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Pre-budget consultations

1st Session
43rd Parliament

Wednesday 17 January 2024

Chair: Ernie Hardeman
Clerk: Vanessa Kattar

Journal des débats (Hansard)

F-46

Comité permanent des finances et des affaires économiques

Consultations prébudgétaires

1re session
43e législature

Mercredi 17 janvier 2024

Président : Ernie Hardeman
Greffière : Vanessa Kattar

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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON FINANCE AND ECONOMIC AFFAIRS

COMITÉ PERMANENT DES FINANCES ET DES AFFAIRES ÉCONOMIQUES

Wednesday 17 January 2024

Mercredi 17 janvier 2024

The committee met at 1000 in the DoubleTree by Hilton, London.

PRE-BUDGET CONSULTATIONS

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

The Clerk of the Committee has distributed committee documents, including written submissions, via SharePoint.

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

Are there any questions? No questions from the committee.

CANADIAN BANKERS ASSOCIATION
MIDDLESEX-LONDON HEALTH UNIT
ONTARIO DENTAL ASSOCIATION

The Chair (Mr. Ernie Hardeman): We will then call on the first presenters: the Canadian Bankers Association, the Middlesex-London Health Unit and the Ontario Dental Association. As I mentioned—as they're coming forward—you will have seven minutes to make the presentation. At the six-minute mark, I will say, "One minute." Everyone has a tendency to stop at the "One minute." Don't stop, because you have only one minute to finish your statement, and if you can't finish it there, I will cut it off anyway. So make sure you carry on.

As you start your presentation, we do ask that everybody give their name, to make sure we get the comments attributed to the right person in Hansard. If someone else speaks during the questions and comments, we also ask them to identify themselves prior to making a statement of any kind.

If there are no other questions, we will start the presentations first with the Canadian Bankers Association. I remind the committee: We have a representative at the table, but I believe the presentation was going to be virtual, so watch for the screen too.

With that, the time is yours.

Mr. Alex Ciappara: Thank you, Mr. Chair. My name is Alex Ciappara, and I am vice-president and head economist at the CBA. Joining me today is Nick Colosimo, the CBA's director of Ontario and Atlantic government relations. He is with you in the room. We thank you for having us as part of the committee's pre-budget consultations.

The CBA works on behalf of more than 60 domestic and foreign banks operating in Canada. We advocate for effective public policies that contribute to a sound, successful banking system that benefits all Canadians, including Ontarians. Our submission, of which all of you should have a copy, offers the banking sector's views and recommendations in the areas that are of interest to the Ministry of Finance.

Canada's banking sector has a long history of supporting Ontario's economy. The sector has paid $5 billion in provincial and municipal taxes in the province last year; disbursed $26 billion in dividends; and operated 2,400 branches and 7,600 bank-owned ABMs, with over 6,300 financial planners and advisers in Ontario; employed more than 194,000 Ontarians; provided $817 billion in residential mortgages in Ontario; and authorized $883 billion in business credit, with $116 billion of that credit devoted to small and medium-sized enterprises in the province.

We applaud the Ministry of Finance for initiating a review of the province's tax system to prioritize competitiveness, productivity and long-term growth in the province. We believe that an efficient tax system is one that incorporates relatively low and flat rates with a broad base, and does not discriminate by asset type or firm characteristics. Commercially, an inefficient tax system that applies taxes on specific sectors distorts capital decisions and hampers productivity.

Recently, the federal government targeted banks with sector-specific taxes, namely the financial institutions tax and the Canada Recovery Dividend. Such taxes on the banking industry will reduce the amount of capital available, restrict investments in innovation and deter foreign investment, hindering the banks' ability to attract essential capital to support economic growth. Given the banks' footprint in this province, this should be a concern to Ontarians.

As such, we urge the Ministry of Finance to advocate to the federal government to undertake a coinciding review of the national tax system, to ensure it aligns with the needs and goals of Ontarians, increases productivity and attracts international capital investment. One step is to advocate to the federal government for the removal of sector-specific taxes such as the FI tax and the CRD.

We also applaud the Ministry of Finance for committing to the Housing Affordability Task Force recommended target of building at least 1.5 million homes by 2031, as owning a home in Ontario has never been more expensive. According to RBC Economics, Ontarians need to devote a record 79.96% and 46.5% of their incomes to cover home ownership costs in Toronto and Ottawa, respectively. Ontario's housing affordability crisis has important social and equity implications that could reverberate across generations. As such, the CBA believes that in order to improve affordability over the long run, expansion of the supply of housing, including rental units and affordable housing, is required.

We are encouraged by Ontario's HST relief to incentivize more new purpose-built rental housing. To further expand supply, we encourage the government to consider expediting project approvals and implementing measures to increase housing density. The CBA is also encouraged by the government's initial $3 billion worth of funding for the Ontario Infrastructure Bank, to attract trusted Canadian institutional investors to help fund critical infrastructure projects. To further expand supply of market housing, we encourage the government, again, to consider expediting project approvals and implementing measures to increase housing density.

