulations on the new job. You're entering a very conflict-intense field right now. The wait-list in Waterloo for sexual assault is a year and a half to get counselling. The wait-list has never been higher.

When you submitted your application for additional funding and made the case for those resources to MCCSS, were you given any rationale as to why you were not awarded additional funding?

1030

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

Ms. Beth Lafay: Just based on my history and my time with SACK, I'm going to defer to our board members to answer that question, if they know any details on that.

Ms. Catherine Fife: And you have less than a minute.

Ms. Beth Lafay: Yes. Yvonne and Tryphena?

Ms. Yvonne Tan: I'm Yvonne, vice-chair of the board.

I do not know if we were given any information on why we were not given any additional increases in funding, other than just austerity measures increasing—

Ms. Catherine Fife: I cannot hear the delegation, so maybe you can follow up in writing, if you don't mind. Perhaps you can send your response to the Clerk—any official response based on why you were denied funding when your wait-list and the need in the community to address sexual assaults in our communities has never been greater.

The Chair (Mr. Ernie Hardeman): We will go to the independents. MPP Brady.

Ms. Bobbi Ann Brady: Thank you to our three presenters this morning.

You're all very honest in your approaches. As MPP Fife said, it's definitely the same issues we've heard from delegation to delegation across the province and what we see in our own ridings.

I think my questions were already asked, but, Beth, I think you had two recommendations that you wanted to get out there, so would you mind letting us know what those are? And what is the current wait-list? Maybe you said that, but I didn't catch it.

Ms. Beth Lafay: We've done a lot of work to be able to creatively approach how we delegate the wait-list. We've come up with multiple programs to be able to serve the communities that are really needing supports right now. We have a program through SMRC funding with the military base here in Kingston, so we're able to give rapid access to folks who are affiliated with the military. We also split our wait-list into two so that when folks are seeking services, they identify which stream they go into based on the type of counselling they need—whether that's our Skills and Support program or our Reflect and Connect program. The lengths of those programs are different. The Reflect and Connect program is for six months, so folks can actually work on their healing and do that with a counsellor, whereas the Skills and Support program is more targeted at allowing folks to experience counselling for the first time.

In terms of our recommendations, we do partner with the police service to do training around trauma-informed practice. We do accompaniments, and we also have a project with the police service based on providing support for unfounded cases that are reported to the police. All of this comes from the sexual assault centre as free public education. So our recommendations are that the finance committee and the government provide stable core funding for community-based sexual assault centres that meets the needs of survivors of sexual violence, inclusive of more flexible program funding. The second recommendation is to distribute funding between sexual assault centres and police services based on reporting statistics and casework, wait-lists and the crisis line, because altogether, those services have a higher demand than the trends around reporting of sexual violence to the police services.

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

Mr. Ted Hsu: My question is for Ms. Lafay. How much has the effect of cumulative inflation had on your budget in the last few years? How much has inflation gone up and your budget not gone up? Do you have a rough idea—

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

Mr. Ted Hsu: —of how many percentages that is?

Ms. Beth Lafay: From what I could see on the Statistics Canada website, it's close to 20% over—

Mr. Ted Hsu: So is it fair to say that funding for sexual assault victims here in Kingston has been cut by 20%, because it hasn't kept up with inflation in the last few years?

Ms. Beth Lafay: I would say absolutely, yes.

Mr. Ted Hsu: That's all I have to say.

The Chair (Mr. Ernie Hardeman): We'll now go to the government. MPP Crawford.

Mr. Stephen Crawford: It's great to be here in the city of Kingston. It has been a while. Thank you, Mayor, for having us here.

My first question is to Sexual Assault Centre Kingston. I want to get a little more perspective on your organization, who you serve and your key needs. How has COVID and the pandemic affected the number of clients you're seeing? Are there changes in demographics? Is there an increase or a decrease in demand? How has it affected your organization?

Ms. Beth Lafay: I think when you look at the rhetoric around COVID-19 and you focus on the word "isolation" and the experience that survivors of sexual assault already feel without the pandemic, that can speak to exactly what that impact is.

We work with a broad spectrum of people, but the most marginalized people are women and gender-diverse folks, Black, Indigenous, people of colour, LGBTQ people, who have all been identified as the most marginalized in our country and in the world. We have to approach our work from a place of kindness and from a place of understanding, and so it requires my staff to always be on top of the most current training and capacity development to be able to meet these populations where they're at and understand what their experience is, not just of trauma, but of their own background, the way they were raised, the economic situation their household was in when they were growing up. When you look at all of these complexities, we have to know everything about everybody all of the time. Our staff have a lot of pressure on them to be able to meet those service demands, and the COVID-19 pandemic has absolutely increased the pressure of that.

Mr. Stephen Crawford: And could you just sum up, if you had one key ask of the provincial government, what would that be?

Ms. Beth Lafay: We need more funding that's flexible. We are given funding and then we have restrictions on what we can do with it. When you're dealing with the diverse populations that we're dealing with, there's no one way to approach working with those people. So all of the restrictions that we have on the funding restricts what we can do to support survivors in the Kingston-Frontenac—

Mr. Stephen Crawford: Thank you for the work you do in your community. I appreciate it.

I'd like to move to the mayor of Kingston now. I certainly listened intently about the opioid crisis. As the committee has travelled the province, we've heard this many, many times.

I want to move the conversation, however, to housing. There was some discussion about affordable housing. I know the government of Ontario recently had Bill 23 put out, and I did want to touch on that as a comment first, before I ask you a question. We've had a lot of support from housing groups. For example, the CEO of Habitat for Humanity said, "The province's proposal to exempt affordable housing from development charges, parkland dedication and CBCs will provide certainty to all affordable housing providers." We've had support from the housing and homelessness—from WoodGreen Community Services, from the Co-operative Housing Federation of Canada. So our government recognizes the need for housing, number one, and secondly, affordable housing, and we want to spur development there.

My question to you, Mayor, is, within Kingston itself, what is the timeline from when someone purchases a plot of land to when someone can actually move into a house? I know every development is going to be different, but can you give us some sense of that? I've seen in my riding where sometimes it's literally a decade from when someone buys the land to when someone can move in, and you can imagine that over 10 years the value of that property has increased tremendously, which increased the cost for new buyers. So we're trying to cut down the timeline. What's the timeline here in Kingston, and what are you doing to spur development, and how can we help you?

1040

Mr. Bryan Paterson: Thank you very much for the question.

I will say, first and foremost, that we absolutely share the same goal of building more housing. I'm an economist by training, so I get that, yes, we need more affordable housing, but we also need to increase the overall supply of housing as a whole. I'm pushing for more middle-market housing. Obviously, we're trying to do what we can here, with our local policies, to encourage more affordable, more attainable types of housing. We've been given a target by the province, and I will tell you right now that we will meet that target and we will exceed it, provided that we can work with our development industry and make sure that every housing unit we approve is actually built—and that is one challenge that I will recognize. I think with the economic conditions, one of the concerns I have is that we are seeing building slow down a bit. But certainly, as a city, we're doing everything we can to approve as many housing units as we can.

Your question about how long it takes—it does vary dramatically, depending on exactly what type of development it is, the size, the location of where it is. Obviously, when it comes to intensification, you're trying to build within the existing city core. Sometimes it's more complicated. We have historical cities, and there are often some environmental and heritage considerations to take care of.

The one thing I will say is that we are working very hard within our own city departments to be able to bring timelines for approvals down as much as we can. One of the challenges that we face is when we have provincial ministries that have to comment on development files—Ministry of Transportation, Ministry of Environment and others. Unfortunately, they do not necessarily abide by our timelines, and sometimes that can be a challenge. We've talked about, are there ways to provide conditional zoning approvals, where we could provide the approval but just say that those provincial agencies then would have to come in after the fact? Obviously, I think that a partnership there would be key. I think if we can all work together on those, get all of those boxes checked and get as many new housing approvals through as quickly as possible, that's really important.

Mr. Stephen Crawford: How much time, Chair?

The Chair (Mr. Ernie Hardeman): You have 40 seconds.

Mr. Stephen Crawford: We don't have a lot of time.

Where do you see your targets, then, in terms of the provincial target? You've been mandated a certain number of houses over the next decade. Do you see achieving those targets?

Mr. Bryan Paterson: Yes, I do. We've been mandated a target of 8,000 over the next number of years. We have worked very hard here in the city to double the amount of new housing that we're approving. It used to be that we would see close to 500 housing units built per year; now we're well over 1,000. We're certainly doing everything we can, as a city, to push that forward, but we need development applications to continue to come forward—

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

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

Mr. Terence Kernaghan: I want to thank all the presenters for coming to committee today. We have heard in many locations that there is a housing affordability crisis, and I think that was stated in all three of your presentations.

Beth, I want to thank you as well as your team, your volunteers, for what you do to not just change lives but to save lives. It's deeply concerning that your funding has not kept up over the years and has effectively been cut.

My question is for Jeremy. You mentioned that housing is a social determinant of health. Kingston has been struggling recently with a drug poisoning epidemic, whether it's fentanyl gummies or the one-year-old who, unfortunately, overdosed but was saved. I want you to touch on the benefits of the safer supply program for this committee.

Mr. Jeremy Milloy: I'll speak briefly on this and then pass it to my colleague.

I am also a historian of drug policy. Based on the research that I have done and my connections in the field, the history of drug policy is that punitive approaches and non-health-informed criminal justice approaches have tended not to work and support health. We found that supporting people in their recovery or in their journey through using substances and supporting people to be healthy in a regulated, safe environment is essential. People who die do not recover. A big part of the pathway that our mayor was talking about is about supporting people's health at source, and we think safer supply could help with that.

I'll pass to Sayyida.

Ms. Sayyida Jaffer: Thanks.

I want to echo what Jeremy just said. There are preliminary pilot programs with safer supply in different cities in Canada, particularly in Ontario—Toronto, London, Ottawa, and other areas. We're seeing preliminary positive results from them in terms of people being able to stabilize, and also just reducing the number of drug poisoning deaths and other kinds of community benefits, like people being able to access pharmaceutical-grade drug supply.

Mr. Terence Kernaghan: Dr. Andrea Sereda in my riding of London is doing some phenomenal work in that field.

Ms. Sayyida Jaffer: She is.

Mr. Terence Kernaghan: Your Worship, Mayor Paterson, it's very concerning that the SSRF funding is going to be ending in April when we see that the FAO has just released that the government has $20 billion to spare. I was hoping that you would be able to explain for this

committee—apart from the human side, but the economic side—how poverty actually has a fiscal impact on the province.

Mr. Bryan Paterson: I think I've talked about the impacts on the health care system. Locally, we see the pressure on our emergency room. I speak regularly with the head of our hospital system, Kingston Health Sciences, about the amount of time and effort and resources that are spent addressing the complex health care needs of the unhoused, and that means less capacity to be able to have emergency room service for other individuals in the community. So I think that's definitely an important piece.

The second piece that I have hinted about is the health of our small businesses in the downtown. To be honest, Kingston's tourism sector is one of our most important sectors. The viability of our downtown is critical. I have small business owners who have been through the challenges of the COVID pandemic for the last couple of years calling my office and saying, "What do I do with unhoused individuals who are camping in front of my store," and it's obviously a very difficult position for me to be in. I'm trying to take an empathetic approach to everyone, recognizing both points of view. I would say, from an economic point of view, having a healthy and vibrant downtown means unhoused individuals having an alternative place to go. I think they would absolutely want to be able to go to a 24/7 shelter that provides a safe, welcoming environment for them. That's better for them, and it's better for the health of our downtown and for our small business owners as well.

Mr. Terence Kernaghan: Absolutely. You've outlined it very well—the diversion of emergency room visits and what financial impact that has.

We've seen from the government many announcements and many measures in regard to affordable housing. Would you be able to explain very clearly for this committee the difference between affordable housing and supportive housing and the need to invest in supportive housing?

Mr. Bryan Paterson: Actually, I believe it was Mr. Milloy who did a good job of that in his presentation.

Affordable housing is addressing the income challenge, somebody who cannot afford market rent. I think we can all agree, given the increase in housing costs, that the number of people who cannot afford market rent is increasing quickly.

Supportive housing takes it a step further. It's affordable housing but also with on-site wraparound supports for individuals who need additional help. To be clear, many of our unhoused individuals don't just need affordable housing. Many of them have mental health or addiction issues that led to homelessness—or the reverse: They became homeless and, just as a coping mechanism, fell into mental health and addiction problems. So these supports are there to be able to help them get back on their feet. You heard me talk about this pathway—imagine a pathway that goes from detox recovery to supportive housing and then to affordable housing, where those supports can slowly be removed, and then into full independent living. I think we've got to provide hope to people who are in those situations and to our community as a whole that there is a road map for people to be able to recover fully. Supportive housing is a critical piece in that.

Mr. Terence Kernaghan: Will individuals who require those supports but aren't provided them be successful if they're merely placed in an affordable housing unit?

Mr. Bryan Paterson: From our experience here as a city, the answer is no. People cannot maintain their housing without those additional supports. We can provide that housing, but for a variety of reasons, if they're dealing with other complex health care needs, before too long, most are back out on the street again. I think we recognize—

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

Mr. Bryan Paterson: —that's why it's not just housing as a whole. That's obviously an important part of it, and that's why the city has taken steps to purchase several properties—to renovate them and to provide them as supportive housing options for individuals. We have made progress there, but the need is tremendous, so a lot more work needs to be done.

Mr. Terence Kernaghan: I'd like to ask a final question of Jeremy. Do you think it's effective or wise to expect that private, for-profit housing developers will create enough affordable housing for the housing crisis?

Mr. Jeremy Milloy: No. As a historian—what we're talking about here are problems that have been inherited over 40 years of disinvestment in public housing. This does not happen overnight, and we're dealing with that now.

Mr. Terence Kernaghan: So they need to take a more active role.

Thank you very much to all the presenters today.

1050

The Chair (Mr. Ernie Hardeman): To the independent: MPP Hsu.

Mr. Ted Hsu: My first question is for Mayor Paterson. Having spoken with the Kingston Police about the people who are living around the integrated care hub, the clients there, police are telling me that many of them are coming from outside the city. Is it fair to say that the city of Kingston is really helping to deal with a province-wide problem, not just a problem that's in the city of Kingston, and therefore it would be appropriate for the province to contribute a significant amount of the funding?

Mr. Bryan Paterson: I think the best way to answer that question is to describe the difficult situation that we're put in as a city, in that the more services and supports we offer, the more individuals travel to access those services. It creates, if I can be frank, a bit of a perverse incentive for cities to be able to—basically, it prevents us from ever being able to offer enough service and supports for everyone in our community. I certainly add my voice to the Association of Municipalities of Ontario and Ontario's Big City Mayors for a province-wide approach and support on this, so that individuals can seek those needed supports wherever they are in the province and not have to travel to other communities. I think that's very important.

Mr. Ted Hsu: Mr. Milloy, I was wondering if you could tell a story of a particular older affordable housing site in Kingston, which, if funds are not provided to renovate

it and for upkeep, will need to be replaced or perhaps sold for market housing, in order to raise funds to keep up affordable housing.

Mr. Jeremy Milloy: I'll share something that happened in my neighbourhood briefly, and then I'll throw it to Sayyida for the larger question.

The apartment building beside me is about eight units. It houses a lot of older people, people on fixed incomes. It was probably built in the 1960s or 1970s. It was recently bought by a real estate income trust from Oakville. It is now being renovated, and people are being evicted.

The real estate market has changed. There is a lot of financialization and money in the market that was not there 30 or 40 years ago. I'm sure Mayor Paterson can agree with that. That's why it's all the more glaring that if the province does not step up with its unique capabilities as a funder and builder, we are going to continue to lose housing.

Sayyida?

Ms. Sayyida Jaffer: That's one of the reasons why we also suggest that the province introduce a multi-unit residential acquisition program similar to the city of Toronto's, because buildings like the one next to Jeremy's could then be purchased by non-profit housing providers, to keep low-income housing affordable and not lose those 20,000 units we're losing each year in this province.

Mr. Ted Hsu: Back to Ms. Lafay: Many parts of our economy are suffering from labour disruptions. Do you have a story about a great staff member who left because they went on to more stable employment?

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

Ms. Beth Lafay: Well, not about somebody who left, but about somebody who was offered more salary somewhere else. Our director of counselling, who has been with us for many years and has a lot of institutional memory and experience in the field—somebody who is local to Kingston—was offered more money, so we had to counter that and offer more, as an organization that is, more often than not, applying for grants to be able to cover folks and hire more counsellors to deal with that wait-list. We had to up their salary in order to keep them.

The Chair (Mr. Ernie Hardeman): We'll now go to the government. MPP Triantafilopoulos.

Ms. Effie J. Triantafilopoulos: Thank you so much to the presenters for being here.

I want to direct my questions to Beth.

Beth, I want to congratulate you on your new position, and I want to thank you and your team for the very important work that you do. I can't underscore enough the importance of protecting women and children in our communities.

I want to ask you some specifics because I'm concerned about the fact that you have not been able to get your application approved. Can you tell me how many people you serve, and how many is it in terms of in person versus the call centre?

Ms. Beth Lafay: Our past fiscal year, we served 3,089 individual counselling sessions to 365 survivors.

Ms. Effie J. Triantafilopoulos: This might predate your coming to the centre, but can you talk a little bit about what happened during COVID? What were the volumes like? What changed?

Ms. Beth Lafay: When everything got forced to go virtual, luckily SAC Kingston had actually been doing a project called Going the Distance. We're executing some research that is funded through WAGE—women and gender equity, I believe; the funder is CFC. That project is actually looking at how successful distance counselling is. So SAC Kingston was actually a bit ahead of the game when the COVID pandemic unfolded.

During my time, the past month that I've been at SAC Kingston, I can say that the volume—we had to be creative in the way we were approaching the wait-list so that it didn't start to look like other counties that are struggling with—I can't remember what Windsor said, but there was quite a long wait-list in other communities.

Ms. Effie J. Triantafilopoulos: Are you the only centre offering your supports within this community?

Ms. Beth Lafay: Trauma-informed, specific for survivors of sexual assault? Yes.

Ms. Effie J. Triantafilopoulos: You mentioned some partnerships that you have. You mentioned the police. Was it also the Royal Military College of Canada? What other partnerships do you have?

Ms. Beth Lafay: We work with the integrated care hub. We work with all of the women's shelters in the area—so that would be Interval House. We work with a lot of the newcomer and settlement agencies. All of that work is funded through grants. We keep hearing from community that this has to be ongoing work, and we only have two years of funding to be able to do it.

Ms. Effie J. Triantafilopoulos: When you were talking about your recommendations going forward and you talked about stable core funding—your issue is that you need something more stable, that isn't grant to grant, in order to be able to do your work. Is that what I'm understanding?

Ms. Beth Lafay: Yes.

Ms. Effie J. Triantafilopoulos: Can you also describe what it is around flexibility that you're asking?

Ms. Beth Lafay: When we get funding and we sign our funding agreement, there are certain restraints that we have on the funding. Most of what we receive is towards counselling staff specifically, so that doesn't include our public education, our outreach assistant, our advocacy coordinator, our crisis line coordinator. So when we get that funding, it's the bare minimum. We're only able to operate at the bare minimum with our core funding. In order for us to do the outreach that we need to do in the community so that folks know about our services and know about our support, we have to be able to do the public education. We have to be able to do the outreach. We have to be able to work with equity-deserving communities. We don't get core funding for that. Our core funding is mostly for counsellors, partially myself, and operation fees.

Ms. Effie J. Triantafilopoulos: That's helpful.

Obviously, you have a number of educational institutions in the community. Everyone knows, of course, Queen's University and what a stellar institution that is.

You may be aware that our government recently passed new legislation supporting a safe learning environment for students, and that law strengthens the ability to address sexual misconduct of faculty and staff at colleges and universities. Have you got any feedback on that particular initiative of the government, any feedback in terms of what's going on on campuses today?

Ms. Beth Lafay: It is a committee that we are involved with. Two other staff members, along with the previous executive director, sit on that committee, and we have partnerships and we're doing events with those people on a regular basis.

1100

Ms. Effie J. Triantafilopoulos: Has there been any feedback coming out of that committee at this point in terms of the impact that the new legislation might have in terms of campus life?

Ms. Beth Lafay: Right now, I think it's challenging to assess the impact. At the meeting that I was able to attend in the past month, I heard that they're putting out lots of surveys to assess students' perspective on the marketing and advertising that's being put out to reach students.

Ms. Effie J. Triantafilopoulos: So, again, it's an education piece that they're doing right now.

Ms. Beth Lafay: It would not be funded.

Ms. Effie J. Triantafilopoulos: I understand.

Thank you so much for answering my questions. Once again, I really commend you and your team for the wonderful work you're doing.

The Chair (Mr. Ernie Hardeman): You have one minute left.

Mr. David Smith: My question is to the mayor.

I can see that you're doing a great job. You just started your term, and it's a struggle to get over some of these hills. I'm glad to hear that you're putting $18 million in support in trying to help your downtown core, which is struggling. My question to you is, how big of a problem is it in terms of numbers? As we travel across Ontario, people talk about it, but we don't have a number we're working with. We all know this is not a one-off situation for any one place. Do you collect any data that you can share with us, to let us know the volume and where we are going, how we are combatting it?

Mr. Bryan Paterson: If you're talking about the number of people who are involved, I would say it's roughly 200 to 250 people.

Lanie, do you have any more specific data on that?

Ms. Lanie Hurdle: I'm Lanie Hurdle, CAO for the city of Kingston.

In the past couple of years, we've seen a fluctuation between 200 to 250; I would say that now we're closer to 300. We do have a by-name list, and basically all of our partner agencies contribute to this list. So all the shelters and social services agencies we have agreements with provide input into that list—

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

That also concludes the time for the whole panel. We want to thank all the presenters both virtually and at the table for all the time you've put in to get ready and to prepare for this and then to deliver the presentations this morning. We very much appreciate your assistance.

QUINTE LABOUR COUNCIL

PETERBOROUGH COMMUNITY HEALTH CENTRE

SOUTH EASTERN ONTARIO PRODUCTION ACCELERATOR

The Chair (Mr. Ernie Hardeman): In the second panel, we have the Quinte Labour Council, Peterborough community health centre, and South Eastern Ontario Production Accelerator Fund.

Each presenter will have seven minutes to make their presentation. At six minutes, I will say "one minute," and at seven minutes, I will stop the mike. We also ask each presenter to state their name for the Hansard to make sure we can attribute the comments to the appropriate person.

We'll start off with the Quinte Labour Council.

Mr. Scott Marshall: Thank you. I'm Scott Marshall, a local high school teacher with the Hastings and Prince Edward District School Board. It doesn't matter how many students I've been in front of over the years—it has been, for me, a 30-year career—it's still somewhat intimidating sitting down in an environment like this, but I really appreciate the opportunity to be here.

I am the vice-president of the Quinte Labour Council, and we represent workers in the Quinte area—Belleville down to Picton, across to Trenton, Madoc and all the way up to Bancroft. I'm presenting a campaign that has been developed by the Ontario Federation of Labour. I'm not going to pretend to be an expert on all the ideas I'm presenting to you, but what I will say is that I know what I'm presenting has come from discussions at the grassroots level at labour council tables across Ontario. The ideas we have for workers and citizens in Ontario have worked their way up to the Ontario Federation of Labour, and we certainly do have the expertise at that level to work with government and to work with partners on implementing the plans and the thoughts and ideas that we have here.

Just a side comment: I live in the Northumberland riding with my family, and I've always tried to be active as a volunteer in my community.

The OFL campaign is really to address the cost-of-living crisis that we see, and we want to be partners in rebuilding stronger, healthier communities by working together and working with everybody.

I think we need to see real wage increases. Inflation is something that's being talked about by everybody everywhere, but it's also being experienced by people living in our communities, and it's really hard on workers. We need to look at raising the minimum wage to $20 an hour. I know there was a lot of anxiety and discussion about what would happen if it was raised to $15 an hour, and we didn't see some of the worst-case scenarios that were presented. I think we really need to acknowledge that a livable wage is something that is needed by workers in this province.

Bill 124 needs to be permanently repealed. It's unreasonable to suppress the wages of workers working in health

care, working in public education. These fields of work are absolutely critical to strong, healthy, well-educated, equitable communities.

We should be looking at doubling the Ontario Disability Support Program and Ontario Works rates.

We need to make it easier for workers to join a union. I'll be the first to admit, unions are imperfect organizations, but I think they're absolutely necessary in creating fairness and equity across our communities.

We also need to keep schools and health care public. We should stop privatizing health care, and we need to restore funding to public schools that supports the whole school, all the students and all the programming. Public health care and public education are absolutely essential and critical to having an equitable society. We should look at eliminating user fees. We should look very closely at ending the staffing crisis in health care.

I would say we are also starting to see a staffing crisis now in public education. We have unqualified teachers working as occasional teachers in our schools, and I think that's a risk for everybody. That's occurring because qualified teachers cannot be found to fill the vacancies we see.

