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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

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ORDERS OF THE DAY

YOUR HEALTH ACT, 2023

LOI DE 2023 CONCERNANT VOTRE SANTÉ

Resuming the debate adjourned on April 27, 2023, on the motion for third reading of the following bill:

Bill 60, An Act to amend and enact various Acts with respect to the health system / Projet de loi 60, Loi visant à modifier et à édicter diverses lois en ce qui concerne le système de santé.

The Deputy Speaker (Ms. Donna Skelly): I recognize the member for Stormont–Dundas–South Glengarry.

Mr. Nolan Quinn: Over 60,000 new nurses and nearly 8,000 new doctors have registered to work in Ontario. In fact, last year was a record-breaking year for new nurses in Ontario, with over 12,000 new nurses registered and ready to work, and another 30,000 nursing students studying at a college or university, providing a pipeline of talent and reinforcements.

But we know we need to do far more, and we're doing more. Hiring more health care professionals is the most effective step to ensure you and your family are able to see a health care provider where and when you need to. Well-trained and well-supported doctors, nurses, personal support workers and more are the people you rely on when you need care.

Here's how we will hire more health care workers to provide more care: By expanding the Ontario Learn and Stay Grant, we will address the unique health care challenges of small, rural and remote communities by recruiting and retaining health care workers in these regions through a dedicated approach.

Last spring, we launched the Ontario Learn and Stay Grant to help these communities build their own health work forces. This program covers the costs of tuition, books and other direct educational costs for post-secondary students who enrol in high-priority programs in more than a dozen growing and underserved communities and commit to work in these communities when they graduate.

This year, we're expanding the program, beginning in spring 2023, targeting approximately 2,500 eligible post-secondary students who enrol in high-priority programs such as select nursing, paramedic and medical laboratory science at the diploma, advanced diploma, undergraduate, master's and post-graduate levels. We're making it easier for health care workers who want to live and work in Ontario. We are significantly reducing unnecessary bureaucratic delays and bringing reinforcements to the front lines of our health care system.

With new as-of-right rules, Ontario will become the first province in Canada to allow health care workers registered in other provinces and territories to immediately start caring for you, without having to first register with one of Ontario's health regulatory colleges. This change will help health care workers overcome excessive red tape that makes it difficult for them to practise in Ontario.

We will also help hospitals and other health organizations temporarily increase staffing when they need to fill vacancies or manage periods of high patient volumes, such as during a flu surge. This will allow nurses, paramedics, respiratory therapists and other health care professionals to work outside of their regular responsibilities or settings as long as they have the knowledge, skill and judgment to do so, providing hospitals and other settings with more flexibility to ensure health care professionals are filling the most in-demand roles at the right time.

At the same time, we are continuing our work to make it easier for internationally trained health care professionals to use their expertise here in Ontario. We are working closely with regulatory colleges, including the College of Nurses of Ontario and the College of Physicians and Surgeons of Ontario, to make it easier and faster for qualified health care professionals to work in Ontario. We are working with these regulatory colleges to ensure health care professionals are properly trained and qualified without facing unnecessary barriers and costs, including requiring colleges to comply with the time limits to make registration decisions. These innovative actions will ensure that our health care system has the staff it needs, when we need them.

Finally, we're bringing the right care to the right place. When people have health care available in their communities and in ways that are convenient for them, they are more likely to seek and receive the treatment they need, when they need it, and stay healthier. Delivering convenient care to people in their communities will help keep Ontario healthier by diagnosing illnesses earlier, starting treatment as soon as possible and keeping emergency room wait times down when you or your family need urgent care.

Whether you need antibiotics to treat your bladder infection or medication for your child's pink eye, being able get those prescriptions at your local pharmacy saves you a trip to the doctor's office or emergency room—or

whether your parent is aging and you need support to keep them at home. This care will be more will be more convenient for you and take pressures off of other areas of the health care system, like doctor's offices, emergency rooms and long-term-care homes.

Pharmacists in Ontario are highly trained, highly trusted and regulated health care professionals. They are often the closest, most convenient option for health care in communities across Ontario. Throughout the last few years, pharmacists played a critical role in supporting patients across the province by supporting COVID-19 testing and vaccination efforts, and educating patients about medication and treatment options. Pharmacists continue to offer families the kind of convenient care close to home we know Ontarians are looking for.

We are expanding the role of pharmacists by increasing their scope of practice, so that you and your family will be able to connect to care closing to home at your local pharmacy. As of January 1, 2023, pharmacists are able to prescribe medications for 13 common ailments to patients across Ontario, and through our recent budget, we've added six more ailments that they will soon be able to treat. These medications treat everyday health concerns like rashes, pink eye, insect bites and urinary tract infections. Visiting your pharmacist to assess and treat these common medical conditions can save you a trip to the doctor and give family doctors more time for appointments with patients who need more specialized care for more serious concerns.

As with visiting the family physician or walk-in clinic, there's no extra cost for Ontarians to receive a prescription from a pharmacist for common ailments when showing an Ontario health card. I know my constituents, like the over 100,000 Ontarians who have accessed these services so far, appreciate that they can get more care closer to home.

In closing, I would like to ask for all members of this House to support Bill 60 to ensure a strong future for our health care system across the province.

The Deputy Speaker (Ms. Donna Skelly): It's now time for questions. I recognize the member for Hamilton Mountain.

Miss Monique Taylor: I had the opportunity to listen to the member this morning and to hear him finish his debate now, but I still have several concerns about what this bill will do to the staffing shortages that we see in our hospitals. We have seen privatization continue to filter into our health care system under the watch of this Premier, and we are seeing recruiting by those privatized companies, swooping in and swooping up our nurses from the public system, as well as PSWs from the public system.

Does the member not believe that privatization is actually making our public health care system the crisis that they're trying to create?

The Deputy Speaker (Ms. Donna Skelly): Back to the member for Dundas-Stormont-South Glengarry for a response.

Mr. Nolan Quinn: You got all the words.

Our government has launched the largest health care recruiting and training initiative in the province's history. Building on the 12,000 new nurses registered to work in the province last year, our government is investing into a range of initiatives to track, train and retain more nurses and to get them into the system sooner, including $342 million to add over 5,000 new and upskilled registered nurses and registered practical nurses as well as 8,000 new personal support workers. We also expanded the Ontario Learn and Stay Grant for health care graduates to receive a full tuition reimbursement in exchange for committing to practise in an underserved community.

The Deputy Speaker (Ms. Donna Skelly): Further questions?

Mr. Rob Flack: I always enjoy listening to my colleague speak, and I look forward to being with him next week in Pembroke, Ontario, as we go through the veterinary consultants' modernization act. You're doing great work.

I find it interesting in this debate all the time—doctors run their own businesses. They have for years. I hope they would agree with that. Help me understand something: When we talk about privatization, we've constantly said on this side of the House that you don't need a credit card, you just need your OHIP card. We're creating improvements day in and day out to stop the backlogs across this province. What is this province going to do to prevent extra billing so our opposition members can be relieved of their fears?

The Deputy Speaker (Ms. Donna Skelly): Back to the member from Stormont–Dundas–South Glengarry.

Mr. Nolan Quinn: Thank you to the great member from Elgin–Middlesex–London. We're expanding oversight and patient protections when it comes to your health. Integrated community health services centres will now have to post any uninsured charges both online and in person. Every community surgical and diagnostic centre must have a process for receiving and responding to patient complaints. Patients cannot be denied access to treatment if they don't purchase uninsured services. We're expanding the oversight of the Patient Ombudsman to include integrated community health services centres that were not included beforehand. These safeguards are in place to ensure that no extra charges occur for OHIP-funded procedures. Ontarians will always pay for health care with their OHIP card, not their credit card.

The Deputy Speaker (Ms. Donna Skelly): Further questions?

MPP Kristyn Wong-Tam: Currently, public, not-for-profit surgical centres have to be connected to a public hospital with an emergency room in case there are complications—and oftentimes, there might be. The government's Bill 60 has changed that. Independent health facilities will no longer be required to connect to a hospital. We know that they may want to take only the healthiest, lowest-risk patients, but that's not always going to be the case. Complications can happen to anyone at any time. How can the government ensure that patients in Ontario will be kept safe, what is their plan in case there are complications under your new system, and what will you do when that emergency arises?

The Deputy Speaker (Ms. Donna Skelly): Back to the member from Lanark–Frontenac–Kingston.

Mr. John Jordan: I think the important thing when you're looking at this bill is it's embracing our community health services sites and bringing them into the fold under Ontario Health so that they are part of a system—and I'm just happy to hear you say "system." They're now integrated into the system and will have collaboration with and communications with and access to information from our hospitals and to our hospitals. This bill is about growing our health care system and developing it into a working system.

The Deputy Speaker (Ms. Donna Skelly): Further questions?

Mr. Anthony Leardi: I'm really, really excited, because we have this awesome doctor in our region—I have the member from Windsor–Tecumseh next to me here. Our region has this awesome doctor; his name is Dr. Tayfour. Dr. Tayfour does cataract surgeries. They used to be done at the hospital, but now thousands of surgeries are being done at a community health clinic run by Dr. Tayfour, opening up all those thousands of opportunities for other people to go to the hospital and get the surgeries that they need. Dr. Tayfour has been a life-saver, and he's been able to do this because of the compassionate policies introduced by this government.

Now, I know the NDP want to go backwards. They don't want any of that to happen. They don't want Dr. Tayfour to do these awesome surgeries that give sight back to people. But we do want life to be better for those people, especially having this delivered by Dr. Tayfour and opening up more room in the hospital for other surgeries.

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My question to the member is this: Does he want to go backwards like the NDP or does he want to move forward like the rest of us?

Mr. Nolan Quinn: Thank you to the member for Essex for that great question. I want to move forward. I have children; I have older parents, so I want to ensure that the health care system is there for them.

If passed, the Your Health Act, 2023, will require applicants to outline how the new community surgical and diagnostic centres will promote connected and convenient care, including its capacity to improve patient wait times and improve patient experiences, as well as its plans to integrate with the health care system.

The legislation will also, if passed, require centres to provide a description of current linkages to health system providers and how the centre will maintain and improve those linkages to promote optimal patient health pathways.

In conclusion, I think it's a great idea that we're speeding up some of the cataract surgeries that you're doing in your community.

The Deputy Speaker (Ms. Donna Skelly): Further questions?

Ms. Sandy Shaw: For the people of the province of Ontario that are worried about health care, you should be worried, because I want to tell you that our publicly funded, publicly delivered, universal health care is under attack by this government. And when you hear this government say "community health facilities," that's for-profit corporations delivering health care.

But I also want to say that your hard-earned tax dollars over all of these years built our hospitals. We built those hospitals with our hard-earned tax dollars. This government is now giving access to those hospitals to private, for-profit operators with absolutely no oversight to make sure that the services that you get are safe and that you don't have to pay more.

My question is, what do you have to say to the people of the province of Ontario that rely on publicly delivered health care? You're dismantling it without any protections for the people of the province of Ontario, including protecting their hard-earned tax dollars that went into building this system.

Mr. John Jordan: I think that one of the big challenges for me as a new member is dealing, at my constituency office and with my constituents, with misinformation. And this bill is about publicly funded health care. It's about expanding public health care. It's about using all of our health service resources and engaging them into the system. We go to our labs; we use our OHIP card. They're private organizations.

Our fee-for-service physicians run a business—

Interjection.

The Deputy Speaker (Ms. Donna Skelly): The member for Hamilton West–Ancaster–Dundas will come to order.

You may continue.

Mr. John Jordan: The oversight is by Ontario Health. The services, the surgeons—any upselling will have to be documented and posted. There is recourse for physicians to go and get retribution and get refunded for anything that has been done inappropriately. The checks and balances are in place in this bill, if you read the bill. It's about publicly funded health care. The word "privatization" isn't even in it.

The Deputy Speaker (Ms. Donna Skelly): We've run out of time for questions.

Further debate?

Mr. Wayne Gates: I'm going to start real slow here about the committee hearings. I had the opportunity to go to the committee hearings with a few of my colleagues and the Conservatives. What was interesting about the committee hearings is they were rushed. They didn't give enough time so people from the north could come down and talk about Bill 60, which I believe—and I guess in three, three-and-a-half years, whenever the next election is, this is what's going to defeat this government, the privatization of our health care in the province of Ontario, which, by the way, Madam Speaker, is the envy of the world. It's the best. It's the envy of the world.

But when I talk about the committee hearings, the north wasn't able to participate. They weren't able to present. And then after we did the presentations, which I think is really fair and what really makes this place work, the official opposition, including the Liberals and, I believe, the Greens, put together 74 amendments to make the bill better, to talk about the issues that I think were important.

I'll ask my colleagues: How many of those amendments do you think the Conservatives listened to or voted for?

Ms. Sandy Shaw: None.

Mr. Wayne Gates: None. Well, let me tell you, I don't say it too often, but right here, the past leader of the Conservatives not that many years ago—we're not going back to the Harris days; we're going back to the Brown days. He had said in this House many, many times that he'll listen to the opposition because it's not just the government that has a great idea; sometimes people around this table do. Seventy-four amendments and you said no to every one of them—every one of them trying to make the bill better. That was a mistake.

Then we decided we'll put an amendment to the amendment so we could try and convince this government how important it is to make sure that the bill goes around the province. This is the most important bill since I've been here—and I've been here for four terms. I believe it's the most important bill attacking our publicly funded health care system. That's how I feel. I believe that if it's that important to this government, they would gladly take it around the province. Go to Windsor—we had a couple of our MPPs from Windsor here. Go to Timmins, go to Hamilton, go to the north, go to Niagara. I'd love to have you come to Niagara. There are lots of good places in Niagara. We could have gone and had—guess what? What did the PCs do? "We can't take it around the province. Somebody might find out what we're doing." Because it's all about control, it's all about secrecy. It's not about accountability and transparency.

Then, at the end of the day, because this bill will get passed because the Conservatives are going to pass it—do you know what it's about? It's about corporations getting billions of dollars of our health care that they've been trying to get since Tommy Douglas brought publicly funded health care into our system. It's not about care, and I'll use myself as an example.

When these private clinics get set up, they're going to take the ones that don't have any health issues—nice and clean, like Shouldice does. Shouldice does the same thing when you've got a hernia. If you've got high blood pressure, they don't take you. If you've got a little belly, they don't take you. That's what Shouldice does, because they want it nice and clean. They get their cheque, make their $20,000 on everybody and away they go. They make all kinds of money. But somebody like myself—and one of the colleagues talked about this. He just did a bill around mechanical valves. It wasn't that long ago, it was a couple of weeks ago. He has a mechanical valve. Well, you know what? So do I. If I had to go to a private clinic, guess what would happen? They would say no because you might have complications during that surgery—and so would he, by the way. That's what would happen.

I asked you guys to take it around the province and you decided not to.

So I'll start on a couple of things that we should have learned from. I'm always willing to learn. That's why I come here, and I listen. I don't always agree with you. Sometimes I might learn something, whether it be from the Liberals, the Greens or my own colleagues, but you would think that we would have learned something from long-term care.

When the Mike Harris government brought in the privatization of long-term care, he said the same thing we're saying today about this bill, by the way. He said back then—I think it was in 2008, in that area; I think he came into power around 2005 to 2013, and he said the same thing. This is going to be wonderful for our parents and our grandparents. They're going to get the best of the best of the best when it comes to care, and through that whole period of time, even before COVID, we had diseases in our long-term-care facilities like C. diff. You know why I know about that? We had C. diff in Niagara. You know what happened? Thirty-nine died in our hospitals from C. diff, and why did they die? Because they contracted out the cleaning services in our hospital, which caused the C. diff in our hospitals. People were dying going in for a simple surgery, like knees and hips, and coming out dead.

So you would think we would learn by what we're doing. In long-term care, we knew we had the C. diff problem, and then you come into COVID. Look, I'm not blaming anybody that COVID came in March, even though I do remember the Premier saying, "Oh, go ahead. Go to Myrtle Beach, go to Florida."

But people were dying of COVID in January and February. But what happened over the next three years, because of our staffing problems—some of our staffing problems, we had today, to this point in time—and I might be out by one or two, all right, so don't get mad at me if I'm out by a couple of deaths, because I hope it's on the lower end—5,500 people have died in long-term-care facilities—5,500. But what's startling to everybody is that 80% of those deaths happened in for-profit long-term care. And why was that? Because they cut back on staffing. Quite frankly they cut back on food. They cut back on PPE. Everything they did was about one thing—Madam Speaker, I see you changed.

Interjection: Ka-ching.

Mr. Wayne Gates: Ka-ching? No. We saw a new Speaker.

Everything they did was about profit. You guys can argue with me on that all you want. It was never about care, what it should have been about. It should have been about care.

1340

Because you know what happened in these long-term-care facilities—I think somebody up there from the opposition said that their parents are old—they died, and they suffered so much because of lack of PPE, lack of staff.

Some guys over there can roll their eyes at me. I don't have a problem with that. Because I've been talking about this over and over again until I'm blue in the face. It's the only way I'm ever going to become blue.

But I'll tell you what, people should not be dying in our long-term-care facilities because somebody wants to make a dollar. It's our moms, our dads, our aunts, our uncles,

our brothers and sisters. We got a lesson here. I think my colleagues understood the lesson. But it got so bad in long-term-care facilities, places like Extendicare; we know what they were about. We know how many people died there.

It got so bad. Do you know what you had to do? I didn't do it. You called in the military. You called them in because they were dying from the basic need of water. Somebody held up a water. I can get water anytime I want. You would think in a long-term-care facility my mom or my dad could get a glass of water to save their lives. You know why they couldn't do it? They were more interested in making money, more interested in making a profit. They didn't have enough staff to run the facilities, so 80% have died in long-term-care facilities in a private-run home.

