Legislative Assembly of Ontario


Assemblée législative de l'Ontario

# Official Report of Debates (Hansard)

SP-25

## Standing Committee on Social Policy

Convenient Care at Home Act, 2023

1st Session
43rd Parliament

Tuesday 14 November 2023

Chair: Brian Riddell
Clerk: Lesley Flores

# Journal des débats (Hansard)

SP-25

## Comité permanent de la politique sociale

Loi de 2023 sur la prestation commode de soins à domicile

1re session
43e législature

Mardi 14 novembre 2023

Président : Brian Riddell
Greffière : Lesley Flores

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# CONTENTS

Tuesday 14 November 2023

LEGISLATIVE ASSEMBLY OF ONTARIO

# STANDING COMMITTEE ON SOCIAL POLICY

Tuesday 14 November 2023

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

# COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Mardi 14 novembre 2023

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*The committee met at 1502 in committee room 2.*

## CONVENIENT CARE AT HOME ACT, 2023

## LOI DE 2023 SUR LA PRESTATION COMMODE DE SOINS À DOMICILE

Consideration of the following bill:

Bill 135, An Act to amend the Connecting Care Act, 2019 with respect to home and community care services and health governance and to make related amendments to other Acts / Projet de loi 135, Loi modifiant la Loi de 2019 pour des soins interconnectés en ce qui concerne les services de soins à domicile et en milieu communautaire et la gouvernance de la santé et apportant des modifications connexes à d'autres lois.

**The Chair (Mr. Brian Riddell):** Good afternoon, everyone. The Standing Committee on Social Policy will now come to order. As always, please wait to be recognized by the Chair before speaking. All questions and comments will need to go through the Chair.

On today's agenda, we will have a public hearing on Bill 135, An Act to amend the Connecting Care Act, 2019 with respect to home and community care services and health governance and to make related amendments to other Acts.

Does anyone have any questions or comments before we begin? I recognize MPP Martin.

**Mrs. Robin Martin:** Thank you very much. I have a motion.

**The Chair (Mr. Brian Riddell):** You are recognized.

**Mrs. Robin Martin:** I move that the committee enter closed session for the purposes of organizing committee business.

**The Chair (Mr. Brian Riddell):** MPP Martin has moved a motion. Is there any debate?

I recognize MPP Gélinas.

**M^me^ France Gélinas:** We have very important people scheduled for 3. I would not want to have the Minister of Health, the deputy minister, the associate minister, the assistant etc. have to wait. Could we wait until they present before we go in camera, just to be respectful to the minister and her team?

**The Chair (Mr. Brian Riddell):** Any further debate?

Are members ready to vote? Shall the motion carry?

**Interjection:** Recorded vote.

**Ayes**

Barnes, Jordan, Martin, Pierre, Quinn, Wai.

**Nays**

Brady, Gates, Gélinas, Shamji.

**The Chair (Mr. Brian Riddell):** The motion is carried. We will now go into closed session.

*The committee continued in closed session at 1504 and resumed at 1602.*

**The Chair (Mr. Brian Riddell):** Good afternoon, everyone. We are here to begin public hearings on Bill 135, An Act to amend the Connecting Care Act, 2019 with respect to home and community care services and health governance and to make related amendments to other Acts.

As a reminder, the deadline for written submissions is Wednesday, November 15, 2023, at 7 p.m. Eastern Standard Time. Legislative research has been requested to provide the committee members with a summary of oral presentations and written submissions as soon as possible following the written submission deadline.

The deadline for filing amendments to the bill is 5 p.m. Eastern Standard Time on Thursday, November 16, 2023.

The Clerk of the Committee has distributed today's meeting documents to you via SharePoint. Witnesses will have been scheduled to groups for three for each one-hour time slot. Each presenter will have seven minutes for their presentation. Following all three presentations, there will be 39 minutes of questioning for all three witnesses, to be divided into two rounds of seven and a half minutes for the government members, two rounds of seven and a half minutes for the official opposition, and two rounds of four and a half minutes for the independent member.

To ensure that everyone who speaks is heard and understood, it is important that all participants speak slowly and clearly. Please wait until I recognize you before starting to speak.

For virtual participants on Zoom, after I have recognized you, there may be a brief delay before your audio and video is ready. Please take a brief pause before you begin speaking. In order to ensure optimum sound quality, virtual participants are encouraged to use headphones or microphones, if possible.

As always, all comments go through the Chair.

Are there any questions before we begin?

## HOSPITAL FOR SICK CHILDREN
## ADVOCACY CENTRE FOR THE ELDERLY

**The Chair (Mr. Brian Riddell):** I will now call on the next group of presenters to please come forward— Hospital for Sick Children.

As a reminder to each of you, you will have seven minutes for your presentations, followed by questions from the committee members. I will provide reminders of the time remaining during the presentations and questions.

The Advocacy Centre for the Elderly and Susan Alksnis will be virtual.

Please state your name for Hansard and you may begin.

**Ms. Krista Keilty:** Thank you for the opportunity to be here.

May we clarify, do we have seven minutes or 14?

**The Chair (Mr. Brian Riddell):** Seven.

**Ms. Krista Keilty:** Okay, awesome.

Thank you very much for the opportunity to be here to make the presentation and contribute to the consultation process and review of the connecting people to home and community care act, Bill 135. This legislation, regulations, policies and practices that underpin delivery of services in home and community care are of great interest to us in pediatric health care—

**The Chair (Mr. Brian Riddell):** I'm sorry to interrupt you. You didn't state your name.

**Ms. Krista Keilty:** Krista Keilty. I'm the associate chief for interprofessional practice for connected care at SickKids.

**Ms. Kathy Netten:** My name is Kathy Netten. I'm a social worker at the Hospital for Sick Children.

**The Chair (Mr. Brian Riddell):** You can continue.

**Ms. Krista Keilty:** We're here today recognizing that it's of great interest to us in pediatric health care to work together as system integration partners, leaders and providers in pediatric care with home care.

To begin in making our remarks, we'll draw from the experiences and expertise of SickKids patients, family caregivers and providers with whom we work, care and partner with across the pediatric system—this is in the transition of thousands of children per year from the hospital to home and community care. The children have ongoing and awfully highly complex needs beyond the hospital, and they include those who are dependent on medical technology—for example, ventilators, central venous access devices, other technologies to support and sustain their life. They are also children who require post-acute care, rehabilitation and complex care across multiple settings: home, community, schools, summer camps, daycares and playgrounds, where they meet home and community care providers across the province.

We'll focus our comments and recommendations on opportunities we see for more clarity—and invite the collaboration in the changes ahead—as we understand Bill 135 intends to make more specific the structures for transformation of a more connected home care.

Today, at a high level, you will hear us recommend three things—first, that the unique and highly sub-specialized needs of pediatrics is a focus and is prioritized in development of new structures, services and practices under the bill. We know the volume of children's services in home and community care is extremely small compared to the service volumes in adult care. Thus, in a move to centralize and standardize through the new service organization, we ask that there be intentional ways that the needs for access, quality and equity for children be addressed and prioritized.

The second overarching recommendation is to value and achieve partnership across the pediatric health system, including with SickKids, in reforming structures, processes and setting standards for delivery of services that will make transitions from hospital and maintenance of home care more seamless for patients and families. We know that connected, integrated care is safer and is more effective in achieving quality and in finding efficiencies in a strained health system.

Finally, and highly important in reforms, is a recommendation to position the needs of children at the core, and family caregivers as central and integral to the high-quality pediatric care that's being designed. With system-wide pressures for highly specialized pediatric beds, advances in medical technology and other innovations, including virtual care, children are leaving hospitals sooner with more complexity than ever. They're often going home in the hands of parents or other family caregivers responsible for highly skilled and vigilant care up to 24 hours per day. These families can provide this care for days to weeks to decades in the context of children now living well beyond their pediatric years. So there is need to support the strengths of family caregivers, to bring health care services to them directly to the care of their child, but also in the context of the need to support respite for family caregivers to enable they sustain the care that they complement other health service providers.

**1610**

Next, I'll speak to some of the points that we've organized under the proposed objects and general powers outlined in the bill. It's our intent to convey opportunities for clarification and considerations and implementation for SickKids and beyond in bringing forward Ontario Health atHome. We understand that the bill will amalgamate the 14 LHINs or regions into one provincial OH structure. Overall, this change fits with our reality at SickKids, where over 80% of the children discharged from SickKids live outside of the Toronto central region.

The current system that we work with now requires many hand-offs from Toronto central colleagues to colleagues in other regions, and while things go well most of the time, we do experience challenges in communication and medical orders, we have experienced challenges in coordination of care, and we also experience that it's challenging in understanding how best to collaborate in leading system integration initiatives across this multiple-layered system.

So what we recommend and see the opportunity for in amalgamation is that new structures continue to embed home care expertise at SickKids. It's imperative that those we work with in the transitions to home and community

care from SickKids know how to navigate within our organization, work with the tenets of child- and family-centred care, have very specialized pediatric clinical expertise and can serve the needs of the population. We welcome fewer hand-offs, and we also recommend that Connected Care @ SickKids be identified as a key partner in operationalizing and actualizing the reforms, given our mandate to build capacity and improve transitions for children beyond the walls of SickKids.

The second order looks at creating a new client service provider and new relationships with service providers. If we understand this correctly, this will change and may expand the type and number of partners in the system who will coordinate and deliver home care services.

In Connected Care @ SickKids, annually, we partner to build capacity in home care and deliver thousands of education sessions for pediatric home care nurses. We provide consultation to hundreds of calls, texts and virtual visits by home care nurses and family caregivers, and we lead to implement evidence-based pathways to improve the quality of care in transition from our hospital to home care.

In the past two to three years, we've seen a rapid rise in the number of SPOs—service provider organizations—who are accessing our services. While we welcome this, at the table that I chair, the Connected Care integration advisory table, we find it challenging to work with a growing number of more than 35 service provider organizations who are seeing pediatric patients across the province.

**The Chair (Mr. Brian Riddell):** You have one minute remaining.

**Ms. Krista Keilty:** Thank you.

This worries us because we need critical mass in pediatrics in order for there to be the competence necessary.

We also know that we're going to be moving care coordination to what we hear around OHTs and client service providers. So as SickKids is not part of an OHT, nor at this time a client service provider, we need to better understand what this means for us and seek to understand how we can work towards a more seamless, connected system with pediatric home care.

We also want to speak about placements—the opportunity for Ontario Health to be leading in placement management services. We know that children do best at home. We want to ensure that that continues to be the first place we look for placements for children, and we welcome the opportunity to build capacity in other congregate sites to ensure the quality of care.

In centralizing accountability for Ontario Health and the delivery of shared services—

**The Chair (Mr. Brian Riddell):** Thank you very much. Your time is finished.

Advocacy Centre for the Elderly—which I am part of, I guess—is next.

**Mr. Graham Webb:** I am Graham Webb. I'm a lawyer and the executive director of the Advocacy Centre for the Elderly. I'm joined by my colleague Jane Meadus, who is a lawyer and an institutional advocate.

Our clinic, the Advocacy Centre for the Elderly, is a specialty legal clinic under the Legal Aid Services Act. We were established in 1984. We've been operating continuously since then, providing legal advice and representation, law reform and community education to and on behalf of low-income, older adults. We receive thousands of calls per year, including many calls concerning home care and admission to long-term care, both of which are affected by Bill 135. The nature of the calls we receive are outlined in our nine-page paper just submitted this afternoon. We think we bring the perspective of the public policy interests of the low-income seniors we serve.

We have nine recommendations to make. I'd like to say the first two recommendations are that the Ministry of Health should not download delivery of home care services to Ontario health teams; and that if the ministry were to download delivery of home care services to Ontario health teams, it should only do so into an easily understood, accessible and fully developed system that's consistent throughout the entire province.

We make these recommendations because we think that Bill 135 promises to deliver a fractured and chaotic system of home care in Ontario. While it purports to simplify the system, it actually does the opposite. It will download the delivery of home care from crown corporations, the LHINs, to 57 or more Ontario health teams and other agencies throughout the province. It will be difficult for people to know where to go. These service delivery agents are not yet fully developed, and it will create a disjointed and dizzying array of service delivery models that will form a barrier to service.

Our next recommendation is that administration of publicly funded home care services should not be downloaded to Ontario health teams that have no corporate structure, nor any required mechanisms for transparency, oversight and public accountability.

Bill 135 would advance and complete the loss of public administration over the delivery of publicly funded home care services in Ontario.

Ontario health teams do not necessarily have any legal structure. They are loosely based collaborations of for-profit and not-for-profit health service providers. They are not required to have any particular corporate structure, nor in fact any corporate structure at all. There is no legally required process for the internal governance, oversight, operations and legal liabilities and responsibilities of Ontario health teams. Ministry of Health literature suggests that at some indefinite time in the future, OHTs will be required to incorporate as not-for-profit corporations, but we don't know when that will happen.

Alarmingly, Bill 135 and the Connecting Care Act do not require any standards of transparency, oversight and public accountability for Ontario health teams.

Our next recommendation is that care coordination for publicly funded home care services and placement coordination for admission to long-term care should not be downloaded to Ontario health teams or other health service providers. We make this submission because of the inherent conflicting interests for service providers. Bill 135 would create conflict between the financial interests of service providers and the health care needs of the home care clients

they serve. Under this model, service providers will become responsible for the care coordination and engagement of publicly funded home care services. Health service providers have a vital and inherent self-interest in the financial viability and profitability of their services and operations. Home care clients have a different and competing interest in receiving home care services that meet their needs. At ACE, we have seen countless occasions where service providers are reluctant to serve sometimes demanding and difficult-to-serve clients. It's our experience that service providers would much prefer to cherry-pick the easier-to-serve clients of home care services and limit access to their services by difficult or demanding clients as much as possible.

**1620**

The downloading of care coordination to home service providers creates the opportunity and the incentive for the care coordination services to focus on the ease of delivery and maximization of profits for service delivery agents to the detriment of the client. This will also cause increased demand for long-term-care beds as home care agencies redirect clients they no longer wish to serve into the long-term-care system.

**The Chair (Mr. Brian Riddell):** You have one minute left.

**Mr. Graham Webb:** Our next recommendation is that the Ministry of Health provide increased and sufficient funding of publicly funded home care services to meet the reasonable care needs of all Ontarians.

Our last recommendations are that the placement of management services and care coordination services be kept together as an independent agency, that the Ministry of Long-Term Care increase oversight into placement coordination services, that the Minister of Health withdraw Bill 135 entirely, and that the Legislature repeal and replace the Connecting Care Act with remedial legislation that restores and implements public administration and not-for-profit—

**The Chair (Mr. Brian Riddell):** Thank you very much for your presentation. Your time is now up.

We will now go to round one. The government has seven and a half minutes.