Slash tuition fees at colleges and universities, because post-secondary needs to be accessible to everyone. Ensure affordable and accessible child care. Treat public sector workers with dignity and respect.

We also need to see that groceries, gas and basic goods are affordable. Let's look at ending the price gouging by the grocery store giants and the oil and gas corporations. We need to pass a right-to-food law that guarantees universal free school meals and make sure every community has access to healthy and affordable groceries. Public transit needs to be accessible and affordable. Fair taxation on the large food and oil companies is something that's necessary.

Rent control and affordable housing—and I did listen to the discussion with the previous panel, and certainly there are lots of ideas out there and a lot of expertise, and what I heard was a lot of evidence, too, on things that work and don't work. We need to launch a province-wide public housing program that builds decent homes in every community. We need to build that housing in a sustainable manner without threatening the environment or the greenbelt, create commercial rent control for small business, and house those without housing instead of policing them.

Finally, we need to make the large banks and the corporations pay their fair share. We see these extreme numbers in profit versus extreme numbers in poverty, and we need to find the middle somewhere, where we're all sharing and supporting one another and working together. We should make sure the wealthiest 1% pay their fair share.

Those are the ideas I'm presenting you today. Again, thank you for the opportunity to speak to you here.

1110

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

The next presenter is Peterborough community health centre.

Dr. Jim Shipley: Good morning. I'm Jim Shipley. I'm a retired physician—emerg, anaesthesia and family medicine. I've worked and volunteered with marginalized groups for the past three decades. I'm a board member of the proposed Peterborough community health centre, or CHC. I'll be presenting today with Dr. Dawn Lavell-Harvard, who will be presenting virtually. Dawn is the vice-chair of the Peterborough CHC, and she's the director of the First Peoples House of Learning at Trent University.

Peterborough's ask: Peterborough is asking for $8.2 million in annual investment to fund a community health centre, and that will provide health care to 6,000 marginalized individuals. Our proposal was submitted by the Peterborough health team to Ontario Health in August of this past year. We have the support of 28 community agencies.

I'd like to share a story with you about a Syrian refugee family I work with. Some of the facts have changed to protect their confidentiality, but the elements that it contains are all too common.

Boudras and his wife, Khadija, and their two boys came to Canada from Syria, and they settled in Guelph as part of a government-assisted relocation, a GAR. There, they were clients of the Guelph CHC. Boudras's diabetes was stabilized and Khadija's PTSD from her time in a Turkish refugee camp was aided by mental health workers and culturally supportive group therapy. The boys received necessary immunizations and much-needed dental care, and the family thrived.

After the year of financial support, Boudras found a job in Peterborough that would let them come off of social assistance, so the family moved. Once in Peterborough—and that's where I met them—they realized that they had little chance of finding a family doctor or a primary care provider, and there is no CHC in Peterborough. Boudras's diabetes once more slipped out of control. More than once, he ended up in the emerg; once, he needed hospital admission. In the end, his job was lost. His poor diabetes control increased his risk of complications such as blindness, renal failure and vascular issues.

The stress of Boudras's health concerns led to a recurrence of Khadija's PTSD, and she has nowhere to turn. The boys suffer in so many ways as their family situation crumbles, and their school is concerned. All of this tragedy is unnecessary.

Canada accepted a record number of refugees in 2022, and the number of new refugees in Peterborough doubled in that year. New immigrants are only a small part of the marginalized population that a Peterborough CHC will serve, and it will change their lives.

The problem: Peterborough has traditionally struggled to attract physicians, both family physicians and specialists. This could reach crisis levels in the next few years; it likely will. Peterborough has a marginalized population that is far above the provincial norms, but it does not have a primary health care model that is designed and resourced to serve that population. Because of this, Peterborough has very poor outcomes on health measures, including high costs—Dawn will share with you some of the other surprising poor outcomes in Peterborough—and our other systems in Peterborough, such as the hospital, are bearing

the burden of this. Of course, that's resulting in higher wait times for emerg and higher wait times for surgery.

The solution: A CHC in Peterborough will attract new physicians to our community, specifically those who prefer to work at a CHC. These physicians would otherwise not come to Peterborough. A CHC would provide comprehensive, accessible care to marginalized individuals who are not, and likely never will be, attached to a traditional primary health care provider. It will generate cost savings to our health system—right patient, right care, right cost—and it will create capacity as a central hub for comprehensive care, including addressing the social determinants of health.

I'm going to turn it over now to Dr. Lavell-Harvard.

Dr. Dawn Lavell-Harvard: Aanii. Boozhoo. *Remarks in Ojibway*.

What I shared with you is that I am from the Wiikwemkoong First Nation on Manitoulin Island. Having moved to the Peterborough area, I am very keenly aware of the challenges that our people are facing in this region and that all marginalized people are facing in this region.

We've come to you today not just to talk about a problem, but to talk about our proposal for a solution, to be part of the solution here. Peterborough desperately needs this community health centre, because the CHC is the only primary health care model that is designed and would be adequate, if adequately resourced, to serve Peterborough's significant marginalized population.

We know the statistics for homelessness. The incredibly high cost of rent and housing in this region means we have a disproportionately high number of incredibly marginalized people in this particular region—not just within the city of Peterborough, but within the surrounding First Nations and the rural areas around us. Indeed, Peterborough is ranked as having the fourth-highest level of marginalization among Ontarians.

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

Dr. Dawn Lavell-Harvard: Okay.

This lack of health care is impacting our health care system. When we talk about an upstream investment in this way, we understand that for an upstream investment, we will be saving money in the long run in terms of the incredibly high costs of emergency room visits, of dealing with health care issues when they have not had an early intervention and they have come to crisis. We're talking about reducing costs and wait times for surgeries, for complex surgeries, for complex care, hospital beds. All of those things could be reduced.

Therefore, this supports all of the people in the Peterborough region, not just marginalized populations, by ensuring that those who are most vulnerable are able to connect in a way that meets their needs, are able to connect with health care in a way that allows for early intervention, so that we are improving their health care and cutting costs on the overall health care system—

The Chair (Mr. Ernie Hardeman): That completes the time. Hopefully we can get some more of your presentation in during the question period.

We will now go to the South Eastern Ontario Production Accelerator Fund.

Ms. Heather Haldane: Hi. Firstly, I want to state that I'm humbled by the breadth that this committee has to hear. I'm here to represent how a government spend, well directed, will bring revenue to the province that will maybe help pay for some of these concerns.

My name is Heather Haldane, and I'm here as co-chair of a volunteer working committee that has a proposal currently before government that is of active interest to finance—and I apologize to MPP Byers, because you've probably heard much of this before; we have been told that we can state that there is that active interest of finance. That proposal requests that the government create a film-stream fund of $25 million annually to be specially set up in southeastern Ontario via MEDJCT—that's the Ministry of Economic Development, Job Creation and Trade—and the regionally focused Eastern Ontario Development Fund, the EODF. The ask is very specific as a film-stream fund within an existing economic development fund. Finance and treasury have discussed this proposal, and the full proposal is downloadable from a website: www.seopaf.ca.

As this is a finance and economic development panel operating across parties, drawing from outside the region—that is, outside of eastern Ontario—I want to start by stating clearly that attracting new business to Ontario and growing the existing film industry out from the greater Toronto and Hamilton area, which many of you represent, and into southeastern Ontario as a new film region through an incentive fund benefits not only eastern Ontario, but all of Ontario. This industry generates revenue and should accelerate economic growth across many diverse sectors, with immediate economic impact.

I appear here today on behalf of the South Eastern Ontario Production Accelerator Fund—SEOPAF—and its volunteer working committee, which is made up of film industry members and regional business stakeholders working together to establish and grow the film and television industry in southeastern Ontario. In 2021, this industry generated $2.88 billion in revenue, and that level is expected to be higher in 2022. Because of the growth of interest from international streamers in setting up shop in Ontario, in 2023 revenue generation should only rise.

Many of you already know from your own stakeholder group how portable the industry is, and have seen and heard of the cross-sector benefit when a film production sets up on location. From accommodations to location rentals to transporting equipment and building suppliers, the spend to support production on location positively impacts the local economy and workforce.

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The Eastern Ontario Development Fund defines its region—and SEOPAF models that as its catchment. To keep it simple, that catchment starts where the current Toronto industry union zone border stops, just east of Oshawa, and continues east from there, north and south of the 401, to the Quebec border. It's large. It includes Kawartha Lakes, Peterborough, Prince Edward county, Frontenac, Thousand Islands and the Rideau Lakes area. It's a well-travelled

corridor, accessible, and of great interest to the film industry.

The GTHA is already overburdened and barely able to supply the workforce needed—nor soon—for the studio builds that are being concentrated there. If unable to meet the workforce or cost demands of this industry, industry interests will increasingly shift out of province. Ontario can't afford to lose this business growth; southeastern Ontario certainly can't. Provincial tracking has southeastern Ontario as the furthest behind in terms of economic growth, well below Ontario's 15.9% average in 2019—that stat is from a government study. Of any region, southeastern Ontario is most in need of an economic booster in 2023.

A successful regional approach will increase Ontario's ability to keep this industry viable in all of Ontario. That idea is not new. A regional approach has been proven in northern Ontario with the launching of the film-stream fund over 17 years ago. Since approximately 2005, government or MEDJCAT, through NOHFC, the Northern Ontario Heritage Fund Corp., invested over $350 million in a stream fund to attract the film industry to the north, and that leveraged over $1.3 billion in return and created more than 5,000 jobs. This fund began at a time, in the early 2000s, when northern Ontario was struggling for diversification and economic growth. That is southeastern Ontario's struggle and challenge in 2023. The opening of the north because of their fund's incentivization of film production increased Ontario's revenue generation.

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

Ms. Heather Haldane: In 2022, the revenue generated in the north was over $400 million from an investment of less than $50 million—an 8-to-1 return on investment. That's a very solid return.

Proving out this economic growth potential is southeastern Ontario's anchor hub in Kingston. Kingston frequently experiences short-term bursts of production activity with series like the Mayor of Kingstown 2021 production. From a modest investment in the series, the Kingston Film Office realized impressive local returns in terms of accommodation, catering, local hires, rentals and location permits. Return on investment minimally projected at 5-to-1 landed closer to 8-to-1.

But Kingston alone won't be able to build an industry that will stay and grow capacity until the region works together to attract the industry and incentivize it to stay by building the local workforce.

In the north, the production hubs that have evolved over time—

The Chair (Mr. Ernie Hardeman): Thank you very much. That does conclude the time. We'll now go to the questions, and hopefully we can get the rest of your presentation in as we go with the questions.

We'll start with the independents. MPP Brady.

Ms. Bobbi Ann Brady: Thank you, Scott and Heather, and Dr. Shipley—my question is actually for you.

I come from the rural riding of Haldimand–Norfolk, and we have a difficult time recruiting new doctors to the area. Can you explain to me how a CHC is actually attractive to new physicians or physicians in general looking for a place to relocate?

Dr. Jim Shipley: I'll try. That's a complicated question. I spent a lot of years with HealthForceOntario, so I've worked in almost every small community hospital across the province. It's, of course, a multifactorial thing because you're not just attracting the physician; you're attracting the physician's family and spouse, and that's a big feature there.

What we think will work for this, and we're working closely with the physician recruiter in Peterborough, is—there is no model in Peterborough for a physician to come, who wants to work in a salaried position where there are lifestyle considerations, where they work in a comprehensive care team. They're trained to work in a comprehensive care team, and then they go out and there's nothing available, in Peterborough anyway, for them to do that. So we think, and we're backed up by the recruiter, that this would really appeal to a different group of physicians than the rest of the practice in Peterborough. Our feedback—and my personal feedback; my niece is finishing medical school—is that there are a group of physicians who are really looking for this and they wouldn't otherwise come to Peterborough and that we would have a chance of attracting them there. We think it's a fairly good chance.

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

Mr. Ted Hsu: I want to ask a quick question of Mr. Marshall. Do you have some proposals? You mentioned making large banks and corporations pay their fair share. If we just start from the corporate tax rate of 11.5% in Ontario, and I believe it's 3.2% for income under $500,000—would you be wanting to change those numbers? And if so, what different numbers would you propose?

Mr. Scott Marshall: I think I said at the start that I'm coming here to present a lot of ideas, and I've hit on a lot of things, and I'm not going to pretend to be the expert who has those numbers. I do think when we look, big picture, at these massive profits that are being made by corporations and then the numbers of people struggling to make ends meet in our community, there's a mechanism to try to redistribute that wealth and see that there's more sharing. So I can't give you those numbers, but I think that the concept is about seeing that there's a better distribution, and taxation is one way that we see that money is shared and spent.

I'm a taxpayer. I'm happy to pay my taxes as long as I know they're being well spent and being spent responsibly and being spent in a way, I suppose, that has a positive impact on my community.

I apologize for not having a direct answer to the question, but I hope you understand the intent of that plan.

Mr. Ted Hsu: I have a question for Dr. Shipley. Maybe this is a little bit self-serving for the riding of Kingston and the Islands, but we—

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

Mr. Ted Hsu: —also have plans for salaried team-based primary care, so I'm wondering where you will be recruiting from to get physicians to come to your community health centre.

Dr. Jim Shipley: Do you mean, is it a dog-eat-dog world out there for physicians?

Mr. Ted Hsu: Right. I'm hoping that you're recruiting from outside of Ontario and, perhaps, Canada.

Dr. Jim Shipley: Yes. We're looking closely at Kingston as a model CHC, because Kingston does a bunch of really innovative things with their CHC—fascinating stuff. We're thinking that our main recruiting drive will be in new graduates, and we think that we'll offer something really unique for them and really attractive for them. We really believe that's what's going to happen.

Mr. Ted Hsu: Ms. Haldane, you mentioned that Kingston will be the anchor hub for film and TV production in southeastern Ontario. I was wondering if you could expand on that and tell us what's here already and why we're going to be able to—

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

We'll now go to the government. MPP Smith.

Mr. Dave Smith: Surprisingly, I'm going to focus my questions on the Peterborough community health centre.

Jim, it's good to see you. Dawn, Suzanne, thank you for very much for joining us virtually.

Obviously, I know a fair bit about this. We've had a lot of conversations, so I'm going to throw a couple of things out there—64% of new grads from medical school want a salary. They don't want to go through the process of OHIP billing. Your proposal is for three physicians and four nurse practitioners, I believe. I may have those reversed; it may be four and three, the other way around.

Dr. Jim Shipley: Yes, four physicians.

Mr. Dave Smith: But my understanding is that the expectation is that likely those will be part-time physicians who will also be potentially hospitalists for us and possibly taking on some family practice. So, effectively, this CHC isn't four physicians for Peterborough; it's eight. Is that a fair comment—that we would be potentially attracting eight physicians to the community instead of just four?

Dr. Jim Shipley: Well, it certainly could turn out to be that way. That will totally depend on the physicians. If the physician finds that the CHC model meets all of their needs and exactly what they want and they're working their 36 hours a week and they have a life—not anything like when I graduated—then maybe that's what they will opt for.

If they opt for two days a week and become a hospitalist or palliative care or any one of many other things you can do in family medicine, such as emerg, that will be totally their choice. But by leaving it to be their choice, I think we have a greater chance of attracting more physicians.

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Mr. Dave Smith: So if I could use an analogy that—forgive me if it's not respectful enough—when we talk about the buffet of things that physicians could offer, this is actually putting something else on that buffet for them that is much more attractive. Perhaps we're putting on the great dessert that is attracting everybody in or that great main course that's attracting everyone in, but there should be a significant spinoff for it. Is that—

Dr. Jim Shipley: I totally agree, but of course, that's from a personal point of view because I have certification in emergency, anaesthesia, family medicine, diving medicine, flight medicine, disaster medicine. So for physicians who want a broad practice, this is a spectacular opportunity.

Mr. Dave Smith: When I was first elected in 2018, we had about 11,000 individuals who did not have a family physician or a primary care physician; now we're at 13,000. And the projection for doctors who will be retiring could bring us as high as 20,000 to 25,000.

Dr. Jim Shipley: It will be 36,000 in 2025.

Mr. Dave Smith: So this is something that has been growing over probably the last decade and a half, and we haven't had a solution so far in Peterborough that has been attractive to attract doctors. This could be one of the tools in the tool box, then, to make sure that we don't find ourselves in a significantly greater crisis in a very short period of time.

Dr. Jim Shipley: Absolutely, but there's also another aspect of that, in that marginalized people are much more likely to not be attached to a primary health care practitioner, and so those are disproportionate. If you look at Health Care Connect, the people who stay on Health Care Connect and can't find a practitioner are the medically complex and the marginalized—so those people will just grow and grow and grow.

Mr. Dave Smith: When we look at this, it's not just physicians; it's also nurse practitioners, and I believe there's a potential for dietitian and other support services. So it's not just a family doctor per se, but it's all-encompassing and it gives a continuum of care for the community.

Dr. Jim Shipley: Absolutely. Across the province, this is the CHC model. It's physician care, nurse practitioner care, mental health care, dietitian, physiotherapy, pharmacists involved, and then people to address the social determinants of health. So there will be housing resources. There will be drug addiction resources. It is a totally comprehensive model. It's not our model. It's the provincial model.

Mr. Dave Smith: Chair, how much time do we have left?

The Chair (Mr. Ernie Hardeman): You have 2.4 minutes.

Mr. Dave Smith: I'll be very quick on this one.

We've got a challenge with an opioid crisis in our community. We have to have multiple tools to address all of these things. We have a challenge with unhoused. This also could be part of the solution in helping to alleviate some of those challenges. It's not just health care, but it's mental health care, it's whole-being care. Is that a fair assessment?

Dr. Jim Shipley: That is totally fair, because none of those problems are in isolation. You don't have somebody who has a substance abuse problem without some kind of a spinoff into their housing, into their mental health, things like that. So if you aren't addressing all of the things that contribute to the problem, then you're doing band-aid care and your chance of success drops spectacularly.

CHCs are comprehensive, and because they're community-based, they're flexible, so if a community has a particular problem, the CHC can adapt, can morph to address that problem.

Mr. Dave Smith: I don't want to suggest that this is a one-size-fits-all solution to all the problems in Peterborough, but it would address a lot of the challenges at different levels. Is that fair?

Dr. Jim Shipley: Right. Right down from ER overuse and surgical wait times to our overdose crisis in Peterborough, I think it has the potential to address, if not every one of the marginalized's concerns in some way, then most of them.

Mr. Dave Smith: Thank you. I appreciate that.

The Chair (Mr. Ernie Hardeman): You have one minute. MPP Byers.

Mr. Rick Byers: Thank you to all the presenters for coming here today and, more importantly, for all you do in the community.

Heather, thank you for your proposal on the accelerator fund. It's good to see you again, here in Kingston.

As you probably know, in the fall economic statement we introduced a tax credit for film and television production. I'm curious if you're aware of that. Would that have any impact on generating support for the activity that you've outlined with your fund?

Ms. Heather Haldane: Well, like anything, it certainly brings a level of funding to the industry. It happens pretty late in the process. This kind of accelerated fund that I'm talking about is actually to develop and begin that process, as opposed to ending it, if you will. It's regionally focused, and that, I think, is the important part of this accelerator fund—

The Chair (Mr. Ernie Hardeman): Thank you very much. We'll have to finish that in the next round.

We'll go to the opposition. MPP Fife.

Ms. Catherine Fife: Thanks to the presenters. It's good to see you.

I want to focus a little bit on Peterborough, because I was there last week. I have to say, you can see that the community is hurting. I think council even voted not to provide washrooms for the encampment, so things are pretty harsh there.

I think that a community health centre is exactly—we've heard from doctors and medical professionals across the province at these delegations that this is the model that will not only attract doctors, but will retain them. The college of physicians actually went so far as to say that when doctors feel supported in that workplace, they deliver better care and they're more committed to the community. And doctors want to spend time with patients, not doing the administrative kind of work, so this makes a lot of sense. The government has already heard me say this today, but the Financial Accountability Officer, the independent budget officer for the province of Ontario, indicated that the government has a huge amount of money in a contingency fund that's unallocated, so the money is there. The return on investment for this model is profound, I would say.

Jim, I wanted to give you a chance to talk about the state of public health in Peterborough. We have heard from many municipalities that they want the province to go back to a 75%-25% model, because we're seeing municipalities—Peterborough is one of them—that had to dip into their reserves to top up public health. After the pandemic, we should know; we should have learned these lessons. I just wanted to give you an opportunity to talk about the demographics of Peterborough and why public health is so important.

Dr. Jim Shipley: Just to touch on a few of your points: There are lots and lots of studies about CHCs. A lot of them are out of Quebec, where it's very popular. The studies show that the clients who use CHCs have a hugely improved sense that they are being well cared for. That comes across loud and clear. Another thing is that a CHC with $8.2 million in funding equates to $1,367 per patient per year, which is startlingly good, since we know that an ambulance costs $425 and a hospital stay is $840 for one day. So this is a cost-effective way.

I'm not an expert on public health, but a CHC will work in conjunction with public health, so if there's a public health concern in the community—which almost always disproportionately affects the marginalized—then the CHC can adapt. The CHC can work with public health to meet those needs. If we had one during the pandemic, we would have been able to access the homeless shelter, with increased immunization rates. We could have prevented tons of hospitalizations and deaths. So I think it's pretty obvious.

Ms. Catherine Fife: Yes. We heard earlier from the mayor of Kingston, actually. Over the last two years they've spent $16 million essentially dealing with between 150 and 200 vulnerable people. If you do the math, the $8.2 million and the return on investment for the entire community—it's there, right?

Nurse practitioners, we heard in Kenora, can take up to 900 patients. They can really alleviate the wait-lists for doctors. I just want to say how supportive we are of this model. With the fact that there are 100 CHCs in Ontario, that Peterborough has never qualified for one is pretty shocking, especially given the demographics and the rate of retirements of doctors.

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Moving on to Heather Haldane, I wondered if you could just review—you gave a really good example for the investment with northern film development, so that is clear. This is a beautiful part of the province, going all the way up to northeastern Ontario, as well—really untapped—and Kingston is gorgeous. Can you give us the exact ask around what you want the government to invest in, from your perspective?

Ms. Heather Haldane: We are requesting essentially what the north receives, and that is $25 million annually. As I say, statistically, it has been studied. It has been in existence for over 18 years now, so there have been studies done on the return on investment. They receive roughly $25 million a year. In 2022, they received $50 million, roughly, and the return on that $50 million was $400 million, so you can see that it grows the industry, but it grows across sectors, as well, and it can grow the workforce if it's implemented through economic development.

Ms. Catherine Fife: Do you know what else draws investment or attracts investment into this province? It's the social infrastructure. It's the health care. It's the education system. It's the infrastructure.

Ms. Heather Haldane: All of that matters.

Ms. Catherine Fife: It's all very much connected.

Ms. Heather Haldane: It is.

Ms. Catherine Fife: Scott, I want to say thank you for being here today. My husband is also a high school teacher and is on stage on a daily basis. This is a very different stage, obviously.

I wondered if you might give us some sense as to the impact—and I hope this isn't unfair—of Bill 124, which is wage-suppression legislation and caps salaries at 1%. We're seeing a lack of staffing in the education system. We've heard from education advocates from across the province that morale is fairly low right now, as well, because it's disrespectful.

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

Ms. Catherine Fife: You have the last minute, on Bill 124. Please let the government know how it's impacting public education.

Mr. Scott Marshall: I'm currently the elected president of the OSSTF in my district, so I hear from teachers all the time, but we also represent support staff across the province. There are a lot of support staff who are not able to make ends meet right now. The teachers I know—there's a huge spike in stress-related illness right now. Morale is at an all-time low. It's very reflective of what I saw when I started my career in 1993, as the Harris government tore down public education.

I think red flags and alarm bells should be ringing right now, because we are headed for a crisis in public education.

The Chair (Mr. Ernie Hardeman): We'll go to the independents. MPP Brady.

Ms. Bobbi Ann Brady: My question is also for Scott.

Scott, you said that the education system right now has many unqualified teachers in it. Can you explain to me what these unqualified teachers are teaching, where they're coming from, why they're there?

Mr. Scott Marshall: Right now, the unqualified individuals are in the building filling in for daily occasional teachers. We are seeing a lack of applications for contract teachers, especially in specialty areas like technology and French, but it's starting to expand. We recently had an unfilled contract position in math. The unqualified teachers aren't there in the permanent contract positions yet. Permanent contract would be those teachers you see on a daily basis who are involved in the planning and the assessment—the things that require the specialized training that teachers have. But managing students and managing a safe learning environment is still something that requires training and qualifications, and the absences and the unqualified teachers we're seeing right now are for the daily coverages.

That's where I say there's a real risk in having individuals who don't have specialized training in teaching filling in for absent teachers. It's not as simple as simply coming into the class and—we don't even have chalkboards anymore—putting the lesson plan up on the whiteboard. Students are students. They're very dynamic. They're very engaging. They come prepared to test whoever's there each day. When a regular teacher is away, I think as parents we should expect that education will continue, and I don't think that's occurring with unqualified teachers being there.