You would think, before you bring Bill 60 in, you would have consultation—that's my next part of this—with health care workers across the province of Ontario. Some of them came to committee. I think there was a couple here that were at committee, by the way. Unions, like the Ontario Federation of Labour, came to committee, because I always listen to the labour minister who is working for workers. Unifor: You guys mentioned Unifor quite a bit, especially the guys from Windsor, trying to take credit for the auto industry up there. ONA, OPSEU, SEIU—Madam Speaker, you know SEIU; not personally, but you know of the organization—CUPE. So my question to the Conservatives was very clear, nice and easy—they represent health care workers in long-term-care facilities, in retirement homes, in our hospitals, in our home care with PSWs.

I said to each one of those organizations—they represent approximately 1.8 million workers in the province of Ontario, hundreds of thousands of them in the health care sector—how important and how much the Conservatives care about working for workers, "Were you consulted on this bill? Were you consulted on the bill?" I think it's a fair and reasonable question. Guess what? Every single organization from the unions said, "We weren't consulted"—never even talked to them.

Do you know, during COVID, what some of those organizations had to face? Whether it was SEIU, Unifor, ATU—do you know what happened during COVID to their members? You know how we're going to celebrate and heighten the awareness and get people talking about health and safety on the job? During COVID, their members died trying to save and take care of our parents and our grandparents, our aunts, our uncles, our brothers and sisters.

Yet this government, because Bill 60 is so important to them and it's so important to moving forward for health care, didn't talk to the workers, didn't talk to the organizations, didn't talk to the presidents. Now, you won't even take the bill into places like Windsor, which is represented by Unifor and has a lot of long-term-care and retirement homes in that community. You won't bring it to Niagara, where one home alone had 40 people die—one home, owned by con men. They died over a period of six weeks, to the point that we had to call in the hospital association in the area to stop the deaths in that particular facility.

I talked to my firefighter friends. They were taking out two and three and four bodies a shift out of these facilities. Yet you didn't go and talk to the workers. How does that happen in the province of Ontario if you're standing up every day saying you're working for workers? Because it's—I can't say that word here, can I? Because it's not accurate. Is that okay?

Interjection: Yes.

Mr. Wayne Gates: It's a myth. Honest to God, it just bothers me that you say you're working for workers but you don't do anything about it.

And let's talk about Bill 124. Let's talk about it. It's in the courts. My good friend from Durham raised that this morning. It's in the courts. It doesn't have to be in the courts. You've got a majority government. You can repeal Bill 124 today. Show those nurses who are exhausted—they've been giving every ounce of energy for the last three years trying to take care of us and keep us alive. Show them that respect. Get rid of Bill 124. You capped their salaries at a terrible time at 1%—and that's not just their salary, but also their benefits—and attacked their collective agreements.

Do you know what those nurses have gone through? Mental health. I've talked to a lot of those nurses. My daughter's partner is a nurse, and she tells me the stories when they're in the parking lot an hour before their shift starts, 45 minutes before their shift starts. Do you know what they're doing? They're crying, because they know what they're going inside those four walls to face during COVID. And what did we do? We didn't do it, because we never supported it. We've never supported Bill 124. We attacked those very people that are giving every ounce of energy in our hospitals.

So I think it's fair, I think it's reasonable and I think it's accurate: Your government could get rid of Bill 124 today. I'm sure our House leader and your House leader could talk and get that done immediately, like that. I think that's something that we should do. We shouldn't be talking about a bill like Bill 60 until we get rid of Bill 124.

I know you guys disagree with me, and that's fair. I don't have a problem with it. Not everybody agrees with me. Even sometimes, my wife doesn't agree with me—well, most of the time she doesn't agree with me. Why would we want to go down the same road as the Americans, a US-style health care system? Today, the number-one reason for bankruptcy in the United States of America—do you know what it is? Health care costs. They die younger in the United States of America, particularly people that are less fortunate, people that live on—I don't know the system they have down there, but here it would be ODSP. Those with disabilities, racialized, Indigenous communities, they die sooner because they can't afford the health care down there. Why would we ever want to go to a system like that?

I've got a few more things before I get into my speech. I might not even get to the speech. To prove what you guys were doing—because you should go around the province. You can't argue that with me. If you're proud of this bill, go around the province and hear from Ontarians. The Ottawa Hospital—a huge issue in Ottawa. Do you know

they set up a brand-new company in Ottawa? It's run by doctors; 21 doctors started up a corporation. Do you know what they do on the weekends? They're using the publicly funded hospitals' operating rooms to operate on patients on the weekend, bringing in the same nurses that are there Monday to Friday, paying them twice as much, sometimes three times as much, in salaries in our own facilities. And then on Friday night, before the operation starts on Saturday, they use the publicly funded workers to clean the operating rooms to get them ready for Saturday and Sunday. And then on Sunday night, they bring the publicly funded workers back in to clean up the operating rooms. Why are we doing that?

Here's a suggestion—and I know you don't always have to take my suggestions. Why do we not use our own nurses in our publicly funded system and utilize our operating rooms on Saturday and Sunday, on a publicly funded, publicly delivered system, rather than paying more money for the doctors and the nurses to operate the same operating rooms? It makes no sense to me—none. It's another suggestion. I've given you two suggestions; I've only got to five out of my 10 points on the front page. Two good suggestions: Get rid of Bill 124 and utilize our hospital rooms. We have to do it a couple of hours a day during the week and then on the weekends using our staff, the staff that's already there. It makes sense to me. I know you guys always say we never give you suggestions. Well, there are a couple of good ones.

1350

We know, because I listened to a lot of you over the last little while with the committee hearings. I was in a lot of committee hearings. We know that in the next five years, you're underfunding health care by $21 billion. I'm not saying that, but that's exactly what's going on. It doesn't make sense to me.

Because one of your members mentioned a fact about closing hospitals and some guy that was Premier a little while ago, do you know in Niagara, we lost the St. Catharines General Hospital? Gone. The Hotel Dieu Hospital? Gone. The Niagara-on-the-Lake Hospital? Gone. The Fort Erie hospital? Gone—urgent care centre now, and now they're saying they're going to close it altogether. Port Colborne hospital? Gone. Welland hospital? You know in Welland today—it's one of the fastest growing areas in all the province of Ontario—that if you need surgery after 4 o'clock, you get transferred to Niagara Falls. That time, from the time you go from Welland to Niagara Falls, might be too late for you. You might not make it to Niagara Falls.

What are we doing so that some corporation can come in and make billions of dollars? Because the one thing we can agree on—and I'm going to agree with you guys on this: There are billions of dollars to be made in health care. They've been trying to get into the health care sector for years. Now, they see the opportunity that they're going to get in there. It doesn't make a lot of sense.

I raised here just a little while ago, and I'm going to raise it again, because I know your members on that side as well as members on this side are suffering from prostate cancer. I've asked a bill to be passed around prostate cancer. But I know on your side and our side—two of my employees in my office, their dads have had prostate cancer. Larry Gibson from Fort Erie—that's something that we could do and we can agree upon. It's another suggestion I made to you.

The other one that I'm going to talk about—I only got a minute left. I want to talk about—tomorrow's the Day of Mourning for injured workers and those killed on the job. We should remember people have lost their lives, but we should fight for the living. The way to do that, quite frankly—I'm going to give you another suggestion. I've had a bill here—other people have had the bill, not just myself. It's called deeming. It's Bill 57.

There's an article in the local paper today in Niagara-on-the-Lake. Look it up; it's called the Local. They talked to a worker who was deemed. He was a farm worker who lost his arm. They deemed him, and you know what happened? They told him he can pump gas with the other arm. Because he was deemed, he's living in poverty.

Why would we not get rid of deeming? Why would we not do it? I don't think any worker in the province of Ontario should live in poverty when they get hurt on the job.

Thank you very much for the 20 minutes. I'm looking forward to the questions.

The Acting Speaker (Ms. Bhutila Karpoche): Questions?

Mr. Todd J. McCarthy: I listened carefully to the member opposite. One of the things about consultation that is helpful when you have been re-elected as this government has, with an even larger majority and a renewed mandate, is that we have over 80 MPPs who are in touch with their communities on a regular basis, are in their communities listening and learning. What we have all learned is how welcome our innovations and our investments in health care are to protect and enhance public health care.

Just one specific example: We often say family doctors, who we're continuing to attract by reducing red tape, know their patients so well, but so do the pharmacists. The pharmacist in our community knows my son Jake and his needs very, very well. Given that this bill and our measures are supporting the access to pharmacists on an innovative basis, will the member opposite consider supporting the bill on that basis?

Mr. Wayne Gates: The unfortunate part about bills is, in every bill that comes before the House, there are parts of the bill that are good. There are. We see that all the time. There are parts of the Working for Workers bill that are good. I believe the washrooms for women should be right in the bill. I believe the firefighters should be in the bill. There are lots of things we can support.

But I can't believe that you're telling me—because I haven't had one person, and I've done this for four terms, and I am in my community every weekend, Saturday and Sunday, before I come back here. I haven't had one person come up to me and say, "Gatesy, can you please privatize health care for me?" Not one. Not one. So if they're not doing it in my riding, I can't believe they're doing it in yours.

Yes, you've got a higher majority. But also, with a higher majority comes more responsibility to do the right

thing, and the right thing would have been to listen to some of the amendments that we put forward—74 amendments. The right thing would have been to take this bill across the province. If you're so proud of it, why won't you go to Windsor? You've got two MPs out in Windsor. Go to Windsor; ask them what they think—

The Acting Speaker (Ms. Bhutila Karpoche): Thank you. Question?

Ms. Doly Begum: I want to thank the member from Niagara Falls for his impassioned speech. I know how much he cares about seniors across our province and our public health care system, and I know that he had a whole list of suggestions and he ended with deeming. If you would like to elaborate on a few other suggestions or talk about how much we really need to address the issue of deeming and what it does to so many workers, including health care workers across our province.

Mr. Wayne Gates: Deeming is one of the worst things that I think we could do to injured workers. I'm a firm believer—I come out of a plant. I come out of General Motors. I worked at General Motors for 40 years. I've taken workers out of the plant, by the way, that got killed on the job. I've seen them lose their limbs. And to go and have to be deemed, where you were getting a paycheque to take care of your family, where your kids could still do figure skating or ice hockey or all those things, and all of a sudden, that's taken away because now you can't afford it because, now, you're in the social system—you're getting paid ODSP, not compensation, because it comes off your compensation cheque.

Why in the world are we sending injured workers—you want to do something for injured workers? The Day of Mourning is tomorrow. Get rid of the deeming. Show them that you actually care about injured workers, because I don't believe any worker in the province of Ontario who gets injured on the job should have to live in poverty, and 50% of injured workers in the province of Ontario are living in poverty.

The Acting Speaker (Ms. Bhutila Karpoche): Question?

Mr. Stephen Crawford: I listened intently as well to the member opposite. I just want to give you a couple of quotes and then get your thoughts on that. From Dr. Rose Zacharias, who is an emergency medicine physician: "We support Bill 60" and its "feature to move lower-acuity surgeries and procedures out of hospitals. This is an important step in reducing wait times."

Another quote, from the CEO of the Ontario Medical Association: "The OMA appreciates the collaboration with Ontario's government and their commitment to thoughtfully implement the shift of more procedures out of hospitals into the community. We are ... encouraged this legislation, if passed, aligns with OMA's recommendation to replace the Independent Health Facilities Act with a more comprehensive framework that strengthens prohibitions against two-tier health care."

My question to you is, why do you not align with what their thoughts are? They're the experts.

Mr. Wayne Gates: First of all, I appreciate the question, but I want to tell you, I'm in agreement that we can have outside clinics. But they should be tied to the hospital. That's the issue. No doctor wants to be on his own and face that responsibility. And I already gave you an example. We talk a lot; I've already given you the example. Somebody like myself, who has had open-heart surgery, has a mechanical valve in his chest, is never going to go to that clinic because they won't take me. That's why it has to be tied to the hospital, so if they do do something to me, the hospital is right there to make sure I don't die on the operating table.

Even the easy surgeries run into complications because sometimes that member or that person that might be getting operated on, they don't know that he has heart disease. It doesn't show up sometimes, right? So what happens is, they get operated on, they have an emergency, and now they've got to wait for an ambulance to come. Do you know what our wait times with ambulances are?

The Acting Speaker (Ms. Bhutila Karpoche): Response?

Mr. Wayne Gates: Pardon?

The Acting Speaker (Ms. Bhutila Karpoche): Response?

Mr. Wayne Gates: Okay, I'm trying to respond. I'm sorry. Anyways, somebody else ask me a question. Hopefully that answered it.

The Acting Speaker (Ms. Bhutila Karpoche): Question?

Mr. Terence Kernaghan: I'd like to thank the member from Niagara Falls for his very passionate presentation and the way in which he stands up for seniors.

1400

I think we've seen the full conclusion of what privatization has done in long-term care, as you've outlined. Just looking over the Canadian Armed Forces report where it talks about aggressive feeding that caused choking, people left in soiled diapers, mattresses on the floor—and just the simple fact that animals are treated better than the way seniors were treated in the for-profit long-term-care sector.

To the member: Seniors helped build our publicly delivered and publicly funded system. Is it wrong to let them get nickel-and-dimed by greedy health care profiteers?

Mr. Wayne Gates: My position is that we should always be publicly funded, publicly delivered, and our seniors should be taken care of. You're absolutely right. They built this great province. I have what I have today because of my mom and my dad who, by the way—I've only got a minute, but my mom and my dad fell under a system where it wasn't publicly funded. We lived in poverty for about eight years. My dad worked for the city of St. Catharines. My mom worked in a fish-and-chip place. It took them 30 years to pay that bill off. They didn't burn the mortgage; they burned their bill that they finally paid off—health care—for me, my sister and my brothers. It took them 30 years.

Is that the system we want to go—and that's just an American-style health care system. That's exactly what it

is, and I already said 45 million people claim bankruptcy every year in the United States of America so some corporation could make billions in profit. I think it's wrong.

The Acting Speaker (Ms. Bhutila Karpoche): Question?

Mr. Ross Romano: I was listening to debate and listening to the member. I've heard this member for years in this House, and whether it be under the previous regime of the Liberal government—close friends with the member opposite, obviously.

I'm just curious, though, for the member: My question is really quite simple. I've been here now quite a number of years. I don't think I've ever seen a situation that we have in this province where you had a government win a second majority with more seats than they had the first time around, seeing an opposition wither away to the size of the caucus now. I'm just curious, have you ever seen a government that is apparently so, so poorly behaving, as you say it, win more seats, win more popularity, deliver more hospitals, more long-term-care homes and do more for the people of this province, despite your concerns?

Mr. Wayne Gates: Actually, unfortunately, I have. The Liberals actually won for 15 years, and they should never have won for 15 years—

Interjections.

Mr. Wayne Gates: No, they got more. Check your record. They certainly got more, and you guys got more with 18% of the vote. You can't forget that. I mean, that's accurate. Because of lower turnout, you ended up getting a majority with 18% of the vote. That's accurate. You can't even argue that.

I can tell you that I'm not saying what the Liberals did for 15 years was right, but I'm going to tell you, and I'm going to look you straight in the face—yes, I've been here for a while, and I'm proud of that. I'm proud that, in my area, I get re-elected all the time by a high majority, by the way, and a lot more than 18%. But I'm going to look you right in the face: Your party was in opposition for 15 years. You were in government for eight years—eight years, when you were closing the hospitals. But for 15 years you supported that Liberal government, 58% of the time of all votes, including scab legislation and the deeming that I'm begging you today, with the Day of Mourning tomorrow, to repeal—support it and get rid of it. We don't need it.

I hope that answers your question. Okay? Thank you very much.

The Acting Speaker (Ms. Bhutila Karpoche): Further debate?

Mr. John Fraser: I just want to start off by saying I won't be supporting Bill 60 and our caucus won't be supporting Bill 60, not because we don't believe in independent health facilities, but we believe that those independent health facilities should be connected to a hospital and not-for-profit. There should be only one shareholder in our publicly funded health care system, and that's the patient.

What this bill does is it opens up the door to more for-profit participation in our health care system. And the challenge that happens there is, all of a sudden there are two things that that corporation has to serve: equity-building and serving the patient. Sometimes those things—not sometimes—often, the patient or the residents' needs are negligent or put second. That's a better way to put it: put second.

If you take a look at the last time somebody said we need more for-profit participation in our health care system, it was Mike Harris. He was talking about long-term care, and I think we've seen the results of that. It was revealed inside the pandemic just what was going on there.

But it also revealed the fact that the people caring for people inside those long-term-care homes, the PSWs and the nurses—well, they didn't have a pension plan, but the companies that owned these long-term-care homes were there, and they were used as an instrument to build equity for pension plans for other people—in other words, building pension plans on the backs of workers who have to work sometimes two jobs, maybe three jobs and don't have a pension plan. That's wrong.

But then we saw in the pandemic that corners were cut. The support for residents, the needs of residents—not in all cases, but in many cases in private, for-profit long-term care—weren't being met.

That's the problem with this bill. It opens the door to do that with more patient care in this province, with surgeries in this province. There's nothing here that says the IHFs have to be connected to a hospital or they have to be not-for-profit. In fact, we put forward amendments, and I know the NDP put forward amendments that said exactly the same thing. We put forward amendments that if you're going to build a for-profit clinic, if you're going to have one there, they don't own the licence; it's the people's licence. You couldn't even put that in the bill. You couldn't even put that in the bill.

For decades and decades, governments of all stripes have built a publicly funded health care system, and it's always a work in progress, but at the core it was a publicly funded health care system that provided, as best it could, access for everyone.