*Interjections.*

**The Chair (Mr. Brian Riddell):** Susan Alksnis has dropped out, so she's not here. I knew that before; I thought I announced that.

We will now go to round one, with the government having seven and a half minutes. I recognize MPP Martin.

**Mrs. Robin Martin:** Thank you very much to the witnesses for coming today and giving us a little bit of your experience, which we really appreciate—hearing your different perspectives on this.

It's our government's intention to improve our home care system. We've been working toward that over the years since we first formed government in 2018, and taking steps, really, to create an integrated and connected system built around patients.

I was interested to hear, from SickKids, your perspective, talking about building the system around pediatric patients and their families and making sure that home care is available for them. When you were presenting, you had quite a lot of information that came rather quickly—I was trying to take notes. You mentioned that there are a number of children you would be sending home after they've had care at SickKids, sometimes with very medically complex conditions. How many children, approximately, are in that situation? Could you help me? I didn't get it.

**Ms. Krista Keilty:** Annually, SickKids refers to home care, at the point of discharge from hospital, 3,000 referrals. Some of those would be re-referrals for children who have been re-hospitalized. That's one statistic that speaks to the volume.

The other statistic that's important is the estimated 2,000 children across the province who are the highest complexity. A large proportion of those children are followed by SickKids and 11 satellite sites from SickKids. And there is another part of that overall sum who are covered off by some of the other tertiary hospitals.

**Mrs. Robin Martin:** I was at an announcement a few weeks ago at Holland Bloorview, which was, I think, dealing with kids that have extensive needs as well. I don't know if that's relevant to what you're talking about.

**Ms. Krista Keilty:** There's a different, sometimes overlapping, population—but the population that we're speaking to, that home care typically provides care for, are children with medical complexity or subacute health care needs.

The extensive care needs funding that Holland Bloorview has received focuses on the delivery of supports for behavioural care, intellectual disability and other disabilities with extensive care needs, and autism.

What we do see is, there's overlapping in the population, so there are absolutely children that Kathy follows as a social worker whose diagnostic list would include the types of services that would be required from home care, as well as extensive needs. And we follow them continuously; we don't drop them from SickKids.

**Mrs. Robin Martin:** You mentioned that a connected or integrated system you think is a system that could be helpful, and having overarching structure through Ontario Health could help. SickKids really is a provincial resource for pediatric care. I think you said 80% of the patients are not in the Toronto area?

**Ms. Krista Keilty:** Eighty per cent of the patients are not in Toronto central region. Approximately 80% are in the greater Toronto region, which means 20% of the whole fall to the rest of the province and the world.

**Mrs. Robin Martin:** Can you help us with why you think having Ontario Health and an overarching structure like that would be helpful to the patients you serve?

**Ms. Krista Keilty:** Sure. I'll speak to what I understand about integrated systems. It means that we have less chance of missing information, so information is more likely to be able to flow. Fewer hand-offs mean safer patients at the end of the day.

We also understand that under an integrated system, we could work towards and achieve a practice standard. When I speak to practice standards around pediatrics in home care, when I speak to understanding how many hours of

service would be available for families and children with any particular care needs—and at this point, we don't see standardization of that across the province, so we see inequities. We also see the haves and have-nots.

We also understand that it's important in an integrated system to strive towards standards of best practice, so evidence-based practice. One of the things that Connected Care does at SickKids is develop with home care what best practice looks like, develop the curriculum, push out the curriculum, and support home and community care service provider organizations to have the capacity to ensure that those competencies are in place with home care nurses.

Having said that, in the virtual visits that are conducted by my team after discharge, when families go into home care, families will describe that they're twice as confident in their own skills after being taught by Connected Care than they are in the skills that they meet with home care providers. At this point, we don't have 100% penetration of Connected Care services reaching all of the home care providers, and in part this is due to a system that, at this point, isn't integrated.

**Mrs. Robin Martin:** I can certainly see the benefits of integrating that care better, especially when dealing with patients who are so complex and vulnerable, as some of the patients are which you are discharging to the care of their parents and home care support, I guess, in those situations. I can see how that could be very important.

I think MPP Wai has a question.

**The Chair (Mr. Brian Riddell):** I recognize MPP Wai.

**Mrs. Daisy Wai:** I do have a question for the SickKids hospital. I hear you; you mentioned a few times about the high-quality pediatric care that you have, and you have highly skilled doctors. I really respect and thank you for that, because we've seen a lot of great work that you have done.

I just want to find out how Ontario health teams can partner with hospitals such as yours—

**The Chair (Mr. Brian Riddell):** One minute remaining.

**Mrs. Daisy Wai:** —and service providers to advance high-quality, equitable services.

**Ms. Krista Keilty:** I think there is an opportunity to focus on practice standards and aim towards achieving that there is a quality of care that would look similar from hospital to home care. We are privileged at SickKids and other tertiary centres where we have more resources around a very small area of expertise. We want to be able to share those resources and be able to offer what that practice standard looks like. That's an important mechanism.

We also want to be able to see integrated technology solutions that are going to help and there be referrals easily tracked, as well as improve the process of medication reconciliation and orders, which promotes safety in transition from hospital to home care.

**The Chair (Mr. Brian Riddell):** That ends the government's seven and a half minutes.

We will now go to the official opposition for seven and a half minutes. I recognize MPP Gélinas.

**M^me^ France Gélinas:** My first question will be to SickKids, then to the Advocacy Centre for the Elderly.

**1630**

I represent a riding in northern Ontario. I have a mother who just came to see me, and her child just started school and is severely sick and needs to be G-tube-fed at school. So the nurse comes and sets it up and then takes off. Then, the machine goes "beep, beep, beep"; they call the mother at work, and she needs to come back and fix it. They're supposed to get respite at night, because he needs 24/7 care. It's Bayshore that has the contract and shows up maybe once or twice a week. The other five nights, they don't sleep. Is this common, or this just because I'm lucky to live in northern Ontario?

**Ms. Krista Keilty:** I'll respond for both of us in this part.

We certainly hear these stories; what I don't want to suggest, however, is that we have the data to inform how common it is. But we certainly can speak to the experience, from where we sit, that families share these stories often. So in terms of families experiencing missed shifts, missed visits at school, missed doses of insulin, as well as sitting on wait-lists for rehab, from where we sit, that's very common—in the way that they currently experience gaps in home care. Gaps widened through the pandemic, for which we're seeing some recovery, but the gaps continue to remain very wide.

**M^me^ France Gélinas:** Would you say that this is something we should be working on?

**Ms. Krista Keilty:** Absolutely. In an integrated system and a system that really leverages inter-professional practice and technologies and ways that we could work together, I can imagine, in the scenario that you describe, that we could be remotely monitoring and supporting this child across geographies, for example. We have the expertise to do that. If we work in an integrated system, leveraging the specialized expertise, we can delegate the controlled act of taking care of the child's G-tube; we can monitor for safety.

But we also know that when we receive safety reports at SickKids from our families, in the virtual care visits that we conduct, and we send them to home care—HCCSS—currently, it's highly variable whether or not we get a response, and it's quite common that we don't close the loop on the quality-of-care issues that the families raise and that we would recognize as opportunities to improve quality of care. So we need to see those kinds of structures in place, and high and clear accountabilities for the specific care needs of pediatrics.

I think the other issue that is important to understand around standardization and the opportunity, but also the threat or danger, is, some of the tools that have historically been used in home care are not as sensitive to the needs in pediatrics as they need to be. For example, we don't have validated tools to assess the need for home care in pediatrics the way we use interRAI tools in adult care. There is a gap in the evidence base to support that the assessment tools that we're using are actually pinpointing the needs and supporting the really quite wide variation in the amount of service that any family may need. And those care needs can change over time. You can imagine, children grow and

develop, and some of them get healthier over time and services can be pulled back, and some of them have degenerative conditions and over time their service care needs need to change and need to increase.

**M^me^ France Gélinas:** Would you agree that there's nothing in the bill right now that addresses any of the—

**Ms. Krista Keilty:** I would suggest that, in my reading of the bill, from my limited expertise in policy analysis, there's lacking specificity in terms of the how. I understand the intent around monitoring for quality, and that that would sit with Ontario Health, but I have notes—and I'll submit them in a follow-up to the committee—that would ask for there to be robust evaluation and outcomes tracking for pediatrics that matter to patients and families, and those metrics may look different than what you're using in adult care.

**M^me^ France Gélinas:** My next question is for the Advocacy Centre for the Elderly.

Same thing: Last week, a constituency week, a middle-aged man, an amputee, came to see me. He now has wounds on his remaining leg and needs to have changes in bandaging twice a day, at 8 o'clock in the morning, and it's scheduled to be 4 o'clock in the afternoon. For the last two weeks, they've come maybe five times rather than—14 times 12; it should have been 28 visits. But Bayshore always phones; they don't have enough.

Is this something that you hear also, or is it because I'm lucky enough to live in northern Ontario?

**Mr. Graham Webb:** No, it's not because you live in northern Ontario. It's throughout the province. We have heard this for 30 years—that there's not enough home care, that people are on wait-lists, that the PSWs don't show up when they're supposed to show up due to staff shortages, and you're lucky if your PSW shows up.

**M^me^ France Gélinas:** Do you see anything in this bill that will improve this to make sure that—

**Mr. Graham Webb:** Sadly, no. One of the fundamental problems is that we need more home care for more people throughout Ontario, and this legislation does nothing to address the underlying problem. In fact, it may make it worse. The coordination of home care has been conducted by 14 crown corporations throughout Ontario, and our clients have been dealing with 14 different boundaries—to figure out which side of the boundary are you on: the Mississauga side or the Toronto side? That will eventually go to more than 57 Ontario health teams, where the care coordination for home care will be delegated to these Ontario health teams throughout Ontario—

**The Chair (Mr. Brian Riddell):** One minute remaining.

**Mr. Graham Webb:** We don't see it as a coordinated system; we see it as an uncoordinated system.

**M^me^ France Gélinas:** So you're telling me that, the way the bill is written, a care coordinator could be assigned to Bayshore, who then decides who gets care and who doesn't because they're the one providing the care?

**Mr. Graham Webb:** Well, Bayshore could be a member of an Ontario health team. There are 57 of these teams, and they're all different. The big home care service providers are all mainly private companies. There's a few not-for-profits left, but they're becoming fewer and far between. In the area of home care service delivery, we expect the Ontario health teams to be dominated by the for-profit service providers. And the Ontario health teams will manage the care coordination, so they will be coordinating the care, handing out the contracts to people who are influential with the Ontario health teams.

**The Chair (Mr. Brian Riddell):** Thank you for your comments.

We'll now continue round one with the independent member for four and a half minutes. I recognize MPP Brady.

**Ms. Bobbi Ann Brady:** Thank you to all our presenters this afternoon.

I'll go to Graham first. I represent a very rural riding, Haldimand–Norfolk, and last year while I was out knocking on doors, I came across many of these vulnerable folks who told me stories about home care cancelling, not showing up—really terrible stories, and my heart really went out to them. What you're telling us this afternoon is that Bill 135, instead of making things better, will ultimately make things worse.

Graham, you were beginning to tell us that Bill 135 should be repealed, and you started to talk about what it should be replaced with. Can you finish that thought for us, please?

**Mr. Graham Webb:** Yes. We asked that the Minister of Health withdraw Bill 135 and they repeal the Connecting Care Act, which would download these home care services to the Ontario health teams. What it should be replaced with is crown corporations, government agencies that broker or manage and coordinate home care services and placement coordination to long-term care. The reason we request this is to avoid the inherent conflicts of interest of the service providers being the ones to determine how much long-term care you get, who gets it, and who is going to be hired to get it.

Our experience is that the people we serve complain about a bunch of things: the PSWs not showing up; not getting enough home care; the poor quality of home care; and, when you complain about this, being cut off or denied home care entirely. We've had to litigate that particular situation.

The constituents that you're seeing in Haldimand–Norfolk are the same people we're seeing in Toronto, in Mississauga, in Brampton, in Sudbury, in Kenora—throughout the province—who are all having problems accessing home care. We don't think that Bill 135 is going to help that. We think it's going to make it worse.

**Ms. Bobbi Ann Brady:** Thank you very much.

Krista, I'll move over to you. I know that there are children from my riding who come to SickKids in Toronto and they get discharged back into our riding. Obviously, you've heard we have a bit of a problem with home care. Do you see that, overall, the supports in rural areas are much more difficult than in urban?

**1640**

**Ms. Krista Keilty:** I think the short answer to that is, the services are often harder to find the further away from

one of the tertiary hospitals they get. Haldimand is not that far, though, and I think about their location to McMaster hospital, for example, and it's not a hard drive to my house either. I often go to a cottage out that way. So the gaps are across the system, but there are pockets across the province that we could pinpoint based on our experience where the gaps are wider, deeper, lists are longer, and where children, for example, are not getting palliative care services and they're needing to die in hospital instead of at home.

**The Chair (Mr. Brian Riddell):** One minute remaining.

**Ms. Bobbi Ann Brady:** So the two things from your presentation that may help with that in an area like Haldimand–Norfolk would be the remote monitoring and also the training of family caregivers.

**Ms. Krista Keilty:** Certainly, those are some of the ways that we could work better together across the system. There will still need to be other reforms around the health human resource gaps that this bill doesn't specifically address, including, for example, fair compensation. That's certainly what I've been informed is one of the key barriers to the uptake and hiring of adequate staffing.

**The Chair (Ms. Jessica Bell):** I recognize MPP Shamji. You have six seconds.

**Mr. Adil Shamji:** Okay. I'll just start by saying that I really admire the amazing work of SickKids and especially of social workers, one of the unsung health care heroes—

**The Chair (Mr. Brian Riddell):** Thank you for your comment, but the time is complete.

We will now go to round two. The government has seven and a half minutes. I recognize MPP Jordan.

**Mr. John Jordan:** My question is for Graham Webb. One of the things you described very well, because I experienced this working in health care, is the lack of standardization and coordination of the home and community care services, particularly provided through the LHINs. My service area was divided into two LHINs, with one basket of services on one side of the street and another basket of services on the other, and a lot of confusion for the providers.

So exactly what you described is exactly what this bill is aimed at correcting, because instead of going through 14 LHINs, it's going through five Ontario Health regions. The 57 Ontario health teams are your voice and your opportunity to sit on the collaborative council and participate and bring issues forward for Ontario Health and the Ministry of Health to address.

Another thing I should add is that Ontario Health is a crown agency, exactly like you're requesting.

My question is, do you not feel that greater standardization and oversight across the province as far as best practices go and services that are required—which is a result of this bill; it's what this bill is aiming at—would be a benefit to your clients?