Furthermore, we urge the provincial government to continue accelerating the construction of social housing to meet the growing needs of Canada's most vulnerable, given the shortage of affordable housing stock. According to Scotiabank Economics, Canada's stock of social housing represents 3.5% of its total housing stock, amongst the lowest in the OECD. A recent study by the mental health commission of Ontario estimated that for every $10 invested in supportive housing, it resulted in an average savings of almost $22 across health care, social services and the justice system, in addition to social returns. Also, given the multi-jurisdictional nature of the problem, we are supportive of a multi-stakeholder housing round table, involving all three levels of government as well as other interested stakeholders.

The banking sector has long recognized that financial literacy is an essential life skill and has a role to play in supporting and strengthening financial literacy through their many programs to help Canadians. The CBA applauds the leadership demonstrated by the government of Ontario to enhance financial literacy outcomes for students through the implementation of mandatory learning about financial literacy into the curriculum. We encourage the province to further its financial literacy commitment through the introduction of a stand-alone course on financial literacy to complement the current grade 10 career studies course. Additionally, we encourage the province to broaden its financial literacy initiatives to encompass targeted programming for priority groups, including lower-income Canadians, Indigenous Canadians—

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

Mr. Alex Ciappara: And lastly, the federal Proceeds of Crime (Money Laundering) and Terrorist Financing Act imposes extensive legislative obligations for banks to detect laundering of money and financing of terrorist activities. The CBA urges the Ministry of Finance to invest in and harmonize its existing tools with the efforts of the federal government. Specifically, it should ensure provincial beneficial ownership aligns with the required federal act, and to invest in law enforcement to support its investigation and prosecution of money laundering and terrorist financing cases, and lastly, to coordinate that work with the federal government's future Canadian financial crimes agency.

Thank you again for the opportunity to contribute to the committee's 2024 pre-budget consultations. Canada's banks are there to support Ontarians every step of the way. We look forward to your questions.

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

Our next presenter will be the Middlesex-London Health Unit.

Ms. Emily Williams: Thank you for the opportunity to speak with you today. My name is Emily Williams. I'm a registered nurse and the CEO of the Middlesex-London Health Unit. I'm joined virtually by my colleague Dr. Alex Summers, the medical officer of health.

London and Middlesex county are growing. In 2011, there were roughly 437,000 people living here, and the health unit received a per capita funding rate of about $58 per resident of our community. By 2021, the population in our region had grown to over half a million people, and we were fortunate to welcome a number of newcomers and growing families within that number. Unfortunately, funding has not kept pace with either that growth or inflationary pressures, lowering the health unit's per capita funding rate in 2021 to just over $55 per resident, representing a structural deficit of roughly $6.4 million for the agency. The population here has continued to grow over the last three years, including more newcomers and more births, further worsening that funding outlook. Inflation continues to rise and the current provincial funding of a 1% increase for public health units is therefore insufficient. For example, the majority of our costs are related to staffing, and our union contracts have been negotiated with a 2% increase to wages for the next two years. Operating expenses are projected to increase by almost 4%.

1010

We have truly appreciated the COVID extraordinary funding that the province has made available to us throughout the pandemic, as it enabled us to provide a robust response in service to our community. While the magnitude of that response is considerably different now, we do require more staff for both our infectious disease control and vaccine preventable disease teams to continue to

support respiratory disease outbreak management and the provision of associated vaccine programs.

The increase in newcomers and new babies to the Middlesex and London community also requires additional resources for those teams, with more infectious disease cases like tuberculosis requiring follow-up and more home visits need by our Healthy Babies Healthy Children team. For reference, the Healthy Babies Healthy Children Program is a proven intervention to support at-risk families with home visiting from a registered nurse. It is funded by the Ministry of Children, Community and Social Services, and the funding for that program has been stagnant since 2012.

To address inflationary pressures and ensure we have the additional positions required for the infectious disease and vaccine preventable disease teams, the Middlesex-London Health Unit undertook a strategic prioritization exercise, including a comprehensive review of all of our work, which resulted in a major restructuring in 2023. This resulted in the reduction of 13 registered nurse positions, two registered dietitians, 1.5 health promoter roles and one director. We also reduced three manager positions, replacing them with front-line supervisory roles. The impact of these changes includes significant reductions in comprehensive school health nursing, particularly in elementary schools, a reduced presence with our community partners and less public awareness campaigns, which are all key interventions used to address public health issues in our community.

In August 2023, the Ministry of Health launched a strengthening public health initiative, which includes a review of Ontario public health standards, encouraging voluntary mergers between health units to improve capacity in the sector and a review of the funding formula for public health. Public health units that engage in mergers will receive additional funding to assist them with that process as well as address any pressures.

The Middlesex-London Health Unit has proactively shared its prioritization work with the Office of the Chief Medical Officer of Health and are eager to continue to work with them on the review of the Ontario public health standards to further refine and define our work to maximize the impact we can make for our community. Unfortunately, the Healthy Babies Healthy Children home visiting program is not part of that review, despite the challenges of inadequate resources to complete this critical intervention.