One of the concerns that have been expressed—and the government tried to address this—is if you are going to create a system where there's going to be up-charging. If people have money, well, maybe they'll get more. Because one of the things that happens—right now it might be okay, but five years from now, maybe that hip that you're getting right now—there's a new one that comes out five or 10 years from now, but the government of the day says, "Well, we'll pay for the old hip that doesn't last as long, but the new one, you're going to actually have to pay for that." That's the risk. The government hasn't done anything to address that, and it doesn't protect, I think, the public interest going forward.

Now, I heard my colleague from Niagara Falls, who's hard to follow sometimes, because he's so good. He has got so much energy. The hospital in my riding is the Ottawa Hospital. There are two campuses, the General campus and the Riverside campus. At the Riverside, here's what's happening. Surgeons who work in the Ottawa Hospital have to rent ORs that were vacant in the Riverside campus; hire nurses off-book, some of them who are nurses who

work in that hospital; then hire a private company to bring in the tools they need, so they could work on weekends just to get the list down that they would already do if they were in the hospital and none of that.

No one has been able to explain to me why that's a good idea, or why they have to jump through those hoops. It doesn't make any sense. If somebody can explain to me how that, in any way, makes any sense from a business perspective, a patient perspective or just a common-sense perspective, please let me know.

At the same time that there are these empty ORs that they're renting out for some reason to the doctors who already work there, there are dozens of women waiting for breast cancer surgery, and they see this happening, this kind of illogical, unnecessary solution getting down the wait-list. And guess what? Only 13% of women were getting their breast cancer surgeries in the safe, recommended time at the General campus, only 29% at the Civic campus.

So you wonder did the hospital get distracted by the wait times, by this kind of illogical solution to something they could already be doing inside the hospital? I don't know.

1410

It's not the kind of health care system that we want for our families—and in this case, our daughters, our moms, sisters. Actually, at the same hospital, for gynecological cancers, it's 29%. Twenty-nine per cent of women are getting their surgeries in a safe time.

Here are some of the amendments that we put forward that were rejected by the government: that these services must operate as a not-for-profit; that there must be strong conflict protection in place with full transparency about ownership fees and violations by these facilities; an introduction of a ministry oversight program in collaboration with the regulatory colleges—that's pretty sensible; patient safety and patient protection—and fees paid to community health centres should not exceed those paid in public hospitals.

The other one was, and I mentioned this earlier, if you're going to go out and sell a licence in our public health care system and pay with public dollars, that licence belongs to the people. It doesn't belong to the people who are running that clinic.

This is going to be a wild example, so stay with me here. Taxi industry: Did you see what happened there? People were allowed to trade licences. Those licences became—

Ms. Sandy Shaw: Currency.

Mr. John Fraser: —currency. Then the bottom fell out of the market. Government had no control. They decided not to have control, just like you're doing here.

What will happen if you don't actually own those licences and say, "You can't transfer them," is they will really be used as a way to build equity, and then you will have no control as to whoever takes that over. I can guarantee, because of NAFTA and everything else that's going on, where those corporations are going to come from. They're going to be gigantic health care corporations from the United States. Just ask any veterinary clinic. Ask any veterinary clinic.

If we don't want our families and members of our communities, our constituents, to be at risk, for God's sake, that should be there. If you're not going to do it in legislation—I don't know if you can do it in regulation, but you need to. That's a big risk.

If you only gave me one thing to do, the first thing I'd say: Make them all not-for-profit. But if you said that's off the table, that's the one thing that you need to ensure to Ontarians, that their health care dollars belong to them, that that licence you give somebody—a private company—is not theirs. They don't own it. It's a right. It's an agreement. It's a contract. But it's not a piece of property. It's not equity. That's the danger in here five years from now, 10 years from now, 15 years from now and 20 years from now, not next week. But you need to do that.

In actual fact, we do that right now in Ontario, because I think that happened with Shouldice. I think we stopped Shouldice from selling that clinic. If it was Shouldice clinic—

Interjection.

Mr. John Fraser: No, we did. Yes. From moving that over—you can't.

The fact of the matter is, if you're granting licences as a piece of property and not a contractual obligation, that's not going to be great for our health care system.

In conclusion, I can't vote for Bill 60, not because it talks about establishing independent health facilities. I think it's good to have facilities that can create proficiency and efficiency for things like cataracts, for things like hernias, for things like endoscopy. The system can work more efficiently. But those independent health facilities have to be connected to our hospital system, and they have to be not-for-profit.

I just want to go back on a couple of things I heard, that the OMA was supportive of the government's position on this. What they did say was, "We believe that they should be public, not-for-profit." That's what they said. That's what the OMA said. And as a matter of fact, the OHA said this when you first came out with the idea, the Ontario Hospital Association.

I don't think they're saying that because they oppose you. I don't think they're saying that because they're partisan. I don't think they're saying that because they don't have the public interest at heart. They're in the business. They know what they're doing. It's good advice. Take it.

The Acting Speaker (Ms. Bhutila Karpoche): Questions?

Hon. Paul Calandra: I wasn't going to, but I guess I'll participate in debate a little bit more today. The member and the member for Niagara Falls brought forward the concept of privatization of long-term care, and by and large, members always talk about Southbridge, Extendicare, Revera and Sienna. Now, Southbridge and Extendicare both are operated for profit, for sure. All of the budgets within that for-profit home, though, when it comes to care, are segregated and only allowed to be used for care.

Now, Southbridge has a collective agreement with the Ontario Nurses' Association, and Extendicare with Service Employees International Union. Revera, which is owned

by the federal government, also has a contract with SEIU. And Sienna also has a contract with the SEIU. These are health care unions charged with overseeing the care in the homes.

Why do you and the members opposite feel that union members working in our for-profit institutions care less about the people that they care for than those who work in other institutions?

Mr. John Fraser: Number one, that's not always the case. I'm not really worried about who owns it, whether it's the federal government, but they're using it to build equity in pension plans—often the case, not exclusively—where people don't have pension plans.

Let's just take everything aside: what I've said and what you've said—what the member said, I should say; sorry. What were the outcomes during the pandemic? What did we see? I'll give you this: There were for-profit homes that did well, and there were some that did very, very poorly and, I note, in my city. I'm telling you—

The Acting Speaker (Ms. Bhutila Karpoche): Response?

Mr. John Fraser: Speaker, I just believe that if you're trying to generate equity and serving people, it creates a conflict that we don't need.

The Acting Speaker (Ms. Bhutila Karpoche): Questions?

Ms. Sandy Shaw: I want to go back to the member for Ottawa South's analogy about this government giving licences to for-profit corporations to operate—medical licences and them being used as currency. That's a fear, but I'm going to tell you that it's already happening when it comes to our water.

Right now, this government has allowed Nestlé, who has these permits to take water from our aquifers, which are a limited, precious resource—Nestlé has these permits to take water at pennies for the litre. And then, when Nestlé was sold to BlueTriton, which is a US equity firm, the government allowed them to sell those licences. That's our water—Ontario's water. They allowed them to sell it to a US equity firm to continue to take water. It's already happening. So your story, when it comes to health care and privatization of health care, already has a precedent.

Mr. John Fraser: I agree. I think that in the public interest, when you grant a right to a company, you're granting a right. That should not be something that's used to build equity. I just don't think so. Because somebody else can end up owning it—a hedge fund.

What I'm saying about these independent health facilities and large US health care corporations—which are not very friendly. Just ask any veterinary clinic. Ask them who owns them and what it's done to, well, number one—if you don't go to the vet—how much it costs you. That's an issue altogether—but what happens to the pay of the people working in those places. We're trying to build a public health care system. We just need the imagination and desire to do what governments of all stripes have tried to do for decades, with success—not finished yet, though.

The Acting Speaker (Ms. Bhutila Karpoche): Question? The member from Lambton-Middlesex-Elgin.

Mr. Rob Flack: Close enough: Elgin–Middlesex–London. Thank you, Speaker.

What I struggle with, and I understand your passion, that for decades now, what I'm hearing is, you just want more and more of the same. That's the road to insanity in expecting a different result. We're trying to come up with solutions. We're trying to come up with different ideas that change the game, that bring better performance, better results, looks after people, looks after families.

1420

It's a fact—more of the same isn't going to work, and I'm not hearing new ideas. I'm hearing more of the same. Can you please give me something that at least has changed from when you were in power, when the NDP was in power and since we've been in power? Give me something new that's going to work.

Mr. John Fraser: In 2007, in this province, we started measuring wait times. At the Ottawa Hospital, like I talked about—general campus—13% of women are getting their cancer surgeries on time; 29% at another one. The reason we measure wait times is so that wouldn't happen. So we'd see that, so that we could manage that. Guess what? It's not being managed. That was an innovation.

Actually 2,200 kids at Hamilton Health Sciences aren't getting the services that they need. Ontario wait times, go and take a look at that. That was innovation; that was a change.

We built 25 hospices—

Mr. Rob Flack: How's it working for you?

Mr. John Fraser: Well, how's it working for you? We provided that for you, and now we have the situation where people aren't getting timely access to care. Is it just up on a website? It is a bit hard to find, which is surprising. It is a bit hard to find, but if you go and look, you'll be able to find it. Take a look at it.

The Acting Speaker (Ms. Bhutila Karpoche): Question?

MPP Kristyn Wong-Tam: Bill 60 seems to leave behind the oversight around private clinics and the delivery of health care through these private, for-profit centres. It talks about a yet-to-be-named oversight body. It doesn't talk about what it's supposed to do. It's very vague on that, and it seems to be that the government is leaving it up to regulations which, of course, are not before this House, and yet we have to assume that it will be there in good faith, well-researched and -documented.

Why do you think the government is leaving that section around the quality and accountability around safety standards vague and unspoken to?

Mr. John Fraser: I'm not entirely sure why the government isn't developing some governance with the colleges to oversee these IHFs. I don't know why.

To talk about the Ottawa Hospital, I know I've been critical, but they established a relationship with a company where they rented the space, but their surgeons were there. That was a solution; it was a good solution. They didn't sell a licence. It made sense. They had governance over it. They had insight into that because it was their people working in a place that allowed them to work there for a

nominal fee, and they could do that because, along with wait times, we actually used that to be able to incentivize hospitals to do better on wait times.

The Acting Speaker (Ms. Bhutila Karpoche): Question?

Mr. Rick Byers: I thank the member for his comments. As I listen to the word "privatization," I think there's elements to that word that are convenient to use, but don't make sense.

But as I heard the member talking about pension plans, and I couldn't exactly get the point, but I wanted to see if I can give him an example that might make sense. The OMERS pension plan—I was there for seven years. Interestingly, in 2007, which I believe was when the Liberals were in power, OMERS bought LifeLabs. They are a fantastic blood-testing company. You go to the doctor, get your blood work done by LifeLabs, guess what? You don't pay for it with your credit card, you pay for it with your OHIP card. Fantastic service when the Liberals were in government. That's exactly what we're trying to do here, Madam Speaker—excellent service, publicly paid for, better service for Ontarians. What are your thoughts on that?

Mr. John Fraser: A little bit of history on this: That's something that we inherited from the previous government, the Harris government. If you want to talk about how labs work here in Ontario, you can come and we can spend the afternoon together. It's not pretty. It's not something you could unwind. You've got to work with what you've got. I know, I've seen what's there. We don't really want to talk about it.

It's the same thing with home care. We have a system that has been built up that's for-profit. If you unwind that thing, it isn't pretty for a lot of people. Somehow you have to try to manage it, and there are great service delivery organizations that are doing that. I wish we could do that in a more public way, but we have what we have.

One of the other concerns that exists with the competitiveness in labs is, we're afraid of NAFTA coming in. So the way that we manage it is to protect the Canadian entities that are already there and not have the Wild West in labs here in Ontario. We could talk more about it, but it's not pretty.

The Acting Speaker (Ms. Bhutila Karpoche): Further debate?

Mr. Rick Byers: Thank you to all the members for this great debate today.

I'm pleased to be in the House today to speak on the Your Health Act, on behalf of my constituents of Bruce–Grey–Owen Sound. I'll be sharing my time today with the outstanding member for Windsor–Tecumseh.

This proposed legislation is another important step forward, ensuring that our health care workers can provide high-quality, connected and convenient care now and in the future.

In committee, the Ontario Medical Association stated: "We welcome the government's proposed legislative framework for new community, surgical and diagnostic centres. It's the right thing to do. It helps reduce wait times, which is critical both for the health of patients and for the health of the system that cares for them. We believe it will free up hospital resources to focus on emergency, acute and complex cases while relieving some capacity issues that are big, and they're real."

Speaker, long wait times have taken a toll, not only on the physical health of people, but also on their mental health due to increased stress and anxiety. For health care to be helpful, it needs to happen faster.

That's why our government is reducing wait times for people across the province by investing an additional $72 million in 2023-24 to make more surgeries available at community, surgical and diagnostic centres to connect people to care faster. This investment will allow hospitals to focus their time and efforts on more complex and high-risk surgeries, ease pressure on emergency departments and reduce surgical wait-lists. Community surgical and diagnostic centres will also coordinate with local hospitals to accept patients who are being referred so that they can get the surgeries they need as quickly as possible.

The people of Ontario will always have access to the health care they need with their OHIP card and never their credit card.

I'd also like to take this opportunity to express my deepest appreciation for our world-class health care workers and their unwavering commitment and tremendous contributions to our province.

The Your Health plan, which is supported by this bill, builds on the significant progress our government has made over the last several years.

Since 2018, we've increased health care funding in our province by $14 billion.

We've expanded Ontario's health workforce with more doctors, nurses and personal support workers. In fact, since 2018, we've grown our health care workforce by 60,000 new nurses and 8,000 new physicians.

We've added more than 3,500 hospital beds across Ontario, including acute, post-acute and critical care beds.

We're building new hospitals in every region of the province, getting shovels in the ground for 50 new major hospital projects, including one in Markdale, in my great riding of Bruce–Grey–Owen Sound.

Since 2021, we've provided funding to support operations of 49 new MRI machines.

We're adding nearly 60,000 new and upgraded long-term-care beds and investing nearly $5 billion over four years to hire more than 27,000 long-term-care staff, including nurses and personal support workers, and increasing the amount of direct care residents receive.

We continue to make it easier and faster for individuals of all ages to connect to mental health and addiction supports by building on our Roadmap to Wellness.

We've made it more convenient to book or take a health care appointment by launching virtual care options and adding more online appointment-booking tools.

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Our government is better connecting health care organizations and providers in our communities through Ontario health teams. Ontario health teams bring together

providers from across health and community sectors—including primary care, hospitals, home and community care, mental health and addictions services and long-term care—who work as one collaborative team to better coordinate care and share resources. Working together, they will ensure that people can move between providers more easily, directly connecting them to different types of care, and providing 24/7 help in navigating the health care system.

Speaker, Ontario is making historic investments of more than $75 billion annually in health and long-term care. But it's clear that money on its own isn't enough. We need to innovate and continue to build on our successes to create tangible, lasting improvements to the health care that is delivered to Ontarians. The Your Health plan is a decisive strategy to ensure Ontarians receive more convenient and connected care. The three pillars of this plan provide a solid foundation to continue modernizing and improving patient care in our province.

I would like to speak to one of those pillars, the right care in the right place. Having the right care in the right place means supporting more care in people's own homes and communities, leveraging virtual care, supporting targeted care needs with specialized supports, building on mental health and addiction services, creating stronger long-term care and reducing emergency department pressures.

When people have health care available in their communities, and in ways that are convenient for them, they're more likely to seek and receive the treatment they need when they need it and stay healthier. Delivering convenient care to people in their communities will help make our province healthier by diagnosing illnesses earlier, starting treatment as soon as possible and keeping emergency room wait times down when people need urgent care.

One of the key parts of ensuring the right care in the right place is expanding care at local pharmacies. Pharmacists in Ontario are highly trained, highly trusted and regulated health professionals. They are often the closest, most convenient option for health care in communities across Ontario. Throughout the last few years, pharmacists played a critical role in supporting patients across the province by supporting COVID-19 testing and vaccination efforts and educating patients about medication and treatment options.

Pharmacists continue to offer families the kind of convenient care close to home that we know Ontarians are looking for. We are expanding the role of pharmacists by increasing their scope of practice so that families will be able to connect to care closer to home at their local pharmacies, such as enabling them to prescribe medications for 13 common ailments. This initiative has been so successful that nearly 100,000 Ontarians have used it since it came into place on January 1.

Allowing pharmacists to prescribe over-the-counter medication for common ailments has proven to be hugely popular, so in our recent budget, we announced that we're expanding it to make care more convenient for people and families. Building on this success, Ontario will be expanding this program to allow pharmacists to prescribe medication for six more common ailments. These initiatives are part of our ongoing work with front-line pharmacists, nurses and other regulated health workers to expand their scope of practice in ways that make it more convenient and faster for people to get care in their community.

Another significant way we're working to provide the right care in the right place is expanding the delivery of home and community care services to help more people to connect to care that they need in the comfort of their own home. From more nursing and personal support services, caregiver supports and respite services, and bereavement and behavioural programs to assisted living services, adult day programs and programs for people with brain injuries, work is under way to provide faster and more convenient access to the care they need.

The province is also working with Ontario health teams and home and community care providers to create new and innovative programs for people wanting to connect to care at home, to help ensure people receive these important services sooner.

We're also making it faster and easier for young people to connect to mental health and substance use support, primary care, social services and more by adding eight new youth wellness hubs to the 14 that are already operating in communities across the province. We're also expanding One Stop Talk, a virtual walk-in counselling service for children, youth and families that provides access to mental health care with a clinician by phone, video, text or chat. Through the new Health811 service, Ontarians can chat online or call 811 to talk to a registered nurse, day or night, for free in multiple languages.

Speaker, these are some important innovations that our government is putting in place, expanding what is possible for health care in Ontario and delivering a new level of care and convenience to families across the province.

Now I'm pleased to pass my time to the member for Windsor–Tecumseh.