**Mr. Graham Webb:** I don't agree that that is what's happening. In home care, the care coordination is being downloaded to the Ontario health teams, and we still have this boundary issue. Ontario Health atHome, as we read the legislation, becomes more or less a funding agency that provides general oversight. But the purposes of the act are to assist health providers, including Ontario health teams, to provide the care coordination, and we don't think the Ontario health teams should be the ones to do the health coordination.

We would be happy with Ontario Health atHome doing care coordination on a provincial basis or on a regional basis, but we're certainly not reading that into the act. What we're reading is that this is a delegated responsibility that's actually several times removed from the Minister of Health. The Minister of Health says, "We're not responsible if your home care worker doesn't show up. We've passed it off to Ontario Health." And Ontario Health says, "We've passed it on to Ontario Health atHome." And Ontario Health atHome says, "We've passed it on to the Ontario health team in your area." And your Ontario health team says, "Well, we've passed that on to your service provider," which may be a for-profit company or a not-for-profit company. And so, the responsibility is so many times removed, and we see that as a bad thing.

**Mrs. Robin Martin:** Chair?

**The Chair (Mr. Brian Riddell):** I recognize MPP Martin.

**Mrs. Robin Martin:** It's interesting to hear you speaking, Mr. Webb. We're trying to bring these decisions closer to the people who receive the services, which I think is a great approach, frankly. The Ontario health teams are going to be the ones in the community; however, they will be subjected to standards through Ontario Health and Ontario Health atHome. One of the great benefits I see for our Ontario health teams is that they will be able to share best practices. We heard about the importance of sharing best practices, particularly with specialized areas of care such as pediatric care, which is certainly something we've heard about here today.

As the system hasn't been working very well in home care, our government is the first government in 25 years to try to make some changes, to make sure the system does work.

I just want to address something that has been bandied about here: that this piece of legislation, small though it is, is not the solution to all of our problems in home care. I don't think anybody on the government side would say that it is.

We do invest, and are investing quite a lot, into home care as well, because we understand that home care needs investments—and that is a billion dollars over three years to get more people connected to care in the comfort of their own home. We're accelerating those investments in our budget in 2023—bringing up $569 million, including nearly $300 million to support contract rate increases to stabilize the workforce, which we all know is so important. We don't want to lose any of our valuable home and community care workers, so our investments are focused on compensation for personal support workers and nurses, and also expanding home care services and improving the quality of care. Total investments in home care, obviously, have increased substantially under this government.

I want to ask SickKids again—I don't care which of you wants to answer; it's up to you. You mentioned in your comments—I think to a question asked by members of the

opposition—that right now home care is highly variable in what people get, the number of hours they get etc. So do you think that best practices or having standards put through a group like Ontario Health is a way to help improve the variability, to make sure that it is more consistent across the board and people know what they're expecting? And how would that affect the care of the patients you're dealing with?

**Ms. Krista Keilty:** To know that the assessment has been complete, that the assessment is valid and that the allocation of the care plan, which includes the resources and the number of hours of service, is aligned with the family caregiver's needs is what we need in the system. The challenge will be in the doing, and in ensuring that the assessment tool is valid, that the competencies are embedded—

**The Chair (Mr. Brian Riddell):** One minute remaining.

**Ms. Krista Keilty:** —in those who are conducting the assessments and that resources and funds are managed appropriately, so we don't run out of dollars before the end of a fiscal year, for example, which we currently experience in different pockets in different regions, which will affect a service plan for a family who may have been unlucky about what month their child was born. These are the realities that we experience today that will continue to be the challenge in a new system, that need to be better managed.

**Mrs. Robin Martin:** I appreciate that. I think everybody is interested in hearing what those challenges are so that we can make sure that we find improvements and we don't end up in those situations.

I know this year we brought forward funding for hospitals—it used to come later; it caused all kinds of problems for hospitals with their budgeting. We made a great effort to make sure that those funds were there. It's another example of where those kinds of changes are necessary.

**1650**

That's why I'm so excited about all of our health workers being able to give input through the committee you're on and others—

**The Chair (Mr. Brian Riddell):** That concludes the government's second round.

We'll now go to the official opposition for seven and a half minutes. I recognize MPP Gates.

**Mr. Wayne Gates:** My line of questioning will be a lot different than the Conservatives on where we're at when it comes to home care. They did mention, though, that they are investing $1 billion. What they forgot to mention is the fact that 30% of that $1 billion goes directly into for-profit companies. That's a mistake, quite frankly. I believe that if we could take that $1 billion and put it right into care—you can imagine how much better it would be for your organizations and Mr. Webb's organizations. We could actually take care of people who need home care, whether it's kids, whether it's adults, whether it's seniors. So it's very interesting.

Also, SickKids, you mentioned the fact that compensation is a big issue. It absolutely is a big issue. It's why we've been struggling for a long time with PSWs, because they're not paid properly. A lot of them are full-time jobs, and they're running from place to place—some of it is not compensated, with their mileage. There's nothing in the bill that addresses that, by the way. If you really wanted to make sure that we have proper home care for kids and for adults, you'd think that you pay them a fair wage. You'd make sure that they have benefits and, in some cases, have an opportunity to join a union or to have pensions. Most of them are women—I think it's around 80% to 82% are women. It would be a very good way to make sure that they'd be able to pay for their rent and everything else that's going up—affordability.

So compensation is a really big issue. It's why our party, and I believe other parties, have said we should get rid of Bill 124. It's an absolute disaster. They're fighting us in the court, spending millions on lawyers, when you actually could—and Mr. Webb, because you're a lawyer, I'm sure you understand that it costs money for lawyers. Imagine, if you weren't spending that money on lawyers and were actually putting it back into, again, PSWs' wages and benefits and making them full-time jobs, how much better off we'd be in this particular sector.

I agree with Mr. Webb on what we should be doing with the bill.

I apologize for a little bit of a speech, but when they say stuff that's not completely accurate, I have to respond.

The other thing I want to ask Mr. Webb: You talked about it—and it might have been SickKids who might have raised this as well, so the two of you can answer this. You mentioned the fact that a lot of your clients are legal aid or involved with legal aid when they have issues—I think you said about the haves and the have-nots. Are either one of you aware that they cut the funding to legal aid, which has made it a lot harder for people who are marginalized to even use legal aid? Maybe the two of you can answer that, because I think it's a big issue.

Mr. Webb, you can go first and then SickKids can go next.

**Mr. Graham Webb:** I'm the executive director of a legal aid clinic under the Legal Aid Services Act. There had been cuts to legal aid in 2019. Some of those cuts have been restored, and I know that Legal Aid Ontario is working constructively with the Ministry of the Attorney General to restore and improve funding to legal aid. We're hoping that will continue. We think there is more money that should be available to legal aid, and we encourage the Attorney General to please support us in the work we do. All of our clients are legally aided. All of our clients are low-income.

**Mr. Wayne Gates:** SickKids?

**Ms. Krista Keilty:** We do sometimes guide families to access legal services, but it's not the most common pathway for us. So it's probably not so much within our expertise—except to say that advocacy for these families is an important aspect of their experience. Many of these family caregivers do that well, but many of them benefit from extra support. It's not always easy to find when they find themselves in that situation.

**Mr. Wayne Gates:** We need to support our caregivers a lot more than we do. That may include compensation, by the way. So that's something that I think both of your organizations should be talking about.

I meet with a lot of caregivers. They struggle because there is no compensation there. That's something that we have to do if we want to fix home care, so that we're encouraging more people to stay in their homes. That would help long-term care, retirement homes. It kind of flows down, and the money they save when you stay in the home—because I don't know anybody—even on that side, they probably want to stay in their home. When you get a little older and you get a little sicker, or if you're a child at SickKids—they want to be home with their parents. We want to stay in our homes as long as we can. So I think caregivers should be compensated too, and there's nothing in this bill that's going to address that.

This is one that you guys touched on a little bit but I would like you to talk about again, and then I'll turn it back to my colleague. We regularly hear concerns locally about missed appointments in home care. It takes a serious toll on family members who are forced to scramble, last minute, to cover the care needs of their loved ones. Do you think this legislation should have some accountability measures for service providers that routinely miss appointments?

I can say that both my father-in-law and my mother-in-law, when they were here, certainly went through this quite regularly with companies like Bayshore and some of the private companies.

Maybe the two of you could answer. That would be great.

**Ms. Krista Keilty:** Certainly, the performance of home care are important data points to track, and more importantly than tracking and monitoring them—which is described in my read of the bill—are the structures that will actually act on and ensure that we're in a continuous process improvement: process with the safety events; safety events around practice; and then also performance, including missed shifts, missed visits, wait times etc.

So I would concur that there is need for there to be the data, reliably collected, available across the system—

**The Chair (Mr. Brian Riddell):** One minute remaining.

**Ms. Krista Keilty:** —to be used to inform the development and operations in complementary structures as well, like mine, so I can know how much connected care to build through my program. But ultimately, the data and the reliability and the accountability for performance and practice needs to be of the highest, highest priority in implementing changes.

**The Chair (Mr. Brian Riddell):** I recognize MPP Gélinas.

**M^me^ France Gélinas:** Graham, you wanted to add something on that?

**Mr. Graham Webb:** [*inaudible*] financial consequences, and one of our concerns is that if the agencies that are making the contracts with the for-profit and not-for-profit service providers are dominated by the service providers themselves, then there is little likelihood of the coordination agencies—the Ontario health teams, for example—implementing strong financial penalties with their service providers, their contracting parties.

**The Chair (Mr. Brian Riddell):** I'm going to cut you off right there, sir. The time is up.

We'll continue round two with the independent member for four and a half minutes. I recognize MPP Shamji.

**Mr. Adil Shamji:** Thank you very much for being here and sharing your perspective on Bill 135.

As you know, Bill 135 closes the chapter on the 14 local health integration networks and replaces them with a single sort of super-agency. One of the things I noticed in my read of the bill is that the previous functions of the local health integration networks do not overlap perfectly with the proposed functions of Ontario Health atHome. For example, Ontario Health atHome doesn't engage in regional discharge planning. It does not engage in direct provision of care where there are no regional service providers. So my question is: Is SickKids prepared to assume these responsibilities? Or who will?

**Ms. Krista Keilty:** Thank you for the question.

I am not authorized today to confirm what SickKids will and will not do in terms of moving forward with the potential to become a client service provider, for example. It is one of the questions that we bring to the table today, to understand and to make comment that there is not clarity in the way that the bill is currently written that would help us understand what to do when a SickKids or, I'll say, a Princess Margaret or a UHN or other specialized hospital that falls outside of OHT structures—where they fit in the proposed changes.

**Mr. Adil Shamji:** What would you like to see?

**Ms. Krista Keilty:** More information, more clarity and more discrete accountability within the bills and within the regs that come—

**Mr. Adil Shamji:** I'll just push you a little bit, in the spirit of us wanting to create the best product possible. In your dream world, who would you like to assume those responsibilities?

**Ms. Krista Keilty:** Go ahead.

**Ms. Kathy Netten:** There needs to be delegation of these tasks so that tertiary care hospitals have a process in place. OHTs are not currently integrated with tertiary care systems, and that could potentially create a gap in service that would need to be addressed by the bill and the implementation.

**1700**

**The Chair (Mr. Brian Riddell):** You have two minutes and 13 seconds.

**Mr. Adil Shamji:** Great.

It sounds to me like there are opportunities for better integration with this bill, so we'll push for amendments to achieve that.

Graham, would you help me understand what changes you would like to see in order to improve health care, and whether you see these in this legislation?

**Mr. Graham Webb:** The underlying issue is the level of funding for home care, if we're talking about home care.

**Mr. Adil Shamji:** Yes.

**Mr. Graham Webb:** The perception that we hear from lawyers working in the system is that hospital workers are paid better than long-term-care workers, who are paid better than home care workers, who are the bottom of the heap, going about their work from home to home. It's difficult for home care agencies to hire workers. That's one of the problems.

The problem that brings us here today, most importantly, is who coordinates and who hands out these contracts. We think that is something that should be very closely held by the government of Ontario, by the Ministry of Health.

**The Chair (Mr. Brian Riddell):** One minute remaining.

**Mr. Graham Webb:** That is something that should not be delegated once, twice, three or four times. It is something that should be done by a disinterested party who has no financial interest in these contracts other than to protect the public interest.

**Mr. Adil Shamji:** As I have sought to understand the current environment, I've heard from stakeholders that, in practice, the local health integration networks don't actually exist and don't actually function right now. Who is awarding those contracts, performing those functions? And if it doesn't go to a single sort of super agency, how do you imagine it actually shaping up?

**Mr. Graham Webb:** To answer your first question, we don't really know. That's because we haven't been consulted. In previous iterations of legislation of the type, stakeholders like ourselves have been extensively consulted before the legislation was brought. Here, that hasn't been the case, and we wish we had more answers for you.

**The Chair (Mr. Brian Riddell):** Thank you very much for your comments. That ends that component.

I'd like to thank everyone today for their comments and thoughts. If you would like to submit any written materials to the committee in addition to your presentation today, the deadline for written submissions is on Wednesday, November 15, 2023 at 7 p.m.

This concludes the first part. and now we will move on to the second part.

## ONTARIO NURSES' ASSOCIATION
## CANAGE
## ONTARIO COUNCIL OF HOSPITAL UNIONS/CUPE

**The Chair (Mr. Brian Riddell):** I will now call on the next group of presenters to please come forward: the Ontario Nurses' Association, which is here in person; CanAge, which is going to be virtual; and Ontario Council of Hospital Unions/CUPE, which will be virtual. Welcome.

As a reminder, each of you will have seven and a half minutes for your presentation, followed by questions from the committee members. I will provide reminders of the time remaining during the presentations and questions. Please state your name for the Hansard, and then you may begin.

Ontario Nurses' Association, when you're ready, you may start.

**Ms. Erin Ariss:** My name is Erin Ariss. I'm a registered nurse and the president of the Ontario Nurses' Association.

I want to thank Chair MPP Riddell, Vice-Chair MPP Gélinas and members of the committee for the opportunity to speak today.

ONA is Canada's largest nurses' union, representing over 68,000 registered nurses and health care professionals in Ontario. We also represent 18,000 nursing student affiliates. Our members include proud care coordinators, nurse practitioners, clinical care specialists, receptionists, mental health and addictions nurses, and palliative nurses.

Our members have substantial concerns regarding this government's Bill 135, the Convenient Care at Home Act, 2023. The amalgamation of services, as is proposed by the bill, will cause greater uncertainty for ONA members and does nothing to improve care for Ontarians. The government has restructured home and community care many times, causing years of instability and uncertainty for workers. Bill 135 proposes to do this yet again. The proposed amalgamation will trigger a province-wide PSLRTA. The nature of this process does not ensure that agreements relating to seniority, recall and non-discrimination in the workplace will be protected for our members.