The Middlesex-London Health Unit meets all of the criteria outlined by the Ministry of Health, suggesting we are not a candidate for a merger. At this point, we have also been unable to find an interested partner. This means that we are not eligible for additional funding in 2024 or 2025 to continue the critical work of the agency.

The funding formula review is slated to occur in 2025, with a launch in 2026. Our main concern is that further loss of public health professionals and important services for the Middlesex-London community will occur while we await the outcome of that process. As you build the next budget for our province, Dr. Summers and I are here asking for your consideration of consistent, sustained and sufficient funding for the Middlesex-London Health Unit and other local public health agencies, as we all play a critical role in the health system.

For our agency, we need funding that reflects both the inflationary pressures we are facing and the population growth in our region, including the needs of newcomers and growing families. Specifically related to those growing families, we would also like to highlight the Healthy Babies Healthy Children Program funding as an opportunity for review and investment in this next budget.

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

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

We now will go to the Ontario Dental Association. Good morning, and the floor is yours.

Dr. Christina Heidinger: Good morning, Mr. Chair and committee members. My name is Dr. Christina Heidinger. I'm a dentist in Kitchener, and I'm representing the Ontario Dental Association today. I practise in Kitchener and serve as the chair of the Ontario Dental Association's political action committee. The Ontario Dental Association is a voluntary professional organization which represents the dentists of Ontario, promotes the highest standards of dental care and advocates for sustainable and accessible care for Ontarians.

With the December announcement launching an enrolment process for the Canadian Dental Care Plan, I'm sure you've all seen dental care feature prominently in the news over the recent weeks. The Canadian Dental Care Plan is something I'll certainly touch on in my presentation, but I must urge a continued focus on the ever-pressing issue that must feature within the budget of 2024: the responsibility of the Ontario government to ensure access to the Ontario government's dental programs for high-quality, timely oral health care for all Ontarians.

As someone who both treats patients every day and engages with dentists across the province, I can tell you that the public dental programs designed to help over one million vulnerable Ontarians who need them are in serious trouble. The Ontario government's public dental programs, including Healthy Smiles Ontario, the Ontario Seniors Dental Care Program, ODSP and Ontario Works, are chronically underfunded, significantly impacting the accessibility of necessary oral health care.

In fact, Ontario spends the lowest per capita on oral health care in all of Canada to the tune of $4.99 per person, less than one third of the national average. Children from low-income families, seniors and individuals with disabilities are suffering from this inequity.

As dentists, we are committed to our patients and our communities. We are asking for your help to significantly improve care for those who rely on provincial dental programs. Dentists cannot continue to bear the financial burden of these programs. For over 15 years, there has been a steady erosion of reimbursement for the cost of care, which currently stands at only 34%.

Our members are at a breaking point. They are subsidizing these programs to the tune of at least $150 million a year. I urge you to think about the local dentists you know from your own constituencies. These small business owners are stewards in your community, and they need your help to end this unfairness and to ensure oral health care is accessible and sustainable.

After decades of hard work, including numerous presentations to this committee, there are signs of some possibility of progress towards fixing these programs through negotiations with the province. I can assure you that Ontario dentists are committed to working collaboratively with you all to make sure that Ontario is a leader in dental care.

The timing could not be more important. As I mentioned off the top, the federal government has announced plans to launch the new Canadian Dental Care Plan as early as May. While there have been few details released to date as to how the Canadian Dental Care Plan will work, it is imperative that the federal and provincial dental programs work in conjunction to improve access to dental care for those who do not have private insurance. This includes not only coordination of the federal and provincial programs, but ensuring that dental offices in Ontario have the staffing resources to handle the anticipated influx of patients looking to access care.

The province is currently experiencing a shortage of dental hygienists and dental assistants. This is causing delay in treatments, cancelled appointments and reduced hours of service. Budget 2024 can also help to alleviate this shortage by reducing unnecessary barriers to care. For example, policy changes can be made to streamline the process for out-of-province dental hygienists and dental assistants to practise in Ontario. There are also opportunities to reduce red tape and eliminate regulatory barriers that make it needlessly difficult for dental assistants to become certified. These recommendations are further detailed in the written submission that you will be seeing from the ODA.

No one should be left to manage dental pain untreated. Now is the time for meaningful action to fix the Ontario government's dental programs, achieve coordination with the new Canadian Dental Care Plan and reduce red tape to address challenges with oral health human resources.

The Ontario Dental Association is your partner in achieving an accessible and sustainable oral health system for all Ontarians, and we have the solutions to help accomplish this important goal. I look forward to working together on meaningful progress in budget 2024 and beyond.

Thank you very much for the opportunity to join you today. I welcome any questions you have. I do have some support staff from the Ontario Dental Association with us as well, so if I can't answer questions immediately, maybe they can help. Thank you very much.