The Acting Speaker (Ms. Patrice Barnes): The member from Windsor–Tecumseh.

Mr. Andrew Dowie: It's really my pleasure to rise in the Legislature today to speak to Bill 60. Ontario is proud to have one of the largest publicly funded health care systems in the world, a system that we're investing nearly $80 billion in this year. I get to witness every day the contrast between another country and ours. I know that Premier Ford and Minister Jones have been clear: Ontarians will always access our health care system with their OHIP card, not their credit card. That's been the record to date and will continue to be going into the future.

Our government knows that wait times have been increasing year after year for surgeries and diagnostic tests. We are not okay with the status quo and know that more work needs to be done. That's why two months ago, our government launched Your Health Act, a plan for connected and convenient care, which includes our innovative plan to eliminate the surgical backlog and reduce wait times to connect Ontarians to more convenient care close to home.

This is in addition to the $880 million of investment that our government has made in our hospitals through the Surgical Recovery Strategy since the start of the pandemic to clear the surgical backlog. This funding can be used to

increase evening and weekend hours in the operating room and remains available to hospitals.

Speaker, we're already seeing results that are delivering better health care outcomes in my region of Windsor–Essex. While cataract surgeries have one of the longest wait times in the province, through the Your Health plan, our government has introduced new licences which will enable community surgical centres to perform 14,000 additional publicly funded cataract surgeries each year.

As my colleague from Essex and I have noted, the Windsor Surgical Centre can now provide over 4,000 new cataract surgeries annually, representing over 25% of the current cataract surgery wait-list in Ontario's west region. A quote from Dr. Wassim Saad, "It's a win-win for everybody." Dr. Saad is the chief of staff at Windsor Regional Hospital, which works closely with the surgical centre.

This is in addition to the recent announcement to accelerate the timeline to build the new Windsor Regional Hospital. Speaker, let there be no doubt that on this side of the House we support Windsor Regional Hospital. We support the work that the hospital has done in conjunction with Dr. Emara and Dr. Tayfour to create the Windsor Surgical Centre. We support locating the Windsor Regional Hospital at its chosen location on County Road 42.

What was the result of this support? Well, there were more PC votes in Windsor than NDP votes for the first time since the 1950s. That's the result of this government's action.

Just this year, we announced that our government is investing approximately $30 million in the current hospital to connect people with improved treatments for patients with cancer and cardiovascular disease. This funding will make it easier for more patients in Windsor–Essex to be diagnosed and treated close to home. This $30 million in funding was announced in 2014; it never flowed under the watch of our predecessors. Our government did the heavy lifting to make it happen—not just talk, but actually doing the work. Our government is giving Windsor Regional Hospital the funds that it needs to provide the best possible care to patients in the region while we work toward building a new and modern hospital.

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Speaker, our core promise to every person in Ontario is this: You will be connected to the health care you need when you need it, whether it's an unplanned 3 a.m. trip to the emergency room with your child or a routine checkup with your family doctor; whether your aging mother needs more support to keep living in the family home she loves, or if you need cataract surgery to fix a problem that has been bothering you for years. Whether you live in a big city, a small town or in a remote spot in the north, Your Health: A Plan for Connected and Convenient Care puts people at its heart by adding and expanding health care services closer to home.

We're taking action to strengthen all aspects of health care, particularly where you access it the most frequently: in hospital emergency rooms; in community settings, like pharmacies and doctors' offices; in long-term-care homes; and through care delivered right in your own homes.

Speaker, we know we can't do it alone. That's why we're hiring and training more doctors, nurses and personal support workers to help us deliver on that promise. This long-term plan is built on three pillars: the right care in the right place, faster access to care and hiring more health care workers. By focusing on improving the health care experiences of Ontarians and growing our health care workforce, we will improve the quality of health care delivery across the province for years to come.

But Speaker, don't just take it from me. Dr. John Yip, president and CEO of SE Health, said:

"Based on SE Health's knowledge of the national landscape, I'm here to say Bill 60 is a good start in eliminating Ontario's surgical backlogs. We are pleased to see this government introduce significant changes to our system that will better serve Ontarians within a publicly funded system. Overall, this bill sets up a good framework to create a system of surgical care that is patient-centred and promotes patient choice."

Speaker, for over 30 years, community surgical and diagnostic centres have been partners in Ontario's health care system. Like hospitals, community surgical and diagnostic centres are held accountable to the highest quality standards, the standards Ontarians deserve and expect across the health care system.

In committee, Dr. Agarwal commented, "I'll say that the Ontario Association of Radiologists strongly supports the current Bill 60 that's being proposed and we applaud the government for its innovative approach to solving a very complex problem," in reference to expanding the integrated community health services centres to address the MRI and CT backlog.

To further support integration, quality and funding accountability, oversight of community surgical centres will transition to Ontario Health. This improved integration into the broader health care system will allow Ontario Health to continue to track available community surgical capacity, assess regional needs and respond more quickly across the province and within regions where patient need exists.

We're also expanding oversight and patient protections when it comes to Your Health. Integrated community health services centres will now have to post any uninsured charges both online and in-person. Every community surgical and diagnostic centre must have a process for receiving and responding to patient complaints. Patients cannot be denied access to treatment if they don't purchase uninsured services.

We're also expanding the oversight of the Patient Ombudsman to include integrated community health services centres. These safeguards are in place to ensure that no extra charges occur for OHIP-funded procedures. By leveraging the support of community surgical and diagnostic centres, we will eliminate surgical backlogs and reduce wait times.

The Ontario Medical Association supports our plan, saying, "We support Bill 60's ... feature to move lower acuity surgeries and procedures out of the hospitals. This is an important step in reducing wait times."

We know that lengthy wait times for surgeries are one of the biggest challenges you and your family are facing in Ontario. While Ontario leads the country in the number of people who receive the surgery that they need for hip and knee replacements, we still aren't meeting the right benchmarks, and we need to do more.

I would like to emphasize that this is all publicly funded. The cost of receiving these insured services in the community surgical and diagnostic centres is covered by your Ontario health card, never your credit card. As the government significantly expands the number of surgeries being done through community surgical and diagnostic centres, it will do so with measures in place to protect the stability of staffing at public hospitals, including requiring new facilities to provide detailed staffing plans as part of their application and requiring a number of physicians at these centres to have active privileges at their local hospital.

Further, Ontario Health will ensure that these centres are included in the regional health system planning. Funding agreements with new community surgical and diagnostic centres will require these facilities to work with local public hospitals to ensure health system integration and linkages, including connection and reporting into the province's wait times information system and participation in regional central intakes, where available.

In addition to shortening wait times, providing these publicly funded services through community surgical and diagnostic centres will allow hospitals to focus their efforts and resources on more complex and high-risk surgeries.

The Acting Speaker (Ms. Bhutila Karpoche): Questions?

MPP Kristyn Wong-Tam: Studies and reports around the world have concluded that a two-tier health care system is generally more fragmented, leaves more potential to abuse and fraud, and overall, because you're administering two systems, generally more expensive. How does this member and how does this government justify the cost, inconvenience and exposure to fraud and fragmentation that their bill is producing?

Mr. Andrew Dowie: I thank the member for their question. Really, the Independent Health Facilities Act dates back to the NDP government of the 1990s, so clearly, there's a role to play for the private sector to operate in the health care space. Ultimately, we are expanding what we know works. There are plenty of providers who are not directly operated by the government who are doing fantastic work. As the government House leader mentioned, staff in private sector facilities are just as caring and compassionate as any other worker. Those employees should be supported, and we're supporting them through this bill.

The Acting Speaker (Ms. Bhutila Karpoche): Questions?

Mr. Logan Kanapathi: Thank you to my colleague the member from Windsor–Tecumseh and also the member from Bruce–Grey–Owen Sound. Previously, as my good colleague confirmed, the member from Lanark–Frontenac–Kingston made excellent remarks about this bill.

Madam Speaker, I've been talking to many front-line workers, family physicians, surgeons, and they were talking about the initiatives of our government, what we are doing, especially hiring more nurses, training more PAs, physician assistants. We should have done it a long time ago. Doctors are burning out. They don't even have assistants to do so much of the work. And this bill is empowering all these things. It's bringing more capacity to our health care system.

My question to the member for Windsor–Tecumseh: Please elaborate about how we are empowering, strengthening this health care system through staffing, such as doctors, hiring nurses and—

The Acting Speaker (Ms. Bhutila Karpoche): Thank you.

Response?

Mr. Andrew Dowie: Truly, I thank the member for his question, and hopefully this bill—and the government does provide support for the workers, and certainly to our physicians. I had the chance to meet Dr. Rose Zacharias of the OMA down at our local hospice, and I can't thank her enough for her brilliance, quite frankly, and I'm happy to see her supportive notes about this. So the physician community sees the value in our bill.

Further to that, you, undoubtedly—you were here before I was, and you will recall what the government has done previously to support our nurses: $5,000 of a lump sum payment in March 2022, 12,000 new nurses registered to work in the province last year among many, many initiatives to grow our workforce and make sure that our staff do not see that burnout going into the future.

The Acting Speaker (Ms. Bhutila Karpoche): Question?

Mr. Terence Kernaghan: I'd like to thank the member from Bruce–Grey–Owen Sound as well as the member from Windsor–Tecumseh for their presentation.

In the discussion about patient clinics, to really put a pin in this, the OMA has actually indicated that they do not support a two-tiered system. They support something that's publicly funded and publicly delivered. They're not in support of health care privatization.

In terms of the discussion, they were wanting these surgical centres to be connected to hospitals. There's one in my city: the Nazem Kadri Surgical Centre. Actually, it has been shown through research that ORs have a minimum of six staff, whereas these surgical centres only have as many staff as is needed, and an OR typically costs $469 per patient, whereas with these surgical centres it's $172.

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So my question to the member is, is it fiscally prudent to allow US-style, for-profit corporations to skim money away from patient care?

Mr. Rick Byers: I thank the member for the question. As a past member of the finance committee, I know he cares about the numbers as much as we all do on this side of the House.

There are two parts to this question. First, let me comment on the relationship of the surgical centres to the existing public health care system. In fact, what we're doing, as both of us and others have commented on, will lead to more integration between these community health centres

and the existing public health system—more integration, not less. I've seen it first-hand with LifeLabs, an example of an excellently run lab testing business owned by an OMERS pension—many municipal members here who are part of it. It provides very good service, paid for with your OHIP card—one-tier health care, not two-tier.

The Acting Speaker (Ms. Bhutila Karpoche): The member from Elgin–Middlesex–London.

Mr. Rob Flack: Again, on the same theme as earlier—and I know the member from Bruce–Grey–Owen Sound has had some experience in the health care sector locally, in his riding. I met with some of your colleagues and acknowledged your financial acumen and also your hands-on experience locally. I wonder if you could share some of that experience. And I want to keep drilling back to—I don't think "profit" is a bad word; "privatization" is. We're not talking about that.

So can the member, in this House, tell us what our government is doing to protect Ontarians from extra billing, in your experience in the health care sector, post-your successful business finance career?

Mr. Rick Byers: I thank the member very much for his question. He's a great colleague to work with.

Yes, for several years, I was on the board of the South East Grey Community Health Centre. This is a fabulous community health centre model which is really driven by nurse practitioners and, in this case, visiting physicians, and a fantastic model, in particular, for rural health care. I saw it in my communities of Markdale and Dundalk. It was a great model, and this reinforced to me the strength of our health care system.

This bill, I believe, will build on that success and have more integration between different providers of the health care system, be they existing clinics, like the one I was involved in, or cataract clinics or hip or knee clinics, providing more access for patients to get the care they need in a timely way.

The Acting Speaker (Ms. Bhutila Karpoche): Question?

Miss Monique Taylor: I've heard from constituents in my riding who have physical disabilities and need physio to be able to keep up their movement and their ability to keep functioning in everyday life. And we know that surgeries are being sold out to private companies to be able to perform those surgeries, so it brings me back to the—and my constituent is not able to get that physio without paying for it. It actually keeps her body moving and functioning and helps her participate in society.

So with all of these private surgeries that are going to be happening, will those patients be able to get the physio and rehab follow-up services that they need, and will they be insured, or will they have to pay for that out of their pocket?

Mr. Rick Byers: Well, let me start with the payment portion of all this. And I'll say it once, and you've heard it more, and we'll hear it more again: payment with the OHIP card, not the credit card. We've heard that, and the opposition and others are trying to—we've said this over and over and over again. That's the foundation of our system today. That will be the foundation of the system in the future.

And all of this will result in expanded capacity. This is what I like about what we are doing—more capacity available to get procedures done in Ontario, paid with your OHIP card. That's the foundation of what we're doing. That's what this bill reinforces, the strengths of our existing system, but expands them in an exciting way.

I'm proud to be a part of a team to support this bill.

The Acting Speaker (Ms. Bhutila Karpoche): Quick question?

Mr. Todd J. McCarthy: I've talked about how we are, in our communities, over 80 PC MPPs with a mandate for this bill and so many other innovative pieces of legislation. What is the member from Bruce–Grey–Owen Sound hearing? Is he hearing the same things as me, that this is great news for health care?

Mr. Rick Byers: I have indeed, and thank the member for his question. We're excited in our great community. We have a new hospital coming in in Markdale, and I think people see increased options for them, particularly in rural—this is one of the challenges we've got, delivery of health care in a rural environment. So people are supportive of what we're doing and want us to keep going and expand capacity.

The Acting Speaker (Ms. Bhutila Karpoche): Further debate?

MPP Kristyn Wong-Tam: It's an honour to rise to speak on behalf of the great people of Toronto Centre. Today, we're speaking, obviously, to government Bill 60. This bill is quite problematic and there are a number of concerns that I know many of my members and colleagues have on the opposition side. But I think one of the biggest challenges for me to accept is the fact that the government is purposefully starving the health care system by taking and diverting highly qualified and trained nurses and other allied health professionals out of our public system and driving them into private, for-profit clinics.

We already know that there's already a significant shortage of highly trained health care professionals who are passionately working in our health care system. Operating rooms are now sitting dark—which is quite hard to imagine, given the crisis that's before us—because they lack nurses. They don't have enough staff in those facilities to keep those facilities going. Surgical procedures and backlogs are at an all-time high. And we know that the hospital beds that the government likes to brag about—and certainly, there might be something worth boasting about—are not very good if there are no nurses to attend to them.

So there's a lack of nurses, there are empty hospital beds, there are dark OR rooms. Surgical procedures and diagnoses are taking longer. They're being delayed and oftentimes cancelled because of a shortage of lab technicians. Ontarians are already receiving less care and are waiting longer because of the decisions that this government has made—decisions that include not investing in staffing, not investing in retention and certainly not paying the wages that they deserve.

At the same time, if you will recall, Speaker, the government spoke to them often and called them heroes. We all did that. If you want to roll back the clock to 2020, there

was a lot of fanfare made about our health care professionals. We were banging our pots and pans on our balconies, on our porches. We were applauding them everywhere. I know there are certainly a lot of burnt-out health care workers who told me first-hand that they really appreciated that love and support. Now, they're saying to me, "What happened to that love and support? Where did all that go?" These are the same health care workers who carried us through the darkest days of the pandemic. They are the same ones who ushered our loved ones out of facilities as they had passed while they were trying to give them the high-quality dignity of care that they deserved, and all of this under the worst and most horrible working conditions.

You can't expect good results when you're denying health care workers and nurses the dignity of good pay, respect and reasonable workloads, as well as fair working conditions. If you cap their wages and disregard their unions and take them to court over your unconstitutional Bill 124—that level of disdain for the workers is just really quite staggering. What's worse is that most of those workers are women and oftentimes racialized women.

I certainly do understand when an exhausted, burnt-out nurse is going to take a job at a private clinic because they have to make those difficult decisions to go get the wages that they need in order for them to care for their families. What I don't understand—and I absolutely reject—is why this government is actively creating the conditions and even encouraging a for-profit, two-tiered health care system in our province and deliberately scooping those highly qualified and trained nurses out of our hospitals. You have the tools; you have the money to make the health care system work. Public hospitals in Ontario are already world-class, but that's going to quickly spiral into a rapid decline until you reverse course.

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The only reason I can think of why this government is so hell-bent on wanting the public system to fail is because they're setting up the system for two-tier, privatized, American-style health care. We have learned that there are 45 million Americans who have gone bankrupt because of high private health care costs. The rich will get faster care. They're going to get, perhaps, better care. But what's worse is that everybody else will have to wait, and their suffering will be prolonged.

But news flash, as I have mentioned, the American-style, two-tier health care system doesn't work. Studies and reports time and time again have pointed to the fact that it becomes more expensive, it's more bureaucratic, it's more prone to fraud, it's more fragmented, and many a time, governments have had to reverse course.

I want to be able to share with you why it's so absolutely critical for us on the opposition side—why we're so passionate about protecting our public health care system.

One of the things that I really want to press upon today is the fact that this bill has an absolute lack of regard for patients' well-being and safety. Public, for-profit surgical centres must be connected to a public hospital with an emergency room in case there are complications during the procedures that require intense patient care—adding a specialist on the fly so that they can get in there very quickly to help save lives and to provide support. This makes good, common sense. It's generally a best practice. It keeps people alive, Speaker.

So you can understand why I'm surprised, when I read this bill, that the "independent health facilities" are no longer required to be connected to hospitals. What is the government's plan when an emergency goes wrong and complications emerge, which, inevitably, they will? What happens when there is a mass scramble and struggle to save that patient's life on the table and there is no one to connect them to? There is no ability to be able to magically produce an emergency room and a hospital attached to it at that point in time, because you've actually decoupled it. You've made it worse.

Complications, Speaker, can happen to just anyone. Imagine if your loved one is forced to have surgery. Nobody wants to go and have surgery; it's an unpleasant procedure. You may be seeing out-of-pocket expenses because you're forced to go to a private clinic. You may be going there because of long public wait times, because the government has starved the public system of the high-quality nurses that they need to run the facilities. How would you feel if that was your family member?