The work that care coordinators do is vital to health care and invaluable to families. Care coordinators ensure the client's needs are met by providing an accurate, timely and full assessment of care needs. The government must provide more information about how existing care coordinators will transition to the new client provider entity. The bill does not include any language about staffing models or the new client providers so that the appropriate care coordinator is available.

The bill opens the door to moving the role of care coordination to for-profit companies. In this scenario, there will be a clear conflict of interest since the assessment and delivery of home care would fall to the same for-profit company looking to maximize its profits.

ONA is also deeply concerned that this bill weakens accountability and regional representation. The bill grants the Minister of Health substantial powers to do policy implementation and resource allocation, but the bill does not set a minimum standard of service for home care in Ontario. This is unacceptable. Ontarians deserve the highest standard of service for home and community care, and that should be set out in the legislation.

We are also concerned about a loss of regional representation at the decision-making table. The consolidation of home care services at such a large scale means the loss of regional representation for rural and northern communities. The board of directors of the service organization must include diverse voices in regional representation, and this should be protected by the bill.

The priority of this government must be to improve the delivery of care to Ontarians, but this bill doesn't do that. What this bill does do is focus time and resources on a merger that no workers were asking for, rather than addressing the most pressing underlying challenges facing home care and community care.

Before building any structure, you need a strong foundation. After four years of the pandemic and many years

of underfunding, our health system is crumbling. Vacancy rates for workers increased exponentially since the start of the pandemic. In home and community care, we face a retention and recruitment crisis.

Ontario's own independent Financial Accountability Office projects that there will be a province-wide shortage of 33,000 nurses and personal support workers within the next five years.

Inadequately low wages are causing workers to leave the sector. Home care workers, who are primarily women and workers of colour, earn less than those who work in hospitals or long-term-care facilities. This government added even more precarity by introducing Bill 124, which violated our members' rights to bargain decent wages.

In addition to low wages, unsafe working conditions that include threats of violence resulting in staff injury are causing more workers to leave the sector.

These are substantial underlying issues facing home and community care, yet this bill ignores the realities and offers no solutions. Instead, our members are deeply concerned that this legislation will expand the role of for-profit delivery of home care. We are concerned that the new mega agency, Ontario Health atHome, will rely on contracting out care to more for-profit provider companies.

We want to be clear: The increased use of for-profit agencies will further erode home care in Ontario. We know that publicly delivered health care is proven to be more cost-effective, reliable and equitable than for-profit care delivery.

ONA calls on this committee to amend the legislation—

**The Chair (Mr. Brian Riddell):** You have one minute remaining.

**Ms. Erin Ariss:** —to ensure the delivery of home care is not for profit and funded through a single source rather than contracted out to for-profit providers.

**1710**

This government's focus should be on fixing the underlying issues impacting care. We need to fix the care worker shortage and improve worker retention in home care. This starts by repealing Bill 124 and paying workers who provide care to our loved ones better wages. And we need to see immediate steps to reduce violence in the workplace.

On behalf of our members and Ontarians who access home care services, we urge the government to amend this legislation to provide workers with more certainty and better working conditions.

**The Chair (Mr. Brian Riddell):** We will now go to CanAge. You have seven minutes. Please go ahead when you're ready.

**Ms. Laura Tamblyn Watts:** My name is Laura Tamblyn Watts. I am the chief executive officer of CanAge, Canada's national seniors' advocacy organization. We are a non-partisan, not-for-profit organization which works to advance the rights and well-being of all Canadians. We are located in Toronto, Ontario. We thank you for the opportunity of making submissions today on this bill.

By background, I'm a lawyer, and I've spent more than 25 years working in the field of aging. I serve on many committees, both federal and provincial, focusing on long-term care as well as home and community care. I serve currently as an expert in the Canadian Standards Association for home and community care. Prior to that, I served on the committee that created the national long-term-care standards.

It's clear that access to affordable, quality home care is going to be paramount in the healthy aging of older Ontarians. We know that staff shortages and wage disputes and lack of access to care have only gotten worse in recent years. We at CanAge have been advocating for strong, targeted policies to address these and other issues, both before and now, hopefully, after the pandemic. But we have not seen the targeted, tangible changes to address these fundamental problems.

Sadly, Bill 135, does nothing to address the critical weakness of Ontario's home care sector—quite the contrary: It creates more problems than it would solve. It undermines existing legislation, creates new vulnerabilities and pushes home care service provision further and further into the private sector. This proposed legislation explicitly erodes individual patient health information privacy rights through the implementation of a mechanism allowing Ontario health teams to disclose records of personal health information for reasons as undefined as monitoring, assessing and evaluating home and community care services. Combined with a newer, far more lax definition of who can be contracted as an Ontario health team, personal health information is less secure than it was.

We're also very concerned because Ontario health teams are not clear in what they already cover or, in some cases, who they actually are. The Ontario health team processes right now contribute to the continued privatization of the health care sector. It opens doors for indeterminate term contracts with for-profit service providers—something that CanAge and other organizations have already identified as a source of steadily rising health care costs for seniors. It also creates significant uncertainties and confusion in oversight and accountability for service providers and the applicability of core protections such as regulation 187/22 of the Connecting Care Act, which is the Patient Bill of Rights.

Bill 135's restructuring of critical features in the home care landscape concentrates administrative authority and control within the Ministry of Health, with significantly less oversight than there is now. The agglomeration of the 14 LHINs across Canada into this single service super-agency and the dismantling of many of the existing reporting requirements previously held in LHINs are subject to concerns about transparency, accountability and process standards. We're concerned that in the end, it opens the door to less care coordination.

I note with approval my colleague, who spoke ahead of time, from the nurses. We would like to reiterate and underscore her concerns.

This does not set a minimum standard of service. Care coordination is not clear. And as an overall concern, this is not a plug-and-play piece of legislation. In many cases, there is a significant lack of oversight when we withdraw

and then replace. The new staffing models are very unclear in this particular model. And when we think about the challenges of having one set of agencies both, as my colleague said, assessing and then providing the care, we believe that this is both a conflict of interest and bad for Ontarians.

We recommend, overall, that this bill be withdrawn in its entirety. It does not serve to benefit vulnerable seniors, or anyone else who is a person who requires home care, in any measurable capacity. By contrast, we believe that it will open the door to confusion. What the home care sector needs, as we have seen time and time again, is significant investment. This is where we need to put our money. We are not focusing enough on the provision of adequate support for home care and too much on the coordination into a super-agency that we do not feel will be beneficial and provides less accountability and transparency.

In sum, if the committee does not choose to withdraw the bill, we would at least offer the following four points:

—that the Ministry of Health develops strong, clearly defined oversight and accountability frameworks for all externally contracted health team service providers, including publicly available information requests and reports. This should include measures to combat conflicts of interest where profit maximization undermines public health interests in contracted, for-profit providers;

—that the Ministry of Health cements individual patient rights to protect their private health information, with opt-in disclosure agreements providing individuals to decide when they want to share their data;

—that the Ministry of Health re-evaluates current spending budgets to sufficiently fund public home care services to ensure the adequate delivery of home care needs for all Ontarians; and

—that the Ministry of Health—

**The Chair (Mr. Brian Riddell):** You have one minute left.

**Ms. Laura Tamblyn Watts:** —creates clearly defined service delivery and cost standards, minimum standards to ensure the alignment of public and private sector costs to consumers in order to combat price gouging or any other type of for-profit practices that would not support the benefit of the vulnerable people we are trying to support.

Thank you very much.

**The Chair (Mr. Brian Riddell):** We will now go to Ontario Council of Hospital Unions/CUPE. You have seven minutes. You can start when you're ready.

**Ms. Debra Maxfield:** My name is Debra Maxfield. I'm chair of CUPE Ontario's health care workers coordinating committee. With me today is Sharon Richer, secretary-treasurer of OCHU/CUPE, and Doug Allan, a CUPE researcher representative.

The Canadian Union of Public Employees represents employees in practically every town, city, village, municipality, hamlet and unorganized territory in Ontario. CUPE is the largest union in both Ontario and in Canada, and it is also the largest health care union. We have tens of thousands of members working in long-term care, primary care, emergency care, home and community care, and in eight Home and Community Care Support Services organizations. The Ontario Council of Hospital Unions/CUPE represents over 40,000 workers.

Ever since the Harris government established a system of compulsory contracting out of home care in the late 1990s, the home care system has been in crisis, and the government has been forced to reform the system repeatedly. None of these reforms resolved the fundamental problems in the sector: privatization, poor working conditions, fragmentation of services, and insufficient delivery models. The government's latest proposed reforms in Bill 135, Convenient Care at Home Act, also fail to address these problems. Compulsory contracting out of home care will continue as a predominant form of delivery. As a result, the almost entirely female—and in larger centres, racialized—home care workforce can expect more of the same: low wages, irregular work, few benefits, and almost no pensions. This will continue widespread staff shortages in home care.

Indeed, even the for-profit providers that did so much to reduce wages and working conditions in the sector complain that wages are too low to attract significant numbers to the workforce.

CUPE has long advocated for the public home care system, with democratic governance and working conditions at the same level as other sectors in the public health care system.

**1720**

Until such reforms are implemented, the ability of home care to provide the services that are needed by the public will simply not be possible. Many home care workers love providing care in the home and would choose to stay there if they could afford it. But the inferior conditions of work mean that many will be forced to move on, breaking continuity, the quality of care, and exacerbating the staffing crisis.

Home and Community Care Support Services employees will also face uncertainty as their employer restructures for the fifth time sine CCACs were created in the late 1990s. This time, the reform creates one province-wide organization, raising important, unanswered questions. What will happen to the work currently spread out across the province? Will jobs currently done in small towns and rural areas be centralized to remote large cities? Will the government assure these workers and small towns and rural communities that these jobs and services will remain in local communities?

I will now pass the mike to Sharon.

**Ms. Sharon Richer:** Similarly, the reforms raise questions about the conditions of work. The CCACs, the LHINs—the Home and Community Care Support Services have used their 14 regional incarnations to impose inferior working conditions on some workers. Under this reform, that excuse is no longer tenable. Ontario Health atHome will be one province-wide organization. The government and its agents commit to start work with Home and Community Care Support Services employees to immediately remove the inferior wages and working conditions where they exist.

The LHINS originally provided significant information to the public, through their websites, regarding their meetings and the input they receive from experts and others. With the current government, the information from the LHINs and the HCCSS of this nature has become much more limited. Unfortunately, consistent with the trend, there are no provisions in this bill for public meetings of the new Ontario Health atHome boards, public notices, public access to minutes and documents, nor other important democratic provisions. There are no provisions of democratic responsiveness to the local communities. This is important, as the creation of a single province-wide organization—the potential for the organization to overlook local community interest is significantly greater.

Communities, especially small, rural and northern communities, need to know that their services will be respected and maintained. The legislation provides for the assignment of employees of Ontario Health atHome to work under the direction of a client provider to deliver care coordinated services. This, of course, raises questions about the location of work for many HCCSS workers, raising significant uncertainty that needs to be dealt with. The government should guarantee reasonable limits to distance that must be travelled—

**The Chair (Mr. Brian Riddell):** You have one minute remaining.

**Ms. Sharon Richer:** —to new work locations. CUPE will be willing to negotiate with the government on reasonable limits, but we have no reassurance that the government or its agents are interested in doing the same.

This aspect of reform also raises the issue of Ontario Health atHome employees' work under the direction of client-provider organizations. At least until now, the CCAC, the LHINs and the HCCSS employees have worked to ensure that home care businesses provide appropriate care to patients. This is necessary, given the compulsory contracting out of such services. But the Ontario Health atHome employees' work under the direction of a provider or organization—it is unclear to us how the necessary independence and oversight will be maintained. It is positive that workers will at least remain employees of Ontario Health atHome, but it is unclear to us—

**The Chair (Mr. Brian Riddell):** Thank you for your presentation.

We will now go to round one. The official opposition has seven minutes and 30 seconds. I recognize MPP Gélinas.

**M^me^ France Gélinas:** My question will be to all three presenters, and I will start at the high level. Do you see anything in this bill that will improve home care, that will improve access to care, that will improve the rights of patients to access care, that will improve the quality of care that our home care system provides? I will start with ONA.

**Ms. Erin Ariss:** The short answer is, no, we do not. In fact, I think it fails to address many issues, including the instability that exists in this workforce and every workforce in every sector of health care across Ontario.

I'd just point to our submission: You can see that the impact of the pandemic has increased the vacancy rate for RNs by 421%, and the vacancy rate for full-time PSWs has risen by 331%. Without addressing that—the violence, the wage disparity, the staffing, not having an equitable voice in the sector, and fundamentally, the lack of transparency, accountability and minimum standard of care—no, I do not see that it improves home care in any way.

**M^me^ France Gélinas:** Ms. Tamblyn from CanAge, same question.

**Ms. Laura Tamblyn Watts:** The short answer is no, I don't see anything in this bill that will improve care. I do, however, see things that will harm care.

**M^me^ France Gélinas:** Such as?

**Ms. Laura Tamblyn Watts:** Let me give you a tangible example. You have someone who is a caregiver at home. She's taking care of her husband, perhaps, with dementia. She's getting exhausted. She doesn't know who to call under this. There's no care coordination. There's a lack of ability to understand how it is she's supposed to get that support that she needs. Who decides on the care now? Who's going to determine it? And if her husband needs some placement in long-term care, they get handed off again to another group that isn't going to be part of the Ontario health team. So it's going to increase both pressures on individuals, pressures on caregivers and, frankly, pressures on the system, which will no longer be even as coordinated as it is now.

**M^me^ France Gélinas:** Same questions to CUPE/OCHU.

**Mr. Doug Allan:** I would say there is no improvement that we can see. It does not destroy the system quite as much as some earlier comments from the government suggested it might. For that, I guess we can be a tiny bit thankful. But really, it's similar to some other policies which—as Rome is burning, and perhaps it's burning nowhere else as bad as in home and community care, this is just fiddling with the teams and creating further uncertainty for the workforce that exists in home care.

It's quite remarkable when even the for-profit providers, which have destroyed the working conditions of home care, now have been campaigning for several years about the terrible conditions of work that they apply to their workforce—because they cannot attract staff, because they cannot fulfill the appointments that they have to provide to people who need home care.

We need to expand home care dramatically, and yet this reform does nothing to actually address the key problems which have developed in home care, which are the privatization of home care, the compulsory contracting out of home care, the low wages, the poor working conditions, the violence that ONA spoke of that afflicts home care workers—none of that is addressed. Instead, we have a rearrangement of the deck chairs, which will unfortunately take up a great deal of the focus of the Ministry of Health and of the stakeholders over the next year to deal with this—the year and longer.