And then the bigger problem is why there is not an interest now in going into the teaching profession, and I think it's because the word is out that it's not so desirable, especially for the level of qualifications that are required.

Ms. Bobbi Ann Brady: That was actually going to be my follow-up question—what is the issue with respect to graduates coming out who are capable of being qualified in our schools? Is it a respect issue?

Mr. Scott Marshall: Absolutely, I would say respect. I think morale is low. Teachers do feel undervalued when there are comments that they are overpaid and underworked. That is starting to be the feeling that is out there. I will say this isn't just a teacher-specific concern. There is a full education team in the schools, and I think this issue is much broader and it affects everybody who's there.

And if you look at compensation—for teaching, it's about six years of post-secondary education. If you have that level of education, you're going to look at whatever other professions may offer as far as compensation. With the wage-restraint legislation that exists right now, I think people are considering that, too, when they're making decisions on which way they're going to head with their post-secondary education.

Ms. Bobbi Ann Brady: How do we head that off, with regard to the disrespect? The overpaid, underworked mentality that has existed for a long time—how do we rectify that?

Mr. Scott Marshall: I know internal polling that we've done—parents actually really like, for the most part, the teachers they know. When we're, as a profession, engaged in our community and making sure we have those connections—

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

Mr. Scott Marshall: —because the schools can't be isolated. I think it's just building this understanding in our communities that our schools are connected to that broader community and what we offer is critical to strong communities, not just between the bells, when the day starts and the day ends. I think recognizing the role public education plays along with health care and all these other public institutions is critical to seeing that everybody really values what goes on there and then values the people who are there working with the students etc.

Ms. Bobbi Ann Brady: Thank you.

The Chair (Mr. Ernie Hardeman): You have 26 seconds. MPP Hsu.

Mr. Ted Hsu: Very quickly for Ms. Haldane—where else could film or TV production go if it didn't come to southeastern Ontario?

Ms. Heather Haldane: I think this is an area that's prepared. It can go lots of places, but it really needs an infrastructure and an understanding from the community and the stakeholders about what that actually means. This area has been doing that level of preparedness for a period of time, so I feel that, in terms of an investment, it's a good place to start.

The Chair (Mr. Ernie Hardeman): We'll now go to the government. MPP Byers.

Mr. Rick Byers: I'll follow up with you, Heather. We were talking, last time, about the tax credit and the stage of funding. I wonder if you could just continue with that, so we understand your perspective.

Ms. Heather Haldane: Again, this is an accelerator fund. It's so important to be able to grow an industry. It's not just simply making it attractive to international streamers and larger groups—but helping an industry here start. The accelerator fund model really is that sort of community-based, local growth of an industry. In order for it to attract the level of production that it needs, because of the distance from the greater Toronto and Hamilton area—the incentive fund in the north has worked incredibly well in terms of incentivizing people to go there, stay there and then grow that industry. And the same thing will happen in southeastern Ontario. A tax credit doesn't function that way. It won't build that industry the way it can be built, and there is a level of business that is out there and existing that could come to this region.

Mr. Rick Byers: I'll pass on to my colleague—well, the Chair can.

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

Mr. Andrew Dowie: Once I'm done, I'll pass to MPP Smith, Scarborough Centre.

My question is for Jim. Thank you for the proposal about the community health centre. Just for my enlightenment, can you share with me what the key differences are between a community health centre and the Ontario health teams that were established four years ago?

Dr. Jim Shipley: It's a totally different model. A community health centre has a community board who governs it, which means they're responding to the needs of the community. And the community health centre—most of them serve a specific population. In our case, we have stated that we will serve the marginalized people of the region, and that's an umbrella term for many, many different groups. An Ontario health team serves everyone, all comers, but it doesn't specifically target those who have a harder time accessing our health care system, such as the marginalized. So that's probably the main difference. A CHC, as I've said a couple of times, can be flexible and can meet specific needs.

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Mr. Andrew Dowie: So, just to confirm, this is really governed by a community board, which identifies where the key priorities are and then allocates resources accordingly?

Dr. Jim Shipley: Correct. Some CHCs have identified that dental problems are huge in the community they want to serve, so they've developed kind of a dental program to deal with those kind of things. Most CHCs have adapted over the last couple of years, during the pandemic, to meet some of those needs more specifically. An OHC doesn't really adapt.

Mr. Andrew Dowie: Chair, I'll pass it—

The Chair (Mr. Ernie Hardeman): MPP Smith, Scarborough.

Mr. David Smith: I want to thank the panel for their presentation.

My question is to Jim and Dawn.

First of all, I want to start on a positive note and say that today, as you know, Premiers all across Ontario are meeting in Ottawa with the Prime Minister to discuss some of those very health concerns and costing and all that. I'm hoping that things come out in a positive way, and that we can have more dollars to go around in that area of concern, amongst other things.

I am within the Ministry of Labour, Immigration, Training and Skills Development; I'm the parliamentary assistant to Monte McNaughton. We do have a number of programs that—I'm not sure if you know about them, Jim; if you don't, then we certainly can get you up to speed in terms of the nominee program, and foreign credentials have now been waived to bring more professionals into Ontario to help with some of the shortfall. As you know, we have a shortage in every aspect of having the right people employers need, and in the medical profession. What do you think of that, and how do you feel that will help the situation?

Dr. Jim Shipley: Again, it's not a simple question. I think that there is a huge untapped resource there, but I also believe that it has to be tapped really carefully. We have incredibly high standards for medical training in Canada, and I think if foreign medical graduates can meet the same standards as a Canadian medical graduate, then I think we should welcome them with open arms, realizing that if we recruit from other countries, we're causing problems in the country they came from. So we have to be cognizant of that, as well. We can't drain qualified physicians from a country that needs them just because we also need them. That's a vague answer to a really difficult question.

Mr. David Smith: Well, the reason I'm asking you the question is that I've seen that you cover many aspects of medical, and you're the best person to give me an answer on what you see as one of those areas of concern that would bother you.

Dr. Jim Shipley: Well, I do believe that primary health care is the cornerstone of all medical health care. So if you don't have enough primary health care practitioners, then the rest is doomed to problems.

Through my years, mostly in emerg, I acted as mentor for many, many, many medical students and was part of a program where—

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

Dr. Jim Shipley: —we had foreign medical graduates who came in, worked with us and we assessed their skills. So I really do know that standards in different countries are not the same as standards in Canada, and that would be a concern for me.

Mr. David Smith: In closing, a quick question for Scott: Scott, I had been a school board trustee for 12 years in the province of Ontario, in the largest board in Canada. Are you aware that teachers in Ontario—and probably around the world—are paid the highest wages? What will turn away someone from high wages? If you can explain that to me in the last couple of seconds, I'd be happy to hear what you have to say about that.

Mr. Scott Marshall: I would point back, I guess, to where Ontario students were performing five or six years ago and our outcomes were among the best in the world. I

think we have a system that has been working when we invest in it properly and we support those—

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

We'll now go to the official opposition. Mr. Kernaghan.

Mr. Terence Kernaghan: Thank you to all our presenters who have arrived here today.

I want to ask a question of Heather. I've been working with Craig Thompson from Ballinran productions, as well as Andrew Dodd with Film London. I wonder if you could speak to the current tax incentive that is available in Ontario for productions that are filmed outside of Toronto. What is that?

Ms. Heather Haldane: I'm not a tax incentive expert, but there is a regional tax credit that applies when you're shooting 150 kilometres from the GTHA—I think that's the zone. The way that it gets applied is that it's against labour, and that's a good way to kind of gauge the impact—because it is the cost of labour. I think that it's effective in the sense of bringing more money into a system where—as a producer, I know—you're always needing that little extra bit to actually complete a production, especially as a Canadian independent. But that regional tax credit comes well down the line and it is something that banks, frankly, make more on than anybody else out of this entire system.

So I think what we're saying is that the industry can grow, but it needs to know a region that's ready for it; it needs to come to it. It needs to be incentivized to come and to stay and to build there. That worked in northern Ontario, and we feel that southeastern Ontario is especially ready for that now.

Mr. Terence Kernaghan: Absolutely. As I understand it, the incentive to film outside of Toronto is at 10%, whereas the incentive in northern Ontario is 50%. But I think you're right; it is an incentive-based industry, and it is something where the investment needs to be made up front rather than down the line, in order to attract folks.

My next question is for Scott. I want to thank you for representing workers in thought, word and deed. Unfortunately, we often see many events where government members will play dress-up and put on a hard hat, put on a safety vest and claim to stand for workers. But what you've outlined here are many things that this government could do and actually represent workers by doing, whether it's the repeal of Bill 124, doubling ODSP and Ontario Works, or making union membership more easily attainable.

I also want to point out that the Financial Accountability Officer just came out with a report today indicating that there will be $1.1 billion cut from education over the next three years, and $5 billion cut from health care.

Your comments about earlier cuts to education during the last Conservative government, in the 1990s, reminded me, as well, of a scenario where John Snobelen was caught on a hot mike talking about creating a crisis within education in order to pave the way for privatization, much like we see with our health care system in its current state.

I want to know if you could speak towards the increasing violence that educators face in the classroom, as well as the growing dysregulation among students.

Mr. Scott Marshall: Thank you for the question.

It really does feel like we are being broken on purpose. Parents, I think, are starting to worry, and our union does represent education workers as well as teachers. The whole education team is feeling this, and the incidents of violence, absolutely, are increasing. We don't have the resources or the adults in the building to be able to adequately meet the needs of all students.

Teachers and education workers care deeply about their schools and their communities. That's part of the morale crisis as well, because they're doing everything they can, and they see that it's still crumbling around them. It weighs on them very heavily, because they know the students aren't receiving the enriched programming that they should be.

Violence is growing, I would say even at an exponential rate. Language, bullying, peer-on-peer violence, disrespect to the adults in the building—it's all there. I know that, just walking through schools, hearing it in the halls, seeing the incident rates that are being filled out. It should be a concern all around, especially when we know that we have had some of the best schools globally and we're losing that.

Every dollar spent in public education returns $1.30 back to our economy, so it's not like dollars spent in education are wasted money. There are real returns there, I think, for our communities.

So thank you for those points. They resonate with us.

I think we need to be looking very, very closely at where our schools are at, what they can do and what we would like them to be.

Mr. Terence Kernaghan: It was also deeply concerning that, throughout the pandemic, rapid testing kits were provided at a much greater volume and a much greater speed to private schools rather than publicly funded education.

We also turned to freedom-of-information documents which have shown that the Minister of Health—in the binder—was made aware that moves such as Bill 124 were creating a crisis within health care and within education, and yet they refused to act and are instead choosing to waste money on this expensive appeal process when they should be taking care of the issue itself.

My next question is for Dr. Shipley. It's a brilliant plan that you have. I think it's one that the government should really easily be able to get behind. Have you made this request in the past for the $8.2 million for a CHC?

Dr. Jim Shipley: We have not. To my knowledge, this is the first time that it has been officially asked.

Mr. Terence Kernaghan: I also know that many individuals who actually do have a primary health practitioner are concerned about their physician retiring.

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

Mr. Terence Kernaghan: How do CHCs address the problem of physician retirement?

Dr. Jim Shipley: Well, they don't—a short answer. Within an Ontario health team, the CHC doesn't address that. But if marginalized people lose their physician, they then have an option: They can then come to CHC and still receive care rather than go to the emergency department.

Mr. Terence Kernaghan: I don't know that there's much time for another question, so thank you all for coming to present today. I very much appreciate it.

The Chair (Mr. Ernie Hardeman): That concludes the time for this panel. We thank you all very much for the time you took to prepare to come here and to present to us. We very much appreciate it, and it's of great assistance to our consultation process.

I also want to remind everyone that the deadline for written submissions is 7 p.m. Eastern Standard Time on Tuesday, February 14. So if there's any more you would like to add to your presentation, don't hesitate to send it in, provided it reaches us by February 14.

With that, the committee is now recessed until 1 o'clock.

The committee recessed from 1203 to 1300.

The Chair (Mr. Ernie Hardeman): I call the meeting to order. Welcome back. We'll resume public hearings for pre-budget consultations.

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

KINGSTON HEALTH SCIENCES CENTRE

PETERBOROUGH REGIONAL HEALTH CENTRE

The Chair (Mr. Ernie Hardeman): I will now call on the next group of presenters. The first one on the agenda has cancelled, so we will start with the Kingston Health Sciences Centre and then Peterborough Regional Health Centre. Both of them will have virtual participation from the screen for the committee's attention.

As I mentioned, you have seven minutes to make the presentation. At six minutes, I will just remind you there's one minute left, and then at the seven minutes, we'll cut it off. When all the presenters have made their presentations, we will then have 39 minutes of questions from the panels. I think for this one, we will start with the government first.

With that, the floor is, first of all, to the Kingston Health Sciences Centre.

Ms. Sherri McCullough: Good afternoon, everyone. I'm Sherri McCullough, vice-chair of Kingston Health Sciences Centre. Thank you for the opportunity to address the group. We are grateful for the many initiatives from our provincial government in its response to the COVID-19 crisis, especially in ensuring adequate funding and support for hospitals so that we could focus on providing care. We appreciate the subsequent action plan for recovery from Ontario Health, their guidance on prioritizing care, and the government's efforts on fast-tracking nurse licensing along with other HHR-related strategies. We are also grateful for the opportunity to share our recommendations and requests with this committee in these pre-budget consultations.

Throughout the pandemic, Ontario's hospitals have done everything asked of them to maintain access to care, but the pandemic and ensuing critical labour shortages have had and continue to have a devastating impact on the health care system, health care providers and leaders. In addition, the daily challenges of addressing ongoing supply chain disruptions while trying to catch up on deferred care are simply overwhelming to our caregivers and leaders.

We know that the Ontario Hospital Association will speak knowledgeably about the critical need to stabilize hospital funding overall, as health care organizations are struggling with escalating costs in labour, food, energy, drugs and other supplies and equipment, so I'll talk to you about the Kingston Health Sciences Centre.

Throughout the pandemic, KHSC served as an essential safety net for team Ontario. We doubled our critical care capacity, taking critically ill COVID-19 patients from around the province, and especially from the GTA. Our laboratory services team developed new tests and techniques and became a vital part of the province's COVID-19 surveillance system. We stood up an assessment centre, built a field hospital, administered vaccines, and developed many innovative strategies to manage the constantly evolving threats. More recently, during the acute-care pediatric care crisis, we pivoted again, doubling our pediatric capacity, this time taking the smallest and the most vulnerable children from across Ontario. But now we need help.

In Kingston, we've been delivering health care for over 190 years and, in partnership with Queen's University, we've been educating medical professionals since 1854. We are proud of our heritage as Canada's oldest continuing operating public hospital. We cannot continue to have staff and physicians going to work every day in the same building that housed Canada's very first session of Parliament. The crowding and the aging facilities are difficult for both providers and patients—and we experience daily struggles in trying to provide care with 21st-century technology in 19th- and 20th-century spaces.

Our existing approved redevelopment plans, originally developed by Kingston General Hospital before the 2017 integration of KGH and HDH, no longer work for the post-pandemic, regional anchor hospital that Kingston Health Sciences Centre has become, or the services we provide.

We are the only tertiary care hospital and academic health sciences centre between Toronto and Ottawa. Our tertiary care catchment area spans over 24,000 square kilometres across southeastern Ontario and includes the ridings of Kingston and the Islands, Hastings–Lennox and Addington, Leeds–Grenville–Thousand Islands and Rideau Lakes, Lanark–Frontenac–Kingston, Stormont–Dundas–South Glengarry, Haliburton–Kawartha Lakes–Brock, and Bay of Quinte.

KHSC also provides care to individuals living in the Far North, in communities along the shores of James Bay. As one of the largest employers in the area, KHSC has over 6,000 employees, 2,000 health care learners and over 1,000 volunteers.

In summary, as you will hear from other health care organizations and the OHA, hospitals must have stable and sustainable funding, along with fair compensation throughout the system. This will allow the focus on providing health care rather than the many financial challenges facing hospitals today.

Here at Kingston Health Sciences Centre, we need the government to sit down with our leaders and work out a realistic redevelopment and funding plan to bring our facilities into the 21st century and provide the critical capacity needed by the 500,000 Ontarians we serve.

Thank you for your time.

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

We will now start with the Peterborough Regional Health Centre. The floor is yours.

Dr. Lynn Mikula: Thank you for having me today. My name is Dr. Lynn Mikula. I'm very pleased to have this opportunity to share with you our vision for the future of Peterborough Regional Health Centre.

PRHC is a regional acute-care hospital. We have nearly 500 beds. Depending on our service, we provide acute regional health care to a population of up to 600,000 people. This includes the residents of Peterborough city and county, Northumberland, the city of Kawartha Lakes, and Haliburton. We certainly have some overlap with our great partners at Kingston Health Sciences Centre. We also provide health care to three First Nations communities, including those of Curve Lake, Hiawatha and Alderville.

I'm the chief of staff at PRHC, and I'm honoured to be taking on the role of president and CEO from Dr. Peter McLaughlin when he retires at the end of March. Dr. McLaughlin is joining me virtually today.

I've also been a doctor at PRHC since 2011. From my very first day, I've watched our dedicated staff and physicians work tirelessly to deliver great care. This was especially true during the difficult last three years. I want to thank all of our staff, physicians and volunteers from the bottom of my heart. I hope that this committee, on behalf of Ontario, will also recognize their dedication and contributions.

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I also want to acknowledge the thousands of people across the province who've had desperately needed surgeries and procedures delayed because of the pandemic and our health care system challenges. Too many people are waiting too long for care. We know and you know that there are very real people behind those numbers, and we share your commitment to doing everything in our power to make sure that they get the care they need as soon as possible, now and into the future.

Last year, we appeared before this committee to present PRHC's vision for modernizing and expanding acute regional health care. What I'd like to do today is provide you with an update on our capital plans and reiterate why they're so critical to the people of our region. I also want to convey the really strong alignment that exists between our plans and the government's priorities as outlined in last week's plan for connected and convenient care.

It's important to recognize that the Peterborough region is rather unique. We have medium and small municipalities, large academic and industrial employers, and rural and farming communities, all in our catchment area. We're one of the fastest-growing communities in Canada, and we feel this growth at the hospital, where we see more than 88,000 emergency departmetnt visits a year and where we routinely have more than 100% of our funded beds occupied. Our patient population is aging rapidly. Our population of seniors over the age of 75 is projected to increase by more than 125% by 2041. And we're in dire straits with respect to our community's mental health and addictions needs. We have the second-highest rate of mental health cases in the province and opioid-related deaths that are 81% above the provincial average.

This dramatic increase in our community's need for hospital services has outstripped our existing facility's capacity, and some care is still not available in the Peterborough region. But the challenge is that we're just far enough away from the GTA that members of our community find it difficult or impossible to travel to Toronto to receive care. This exacerbates existing health inequities.

Recently, pressures felt by Toronto-area hospitals have further decreased access to specialized services. Peterborough can no longer be dependent on Toronto for our health care needs. Growth and expansion of local health care services is essential to supporting our patients.

PRHC works very closely with our partners across the central-east region of Ontario. This collaboration was foundational to our master plan, which really reflects a collective vision for how PRHC needs to grow to support the needs of our patients.

Our proposed master plan unfolds in two major projects. The first is the regional program expansion project. This is an early project that makes use of existing shelled-in space in the hospital to expand our regional tertiary and specialized programs. This will bring new services to our region and reduce demand on overtaxed Toronto hospitals. This will be followed by our longer-term vision for a major redevelopment on our existing site that will expand our busy emergency department, and add ICU and acute in-patient capacity.

But today I want to focus on the first phase, the regional program expansion project. This plan addresses our region's most urgent priorities, and it will accomplish five things: It will build a fit-for-purpose mental health and addictions crisis response unit. It will improve access to surgeries with the construction of a hybrid operating room. It will improve access to cardiac care with the construction of a third cardiac cath lab. It will renovate and expand our oncology services, which have grown dramatically over the past several years. And it will see the construction of a state-of-the-art command centre, which will more effectively coordinate care.

This early-works project is uniquely and strongly positioned to move very quickly from approval to the delivery of patient care services because the space is already built and shelled in. It exists; it simply needs finishing to become operational. PRHC has already secured the local-

share portion of project costs, working closely with our foundation. The Ministry of Health has completed its review of this proposal, and we're awaiting approval to move the project on to the next stage.

What we're asking is that you recommend that the 2023 budget include an announcement of a planning grant to move this project into functional programming.

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

Dr. Lynn Mikula: This would be a welcome signal to the people of our community that the era of dependence on out-of-region care is coming to an end, and that the government is committed to building on mental health and addiction services, maximizing surgical capacity, and expanding hospital services to meet the care needs of our region.

Our goal is to provide the people of our community with the care that they need, closer to home, in the years and decades to come, and our proposed master plan charts this path forward. We know that the time is now to build for a future that will be as caring and supportive as the past, and we believe that a planning grant would be a modest but concrete next step demonstrating that Queen's Park shares our goal.

Thank you very much for the opportunity to appear today. I look forward to addressing any questions.

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

We'll go to the government first. MPP Cuzzetto.

Mr. Rudy Cuzzetto: I'd like to thank the presenters here today.

Sherri, you touched on a supply chain issue in health care. Could you explain that to me?

Ms. Sherri McCullough: Actually, that is an operational question, so I'm going to use my lifeline here and defer to my "find-a-friend," Jason Hann, who is our executive vice-president of patient care and our chief nursing executive.

Jason, do you want to talk about the supply chain, please?

Mr. Jason Hann: Sure.

Good afternoon, and thank you for the opportunity.

It's a global as well as a provincial supply chain when it comes to drugs, surgical supplies, critical supplies. As a result, there's a regional approach as well as a provincial approach about allocating across the province. Certainly, as a result, we've seen a cost in supplies, as well as shortages. This past weekend, for example, we ran into some shortages in our cardiac program, and we had the help of our partner site in southwestern Ontario.

Mr. Rudy Cuzzetto: But do you have an issue, even through Health Canada, to approve any drugs, as well?

Mr. Jason Hann: We don't experience Health Canada challenges with approval. That works through the system pretty fast and efficiently. There's a good process in place. We're more experiencing now that we need X number of drugs or supplies and they're not available to us, or they're on limited supply. So we really have to think about our operational planning and care delivery models for that.

Mr. Rudy Cuzzetto: And on the labour shortage—I know that it's across the country and across the world. Some people think it's only in Ontario, but it's happening across every province, and even in Europe; all over the world. That has been occurring here as well. What do you see happening in the future, with all our plans that we've put into place, with our new medical school and training more foreign-credentialed people, getting them into the workforce?

Ms. Sherri McCullough: Jason, again, over to you, since it's operational.

Mr. Jason Hann: Thank you for the question.

At the local, regional, provincial and national level, there's a health human resource challenge with nursing and physicians. With the foreign, internationally educated health care providers coming to Canada, it will certainly help.

With this, compensation is very important, but it's not just one thing; we really need to stabilize our workforce, and that comes to you—if you review any literature with nursing, it's staffing, scheduling, access to education and resources, and work-life balance.

We need to collectively look at how we're educating people and look at the curriculum so that we can get more people into the system—not faster, but increasing our intake and really looking at making sure that they're ready for practice when they come out into reality.

It's not one solution. It's not a one-year fix. This will be multiple years, to stabilize our workforce.

Mr. Rudy Cuzzetto: I'll pass it on to Dave.

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

Mr. Dave Smith: Sherri, I'm the MPP for Peterborough–Kawartha, so please forgive me; I'm going to ignore you. I'm going to focus solely on PRHC here.

Dr. Mikula, you mentioned that this is already shelled-in space. One of the concerns that the Ministry of Health always has is how long it will take to build something. This is already built, is it not?

Dr. Lynn Mikula: That's correct. We took the opportunity when we had to replace our MRI, and we built a new suite for the MRI. In fact, we built a two-car MRI garage, and we're thrilled to have government funding to launch a second MRI. Thank you very much for that. We took the opportunity, working with capital branch, to self-fund the construction of five additional storeys on top of the MRI two-car garage. This shelled-in space is fit-for-purpose for clinical care, ready to go. It's beautiful. We've toured some people through it. It just needs approval to now move on to the finishing stages. Many of the uncertainties and risks related with construction from the ground up are dealt with; we're looking at FF&E and functional programming.

Mr. Dave Smith: One of the things that I have discovered about PRHC since I was first elected is that you're always forward-thinking on things.

Building five extra storeys and self-funding that so that you are ready to do something is something that I would say the Ministry of Health struggled with understanding. Is that fair to say?