What this bill is doing is actually shameful and wrong. Why is this government not setting out and prioritizing the delivery of publicly funded, high-quality health care for all Ontarians? Why are they leaving so much to be determined later on?

There is some vague language about a yet-to-be-named oversight body to make sure that the system runs well. That sounds fine, except we need to dig deeper: How are you going to regulate a private system when you have no details in the bill right now? The regulations are to be determined later on, and you want us to just trust you that you've got this?

Speaker, forgive me, but I don't trust this process. I certainly don't trust the intentions of the government, because they haven't earned it, given all their actions to move to the privatization of health care.

We want to be able to keep Ontarians healthy. It's absolutely critical for us as parliamentarians to do everything we can to protect our residents. But what I know about health care facilities, especially if you're leaving them unchecked with no strong regulatory body with enforcement afterward, is that these health care private facilities, as we have seen in the US, will engage in something called cream skimming: They will select the healthiest, least-risky patients, who are then the cheapest to operate on, to pocket that extra cash. Everybody else who doesn't have an American Express Gold Card in their pocket will have to get in the back of the line.

That is not fair, Madam Speaker. It is actually, I would even argue, un-Canadian. This two-tier health care system is created merely to propagate and to create profits for the existence of these new private clinics, and we're seeing them even though the bill hasn't passed. They are already emerging in Ontario.

The system will also ensure that those who have more complications, who require more complex surgery, will be sitting in the public line, which has been starved by the government. These private health care facilities will select their wealthiest patients, who have the ability to pay for all the extras, the little bells and whistles. The bill will try to mitigate this, but it doesn't go far enough, as oftentimes these government bills don't. It's so vague. It speaks to it, but there's nothing that actually enforces it. And as we know, Speaker, regulations and laws without actual enforcement are useless.

The private clinics may make optional changes, which would seem unavoidable, and they will upsell patients. We're already hearing about those stories—I know I am, Speaker—and it continues to flood into my office. There is nothing to prevent the private clinics from only choosing to work with the tools and the procedural styles that they want to, which means those that are not covered by OHIP. For example, Speaker—this is a very common example—some vein surgeries have two options: a minimally invasive glue-based method that is faster and that does not require anaesthesia, and there is no downtime for recovery, and it is not OHIP-covered. It's simple. There is also another procedure that is generally requiring full anaesthesia, and it is more invasive and more painful. Would you think that the private clinic is going to offer them the publicly funded system, or are they going to ask them to pay for it out of pocket? The pressure will be there. It will be, because it is already being reported.

Higher-quality equipment that facilitates better outcomes should not be hidden away in private clinics for the wealthy. They should be studied and, if appropriate, funded and put into our public system. This is why there have to be clearer rules and consequences for private clinics, Speaker, because there is a lot of misleading information that is put forward. It also includes billing practices. Under the new system the government is proposing, we are going to see higher pressure for upselling, and there's going to be much more vagueness on what the true cost will be until afterwards.

I'd like to think that we could force these clinics to publish their eligibility and rejection criteria. Wouldn't that be nice, Speaker? They're going to be funded by our private dollars, going into for-profit coffers. We should know who they are accepting as patients or who they are rejecting, so we know who these clinics are going to truly serve. And yet, Speaker, I'm very confident that the government is not going to even introduce an amendment such as that, something that will ensure greater accountability on where our public tax dollars are going to go. I think Ontarians have the right to know who these facilities are serving and who this government is investing in.

This legislation does not lay out the requirements for the continuity of care or do anything to address the horrendous family doctor shortage in the province. Patients undergoing surgery need to be followed up by a family doctor oftentimes for advice, for care after the surgery. Even if a patient already has a family doctor, which is good for them, there's no clear outline on how the communication is being managed between the for-profit clinics and the family doctor.

There's no integration of the broader health care system. I'm concerned that patients will get lost in the system, as we are already seeing, Speaker, because of the incredible shortage of staff, despite the fact that these individuals will need rehabilitative supports or, perhaps, after-surgery critical care.

This bill does not indicate where the patients will go after their surgery. They will be left on their own. And so, even if the surgical procedure is successful, if an individual patient does not receive the necessary aftercare because of surgery, they could fall back into illness.

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Speaker, there is really so much in this bill that is so wrong, and unfortunately, I've got to keep going because I'm going to talk about the other things that are wrong with this bill. I want to be able to talk a little bit about innovation, because this government has talked about how it likes to innovate, and the fact that they're moving things forward in a technologically advanced way, and how everybody else in this House seems to be a Luddite. Well, let's talk about innovation for a little bit.

This bill misses an opportunity that is so easy and simple for the government to pick up, and that is to establish a centralized specialist referral system. It's an easy fix, Speaker. It touches on data-driven technology that can actually place the surgical wait-list and the wait times and the specialist into an open environment that is accessible to the referring doctor, to the patients who are looking for that information and even to the health care worker. Last week in this House, I asked a very simple question, potentially proposing to the government that they create a centralized wait-list data bank, something that the BC government has done, placed it onto their website; we can all go look at it right now, and we can see how many days, how many weeks or how many months—if it's a really complicated surgery—is that person, the patient, in the queue for.

Patients, with the advice of their doctor, should be able to choose the specialist that they want to see, because everybody should be given some choices. However, it needs to be open and transparent. The Ontario Medical Association has said that a centralized wait-list could cut the times by 20% to 30%. I want to reiterate that, Speaker: a 20% or 30% reduction in wait times just by making the data publicly available. How about that? Such a simple, elegant innovation to health care provision that's already being done in other jurisdictions in Canada. Our current system has been described by doctors as sort of looking through a pinhole. What they're telling you is that they don't really see the full picture, and so oftentimes with the specialist that they're referring to, they really don't always know what's going to happen on the other end because the information is not open and not transparently shared.

British Columbia has already implemented the system that I've just described, and they've seen an 11% drop in

the number of patients who have been waiting more than six months for knee and hip replacements. Saskatchewan ran a program like this for four years that covered all surgical procedures and their numbers were spectacular; I actually thought there was a mistake in the print-out. They saw an 89% reduction, Speaker, in the number of patients waiting for three months and longer for surgery. Talk about innovation; talk about bringing better health care to Ontarians.

The Canadian Association of General Surgeons has shared that most of their membership is on board for a centralized wait-list, but they need the government to come to the table to run it and to maintain the infrastructure. Why is something so simple, so elegant, so proven as best practice to deliver better results, not in this bill? I don't think it's a very big ask, especially considering the big win that will be available for the patients because they will know and have access to better-quality information, as well as those who are referring them to those services.

Big wins like this are absolutely impossible if the operating room is dark due to the lack of staff. If we don't have allied health professionals qualified and ready to go to actually make sure that the health care system works, then of course we are not going to be able to get those big wins. It's so much easier to say, "Well, we're going to create innovation by contracting it out, by making public funds accessible for private profiteers out there." So while there is this odd doublespeak, Speaker—and I really struggle with it, because the conditions for creating a high-quality, world-class health care system are here. The money is in this province. The coffers show us that the dollars are there, and yet the government's steadfast devotion to racing to the bottom, to contracting out, to upholding Bill 124 even though it's been deemed unconstitutional, to demonizing the nurses and the health care professionals and the union workers has just been really—Speaker, I can tell you, it's setting us on the wrong course. It's going backwards.

I think, Speaker, Ontarians want us to do better. Ontarians are expecting the parliamentarians in this House to actually fix the health care problems that we have. They want this government to keep their promise, when they said—when the Premier said that he was going to get rid of hallway medicine. Instead, for five years, things have gotten consistently worse and much more expensive, with no help in sight.

So this bill cannot be supported. And, yes, if we have to say no, these are just some of the reasons why. Because no one believes that this bill is going to fix the health care system and end the problems that are plaguing our health care professionals. They don't believe that this government is going to deliver the solutions that they need today in Ontario.

The Acting Speaker (Ms. Bhutila Karpoche): Questions?

Mr. Graham McGregor: Point of order.

The Acting Speaker (Ms. Bhutila Karpoche): Point of order: the member from Brampton North.

Mr. Graham McGregor: I'm just rising on a point of order to welcome some friends to the Legislature. We have renowned community activist in the city of Brampton Jotvinder Sodhi. We've got his wife Kulwinder Sodhi, his daughter Jasmine Sodhi, and visiting us from India, we've got Dr. Jagjit Singh and Dr. Roopen Singh—

The Acting Speaker (Ms. Bhutila Karpoche): Just a reminder that you cannot use a point of order to introduce guests. Thank you.

Questions?

Mr. Terence Kernaghan: I'd like to thank the member from Toronto Centre for sharing their concerns about two-tier health care. They are concerns that I share myself. We hear about transparency and accountability in word alone from this Conservative government on frequent occasions. But, for the interest of clarity, does the member think it would be transparent and accountable for this Conservative government to tell Ontarians that they will be paying millions to health care profiteers with their health card?

MPP Kristyn Wong-Tam: That certainly would be a more accurate description of what I think is before us, as opposed to denying that people are going to have pay with their credit card. Because simply by walking into that clinic and being upsold, by being part of the cream-skim, they are going to have to pay. My own parents actually just went through that experience with an eye clinic when they had cataracts replaced.

The Acting Speaker (Ms. Bhutila Karpoche): Question?

Mr. Todd J. McCarthy: My question to the member opposite is: Instead of always saying no to innovation, instead of saying no to progress, instead of saying no to protecting and enhancing public, universal health care, why can't the member say yes to thousands more nurses, thousands more PSWs and more medical seats in medical schools than we've seen in decades? Why does the member opposite insist on clinging to outdated, retrograde measures such as what the NDP did in the 1990s as government by freezing medical school places? Why?

MPP Kristyn Wong-Tam: I have been an elected official for 12 years and—

Interjections.

MPP Kristyn Wong-Tam: Thank you. I have, on many occasions, said yes to a number of great programs, a number of great policies and a number of excellent services that will benefit my community.

If I thought this bill was going to make life better and healthier for my community, absolutely, I would sign on board. But there were 74 amendments that were provided in committee which this government categorically refused. So if the bill is not improved, there's no way we can support it.

The Acting Speaker (Ms. Bhutila Karpoche): Questions?

Ms. Sandy Shaw: I just want to be clear that the title of this bill is absolutely an oxymoron. The point of this legislation is to introduce private, for-profit clinics in our communities. The bill in fact repeals the name, which used

to be called "independent health facilities," and changes it to "integrated community health services." But there are currently 900 independent health facilities, 100% of which are already for-profit. So this has nothing to do with providing the kind of care that people need: publicly funded, not-for-profit care. This is a bill that does nothing but hand over the riches of our health care system to corporations.

1520

So can you speak again about how the title of this bill and what the members are saying are completely at odds with what is going on here?

MPP Kristyn Wong-Tam: Thank you to the member for her question.

I think we've all learned that in this House government bills often come with a title that sounds quite benevolent, rather harmless—and then you start to dig into it. I know it's an easy speaking point and it's on brand for the government to keep it simple and get things done, but unfortunately, they're not doing the right thing.

A two-tier health care system will create greater inaccessibility to health care. It's going to cost more to administer. It's going to create more fragmentation. It's going to reduce the quality of care in the public health care system, which is what we're already seeing.

The Acting Speaker (Ms. Bhutila Karpoche): Question?

Mr. Andrew Dowie: I thank the member from Toronto Centre for her remarks. My local experience has been, I'd say, opposite, given the additional capacity given by the Windsor Surgical Centre, and it means people are in misery for less time before treatment. The Your Health plan will reduce the surgical backlog and improve the quality of life for patients and care in Ontario. I've witnessed it in my own community.

Will the member opposite support their constituents by supporting this bill, to ensure Ontarians aren't waiting too long for surgeries and procedures?

MPP Kristyn Wong-Tam: I thought I'd made myself evidently clear that, number one, this bill is not supportable.

If you want to fix health care, then publicly fund it now. We've got a health care system that's in crisis, that's underfunded, where we have professionals leaving in droves; other provinces are actively reaching and recruiting from ours. If you want to stop that bleeding, if you want to reverse the trend, you have the ability to do it. You're sitting on $20 billion in the coffers. Just release it. Fund it now.

The Acting Speaker (Ms. Bhutila Karpoche): Question?

Miss Monique Taylor: On May 26 and May 27, the Ontario Health Coalition will be holding a referendum across the province, and they will have a thousand voting locations throughout the entire province. The ballot question will be, "Do you want our public hospital services to be privatized to for-profit hospitals and clinics?"

I'd like to ask the member how she will participate in this referendum and if she believes that anybody from the government side will also participate in the referendum.

MPP Kristyn Wong-Tam: Thank you very much for the question.

I really must commend the Ontario Health Coalition for doing the exceptional work that they're doing to try to educate the public about this bill and to make sure that we have a say in it. I think that having a referendum is absolutely important, especially since the question isn't being asked to the general public. The bill hasn't travelled; it's not going to the different communities. So, absolutely, I would participate in promoting that referendum.

I also would like to say that I've already started to canvass in my community, just to explain to them what this bill means. They've been doing their own research, and I have yet to meet a single resident who actually supports Bill 60. I've knocked on hundreds of doors. I haven't had a chance to speak to thousands of people—they're not always home—but certainly, I've spoken to hundreds, and not a single person supports this bill.

The Acting Speaker (Ms. Bhutila Karpoche): Questions?

Mr. Todd J. McCarthy: Speaking of stakeholders and other input, would the member opposite care to comment on Anthony Dale and his endorsement of Bill 60, as president and CEO of the Ontario Hospital Association? "With the introduction of the government's Your Health Act, Ontario is setting the foundation to expand and integrate community-based surgical and diagnostic centres into the public system." And it goes on.

Dr. Rose Zacharias: "The OMA is very encouraged by this next important step to reduce wait times."

Why can't the NDP say yes to positive, innovative change in our public health care system to maintain it and improve it?

MPP Kristyn Wong-Tam: Thank you for the question. I really appreciate the opportunity, especially when I hear from the government members—they pull up endorsements and letters of support, but really, they're letters, but not always with full support. I've heard now from far more health professionals and administrators that they find a two-tier health care system problematic. So reading clips and bits of a letter, I think, is—of course, we don't have the time to read the whole thing. However, I do want to stress that it's absolutely important that you take a look at the totality of all that the health care professionals and the administrators are saying, and they're saying that this bill is going the wrong way.

The Acting Speaker (Ms. Bhutila Karpoche): Questions?

Ms. Sandy Shaw: I was very interested to hear you talk about the people in your community and what they're concerned about and what their fears are. Do you want to take a few minutes, or some time, to talk to us about some of your constituents who are already facing long wait times, are already struggling to get the surgeries that they need, are already being surcharged when it comes to cataract surgeries? What are their fears with this bill: that things are going to get worse for them and not better?

MPP Kristyn Wong-Tam: Thank you very much. I will just share two quick examples. I've got a health care

professional in my community. His name is Blythe. He wrote a really long and eloquent letter, which I didn't have a chance to read into this House, but I will tell you that he's actually demoralized and he's left the health care system, largely because of what he's seeing. It's too heartbreaking for him to stay in it.

I have another letter from a constituent named Lorrie who had a very urgent matter that she needed to attend to. She couldn't get the health care that she needed and they told her to go to a private clinic and pay for an MRI.

Just a couple of short examples, and there are thousands more of these stories out there.

The Acting Speaker (Ms. Bhutila Karpoche): Very quick question?

Mr. Ric Bresee: I'll make it a very quick question if I can. My doctor, my specialist, my LifeLabs bloodwork, they're all done with private corporations. Which of those would the NDP have us close?

MPP Kristyn Wong-Tam: I'm not proposing that you close those. I mean, there's already an act that allows them. The provision is there. But you're actually starving the system and opening it up for more—

The Acting Speaker (Ms. Bhutila Karpoche): Thank you.

Further debate?

Mr. Adil Shamji: It's an honour to rise in the chamber to address the euphemistically-named Your Health Act. I'm going to mention that it will take a significant amount of restraint to maintain the decorum in this chamber, but I do want to acknowledge that we have some incredible youth from Oakville who are here because they are going to inherit the health care system that we design. Their parents and their grandparents are going to be using it, if they're not already using the health care system, and we must be deeply invested in ensuring that this health care system will be there for them, now and forever into the future. And I'm sorry to say that this bill is the first of many more steps that will see it undermined, dismantled and deregulated.

So, where are we right now? We have gone through a series of public hearings, clause-by-clause review and had the opportunity to submit innumerable amendments. In my case, I have submitted so many amendments to improve this bill that the package I submitted for review by the Standing Committee on Social Policy outnumbered in pages the number of pages in Bill 60 itself. That's right. This bill, unfortunately, is so flawed, so sloppy and so poorly conceived that it has taken more work to fix it than to write the bill itself. But, of course, this government is not interested in fixing anything. It will come as no surprise that they actually voted down and said no over and over and over again to improvement after improvement after improvement that I proposed.

Today I'm going to demonstrate three things, Madam Speaker. The first is that I'm going to show how this bill is fatally flawed. I'll demonstrate this by my testimony and also by referring to the feedback that was received during public hearings. I will demonstrate that it was salvageable and I will walk you through my amendments, which were all voted down. And then I will demonstrate that it must not be passed. I will demonstrate that by showing how the members across opposed every single attempt.

This government loves to rail against the status quo, without acknowledging that they, in fact, are the status quo after governing for five years. The moment they took power, our health care system immediately embarked on a significant nosedive. They cut hundreds of millions in public health funding, cut staffing solutions like the practice ready assessment program and they enacted unconstitutional wage-capping legislation like Bill 124.