We'd be so much better if we focused instead on developing a democratic, publicly accountable and publicly delivered home care system, and got rid of the inefficiency which is built into the system by requiring duplication of services that comes about with compulsory contracting-out.

**1730**

**M^me^ France Gélinas:** I will start with OCHU/CUPE. Were you consulted before this bill was put forward?

**Mr. Doug Allan:** If I may again—sorry, Sharon and Debra—because I was involved with this: We were informed at several attempts by the Ministry of Health staff—and I do thank the Ministry of Health staff for informing us. I wouldn't quite call it consultation. We did express our concerns, and we do appreciate the Ministry of Health staff for at least listening to us. They're working with a certain government, so—

**M^me^ France Gélinas:** Did they take into account any of the recommendations that you made?

**Mr. Doug Allan:** None that I am aware of. I would say that it's not as bad as it could have been, but—

**M^me^ France Gélinas:** But you set the bar pretty low?

**Mr. Doug Allan:** I'm setting the bar pretty low. We feared the worst, and we got something not quite as bad as that.

**M^me^ France Gélinas:** I'll go back to CanAge. Were you consulted before this bill came out?

**Ms. Laura Tamblyn Watts:** We wanted to be, and we reached out on several occasions to see if we could. We were entirely un-consulted. That's unusual; we're usually part of both government processes and public consultations. We were very surprised at how this process went.

**M^me^ France Gélinas:** To ONA: Were you consulted as to what was coming with this bill?

**Ms. Erin Ariss:** I would echo what CUPE just said. We were informed by the Ministry of Health staff what was coming. And again, I would echo that it is not as bad as we thought it would be.

**M^me^ France Gélinas:** I won't ask how bad it was—what you expected.

What you've told us is, really, that it's not going to improve care; it's not going to improve wages; it's not going to improve working conditions for your members. At the end of the day, home care relies 100% on workers. If you don't have continuity of care, if you don't have continuity of caregivers, you cannot have quality care.

**Ms. Erin Ariss:** No, you cannot have quality care. I'm a registered nurse; I understand that personally and professionally—

**The Chair (Mr. Brian Riddell):** I'm going to have to cut you off there. Sorry.

We'll now go to the independent member for four and a half minutes. I recognize MPP Brady.

**Ms. Bobbi Ann Brady:** Thank you to all our presenters this afternoon in this round.

I want to follow up with what my colleague was saying: that as decision-makers, we aren't expected to know everything, but we do rely on the expertise of professionals like all of you. It is disheartening, because maybe we could have saved a lot of time; we could have gotten things right if the consultation would have been done ahead of time—rather than floating a bill that nobody seems to be very happy with.

I'd like to know, maybe from all of you, if you could hypothesize what the reasons are that this bill is moving forward in its current state, given the fact that many of you did express frustration with it in the beginning. I'll start with ONA.

**Ms. Erin Ariss:** We are very concerned that this is just another effort to further privatize Ontario's health care system, to further privatize a sector that was initially privatized by the Harris government in the 1990s, because it is very hard to believe that it is anything but that.

This legislation will not improve the sector. It does not provide a minimum standard of care. There is no public accountability process. And we just see that it doesn't provide any accountability for any private, for-profit provider—

**Ms. Bobbi Ann Brady:** Before I move on to CAMH, can I just interject—

**Mrs. Robin Martin:** Chair, point of order.

**The Chair (Mr. Brian Riddell):** We'll just pause for a second.

Point of order, MPP Martin?

**Mrs. Robin Martin:** I'm sorry to interrupt the witness and your questioning, but the question that you asked is all about speculating on the government's motives, and as you know, it's inappropriate to speculate on motives. So I think your question is unparliamentary and it shouldn't be allowed at this committee.

**Ms. Bobbi Ann Brady:** Fair enough. I'll move on to my next question, then.

We keep talking about the standard of care. What should that look like? I don't have a grasp of what you would actually believe the standard should look like.

**Ms. Erin Ariss:** Standards should be patient-focused, family-focused. They should include diverse perspectives from all regions, all groups—including equity-seeking groups—in Ontario. They need to have the patient and their families as the primary stakeholder in the process, and consultation should come from those providing the care, experts in the areas—experts in nursing and social work and other allied professions, including medicine. It should not be driven from for-profit providers.

**Ms. Bobbi Ann Brady:** Moving on to Laura: You actually spoke about targeted, tangible changes as well, and I'm wondering what you feel those targeted, tangible changes would be.

**Ms. Laura Tamblyn Watts:** If we could do it better, the first thing that we would do is take our broad model and turn it upside down. Home care needs to be the first and best-financed aspect of seniors' care—and for that matter, also people who require home care. We know that it's the cheapest form of care. We know that long-term care is about $1 million per bed for building—just to build a new bed is about $1 million.

**The Chair (Mr. Brian Riddell):** One minute remaining.

**Ms. Laura Tamblyn Watts:** Home care is very effective when we actually provide adequate amounts of home care with the type of solid wages and wage equity that we need to see. Bill 124 is particularly problematic, and I echo my colleague's point on that.

I also want to say that, when we're thinking about standards of care, we don't just think about the one person

who's receiving care; we think about supporting the people who are already providing it for free—family caregivers, who are providing, overwhelmingly, the bulk of care in Ontario. This makes it more complicated for family caregivers and will actually burn them out faster, because that one piece of care coordination that we do have right now will seem to disappear.

We need to make sure we have minimum standards and that, whatever this bill does, streamlines and supports a more accountable, more affordable, more appropriate, more robust and more stable—

**The Chair (Mr. Brian Riddell):** Thank you for your comments.

We'll now move to the government for seven and a half minutes. I recognize MPP Pierre.

**Ms. Natalie Pierre:** Thank you to all of today's presenters.

My question and comments are to CanAge.

I just wanted to state that there is no change to privacy practices based on this legislation and no changes in information-sharing among the parties.

The Ontario government is building on the work that has already been done to better connect people in home and community through Your Health: A Plan for Connected and Convenient Care, by moving forward to the transition of home care to Ontario health teams. We have a shared goal of improving care for patients.

We've listened carefully and worked closely with service provider organizations, home and community care staff, patients, families and other system partners, and we are now moving forward with the next steps to transition care to Ontario health teams. With these proposed changes, we will improve the way people connect to home care services, and we will break down long-standing barriers between home care and other parts of the health care system.

The government has introduced legislation to consolidate the 14 Home and Community Care Support Services organizations into a single new service organization called Ontario Health atHome, which would be a subsidiary of Ontario Health. Ontario Health atHome is intended to provide a strong, centralized and stable organization for the provision of home care now, and eventually to provide operational supports to Ontario health teams to support their provision of home care in the future. All employees of Home and Community Care Support Services organizations would become employees of Ontario Health atHome as of the date of integration. HCCSS staff will continue to be valued contributors to home care delivery.

If the legislation is passed and comes into effect, then, in the short term, Ontario Health atHome would continue to coordinate and deliver home care, keeping continuity within the services HCCSS organizations deliver today. Maintaining consistent quality standards to patients as we go through this transition remains our government's top priority. As OHTs are designated and take on responsibility for home care delivery, Ontario Health atHome would shift to providing them with home care operational supports, including care coordination.

This is one of a number of initiatives the government is taking to support Ontario health teams to deliver and transform home care.

There is nothing in this legislation that changes the role of non-profit and for-profit providers in home and community care. Ontario Health atHome will be a crown agency, just like Home and Community Care Support Services is right now.

**1740**

**Mr. Adil Shamji:** Point of order.

**Ms. Natalie Pierre:** My question—

**The Chair (Mr. Brian Riddell):** Point of order.

**Mr. Adil Shamji:** I think the member across may be getting to what I was going to wonder, which was: Is there a question?

**Mrs. Robin Martin:** She just said, "My question—"

**Mr. Adil Shamji:** Yes.

Chair, I might ask what your thoughts are on multiple-minute preambles to questions.

**The Chair (Mr. Brian Riddell):** I'm going to let her continue.

**Mr. Adil Shamji:** These are public hearings. This is for the public, not for individual soliloquies.

**Mrs. Robin Martin:** We're allowed to use our time in any way we see fit.

*Interjections.*

**The Chair (Mr. Brian Riddell):** I appreciate—

*Interjections.*

**The Chair (Mr. Brian Riddell):** Please let me answer. MPP Gates, let me answer, please. Thank you.

You may continue.

**Ms. Natalie Pierre:** My question: What parts of home care and long-term care placement today that are working well would you like to see remain as part of the future system?

**Ms. Laura Tamblyn Watts:** What I appreciate about those comments is your passion to improve home care for all Ontarians.

This government has been making significant steps to improve both long-term care and home and community care.

With great respect, I think this bill does not achieve some of those goals that the government is trying to move forward with.

I think what works well and is not in this bill is the care coordination piece—although, it could certainly work a lot better. I think what works not as well and will work worse is the funding. And I think what's even more concerning is that conflict-of-interest question about assessment and delivery.

**The Chair (Mr. Brian Riddell):** MPP Martin, I recognize you.

**Mrs. Robin Martin:** We did hear something about consultations with unions. My understanding is that the Ministry of Health consulted with all of the unions involved in HCCSS, Home and Community Care Support Services; and that CUPE, who is a witness here today, was consulted twice, both before and after the legislation was introduced, and that no concerns were raised by them. In fact, the

ministry had the impression that they were quite comfortable with the legislation as proposed.

As indicated by my friend MPP Pierre, our plan is really grounded in not disrupting the workforce. We know we need to keep our home and community care workers. We highly value them, and we want to make sure that they are protected and that we make sure we have an appropriate system for them.

The groups represented by collective bargaining agents on the collective agreements would be ported right over to Ontario Health atHome. We're working with the Labour Relations Act and PSLRTA, as they call it. Both frameworks are well-known, as I understand it, to the unions and seniority is dovetailed. We're trying to move with incremental process. That's why we've had several pieces of home care legislation—to make sure that we keep the workforce stable, and to also make sure that we improve home care for everybody. That's where we're trying to get to.

I, personally, think that this is a step in that direction. It doesn't solve all of the problems, as we've said before. But we're here to try to improve the system, and that's what we're doing with this piece of legislation. That was why we were so careful to consult with the unions to make sure that everybody knew what was happening and knew about the incremental process, and to make sure that—

**The Chair (Mr. Brian Riddell):** One minute remaining.

**Mrs. Robin Martin:** —we understood that the collective agreements and everything will remain in place and be ported over to the new entity, Ontario Health atHome.

I wonder if I could ask the representative of ONA who is with us today—you talked about how important it is to focus on fixing underlying issues with our health care system, and I think you mentioned something about the number of workers and also the wages etc. As you know, we have improved wages for a lot of the sector, and we also have been trying to do all we can to retain, recruit and improve the number of health care workers in the system. So I believe that—

**The Chair (Mr. Brian Riddell):** That ends the government side's time.

I will now move to round two with the official opposition for seven and a half minutes. I recognize MPP Gates.

**Mr. Wayne Gates:** The president of ONA—can you answer her question? I'll give you some time to answer that.

**Ms. Erin Ariss:** I can answer that.

We see that the Financial Accountability Office projects that there's a province-wide shortage of 33,000 nurses and PSWs—and that's projected for 2028. As I said before, the vacancy rates are increasing. They have increased throughout the pandemic. If you look at what happened with Bill 124, health care professionals and nurses left all sectors, including this one, in droves—and not to mention the absolute despicable violence that this sector, in particular, experiences day in and day out. This has not been addressed. Things are going to get much worse.

**Mr. Wayne Gates:** I appreciate you answering that question.

We know there's a crisis in health care. We know there's a crisis in home care. We know there's a crisis a long-term care, where 6,000 people lost their lives—most in a private, for-profit long-term-care facility; it was around 82%, which works out to about 4,200 of those people. Math wasn't my best subject, but it's certainly in that area.

I can tell you that this bill is not going to help us at all. It's going to do nothing for Bill 124; you guys can agree or disagree with that. This bill is doing nothing for the violence that is happening every day in our hospitals. It is making it worse every single day that a nurse or a doctor goes into an emergency room—a lot of issues around that.

This is how I describe the bill—I might be wrong, and I'll let all of you guys answer this: It reminds me a little bit of shuffling the chairs on the Titanic. It's still going to sink. And that's what's happening to our health care.

My colleagues said they're investing $1 billion in home care. That sounds like a great number. The reality is that 33% of that is going to profit, which works out to—$330 million is going directly into a for-profit. Wouldn't it be nicer if the $1 billion went to all your members—for CUPE and for yourselves? Wouldn't that make more sense? Maybe you can start by answering that.

**Ms. Erin Ariss:** It would absolutely make more sense. Then patients, residents and clients in Ontario would receive timely care, the care that they deserve.

We are seeing in Atikokan, for example, that the waitlists have grown to more than 60 days. That is unacceptable. These clients deserve more.

I was just told this morning, when I was meeting with members, that patients are dying before they receive care. That's because of vacancies. There's just not enough staff in any sector of health care, but in particular, this one.

**Mr. Wayne Gates:** If CUPE would like to—either one of you groups could answer that, whoever wants to go next.

**Ms. Laura Tamblyn Watts:** I think it's not so much shuffling the Titanic chairs as much as it is moving to a different boat that also doesn't work, that actually has a hole in it.

We are not moving forward in supporting our health care workers, in bringing more people into the sector, in stabilizing the financing of this area. What we're doing is creating a super-agency that I don't think provides greater accountability and is less likely to provide better care.

**Mr. Wayne Gates:** CUPE?

**1750**

**Mr. Doug Allan:** I think the Ministry of Health is well aware of our disdain for the for-profit system that they introduced in the 1990s and continue with through this reform.

What this does, by the use of compulsory contracting out, is, it inherently fragments the system, which is something the government claims it wants to end. Inherently, privatization fragments care. It also creates a system where there has to be a duplication of care, because we have to have care coordination done by one organization and delivery of care by a separate organization. That is necessary. That may be weakened through this reform because

of this notion, which we find baffling, that they are going to put care coordination employees under the direction of the client providers, which we think is a clear conflict of interest. But again, it will also just inherently drive the inefficiency of this system, which requires extra staff—staff we do not have.

If you want to end this fragmentation of the home care system, if you want to find extra capacity in our home care system, if you want to deliver it at a more reasonable price and also be able to afford better conditions of work for the staff, you have to end this privatization, which this government, unfortunately, in our view, is so fascinated with and keeps on driving their policy on. Without ending this process, we're inevitably going to have more and more reforms, just as we've had five different reforms since the Progressive Conservative government introduced the CCAC in the 1990s.