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

We will now start the first round of comments and questions, and we will start with the official opposition. MPP Kernaghan.

Mr. Terence Kernaghan: Thank you to all our presenters here today as well as those appearing virtually. My first questions will be for the Middlesex-London Health Unit, Emily and Alex. I want to thank you for coming to committee today. I know the important work that you do for our community, and I can't thank you enough. I know that we've spoken in the past about what these looming cuts would look like and I'm sorry to see that it has come to pass.

I know you've done a lot of work on the restructuring. It has been called a strategic prioritization, but I think it's important for the committee to recognize that it's almost like saving the furniture—25.5 FTEs can't be good for morale within the organization. We're already in a health care worker retention crisis, so how have these cuts and this restructuring impacted folks in the organization?

Ms. Emily Williams: Thank you, and through you, Mr. Chair, to MPP Kernaghan, it has been tremendously difficult. We did attempt to reduce the number of actual people being laid off by offering a retirement incentive. We have also utilized some specialization through human resources and change management to work with our new teams as they transition. But it has been tremendously difficult as we have seen, even with those retirement incentives, an incredible amount of intellectual property and public health expertise leaving the agency. So, thank you for the question. It has been very difficult.

Mr. Terence Kernaghan: Understood. In your submission, you mentioned one of the programs being significantly reduced is school health nursing, so this next question will be for Dr. Summers. This is the budget committee of the province of Ontario. Can you share with this committee what some of the potential downstream consequences are of reducing students' access to school health nurses?

1020

Dr. Alexander Summers: Thank you, member Kernaghan, and through you, Mr. Chair: Prior to the cuts that were made this fall, we had registered nurses in many elementary schools across Middlesex and London working with principals, administrators and teachers to provide healthy school environments. That means facilitating classes and courses around healthy relationships, which prevents substance use, which prevents intimate partner violence and which ensures quality learning as people enter secondary schools.

Regrettably, we're no longer able to be present in elementary schools in our region. So our only presence is when we're there for dental screening, recognizing our partners from the ODA today, as well as our immunization work. But other than that, we no longer have registered nurses that are doing the preventative work that lays the groundwork for healthy child development into the secondary school stage. I do think this is a significant loss, regrettably, as we start the 2024 year.

Mr. Terence Kernaghan: Thank you, Dr. Summers. I hope this committee will take pause and recognize that because of funding cuts, they're ignoring all elementary school children and their foundational health for the future. So I hope that that will be acted upon.

To Emily, you specifically mentioned the Healthy Babies Healthy Children home visits program and how the funding has been stagnant since 2012. Can you speak to the importance of this program?

Ms. Emily Williams: Certainly, and I will, through you, Mr. Chair, to MPP Kernaghan, invite Dr. Summers to provide additional comment.

But specific to the finances, we have supplemented that with the use of our cost-shared funding, so the Ministry of Health funding. We have supplemented the staffing by providing additional positions out of that funding source. But about 60% of the babies born to families in Middlesex-London qualify or are deemed as being at risk and requiring public health nurse visiting in their home.

With the increase in births in Middlesex-London, that's meant an additional 212 families that we are required to see. Unfortunately, as we know, at this time, our staffing does not allow us to see all of those families or all of the babies that are born in Middlesex-London. We are able to screen about 70% of them, so if we were able to screen a 100%, those numbers would go up.

Over time, the Middlesex-London Health Unit has changed its risk criteria to ensure that we are seeing those at highest risk, but not necessarily everyone that would qualify.

I would invite Dr. Summers to add comment.

Dr. Alexander Summers: Thank you, Emily. Again, through the Chair, thank you, member Kernaghan. The loss of being able to see every vulnerable child and family is that we're not able to have intensive nursing support available. We all know that those first six months, 12 months and 18 months are so critical in setting the stage for a successful life.

The first 1,000 days for a child are absolutely essential for a healthy life, and regrettably, we are missing kids. We know that there are families that would benefit from the support of a nurse in their home, be it around breastfeeding, literacy, developmental milestones, general parenting support and identification of early illnesses or deficits. These supports, regrettably, aren't in place for some higher-risk families, and historically, they were. That certainly is a loss for us in our community. This is not unique to Middlesex-London. This is a challenge that's being faced across the province in all public health agencies.

Mr. Terence Kernaghan: Thank you very much. Some of the most significant milestones in a human being's life are occurring within that nascent period. So I hope that the committee will take pause and listen to these concerns.

Next, I would like to move over to the Canadian Bankers Association, to Alex and Nick. I want to thank you for your support of enhanced consumer protection and your focus as well on financial literacy. I think that we can all agree, we're glad for the prohibition on door-to-door sales of HVAC equipment, but we know that it's still in our communities—

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

Mr. Terence Kernaghan: Many unethical folks have found workarounds and the problems persist.

The government has recently committed to studying NOSIs and liens against title. I wanted to see if the CBA had any comment on that.

Mr. Nick Colosimo: Certainly, MPP Kernaghan. Through you, Mr. Chair: First, we've appreciated the co-operation we had with you and your colleagues.