Instead of solving these issues, getting at the root cause of the challenges we face in our health care system, they are proposing this poorly conceived superficial policy that lacks thought, detail or any semblance of understanding about the challenges that we face today. It continues in a series of failed policies, like the failed effort to increase credentialing of foreign-trained health care workers; the failed effort to regulate temporary, for-profit nursing agencies; and the failed effort to reassure us that Ontarians will always pay with their OHIP card, not their credit card.

I've heard enough about LifeLabs and how we will always pay with our OHIP card there. To any of the gentlemen across, try and get your PSA test, and when they ask you to pay $30, hand them your OHIP card and tell me what happens. We don't need to look further than virtual primary care to discover OHIP services already locked up behind paywalls and credit cards in this province. Try and book an appointment with a virtual primary care service, and when they ask you to pay $70, hand over your OHIP card and tell me how that goes.

1530

Here is the issue: The rate-limiting step in our health care system is health human resources and staffing. The Ontario Hospital Association has acknowledged this: "The OHA has consistently advocated that Bill 124 should not be extended nor should additional restrictions be imposed due to its impact on availability of HHR and other impacts on hospital operations." Yet this government persists stubbornly on Bill 124, defending it even after it has been noted to be unconstitutional. I would like to thank the OHA for their incredible efforts during the pandemic and as they continue afterwards.

Let's also not forget that by 2028, this government will have underinvested by over $23 billion according to the Financial Accountability Office. That is not addressed in this bill. One of the most shocking things about that figure, by the way, is that it's $23 billion of underinvestment in relation to promised investments. It doesn't speak about the many investments that have not even been promised. The fact is that this government is a master class in tokenism. In the last budget, I think they said that they're going to bring in 50 foreign-trained medical doctors—50—when we have 2.2 million patients who don't have access to a primary care physician. That's not in this bill.

So amidst this comedy of incompetence, we have a murky new bill that proposes moving surgeries and diagnostic services out of hospitals in an unregulated manner, and I have pointed out the shortcomings of it from the very

beginning. I pointed out that its full impact won't really come into focus until it has been passed because so much of the stuff that matters in making this bill successful has been left to the regulations. Who will perform oversight? Is the oversight body external or internal? Without such details, how can we possibly believe that there are credible protections against upselling or upcharging? After all this government has, of course, as we all know, ignored all of the recommendations by the Auditor General in regard to upcharging and upselling in out-of-hospital facilities.

So here's what's wrong with Bill 60: As I mentioned, it completely misses the point of our health care crisis, notably the fact that there are massive staffing issues and massive underinvestment. It barely even pays attention to the things that matter—oversight, protection against upselling and upcharging—and it doesn't deliver any of the details. It asks us to sign a blank cheque. Believe it or not, it proposes to redefine what is a "physician," what is a "registered nurse" and what is a "registered practical nurse." And believe this: It doesn't say what the definition is going to be. It just says the old definition was thrown out the window and the rest will be decided in the regulations, an opportunity when we will not be able to have any say in the matter whatsoever.

I want to pause and be clear about something: There is merit to moving surgeries and diagnostic services out of hospitals. It can reduce the backlog and increase accessibility to services, but it needs to be done the right way. This is the way to do it:

—it needs to be done in a not-for-profit manner;

—linked to hospitals;

—monitored with strong ministry oversight;

—compensated at the same rate as hospitals;

—prevented from draining the public system of health human resources;

—there should be no opportunities for profiteering or upselling; and

—above all, it must be safe.

I'll speak very briefly to the challenge of for-profit care delivery, because I've heard it come up over and over again in the debate today. There are consistently worse outcomes in for-profit health care. Health care must always prioritize patient health, never private wealth. We have seen in countries all around the world and throughout Canada what happens when for-profit interests take priority. We saw it in for-profit long-term-care homes, where there were worse outbreaks and more deaths. We've seen it in for-profit vaccination clinics here in Ontario, where there is increased wastage and less uptake of vaccination compared to the ones that were offered by hospitals—and over and over and over again.

We've also heard, even in the debate today, a number of people speak to some people who have said that they think Bill 60 is passable, and I want to quote some of those very same people.

The Ontario Association of Radiologists: Dr. Vik Agarwal, who was just quoted a little while ago—in the public hearings, he identified the following concern in regard to corporate, for-profit interests: "I guess what I was saying is that I'm a doctor. My interest is in treating patients. I'm not a businessperson. I look at spreadsheets when my accountant shows me a spreadsheet. I'm not a slave to a line on a spreadsheet, whereas people I know in business, they're very concerned about their shareholders and what they're paying out. So what I would say is that if you have people owning these clinics who aren't physicians, we open ourselves up to risk." He proposed an amendment that these out-of-hospital centres should be operated and led by physicians. That was voted down.

Dr. David Graham from Scarborough Health Network said the following: "I would also say that, when you read the bill and look at guardrails that are provided, I think the biggest concern for a lot of people is on the health human resources part of the bill. Requesting that detailed planning comes out that actually outlines what those resources are by procedure I think is an important safe guardrail for that." That has not been done in this bill.

I'll skip the remaining quotes, but I've got Dr. David Graham; I've got Dr. Kevin Smith—all hospital CEOs, all very respectable individuals.

I've outlined the protections that need to be in place. I've outlined the fact that there needs to be accountability and transparency on things like what the definition of a doctor should be.

And here are the very concrete ways in which I tried to salvage this government's bill. I submitted 45 amendments, and they were not controversial. Try this: "The director and the inspectors shall have a duty to consult Indigenous people in the planning, design, delivery and evaluation of health services in their communities." What could possibly be controversial about that? I thought we were serious about truth and reconciliation here. That was voted down.

I submitted an amendment to make sure that—maybe it would be nice to have someone competent overseeing the integrated community centres. So I said, "A director must be chosen by a competitive process, and must be an individual employed in the ministry or by Ontario Health, or an entity such as a regulated health college that has a responsibility to act in the public interest...." That sounds extremely reasonable to me, non-partisan, and for which there is plenty of precedent. It was voted down.

I submitted one about staffing: "The application must include a health human resources plan that satisfactorily deals with how the operation of" these service centres "will be coordinated with local hospital and regional needs"—and I gave some criteria. It was voted down.

Let's prioritize patient care. We've seen what happened in for-profit long-term-care homes. Given the opportunity to support not-for-profit, this government has said no. I said, maybe there's a way that we can protect even within a for-profit model. I said, make the directors of a for-profit corporation fiduciaries of patients, meaning that their obligation to protect patients must come before their obligation to protect shareholders. Who could possibly disagree with that? This government.

Speaker, 45 times over, this government said no to the things that would protect all of us.

So now we have a bill that misses the mark, a bill that was significantly but not fatally flawed in the beginning but is fatally flawed now. We heard these errors articulated

by so many people who came through the door during public hearings. We saw this government ignore the advice of every single person. I received emails from some of the people who came and gave public testimony, in fact, saying that they felt insulted by government members who ignored them, who spoke over them.

I proposed so many concrete ideas to make this bill stronger, and again, this government—I suppose that when someone makes an accusation about something, it actually reveals more about themselves—voted no to all of them.

So this bill fails. It puts patients at risk. It undermines our health care system. It worsens our staffing crisis. It must not be passed.

The Acting Speaker (Ms. Bhutila Karpoche): Questions?

Mr. Todd J. McCarthy: The member from Don Valley East is a member of the Ontario Medical Association. Allan O'Dette, the CEO of that Ontario Medical Association, said this about Bill 60: "The OMA appreciates the collaboration with Ontario's government and their commitment to thoughtfully implement the shift of more procedures out of hospitals into the community. We are very encouraged this legislation, if passed, aligns with OMA's recommendation to replace the independent health facilities act with a more comprehensive framework that strengthens prohibitions against two-tier health care...."

How can this member opposite not support Bill 60 in light of what the head of his organization says?

1540

Mr. Adil Shamji: The quote that was just provided is just so typical about how this government governs the things that matter most to all of us, because what he said wasn't the complete story. If he kept reading, he would know that the Ontario Medical Association has published a report in which it explicitly says that out-of-hospital surgical facilities are recommended—they want them to happen—in an explicitly not-for-profit manner.

So I have no problem speaking to the words of the person who represents the organization I belong to, the Ontario Medical Association. I have no problem speaking to that. All I ask is that we speak to all of the words that the OMA has said, and the OMA has said that these facilities should operate in a not-for-profit manner, which is not what Bill 60 does.

The Acting Speaker (Ms. Bhutila Karpoche): Questions?

Mr. Tom Rakocevic: The member spoke very passionately, with a lot of experience, on this issue. I want to note that we've heard government members read out quotes from doctors, so I'm really happy to be able to hear the opinion of a doctor here in this chamber who is speaking quite against the legislation. But you mentioned the PSA testing, and very recently, the Conservative government voted against a motion to have this important men's health option covered by OHIP. Can you talk a little bit about that? Was that a good move or a bad move by the government?

Mr. Adil Shamji: Thank you very much for your question on that. PSA is a leading cause of death amongst men in our country, and it is preventable if it is caught early. There are two ways to catch it early. One is a digital rectal exam, which I'm sure that no one in this chamber would relish, and the other way is a blood test. Now, both of those methods are not perfect methods, but every patient in Ontario should have the opportunity to choose a manner in which they can be protected from having a preventable but sometimes fatal cancer.

There are many reasons why the digital rectal exam—and I leave it up to your imagination. But even in the most marginalized and vulnerable populations, there are many reasons for which getting that rectal exam is not the right option, that getting the prostate-specific antigen or PSA test is the right option. And charging $30 for a PSA test actually discriminates against the people who are at highest risk of having prostate cancer in the first place, because we know it is in those marginalized and vulnerable communities that they cannot afford the test, and those are the ethnicities and communities most likely to succumb to prostate cancer.

The Acting Speaker (Ms. Bhutila Karpoche): Questions?

Ms. Doly Begum: I want to thank the member for his speech. I know how passionate he is on this issue, especially being a health care professional. One of the things that you touched on already was how our public health care facilities and our public health care workers are taken away overnight, and then turned into private health care facilities, and then the public health care workers are then used for service that we should get in our public health care system, and how scary this is in terms of the trend that we're setting. I always talk about what it means for my family to have that public health care system and the ability to walk in and get that service. I know this government talks about how you're going to pay with an OHIP card, not your credit card, but we are already seeing the reality. So I would love to hear your thoughts, as a doctor, on what's happening.

Mr. Adil Shamji: I think at the very crux of your question is, what will happen to staffing under this model? And we have contended that it will siphon health care workers out of the publicly funded health care system. That is certainly my opinion, but I will ask you not to take my word for it. We've heard from many CEOs. This one, Dr. Kevin Smith, who I didn't get around to quoting in my earlier remarks, actually said, "For me, the greatest worry is people are so tired and burnt-out ... that we run the risk of not having adequate people for the true emergency, for the true in-patient stay."

"The number one unintended consequence I think we all have is the health human resource shortage." He gives some examples of why it would be more enticing to go into a private clinic, and he says, "Doesn't that sound attractive? And, of course, it does."

There are no protections. You can say over and over again, as many times as you want, that there are protections in this bill. But the very reality is that they are not in the bill. I invite anyone to point to them. But it's superficial, it's cursory and, in theory, all left to the regulations, and I question whether those will even appear.

The Acting Speaker (Ms. Bhutila Karpoche): Questions?

Mr. John Fraser: I want to thank the member for his last answer, because it pretty much answered my question. The concern here is setting up a parallel system that competes for what is probably the most valuable resource that we need right now, which are front-line health care workers in our hospitals, in long-term-care homes, in our community.

I know that Bill 124 had a big effect on the retention and recruitment of nurses, for instance, and other front-line health care workers. Can you further expound on why there is a risk to our public health care system because of the human resource crisis we have right now and siphoning off those resources, those people on the front lines that we need?

Mr. Adil Shamji: Thank you very much. The reality is that the backbone of our health care system is our health care workers. We have been pushing them harder and harder and harder over the course of the pandemic. They are suffering from mental health challenges. They are suffering from burnout. They are not feeling valued. Bill 124, the unconstitutional wage-capping legislation, has told them concretely that they are not valued.

As they go to the few places that remain that have the potential to pay them more, which far too often is in acute care and now lately has become temporary for-profit nursing agencies, which this government will not take any action on, the result has been that all the other places where we need health care workers, such as primary care, home care, community care and long-term care, cannot staff their facilities. And so the legs of our health care system are getting pulled out from underneath it.

This is the fundamental problem. Our health care system and our hospitals are not made out of beds and concrete. They are made from health care workers, and this government does not value them.

The Acting Speaker (Ms. Bhutila Karpoche): Questions?

Mr. Andrew Dowie: I want to thank the member for his viewpoint and perspective, being right in the field. I wanted to just ask if you have any thoughts or have a degree of support for the measures to expand the scope of pharmacists so that they can prescribe and get into that space that was previously in the sphere of physicians themselves.

Mr. Adil Shamji: I thank you for that question. The first thing that I will say is, expanding the scope of practice for pharmacists is a measure that has been foisted upon us because this government does not value primary care. If we got primary care right, we could actually do something about that.

I want to point out that, even as this government brags about creating new places in family medicine, the current places that are available in our universities to train new family medicine graduates aren't even getting filled; they're not getting filled. So what's the point in creating more, because this government has made family medicine and primary care so unattractive?

But in the crisis that we're in, a crisis of this government's creation, we need all the measures on the table. We do need to expand the scope of practice, but it has to be done the right way. Even though there is room for pharmacists to do more, this government has not implemented any regulations or protections to make sure that they communicate with primary care, to make sure that there's adequate documentation, to make sure that there's adequate regulation and requirements to ensure that physical examinations are done properly. Again—

The Acting Speaker (Ms. Bhutila Karpoche): Thank you. Questions?

Mr. Rob Flack: I appreciate the passion and experience the member opposite has in the health care system, but I believe our health care plan will reduce surgical backlogs and improve quality of life for patients throughout this province. Will the member opposite please identify, to my constituents at least, that by supporting this bill, it will ensure Ontarians aren't waiting too long for surgeries and backlogs? It is there. We have to fix it. We have a plan. We're giving it. I think it will work.

Mr. Adil Shamji: My message to your constituents is that they want a family doctor and this government is not doing anything about that. If they can get to a family doctor, we can start dealing with the issue of those surgical and diagnostic backlogs. That's the message I would ask you to take back to your constituents.

The Acting Speaker (Ms. Bhutila Karpoche): Further debate?

Hon. Paul Calandra: It is always a pleasure to get up and rise on anything in the House. As I begin, I just wanted to reference an article from the Toronto Star, of all places, back in 2017. I'm going to read the quote for you. It talked about what was, at that point in 2017, a horrific situation in our hospitals in the province of Ontario. It's a very long, extensive article, and it says, "There are three main causes of the growing pressures, health-care leaders agree: a population that is growing, aging and showing up in the ER sicker than ever; a health system that is not robust enough ... such as in the long-term care and home-care sectors; and five years of austerity funding with minimal increases to" operational "budgets from the province"—governed by the Liberals, of course. "When inflation is factored in, hospital budgets have actually fallen....

"The OHA has told the province that hospitals cannot go on at this rate without significantly compromising front-line care."

1550

That was from 2017. That was at the conclusion of what was, at that time, colleagues, 14 years of Liberal rule in the province of Ontario.

I've found this debate very, very interesting, because the NDP, when they had the one opportunity—and it's relevant. They'll holler back, "Oh, it was so long ago, it's not relevant." But it is relevant. When they had the opportunity—

Interjection.

Hon. Paul Calandra: And the member from Parkdale–High Park—not Parkdale–High Park, wherever it is.

Interjection: Spadina–Fort York.

Hon. Paul Calandra: Spadina–Fort York is laughing, “Oh, it was so long ago. Ha ha ha.” You know what’s not funny, colleagues? They reduced acute care beds in the province of Ontario by 8,000 beds. That is your record. You can say that’s a long time ago. They reduced it. The Liberals then went a step further and reduced it even further to the lowest part—

Mr. John Fraser: You closed 26 hospitals.

Hon. Paul Calandra: You reduced acute care beds—

Interjections.

The Acting Speaker (Ms. Bhutila Karpoche): Order.

Hon. Paul Calandra: Colleagues, just wait. You’re hearing the member from Ottawa Centre scream, “We opened up six hospitals.” They opened up one in Markham, but you know what they did? They didn’t open up any of the floors in the hospital. That’s the Liberal record; they will build the building but don’t open the floors.

They reduced it by 8,000 beds. The Liberals went one step further and reduced it to the lowest ever in the province. Do you know where we’re at today, Madam Speaker? I’ll tell you where we’re at today. From a low of 18,800 to what is today 33,000 acute and complex-care beds in the province of Ontario.

The member for Etobicoke can talk about it all, wax poetic about the Liberals and everything that they wanted to do, but that is the Liberal record. That is the Liberal record.

Mr. John Fraser: Twenty-six hospitals.

Hon. Paul Calandra: The member for Ottawa Centre—

Interjection: It’s Ottawa South.

Hon. Paul Calandra: —who was the parliamentary assistant to the Minister of Health, was unable to even get funding to have improvements at his own hospital. It took a Progressive Conservative government to increase funding for the Ottawa Hospital, CHEO—Madam Speaker, it was us, a Progressive Conservative government that did that.

Let’s put it into contrast: They reduced it by 8,000; they went even further—18,000 acute care beds in one of the richest jurisdictions in the entire world.

Now the member for Ottawa Centre laughs. He should not laugh, because it is his government over 15 years that brought us to the situation that we’re at today. It is absolutely shameful that he sits there—

Hon. Nina Tangri: Chuckling.

Hon. Paul Calandra: —chuckling, like it is funny that this province had to endure what it did during COVID. Do you know why we endured what we did during COVID? Because they starved the system. One thousand ICU beds—again, in the richest province in one of the richest jurisdictions in all of the world. The Liberals left us with 1,000.