**The Chair (Mr. Brian Riddell):** One minute remaining.

**Mr. Doug Allan:** Unless—

**Mr. Wayne Gates:** I'm going to try another question. I'm sorry to cut you off, but I think it's important to get this out and get it on the record.

Consultation—we're going to do this for a week and a half, and the bill is going to be passed. It should have went around the province.

We all know that this government continues to push for further privatization in the health care system. Mike Harris first privatized our home care system, and we know that this bill will allow further privatization in the service delivery.

Could one of the presenters expand on the dangers of privatization in health care and, specifically, home care?

**Ms. Erin Ariss:** We need only look to what has happened in the hospitals; for example, with joint replacements. We know with cataract surgeries, there's upselling, but we also know that outcomes are worse.

We know that our publicly funded, publicly delivered system provides more cost-effective, more reliable, safer care.

**The Chair (Mr. Brian Riddell):** Thank you for your comments.

We'll now move to the independent members for four and a half minutes. I recognize MPP Shamji.

**Mr. Adil Shamji:** One of the recurring themes that has come through all of your remarks has been the need to address the root causes of the challenges in home care—repealing Bill 124, addressing workplace violence, ensuring that there's adequate funding and that those dollars are actually spent. The government has given no indication that they will act on any of those things. So, all else equal—and to be clear, I have no intention to defend the legislation before us—but assuming they take no action on any of these things, is our home care system better off or worse if we pass Bill 135?

Erin, may I start with you?

**Ms. Erin Ariss:** I think we'd be worse off. It's already a precarious work environment for our members and workers in general. It's just another iteration of reorganization. It adds to the instability. We already know that this sector is understaffed and has a recruitment and retention crisis; it is worse than any other sector right now. We know that workers in this sector are leaving to work outside of health care, in particular, but we're hopeful that they won't. This legislation will do nothing for recruitment or retention and will just worsen the crisis that's already there.

**Mr. Adil Shamji:** Laura, assuming no action is taken on the root causes, are we better off or worse with Bill 135?

**Ms. Laura Tamblyn Watts:** We are worse. And I would just completely adopt what my colleague from the nurses said and add this: In addition to the paid staff, it's going to burn out family caregivers who are providing the majority of care, who look for coordination, and who trust that the government will provide affordable home care when they need it. This does nothing to help. It's going to burn out the people and the resources that we have now and actually reduce our ability in the system to provide care.

**Mr. Adil Shamji:** Debra or Sharon, would you like to provide your perspective?

**Ms. Sharon Richer:** As Erin has articulated, I think it's going to make it worse off. Members are fearful for what this bill is, and they're going to be looking for other jobs in different parts of health care in which there are vacancies in higher-paid positions, and this is another problem that is exacerbating what is happening in home care.

**Mr. Adil Shamji:** In the current home care environment, we already see rampant profiteering. A perfect example of that is temporary staffing agencies, temporary nursing agencies, that are engaging in price gouging and, as I said, profiteering.

Under Bill 135, recognizing that there's already a lot of profiteering in the home care system, is your sense that the risk of profiteering is greater, worse or the same?

**Ms. Erin Ariss:** I don't see that there are any controls to limit; I think it just opens the doors wide open.

**The Chair (Mr. Brian Riddell):** One minute remaining.

**Ms. Erin Ariss:** We have not seen evidence that there are any controls or accountabilities in place—and that's another added layer of this. There's less transparency, it seems to ONA, than there is currently.

**Mr. Adil Shamji:** Laura?

**Ms. Laura Tamblyn Watts:** There's less control, less oversight, and it's significantly worrying from a financial and governance point of view.

**Mr. Adil Shamji:** Debra or Sharon?

**Ms. Sharon Richer:** Doug, did you want to answer this?

**Mr. Doug Allan:** I don't see that, no; not at all.

**The Chair (Mr. Brian Riddell):** I'll go to the government for seven and a half minutes, and I'll start with MPP Jordan.

**Mr. John Jordan:** I've mentioned this before, but I have worked in health care for the last 21 years. I've worked with the LHINs. I've worked with home and community care. It's not working. The status quo is not where this government is willing to stay.

When we present a bill that's offering more standardization, the implementation of best practices—not differently in every region—the accountability for that goes with a provincial agency, Ontario Health, so it will be standard-

ized. Standardization is very important for our providers so there's no confusion when they are referring somebody to home and community care.

All health care organizations have the opportunity to participate in their Ontario health team and therefore feed information into Ontario Health. That's accountability—addressing duplication through better coordination.

Do you not feel that this is something that will move the dial very far on the problems we currently have with home and community care? I'm asking anybody who wishes to answer it. We're all in the same business: health care.

**Ms. Laura Tamblyn Watts:** I certainly agree that accountability is extremely important, and I certainly agree that a streamlined approach is very important. I can't emphasize enough how important that care coordination is, and I really appreciate your focus on ensuring that Ontarians get that, both for families and for patients themselves. With great respect, I do not feel that this bill will achieve those things.

**1800**

**Ms. Erin Ariss:** Standardization, I feel—if it's implemented correctly, yes, but standardization often does not consider individual needs. No client is on an assembly line—like the Lean approach to health care, for example, which we know is a failure.

Best practices require staff. We have already said—and it is well reported and well researched—that there is a staffing crisis in all sectors of health care in Ontario. So you can have all the best practices you like, but you will not have staff to implement that.

**Mr. John Jordan:** I love to talk about staffing, because this government has really moved staffing. I'm sure a lot of those 68,000 registered nurses you have are a result of the efforts of this government—the learn and stay program, additional dollars going into our nursing programs. The last time I checked, which was before the summer, over 6,700 internationally trained nurses came into the system. Those are all a result of the efforts of this government.

It's frustrating for me to hear that this government isn't doing anything about staffing when your membership is what it is as a result of the efforts of this government.

My question is, are you aware of these efforts? Are you aware of these programs that this government has put in place?

**Ms. Erin Ariss:** I'm aware of them in principle. I can tell you that our membership has not increased—and we represent over 90% of the registered nurses in this province; in fact, it has decreased.

I can tell you that I am aware of the programs in some schools, but they are not in line in what was offered to the police students, in particular, and we would like to see a commitment like that granted to nursing, where tuition is paid for. It should be, and that would help.

With respect to IENs, there are simply not enough IENs to fill the vacancies in health care—and then there's what is happening in the countries of origin, where they, too, now are having a downstream effect of their own crisis because we have not been able to recruit and retain our own in Ontario.

**The Chair (Mr. Brian Riddell):** I recognize MPP Quinn.

**Mr. Nolan Quinn:** We can all agree that the status quo is not working.

I have to admit, as well as MPP Jordan, that I did work for Saint Elizabeth health care for two years, back in the early 2000s, and the health human resource shortage was very prevalent then. Ultimately, what we recognized in the HR department is that, quite often, the health care professionals would jump into home care, get upgraded on some skills, and then they would move on. It was part of their career path. They would move into a different career orientation after they had received the upgraded skills on the home care side, and then they jumped into the hospital scene at a higher rate of pay. So this isn't anything necessarily new. It has been going on since the early 2000s, when I was in the HR department at Saint Elizabeth home care.

I'm going to chat a bit about the health care workforce—just with my HR background. There are expected to be no job losses arising from the proposed transition of Home and Community Care Support Services unionized staff to Ontario Health atHome. Collective agreements would remain in force through the transition to Ontario Health atHome. As OHTs become designated and take on responsibility for home care delivery, care coordinators would continue to be employed by Ontario Health atHome and would work in new models of care led by OHTs.

Home and Community Care Support Services staff will continue to be valued contributors to home care delivery. The home care workforce is valued. The health care system depends on these workers, and more home care workers will be needed in the months and years ahead. Workforce stability is an important part of this plan. We need a stable workforce to be able to ensure we're providing the care we need.

Through these carefully planned changes, the incremental changes, it is expected to become easier for home care workers to work with other providers as a team to deliver care that meets the changing needs of your patients and their families.

I know my colleague MPP Pierre did mention this, but I will reiterate it again before I do get to my question—just so MPP Shamji is well aware.

**The Chair (Mr. Brian Riddell):** One minute remaining.

**Mr. Nolan Quinn:** Nothing in this legislation changes the role of non-profit and for-profit providers in home and community care.

My question for the CUPE members is, what are some of the opportunities your health care members have identified to help transform our health care system?

**Mr. Doug Allan:** I think one of the opportunities that we identified was that if the provincial government dropped its campaign to reinstate Bill 124, which will limit wage increases in the broader provincial public sector, including in the home care sector, to levels far, far below the current rate of inflation—we think if you took that step, that would be a vote of confidence in our health care workforce, in our home care workforce, and would help us to recruit and retain staff in the sector.

That is the overriding problem we're facing right now, and we hope the government would show some respect to home care workers—

**The Chair (Mr. Brian Riddell):** Thank you very much for your comments.

I'd like to thank everybody for their comments today. If you would like to submit any written materials to the committee in addition to your presentation today, the deadline for written submissions is Wednesday, November 15, 2023, at 7 p.m.

## MS. EDELWEISS D'ANDREA

## LIEUTENANT COLONEL RITA LEPAGE

**The Chair (Mr. Brian Riddell):** We will now call our next group of presenters to please come forward: Edelweiss D'Andrea, Ontario Health Coalition, and Rita LePage.

We'll start with Edelweiss D'Andrea. You have seven minutes.

**Ms. Edelweiss D'Andrea:** Thanks. I'm a mental health occupational therapist living in Ottawa, and I am here to talk about declining work conditions and to reflect on the impacts of privatizing health care in Ontario.

Despite graduating in 2017, I am unemployed. I've worked at a psychiatric hospital and in long-term-care facilities for the public health care system in Quebec, and I've also worked at Globalité, which is a private sector company for people on long-term disability. Before that, I worked for many years in communications, so this is my second career. I have experience with the workforce, which informs my assessment of the workforce conditions.

I am actively looking for work. I have applied for hundreds of jobs. I have been looking at job postings for six years now, since I graduated. Almost all the jobs advertised are in the private sector. These jobs are contract worker jobs, where the employer pays nothing towards employment insurance or income tax. After expenses, including driving, which you are expected to do when you work in the community, most of the jobs work out to about minimum wage as a health care worker, and that's for someone who has a master's degree.

Despite the low pay and job security, there is a great deal of responsibility and obligations associated with working and being part of a college—so a regulatory body. The biggest change for workers with respect to home care is that you need a car. You're expected to drive around all day, and days are very long if you have a full caseload. So you're expected to do eight hours a day of visiting with clients and patients, and then you're also expected to drive around. It's like being an Uber car driver in addition to being a health care worker.

**1810**

After five years of looking for work in Ontario, for the very first time I landed my first job in Ontario in the spring of 2023. It was with Bayshore, which is primarily a private home health care provider. I was doing return to work or return to duty with military personnel out of the Montfort Hospital. I only had a few hours of training, remotely, by someone doing a similar job over that time period, over the two months and a week that I was there. It ended badly, I think partly because I expressed some reservations about having to treat people unequally. Nonetheless, it was a shock when I was let go. They called me at the end of the day, and I must have been quite in shock because, as I was going down the stairs—I was carrying a box of books—I almost fainted and fell down the stairs.

I am still actively looking for work in mental health occupational therapy. It can be a great job, but it isn't, unfortunately, because of privatization. What they don't tell you when you're getting into health care is about moral injury on the job, which is, unfortunately, increasing because of privatization.

You may have heard about moral injury among the military. It is psychological distress related to violating deeply held values and beliefs. However, trauma specialists say that it is actually far more common among health care workers than it is among the military; that's because you can't put patients' needs first because of systemic and institutional obstacles. It was especially true and evident in the first year and a half of the pandemic, when 20% of the health care workforce left.

The sad truth is that we are headed toward a US-style health care system, and private health care is not as effective or cheap as the public health care system.

I have some numbers. In 2022, Canada spent 12.2% of its GDP on health care, about 75% of what they spend in the US; the US spends 16%. Despite spending less, Canada's health outcomes were better in 2022—

**The Chair (Mr. Brian Riddell):** You have one minute remaining.

**Ms. Edelweiss D'Andrea:** Thank you.

Canada outperformed the US on life expectancy by mortality—82.8 years versus 79 years—and infant mortality was about 50% higher in the US—5.8 deaths versus four per thousand.

Dismantling all public governance, as is being proposed, will only make patient protection worse, and the impacts on health care are profound. I would hope that Ontario reverses the trend and [*inaudible*].

**The Chair (Mr. Brian Riddell):** Thank you for your presentation.

Ontario Health Coalition did not attend today, so we'll go to Rita LePage. You will have seven minutes when you're ready to start.

**Lieutenant Colonel Rita LePage:** Thank you. Rita LePage is my name. I was a senior officer and a 31-year veteran of the Canadian Forces. It seems like a theme here. I live in St. Catharines, Ontario.

My 90-year-old mother is blind. She suffers from dementia. She has colon cancer, she has cardiac issues, and she has walking and balance issues. There is literally nothing she is able to do for herself. Yet she's happy, she sweet, she's co-operative, she is grateful for me, for her care and for her caregivers.

I retired to take care of my mom. That was eight years ago. For six and a half years, I have cared for her 24 hours a day without assistance. One and a half years ago, she

suffered a fractured pelvis after falling. Three months later, upon discharge from hospital, I began receiving PSW home care through ParaMed, and, oh my God, to this day I am grateful, because I have three hours every day to do the grocery shopping and to do, maybe, something for myself.

I appear here today as a concerned daughter, as a full-time family caregiver, and as a fierce advocate for my mom and the home care she receives.

I also volunteer on a home care Patient and Family Advisory Council; in fact, I'm the co-chair. The council comprises 12 patients or family caregivers residing in remote, rural and urban areas throughout Ontario.

Two things are very, very clear after my year and a half on the council: We all have remarkably similar stories and challenges when it comes to accessing timely, punctual, appropriate, consistent home care and equality of access. Despite the similarity of our challenges, the reasons are very disparate for them: population density; per capita percentage of elders in the community; number of home care providers available in various communities, especially the remote communities; and distances needed to travel from one client to another by care workers, especially in remote and rural communities—that and the wide spectrum of care that's required by various patients.

I have some questions and concerns about changes proposed in Bill 135. Currently, there are two levels of accountability and reporting. There are 14 LHIN boards of directors who are accountable directly to the minister. Bill 135 details four levels of reporting: minister, to Ontario Health, to Ontario Health atHome, to 58 Ontario health teams. That is a lot of added bureaucracy and levels of accountability, seemingly making complex any effort to navigate the system to resolve issues.