Certainly it is something that we have looked at. It's something of concern. Anything that does harm consumers, such as what you had mentioned on that sales front, is very concerning. Is it something that we have delved on in our submission to the committee, at the CBA? It is something that we have addressed minorly. Our focus is predominantly on pieces related to the financial sector as it pertains to payment service providers, for example; that is a big one—

The Chair (Mr. Ernie Hardeman): Thank you very much. Your time is up.

We will now go to the independents. MPP Hazell.

MPP Andrea Hazell: Good morning, everyone. Thank you for your detailed presentations today, and thank you for coming in.

My first question is going to go to the Middlesex-London Health Unit, to Emily and Alexander. In my travels with this pre-budget consultation, I've heard from many agencies like yours of the financial crunch. I'm going to keep saying this over and over again: Your presentation with your issues, with your financial crisis that you're experiencing, is not new. It tells me that all across the board in Ontario, there is a financial crisis in the health care sector.

Some of the issues we're hearing that you've described are staff shortages, retention issues, a funding crisis—I'm going to say it again—and burned out staff. I can imagine what this is doing to your remaining staff who have to give those same services and cut-off resources. When you don't have the resources to provide the services for our vulnerable people, how do you continue to operate?

Ms. Emily Williams: Through you, Mr. Chair, to MPP Hazell: Before I turn it over to Dr. Summers, on the impact to our population, from a financial perspective, we have undertaken efficiency reviews in the organization in terms of reducing general expenses by over half a million dollars, and we have cut staff positions. So we've reduced positions within the health unit, public health professional staff, as well as management positions, to respond to the financial pressures.

Over to you, Dr. Summers.

Dr. Alexander Summers: Thank you for the question, MPP Hazell. Through you, Mr. Chair: The impacts on our work continue to be realized. Unfortunately, the impacts of cuts today, when it comes to prevention, which is what we do in public health, are often not felt until years down the road.

Our absence in schools is certainly felt now but it's really going to be felt when we see, 20 to 30 years down the road, kids who didn't necessarily get the support they might have required.

Similarly, it's true for our HBHC Program, our Healthy Babies Healthy Children Program. We know that even in the services we're continuing to provide, we're having to make tough choices. We want to provide vaccination services to everybody, because we know that people are struggling to find a family physician, particularly those who are new to the country. But even then, we're struggling to meet the demand. We are having to limit who is eligible to receive a vaccine in our vaccination clinics, even though we've invested further in that group, just because we do not have enough money to provide the services that we wish to provide.

MPP Andrea Hazell: Thank you for that, for the record.

I want to go to Alex and Nick from the Canadian Bankers Association. I know we use the FI tax and the CRD, we use those acronyms. We are bankers; we use a lot of acronyms. Of course, we want to increase the productivity in Ontario.

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

MPP Andrea Hazell: That's jobs and our revenue. You were saying one step is the removal of sector-specific taxes. Can you elaborate on that, just for the record?

Mr. Alex Ciappara: Yes, I'm happy to. Those taxes that the industry has been targeted with take away the ability to add to the bank's capital, and that capital enables banks to lend money. For instance, under OSFI, a large bank has to have a capital ratio of 13.5%. What the really means is that for every dollar's worth of capital, a bank is able to lend an additional $7.50, so sector-specific taxes hinder a bank's ability to provide financing for—

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

We now go to MPP Bouma.

Mr. Will Bouma: I'd like to thank all of the presenters for being here today. I have questions for you all. We'll see how much time we have, but I know my colleagues want to ask some questions also.

I wanted to start with the bankers. Thank you, Alex and Nick, for your presentation today. I appreciate the supportive comments regarding the review of the tax system, and I know that the parliamentary assistant to the Ministry of Finance will be urging Minister Bethlenfalvy to take that issue up at the next federal-provincial-territorial meeting.

I'm just curious, because I've seen this in my community, that home prices are somewhat coming down. Speaking to my bank manager, as people are coming to renew, it's getting very difficult for them in many situations. I was wondering if you could give us a quick idea of what that housing market is looking like in Ontario, as far as affordability goes, with the interest rates as they are right now, as far as people coming up for renewal seeing sometimes thousands of dollars more in payments. I'll start there.

1030

Mr. Alex Ciappara: Yes, I'm happy to. No doubt about it, housing affordability is a critical issue in this province, in this country. I provided some statistics in my opening remarks around that.

To your point about higher interest rates and open customers, banks are there to help their customers. In the front end, when a borrower takes on a new mortgage, they get stress-tested at a higher interest rate to ensure that they're able to handle a higher interest rate. So there's the stress test. But as the mortgage renews and perhaps a borrower might run into problems with respect to paying that mortgage, the bank is there to help the customer through any number of tools to help them manage that payment increase. They can extend amortizations. They can skip a payment. There's a number of tools that banks have in their arsenal to help a customer out. And it really depends—they look at it on a case-by-case basis as well. So there are a number of tools that banks can use to help customers out.