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Dr. Lynn Mikula: I think it's fair to say. I wasn't part of those initial conversations, but I do think there was a

question of, "What are you hoping to achieve?" We've put a great deal of effort into our master plan, again, working with all of our partners, to say, "Our regional programs need to grow. We know that's where the biggest need is—these specialized programs that provide care for complex patients throughout the region. Do you support this?" And they said, "Absolutely. This is what we need you to be doing as well." So we were able to present this collaborative planning, this unified front, to say, "We know this is where we're going to go. We're going to get ready for it now, and then we'll work with you on finishing the process." That's where we're at now.

Mr. Dave Smith: Again, I'm kind of in the know on some of these things, and I'm leading some of the questions I'm putting out there. But I think that over the last number of years, the forward planning that you have done, the vision that PRHC has had positions you well to show that when you put forward a proposal like this, it's not just put together in the heat of the moment; you've actually planned this out over a number of years. Now you're ready to implement, and it's just a matter of our government saying yes to it. Am I correct in that?

Dr. Lynn Mikula: That is correct. And I will further add that in terms of the clinical component of advancing our services, advancing our cardiac care, advancing our operative care, we're already starting to work with other organizations that will partner with us to make sure that we are prepared, not just from the structure perspective, but clinically good to go, good to launch. We just need that planning grant.

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

Mr. Dave Smith: Thanks, Chair.

You mentioned oncology. You mentioned cardiac and a couple of other things. My community knows that my family experienced cancer—it was 41 trips to SickKids hospital, 13 weeks of staying at SickKids hospital, in particular. That's a real challenge for a number of people in our community. How will this help those families who normally would have to go to Toronto?

Dr. Lynn Mikula: All the time, we see people who in fact choose not to receive care rather than travel to Toronto. Our goal is to do away with that. We don't want that to ever happen again, and this plan is a big step in that direction.

Mr. Dave Smith: It's only 140 kilometres, but we would have to leave at quarter to 6 to get there in time for a 10 o'clock appointment. That travel, I think, is something that is completely lost when we look at the numbers on a sheet of paper, so being able to say that people in our community won't—

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

I will now go on to the opposition. MPP Kernaghan.

Mr. Terence Kernaghan: Thank you very much to our presenters today. I want to thank not only yourselves but all of your staff and all of the wonderful people who provided health care throughout the pandemic, an incredibly difficult time in Ontario's history.

My first questions will be for Ms. McCullough. You mentioned the need for the province to stabilize funding, and you also mentioned fair compensation throughout the system. Did you happen to have any concerns about Bill 124 in particular?

Ms. Sherri McCullough: Again, I'm going to pass that over to Jason. That is an operational matter, not governance.

Mr. Jason Hann: Thank you.

Bill 124 is no longer in effect. We work with the Ontario Hospital Association—and working with respective unions to negotiate fair compensation for all of our employees at Kingston Health Sciences Centre as well as for the province.

When it comes to funding models, we look with the OHA as well as with the ministry to really stabilize funding models. There's a lot of funding that you get in a year, or you plan for a year, so we're really looking for those models that support current staffing as well as projected bed utilization and service delivery models—that we cannot just think for this year or next year, but multiple years of growth and redevelopment.

Mr. Terence Kernaghan: What was the most recent budgetary increase as delivered by the province?

Mr. Jason Hann: We had a number of supports from the government with funding—everything from transitional care units, which was a couple of million dollars, to staffing models with support roles in the organization. The exact dollar amount is well into the millions. I don't have that exact figure with me.

Mr. Terence Kernaghan: Okay. I want to ask—and we've heard this from other delegations in other locations—would you like to see the province establish a health care human resources strategy to recruit, retain and return nurses to the field of health care?

Mr. Jason Hann: The answer to that is yes—and we need to have a national, a provincial, and a regional. The challenge in the health human resources, and for our colleagues who we're good partners with at the Peterborough hospital, is that we're all competing for the same physicians and nurses, so we really need a provincial strategy. We don't want staff or physicians going from one hospital to the next. It creates a lot of disruption in the system.

Mr. Terence Kernaghan: We've heard from others also concerned about opening up private, for-profit clinics which will ultimately be a drain on the already limited pool of nurses who are within our health care system. Thank you.

My next questions will be for Dr. Mikula. I was interested in hearing more about your mental health crisis response unit. Could you please describe that for the committee?

Dr. Lynn Mikula: Our role, as an acute-care hospital, is for people with a mental health or addictions crisis who need that urgent medical care and urgent medical stabilization, and the purpose of our crisis response unit is that—this is not care that can be delivered in a community setting. This needs to be hospital-based care. Currently, we do this in a very small area in our emergency department.

It doesn't have windows. It's overcrowded. It has safety concerns for patients, their families and our staff.

We need a purpose-designed space that is healing, that is intentional, and that allows us to do our job and then work with our community partners to make sure that care can then continue in the appropriate setting.

Mr. Terence Kernaghan: Would it be helpful for there to be legislation in place that recognizes mental health as important as physical health and ensures that mental health services are funded through OHIP?

Dr. Lynn Mikula: Without seeing that piece of legislation, it's hard to know exactly which problem it would address. I do know that the government has shown a lot of commitment to mental health and addictions funding. I do think that we still have work to do, as a health care system, to make sure that our planning is coordinated and that we're looking at the entire continuum of care. If legislation would support that, then I think it would definitely be a big bonus.

Mr. Terence Kernaghan: Just to return to the mental health crisis response unit: There's a very interesting initiative going on in the London area with London Health Sciences Centre, and they're actually talking about potentially having a different emergency intake for mental health, because it can be very difficult and very problematic for individuals who are seeking help for their mental health to be in the same location as people who are struggling with their physical health.

You mentioned allocated funding for mental health first responders. Would they be travelling in the community, or—pardon me; I was thinking of another presentation. Let us see.

In Peterborough, would you also like to see a provincial strategy for health care recruitment, retention and returning?

Dr. Lynn Mikula: I think I'll echo my colleague's comments that it is very challenging right now. We're all competing for the same pool of talent. We need more talent and we need to not be in competition with each other, so an approach that addresses that, that has us all working together rather than in opposition to each other, would definitely be welcome and helpful.

Mr. Terence Kernaghan: How much time left, Chair?

The Chair (Mr. Ernie Hardeman): You have 1.4.

Mr. Terence Kernaghan: Did you have any concerns about Bill 124? Have you heard that among the nursing staff within your hospital?

Dr. Lynn Mikula: There's no doubt that Bill 124 has been a morale challenge for our nursing colleagues. Especially through the last few difficult years, that confluence of events has been challenging. I think we're going to now wait and see, work with the OHA, work with government on the next steps as we move beyond it.

Mr. Terence Kernaghan: I believe delegations yesterday pointed out that it was—I believe the words that were used were that it was "demoralizing," but also "humiliating" to—

The Chair (Mr. Ernie Hardeman): You have one minute.

Mr. Terence Kernaghan: —health care workers who had worked so hard throughout the pandemic, and then to be delivered this wage-suppression legislation. I know that according to many nursing organizations, many have left the field as a result of that direct attack on their collective bargaining rights.

I want to thank you both for coming here today.

The Chair (Mr. Ernie Hardeman): We'll go to the independent. MPP Brady.

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Ms. Bobbi Ann Brady: My question is for Dr. Mikula. You say that the Ministry of Health has approved the current phase of your project. When did that happen?

Dr. Lynn Mikula: We are at the moment, now, when all the questions have been resolved and we are awaiting approval, which can come in various forms. That's actually our ask—for the official approval to now move into the functional programming.

We've worked very collaboratively with the capital branch and resolved all of the questions. They're very happy with the plan—not only this first phase, but how it fits into the longer-term vision, that all of those pieces flow together. They have said, "We've resolved all of our questions. There is no further action needed from you, from our perspective."

Ms. Bobbi Ann Brady: We've heard elsewhere across the province that perhaps moving to the next phase needs to happen a little faster, because time is money. Do you know what the price tag on waiting costs your project?

Dr. Lynn Mikula: I'd have to get back to you on that. It's very difficult in the current inflationary environment to actually say with any certainty. We do build escalation costs into our plans. Things are a little out of hand right now, though, with funding costs, with construction costs. Certainly, the longer we wait, the more expensive we believe it will be.

There's also the cost to patients who do not have access to those services right now. That's a human cost; it's very hard to put a dollar figure on, but that definitely keeps us up at night, as well.

Ms. Bobbi Ann Brady: I appreciate your ask of moving on instead of money.

I was wondering as well if you could explain to me what the hybrid operating room is.

Dr. Lynn Mikula: A hybrid operating room is integrated technology that allows surgeons to take advantage of advanced imaging technology while they're working. It allows them to do quite major—typically, cardiovascular—procedures, such as repairing a big aneurysm or dealing with a stroke, through a minimally invasive approach, which means that the patients can go home much sooner, sometimes even the same day, with much less pain and a return to their full, functional status much quicker.

Ms. Bobbi Ann Brady: And the command centre—would that be like a regional command centre or is it just for—

Dr. Lynn Mikula: That's an interesting question, because the answer is, a bit of both. The hospital's command centre would be primarily designed to support patient flow within the hospital, but we partner very closely with the smaller hospitals in Lindsay, Haliburton, Campbellford

and Cobourg. We exchange a number of patients. They come to us for more advanced services. We repatriate them. We're all on a shared clinical information system, so the command centre would tap into that and take advantage of it and, in fact, be able to coordinate that movement of patients throughout the entire geography more effectively.

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

Mr. Ted Hsu: How much time do I have?

The Chair (Mr. Ernie Hardeman): You have 1.1 minutes.

Mr. Ted Hsu: Okay.

Ms. McCullough, you spoke about aging facilities. I was wondering if you had a one-minute story about aging facilities, just to illustrate what we're facing here in Kingston.

Ms. Sherri McCullough: Absolutely, I do. Thank you for the question.

As you all know, last weekend we were plunged into an incredible deep-freeze here in eastern Ontario. As a result of that, once again in one of our buildings, on the Hotel Dieu site—which was built in 1833—we had a major flood. As of yesterday afternoon, the estimated insurance claim is reaching $10 million.

In the last three years alone, we have had $13 million in insurance repair to these buildings. Literally, they were built in the 1800s—the original parts of our hospitals. They are the two oldest hospital buildings still operating in Canada. I wasn't joking when I said that the first session of Parliament was held at the KGH site in the early 1800s. They weren't built for what we encompass today.

The Chair (Mr. Ernie Hardeman): We'll now go to the government. MPP Byers.

Mr. Rick Byers: Thank you both for your presentations and others supporting—it's very, very helpful this afternoon. I have questions for each organization on operations and capital, because you were asking on both.

Sherri, you've mentioned in your remarks the challenge we've been through and your operations have been through in the last years, of course. You talked about surgeries and procedures and whatnot. Of course, as things opened up, there was a huge wave again. Can you give us a sense of where things sit from that point of view, in terms of surgery backlog? Are you getting through it? Are you making progress?

Ms. Sherri McCullough: We're working, obviously, as hard as we can. We have 11 operating rooms operating at the KGH site, and seven at Hotel Dieu.

Jason will have the numbers on our backlog—what we've started, where we're at today. We did have, from Ontario Health, instruction on how to prioritize the surgeries and how to get on with them.

Jason, could you provide an update, please?

Mr. Jason Hann: Sure. Thank you.

As of today, we just have over 7,000 patients on our surgical wait-list. We are at 100% throughput at both of our sites, which Sherri spoke to. And within our allocation for our OR—40% of all our OR resources are now allocated to patients who have exceeded their wait-time window. In the context of the mandate of Kingston Health Sciences Centre, being a tertiary academic centre, we do have a lot of unplanned work, whether it's neurosurgical care, cardiac care, emergency surgeries and trauma. So it's certainly a part of our work there. We're meeting the Ontario Health target set out—the 45%—since about three months ago, with the focus, but we still have a lot of work to do. We have huge wait-lists, like many other health care organizations across the province of Ontario, due to the big ramp-downs and the backlog in surgical care. We're also seeing patients coming with deferred and more advanced stages of disease as a result of waiting longer.

Mr. Rick Byers: We encourage the continued progress in that area. It's very important.

On the capital side, I must say, I'm intrigued by your comments that this hospital was used by Canada's first parliamentarians. Interestingly, Queen's Park is a very old building and needs a lot of work, so we may need to come to your hospital and use it for a period of time. I hope you'd be welcoming of us.

Ms. Sherri McCullough: Absolutely.

Mr. Rick Byers: We're very, very nice people.

Can you give us a sense on the redevelopment and what stage you are at with the capital-planning process—and apologies; you mentioned it in passing. Can you give us an update on anything we can do to help? The better informed we are, the more we can help you push things through.

Ms. Sherri McCullough: Well, what we really need to do is, we need to sit down again together. The plan that was formulated before the pandemic no longer works, so we're at a real impasse right now. We want to talk about a different plan that will suit our needs. The plan that was developed before doesn't suit our current needs, let alone our future needs.

My friend from Peterborough was explaining how important the vision is to plan for the future. What you build today has to last you a long time—especially if you live in Kingston; it has to last a really long time, apparently.

Jason, do you want to add anything to that?

Mr. Jason Hann: Sherri, you've covered it well.

The original redevelopment was in 2017, so we need to sit down and look at where—we have two operating hospitals. Our mandate and our services are growing just due to demand in care, so it's almost like we need to start over—and what does the new KHSC really look like?

Our current physical infrastructure, the two oldest hospitals—there are some pieces built on, but just our facilities, as we bring in new technology—we don't have the resources or even the water throughput in our facilities at times to care for all of our patients. Bringing in new technology to support care—just our electrical infrastructure is a challenge for us on any given day. So we need a blank canvas to start.

We certainly welcome any support. And you're welcome to come for a visit. Sherri and myself would be more than happy to tour you around.

Mr. Rick Byers: Terrific. Thank you. I appreciate it.

Lynn, to you: Firstly, I was intrigued by—and perhaps a little bit more. In your partnering with other hospitals—are they part of your regional health centre corporation, if you will, or is that a partnership arrangement? I'm in rural, and we have—Grey Bruce Health Services, for example, has six hospitals in the centre, corporately. But that's not the case for you—this is literally partnering work?

Dr. Lynn Mikula: It's not, and I think the level of collaboration that we have amongst hospitals that are not part of the same corporation is unique and is quite remarkable. It's something that didn't always exist. Especially over the last few years, we've really worked hard to forge it, and now we talk all the time. We have discussed, collectively, our capital plans. We've made sure that they mesh rather than compete. We've made sure that we have a truly collective vision for what our region needs and each of our roles in it. So without being part of the same corporation, I would say that we are still very much on the same page.

1340

Mr. Rick Byers: Good for you. That's excellent work and not easy to do, so thank you.

On the backlog—can you give a sense as well on how your centre is doing?

Dr. Lynn Mikula: I think rather than speaking about numbers, I'll speak about time. Especially for services that are not available in our region—if someone needs a more advanced and interventional cardiac procedure that we can't offer, it is a two-year wait-list for those patients to be seen, on average, out of town. For oncology, our space is so crowded and our demand has grown so significantly that, even though the team is running full tilt—after-hours, weekends—we are not meeting our wait-time targets for cancer care. We can certainly share with you the numbers of patients waiting for hips and knees, but it is those other services that are really truly concerning us and that we're trying to address with this program, with this proposal.

Mr. Rick Byers: On the capital program, it sounds like things are well in hand. I'm not sure I heard you say whether you're getting sufficient support from your local MPP on this matter—no, no, no, just kidding. It's outstanding support, I think.

Anyway, it sounds like everything in the system and in the interaction with the Ministry of Health or Ontario Health is as you want it, and so it's just, as you say, getting the final approval that you're waiting for. Is that correct?

Dr. Lynn Mikula: That's exactly it.

Mr. Rick Byers: That's good to know.

We'll take both of these back and do what we can to follow up. Thank you both for your presentations.

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

Ms. Catherine Fife: Thanks for presenting. I was offsite, but I was listening.

Obviously, health care has been the dominant issue that has been brought to this committee at all of our locations. Some of those stories have been very emotional; some of them have been very desperate. People are really looking for a change in how health care dollars are invested, either upstream or addressing crisis exactly where it's happening.

My first question is for Jason Hann, the executive vice-president for patient care and chief nursing officer. I want to delve into some of these surgical times, Jason. The 7,000 surgical wait-list that you referenced—you said that 40% exceeded the recommended wait-list. Can you tell us a little bit more about those stories of the people who have been waiting and have exceeded the provincial standards for that wait-list, please?

Mr. Jason Hann: The longest wait-list we have is for cataracts and hips and knees, but within that we've put a lot of focus on our cancer surgery patients to get them in for surgical procedures. A lot of the patients who are waiting are not urgent, urgent cases, but it really impacts quality of life—whether it's a hernia or whether you need some type of plastic surgery. You think about your overall functioning, whether you're a child or an adult, and you're waiting a number of days or years or months for surgical procedures. You have to think about the individual's quality of life, their functioning at work, their home life and just their overall quality of life and their overall mental well-being.

For example, a child waiting for pediatric surgery—that inhibits their ability for growth and development and interacting with their friends.

And then if you think about somebody who is of elderly age—having access to surgery can certainly keep them at home; it may avoid hospital admissions—just their overall functioning and just helping to prevent further functional decline.

Ms. Catherine Fife: Can I just ask a question about how you prioritize? Hips and knees, a lot of pain; cataracts, obviously debilitating—if you can't drive, you often can't get to work. These cases often come into our MPP offices, and they ask us to advocate. So I just want to get a better sense of how you prioritize these surgeries.

Mr. Jason Hann: It's a good question.

There's a wait time associated with the time-sensitive cases. For example, we have cardiac surgery as a priority for us, so this past November, we put on extra cardiac surgery days for this fiscal year to help catch up, for lack of a better word, with the wait-list for patients waiting for cardiac surgery. We have dedicated time every week at both of our hospitals for cancer surgery cases, so that could be scheduled or last-minute—patients who have had a recent diagnosis, who need urgent access to the OR for that surgical procedure would be an example.

Ms. Catherine Fife: We've also heard, though, from various sources who are connected to hospital administration and advocacy, that our surgical suites in the province of Ontario are not being used to their full capacity. I would really appreciate if you could tell the committee what would be needed to make that happen.

Mr. Jason Hann: There are surgical suites across the province that are not being fully utilized, whether it's weekends or evenings, and that comes down to health human resources. So that comes from nursing—

Ms. Catherine Fife: I'm sorry, can you just—

Mr. Jason Hann: Health human resources.

Ms. Catherine Fife: Okay.

Mr. Jason Hann: If you have the physical infrastructure, you need nurses, you need surgeons, you need anesthesiologists, and you need support staff to care for those patients around those operating rooms. So it comes back to workforce planning, and provincial strategy would be something that would help support that.

Ms. Catherine Fife: We have been advocating for a progressive and aggressive—and assertive, I think, at this point in time—health human resources strategy for the province. The government has started down the road to do recruitment, but retaining experienced and trained nurses and health care workers in our system—can you speak to how important it is to retain those staff in our system?

Mr. Jason Hann: Yes, it's one of the most, if not the most, important things. You can recruit and you can educate and you can train staff, but if we're not retaining them and they go to work in other places or they exit out of the profession, they're not easy to replace. An operating room nurse—it's a number of years before they're proficient at all of the different services. If you think you have 10 OR nurses leaving Kingston Health Sciences Centre today, that's a significant gap. That could impact three or four operating rooms at any given day. That would be an example.

Ms. Catherine Fife: It's powerful to hear that from someone who is on the inside and who is, really, essentially speaking truth to power.

We did have one nurse who told the government that you can have all the recruitment strategies you want, but if you are funding beds and the infrastructure but not the operational and human resources, then you're just funding furniture—and furniture does not take care of people; it's the human power contained within our health care systems. So thank you very much for that, Jason.

Lynn, I want to move over to you. I read through the application here, and you've made a compelling case for investment. I do remember the regional hospital coming forward; I think it was last year when we were doing all this by Zoom. It's so much better in person, I have to say.

You've been very vocal about violence in the workplace, and I do want to thank you for that. I'm sure, Sherri, you would also echo this. The state of affairs within the workplace, which is the place where we also care for people, has really reached a tipping point. I will say—

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

Ms. Catherine Fife: —Bill 124 has impacted that.

Lynn, I want to give you an opportunity to talk about how important it is to support the people who are working in our health care system, especially when they're dealing with violence.

Dr. Lynn Mikula: It is our number one priority to make sure that our staff and physicians and volunteers feel safe at work and feel that they are engaging in meaningful work. These are people who went into a caring profession to care, and the environment needs to support that. Overcrowding is stressful for absolutely everybody: for the staff, for the patients, for their families. We are not the only hospital facing overcrowding; almost every hospital can say the same. That detracts from the caring environment, and that is why these investments truly are human in nature. This is not a building; this is a caring space that we are hoping to develop, and that will better support our staff and our patients.

Ms. Catherine Fife: I really hope—

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

We'll go now to the independent. MPP Hsu.

Mr. Ted Hsu: My question is for Ms. McCullough. The Kingston Health Sciences Centre recently offered cash incentives to recruit RNs, RPNs, medical lab technicians—something like $10,000 for new employees, a $3,000 referral bonus, $15,000 relocation money. I'm keeping in mind here that we know the province—especially from the FAO report today—has contingency funds on hand, money that could be spent on things. How have your own cash incentives worked? Have they resulted in new hires?

1350

Ms. Sherri McCullough: Well, before I hand this over to Jason, I want to say that this is the first time that I can ever remember in my time in health care that we have had to use agency nurses, who are extremely expensive—and very demoralizing to work alongside of a staff nurse, when this person is getting paid a great deal more money than the staff nurse. These are extraordinary times, and I don't ever remember offering signing bonuses either.

Jason, do you want to talk about the incentives, please?

Mr. Jason Hann: Sure.

Thank you for the question.

We are offering the incentive from January to the end of March of this fiscal year. We're focusing on critical care, as well as our in-patient medicine units.

To Sherri's comment: It's the first time in history at Kingston Health Sciences Centre that we had to partner with agency nursing to help support our 24-hour care that we provide.

We are seeing some uptake—but if I go back to some of the previous questions, this is where provincial strategy and national strategy and health human resources planning is so, so important, because we're all competing for the same resources. There are a lot of organizations that are offering these types of incentives to recruit, as well as help to retain some of our staff. We know, for our nurses who are working in very challenging situations, there's an incentive if they can refer and secure somebody for a minimum of a two-year commitment at Kingston Health Sciences Centre, as a reward to them to help get people into our organization.

It's a caring profession. The job is challenging, but people go into it for all the right reasons.

We'll know more at the end of March what the success will be, but we are seeing some uptake to date in queries, and we've had some successful recruitment—not what we would certainly want, but some small numbers there.

The Chair (Mr. Ernie Hardeman): That concludes the time for this panel. We thank you very much for taking the time to prepare and to be here to enlighten us to the situation, and I'm sure it will be of great assistance as we

report back to the Minister of Finance on what he should do in preparing the budget.

MS. NINA DEEB

UNITED STEELWORKERS

ONTARIO SHORES CENTRE FOR MENTAL HEALTH SCIENCES

The Chair (Mr. Ernie Hardeman): Our next panel is Nina Deeb, United Steelworkers, and the Ontario Shores Centre for Mental Health Sciences.

As with the previous delegations, you will have seven minutes to make a presentation. At the end of six minutes, I will say, "One minute left." Don't stop talking, because you will have one more minute, but at seven minutes, it's all over. We do ask that everyone identify themselves before they start speaking to make sure we have the right name to the right presentation in our Hansard.

With that, the first is Nina Deeb.

Ms. Nina Deeb: My name is Nina Deeb. I've been a full-time realtor since 1996, and my recommendations on the budget are all housing-related, pretty much.

The first thing I would like to point out upon looking over the financial statements is the land transfer tax increases from 2019 to 2022; there's an increase in revenues to the province of $2.618 billion.

Provincial sales tax on new homes, mortgage default insurance and closing costs—there's a provincial increase in taxes of $1.738 billion.

Personal income tax and capital gains—there's an increase here of over $4 billion.

Corporations and capital gains—that's approximately $10 billion.

What I'm looking for from the province and what I'm hoping that the province will bring forth and make available to the municipalities—I'm looking for $15 billion from the province that the province should download to the municipalities to make affordable housing available. I heard what the mayor of Kingston said this morning—that they've invested $18 million. They could have, just with that money alone, made 90 units available forever for the municipality.

Waiving development charges does not help us get there—because these costs are real. There are real costs to roads, there are real costs to bringing services out to new buildings and new subdivisions, and those costs should be paid by the developers.

So I'm not looking for freebies as far as paying the way, but the province and municipalities do have a lot of land—over 80% of the land in Ontario is held by government, so we don't have a land shortage. The land could be made available in this situation. We need these units right away. So that's my recommendation on housing, and that's something that we could put to work right away to give us—if Canada Mortgage and Housing Corp. matches, which I think they should, that would give us $30 billion. We could have approximately 150,000 units available this year, and that's a plan that could really work.