The 14 LHINs are crown agencies, assigned their own budgets and responsible to negotiate their own care contracts. This gives them the flexibility to craft and negotiate contracts which meet the specific demographics and geographic considerations of their areas of responsibility. We'll move to one crown agency, Ontario Health atHome, which assumes all budgets, contracting, staff, assets, accountabilities and liabilities previously given to the LHINs.

My concern is that centralized care contracts become huge, generic and may no longer meet the demographic and geographic-specific needs of regions throughout Ontario. And yes, there will be 58 Ontario health teams throughout the province; however, in the proposed model, they are not decision-makers, as were the LHINs, but simply implementers of a policy made by a centralized agency, and that gives me pause. It concerns me as a caregiver to a vulnerable mom that rather than speaking to local decision-makers at the LHIN, which sometimes is hard enough, I will be made to navigate various and distant levels of bureaucracy to address care shortfalls and policies that may not serve the needs of vulnerable patients, through changes to either the assessed frequency, duration or range of care that's being offered.

With Bill 135, we know what the plan is, but what are the gaps that necessitated four levels of bureaucracy and a centralized budget and contracting agency? I can't find your homework—the analysis that led to Bill 135. The government gave me an answer but did not tell me how it arrived at that answer to a problem I didn't even know I had. Bottom line: Do patients benefit?

My background is military, as I mentioned. Military are exceptional planners, from analyzing the problem set to defining quantifiable goals to achieving the desired end state and then designing a campaign plan to achieve the end state. We strive to anticipate the second- and third-order effects. We look at the intended and the non-intended consequences, and we plan for it. We identify decision points. Throughout the campaign, we anticipate things that may go wrong and plan what to do if and when these occur. We plan for surprises and have both feedback mechanisms—

**The Chair (Mr. Brian Riddell):** You have one minute remaining.

**Lieutenant Colonel Rita LePage:** Has Bill 135, this intense planning process—is that what the 12 expedited OHPs will serve to do? Are there mechanisms to learn from these 12, loop back and make changes as we go?

**1820**

I've read Bill 135. I've read the news release. I've read every document in every length. They tell me how much better Bill 135 will be for my mom. But I share with you a mantra invoked frequently during my military career: Show me, don't tell me. Show me that Bill 135 will be better for my mom. Demonstrate to me that Bill 135 will improve the front-line care that she and thousands like her receive—I don't know if it will or will not. All that I care about is her care and the care of the thousands who are vulnerable.

I urge you to think long, to plan hard, and test often, because you are affecting lives, and those lives better be improved.

**The Chair (Mr. Brian Riddell):** Thank you for your comments.

We'll now go to round one, starting with the independent members for four and a half minutes. I recognize MPP Brady.

**Ms. Bobbi Ann Brady:** My first question is for Edelweiss. I think you said that you had reservations about treating people unequally. Can you explain what that meant?

**Ms. Edelweiss D'Andrea:** I don't want to get myself into trouble. I don't want to get anyone else into trouble. But there was an expectation that I treat senior-ranking military officers better than lower-ranking officers.

**Ms. Bobbi Ann Brady:** Thank you.

Over to Rita: What I'm hearing from you, Rita, is that the current system isn't perfect, but Bill 135, obviously, has some problems in it. You see some huge concerns. What do you feel the government should focus on rather than Bill 135?

**Lieutenant Colonel Rita LePage:** I don't know what it will achieve. I've read it, but what I'm concerned about, as a concerned caregiver to my mom, is that this does not deteriorate care that can be stressed already. There is unequal access. There are assessed needs versus the health care that's available. If we have to put resources to any-

thing and money to anything, I would want to make certain that people have equal access to quality care in a manner that's timely, punctual, and consistent. Those are some of the challenges we don't have. To a large extent, that is the front-line workers—how they're scheduled and how they're coordinated.

I have had a very, very good experience; I'm very, very grateful for it, but I do know—and on our patient and family advisory council—members who are very challenged.

So I just want that Bill 135, if it goes forward, addresses those things, or at least that they test-score it and that if it fails the test to improve patient care and the experience that they receive, it's flexible enough to make the changes required along the way.

**Ms. Bobbi Ann Brady:** You mentioned that you're very grateful. It's wonderful that you receive the timely care and that you haven't experienced all the many problems that you hear others explain at the committees that you sit on.

Are there any patterns to some of the issues or concerns that you hear on the boards you sit on? Is this more of a rural issue or is it more associated with the level of care needed?

**Lieutenant Colonel Rita LePage:** It's the full spectrum. In rural areas, it has to do with the density of home care providers that are available, the distances that they have to travel and the time that they're given, perhaps. In urban areas, sometimes, they're overtasked.

I live in the Niagara region. I think we have the highest density, percentage-wise, per capita, of elderly, who are one of the main communities that access this care at home.

**The Chair (Mr. Brian Riddell):** One minute remaining.

**Lieutenant Colonel Rita LePage:** So there's a lot of travel, and there are a lot of patients who have to be seen in one day.

**The Chair (Mr. Brian Riddell):** I recognize MPP Shamji.

**Mr. Adil Shamji:** Edelweiss, Rita, thank you very much for your really thoughtful and careful remarks.

Rita, I want to start with you. I was happy to hear you talk about the importance of second- and third-order effects.

I know that you've looked at this bill quite extensively. Are there any second- or third-order effects that you anticipate based upon your understanding of Bill 135, for better or for worse?

**Lieutenant Colonel Rita LePage:** I hope not to anticipate any, but my concern is that centralization of contracting may not provide the level of diversity that is evident in each of the 14 LHINs now and will be very evident in each of the 58 Ontario health teams. Edelweiss—

**The Chair (Mr. Brian Riddell):** I'm sorry, but I have to cut you off there. The time is up.

We will now go to the government for seven and a half minutes. I recognize MPP Martin.

**Mrs. Robin Martin:** I want to thank both of the witnesses for their service in our health care system and their military service. I really appreciate all you're bringing to the table today. Thank you so much for your comments.

Rita, I've also cared for both of my parents and had home care. I understand the amount of pressure that you're under and how grateful you would have been to have the three hours a day to actually do the shopping and maybe have a shower yourself and be, maybe, happier when you were trying to help care for your mum, because you had a few minutes to care for yourself.

We certainly understand how important it is to make sure that we have good health care services and good home care services for Ontarians. Frankly, it's less expensive to deliver home care than it is some other kinds of care, and we want Ontarians to be able to stay at home and have the home care they need and not end up in hospital when they don't need to be in hospital.

I just want to mention that I've been there, and I have some understanding of what you're going through. My mother had lung cancer for 10 years before she passed. It is very challenging, but also very rewarding because we get to be there for them, which we should be.

So I appreciate what you're bringing to your discussion, and I did want to assure you that we are being careful in making changes to the system.

The whole approach of Ontario health teams is to build care around patients and to move more care out into home and community, where people want to be, so that we don't just have hospitals and long-term-care facilities to offer people, but more support at home. That was the genesis of us trying to modernize home care through the other pieces of legislation that we've brought forward, and now through this piece of legislation.

Ultimately, the idea would be for your Ontario health team, which would be local to your area, which would be a group of providers working together to have care coordination embedded there so that there would be a seamless transition from your other care providers—your hospitals or your long-term-care—to home care, where that's needed. That's where we're trying to get to, but we know change is scary, and we also know that we need to protect our workforce and make sure that we keep them, which is why we're working incrementally. We intend to start working with 12 Ontario health teams, with the integration of home care there, to see how this works, and then to share best practices. We're working, as I said, step by step, and I want to assure you that we all want to make sure that the care that you're getting for your mother is not jeopardized in any way.

I just wanted to ask you, because you've had some opportunity with the home care system and you said you had some positive experiences, what worked in your experiences and what could be improved—or maybe from some of the other people on your advisory council, if you wanted to share that.

**1830**

**Lieutenant Colonel Rita LePage:** Yes, it's a delicate matter, assigning health care workers to individual patients in their homes—it's really quite intrusive, especially at the beginning—and some work and some just don't work.

Where I can advocate for my mother when things were not working and ask for changes to be made, or people, in fact, to be made—a lot of seniors don't have the advocates who speak up, or they're concerned about it.

The other piece is the assessed needs. When Mom left hospital, she was assessed as requiring three hours of assistance a day. When the LHIN person came to the home, they said their formula added up to two hours, but they would leave it at three hours to see how that went and they'd re-evaluate. So just within my own region, you see the disparity of two hours versus three hours which, frankly, makes a huge difference, I can tell you.

I thought, I've got a voice, I use it and I advocate—I am not expecting perfection, but what I'm expecting is improvement. I'm concerned about added bureaucracy. I don't know the system that well; I've been in it for a year and a half. I can advocate, but many can't, and that shouldn't be the mechanism that guarantees better care—your ability or inability or fear to advocate for yourself lest something be taken away from you. They have been very, very responsive to all my concerns, and it's like new members of the family at this point—the care that we do have from the very, very special people we have caring for Mom, but it took a while. Sometimes, when I get a holiday replacement or a sick replacement, I say, "Just don't bother," because it takes me about an hour to orient anybody to her and her needs and how she needs to be assisted.

So there are concerns. People have different people every single day, strangers coming into their home basically every single day. When you're doing intimate care, bathing care, toileting, dressing, these things make a difference. Consistency and continuity of care are probably two of the things that most people I know—the family and patients who are on the committee—are most concerned about. They want consistency, they want continuity, and they want that for their parents or their children—

**The Chair (Mr. Brian Riddell):** One minute remaining.

**Lieutenant Colonel Rita LePage:** —[*inaudible*] dignity.

**Mrs. Robin Martin:** Thank you very much, Rita. I appreciate you sharing that. I can see that those are goals that a lot of people would share.

What we're trying to do is to make sure we get to a place that improves the care that we're delivering at home and across our health care system.

I know my colleague MPP Barnes had a question.

**Ms. Patrice Barnes:** Thank you so much.

Edelweiss, you talked about actually working in the system and having a hard time getting a job placement right now to get back in the system. What would be some of the things that you think in this legislation would change or assist in that piece that you talked about?

**Ms. Edelweiss D'Andrea:** Well, the work conditions are very poor, and they're getting worse because of privatization—

**The Chair (Mr. Brian Riddell):** I'm sorry; I'm going to have to cut you off there. The time is up.

I will now move to the official opposition for seven and a half minutes. I recognize MPP Gélinas.

**M^me^ France Gélinas:** Madame D'Andrea, est-ce que vous parlez français? Ça va si je vous pose les questions en français?

**M^me^ Edelweiss D'Andrea :** Oui, allez-y.

**M^me^ France Gélinas:** OK, merci.

Je voulais juste vérifier. Lorsque vous nous avez parlé de votre histoire, est-ce que j'ai bien compris que si on vous avait offert un emploi permanent à temps plein avec de bons salaires, de bonnes conditions de travail, des avantages sociaux, peut-être un plan de pension, et une charge de travail raisonnable—vous avez cherché pour ce genre de travail, mais vous n'avez pas été capable d'en trouver. Est-ce que c'est ce que vous nous dites?

**M^me^ Edelweiss D'Andrea:** Oui, exactement. Je travaille en santé mentale, et le grand obstacle, c'est que je n'ai pas de voiture. Alors, si je compte tous les frais associés à m'acheter une voiture, ça revient au salaire minimum.

**M^me^ France Gélinas:** Est-ce qu'il y avait des emplois disponibles permanents à temps plein, ou si c'était seulement contractuel?

**M^me^ Edelweiss D'Andrea:** La plupart des emplois sont avec le secteur privé et c'est du travail à contrat. Ce n'est pas permanent; il n'y a pas de sécurité. Ils ne sont pas syndicalisés.

Les conditions de travail font en sorte qu'ils ont un très grand roulement de personnel et c'est parce que le travail est tellement difficile. La charge de travail est tellement difficile et les conditions de travail font en sorte que ce n'est pas tenable.

**M^me^ France Gélinas:** Est-ce que tu pourrais nous donner des exemples des conditions de travail et des charges de travail, de quoi ça avait l'air?

**M^me^ Edelweiss D'Andrea:** Alors, la plupart des emplois qui sont disponibles, c'est du travail à contrat. C'est du travail en communauté. C'est d'aller travailler huit heures par jour avec des clients, des patients, mais étant donné que c'est à domicile, il faut se déplacer pour arriver à la maison, et on est seulement payé pour le temps avec le patient, avec le client. Tout le temps en déplacement n'est pas considéré.

Tous les emplois—que je sache—en santé mentale exigent du travail la fin de semaine et un travail de nuit. Alors, toutes les deux semaines, il faut travailler deux jours entre 10 heures du soir et 6 heures du matin. Ce sont des conditions de travail que—c'est difficile.

**M^me^ France Gélinas:** Et désolant. Est-ce qu'on vous demandait d'être votre propre employeur? Oui, hein?

**M^me^ Edelweiss D'Andrea:** Oui, il n'y a pas de sécurité de travail. Il n'y a pas de droits.

J'ai travaillé comme fonctionnaire, et ça m'a choquée : la différence entre le respect et les conditions de travail. Je ne me serais jamais attendu à ça. J'ai une maîtrise, j'ai trois diplômes, et on vous traite comme un employé de McDonald's.

**M^me^ France Gélinas:** Est-ce que tu es ergothérapeute?

**M^me^ Edelweiss D'Andrea:** Oui.

**M^me^ France Gélinas:** Avec une spécialité en santé mentale?

**M^me^ Edelweiss D'Andrea:** Oui.

**M^me^ France Gélinas:** On a tellement besoin de tes services partout en Ontario, mais ceux qui offrent ces services-là offrent des conditions de travail désolantes.

**M^me^ Edelweiss D'Andrea:** Oui, exactement. Ce n'est pas seulement le travail d'ergothérapeute que je cherche maintenant—étant donné qu'il n'y en a pas. J'ai élargi ma recherche pour travailler comme gestionnaire de cas et, encore là, il n'y a pas d'emplois.

**M^me^ France Gélinas:** OK. Merci.

Ms. LePage, I would like to thank you for everything that you do for your mother and for having the courage to share that information with us.

What you are saying is really true: To have quality care, you need to have continuity of care; to have continuity of care, you need to have continuity of caregiver. None of that is possible if we don't treat our home care workers with dignity and respect.

I was talking to Ms. D'Andrea—if we were to offer permanent, full-time, well-paid jobs with benefits, with a pension plan, with a workload that a human being can handle, we could recruit and retain home care workers and pay them for the time it takes to go from one patient to the next. Would you agree?

**1840**

**Lieutenant Colonel Rita LePage:** I would agree. I do know that they are concerned. Of course, the people who come to our home, who we've become familiar with, talk to us about their challenges. Overall, they're generally happy, but their situation can be improved, definitely.