I will say too that one of the driving factors when it comes to an individual's ability to pay a mortgage is the ability to have a job. We've seen labour markets being, I think, surprisingly strong despite the higher interest rates. In speaking to some of my members and seeing the results of some of my members, I think we're seeing borrowers manage the higher interest rates at renewal time partly because of the things I've outlined before: the higher stress test, the desire for banks to work with their customers. So we're not seeing a lot in the way of higher delinquencies in individuals and borrowers able to pay off their mortgages or pay down their mortgages.

Mr. Will Bouma: Good. No, I appreciate that. It doesn't sound like we're heading into a huge crisis yet, and I appreciate that update.

Something I've been curious about for a long time is: Do you have any data—because you mentioned in your comments that it should be easier and faster to build new dwelling units across the province of Ontario. Delay costs so much. I have talked to people who have made significant investments in properties, trying to get them ready for higher density.

Is there any data out there on what it costs for an average dwelling unit, whether that's an apartment or a condominium or a house, freehold or attached—if it takes four or six years to build a home and the investments of whoever is developing that. How much cost is added onto an average dwelling unit just by interest payments on the money that's been fronted to get these processes going for an average dwelling unit?

Mr. Alex Ciappara: I haven't seen data around the delays—well, I have seen data around the delays; I just don't have the data at my fingertips. But I'm sure I could pull that up for you.

To your point about delays, I saw the FRPO talk about delays, and they mentioned that it takes 100 months from the time a developer puts in place an application to actually completing that construction site. So it takes 100 months to do that. That's a tremendous amount of time to get a building built.

But in terms of the costs? Quite high—but I don't have the numbers at my fingertips.

Mr. Will Bouma: Okay, but I think we could safely say that it probably adds tens of thousands of dollars to an average dwelling unit. Thank you. I'll leave you alone for a minute.

Just quickly to the dental association: Doctor, thank you very much for joining us today. I'm a practising optometrist, with no retirement from this game. I keep my licence up, so I see patients a few hours a week to keep that going. I understand the frustrations where you're coming from. I also know the public benefit, but I don't know how to quantify that, of being able to provide proper dental care. I know that with the stagnated amounts that the province is paying for dental care, it's very difficult for dentists actually to just to be able to pick that up. I've always loved the partnership that the province has with private optometry clinics and private dental clinics in order to provide that care.

Do you have any hard numbers on the return on investment that we would see socially and economically from people not ending up in emergency rooms? To see that investment in reimbursement rates for dentists to be able to provide the public programming—right now, it's at a loss, I think, for most of those patients. What does that look like so that I can carry that message and Parliamentary Assistant Byers can carry that message of what increasing those reimbursement rates to your private clinics—

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

Mr. Will Bouma: —would mean for patients in the province of Ontario?

Dr. Christina Heidinger: There's a few returns on investment for that. We're probably going to have to submit the numbers for you because we're down on time. But one of them is the return on investment in the number of people that don't have to go to emergency care. I think you're looking at $500 a person that goes through that. I'm not sure the number of people that go through that, but—

Mr. Will Bouma: But I think you can easily say that a couple of hundred dollars spent on preventative care would translate into thousands of dollars—

Dr. Christina Heidinger: Exactly, but even if they have a dentist to go to—so it's not just only preventative care. If you have a dental home that you can go to, you don't have to go to the emergency service. And the emergency services at the hospitals just give you antibiotics and pain tablets. They don't get the treatment done, and a few months later they're back in again. So you're serving a lot of that.

You're also getting more people into the workforce if they can smile. It makes a big difference. I've seen it in my patients. You give them a smile and all of a sudden, bang, they're off their Ontario Works and—

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

We now go to the official opposition. MPP Sattler.

Ms. Peggy Sattler: Thank you to all three of our presenters this morning.

I wanted to start with some questions for the Middlesex-London Health Unit. One of the alarming sentences from the presentation that we have before us this morning is that the funding challenges that you are experiencing, and the funds that have been provided by the government so far, are "insufficient for our health unit to be able to continue certain mandated services under the Ontario public health standards."

One would expect that when the government creates Ontario public health standards, they would fund health units to be able to deliver on those standards. You've spoken about the mandatory Healthy Babies Healthy Children Program, but are there other mandated services under the Ontario public health standards that are being compromised by the government's failure to appropriately fund health units, and, in particular, the Middlesex-London Health Unit?

Ms. Emily Williams: Through the Chair: I would go to Dr. Summers.

Dr. Alexander Summers: Thank you, MPP Sattler, and through you, Mr. Chair: There are a number of programs where we are not fully meeting the Ontario public health standards. Particularly, when we look at chronic disease and injury prevention, we are limited in our ability to support municipalities and other community groups in their ability to prevent illness and disease. Examples of that are a limited ability to work with municipalities on how to design communities in a healthy way. We're limited in our ability to support our community in response to the opioid drug crisis. We are doing our very best, and yet there is more that we could be doing to actually support around assessing the needs for additional harm reduction services or other upstream interventions that could avoid problematic substance use.