My next item of interest is the non-resident speculation tax, from page 97. This tax should apply to apartment buildings; it should apply to residential units six units and over; it should apply to agricultural land. I would like that exemption to be removed for these players. These players are what is driving our costs up on rental costs for the people of Ontario, so that exemption should be removed, I think.

Also, from page 150, the financial markets—the Bank of Canada has raised its overnight rate eight times since March 2022. What that means for the consumers—so right now, prime rate is at 6.7%, and this is an increase of 4.25% since last March. Last February, a payment on a $600,000 mortgage at 1.35% was $2,026 a month. With the increase to the variable-rate mortgages, that same mortgage now at a variable rate would be either 5.75% on a high-ratio or 6.25% on a conventional. To many of these new consumers in housing, this means that their payment went up almost $1,400 a month, so their payment now has gone to $3,424 a month. If you look at the way qualifying formulas work, this has actually created a reverse socio-economic formula on qualifying that could potentially—and likely is—consuming the entire income of the people who are in these mortgages. So this is forcing foreclosure within the actual formula—the way this formula is working.

The Bank of Canada—we should have used monetary policy, but we should have used it in 2017; we shouldn't have waited until March 2022. So the timing was very miscalibrated here, and that's something that needs to be looked at. People are in a very, very dire situation right now with where their mortgage payments are. These people can't afford that. They can't afford to be paying more than their entire income on these mortgages. And it's just benefiting finance. It's at the expense of the everyday—these aren't house flippers. House flippers don't take long-term mortgages; they take short-term, no-penalty mortgages because they know they're flipping. These are everyday people living in these houses, more than likely. So that's one thing I want to point out. It's not sustainable. It's a 68% increase on these consumers. Some 50% of the mortgages in Canada are variable-rate mortgages, and about 25% of mortgages come up for renewal each year, so it's affecting people who didn't even buy in that market. They're just coming up for renewal now, and they have these rates to contend with. They rose very high, and it's not sustainable for the people.

The other thing I noticed is the MPAC new class of properties. This new class of properties takes the taxes off one class and proportions it to the rest of the tax base. This shouldn't go on. Everyone should pay their own taxes.

1400

I'd like to speak on the development charges. Development charges pay for real costs, and we need the services. We need the infrastructure to have a subdivision grow, to have the services. We need transit. These are things that we really do need. We cannot be waiving development charges on properties over $1 million. We need to be collecting these fees from these developers, and the municipalities need this money. I think we should leave the

municipalities alone so that they can actually service—that's who's supplying the housing now; it has been downloaded to them since the 1990s.

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

The next presenter is the United Steelworkers.

Ms. Briana Broderick: Thank you. My name is Briana Broderick. I'm vice-president of USW Local 2010 and 2010-01, representing approximately 1,500 support staff and academic assistants at Queen's University.

I want to share some of the challenges that, in particular, my members—but more broadly, workers—have faced over the last couple of years. Many of these issues could and should be addressed by a provincial budget structured to bolster supports for working families and provide robust public services.

One of the biggest challenges my members are facing is the fallout from Bill 124. Bill 124, Protecting a Sustainable Public Sector for Future Generations Act, 2019—and I've taken this right from the Legislative Assembly website—"is to ensure that increases in public sector compensation reflect the fiscal situation of the province, are consistent with the principles of responsible fiscal management and protect the sustainability of public services." Bill 124, of course, imposed a three-year moderation period in which those workers affected could not receive total compensation increases in excess of 1%.

It's interesting to note that right in the foreword of the bill it speaks to fiscal responsibility. This argument was roundly rejected by Justice Koehnen when he ruled that the bill infringes on a worker's right to freedom of association and interferes with free collective bargaining. In his ruling he wrote, at paragraph 13, "Ontario was not facing a situation in 2019 that justified an infringement of charter rights. In addition, unlike other cases that have upheld wage restraint legislation, Bill 124 sets the wage cap at a rate below that which employees were obtaining in free collective bargaining negotiations."

He went on to say, at paragraph 289, "Ontario has not, however, explained why it was necessary to infringe on constitutional rights to impose wage constraint at the same time as it was providing tax cuts or licence plate sticker refunds that were more than 10 times larger than the savings obtained from wage restraint measures."

In addition, the inclusion of university workers and those in the long-term-care sector could be interpreted as particularly punitive, as there is no rational connection between the restrictions imposed by Bill 124 and its stated purpose. These institutions have additional sources of revenue to fund wage increases.

In fact, at paragraph 337, Justice Koehnen states: "The fact that it may be more politically convenient to infringe on a charter right than to refuse additional funding to long-term-care homes or universities does not, however, justify the infringement. If political convenience were the test, it would be far too easy to infringe on charter rights on a regular basis."

Instead, what we saw was the weaponization of the legislative process, bolstered by the false narrative that Ontario was facing an economic crisis, to target the government's perceived political opponents: the highly unionized public sector workers.

The bottom line is that Bill 124 has hurt workers. My members struggle with inflation and the rising cost of living. We were not able to negotiate the wage increases that our members would have needed to help alleviate—don't get me wrong; it wouldn't have fixed inflation. Wages have not kept pace with inflation for as long as I've been alive. But it would have helped. Working people are struggling with buying food, paying rent and affording basic necessities. That has been compounded by a purposeful move of this government to use a false budgetary crisis to justify restricting their wage.

We recently met with the Unity Council, which is a meeting of the major unions on campus. The president of PSAC 901, who represents teaching assistants and post-doctoral fellows, reported that 70% of her bargaining unit accessed a food bank.

At least 863,000 Ontarians in 571,000 households live in deep poverty.

Twelve years ago, I was a graduate student at Queen's. While money was tight and budgeting was a challenge, neither I nor my friends used a food bank. If I were a student now, based on those numbers, it would be hard to have a friend who didn't access a food bank. The world has changed, but the funding packages have not, and graduate students can no longer afford to live and study. Neither were they able to bargain meaningful wage increases, because of Bill 124.

It is deplorable that the Ontario government would continue to pursue and commit more resources to the appeal of the Superior Court's ruling which struck down this legislation.

In fact, Bill 124 wasn't the first time we saw the Ontario government use budget and imaginary economic crisis or a deficit as a narrative. As of this morning, the Ontario Financial Accountability Office projects a budget deficit of $2.5 billion in 2022-23, significantly smaller than the government's deficit projection of $12.9 billion. With revenue growth projected to exceed program spending growth, the FAO projects a budget surplus of $1 billion in 2023-24, growing to $7.6 billion in 2026-27. This discrepancy is significant. One must ask, why would the Ontario government report a significantly greater deficit than actually exists? What would the government gain from manufacturing an economic crisis?

The Canadian Centre for Policy Alternatives published an article on November 15, 2022, by Sheila Block. In part, her article states:

"The government recorded a $2.1 billion surplus in fiscal year 2021-22, which ended in March. Now it is predicting a $12.9-billion deficit for 2022-23. That's a $15-billion deterioration in the province's bottom line at a time when inflation is driving revenues sky high. It's simply not a credible number....

"This doesn't add up: While high inflation rates are bad for many things, they are very, very good for tax revenues….

"Let's not forget that this year's budget contains a $3.5-billion contingency fund in addition to the ordinary $1 billion reserve finance ministers typically use. If some or all of that $3.5 billion"—

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

Ms. Briana Broderick: —"remains unspent—and the government has literally no plans to spend it—Ontario's surplus will be even bigger this year than it was last year."

It is obscene in an economic reality that sees higher costs of living, inflation driven by profit and suppressed public wages that this government would consider privatizing basic services such as health care and education. Asking workers to pay out of pocket for access to what should be basic human rights is unconscionable.

The government should consider stopping their appeal of Bill 124 and introducing pro-worker elements such as paid sick days, such as the 10 paid federal days, and adding processes which would make it easier for workers to join a union, as well as recognizing the damage that restricting wages has done to working families and fully funding all public services—including the elimination of user fees, ending the introduction of private health care options, and properly funding our public education system.

Thank you, and I'd be happy to take questions.

The Chair (Mr. Ernie Hardeman): Thank you very much. We will now will go to Ontario Shores Centre for Mental Health Sciences.

Dr. Phil Klassen: Thank you so much, Mr. Chair and members of the standing committee. You have a one-pager in front of you that can be used as a bit of a guide to some of the things that I'll talk about, and there's a photograph there that may also be of assistance.

My name is Phil Klassen. I'm a psychiatrist, and I'm vice-president of medical affairs at Ontario Shores Centre for Mental Health Sciences, which is one of four free-standing mental health facilities in the province of Ontario. It's an approximately 340-bed hospital that serves a variety of general psychiatry and subspecialty psychiatry needs. It has a mandate that goes beyond its region; we have a number of provincial programs. And it's a teaching hospital, both with the University of Toronto and with Queen's University. We have about 300 or 400 students a year.

I'm here to talk to you today a little bit about something that I think is important, which is mental health emergency services. I don't think that I need to convince anybody around the table that conventional emergency rooms are challenging places for people who go there primarily for mental health reasons. In Ontario, about one in eight—12%—of people who go to the emergency department go primarily for a mental health or substance-related problem.

As you probably also know, they will typically wait a long time in acute-care emergency departments that really were not designed for this kind of an experience—even in mental health emergency departments. At the end of the day, as somebody who has worked in acute-care emerg and who has worked in specialized mental health emerg, it remains the case that after that period of time waiting—sometimes a very long period of time waiting—really all you're going to get is a disposition—admit/no admit—and if "no admit," a follow-up appointment. I think that we can do better than that. A part of that is that a lot of emergency staff really are not trained to deal with mental health difficulties.

1410

At Ontario Shores, we've looked around for different kinds of models that may be of benefit to the system; we think we've found one that is very unique. It's called the EmPATH model—and I think the acronym is probably on your one-pager; although I don't have a copy of it in front of me, so I'm not sure what's on there. This is a model that has come out of the United States. There are a number of these units in the United States. There are no such units in Canada. We think it's a wonderful opportunity to test something that ultimately, I think, could and should be scaled up as a very different way of dealing with things.

You will have a number of hospitals, I think, that will have come to you around mental health emergency services. Many of them are aware of the EmPATH unit. It's a big promise. It's a big commitment—not necessarily financially, but culture-change-wise—to do an EmPATH model, and I'm not aware of anybody else who has really offered that.

There are a number of very unique features to the EmPATH model that I think are worth knowing about, and I can tell you, as somebody who has visited them, that I don't think the transposition to Canada is an issue. I've seen these work in very marginalized, very disadvantaged communities in the United States. We visited the first one ever in Oakland, California. I'm not anxious about the fact that it's an American creation. We remain in touch with people running EmPATH units in a number of different communities in the United States, getting their learnings and helping us to try to prepare to do this.

So what's unique about an EmPATH? It's only mental health. First responders are sent home—on average, the promise is—within 20 minutes. The wait times are normally about two to three hours. The patient is seen immediately by the psychiatrist. The psychiatrist's office is right by the front door. The patient can be there for up to 23 hours and 59 minutes. The patient is actively treated with pharmacotherapy and psychotherapy for those up to 23 hours and 59 minutes. And they're treated in a very unique milieu. We've visited them. We've seen them in action. You have a picture there. It's an open milieu with recliners, which has a tremendously calming impact a lot of times on these folks. The places we visited have restraint and seclusion rates of less than 1%, which is dramatically less than what you see, typically, in traditional kinds of emergency departments, where a lot of people are in seclusion or restrained in the hallways of the emergency department. These features, I think, make this kind of setting extremely unique.

I can tell you, also, that one of the advantages of this space is that it has surge capacity. Our proposal is for 32 recliners, but we can scale down to 24 recliners; we could scale up. It's a space with recliners. You add staff, you subtract staff, but you don't have a fixed number of rooms, which makes a lot of sense. We've offered a custom geography; I won't get into details as regards that.

There are potential savings. We all know that people talk about savings—they are potential savings.

In our region, the region in which Ontario Shores is, we've seen a very significant increase, a 25% increase, over the last number of years in emergency department visits for mental health and substance use. Emergency departments in this region are very crowded. We can take that load and bring it into the EmPATH unit. We can get police and EMS out much, much more quickly with this kind of a process, and we can produce better outcomes.

We have a number of promises, and one of those promises is that—provincially, admission rates from an emergency department for mental health are about 33%. That was my experience at CAMH, too. The best units in the United States do 20%, so that's a very significant reduction in the number of admissions.

I think the picture tells a great story, and we've seen these units, and they really do look like that—

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

Dr. Phil Klassen: Thank you.

The last promise that we also make to you is patient satisfaction. The promises are a 20-minute wait on average for police and EMS, high patient satisfaction, very low restraint and seclusion in a recovery-oriented environment—seen within 20 minutes.

I think that if we have the opportunity to showcase this at Ontario Shores, where we have the kind of academic setting and the kind of staff and the kind of funding model for psychiatry and other professions—and the kind of, relatively speaking, allied health and nursing stability—I think we could do something very unique for Canada and very unique for Ontario. We're hoping for a planning grant to support that, please and thank you.

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

We'll start this round of questioning with the official opposition. MPP Fife.

Ms. Catherine Fife: Thank you to all the presenters.

It's good to see you again, Nina. You came to committee.

It's really nice to meet you, Briana. I'm a big fan of the work of the Steelworkers—strong voices for workers across the province.

Phil Klassen, I just want to say to you that mental health and addictions has been one of the heaviest topics that this committee is dealing with. I think it's partly because things have gotten so bad in this province with mental health. I think the pandemic accelerated or entrenched some of those deep-seated mental health issues.

In Waterloo region, too many people are going to the emergency room to seek mental health supports. The feedback that we get is, and the hospital will tell you as well, that the hospital doesn't necessarily have the capacity or the training of staff to deal effectively with someone who is in crisis. Police have told us, "We're not the best people to deal with a person who is in crisis," even when they have de-escalation training. The cost of people seeking emergency mental health supports is well documented. And you make a very good case.

Everyone talks about savings, so we try to talk to about the return on investment, as New Democrats, because we feel that there are compassionate models of care that can be funded that improve the quality of that experience but also absolutely save money down the line.

The mayor of Kingston was here earlier, and the Ministry of Health told him that when folks are going to the emergency room, it's $1,600 a visit.

If you look at the money and you do the math, the case is there for the model that you're proposing. I just want to give you an opportunity to express (1) the urgency as to why this investment needs to happen and (2) why it is a more compassionate and effective model.

Dr. Phil Klassen: It's fundamentally intended to be a more compassionate model. It's fundamentally intended to give people a safe and comfortable and communal space with active treatment and choice. There are typically laundry facilities, some snack facilities, an outdoor courtyard, those kinds of things—a place to decompress. It's really an emergency department extension of the recovery model of care, which you may or may not have heard of. It's a very patient- and family- or carer-centred model of care. In terms of being effective, it's a model that's in about 17—it's growing constantly; you have to stay on top of it—mostly academic health systems in the United States, and it does consistently reduce admission rates.

The savings piece of it is really about reducing admission, because as you know, admission to a mental health facility—time spent in bedded care—is a very expensive piece of it.

I think, though, the most important part of it is that it's an important paradigm change. ED is just admit/no admit, go/no go, those kinds of things—which is not necessarily a bad thing for a rash or other kinds of physical problems. But if you wait for a long, long time in a high level of distress and in a rather chaotic environment—it just feels like that's not the model we should be using anymore. I think the model we should be using is a model where we're going to do something for you.

If people are very low acuity, there is another pathway to an outpatient appointment. In fairness, you're not going to take every level of acuity. We do it by CTAS score, the Canadian Triage and Acuity Scale. It's an emergency score that's used. We want the highest acuity patients—we want EMS and police. We want the highest acuity patients, because you can deal with the highest acuity patients in this kind of a setting.

So it's about an important paradigm shift which involves compassion and economics, I think—both.

Ms. Catherine Fife: Yes, and I think your point is that it's different pathways to mental health. If you are triaging those acute cases, you actually are alleviating some of the pressure that's on the system as a whole.

As MPPs, all of us have cases that we're dealing with. In particular for me, a young woman—when you transition from a child into an adult, there's a gap in services there. When people have enough courage to come forward and ask for assistance—because it takes a lot of bravery, I think, to admit that you're struggling—then that care needs to be available and it needs to be just in time, sometimes, otherwise, we lose people.

The government certainly has the money to do this. It has to be a priority, I think, in this budget of 2023.

Thank you very much for presenting today.

1420

Moving over to you, Briana: No delegation has come before this finance committee in this session and said that Bill 124 is helping—nobody has. In fact, it's well-documented now, it's well-researched—the evidence is very clear that Bill 124 is driving experienced, compassionate health care workers out of the system. Meanwhile, the government is trying to recruit people into a system that is broken. And the recruitment is actually being hampered by Bill 124, because Bill 124 is making working conditions so untenable and cruel and callous in our health care and in our education system.

I don't know if you mentioned it, but Bill 28 was really a catalyst time for this province, when labour came together and said, "No, you can't run roughshod over the rights of people in this province just because you have an agenda."

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

Ms. Catherine Fife: I want to give you the last word on how important it is to have a government that understands that if you really want to build a strong province, you actually have to be respectful of the workers who are working in that province.

Ms. Briana Broderick: In addition to working at Queen's University, I also represented health care workers, particularly in long-term care, and I can tell you that the impact of the pandemic and the impact of Bill 124, as well as—I heard the previous speaker talk about agency workers. It has completely demoralized that profession, quite frankly. And if you want to go even deeper, if you look at the Stout award, which is the latest award that has set the precedent for negotiations at HLDAA going forward—even something like the Stout award, employers are—

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

We'll now go to the independent. MPP Brady.

Ms. Bobbi Ann Brady: Nina, the non-resident speculation tax that you referred to—I'm just wondering, in this neck of the woods, is there a lot of foreign investment in agricultural land right now? I come from a very rural area where we're not seeing that.

Ms. Nina Deeb: Yes. There have actually been witnesses before the committee on Bill 23 that they—I think the number I heard is, they're losing over 300 acres a day of agricultural land in Ontario. That's just the professionals who came forward. I don't specialize in agricultural.

Ms. Bobbi Ann Brady: I talk about that 319 acres frequently, because my farmers are concerned about that as well, but I just didn't really realize that it was foreign investors who are gobbling up that land. It's not in my neck of the woods, so that was interesting to me.

Ms. Nina Deeb: I could explain the foreign investment portion to you. The foreign investors have actually opened offices in Canada. Blackstone is one of them; they've actually opened an office in Toronto. Blackstone is a global corporation, and that's who has been speculating Ontario. They had a speculator here from 2014 to 2018 who decided Canada was a good place to speculate, and that is Andrew Lapham, who is married to Caroline Mulroney. So Blackstone has been here speculating. I guess they could be considered Canadian—they have a Canadian arm—but they are a global corporation.

When I got into real estate in 1996, they owned no rental units—global finance didn't own any. I've taken inventory of my region; every high-rise in my region is either a luxury condo of some sort or it is real estate investment trusts. The largest players in my region are Starlight, which is Blackstone; Killam properties, which is another real estate investment trust; Centurion—those are the new landlords in Ontario. They've absorbed all our rental stock. I've watched it happen; they actually put their signs up on them as they buy them. They've bought them in large blocks.

Ms. Bobbi Ann Brady: Thank you for that.

Briana, I'm a big supporter of the Steelworkers as well; I have 1,100 of them at the Stelco plant in Nanticoke. I don't have any questions for you, but I sure love the work that's being done by our Steelworkers in my riding.

Phil, with this EmPATH model, you wouldn't be able to keep them past the 24 hours?

Dr. Phil Klassen: People have played with that number a little bit. We've been in constant contact with Dr. Scott Zeller, an emergency psychiatrist from California who actually has published on this and was sort of the originator of this. I think you lose some of the impetus for active treatment if you make it longer. Some people have extended it to 48 hours, 72 hours. Particularly in neighbourhoods that have high levels of substance misuse where you may just need to keep—

The Chair (Mr. Ernie Hardeman): You have one minute.

Dr. Phil Klassen: —them a bit longer, people have done that. But typically, to make sure that there's a sense of urgency about the treatment and a sense of urgency about using that time, most units will say, "It's 23 hours and 59 minutes, so go team."

Ms. Bobbi Ann Brady: But that may include a plan for the next day, and the next day, and the next day.

Dr. Phil Klassen: It may result—of course, it results in a discharge. In 80% of the cases, it should result in improvement, a plan, follow-up and discharge.

The Chair (Mr. Ernie Hardeman): We'll go to the government side. MPP Crawford.

Mr. Stephen Crawford: Thank you to the presenters today.

First, I'd like to make a few comments before I move to some questions. We certainly share your concerns about housing, affordable housing. I think that's really across partisan lines—that people understand the concern we have for shortage in housing.

I did want to clarify something, however, because you did talk a little bit about Bill 23 and the development charges. The development charges which are reduced in that bill for housing is affordable housing, it's not-for-profit housing, it's rental housing. We have cross-border support from stakeholders on this. I'll give you an example.

We have Habitat for Humanity supporting this legislation. We have housing and homelessness, WoodGreen Community Services, in support of this legislation. I have a quote here from the Co-operative Housing Federation of Canada: "The commitment to waive development charges for all affordable housing developments will have a tangible and positive impact on the ability to develop new, affordable co-op homes in Ontario. We also look forward to engaging with the province in order to reduce the property tax burden on affordable housing providers, including co-ops." I want you to understand that that's not targeted to people who are building $10-million mansions, but affordable, rental, not-for-profit—we want to give those people the most support we can. We've got a lot of support from those organizations. So I wanted to clarify that for you.

Briana, thank you for coming in. It's great to be here in Kingston.

I did want to make the point that when our government did take office in 2018, Ontario was the most indebted subsovereign government in the world. That's a fact. If that's not an urgent situation to deal with, I don't know what is.

I know you're concerned about workers. We had 300,000 manufacturing jobs leave the province in the previous decade. What our government has put into place are policies that are incenting business to come back to the province, to invest in the province, and that's creating new manufacturing jobs in this province, new jobs which are both union and non-union jobs. We're getting great support from many unions because they recognize the growth and the incentives we're putting in place to create a more prosperous province. It's good for workers. It's good for unions. It's good for everybody in the province, and it's going to help pay the bills that we have with education and health care. These are critically important services we need to provide for. I think it's about creating that environment that attracts business.

In my riding, for example, in Oakville, I can tell you that Ford of Canada, which employs thousands of workers, was very close to leaving the country because of high energy costs, tax burden, regulatory issues. We've worked collaboratively with the federal government and incented them to stay to create EV manufacturing jobs right here in the province, so we're excited.

We need to incent business to create these opportunities, and I think that's critically important.

I think we have our issues in Ontario, no doubt about it, whether it's health care—and there are certain things we need to do more on, and we've been hearing that today—and there's certainly an opioid crisis and a mental health crisis, which I want to ask Phil about. But I think we're moving in a positive direction, from the point of view of creating jobs and prosperity for the province to be able to finance the social services that we so, so dearly need.

1430

To my point now, to Phil: I'd like to ask you a little bit about your organization. Obviously, you're seeing a growing need for mental health support, and we're seeing that across the province; it's not just here. We've travelled the province, and there's no doubt this is a growing problem. We want to be able to help support you. Could you give me some sense on the area that you would be serving and what has been the trend in the last couple of years that you've noticed, particularly since COVID?

Dr. Phil Klassen: Great questions.

We started this, actually, pre-pandemic, looking into this, talking to stakeholders, talking to people in the region, because we're a regional and provincial provider. Durham regional police and EMS—we have the slide deck with their slides in it about the number of mental health apprehensions and what was happening even pre-pandemic; it was climbing, and it was the same thing with emergency department visits for mental health and addictions. As you probably know, immediately as the pandemic stopped, it went down—and then is returning to a higher level.

We have offered in our proposal a custom geography of a 30-minute drive from our door, if I can put it that way, and the numbers that relate to that and the pressure we could take off the system. Of course, success could do things to that. The EMS and police further afield than 30 minutes have said, "If we're out of your hospital within 20 minutes, never mind the 30-minute custom geography, we'll drive to you from a lot farther away than 30 minutes, if you can release us in 20." But the proposed custom geography—and of course, 30 minutes driving in an urban environment is a bit of a jagged figure—is a 30-minute drive at normal speeds.

Mr. Stephen Crawford: How much time is left, Chair?

The Chair (Mr. Ernie Hardeman): You have 1.5 minutes.

Mr. Stephen Crawford: In terms of your profession, have you seen a lot more incidences of mental health crisis in the last two or three years?

Dr. Phil Klassen: The emergency departments are so full, and our wait-list for in-patient care transfers of patients that acute care has not been able to treat effectively has never been higher. I don't even want to tell you the number. Our outpatient wait-list has never been higher. I'll tell you the number, but it's scary: It's 4,000 people, despite all the investments that we've made in ambulatory care. And our wait for in-patient care from emergency departments and in-patient units in our region has never been higher.

Mr. Stephen Crawford: And if I understand it correctly, in a simplified format, essentially what you're proposing is like an emergency room for mental health crisis?