Now he’ll say, “We built more.” Yes, they built more in Markham–Stouffville. They just refused to open them up. They wouldn’t give the hospital the funding to staff those acute care beds. So great job. Build them, but then don’t staff them. Build them but don’t staff them: That’s the Liberal math on all of this. That is their record.

They talk about private health care. This is the chestnut as always. This is the chestnut always that you get from Liberals and NDP. Now let’s go back: To make it even worse, colleagues—I almost forgot—when the Liberals were in power for 15 years, for most of that time, there was a Conservative government in Ottawa. That Conservative government transferred to the province of Ontario over 6% a year for health care. Do you think that the province of Ontario, under the Liberals, used that 6%? Not even once. Did they use 5%? No. Did they use 4%? No. Did they use 3%? No. Did they use 2%? Sometimes—not all of the time over those 10 years. Was our population increasing? Yes. Were they building long-term-care homes? No.

The member for Ottawa Centre laughs in his place. This government has approved more long-term-care homes in his riding than he was able to get over 15 years in the entire province. That is the Liberal track record.

Now, where was the member for Etobicoke—he’s waxing so poetic; he’s so angry—where were you when they were cutting funding each and every year that you were a doctor on the front line? Did you storm the barricades and say, “We need more”? No. You were putting people up—according to the Toronto Star, according to your own OHA, according to the OMA—emergency rooms at that time were putting people not only in closets, but outside of the hospital because they had no room. Why? Because the Liberals had an austerity plan that crippled our hospitals.

He talks about innovation—this is one pillar, colleague. Everybody knows that. This is one pillar, right? We started in 2018 and we’ve talked about it time and time and time again. We said we have to build a better health care system, so we started in 2018 with beginning to re-fund the health care system that was so crippled by Liberals, supported by NDP. And let’s not forget, colleagues, the NDP between 1990 and 1995—not only did they close 8,000 beds, but they left the province of Ontario with a deficit that was the equivalent of $25 billion in today’s time. They closed hospitals, they closed wards, laid off nurses, took 8,000 acute care beds off-line and left us with a deficit of $25 billion in today’s dollars—extraordinary record by the NDP, extraordinary record of futility, but it’s worse.

We said back in 2018 we had to do better, right? We knew we had to do better, so we started off with Ontario health teams. And I’ve said it and I’ve talked about it time and time again: We said we had to build a better system, because we believe, unlike the opposition, that our health care workers do good work, but sometimes people have troubles accessing that system. I’ve talked a lot about how somebody who gets hurt in one part of the province, but then might go—my own father-in-law; hurt in Ajax, had to come live with us in Stouffville. While trying to transfer his home care from Ajax to Stouffville—an absolute nightmare under the system apparently supported by the member for Etobicoke who wants to run for the leadership of the party—

Mr. Adil Shamji: Don Valley East.

Hon. Paul Calandra: Don Valley East, that's right. They got wiped out of Etobicoke, didn't they, colleagues? They did, that's right. They got wiped out. You're right. You got wiped out.

So we said we have to build a better system, right? You shouldn't have to struggle to access health care in the province of Ontario. We're the richest jurisdiction in Canada, one of the richest jurisdictions in the world, and yet you have to struggle to get in the system. Once you get in the system, it is a great system. It's wonderful. They work hard.

Do you know how difficult home care was? Not only was it hard just to transfer it, but under the system left behind by the Liberals, you were stuck in paperwork hell and the people who came to deliver the services were exhausted. They needed more help. There was not a robust long-term-care system to help out. There wasn't a robust home care system to help out. Our acute care system was struggling to add capacity because the Liberals, in their wisdom, thought it was smart to reduce capacity in acute care while at the same time the population was aging. They thought that was a good idea.

The member for Don Valley East—I can't wait to see what his platform is going to be as Liberal leader. "Support me, I worked on the front lines while saying nothing when the Liberals cut hospitals, when the Liberals did nothing in long-term care. Talked not a word about innovation, sat on the sidelines and supported the NDP as they cut thousands of hospital beds and then doubled down when the Liberals did that." Can't wait for that platform; it's going to be a real great one, Mr. Speaker.

But we said we had to change it, so we did. We brought in Ontario health teams. Then we said it's not just enough to make the system easier, you have to build more hospitals, and we did that. We're doing that. Over 50 hospital projects across the province; old hospitals being upgraded—why? Because they starved our hospitals. Don't take it from me, take it from your best buddies at the Toronto Star. Take it from the OHA. Take it from the OMA. They begged the Liberals to stop the austerity of five years, and they did nothing, Madam Speaker. So we're making those projects.

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Then we looked in smaller communities, and we said, "Why is it, under Liberals, if you are a hospital operator in a city, your budgets are twice as much as those in smaller communities?" What is it that is so wrong with living in a rural community that you were punished by the former government? I don't know. We said that's inappropriate, so we started to have small and medium hospital budgets—we made them the same as those in large urban centres, right? So not only did we increase their budgets, not only did we end the austerity; we equalized them.

Then we said, "Do you know what? Because they haven't done anything, we'll rebuild those hospitals for you." It has to be done, because as part of our Ontario health team movement, we need hospitals.

But then, we went a step further. Our hospitals have to be new. You want to attract people. The reason people were leaving Ontario was because you gave them old, outdated facilities. That's the reason people were leaving the province of Ontario. We have hospitals in this province that were so old—why would you have worked so hard to become a nurse, a nurse practitioner or a doctor only to come into one of our 70-year-old hospitals and not have the equipment that is needed to do so? We've changed that. We're making those investments, and they're coming back. Record numbers are coming back to work in our Ontario hospitals.

Then we went a step further. You want an Ontario health team to work? You need long-term care. So we said we have to build long-term care. We know we needed 60,000 new and upgraded beds. Now, what does that mean? That means 60,000 new beds, colleagues, because 30,000 of them are brand new and 30,000 of them are tearing down old, outdated facilities left behind by the Liberals.

Mr. John Fraser: Actually—

Hon. Paul Calandra: Over 450 in your riding. I thought you were Etobicoke for a minute, but I forgot you got wiped out there. But over 450 long-term-care beds, so between the two of them, I have doubled the output that they could not accomplish in 15 years, between those two ridings. There is not a riding in this province, there is not a community in this province—urban, rural—that has not been touched by what we are doing in long-term care. There's not one.

And why are we doing it? While they starved rural Ontario, we said, "We're going to bring long-term care into rural Ontario." Because do you know what? People want to live in communities they helped build. They want to live close to their family and friends, and they couldn't do that under Liberals. They couldn't do that under the NDP. But under a Conservative government, when I'm in Athens, Ontario, a small community, and I'm turning sod for a new 168-bed long-term-care home, they say that this long-term-care home is the biggest property taxpayer in the community. It is the biggest driver of jobs in the community. And do you know what the residents say? "For the first time, I can live in a community that I helped build over 60 years, and I continue to be with my family and friends." They're saying that in communities across [*inaudible*].

But then, they double down. They double down and they say, "Well, the quality of care." They double down. They put for-profit against not-for-profit in long-term care. They always talk about it. I mentioned this in one of my questions. They talk about the quality of care. Well, there's Southbridge—these are the ones they bring up all the time, colleagues: Southbridge, Extendicare, Revera, Sienna, peopleCare. These are our major for-profit homes. Having said that, Revera is owned by the federal government, so you all own Revera homes. Southbridge—

Mr. Nolan Quinn: Beautiful facilities.

Hon. Paul Calandra: Beautiful facilities, but do you know who does the care in Southbridge? Well, they have union contracts with the ONA and SEIU. That's who does the care in Southbridge. Do you know who does the care in Extendicare? SEIU and ONA. They have union contracts

that spell out, "This is what the wages are. This is what your pensions are. These are your sick days." Do you know who does it in Sienna homes? Shocking: ONA, SEIU and other health care professionals. It's the same with peopleCare. Do you know who does those services in our hospitals? ONA, SEIU, the very same people.

They will get up here and say to you, Madam Speaker, that for some reason, if you work in a for-profit long-term-care home, you don't care about people as much as you do if you do it in a for-profit—

Mr. John Fraser: That's not what people are saying.

Hon. Paul Calandra: You can't have it both ways. You can't scream out, "No, I don't." You can't say that. You can't have it both ways—

Interjection.

The Acting Speaker (Ms. Bhutila Karpoche): The member for Ottawa South will come to order.

Hon. Paul Calandra: He says, "Oh, it's the employer's problem." Well, the accounts that take care of care in every single long-term-care home are fixed. You can't take money for nursing care and give it to shareholders. You can't take money for meals and give it to shareholders. Those budgets are all fixed. Do you know why? Because in the Fixing Long-Term Care Act, we fixed that. Do you know what else we did? We brought on 200 inspectors. They never did it. We did it. So that's the difference. You can't have it both ways.

We think that we can still do better, so Bill 60 is another step along the path of ensuring that the richest jurisdiction in North America can properly care for its people. And you get the same old chestnuts: "Oh, private health care—it's going to be broke, it's going to be bankrupt. Oh, my gosh." When I was in Ottawa, it was, "George Bush is doing this, George Bush is doing that. The whole world is falling apart." It's the same old thing. Margaret Thatcher said it best—the Liberals and NDP, as long as the rich are less rich, they don't care how poor the poor are. That's what they care about. That's not what this province is about.

Can we have a better health care system? You're darned right we can have a better health care system.

Can we build a health care system that is integrated? Of course we can. How is that not possible in Ontario in 2023? We can do that. That's what we're building.

Can we have a system that doesn't cause you grief and stress just to access it? Yes, but to do that, we needed to increase budgets. We did it. We needed to build new hospitals. We're doing it. We needed to build new long-term care. We did it and are doing it. We needed to bring new workers into our system and attract them back; in record numbers, they are coming back to the province of Ontario—over 30,000 people in our nursing colleges to take up jobs in our new long-term-care homes; in our new hospitals; in the new, robust home care that we are building; to work in mental health, an area that was completely and utterly ignored by the opposition.

After 15 years, after almost bankrupting the province of Ontario and bringing us to our knees, what do they have to show for it? Nothing. They have nothing to show for it. In five years, this government has done more to rebuild health care, home care, long-term care—and do you know why? Because it is good for the economy, as well. Do you know how we attract jobs to our community? By improving our health care system, by making our communities stronger, by making our school system stronger. That's something that they never, ever understood, because for them, it is old ways or no ways at all, and they'll use the same old failed argument. The very same people who destroyed our health care system are now telling us they have the fix for it.

Well, you had your chance. You failed, and now we will fix it for the next generation of the people of the province of Ontario.

With that, Madam Speaker, I move that the question now be put.

Interjections.

The Acting Speaker (Ms. Bhutila Karpoche): Members, please be seated.

The government House leader has moved that the question be now put. I am satisfied that there has been sufficient debate to allow this question to be put to the House.

Is it the pleasure of the House that the motion carry?

All those in favour of the motion that the question be now put, please say "aye."

All those opposed to the motion that the question be now put, please say "nay."

In my opinion, the ayes have it.

A recorded vote being required, it will be deferred to the next instance of deferred votes.

Vote deferred.

The Acting Speaker (Ms. Bhutila Karpoche): Orders of the day? Government House leader.

1610

Hon. Paul Calandra: I think, if you seek it, you will find unanimous consent to see the clock at 6.

The Acting Speaker (Ms. Bhutila Karpoche): The government House leader has moved a unanimous consent motion to see the clock at 6. Is it the pleasure of this House that the motion carry? Okay.

PRIVATE MEMBERS' PUBLIC BUSINESS

MINISTRY OF CORRECTIONAL SERVICES AMENDMENT ACT (PAROLE), 2023

LOI DE 2023 MODIFIANT LA LOI SUR LE MINISTÈRE DES SERVICES CORRECTIONNELS (LIBÉRATIONS CONDITIONNELLES)

Mr. Yakabuski moved second reading of the following bill:

Bill 96, An Act to amend the Ministry of Correctional Services Act / Projet de loi 96, Loi modifiant la Loi sur le ministère des Services correctionnels.

The Acting Speaker (Ms. Bhutila Karpoche): Pursuant to standing order 100, the member has 12 minutes for their presentation.

Mr. John Yakabuski: I really appreciate the opportunity to bring this bill before the House this afternoon, April 27, 2023. I reference that date because I'll reference another date: September 22, 2015. A lot of people know exactly what they were doing that day because of the news they heard that morning.

I was with my caucus colleagues—and, in fact, members from all parties in the House—in Finch, Ontario, for the International Plowing Match of that year. I'm very grateful to then-Attorney General Yasir Naqvi, who approached me before the formation of the parade to tell me. He said, "Yak, I've got some terrible news from your riding." He proceeded to let me know about a police hunt that was on and a chase that was on for a man who—at that point, we knew that at least one person had been murdered, and that was Carol Culleton, a woman who knew the accused and had a relationship with the accused.

The day progressed and it was troubling for all of us. At the end of the day, when we were heading back, my colleague from Haliburton–Kawartha Lakes–Brock was with me at the time because we had to drive back to Toronto from Finch—a long drive and not much else to talk about but the events of that terrible day.

The events of that day ended with the murders of three women: Carol Culleton, Nathalie Warmerdam and Anastasia Kuzyk. Anastasia was the only one of the three that I actually knew, because both she and my wife were involved in the real estate business. So I knew Anastasia, but I didn't personally know the two other women. But I did know Basil Borutski, because we actually went to school together at Madawaska Valley District High School, born the same year, 1957.

It was a time, after that day, that the community, the county—in fact, the province; it became a story of national proportion. And one of the things—not just the terrible, heinous situation and the facts around the murders, but the questions that arose: How, in this day and age, are we allowing this to happen?

Now, to go back a little bit, I can tell you that Basil Borutski had a 26-year relationship with his wife that was an abusive relationship—her maiden name was Mask, Mary Ann Mask—and can say that there were more than a few contacts with the police. Somehow, every one of those, he seemed to skirt by or get the charges dropped. But it would appear that this was a time bomb just waiting to go off at some time, at some point.

His first real incarceration was after an assault on Nathalie Warmerdam, who he had a relationship with. He was incarcerated for just under two years for that offence, but then he was released. And on that release, he refused all the terms of his parole, never attended any of the partner assault response program that it was dictated he should attend.

It just seems we're in a system where things got forgotten or ignored or were allowed to go on, and this is the catalyst of why I brought forward this bill in the first place. The first time I brought forward this bill was September 22 of 2016, which was one year to the day of the murders. It's taken us to this year—sorry, to last year, 2022, to actually hold a coroner's inquest to try to determine how we could all do better—because better we must.

The coroner's inquest took place in my riding. That was one of the points of contention at one point as well: Would the inquest actually be held in Renfrew county? We insisted and the county insisted that it be held in the county, where the crimes took place. It took several years to be able to get that established.

I want to thank Attorney General Downey, then-Solicitor General Jones and, at the time, associate minister of women's issues Jane McKenna for agreeing with me that we would put $150,000—$50,000 from each of those ministries—to help local people and local advocates against intimate partner violence be part of that hearing.

It was clear that throughout this entire time Mr. Borutski was totally unremorseful for any of these crimes and was one who always portrayed himself as the victim: the victim of the system, the victim of partners who were dishonest, or all kinds of—he was always portraying himself as the victim. He was a master manipulator.

One thing that the inquest shows is that we're not going to continue to sit back while these things happen.

I want to thank as well the Solicitor General and my colleague from Oakville North–Burlington, who has been active with regard to Keira's Law. It's a federal law, but we are now adopting that.

Another reason to be supportive of Bill 102—if I may read this, Speaker, in Bill 102: "The schedule also amends the act to prohibit a person from being appointed as a provincial judge unless the person undertakes to participate in courses designated for newly appointed judges by the Chief Justice of the Ontario Court of Justice. The Chief Justice is authorized to establish courses for newly appointed judges and for the continuing education of judges, including courses respecting the following: sexual assault law; intimate partner violence; coercive control in intimate partner and family relationships; and social context, which includes systemic racism and systemic discrimination. The Chief Justice is required to submit a report to the Attorney General respecting courses on these topics."

The reason I bring this in and I talk about Keira's Law—and I also want to point out that my colleague from Etobicoke–Lakeshore is also going to be bringing forth a motion in the future that will allow people to have sightlines if a person they're considering or wondering about an intimate partner relationship with has a background that sets out the red flags that to them say, "Be careful, be aware or maybe head in the other direction."

1620

What I'm talking about today—and maybe I should explain that, and I apologize to the members. My bill, essentially, which is very similar to the bill that I proposed in 2016, would require that the parole board—maybe I'd better read it: "If parole is granted to an inmate sentenced for an offence that the board considers to be an offence of

sexual or domestic violence, and the board considers the inmate to be a safety risk to the victim of the offence,

"(a) the board shall consider the appropriateness of electronic monitoring; and

"(b) if the board determines that electronic monitoring is appropriate, the board may impose conditions with respect to electronic monitoring."

I don't know, nor does anybody, what might have happened if Basil Borutski would have been subject to electronic monitoring, but I believe absolutely, with all my heart, that the chances of those women surviving would have been greatly increased, and perhaps they would all be with us today.

So what we have here—and recently, Speaker, the county of Renfrew declared intimate partner violence an epidemic. The hearing put forth 86 recommendations, of which our government is considering each and every one and has already responded to many of them. The electronic monitoring, essentially, was recommendation 48. I don't know that each one of these individually is going to change the world, but incrementally, every single thing that we can do here today and in other days will make it safer for people in an intimate relationship, women in an intimate relationship, to be able to avoid that terrible fate that these three women fell victim to. Each and every thing that we can do is going to improve the chances of us someday eliminating the scourge of intimate partner violence.