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We are certainly limited in our ability to achieve our school health expectations. We are expected to support schools in creating healthy school environments. I think we could do a lot more than we're currently doing, and certainly than what we've done historically.

We are limited in our ability to do vaccine preventable disease delivery. We know that there are people who we need to be seeing to deliver vaccines, and yet we're still not able to get enough needles into arms, even for childhood vaccines. We know that the primary care system is not as of yet able to support vaccine administration like we wish.

We're also still limited in our ability to do our public health dental work, and I'm so grateful to have our partners from the Ontario Dental Association with us here today. We know that we also support dental work, and yet we're not able to see all the seniors who are eligible for our senior dental program as of yet.

That's probably just a quick snapshot of all the services where we are still struggling to do all of the work that would be expected of us.

Ms. Peggy Sattler: Thank you very much for that information. That, I think, should be a huge concern, certainly within our community, but hopefully the government has heard the implications of the funding challenges that you're facing.

The other issue that your presentation addressed was the population growth that we are seeing, particularly here in Middlesex-London—we saw London, the fastest-growing city in Ontario, and the number of newcomers coming into our region.

Your submission talks about vaccine preventable diseases with regard to the growth of newcomers in the region, but can you talk more generally about some of the implications of when you are limited in your ability to serve newcomer populations beyond vaccine delivery?

Dr. Alexander Summers: Through you, Mr. Chair: Thank you again, MPP Sattler. Newcomer families to the Middlesex-London region bring so much wisdom, skill and ability. They're young, as well, and we know that these are families that would greatly benefit from the early-childhood interventions that we, as a public health unit, provide. Those programs include programs like Smart Start for Babies, which are parenting classes that support parents as they prepare to expect a child. We would love to be able to expand those services, and we need to, with increasing newcomers who maybe don't have the connections or the resources available to other families.

We also need to expand our Nurse-Family Partnership program, which is an even more intensive nurse-led home visiting program for young families and young mothers. That, again, gives that high-intensity nursing in-home support to ensure the best start in life.

We also know that with newcomer families arriving in Canada, there are other diseases that come with them, such as tuberculosis. We've seen an increase in tuberculosis cases that require follow-up and investigation, largely amongst newcomer family groups who did not receive the type of health system support that we would wish that they would receive when they were in the countries that they're coming from. That's probably a quick snapshot of some of the other services that newcomers also benefit from.

I'd also highlight that the school health services that we were providing in elementary schools were really focused on providing supports to families that are new to Canada, making sure that that transition into the schools are as healthy as they can be. Again, we are limited in that support at the time being.

Ms. Peggy Sattler: Thank you, also, for that response.

I wanted to ask a question of the Canadian Bankers Association. One of the statistics that you cited in your presentation that I found quite startling was that Ontario's social housing stock represents only 3% of the total housing supply—

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

Ms. Peggy Sattler: —which is the lowest in the OECD countries. I wondered if you have a target as to what would be an appropriate level of housing stock for social housing to represent. And how do we get there in Ontario? Try to do that in 25 seconds.

Mr. Alex Ciappara: Thank you very much. That figure is actually for all of Canada, but given Ontario is the largest portion of that, it's probably reflective of Ontario as well. I think the average for the OECD is about 7% of total housing stock, so that's a good target to shoot for. How to get there: things like the Ontario Infrastructure Bank. One of its priorities is to invest in affordable housing and partner with institutional investors and longer-term investors to get affordable housing built.

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

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

Mr. Adil Shamji: I'd like to start my first question off directed to Middlesex-London Health Unit. Yesterday, there was a quite significant report from Ontario Health that demonstrated that emergency department performance is some of the worst in our province's history. Here in this region, the southwest, 10% of patients are waiting for longer than eight and a half hours in the emergency department; 10% of patients are waiting more than 31 hours to get admitted to hospital.

Taking all of that into consideration, I was wondering if you could speak a little bit about the role that public health can play in relieving pressure on emergency departments in our acute care sector and specifically how the funds that you're asking for could contribute to improving these metrics.

Dr. Alexander Summers: Thank you, through the Chair, for that question. The data presented through Ontario Health is startling and highlights the significant need for upstream solutions, preventative solutions, which public health units play a critical role in helping to achieve. With sufficient funding, local public health agencies are able to support the development of healthy communities, and we do that through working with municipalities and other community partners to make sure that social programmings are health-oriented, that critical public infrastructure is health-oriented, and in doing so delay the onset of chronic diseases, which subsequently reduces the burden on presentation to emergency department.

We also can reduce the burden on primary care, which we know is one of the reasons why people are going to emergency departments—because they cannot access their primary care. That backlog is significant.

We know that through investments in early-childhood interventions, like the type of support provided by intensive nurse-led home visiting programs, we can nip problems in the bud. We can address parenting concerns. We can address feeding concerns. We can help with health literacy that helps people mitigate problematic health concerns early, so that they don't end up in emergency departments.