Dr. Phil Klassen: There are mental health emergency departments out there that see only mental health—there are a few of those. What we're proposing is something more definitive than disposition: "We will help you to get over this crisis." We're going to bring CMHA's or other resources in-house that are going to be installed in the emergency department; OHC partners will be installed; a more definitive period of treatment, up to 23 hours and 59 minutes—the average is usually about 10 to 18 hours—and a warm hand-off, which is I think very different from acute care: wait, wait, wait; a short interview; admit or no admit.

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

Mr. Terence Kernaghan: Thank you to all our presenters here today.

Thank you, Nina, for coming back to committee and for drawing really important not only financial implications of the change between 2019 and 2022, but also speaking truth to power about Bill 23. Despite growing calls from municipalities and AMO to pause—if not completely withdraw—this bill, unfortunately it has been met with blind ideological adherence to continue this. It reminds me of another bill in the last Legislature that was suddenly going to incent the creation of more housing, which was to remove rent control completely for buildings created or occupied after November 2018, which did nothing except to destabilize people in their homes.

In terms of the waiving of development charges, my question is, if developers are not paying for these, who would be on the hook to pay for roads and services and all the things that are required?

Ms. Nina Deeb: That's the rest of the tax base. That is what municipalities are so upset about. They're having to raise their taxes significantly to make up for this, for what the developers are not paying.

I was one of the witnesses who was not heard on Bill 23. I'm very familiar with Bill 23. The mayor of Aurora gave an example that a $1.1-million build in his city would have development charges waived. I don't think that's helping. We are socializing the costs and privatizing the profits.

Mr. Terence Kernaghan: If these development charges are removed from developers, will they then pass on this cost savings to purchasers, when there's no oversight?

Ms. Nina Deeb: There is absolutely no guarantee, and it doesn't make business sense to do that. It makes sense to sell for the most profit that they can sell it for. The savings will not be passed on.

Mr. Terence Kernaghan: I also want to thank you for talking about the non-resident speculation tax and the exemption and pointing out directly who benefits from this. It's deeply concerning that we have REITs buying up single-family homes as well as rental properties. Even within Bill 23, there is the allowance to take rental units and turn them into luxury condos. The official opposition shares your concerns.

My next questions are going to be for Briana. You pointed out that in the body of Bill 124, it talks about responsible fiscal management. Do you think it's fiscally prudent for this government to appeal a court decision that they have already lost?

Ms. Briana Broderick: No, I do not. Quite frankly, whatever the situation was in 2018 in terms of an economic crisis, the court has already ruled that that situation did not exist in 2019. So it makes no fiscal sense. It is not responsible to challenge legislation that has already been struck down and to further jeopardize working families in Ontario.

Mr. Terence Kernaghan: I want to also thank you for speaking truth to power.

Earlier this morning, we brought up John Snobelen, who was caught on a hot mike indicating that he was trying to create a crisis in education in order to pave the way for privatization. That is obviously a concern that we have with health care opening up private clinics to cherry-pick the easiest, most lucrative surgeries from the public system, to take already diminished staff from the public hospitals.

Also, I was particularly taken by your comment that a large proportion of your bargaining unit are using food banks. What proportion of your folks are having to rely on food banks regularly?

Ms. Briana Broderick: That was a comment not from my bargaining unit, but from the teaching assistant and post-doctoral union on campus, which represents graduate students. That union, PSAC 901, reported that 70% of their membership is currently accessing or has accessed food banks, which is absolutely disgusting.

Mr. Terence Kernaghan: Most definitely. Food banks were actually created to be a stopgap measure, not something that was regularly used, and yet we see an overreliance on them.

I also want to thank you for pointing out the fiscal mistake of the licence plate sticker refund and the money that was spent on that.

Also, for this committee—just take a look at the 407, one of the greatest transfers of public wealth into private hands. There was a $1-billion fee that was owing to the government that they forgave to a multinational corporation throughout the pandemic, which was also deeply concerning.

My next questions are for Phil. It's a very intriguing model that you've brought forward here for the committee. You've indicated that it could potentially realize $10.7 million in annual savings. What is the cost of this program? I'm not sure that I saw it in your handout.

Dr. Phil Klassen: The operating cost—of course, that's partly what a planning grant, I guess, will help us with. But the operating cost is somewhere in the range of between $7 million and $10 million, I think, if I remember that correctly.

1440

Mr. Terence Kernaghan: This is part of what could potentially be an excellent continuum of care, really prioritizing mental health and taking that into consideration.

I want to give an example. In my riding, there is what is known as the COAST program. It is a program that is funded by CMHA, as well as—

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

Mr. Terence Kernaghan: —the London Police Service, where a mental health care practitioner is responding to those mental health calls, rather than sending a uniformed officer.

I also think your model, where you're making sure folks are taken care of in a timely fashion, is incredibly important, because the last place people want to be is in a hospital, but you want to make sure that they get the care they need and deserve. So I want to thank you for bringing this forward today.

The Chair (Mr. Ernie Hardeman): To the independents: MPP Bowman.

Ms. Stephanie Bowman: Thank you all for being here today. It's very interesting to hear all of your presentations.

I have two questions, one for Briana and then one for Phil.

Briana, we touched on the workers who are using the food banks. I guess that is, as I think you said, something different right now, not just for the members who you referred to—but we're seeing a lot of that in the news, and hearing from other groups about people who are employed, who have jobs, going to food banks. Again, to have to rely on that when you are working and have a good-paying or even a modest job is something that I think we haven't seen before. Could you talk a little bit more about what you're hearing in terms of the personal impact on those people who are having to do that for probably the first time in their lives?

Ms. Briana Broderick: Sure. I said in my statement that 12 years ago, I was a graduate student at Queen's, and the funding package remains the same. But what is particularly concerning was the inability of those graduate students to go out and bargain fairly and bargain an agreement that would reflect their true value.

I think that many working people, in bargaining units and non-unionized, struggle with the cost of living. We know now that inflation is being driven by corporate profit—not labour costs, not anything else; it is corporate profit. The impact of that on members who are trying to buy fresh food—when chicken breast is $35 a package, what are you going to do? Interest rates have risen, and people can no longer afford their mortgages. They can't afford rent. If you can't afford your house and you can't afford food, it doesn't really matter how much money you're making; it is not enough.

Ms. Stephanie Bowman: How much has a typical worker in your union or member—what has their wage gone to, from 12 years ago when you were working to now?

Ms. Briana Broderick: I don't have that data, but certainly if we look at inflation, all public sector workers are restricted to 1% in total compensation, and what that means is 1% in their wage package, but also in any of their benefits package, so unions couldn't bargain for increased vacation, couldn't bargain increased benefits, couldn't bargain anything. It all had to be contained within that 1%, so there was no offsetting the hurt.

Ms. Stephanie Bowman: I appreciate that. I'm going to move on, because I've only got a limited amount of time.

Phil, thank you again for bringing this model forward. I really love the idea of looking around the world, finding innovative ideas and trying them, in all sectors, so I applaud you and your organization for that. The planning grant would be how much, approximately?

Dr. Phil Klassen: I think the request was somewhere between $800,000 and $1 million.

Ms. Stephanie Bowman: Okay, so call it $1 million, to evaluate a new and innovative way to help—not solve, but help—

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

Ms. Stephanie Bowman: —the mental health crisis. I think that would be money very, very well spent.

Could you talk about any other challenges that you might have in actually implementing the model? If you get the grant and then you get the money to proceed, are there any other potential challenges that you see that you might need help with?

Dr. Phil Klassen: Well, there are always HHR challenges these days in health care—nurse practitioners, physician assistants, nursing staff etc.

I think one of the biggest challenges is, it's a big model change. You need an organization to pilot this that is ready to really commit to a very—there's no nursing station. The physicians, the social work staff, the peer support, the nurses are in the milieu. You go into interview rooms to have private interviews and to do treatment, those kinds of things—but you're there. You're on all the time. You're defusing crises. You're preventing control measures, you're taking people aside into a room for psychotherapy or to discuss medication options—

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

We'll go to the government side. MPP Cuzzetto.

Mr. Rudy Cuzzetto: Thank you to all the presenters here.

Nina, I heard some questions that were asked to you about rent control earlier on. As a government, we removed rent control on newly built rentals in the province of Ontario, and we've noticed that the rental starts have been the highest since 1991. And do you know who, in 1991, removed rent control? Bob Rae. It worked for the NDP, so I think it's going to work for us today, as well.

On the DC charges that we were talking about: Like my colleague here has said, we're going to remove them on purpose-built rentals and affordable homes.

I have an Indwell project in my riding. We've been speaking with the Indwell group, and they build only affordable homes, and they charge approximately $560 a month for rent. They said that with Bill 23, they will be building more of these homes throughout the province of Ontario.

So these are good things that we're doing, as a government, to stimulate the market so we can build the 1.5 million homes.

I noticed you said a little bit earlier on that we could build 1.5 million homes in a year. Unfortunately, that can never happen. First of all, we don't have the labour to do that in the province of Ontario—to build that many homes that quickly—but I wish we could.

As well, I would like to speak to the United Steelworkers about the shortage of labour. As you know, we are going to be the number one jurisdiction in North America to build electric cars. We're going to have to build new plants here in the province; we have to build bridges. How do you see us, as a government, working together with the

Steelworkers to get more employees into helping us build the bridges we need, the factories we need?

Ms. Briana Broderick: Well, hire union contractors and you'll have all the labour you need.

Mr. Rudy Cuzzetto: I come out of Unifor, so I understand where you're coming from, as well. But how do we hire them? Do we have that many people in the province of Ontario to do that?

Ms. Briana Broderick: There is a worker shortage. That worker shortage needs to be addressed through properly funding education; it needs to be addressed through properly funding apprenticeship programs and properly funding universities, which, by the way, are not properly funded. There are no publicly funded universities left in Ontario.

The way to get things built is to attract good unionized labour, with high-paying jobs, with great benefits, with health and safety protections. If you put those measures in place and if you have a budget which supports workers and their families, I'm sure that you can get all the infrastructure built that you need.

Mr. Rudy Cuzzetto: Well, the thing is that, right now, we have 400,000 available jobs in the province and we have problems filling them. That's why we need immigration to come here into Ontario—and not only once we get the immigration; we need to build the homes, too. So it's a whole thing that we have to work together and build together.

I'll pass it on to my next colleague here.

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

Mr. Dave Smith: Phil, I'm looking at your proposal here. Just so I understand: You're looking for $5.47 million in annual funding. Is the upfront cost $3.8 million plus $800,000 plus $222,000? They're two separate things—an upfront cost to start up, plus $5.47 million annually?

Dr. Phil Klassen: I didn't keep a copy of that sheet for myself; my apologies. Could somebody lend me a copy? I handed them all over.

Obviously, it's a capital grant—

Interjection.

Dr. Phil Klassen: Thank you, yes.

Mr. David Smith: I think this is the one you need?

Dr. Phil Klassen: Yes, thank you.

Mr. David Smith: My pleasure.

Mr. Dave Smith: "Ontario Shores mental health services requests the government of Ontario to allocate a planning grant in the amount of $800,000"—

Dr. Phil Klassen: Yes, the other two are quite separate. The GTU—

Mr. Dave Smith: If we're going to make a recommendation on that, I don't want to recommend the wrong amount and not have enough for you on it. That's where I'm going with it.

Dr. Phil Klassen: So, only for the planning grant—the $800,000-and-change planning grant.

1450

Mr. Dave Smith: Just the $800,000 planning grant?

Dr. Phil Klassen: Yes.

Mr. Dave Smith: Okay. And that will be to create the EmPATH model at Ontario Shores?

Dr. Phil Klassen: Yes.

Mr. Dave Smith: Okay. I understand that. So then the other costs will be likely next year's budget—the 2024 budget; not the 2023 budget.

Dr. Phil Klassen: Yes, the other costs are completely separate from what I'm here for. I'm here only to talk to you about the planning grant. That's it.

Mr. Dave Smith: One of the other things that you say here, under the benefits, is that you'll divert 10,000 patients to Ontario Shores, saving $3.6 million. I heard you talking about—and the NDP have mentioned a couple of things along this as well—that everybody likes to hear about savings, and those are great things. The reality is, though, there are no savings, because what you would be doing is diverting 10,000 patients who would have gone to a facility that wouldn't have done what those individuals needed. So where I'm going with that is, 10,000 people who need a different level of service will get the level of service they need, and 10,000 who need service at a traditional hospital will get that, so effectively that $3.6 million is helping 20,000 people, not 10,000 people.

Dr. Phil Klassen: Yes. I think that the potential for savings—you're right; a lot of this is theoretical. It remains theoretical as long as emergency department visits and emergency department return visits and hospitalizations continue to rise. If, on the other hand, the model is successful in reducing admissions and reducing emergency department return visits, as it is in the United States, then what is a theoretical proposition at the front end could become an actual proposition later.

Mr. Dave Smith: Where I'm trying to go with this is to build a stronger case for you. We have hallway health care—

Dr. Phil Klassen: There are no hallways in this building. We've been listening.

Mr. Dave Smith: —but the 10,000 people who are not going to be in another hospital, they're going to be here, and there are 10,000 others then who may have been treated in the hallway—

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

Mr. Dave Smith: —who may not actually be in the hallway in the hospital anymore because you've opened up a room in the emergency department that would have been occupied by somebody who was going there because that was the only place they could go, and you're suggesting that we're going to provide a different avenue that is care where they need it, when they need it.

Dr. Phil Klassen: You're right. These people are in emergency departments now. We're happy to absorb the increase. The savings are "theoretical" unless and until you have a model that reduces emergency department pressures and admission pressures and ambulatory pressures.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time, and that does conclude the panel and the presenters and the questioning.

We thank the panel for the time you've taken to prepare for your presentations and making the presentations here

and helping us in our deliberations as we prepare for the next budget.

KINGSTON FRONTENAC PUBLIC LIBRARY

ONTARIO INSTITUTE FOR REGENERATIVE MEDICINE

YMCA OF EASTERN ONTARIO

The Chair (Mr. Ernie Hardeman): The next panel is Kingston Frontenac Public Library, Ontario Institute for Regenerative Medicine, and YMCA of Eastern Ontario.

We'll ask each of you to make your presentation in seven minutes. At the six-minute mark, I will say, "One minute." Don't stop; you'll have another minute, but at the seven-minute mark we'll cut it off to make sure everybody gets equal time.

We hope that each one of you will start with giving your name prior to speaking so we can get it all right and attribute the comments to the right name going forward for Hansard.

With that, the floor is yours, Kingston Frontenac Public Library.

Ms. Laura Carter: Thank you to the Standing Committee on Finance and Economic Affairs for the opportunity to speak in today's 2023 pre-budget consultations. My name is Laura Carter, and I'm the chief librarian and chief executive officer of the Kingston Frontenac Public Library.

Public libraries are Ontario's furthest-reaching, most cost-effective public resource, providing a variety of services tailored to the needs of our communities. Libraries serve as community hubs, connecting people with the resources they need and with each other, both inside and outside the library.

Ontario's libraries demonstrated our innovation, creativity and strength over the past couple of years as we pivoted from pandemic lockdowns to reopenings, a return to normal services, and sometimes back again. We maintained access to critical services and responded to the changing needs of our communities, ensuring people had access to Internet even if that was accomplished through WiFi available in our parking lots. We offered computers to access vital government services and information, and free printing for people who needed vaccine certificates. As soon as regulations allowed, public libraries in Kingston and Frontenac, and across the province, opened our doors to provide spaces where the most vulnerable in our communities could get warm, stay cool, and access washroom facilities and drinking fountains.

The importance of the library as a free, welcoming space that is open to everyone cannot be overemphasized. Mayor Paterson spoke earlier today about the addictions, housing and mental health crisis in Kingston, and the urgent need for investments in this area. The impact of that crisis is felt across our region, and the impact definitely affects everyone.

Public library staff are on the front lines of this crisis, with many vulnerable people visiting us every day to use computers, to read books, magazines and newspapers, to charge their devices, to meet with caseworkers, or just to be out of the cold.

Public libraries are organizations that routinely share, connect and collaborate, and we take that approach locally, participating in many committees, boards and round tables, including the Homelessness Collective Impact Committee, organized by the United Way of Kingston, Frontenac, Lennox and Addington, in partnership with Kingston, Frontenac, Lennox and Addington Public Health.

We also work on a provincial level. One of the ways we do this is by advocating for a strong public library service for everyone in Ontario. We are a member of the Federation of Ontario Public Libraries, we actively contribute to the Ontario Library Association, and we directly benefit from the work of the Ontario Library Service.

Library staff from across the province routinely work together for the advancement of all. Together, we can maximize the return on investment in libraries and increase efficiency in the library sector. By investing in public libraries, Ontario will directly support people, their communities and local economies, no matter where they live in our province.

There are three critical investments that will stabilize Ontario's public libraries and ensure we can continue to perform our vital role while actively recovering from the impacts of the COVID-19 pandemic.

The first priority is to keep local public libraries across Ontario sustainable by maintaining existing provincial operating funding. Provincial funding for public libraries has been frozen for over 25 years. While the majority of public library budgets are municipally supported, the provincial funding is critical to support operations, shared resources, broadband connectivity and pay equity. The provincial investment in public libraries in Kingston and Frontenac works out to $1.83 per resident per year. Continuing to maintain this critical provincial funding at existing levels is vital to supporting the sustainability of public libraries.

Equally if not more importantly, please work alongside First Nations public library leaders to implement a sustainable funding model for First Nations public libraries. As an immediate first step, the First Nation Salary Supplement must be increased to ensure all existing First Nations public library staff are fairly compensated for the work they do. Public libraries on-reserve are deeply important to maintain a sense of community and minimize social isolation. Many of these communities are remote or face systemic social and economic challenges. Provincial funding through the Public Library Operating Grant and primarily through the First Nation Salary Supplement grant provides, on average, $15,000 a year to each of the existing public libraries on-reserve. While band councils may provide some support for utilities, Internet and phone, there is little to no funding available for collections, programming and technology. Many public libraries on-reserve operate with only one staff who is expected to perform many functions. An investment of $2 million annually would sustainably fund library operations for existing First

Nation public libraries and ensure a living income for library staff in these communities.

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Finally, provide critical e-learning support and fair access to modern digital resources for all Ontario public libraries by creating an Ontario digital public library. The Ontario government has recognized the crucial importance of public libraries and broadband access, making a $4.8-million investment to install or upgrade broadband connectivity at over 100 public libraries, and we are very grateful for that investment. However, many Ontario public libraries, particularly in smaller and remote communities, struggle to afford and cannot provide high-quality e-resources, e-books and other online resources their communities need. These resources are expensive, especially when purchased on a patchwork, library-by-library basis. By leveraging the province's significant purchasing power and the library sector's collective expertise, we can create a provincially funded resource that will ensure all Ontarians have access to a common set of high-quality e-learning resources and more e-books through their local public libraries.

This partnership between the Ontario government and local public libraries is vital. Providing these critical supports are needed for us to continue to work together to develop and deliver important government services, locally relevant resources, and to support economic development close to home in the communities where people live.

Thank you for your time.

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

The next presenter will be the Ontario Institute for Regenerative Medicine.

Dr. Tim Smith: Good afternoon, everybody. I'm delighted to be here.

I'm here to talk to you about a very interesting topic: regenerative medicine and stem cells. As you probably know, regenerative medicine is an emerging medical field that is generating life-saving technologies for people in need. Its origins go back to the discovery of stem cells, which actually occurred in Toronto. While I recognize there are many groups in front of you in this tour with very worthwhile requests for funding, I would say none are more important than being able to fund the future of health care and, certainly, regenerative medicine and stem cells are an integral part of that.

My name is Dr. Tim Smith. I am the CEO and one of the co-founders of Octane Medical Group. Octane Medical is a cluster of about six different companies that are actively involved in the development and commercialization of regenerative medicine technologies. When it comes to rebuilding our health care system and helping to grow our provincial economy, Ontario cannot afford to miss out on this $150-billion opportunity globally.

At the Ontario Institute of Regenerative Medicine, or OIRM for short, our mission is to accelerate the translation of stem cell and regenerative medicine technologies out of the academic institutions and bring them into Canadian-led businesses. This is driven by the creation of companies and fostering these companies, and the key role of OIRM is really to enable this progression—the growth of clinical trials and moving technology out of the academic labs and into commercial venues. We have a track record of success. We—we being OIRM; I am the chairman of OIRM—previously were funded from 2015 to 2020 with $25 million. We were very lean as an organization, and we actually deployed about more than 80% of those funds directly into the community. From that investment going into the community of about $21 million, $22 million, we were able to leverage $174 million in support of these technologies. We generated five new companies, we generated approaching 800 high-QP jobs, we led $300-million-plus of Series A funding, and we started 17 clinical trials involving stem cells—extremely productive work with a relatively low investment from the Canadian government.

In 2021, in pursuit of trying to maintain our infrastructure in the absence of funding and in the hope that we will be again re-funded as OIRM, through some parallel funds outside the funding from Canadian government, we were able to initiate a kick-start program with limited funding that generated three new start-ups. So even though we have not been funded, we tried to maintain our initiative in the community.

So we've come a long way, we've demonstrated great success, but we're now at a crossroads. There are many very intriguing technologies that are coming into the clinic, and we desperately require another round of $25 million to really bring these technologies forward. Our projection is, not only are we going to meet this $174 million in leverage that we attained last time, but because of the pipeline that we've been fostering over the years, we're able to actually double and triple that sort of output—because it takes a long time to bring these technologies into the clinic. So we've done that for five years. We've got a large pipeline, and we'll be even more effective going forward.

Thank you very much for your time.

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

The last presenter is the YMCA of Eastern Ontario.

Mr. Rob Adams: Thank you to the committee members for allowing me to join you today. I am Rob Adams. I'm the CEO of the YMCA of Eastern Ontario, a regional YMCA, with programs and services available in Kingston, Gananoque, North Grenville and many surrounding communities.

The YMCA of Eastern Ontario is defined by what we do, not necessarily by our own buildings. We are part of a provincial network that includes 14 associations across the province, active in over 125 communities. The Y has an enduring presence that gives us a window into how people here in Kingston and the area and the rest of the province are doing, what they need and what we can do better to help them reach their full potential. The YMCA in this region alone has been in this area for over 160 years, so it has evolved over time, meeting the needs of those who need us the most.

As many of you are aware, the YMCA has evolved over time, responding to the needs of our communities and

adopting innovative and new approaches to address complex health and social challenges.

The recommendations that I am bringing forward to the committee are not just for this community, but for the province as a whole, with the hope that it will help strengthen the sustainability and viability of our charity so that we can do the best work possible for the growing number of Ontarians who rely on our programs and services.

I am asking you to consider commitments and investments into four critical areas: (1) the child care workforce, (2) opportunities for young people, (3) community recreation for all, and (4) mitigating inflationary pressures for charities.

I will start with the urgent issue of the child care workforce. I know you are familiar with this issue. YMCAs across the province have been advocating for solutions that will help us deliver on the province's commitment to the Canada-wide Early Learning and Child Care Agreement, which the YMCA supports. We know that families are excited about this program. We know that licensed, not-for-profit child care provides incredibly enriching and stimulating programs for kids. And we know we want more kids to benefit. To make this happen, we need to invest in Ontario's child care workforce now.

Ontario Ys provide nearly one fifth of all child care spaces in Ontario—76,000. We are proud to have worked with this government on the progress made towards making affordable, quality child care a reality in this province. At YMCAs across Ontario, we need to hire an additional 1,400 educators just to reach pre-COVID levels. To expand beyond our licensed capacity by even 20%, we need close to 3,500 educators. Of those educators who are working in child care today, a declining percentage are registered early childhood educators—a typical indicator of quality. What does this mean operationally? We have the space to provide more child care, but we don't have the staff. This leaves families on wait-lists and sometimes out of the workforce, because we know that when parents can't access affordable, high-quality care, they have to stay at home. We are calling on the government to address this workforce shortage.

Our recommendations from the YMCA:

—invest in child care workforce compensation on par with municipalities and school boards; fully fund benefits and pensions; fund gaps to turn split-shift roles into full-time positions; enhance compensation for all educators, including registered early childhood educators and early childhood educator assistants;

—invest in an early childhood education workforce public recruitment campaign and incentivize colleges and universities to grow their early childhood education programs and develop different levels of credentials and/or specializations;

—recruit newcomers and new immigrants to the early childhood education sector and recognize home-country credentials;

—focus on greater child care funding, predictability and consistency at the municipal level, allowing operators to develop optimal staffing plans and reduce the administrative burden on child care staff;

—exempt charities like the YMCA from Bill 124 so that operators can raise compensation at a time when it is needed the most.

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With a comprehensive workforce strategy to recruit, train and retain the outstanding professionals caring for children, we will make huge strides on the commitment to build 53,000 more licensed child care spaces by 2026. We want the help of the government to deliver on the CWELCC commitments, and with the right investments in budget 2023, we'll get closer to the thriving child care system that the province needs.