I want to say that we can take one of these steps today by allowing the parole board that ability to electronically monitor those people. And let's be clear: They will have been identified as someone who poses a real and present risk to their former partners of being victimized again. They were victimized once; these three women paid with their lives. Let no one else be a victim again.

The Acting Speaker (Ms. Bhutila Karpoche): Further debate?

MPP Kristyn Wong-Tam: Thank you to the member across from Renfrew-Nipissing for tabling this motion. I have the privilege and the honour of speaking to it as the critic of the Attorney General.

Bill 96 is a very simple bill. It is proposing to enact one of the 86 recommendations that came from the Renfrew county inquest—the largest femicide in the history of the country in Ontario. It is commendable. It also leaves behind some questions that need to be answered, and I want to just recognize that this conversation, for many, including the member across, because it's so deeply personal, is not necessarily easy. I'm glad that we're having this conversation today, because I think it's an important one. I would encourage us to expand from here and continue going, so we can continue to do more.

Let me take folks back to that morning that was described, September 15, 2015. On that September morning, Ontario lost three women to preventable gender-based violence when they were murdered in Renfrew county. Anastasia Kuzyk, Nathalie Warmerdam and Carol Culleton were all victims of intimate partner violence, all killed by the same man. The perpetuator had a history of abusive behaviour towards women, and he demonstrated a pattern of violence that spanned over 40 years, making his crime predictable, preventable and a tragedy that authorities should have seen coming.

In June 2022, after a very lengthy and emotional process and hearing from witnesses ranging from academic experts to law enforcement, a jury into the historic Renfrew inquest released a report with 86 recommendations, all designed to prevent further intimate partner violence and gender-based violence. These recommendations were directed to a number of public bodies, which included the federal government, the provincial government, the privacy commissioner of Ontario and the province's chief firearms officer. The vast number of those recommendations—out of 86, 68 of them were actually directed here right to this chamber; 80% of it falls under provincial purview. Therefore, we have the opportunity here in this chamber to act upon it so that we can honour those fallen victims.

The coroner's office asks those named in the inquest recommendations to provide some responses and to indicate if there's any progress, so the government has responded by providing a 55-page document. Speaking to lawyers who've been following the case very intimately and with a lot of interest, they have noted that most of the government's responses have been "vague and lacking," and there is always the deferral that one day we will continue to explore and do something about it at some point. This is not necessarily good enough, especially for those who are committed to ending gender-based violence and intimate partner violence. It has now been eight years since that tragic and horrifying day, and the Renfrew triple femicide has been seeing the clock slip away. I certainly know, having spoken to the son of Ms. Warmerdam, that they don't want to wait any longer.

So I am encouraged to see this motion. I want to be able to commend the member across for bringing it forward, especially since it deals with recommendation 48, as noted. But I can't help but think whether or not the victims would be alive today. Would Nathalie Warmerdam be alive today had the bill been enacted sooner? We don't know. I'd like to think that the more we do, the more we can support and prevent that type of violence. But we also know that a one-size-fits-all approach is not going to work, especially for an issue this complicated.

Let me just read into the record briefly—I'll try to summarize it—what recommendation 48 actually says, because it actually goes much further than what the motion is before the House. Recommendation 48 from the Renfrew inquest states: "Explore the implementation of electronic monitoring to enable the tracking of those charged or found guilty of an IPV-related offence and enable the notification of authorities and survivors if the individual enters a prohibited area relating to a survivor. In determining the appropriateness of such a tool in Ontario, monitor the development of programs, utilizing such technology in other provinces, with specific consideration given to:

"(a) coverage of cellular networks, particularly in remote and rural regions,

"(b) storage rules and protocols for tracking data,

"(c) appropriate perpetrator programs and supports needed to accompany electronic monitoring,

"(d) whether the tool exacerbates risk factors and contributes to recidivism,

"(e) understanding any impacts after an order for such technology expires,

"(f) frequency and impact of false alarms,

"(g) the appropriateness of essential services being provided by private, for-profit partners."

My concern with the motion, even with its good intentions, is that it doesn't go far enough. Oftentimes we see when motions come forward on behalf of the government members that there might be some limitation, and in this case, based on what I've just read, which is recommendation 48 directly from the inquest, you can see that there are a significant number of shortcomings.

We need to talk about who this legislation currently leaves behind. This legislation is very much law enforcement-driven, so therefore, it's reactionary and will end up leaving behind intimate partner violence survivors who did not or could not engage with law enforcement and the criminal justice system. It doesn't protect all survivors who did engage with the criminal justice system; it only protects those who stayed in the system and persevered long enough to have their abuser be convicted and, eventually, out on parole.

1630

For those who don't connect with the system, it doesn't support them at all. The folks who are left behind are oftentimes poor survivors, rural and remote survivors, racialized survivors and those who feel that engaging with the police or justice system could be more harmful than helpful. And we know that Black and Indigenous Ontarians don't always feel comfortable engaging with the police due to systemic and historic violence against them. This response is due to the heavy law enforcement focus out of recommendation 48.

It also tends to be extremely expensive. I would like to see a cost estimate on how this program will be implemented, especially since Ontario's rape crisis centres are already dramatically underfunded. We should be able to support the organizations who are on the ground providing support to the survivors, helping them get out of those intimate partner violence and domestic violence relationships so that they can gain a pathway to recovery without having to engage in something that's reactionary in case the technology works. We can do it better, and that is entirely within the purview of the provincial government.

This bill also leaves behind survivors other than those who are named in the case. Obviously, this is a very complex issue, since giving data about someone's whereabouts and their proximity to another person has to be handled very carefully. However, we do know that many of these individuals may not always be effectively tracked because we know that sometimes technology will fail and sometimes the system and the coverage of the cellular network doesn't work, which is why we talked about how does this support women in the rural and remote communities, who, of course, are all the women who were killed during the Renfrew femicide. The jurors had noted that this bill could leave rural and remote survivors at greater risk, since cellular and other coverage can be spotty. It's not a one-size-fits-all solution for the people of the north and people of the remote communities.

There isn't necessarily any information in the motion about storage and protocols for tracking data. And that is something that we need to be able to sort through in order for this bill to work effectively. Unfortunately, there's nothing in there that talks about the centralization, the storage and the monitoring of this information.

Appropriate perpetrator programs and supports need to accompany electronic monitoring. This is something else that the bill does not necessarily speak to. You can't track someone one day and just call it a day done; you need to be able to support them so they don't reoffend.

Whether the tool exacerbates risk factors or contributes to recidivism is left to be seen. However, I can only imagine that if someone is actually being tracked, they may feel resentful or angry, especially if they're not getting the results that they're looking for when what they really need is a pathway to recovery. How do we prevent this violence from happening again? Because, as we noted, the killer of the Renfrew inquest had been known to be a violent individual for 40 years. It should have been preventable as it was predictable.

And I certainly understand that any talk about such technology requires a more fulsome and comprehensive approach, and we need to be able to think that this motion has to be trauma-informed and survivor-centred.

What about the frequency of false alarms? What happens there? What happens if there is no alarm because the technology doesn't always work? How do we ensure that the private, for-profit service providers—because this is a service that's not going to be necessarily covered by government; you're asking the courts and other administrators to take care of it. How do we ensure that it's going to give the very best results to the women and the survivors, who are sometimes men? How do we make sure that they get the very best supports that they can?

We have to be able to think through constructively and, I think, structurally and systematically how to support survivors. Eighty-six recommendations came out of the Renfrew inquest—86, Speaker. If we peel off one and it is vague, we're not honouring those survivors and victims at all.

The first recommendation out of the Renfrew inquest is to have this government, which will cost them absolutely nothing, declare intimate partner violence an epidemic. Why don't we start there, and then adopt number 4, which is to create an implementation framework to carry out the rest of the 86 recommendations. Thank you.

The Acting Speaker (Ms. Bhutila Karpoche): Further debate?

Ms. Christine Hogarth: I rise to support Bill 96 by my colleague the member from Renfrew–Nipissing–Pembroke.

Speaker, this bill complements and strengthens all the measures this government is undertaking to make our com-

munities and our loved ones safer. We do so against a background of unprecedented acts and often random violence and loss in the city and in our province.

Only yesterday, we in this House debated the adoption of a motion put forward by my colleague the member from Sarnia–Lambton, designed to assist the police in locating vulnerable missing persons, particularly those with dementia who are prone to wander.

A few days ago, I was pleased to attend an event with the Premier and the Solicitor General at Toronto Police College to announce new measures to promote police recruitment and retention.

Earlier this month, I was honoured to submit a motion in this House calling for the adoption here in Ontario of Clare's Law. This, as you may recall, is a package of measures first introduced in Great Britain that would enable people in current or former intimate partner relationships to obtain from police a potentially violent intimate partner's prior record of abuse, if that person asking for this information has reason to believe she or he is under threat.

Earlier this year, Speaker, I was privileged to be a member of the legislative committee tasked with conducting a hearing and drafting a report on bail reform in the face of a seeming epidemic of violence and violent assaults in our city and province committed by those who had no right to be back on our streets in the first place. I so vividly recall the expert testimony that said bail reform would save lives.

That's why this government fully supports the law known as Keira's Law, which is part of our proposed legislation that we debated last evening.

I say to this House, the member from Renfrew–Nipissing–Pembroke is today laying down yet another marker toward a more innovative, responsive and effective approach to community safety in our province as it relates to parole measures. It is fully aligned with our government's efforts to think outside the box when it comes to policing, safe streets, stronger, healthier communities and protection for our most vulnerable.

This latest initiative, the proposed bill at hand, would enable parole boards to consider whether electronic monitoring is appropriate in cases of an inmate who has committed sexual or domestic violence and then to act on their judgment. After all, individuals who fall into this category often represent a risk to the safety of their victims.

Speaker, the people in my riding of Etobicoke–Lakeshore tell me time and time again that they have earned and deserve the right to live free from the threat of violence and criminality. No doubt all members in this House hear the same thing day after day.

Let us all get behind this initiative by the member for Renfrew–Nipissing–Pembroke in delivering on that promise.

The Acting Speaker (Ms. Bhutila Karpoche): Further debate?

Mr. Todd J. McCarthy: It is an honour to address this House today to speak in support of my colleague's proposed bill, An Act to Amend the Ministry of Correctional Services Act, Bill 96.

The amendments of this act—including section 2, adding section 35.1—would, if passed, mandate that any parole board which is adjudicating an application for parole from a person convicted of a sexual or domestic violence offence first consider the appropriateness of electronic monitoring of the parolee and, if found appropriate, impose conditions with respect to that monitoring. This would require a parole board to take into account consideration of the risk to public safety and in particular the risk to the victim and the victim's family—the possibility of the convicted person reoffending.

Speaker, we have heard far too many—far too many—situations where offenders and repeat offenders have either been released on bail or released on parole and have come back into contact with the victims of their crimes, causing these victims to relive the trauma or, worse, to become victims of homicide. Our parole system is flawed with inefficiencies favouring the charter rights of convicted persons, with no regard for the charter rights of the victims of their crimes.

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Speaker, there are intervention strategies and techniques in place to reduce recidivism, and some progress has been made, but it's not enough. It is the duty of all parliamentarians in this House, regardless of political affiliation, to put public safety first and provide parole board members with the mandate to implement these conditions where appropriate.

We pledged to the people of Ontario that our government would take the lead on justice reforms and restore confidence in our criminal justice system. So I applaud my colleague from Renfrew–Nipissing–Pembroke for introducing this bill, as these amendments, if passed, will make a difference to public safety, will reassure victims of sexual and domestic violence that their right to security and safety are paramount, and will provide parole boards with the ability to impose stricter conditions on a case-by-case basis.

The Charter of Rights contains many rights, and section 1 of the charter requires those rights to be balanced. By endorsing this bill, hopefully unanimously, we can stand up for the section 7 charter rights of victims of crimes and their families to life, liberty and security of the person. Therefore, I urge all members of this House to unanimously support this bill.

The Acting Speaker (Ms. Bhutila Karpoche): Further debate?

Ms. Laurie Scott: It's a pleasure to rise today to speak on Bill 96, brought forward by my colleague and friend the member from Renfrew–Nipissing–Pembroke, which would give parole boards the power to determine the appropriateness of electronic monitoring for abusers at high risk of violence.

Madam Speaker, I can tell you about a long history of work that has been done on sexual violence and harassment and human trafficking in the Legislature by many colleagues in the Legislature, starting back with the Select Committee on Sexual Violence and Harassment that we did in 2014. The member for Renfrew–Nipissing–Pembroke was part of that. Today, he brings forward a motion to address a horrific crime that occurred in his riding—it's his second time introducing this bill—and to acknowledge the tragic stories of Carol, Anastasia and Nathalie, who were taken from us in a very tragic situation and crime in his riding.

We've heard how the increase of crime, violence against women, gender-based violence has grown immensely, and that 44% of women in Canada have experienced some form of violence by an intimate partner in their lifetime.

I've worked for many years on anti-human trafficking laws to raise awareness, to provide education and to provide the tools through many ministries on our government's side: through education; the Attorney General; the Solicitor General; labour—increasing the fines for human trafficking; the ministry of children and family services—social services now; colleges and universities. Many ministries have done a collaborative approach to tackling gender-based violence, violence against women, and there's always more to do. The Saving the Girl Next Door Act was the first in human trafficking that I brought forward several times to push the government of the day forward on that file.

And we've heard today the many examples, from Keira's Law—that the member from Oakville North–Burlington brought forward a motion. The Attorney General and the Solicitor General are both bringing forward Bill 102 this week, which incorporates the mandatory training of judges and justices of the peace in our justice system, so that they have the training needed—trauma-based training, trauma-informed training—so that our judicial system has a completeness to it, so that victims of violence—predominantly, we're talking here about women; 88% are women—feel safe, so that they can go through a criminal process, knowing that our judiciary has the training and that they will be safe in their communities should they return. And Bill 96, with the parole board having that authority now, is another step forward for their safety in Canada.

The Acting Speaker (Ms. Bhutila Karpoche): Further debate?

Mr. Rob Flack: Like my colleague from Renfrew–Nipissing–Pembroke, I know exactly where I was on the afternoon of September 22, 2015. I was sitting in my office at work when my wife phoned me and said, "There have been some terrible murders in the Ottawa Valley and we should talk about it." Obviously, I was both shocked and anxious, because these murders took place very close to our cottage, our summer home, our farm at Lake Doré in Renfrew county.

Sadly, when we learned the names of the women who were murdered, I was taken aback when I heard the name Anastasia Kuzyk, a woman I briefly knew, who worked at the Wilno Tavern near Killaloe, also known by the member of Renfrew–Nipissing–Pembroke's family, as he mentioned. Denise and I, our immediate response was, "How could this happen and why would this happen?" We went home and talked about it all night in shock.

Known for a history of violence against women, Basil Borutski went on a murderous rampage on September 22 of that year, killing Anastasia Kuzyk, Carol Culleton and Nathalie Warmerdam, all on their own properties. Sadly, these murders were all related to intimate partner violence.

Speaker, prison didn't work for Borutski, and probation parameters failed with Borutski. With his level of risk escalating over time and as a perpetrator of domestic violence with a tendency to reoffend, Borutski slipped through the cracks. If the parole conditions of electronic monitoring as outlined in this bill had been law in 2015, perhaps these murders could have been intercepted and these heinous crimes could have been prevented.

Will this bill prevent all future crimes of intimate partner violence? Perhaps not. But if this bill saves just one life, it's worth passing this legislation. Speaker, it is a smart and effective start to ending intimate partner violence. I fully support the member's bill and for leading the way to enact Bill 96. I am confident this legislation will save lives and make Ontario a safer province to live in.

Finally, Speaker, may God bless the families of Renfrew county who tragically lost their mothers, daughters and loved ones.

The Acting Speaker (Ms. Bhutila Karpoche): Further debate?

The member from Renfrew–Nipissing–Pembroke has two minutes to reply.

Mr. John Yakabuski: I want to thank all my colleagues, the members for Toronto Centre, Etobicoke–Lakeshore, Durham, Haliburton–Kawartha Lakes–Brock, and Elgin–Middlesex–London.

I do want to specifically address the member for Toronto Centre. I know in the remarks they spoke about not going far enough and not enough being done. We recognize that. This is one step, and certainly the job is not finished and the work of our government is not finished either. I can assure the member that in the future you will see a manifestation of that commitment on the part of all to end intimate partner violence.

On the issue of cellphone coverage, it's an accurate point as well. Our commitment to expanding that through 2025 to everyone in Ontario will certainly deal with that shortcoming as well.

I want to say, I consider myself very fortunate—I hope I don't get too emotional. I grew up in a home of 14 children. I never once witnessed my father raise his voice to my mother, let alone his hand—not once. It's difficult to understand sometimes how this happens in a home, in a family.

This bill today will hopefully see that if someone is victimized by intimate partner violence, and if that person is released, we have taken one small but significant step in ensuring that they're not victimized a second time.

The Acting Speaker (Ms. Bhutila Karpoche): The time provided for private members' public business has expired.

Mr. Yakabuski has moved second reading of Bill 96, An Act to amend the Ministry of Correctional Services Act. Is it the pleasure of the House that the motion carry? The motion is carried.

Second reading agreed to.

The Acting Speaker (Ms. Bhutila Karpoche): Pursuant to standing order 100(h), the bill is referred to the Committee of the Whole House, unless the member has a preference for a committee?

Mr. John Yakabuski: Yes, Speaker, I would ask that the bill be referred to the Standing Committee on Justice Policy.

The Acting Speaker (Ms. Bhutila Karpoche): Is the majority in favour of this bill being referred to the Standing Committee on Justice Policy? Agreed. This bill is referred to the Standing Committee on Justice Policy.

All matters relating to private members' public business having been completed, this House stands adjourned until Monday, May 8, 2023, at 10:15 a.m.

The House adjourned at 1651.

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