**M^me^ France Gélinas:** You were giving us an example that when a new worker comes just to cover a sickness or something, you say, "No, I will handle it myself." Why is that?

**Lieutenant Colonel Rita LePage:** Well, because my mother is blind, because she needs toileting, she can't tell whether she's clean or not. She tries, but somebody has to follow up. She needs support. She walks and she's not bedridden, but everything has to be supported, all movement—how she moves, how she gets into this kind of chair, what you need to do with the walker, how it has to be steered, because she needs the walker but she can't steer it. Well, she could steer it into a wall. It takes time to make sure that they know how to toilet her, how to bathe her, how to dress her, how to walk with her, how to transfer her. That takes some time before I feel that I can leave the home and she is safe from a fall. So it does take time, and by the time we've done all that—yes, it happens. I just change my plans to be flexible. It's one thing when they're on holidays and they've given you plenty of notice; it's a different thing when they're ill. And I understand when somebody is ill and it's a last-minute thing—there will always be that challenge. Unless it's somebody who has cared for her before, it is challenging. But it really is [*inaudible*] dependent.

**The Chair (Mr. Brian Riddell):** Thank you for your comments. That ends round one.

We'll now go to round two. The independent members have four minutes and 30 seconds, starting with MPP Shamji.

**Mr. Adil Shamji:** Rita, if we go back in time about 15 minutes, you were walking us through your analysis of possible second- and third-order consequences from Bill 135. You talked about a lack of diversity and experience in services and that kind of thing, but unfortunately, we got interrupted. I just wanted to ask if there was anything else that you wanted to add to your answer.

**Lieutenant Colonel Rita LePage:** As I scroll back, not really. I think that the second- and third-order effects only become evident when we—excuse the military term—war-game it, when we test it, but we never test it in real life. In the military, we say, "A plan never survives first contact with the enemy," and so the time to sort out second- and third-order effects is before implementation, when you have to test it and model it and say, "What will work and what won't work? What's becoming evident?"

I don't know what those second- and third-order effects are, but I am concerned. I know we have a hard time understanding who's accountable for what and who to call if there's a problem—and that's when we've got two levels; with four levels, I think I'm going to need a flow chart to know who's accountable and for what. That's one of the things that we often talk about as caregivers—that we don't know who to call to escalate challenges that we may have, so that's an order effect that comes into play that affects families and caregivers and patients as well.

**Mr. Adil Shamji:** For both of you: If you can imagine you're in the room with us as we go through the process of writing amendments and trying to make the bill as strong as we can, if that's possible at all, is there anything that you would like to see in it that would make you more comfortable entrusting it with the care of your family members?

**Lieutenant Colonel Rita LePage:** As I said in my soliloquy, I want people to show me, not tell me. A lot of the bill is, "Take this out, replace this. Amend the 2019 act with this." It doesn't really give me a good picture. I drew my own line diagram to try to understand what changed, but I will say that case studies and examples of what would change for us as caregivers to family members or for patients who are able to navigate the system themselves is—I want to see it. I want to understand through, perhaps, case examples of how this will actually work.

Our concerns may or may not be founded. We don't know until we see what this means, and take this out and change this word to this and this accountability here and there. As the bill is written, as any bill would be written changing a previous one, it's really difficult to picture that and what that actually is going to mean for us. It doesn't lessen the concern, though.

**Ms. Edelweiss D'Andrea:** This is not a popular thing; it's not what you want to hear, but the reality with the private sector is that their top priority is profit.

**The Chair (Mr. Brian Riddell):** One minute remaining.

**Ms. Edelweiss D'Andrea:** That comes at the expense of care. There is no doubt that private corporations—and we know very well from the US—siphon funds from health care into profits. That's just the reality of private versus public. For that reason, I'm very concerned. Ontario

already spends the lowest per capita for hospitals and is among the lowest per capita for all other health care.

**The Chair (Mr. Brian Riddell):** We'll now move to the government side for seven and a half minutes. I recognize MPP Barnes.

**Ms. Patrice Barnes:** In my area of Durham, Central East is supporting the Durham Ontario Health Team leading project, which is an integrated system of care for the residents of a downtown Oshawa neighbourhood. The health status of the residents who fall within that catchment area is significantly below that of the Durham area, based on the higher utilization of emergency, community and social services, along with higher rates of chronic conditions when compared to the regional average.

Additionally, in our downtown area neighbourhood is a mid-rise, 10-storey apartment building with 150 residents who are 60 years or older, with rent geared to income and socio-economic challenges. Through the downtown Oshawa neighbourhood integrated model of care, patients can access care through various providers on-site, including care coordinators, community paramedicine partners, Lakeridge Health, mental health services, and Community Care Durham-contracted service provider organizations. Care may also be accessed through self-referrals and primary care referrals. The patient pathway is premised on the principle of "no wrong door" to care and service.

I'm just putting that out there as a case study, when we talked about an example of care that we brought forward as to how this would look on the ground—

*Interruption.*

**Ms. Patrice Barnes:** Bless you.

With the talk around moving forward with transitional home care to Ontario health teams, we've heard on the ground, we've heard from community members that they want to be able to have something that is integrated, something that's easily accessed, something that speaks to the care that they need at the time that they need it. The government has listened, and we're moving forward with that with different incremental pieces of legislation, Bill 135 being the next step.

My question is, having heard a method-of-care pilot that's already running, that's already in place, what are your thoughts around what that would look like or the changes that you'd want to make to that level of health team that is on the ground? That's for both of you.

For the health team model that we have, that sample piece in Durham—is that something that you were envisioning the care to look like as it stands with the rollout of this legislation? Would there be a concern around a model of care that looks like that—recognizing that in communities, we also hear from community members that they're sometimes not able to access the LHIN or they have a little bit of trouble navigating the LHIN.

**1850**

You've talked about that, Rita, a bit, in regard to having to advocate. It's great when you have a caregiver who can advocate for you, but I know there are also seniors who have had a really hard time navigating the system as it stands. I just wanted to get your feedback on that sample case study model of care that exists now, as it aligns with some of the concerns that you might have for Bill 135.

**Lieutenant Colonel Rita LePage:** I am not familiar with the Durham model or test model at all.

**Ms. Edelweiss D'Andrea:** The one comment that I have to make is that vulnerable populations, including low-income people, will be especially vulnerable and hard-hit by this transition. Currently, the only public sector involvement is the coordination and oversight of what is almost exclusively private companies that are delivering the care and hiring the workers delivering the care. Already there is minimal accountability. When a health care worker doesn't show up for an appointment, patients or patients' caregivers have reported that they have incredible difficulty finding out what happened and preventing it from happening. They don't even keep track of the missed appointments.

My mother is in Montreal. She's 86 years old. She gets visited every day by a health care professional for medication and also once a week for bathing. If she is not there when they come, they are required to come back. If she is still not there, they are required by law to either get in touch with us and have us go over there or to actually have the emergency services come in and investigate. In Ontario, that is not the case.

The only piece of oversight that exists now is the public system, through what used to be the LHIN, I think. Now this bill, Bill 135, is dismantling that, so there will be no public oversight. It will be the private sector, whose primary motivation is for profit, that will be monitoring the—

*Interjection.*

**The Chair (Mr. Brian Riddell):** Excuse me. A point of order. Go ahead.

**Mrs. Robin Martin:** It's not a point of order. I have a question.

**The Chair (Mr. Brian Riddell):** Okay.

**Mrs. Robin Martin:** Excuse me, Edelweiss. I just wanted to use our time.

I would mention that there is nothing in this bill that changes anything about the not-for-profit or for-profit providers. Nothing changes with that. In fact, the only people talking about privatization are not any members of the government—because there is nothing in here that has anything to do with that.

**The Chair (Mr. Brian Riddell):** One minute remaining.

**Mrs. Robin Martin:** What I have heard is Jane Philpott, the former deputy minister, saying that sometimes these words are weaponized.

Our government has no intention of making anything harder for patients. We want to make sure that we serve patients better. That's why we're here today.

The example my colleague gave about Durham was one example of a home and community care service in a system that has been piloted and is working very well in Durham. I went to one the other day with my colleague MPP Pierre, in Burlington—also working very well.

Rita, what you're talking about is home care in your home. I know Southlake@home piloted—because you were

asking for examples of how this works, and we're trying to offer you some. Southlake@home piloted where the home care provider comes to your bedside. They're with your doctor and nurse in the hospital and have your discharge papers, so you know who will be providing care to you at home and when they will show up, and you will have met them with the other care team members, so that the poor home care worker is not just off on their own without adequate instruction or linkages to the rest of the team. That's the kind of model that would be more suitable to what you and your mom have, to make sure that—

**The Chair (Mr. Brian Riddell):** I'm going to have to cut you off there. Sorry.

We will now go to the official opposition for seven and a half minutes. I recognize MPP Gates.

**Mr. Wayne Gates:** Welcome. I will address something that my colleague said, on the other side of the room: that they don't raise the privatization, there is nothing in the bill. That's because, under Mike Harris, they privatized home care. It has gone on for years and years and years. That has been the problem.

You're exactly right, Edelweiss, that if you're a private company, your whole goal is to do two things: to make money, and to make sure the shareholders are happy. That's the reality. The government is saying they're not talking about it in the bill. They may be embarrassed by the fact that, over the course of the last 20 years, we've had private into our home care; we saw it go into our long-term care—again, under Mike Harris.

We all saw what happened during COVID, when we lost 6,000 of our moms—I know, Rita, you could appreciate this. We lost our moms, our dads and our grandparents.

So when the government says there is nothing in here about private—well, it's because they already have private in here. What we're saying to them is that it would be a lot better to take the private out of home care, to take the private out of long-term care, and reinvest those private dollars back into care. Then, it's all about care—it's all about care for Rita's mom; it's all about care for you, trying to get a job that you feel you can do and help the system. So when they talk about that, that's why they say that. I just thought I would address that, because they raised it; not because I was going to.

You talked about Montreal. I'll give you an example. In Montreal, when we were going through COVID—and as we know, people were dying every single day, particularly for a period between March and around May, going back three years ago. It was Montreal and the Quebec government that said, "No, we're going to hire 10,000 PSWs so that we can take care of our seniors"—because, at the end of the day, we have everything that we have because of our moms and dads. Rita, you probably know that. That's why you've given up a number of the years of your life to take care of your mom—because when you were small, that's who took care of you.

I will say, Rita, I remember your name really well because my wife's name is Rita. You retired to take care of your mom. My wife retired to take care, at that time, of her dad. She was a principal and took care of her dad. Unfortunately, her dad passed, and just after that, Grandma got sick, and she took care of her mom. Then, her mom died. When we talk about it, she always says it was the best decision she made in her life. She had no regrets about taking care of her parents. That's probably very similar to how you feel, Rita.

What you're saying is, "I just want to make sure that, whatever bill comes forward from the government, it's going to help my mom; it's going to help me, obviously, have a few minutes to myself." So I'm going to ask you a question on that.

When you say that your mom is getting three hours—which sounds very low, by the way. I don't know if you've talked to your local MPP or not—I'm from the Falls, but it might not be a bad idea if you do talk to your MPP; maybe they can get you a few more hours for your mom, because there is a process that you can do that. Do you ever come across where a PSW doesn't come, doesn't show up to appointments, or you're having different PSWs come who make it harder for retraining or knowing exactly what your mom needs in that quick span? Three hours, like I said, goes by very quickly, especially if you're doing what you're saying: bathing, toileting and all that kind of stuff. That takes awhile. So let me know if that's a concern at all.

**Lieutenant Colonel Rita LePage:** Well, of course it is. I have very regular PSWs. There are two different companies involved in my mother's care: one, ParaMed, from Monday to Friday, and Right at Home on Saturday and Sunday. None of them are ever sick, nobody misses, but holiday replacements are sometimes challenging. I know that's not everybody's experience. I know people have had various experiences; mine is good because we've traded off here and there, and I have come up with the three people who would suit my mother's personality, who sing at the top of their lungs, who sing while my mom plays the harmonica. It takes awhile before you find the right fit and the right person to make everything okay. I've had the luxury of that and the pleasure of that and—you're right—the absolute honour of taking care of my mother. And I am grateful for the care. I note that others have been far more challenged. I've got friends, I've got family members who are living in different areas and who are more challenged in getting that kind of care. So I am, I know, one of the lucky ones.

I do know that replacements are difficult and challenging, and it's not worth my time. I need to know she's safe. But I've never had nobody show up—I'll get a phone call from the company saying that they can't find anybody for that day, and I'll say, "That's fine. I'm good," because I've got the flexibility to do that. I'm also cognizant that every family doesn't have that flexibility. Because I'm retired, because I have a decent pension, I have the flexibility to do that. I am not the most common kind of person out there, who's willing to do this and not work, where I still could be working, so I'm blessed and I'm honoured, and others don't have the luxury to do that.

**Mr. Wayne Gates:** Before I turn to my colleague, I will say that I'm from the Falls—you're from St. Catharines—

and I also represent Niagara-on-the-Lake. Well, in Niagara-on-the-Lake, 43% of all the citizens there are seniors; the average for the province of Ontario is 28%, and they're saying that—I think it's the next 10 years—the average will be 43%. So we need to be better—

**The Chair (Mr. Brian Riddell):** One minute remaining.

**Mr. Wayne Gates:** Okay, I'll just turn it over here. But we need to take better care of our seniors.

**Lieutenant Colonel Rita LePage:** We do.

**The Chair (Mr. Brian Riddell):** I recognize MPP Gélinas.

**Mme France Gélinas:** I fully agree.

Do you see anything in this bill that would improve the responsiveness to the community for home care? I'll start with you, Rita.

**Lieutenant Colonel Rita LePage:** If there was a true and seamless integration of primary caregivers, as well as hospitals, as well as the OHTs, in terms of what the needs are, and that it's discussed—that it's not just left to one person to assess what the needs may be. Obviously, primary caregivers in hospitals who are discharging patients have a better sense of what those needs are, I believe, than somebody who comes and just interviews you in the home. If there's an integration and an absolute seamless process to access all those things—and I know that the bill talked about sharing that information between those different health care providers—then I see some benefit. But again, they're words on a paper right now, and I'd like to see how it works to get that kind of integration—

**The Chair (Mr. Brian Riddell):** Thank you for your comments.

If you would like to submit any written materials to the committee in addition to your presentation today, the deadline for written submissions is Wednesday, November 15, 2023, at 7 p.m.

This concludes our business for today. Thank you again to all the presenters.

As a reminder to the committee members, the deadline for filing amendments to the bill is 5 p.m. Eastern Standard Time on Thursday, November 16, 2023.

The committee will now stand adjourned until 9 a.m. on Wednesday, November 15, 2023, when we'll resume public hearings on Bill 135.

*The committee adjourned at 1903.*

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