Opportunities for young people: The YMCA supports the government's focus on helping Ontario's children and youth catch up after years of learning disruptions. Pandemic cancellations and lockdowns resulted in fewer people getting trained, specifically as lifeguards, and fewer children participating in swimming lessons. Today, there are growing wait-lists for swimming lessons, but we cannot find enough qualified staff to teach kids how to swim. Aquatics investments are a win-win: More kids have a chance to develop an essential water life skill thanks to more young people with meaningful and rewarding jobs as lifeguards. We recommend that the government fund charitable and not-for-profit aquatics organizations to provide free certifications and training for lifeguards and swimming instructors.

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

Mr. Rob Adams: A community health fund: As a charity with a commitment to physical, social and mental well-being, we know that physical activity and social connection are directly linked to positive mental health. We have always focused on removing financial barriers for community members, so we need to ensure that our programs are accessible to all. However, with rising operational costs and the needs in our communities, we need help to do more. Our recommendation is to establish a community health fund, with grants available to charities and not-for-profit providers to deliver free and/or low-cost programming to equity-deserving communities.

From an inflationary support standpoint, we recognize that there are many capital projects that are happening, and operational costs are happening. Inflation is rising. We would appreciate that the charity and not-for-profit sector receive some form of inflationary support grant system. Thank you.

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

We will start the round of questioning with the independents. MPP Bowman.

Ms. Stephanie Bowman: Thank you all for being here. I have to say, I love all of these topics, and I have a short amount of time, so I'm going to do a few quick zingers.

I'll start with the library. Laura, just to confirm: You're asking to maintain provincial funding levels. Why aren't libraries asking to go beyond current levels?

Ms. Laura Carter: We're asking to maintain the current levels of the Public Library Operating Grant because we recognize that obviously there is limited money, so we are asking for the increase in funding to go towards the Ontario digital public library—that is an estimated ask of around $9 million a year—and the First Nation Salary Supplement. That's where we see the greatest need at this point.

Ms. Stephanie Bowman: Thank you for the clarification.

Dr. Smith, it's fascinating stuff. I just finished The Code Breaker, so I'm all tuned up on DNA, RNA and all this stuff. I think it absolutely is the kind of investment that does take us into the next age of medicine. Again, it's very exciting work.

I want to understand just how you guys work with other accelerators like MaRS and others in that network. Are there things that you can learn and share to make these investments even more worthwhile?

Dr. Tim Smith: Yes. There are a number of accelerators in the health care system. The unique aspect of OIRM is that it's provincial and it's focused on very much the academic, and moving technologies into the clinic. Most of the accelerators really get involved once there's a corporate start-up, so the problem is that there just is not the evolution of the technology to get it into a start-up.

We're even a front end to the people who help, and so the role—or the historical role, and the role that we propose going forward—is to use the provincial funding to really bring out these early technologies and get them into clinical trials, and to try many of them as quickly as possible, because there's no guarantee that any particular approach is necessarily going to work. So you just have to be fast. It's an area that evolves very quickly. You have to be fast and nimble. That's our role at OIRM—to streamline that translation.

Ms. Stephanie Bowman: That's very helpful. Thank you.

I will finish with Rob. I know that a number of the Ys across the province have gone through some consolidations to share best practices and do things better, more effectively. Could you talk about the role of that, moving forward, and how that means you can leverage any increased funding that you do get from the government?

Mr. Rob Adams: A good example is that our Y merged. I was hired as a shared CEO between Brockville and Kingston, and in 2019 we merged to become the YMCA of Eastern Ontario. So we were able to leverage our talents and our skill set to increase our impact and our reach, which many other Ys are looking at. They're also looking at partnering with municipalities in terms of infrastructure and municipally owned buildings, and running them as YMCAs. In terms of economies of scale, yes, there's opportunity for that. I think, from a strategic standpoint, you're going to see more dialogue at the board level to do that.

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

Mr. Rob Adams: It still doesn't replace boots on the ground in terms of child care. As an example, in eastern Ontario, from Kingston to Brockville, our licensed child care spaces—we have roughly 400 families on a waiting list that we could get into child care if we had the proper staffing. While there are opportunities to leverage expertise and supports and increase our reach, from a front-line standpoint we still need that support.

Ms. Stephanie Bowman: I just want to highlight that I think, again, non-profits like yourselves and libraries are always trying to do things to be more efficient and innovative and to deliver more services with what you have. You're good stewards of your resources, so thank you.

The Chair (Mr. Ernie Hardeman): We'll now go to the government. MPP Dowie.

Mr. Andrew Dowie: Thank you to the presenters—all fascinating disciplines. I'll try to go fast, because I've got a question for each of you.

I'll start with Laura. Thank you for your presentation. I know we heard some similar comments from Timmins about the digital collection, understanding that the world has evolved a little bit in terms of how materials are purchased—especially for digital materials, but even for your normal, physical materials.

Could you elaborate, a bit, as to how—if you were to buy or lease a book, whatever the case may be, how much use does a user get out of it, and how many times do you have to renew it?

Ms. Laura Carter: I am so glad you asked that question, because I cut that content from my comments. In terms of digital resources, in particular, I looked at a recent invoice for the Kingston Frontenac Public Library where we paid $134 for one copy of a downloadable audiobook. That allows one person to use that book at one time, similar to a physical book, and we only have it for two years. So we are constantly having to look at our collections and say, "Oh, do we need to buy that again? Where's the demand?" In a library of our size that is really well supported by the municipality, we do have the ability to get a decent-sized collection together, but if you're looking at $134 for that e-book or $65 or more for another one, and having to continually re-buy those resources, that's a huge burden. When you're looking at print resources, we sort of average about $25 per item; of course, those we keep until they physically fall apart or are no longer relevant. So there's a big disparity in the cost.

If we're looking at leveraging the investment and increasing efficiency, we're buying books for us, Brockville is buying their own, Belleville is buying their own. We do come together and cobble together some sharing. We do share our e-resources with other libraries, but if there was an organization—the Ontario Library Service, which is already funded by the government to provide resource-sharing—to facilitate that at a provincial level, we probably wouldn't need as many copies of things we're buying, so we could get more things. It would also ensure that smaller, rural, more remote communities would have greater access.

Again, in Kingston and Frontenac we also pay for Mango language learning, LinkedIn Learning, PressReader—that's newspapers and magazines from the world.

When we're talking about healthy communities, we need a literate, active society, we need great health care—you've heard lots of stuff. The library touches on all of those things. So we're doing it, and I think we do a really great job, but I think with a province-wide investment, we could really be more efficient and we could provide better service, particularly to those living in smaller and more remote communities.

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Mr. Andrew Dowie: Thank you very much.

Next I'll move to Rob. Thank you to the YMCA for all the support you give to youth and youth programming. I noted in your presentation, there's the one focus—I'm understanding that the predominant theme is on child care.

I do want to explore the instruction for lifeguards. I know we've had cases reported where, say, school groups have gone and there has been a drowning—at least from one case in the city of Toronto. Youth organizations external to the YMCA are looking for lifeguard training. Can you elaborate a bit as to your role in aquatics development and how much impact having support for aquatics programming could have in our broader society?

Mr. Rob Adams: I'll start with the gap it has created first. During our lockdowns, there has been about a two-and-a-half-year lag of a cycle through of youth getting their aquatics certifications. We're the largest employer of youth—one of the organizations with the highest employment of youth. As our lifeguards leave us, as they go to post-secondary school, they then become the lifeguards of the universities and colleges of municipalities, and then we have another feeder system coming through to be the lifeguards of the Y. But because that hasn't happened, all aquatics facilities—not just the Y, but city facilities, university facilities—are having a national lifeguarding shortage.

We're seen as experts in the field of water safety and aquatic safety, which is why municipalities are now looking to us as partners to work their pools or work their waterfronts. We have a graduated swim program system in place that's recognized by the Royal Life Saving Society. So you can get Y lessons or Royal Life Saving Society lessons. From an aquatics safety standpoint, we are seen as that expert to deliver water safety across the province and across the country. To be able to offer that up to school groups, user groups, seniors—because that's another population that we didn't hit on, but it is a very big population that the Y serves—from an aquatics safety standpoint, given the region that we all live in, it's a very important piece that we understand that this is a very important life skill, not just a nice thing to have.

Mr. Andrew Dowie: It's a very commendable youth employment and skills development initiative to get young people to have a career and to feel like they're contributing to society early on.

I'll move to Timothy. Could you describe a bit more about the Kick-Start Innovation Investment Program that the institute delivers?

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

Dr. Tim Smith: Canada really has a fantastic scientific footprint in the space of stem cells and regenerative medicine. The challenge is to try to bring those scientists forward with a potential commercial avenue for their technology before it actually gets published. So Canada has a wonderful scientific footprint.

What we do with Kick-Start is really go out into the community—they're aware of OIRM—and actually introduce them to the road map, give them a road map to follow for a potential commercial opportunity before they necessarily go and publish. That's what we've done with Kick-Start. We brought three companies forward on that basis.

Mr. Andrew Dowie: How much time is left?

The Chair (Mr. Ernie Hardeman): You have 20 seconds.

Mr. Andrew Dowie: Thanks to the presenters. I truly appreciate all that you're doing in your various areas. You're groundbreaking in your own respective ways.

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

Ms. Catherine Fife: Thanks to all the presenters.

Timothy, I want to start with you because you made a very bold statement at the beginning of your presentation about your call to action, really. I'm part of OBIO, with the all-party caucus, and there have been some issues to accessing seed money, start-up money, stage A, stage B—the pipeline in innovation, particularly around medical investment and science investment, is long-standing now. I want to give you an opportunity to share with the committee the human story behind the investment and the true potential to actually hold the jobs here but also improve health care and the quality of that care in Ontario.

Dr. Tim Smith: All of these technologies go through a series of gateways, if you will. The most critical is to get the technology at the level of development that it can move into clinical trials, and that may be through a series of preclinical work, it could be lab bench work, it could be some early animal studies and so on.

From a human perspective, what we work on is having a relationship with the academic pioneers in our community—and that's across Ontario. Through different conferences and so on, they get shown a road map that they can follow to get advice on how to actually take the next step towards a clinical trial. A lot of them have fantastic ideas; they just literally don't know how to move the technology forward.

To give you an example, we sponsored an early technology called Inspire therapeutics. It's a technology involving gene therapy. This is an inhaled gene therapy that transfects the lining of the lungs and can actually cure fatal diseases. There's SP-B surfactant disease in babies where they only live for a few months, and they are 100% cured. Also, cystic fibrosis, a terrible disease where people build up mucus in their lungs because they lack a certain genetic code in their lung lining cells—by inhaling this gene therapy, you can actually fully cure their dysfunctional cells, and they are then cured of cystic fibrosis. So these are life-changing therapies. But it doesn't happen immediately. You first have to get the technologies off the research bench and moving down a path towards clinical trials and commercialization, and Canada just doesn't do a great job of that. We were showing such great success

with $25 million. We brought in a lot of progress across many different technologies. Some have been purchased by Bayer. We're not trying to advocate that we're trying to develop technologies only to spin them off for other global acquisitions, but Bayer purchased one of the technologies sponsored by OIRM, in the very early days, for a billion dollars. The opportunity for leverage on the provincial contribution to trying to educate the community on how to be more like the global community of fostering biotech is hugely important.

Ms. Catherine Fife: That's actually good context.

On the cystic fibrosis example itself—the government finally approved just one of the drugs that can be used with CF, and I think one dose costs $120,000.

Dr. Tim Smith: And that is just symptomatic control; it doesn't actually cure the disease. We're talking about cures.

Ms. Catherine Fife: That's right. That's the important part that I actually wanted you to get to, so well done; well played.

So $25 million—this would be the second round of clinical trials? Is that where you are right now?

Dr. Tim Smith: We had a first round of $25 million, which was distributed across probably 30 different projects. It's not all focused in one clinical trial. We obviously need to try to bring programs forward wherever the greatest need is—and actually, it's reviewed in terms of not only its scientific merit by an independent committee, but also its commercial merit. So we triage all the different applicants, we sponsor something like 30 programs, and it's really to take it to the next stage. If they have animal work, then we can get it to clinical work. If they have bench data, maybe we can get them into animal—and also trying to help them with their IP and making sure that they've got something foundational that you can then create a Canadian company, an Ontario company, around.

Ms. Catherine Fife: Yes, and that's also the goal. We do bleed out a lot of really good jobs because we don't commercialize the research here, and then we export the products and the jobs.

It was very interesting to hear from you today, and I certainly hope that seed money comes. I think that the return on investment—because this is the language that we started using with everything right now, because you have to make the case for that investment, and I think you've done that.

1530

Rob, I'm a huge fan of the YMCA. The work that you're doing in Waterloo region is quite something. The lifeguard skills and the training—we've heard that across the province, especially in some rural and remote communities where they're surrounded by lakes. There's the life skill, but then there's also the job potential.

Do you have an estimate—I didn't catch an estimate—for what you would be asking for for accessing training, so that people can—

Mr. Rob Adams: I don't have a total number on that, but I'll give you an example. For a team to get the proper certification—bronze cross, medallion, NLS and your instructors—you're roughly sitting at around $1,200 per participant, and so the challenge is that it's not insignificant for a youth to pay that out, as a family. Sometimes other opportunities may present themselves, and they'll get going on making some money somewhere else—

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

Mr. Rob Adams: —and they may miss out on—

Ms. Catherine Fife: Okay. That's good. Well, I think that makes a lot of sense. Just so you know, we've heard it in other places.

Laura, I feel like sometimes it's Groundhog Day for the libraries' association, because your asks are simple, you've proven your worth, the digital library piece makes so much sense. But just to echo the fact that libraries have only had status quo for so many years—you have to be getting frustrated a little bit about the ask.

Ms. Laura Carter: I think there is some frustration around the Public Library Operating Grant, and that's the amount that has been frozen for 25 years.

We have seen one-off project grants, certainly, come from the government over the years, but I think just the ability to leverage the funds—

The Chair (Mr. Ernie Hardeman): Thank you very much. That's the end of that explanation.

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

Ms. Stephanie Bowman: I want to pick up again with the OIRM and talk a little bit about—I know with other accelerators and other industries, one of the advantages they talk about is keeping talent here in Canada. Could you talk a little bit about—I know you're not an accelerator; you don't use that phrase, but that kind of model, where you're keeping talent. Can you talk a little bit about that and what this $25 million can do, and other phases of funding?

Dr. Tim Smith: Well, I can tell you in very real terms, because one of my other hats is CEO of these six different biotech companies. We do a lot of outreach to Canadian academic institutions. I would say all of the six primary technology areas that we have at Octane are partnered into one or more Canadian academic institutions, as well as US and European institutions.

What's really important is that the people we work with understand what we as an industry need as core principles, support, analysis, evidence, proof, prototypes, performance records. The Canadian community really struggles with that because they haven't been brought into it; it's not in their nature to actually go into these sorts of collaborations understanding how a corporation really thinks and needs and moves, and the speed.

What OIRM does is to educate and to enable these Canadian researchers, clinicians—very visionary. It's not a lack of competence, vision, capability; it's just a lack of experience in the area of commercialization and business. That's the role of OIRM. So I think that the real change that we're trying to propose here, and we've shown evidence of it, is, once you do that—and Octane is an example of success; we've raised about $500 million through working with communities who really understand how to

commercialize these types of high-tech biotechnology programs.

Ms. Stephanie Bowman: It's very exciting. I love the term "return on investment." You talked about how one grant then fosters a whole bunch of other—or seed funding fosters more seed funding.

Dr. Tim Smith: It's super important to realize that we're funding a pipeline here, and what you fund in the early years pays back more as time goes by. So the first chunk of funding has created all of these opportunities that kind of get stopped. Even though OIRM tries to keep them moving, the next round of funding will generate even more success because of the pipeline fill that we're able to do in the first period.

Ms. Stephanie Bowman: Again, I'm new in my role as an MPP and learning about these processes in decision-making. Did you get an explanation about why the funding stopped? You haven't had funding since 2020, I think you said.

Dr. Tim Smith: Well, I think that there are lots of demands on funding, and I think that there was a decision that needed to be made before there was a critical review of the performance of this particular group. There was a blue-ribbon international panel that reviewed OIRM too late to maintain the funding. I don't understand exactly, obviously, why these things—

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

Dr. Tim Smith: But this international community reviewed OIRM and gave it a very, very good report in terms of its performance globally.

I think we've evidenced that we can achieve these very important goals, and I think we're in a good position to be re-funded.

Ms. Stephanie Bowman: Thank you.

Again, in respect to our library discussion, the digital library—it sounds like it's an existing model. I think some of the libraries I use might tap into that. Is it something that would then allow the funds that are being used right now by those smaller libraries to be redirected into other things that could serve the community, given the increasing demands on libraries?

Ms. Laura Carter: Absolutely. I would say that some libraries probably would maintain some local collections relevant to their own communities, but we could share a broad base—

The Chair (Mr. Ernie Hardeman): I hate to do this again, but the time is up.

Now we'll go to the government. MPP Byers.

Mr. Rick Byers: Laura, I'll ask you a question, to continue.

I'm certainly happy there was a reference, MPP Fife, to Groundhog Day; I very much appreciate that. I was there last Thursday and couldn't join you in Timmins. Fireworks at 7 a.m. and Wiarton Willie at 8:07—it's something to see.

Anyway, Laura, thank you.

And thank you to all the members today for all your work and what you're doing in the community.

Laura, you mentioned provincial funding, unchanged for a long time—message received. Can you elaborate a little bit on your funding sources for your organization? Are they different across library associations across the province, typically?

Ms. Laura Carter: Typically, most Ontario public libraries receive the bulk of our funding through our municipalities. In Kingston and Frontenac, this goes back to 1998 and amalgamation. We have an agreement where the city provides 87% of our funding, roughly, and the county, 13%. The provincial funding grant that we have is somewhat outside of that. That would be true across most Ontario public libraries, First Nation libraries excepted. We're relying on the city or the county, depending on our situation. Again, we've got 162,000 people in our service area, so we have a pretty good tax base to be able to fund these more expensive items. But when you're looking at a very small library, so one branch—we have 16 locations—they just can't afford the resources.

Going back to the pipeline analogy earlier, in terms of the investment, early literacy is linked to all sorts of things—keeping people out of poverty, school success—that drive our economy.

Looking again at what I was saying, we're not then all buying 16 copies of Danielle Steel's latest book; we're looking across the province to say, "How many do we need? How can we free up the municipal, provincial and other dollars to then fund other initiatives?"

Mr. Rick Byers: Thank you very much.

Mr. Smith, thank you for your presentation.

I want to make sure I understand your funding model. You mentioned the $25 million from the province. I think I heard you say there's government of Canada funding as well—is there private sector in addition to that? I'm just curious about the model you have.

Dr. Tim Smith: In OIRM, there isn't a private sector funding per se of OIRM programs. Where the private sector comes in is really getting into the business area to support these companies. For example, this kick-start program—which was initiated in the past year in the absence of Ontario funding—was able to put in $100,000 into three companies. As a result of the $100,000, then we can go out, build a pitch deck and bring in independent third-party funding. For example, for one of them, this gene therapy for the lungs, we're out raising $25 million on the strength of $100,000 from OIRM, and it's likely going to be successful.

1540

Mr. Rick Byers: ROI, as you mentioned.

I'm passing to Mr. Smith.

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

Mr. David Smith: First, I would like to speak to Laura. I want to thank you. Libraries have always been a part of the community, and I know the source of your funds—most of it is coming from the local municipality.

What percentage of your overall budget is coming from the province?

Ms. Laura Carter: For the Kingston Frontenac Public Library, it's approximately 3% that we get directly from the province.

Mr. David Smith: And it has been frozen for 25 years?

Ms. Laura Carter: That's correct.

Mr. David Smith: I'm very concerned, because I know that reading, writing and learning to do a lot of things take place in a library, and everyone must have access to that. I know that we are working on a plan right now, and our government is continuing to expand broadband, so I'm hoping that it gets to you and you don't have to give back—whatever you just said, that you plan to give back that money. That feels heartbreaking in my mind.

Rob, I learned to swim at the Y. I've done a lot of stuff at the Y. When I'm not being as good as I'm supposed to be, my mom sends me to the Y. So I'm looking forward to seeing how best we can support those needs that you have, that are for the community, so that we can take it back and put it in to get some assistance for you.

Dr. Smith, you happen to have the same last name as me and my brother over here. I want to let you know that I'm very concerned and happy for what you're saying, because we've got so many health pressures, and the stem cell appears to be the way of the future. A lot of the conventional ways we used to do things, from what I'm seeing—and I'm taking a strong path in that, because I played football, and I've got some pains right now that need to get some of those stem cells, so I'm here trying to determine: Should I replace my knee, or should I go stem cell?

I'm very concerned with all that research and development, and I hope Ms. Fife is not correct when she says that the products and the jobs are going to go. We want those jobs to stay right here, so we want to make sure that we answer your call. I'm actually surprised, in those types of research and development, that we're just talking about $25 million.

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

Mr. David Smith: I see that as way more than that—so you're really putting things together with your six sorts of persons who are doing those experiments and all that.

I'm looking forward to the day when we can have more operations taken to replace the surgical knife, if you can avoid it.

Dr. Tim Smith: That's happening now in one of our products at Octane—knee replacement. Your own cartilage returns, so you don't actually have to have a metal or plastic knee, and that happens a lot earlier in your football career.

The key thing is that California, for example, just got renewed $5.4 billion for stem cells—and we're talking about $25 million. But it doesn't matter; what we're really doing is priming the pump here. We're getting technologies into commercial venues that otherwise just wouldn't even occur. Even $25 million in a Canadian context is hugely, hugely significant. I know that from the point of view of running my own businesses. If you can just—

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

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

Mr. Terence Kernaghan: Thank you to our presenters here today.

Dr. Smith, I want to thank you for appearing at the committee and for what you've brought forward to us. It's a clear example of solutions that are made in Ontario, something this government should favour. With the noted return on investment, I'm very pleased to hear assurances that we just heard from this government that they do plan on investing. That's wonderful news.

My question will be for Laura. You've presented an important case, and we've heard throughout the province how it has been a quarter century of no funding change for libraries, despite how cost-effective they indeed are. You were speaking earlier about the Ontario digital library. I remember back in the day when there were interlibrary loans. Could you please explain to this government once again how an investment of this type would be effective and how it would be something that all library locations could leverage?

Ms. Laura Carter: To back up one step, I would say, 10 years ago, the Toronto Public Library did an economic impact study, and at that point they said $5.63 of return on investment for every $1 invested—and that was just in the Toronto Public Library. So then if we look at that on a provincial scale—as you alluded to, we continue to do interlibrary loan across the province now. If we're looking at it from a digital point of view, it levels the playing field to give everyone access to these vital resources. We've got language learning, we have coding, we have other soft skills that you need in the job market. We have a 3-D printer at the library, for example, to get people interested in those careers that will drive our stem cell research.

In terms of how it will work, the Ontario Library Service already delivers province-wide programs. So we streamline the staff investments. Right now, we're all talking about how we can share—we're all trying to look for money. They administer the program, and we provide our expertise. Everyone gets the benefit, rather than this patchwork quilt.

We have quite a good collection, if I do say so myself, but a very small, one-branch library not that far from here cannot afford anywhere near the resources that we can afford.

Mr. Terence Kernaghan: So it would be an initiative that would benefit those small, rural libraries as well as larger municipalities.

I was also hoping you would explain for the committee how a maker space—or, I believe with your location, it's known as a Create Space—provides an introduction to working with your hands, to the trades and how it's part of an integral pipeline that would help this government achieve its stated goal of membership in the trades.

Ms. Laura Carter: Thank you very much for that question.

We just had, this past weekend, a repair café program. We had local makers, fixers, experts, and people brought in whatever their project—I saw some bikes; there was a clock; there was a light. So not only do they keep those items out of landfill, but they help those people learn how to fix those items. We did it for adults, and we also did one for kids to show, how does this work, how can you use your hands and an introduction, one on one, to these experts in our community who, like you say, may be working in the trades or may be working in a variety of different settings.

We run those sorts of hands-on—sewing, carpentry, knitting, and then we also do the digital design and creation of a product. So a child can design an object, come in with an adult, use the 3-D printer and actually see it happen and see how those skills that they're learning and coding can actually be tangible.

Mr. Terence Kernaghan: After the removal of shop classes from schools in the late 1990s, those opportunities do not exist within elementary schools—except for within public libraries. So thank you very much for that.

Rob, I want to thank you for all the work the YMCA does. It is truly phenomenal.

Do you think it's important for the government to prioritize licensed, not-for-profit child care, as opposed to a for-profit model?

Mr. Rob Adams: It would be very hard to justify paying for-profit child care providers when it's just revenue to them, whereas we're trying to operate with thin margins, as it is, as a registered not-for-profit charity. So we're just looking to cost-recover and help pay for administrative costs to make it affordable for all families. If you don't separate the two, then it's just really going into the pockets of the operator for a for-profit operation, where it doesn't do that with the Y. From a charitable standpoint, our mission is to, obviously, be healthy, vibrant and sustainable, but everything we do goes back into the community. That's just child care. The Y has evolved over time. We're far beyond a pool and a gym, what traditionally some people recognize us as. Even in this area, we provided housing before—newcomer services, employment and education and housing. As the pandemic has shown, particularly in this area—these are things that we're looking at now. The Y is much more than just a for-profit child care provider; we're meeting the needs of the community. I think that's the biggest difference.

1550

Mr. Terence Kernaghan: When money is allocated for care, it should go towards care, not towards someone's profits.

Also, why is wage parity important?

Mr. Rob Adams: Wage parity is important because we're seeing—before the pandemic, we were seeing a drain from seeing people enter the early childhood education field—

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

Mr. Rob Adams: —coming to the Y to gain experience, and then they would often leave to go to school boards or those sorts of areas where—again, funded very differently than the YMCA. From a wage parity—I don't think the YMCA would expect a total wash, but to close the gap would make us more competitive, more attractive when it—working for the Y comes with other benefits as well.

Mr. Terence Kernaghan: Most definitely.

Thank you to all our presenters for coming today.

The Chair (Mr. Ernie Hardeman): That consumes all the time for this panel. We want to thank you again for all the efforts you went through to prepare for this and to be willing to sit up and tell us what all your deliberations came to. Thank you very much for being here. We very much appreciate it.

CUPE ONTARIO

The Chair (Mr. Ernie Hardeman): We now have the one presentation that the committee has been waiting for all day, that being the last one. We have CUPE Ontario. I see Fred making it to the table.

Thank you very much for being here. As I've been telling every panel, you'll have seven minutes to make your presentation. At six minutes, I will say, "One minute," and then I will cut it off at seven minutes. And then we will have the circulation for the questions.

With that, the floor is yours. Please state your name for the record when you start.

Mr. Fred Hahn: Thanks very much. My name is Fred Hahn. I'm the president of CUPE Ontario. CUPE represents 280,000 members in the broader public sector who perform every service imaginable. These workers remain on the front lines of public services while the pandemic continues. Despite claims that we're done with COVID or that we need to get back to normal, last year more Ontarians died from COVID than in any year past.

Coupled with this continuing public health crisis, our members and their communities are facing an unprecedented cost-of-living pressure. Thousands could lose their jobs and/or housing due to rising inflation rates. Within the last six months, one in five Ontarians have found a meal at a community organization like a food bank. Ontarians are watching, and they desperately need support in the next budget.

The truth of the matter is, Ontario's economic outlook has dramatically improved. According to a report just released this morning from the Financial Accountability Officer, Ontario's budget will have a surplus of $1 billion in 2023-24. Astonishingly, that same FAO report projects a total funding shortfall of $7.1 billion over three years in five main important sectors, most notably a shortfall of $5 billion in health and $1.1 billion in education. How can that be? It's because of an accounting change made by the government allocating $19.7 billion to other programs, contingency funds.

The FAO and the Auditor General have remarked on this accounting change. According to the provincial Auditor General, the government is overstating expenses, leading to a perception that the government has less funds available for decision-making than can be reasonably expected. Ironically, at the same time, this accounting change allows the government to claim it is spending record amounts, when in fact most of those resources are being targeted to the services Ontarians rely on most. This false picture of the economy works its way into our communities with starved public services, challenging labour negotiations, but it undermines the legitimacy of the budgeting process itself, and it erodes public trust. In fact, a recent survey highlighted that 58% of Canadians believe their government leaders are purposely trying to mislead them.

The FAO report released today does show that there is ever-increasing economic room to directly fund budget lines for public services. It forecasts a $7.6-billion budget surplus by 2027-28. But despite these positive fiscal circumstances, program spending, outlined in the 2022 budget in its future projections, paints a different picture: deep austerity in various sectors, not reflecting the public service challenge we face or the government's capacity to meet them.

Budgets are about choices. They're more than an expense-allocation exercise; they should reflect our values and show that government understands the needs and demands of the public.

CUPE members are left frustrated by a lack of commitment to public services, to the work they do. Since the Conservatives were re-elected, our members and their families and friends have all seen and heard the same things:

—the Financial Accountability Officer reporting, time and again, underspent budgets in the billions;

—a government passing reforms to diminish the ability of municipalities to fund services and build infrastructure, found deeply troubling by municipal leaders, including the Association of Municipalities of Ontario;

—a plan to privatize public hospital services that will only serve to poach staff in the public system and end up costing us all more as profit gets factored in; and

—the worst recruitment and retention crisis in the public services in a generation.

Ontario continues to spend the least in program spending per capita when compared to other provinces. For five of the last 10 years, Ontario has spent the least, and in the other five years, it spent the second-least. If we spent just the rest of Canada's average per capita, it would have amounted to an additional $27.4 billion in program spending last year alone. Ontario also spent second-least in program spending relative to GDP compared to other provinces. If we spent Canada's average of the rest of the provinces, 21.5% of GDP, that would amount to $42.6 billion in program spending, and we can afford it.

We're at a time of enormous corporate wealth and profits. Last year, corporate profits went up 14.8%; the year before, 24.2%. If Ontario raised the corporate tax rate just 1%, from 11.5% to 12.5%, it would raise an astonishing $3.7 billion annually, and we'd still have less than the average of the corporate tax rates across the country. Notably, this one measure, in just one year, would generate almost double the money the government itself reported that it saved over four years with wage suppression in Bill 124.

Without a substantial increase in funding targeting wages and a repeal of Bill 124, staffing shortages will not abate any time soon, and public sector staffing shortages will continue to grow, adding to the already 380,000 jobs currently unfilled in Ontario.

The government has cut its ability to react to ongoing economic challenges. According to the Canadian Centre for Policy Alternatives, the government has introduced over $8 billion in annual tax cuts since coming to office in 2018. The reversal of these tax expenditures, reallocating funds toward public services, would substantially benefit Ontarians.

We will have a full spectrum of analysis and recommendations for you in our written submission, but I want to provide just a taste of a wide range of recommendations that our members, who are on the front line of public services, are hoping to see in this budget. They include:

—real rent control coupled with targeted funding for municipalities to build more affordable housing and create more shelter options;

—an immediate doubling of ODSP and OW rates for a start, with indexing to inflation built into the future;

—increasing funding to public schools to enable much-needed hiring of additional support staff, like education assistants and custodians, who provide the supports our kids need to succeed—

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

Mr. Fred Hahn: —funding our public hospitals to enable the use of closed operating rooms, increasing health care workers' wages and funding the promise of four hours of care in long-term care with more permanent, full-time jobs;

—fighting the cost-of-living crisis by protecting working people's incomes with real cost-of-living adjustments funded and targeted to wages throughout the broader public sector; and

—finally, making life more affordable, a real return on investment, to fund public services that are publicly delivered to keep pace with inflation and population growth.

It allows for good full-time jobs, strong public services, post-secondary, social services, education and health throughout all of our communities. These are the things that we need, and we have the room to do them. Now is the time to make this change.

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

We'll start the questions with the government side. MPP Triantafilopoulos.

1600

Ms. Effie J. Triantafilopoulos: Good afternoon, Mr. Hahn. I've got a few questions I'd like to explore with you through your presentation. I know that you went through it rapidly, but you did say there's also going to be a written submission that you're going to give us. That's terrific.

What I wanted to first talk about was our government's commitment, particularly through the health crisis we've experienced coming out of COVID. It's my submission that we've actually made historic investments in hospitals, with an additional $3.3 billion this year alone, bringing the total investments in hospitals to date to $8.8 billion since 2018, when we were first elected. In addition, in 2022, our government invested $182 million to support critical upgrades and repairs at 131 hospitals and 65 community health care facilities across the province. This is in addition to the $1 billion we're investing over the next year in 50 major hospital projects across the province. So I'd like to ask you, doesn't this demonstrate a significant commitment to the future of our public hospital system?

Mr. Fred Hahn: There's no question that those numbers sound, on their own, incredibly impressive. What's challenging is that they don't factor in and they aren't compared to the realities of inflation in the health care system. Inflation in the health care system rises faster than inflation in our communities. We've always known this—in fact, the Ontario Hospital Association and others have talked about this, with your government and previous governments—and there's population growth and acuity factors to factor in. It's remarkable that this seeming increased funding isn't meeting the needs in our communities. We can see this, with hallway medicine in hospitals; with people waiting hours, sometimes days, in emergency rooms; with people being on cots in hallways. It is the job of the Financial Accountability Officer of Ontario to look at budget projections over the next number of years. A report released just this morning says there's a $5-billion shortfall in health care funding, and I think people are experiencing that in our communities. It's ringing less and less true.

I know a lot of the presentation I made today was about numbers. People talk about numbers during budgets. But the truth of the matter is, the proof is in the pudding in terms of what people are experiencing in their communities. They're seeing operating rooms that are closed because there aren't enough staff to operate, and they're hearing the government talk about wanting to move surgeries out of hospitals into for-profit facilities. It's quite clear that people don't think this makes sense, and it's quite clear that there's the ability to actually change course here and invest in our public hospitals, invest in staff in public health care, ensure that their wages actually help to keep pace with inflation, and make sure that the supports communities need are there so that we don't have emergency rooms that are closed, we don't have maternity wards that are closed, we don't have people having to drive hours and hours to get primary care. That is the reality on the ground in far too many places in Ontario, and it is within the government's ability to make a real change in this budget to that reality.

Ms. Effie J. Triantafilopoulos: One of the things I will agree with you on is that we in fact inherited a broken system. The investments that should have been made by previous governments had not been made. They hadn't been made in terms of human resources, recruitment and retention. They hadn't been made in long-term care, as you so well know. They hadn't been made in infrastructure. So not only did we have to, as a government, address the pandemic, but we moved on all fronts to address those challenges and those deficits.

One of the things I want to talk to you about, too, is the whole issue around long-term care. As you know, we had a waiting list of 38,000 people waiting to get into long-term care. For decades, previous governments had promised four hours of direct care for long-term-care residents. Well, we listened to you and to other organizations, and we delivered on that commitment. It's part of our legislation today. As a result of being able to move to four hours of direct care, we also are recruiting 27,000 new personal support workers and nurses to be able to fill those spaces. So I would put to you again: We are well on our way to taking care of our seniors and our most vulnerable in society. Perhaps you could respond to that.

Mr. Fred Hahn: I appreciate the question, and I think that the question of human resources is incredibly important.

Your government passed Bill 124, which capped the wages of health care workers, which made it incredibly difficult for people to continue in those jobs. It made it impossible, in many cases, for the hiring of full-time workers. It hasn't done anything to encourage the hiring of full-time workers. We still have literally thousands of members working in long-term care who don't have access to paid sick leave because they're not considered full-time, and yet they're working full-time hours—part of the funding problem.

It is good to know, and we were deeply happy to see a move to recognize the need to have full-time care—four hours of hands-on care, legislated in the law. The thing about it is, it needs funding to back it up, and it also needs a comprehensive human resources strategy. Hiring 27,000 folks—

Ms. Effie J. Triantafilopoulos: We've actually put $5 billion of funding in order to resource it properly with staff.

Another question that I'd like to put to you is on this whole issue around new nurses being able to be recruited. As you know, 12,000 new nurses were registered to work in Ontario last year, and another 30,000 nurses are studying at community colleges and universities as we speak. As we move forward in the coming years, we're going to bring all of those new nurses online.

We've also been able to incentivize the colleges and universities, and are offering free tuition to those individuals who want to work in rural and remote communities. We know there's a great need in northern and rural communities. We've just come from northern communities, and we've heard that. We are making the investments we have to make, and I believe that nurses are coming into the sector accordingly, irrespective of whether Bill 124 is in place.

Mr. Fred Hahn: Well, what we're hearing from their representatives—we're hearing from front-line nurses is something quite different—

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

Mr. Fred Hahn: Hiring 27,000 PSWs and nurses in long-term care sounds laudable, except when 35,000 folks are leaving the sector every year based on retirement and the burnout that's happening as a result of the crushing workloads and working short every shift. It is a real challenge. Again, numbers are important, but they have to be compared against the reality.

Ms. Effie J. Triantafilopoulos: I understand.

Mr. Fred Hahn: Anyone who goes into a long-term-care facility today—I can guarantee you this—in your riding, or in your riding, or in your riding, or in yours, will be working short-shift, they will be working with agency staff. There aren't enough folks to do this important work,

partly because their wages are chronically low, partly because the workloads are incredibly crushing.

The commitment on paper to four hours of care is important, but it is only on paper. It doesn't exist without real funding, without a real human resources strategy that includes full-time jobs, that gives people access to paid sick leave, benefits—

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

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

Ms. Catherine Fife: Thank you, Mr. Hahn—thank you, Fred.

When I was in the briefing this morning with the FAO and I saw those numbers come up—year after year after year of deliberate, intentional underfunding in health, in education, in justice. In the report it said that over the next three years we found that the province has allocated a cumulative $19.7 billion in excess funds to other programs, which is unallocated. It's a huge contingency fund. It definitely affected the way that I was working here today, because we started the day off with the mayor of Kingston saying, "Is there money?"—and there is. There is money for these programs. We heard from the FAO today that even if the government chose, at the end of this budget cycle, to top up this in-year deficit, this in-year underspending, that would not impact the economic outlook for the province. So it's not only the right thing to do; the money is there.

What does that say—because we've heard about Bill 124; the government absolutely is digging in on it. In fact, they're in court. But not one presenter, over all of these dates, said to us, "Bill 124 is a good piece of legislation, and it's helping us in health care and education"—not one presenter. The retention and recruitment issue that your members are facing has to be completely demoralizing. We're going to keep fighting, obviously. But what does it say about the mindset of this government as they go, cap in hand, today, to the Prime Minister, asking for more money that's not enveloped and has no strings attached?

Mr. Fred Hahn: It feels as though there's a deep disconnect between some of you who are sitting in Queen's Park and what's happening in our communities. I would encourage everyone to think about going to their local hospital and just spending some time there. Again, you're going to see that people are working short-shift, people are run off their feet. You're going to see people in hallways, on gurneys. And it doesn't have to be this way.

1610

It is deeply troubling that when so many Ontarians are dealing with a cost-of-living crisis the likes of which many of us have not seen in decades, that when they need care, when they rely on their kids to be in good-quality schools, when they need affordable child care, when they need important services in their communities, they are told time and again it just isn't possible, when in fact we see that there's money available and that there are surpluses at government, and when there are budgeting processes that have billions of dollars put into funds that are unallocated, making it sound as though the overall expenditures are growing and that things are working, except that money isn't being dedicated on the ground to the things people actually need.

I really want to talk about corporate taxes for just one minute, because I think it's startling—this was also part of what the FAO reported this morning. A 1% tax increase could raise $3.7 billion in one year alone, more than four times—more than four times—what the government itself claims to have saved by suppressing people's wages over four years with Bill 124. There are ways to do this; there is money available today, and there is money available in our systems that could be redirected in a way that would actually help business and help corporations. When we increase people's wages, they spend it in their local communities. They help local small businesses. It would be good for our economy.

Ms. Catherine Fife: Yes, absolutely.

I'm going to pass over to MPP Kernaghan, Chair.

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

Mr. Terence Kernaghan: Thank you, Fred, for coming to present at committee today. And thank you for pointing out what the Financial Accountability Office has revealed about this government.

With these accounting changes, does it remind you of a shell game?

Mr. Fred Hahn: Yes. I think people care deeply about the services they rely on in their communities, and they trust that the government is doing its best to actually provide the resources necessary to provide those services. But when there are ever-increasing amounts of money being diverted into funds that are simply contingency funds that aren't allocated, when those funds often, in many cases, are spent in other ways or not spent at all, when people see ever-increasing needs in their communities, both in their local hospitals and in their long-term-care facilities where their parents and grandparents are, and the need for affordable child care and their kids' school—how many times do we have to go to the parents to fund programs that used to be delivered by the school, for Pete's sake?

People do their best, and they count on the government to do its best, but it does seem like there is an ideological block here. When there's money available, when the economy is generating that money for government, the role of government is to spend that money to assist in public services that help everyone and therefore help the economy. Talk about return on investment: Every dollar spent on public services generates many multiple times that in communities and in value for the people of Ontario. It's what the next budget needs to show—a real commitment, moving money away from these unallocated funds, actually allocating money and spending it on the services people rely on.

Mr. Terence Kernaghan: I think it would be easier for Ontarians to understand, if there wasn't the $5-billion shortfall in health care spending and the $1.1-billion projected shortfall in education spending over the next three years—that there would actually be money placed in these contingency funds.

I did want to ask, did you know that money can be placed in these contingency funds and spent without any scrutiny or oversight?

Mr. Fred Hahn: Yes. This is an important point that I had hoped to be able to raise, because they're different—these contingency funds—aren't they? There's no requirement to come back to the Legislature.

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

Mr. Fred Hahn: There's no requirement to actually be accountable for the ways in which—we're talking here about billions of dollars being put into contingencies that have enormous discretion by government. And I suppose if they were actually spending that to make sure we didn't have hallway medicine, if they were increasing the wages of health care workers so that they weren't leaving our public health care system in droves, if they were using it to invest in public, not-for-profit child care spaces, maybe we wouldn't feel so upset about it. But that isn't, it seems, what they're doing, because it's a very different reality on the ground.

Mr. Terence Kernaghan: Absolutely.

With the estimates process, typically we have 15 hours to scrutinize the estimates by this government. Unfortunately, because of some changes by the government, we received only 20 minutes of scrutiny—15 hours, and there was only 20 minutes provided to the official opposition to go line by line to take a look at the estimates process. That's even though we reached out and tried to schedule times, gave plenty of notice—

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

We'll go to the independents. MPP Brady.

Ms. Bobbi Ann Brady: Mr. Hahn, thanks for appearing today.

I get a bit confused sitting through all these delegations because we hear from folks who say, "Well, it's an employee problem; we don't have enough employees." I hear you say this is a money problem. I hear my colleague across the way talk about the increased funding that the government has put forth. So I'm left scratching my head and I can't help but wonder, is this a money problem or is this how we spend the money? Continually throwing money at a broken system, whether it's health care, education, whatever, doesn't make the problem better. We've seen that in the past.

We all see that education is in crisis, we see health care in chaos, and I don't understand it, because we see it and yet there is no plan to fix it other than to throw more money at it. I don't see that as a plan. It's not working. It hasn't worked in the past.

My constituents say to me, "It looks like this chaos is being created purposefully." How do you feel about that sentiment and my idea that you can't continually throw money at broken systems?

Mr. Fred Hahn: I think that when you hear from folks that there's an employee problem and from folks like me that it's a money problem, those two things are linked. There's a reason why we're losing PSWs in long-term care: Their wages aren't keeping pace with inflation, they don't get access to full-time work, and their workloads are crushing. There's a reason why nurses are leaving our public health care in droves: Their wages haven't kept pace with inflation, and they can go to the private sector and use their skills and talents and make more money. So there is actually a money problem that leads to a staffing problem.

Our systems can and should be continuously looked at for improvement, but to say that a broken system deserves no more money—I fear it sometimes could lead people to say, "Well, then why don't we go to private sector alternatives?" So I just want to circle back to the idea that moving surgeries out of public hospitals into private facilities will only serve to make the system worse because it will drain more staff from the public system and it will absolutely cost more as profit is factored in. We saw this so clearly and in such a stark way during the pandemic when it came to for-profit long-term care, where more seniors died, where more staff got sick, where more staff died, frankly.

Ms. Bobbi Ann Brady: I'd just like to clarify, Mr. Hahn, that I didn't say that I don't believe in more money going towards broken systems, but you have to understand what the problems are in that entire chain of events in order to apply more money to it. If you don't know what those problems are and you don't know exactly how you're going to fix them, then I'm not sure that money, at that particular time, is the right thing to do.

Mr. Fred Hahn: We have one of the most—in fact, the leanest spending on public services per capita across the country. I said this in the presentation—that for five out of 10 years, we were the lowest, and the other five we were the second-lowest spending per capita on public services. We have the largest population and in many ways, the most diverse population in terms of the size of our province, the range of our province, and yet we spend the least amount on public services. It doesn't make sense, and so this idea—

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

Mr. Fred Hahn: —that we hear, that things are broken—things are broken because they aren't funded properly. Things are broken because there isn't accountability. Things are broken because we're not actually funding services the way people need them in our community.

Ms. Bobbi Ann Brady: Thank you. My colleague has a question for you.

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

Ms. Stephanie Bowman: Thank you, Mr. Hahn, for being here. I really appreciate your passion for your work as well as the excellent presentation you did.

You used the words "accounting change." I'm a chartered accountant, and when I hear that, I think about a "rule change." So I just want you to think about it in a different way. I'm going to suggest you think about it as a slush fund. It's actually not an accounting change; it's a slush fund, and that is a problem. It does create a lack of transparency.

The government, as has been pointed out, certainly, by the opposition—there is the money there, and certainly we don't want to waste money, as MPP Brady has said, and spend it on the wrong things. We want to spend it on the right things. Any—

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

Any further comments? No further comments.

We want to thank you very much for coming in and sharing your thoughts with us and for the time it took you to prepare and, obviously, to come here.

I want to thank all the presenters who have presented today.

As a reminder, the deadline for written submissions is 7 p.m. on Tuesday, February 14—

Interjection.

The Chair (Mr. Ernie Hardeman): You had something?

Ms. Catherine Fife: Yes, I do. I have a motion, but I was just going to let you finish.

The Chair (Mr. Ernie Hardeman): As a reminder, the deadline for written submissions is 7 p.m. on Tuesday, February 14.

And now I'd better stop there, if you have a motion.

Ms. Catherine Fife: Thank you very much, Chair. It has been a good day.

I just want to say that most of us now have seen the extensive list that came through of delegations for Toronto. It is seriously oversubscribed, and so I do have a motion proposing that we add an additional day. I realize it's last-minute, because we just got this, and so I'm happy to read the motion into the record for consideration tomorrow, if that's amenable.

The motion reads as follows:

I move that the Standing Committee on Finance and Economic Affairs meet for pre-budget consultations on February 15, 2023, from 10 to 12 and from 1 until 6 p.m.; and

That the witnesses who requested to appear for pre-budget consultations in Toronto who could not be accommodated on February 14, 2023, be invited to appear in Toronto during the allotted time; and

That witnesses appearing be permitted to participate in person or participate remotely; however, a maximum of one individual may appear in person on behalf of an organization, and any additional representatives of that organization shall participate remotely; and

That witnesses shall be scheduled in groups of three for each one-hour time slot, with each presenter allotted seven minutes to make an opening statement, followed by 39 minutes of questioning for all three witnesses, divided into two rounds of seven and a half minutes for the government members, two rounds of seven and a half minutes for the official opposition members, and two rounds of four and a half minutes for the independent members of the committee as a group.

I'm happy to forward this to the Clerk so that we can circulate it to all members. Is that amenable? It would be in order to talk about this tomorrow, because we only have two hours of delegations tomorrow. Is that right?

The Chair (Mr. Ernie Hardeman): Any comments?

Mr. Stephen Crawford: To the member opposite: Perhaps the Clerk could print it and we could look at it and discuss it tomorrow morning?

Ms. Catherine Fife: That's right. That's what I'm proposing.

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

Mr. Dave Smith: So this is not a motion that's being moved? Because my understanding is that we cannot—

The Chair (Mr. Ernie Hardeman): The motion is being tabled with the Clerk for further discussion. Did I get that right? Did you want to move it today?

Ms. Catherine Fife: I wanted to give the government members time to read the motion, and if they're amenable, we could discuss it tomorrow.

Mr. Dave Smith: So it's not being moved? The reason I'm asking that is because my understanding procedurally is that we cannot adjourn as long as there is an open motion on the table. You're simply presenting it to us for discussion? You're not moving it?

Ms. Catherine Fife: I did read the motion, that I move it, but the Clerk said that was fine.

The Clerk of the Committee (Ms. Vanessa Kattar): If the committee is okay to consider it tomorrow morning, I'll put it on the agenda for tomorrow morning.

Ms. Catherine Fife: Okay.

Mr. Dave Smith: Sure.

The Chair (Mr. Ernie Hardeman): It hasn't been introduced; it's just going to be left with the Clerk for circulation.

As you all know, normally in committee, when something is moved, the first thing we do is ask for it to be printed so we can all see it. If we did that now, that would have been done, but then we wouldn't have given it to anybody, because we wouldn't have been here, so I think we're doing it the right way. We'll get it, the Clerk will have a copy and everybody can study it in the evening, and then we'll deal with it tomorrow.

Ms. Catherine Fife: Okay. Use that gavel, please.

The Chair (Mr. Ernie Hardeman): With that, the committee is now adjourned until Wednesday, February 8, in Peterborough.

The committee adjourned at 1624.

STANDING COMMITTEE ON FINANCE AND ECONOMIC AFFAIRS

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