We can also support expanded vaccination efforts, which we know reduces respiratory illnesses, which reduces burden on presentations to emergency departments. This fall, regrettably, only 16% of those over the age of 12 in Middlesex-London region received a COVID vaccine this fall—only 16%. That means, regrettably, that many people were more vulnerable for COVID than they needed to be. Public health agencies can serve a significant role in increasing vaccination uptake that would subsequently reduce the burden on emergency departments.

Mr. Adil Shamji: Thank you, Dr. Summers. If I may be so presumptuous as to reflect on my own experience as an emergency doctor and to add to your answer, one of the challenges that I and my colleagues have certainly noticed is the opioid epidemic, and I think that public health units play a spectacular role through harm reduction and other efforts to reduce the burden of the opioid crisis, and we thank you for being able to contribute to that.

My next question is for the Ontario Dental Association. Again, reflecting on my own experience in the emergency department: What role do you think that you can play?

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

Mr. Adil Shamji: And just very quickly, responding to my friend MPP Bouma, who asked about the potential financial impact: There was a study in 2019 that said unnecessary dental visits to the ER cost OHIP $40 million.

Go ahead.

Dr. Christina Heidinger: If I can refer to David Gentili or Sara Cleland from the ODA, they may have looked up those numbers for us, or have them on their fingertips. They can tell you about the emergency benefits.

Mr. Adil Shamji: Perfect.

Mr. David Gentili: David Gentili, ODA. There are more than 66,000 unnecessary visits to emergency rooms for dental issues. This is reported through Public Health Ontario. These are for non-traumatic issues, issues that could have been treated at a local dental office. We estimate that this costs the province approximately $34 million, but that does not include the piece of visits to physicians' offices for the same—

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

We will now go to the government side. MPP Harris.

Mr. Mike Harris: Thank you to our presenters here today. I as well made the drive down from Kitchener, so it's good to see you.

I wanted to start the questions by talking a little bit about the seniors' dental care program. We have a great organization—healthcaring KW they're called now—that administers the program in downtown Kitchener. Last year, they received a funding increase—I think it was about $318,000—to put the total programming at around almost $2.3 million for the year. Is it enough? I think we all know the answer is no. Should it be more? Absolutely.

When we look at what that program can do—and we've talked a little bit about diversion from hospital, but let's talk a little bit more of what it means to your overall well-being and how that can actually translate and help you in your daily life. I don't know if maybe you could talk a little bit about that overall dental care piece for seniors and how critical it is, not just to keep them from the ER or wherever else it may be, but to help them be more integrated in the community. We're talking about less pain, less chronic illness and less keeping them from being able to integrate a little bit better.

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Dr. Christina Heidinger: For sure. Even though the Canadian Dental Care Plan has been in the news lately, there has also been a lot in the news about relationships of oral health care and your general health. There's a really strong relationship to diabetes. There's a strong relationship to arthritis. There's a strong relationship to brain problems with dementia.

In fact, I think in the States, they've got a program going, Healthy Mouth, Healthy Brain, because there's a lot of research coming out. Especially with pneumonias and things, people who aren't getting in for their regular cleanings and scalings and getting their mouth looked after—you have a lot of bacteria right here. This is a nice reservoir where a lot of things can be very infective. So when you have healthy people with healthy mouths, it also helps affect the rest of their bodies.

Again, if everything is being healthy, they're going to be getting out into the system and into community and being able to talk better. Dental pain is one of the very big things that people leave work for or leave schools for. I'm not sure that there are any statistics about seniors, if they don't participate with dental pain, but it is a problem. The seniors programs themselves—it would be very good to utilize a community dentist with that. The way the program is set up right now, it doesn't really use a community dentist very much at all. It's focused on that. So actually going back to their house, their home dentist, would be ideal.

Mr. Mike Harris: Let's talk a little bit about that for a second. I want to leave some time for my colleague, Minister Flack. When you say home dentist or not using a community dentist—I know that the program that is currently being used in Kitchener specifically is administered by healthcaring KW which used to be the inner-city health centre, I think it was called. Tara and her team there do a fantastic job, and they're doing that out of clinics within their building, if you will. Would you say that it's better to be administered through that, where you have a much more holistic approach to health care where they also have family docs on site, they have other folks in the mental health space and addiction space as well, or do you think that should be moved out into the physical community?

Dr. Christina Heidinger: There's not a problem with keeping that holistic point of view. It's the numbers. How many are you actually going to be servicing? You've got a high volume—I don't know what the statistics are of population of seniors in our area. Most of them start—you've got 75% people visiting dentists in general, so you've got 75% of your seniors who have a home dentist who they're used to. Then you go to these systems and you have wait times. We've got the statistics on the wait times.

Mr. Mike Harris: So being able to utilize your dentist you've been—

Dr. Christina Heidinger: Exactly. I mean, if that dentist feels that they're not being able to do that, for example, if it's not wheelchair accessible, you can be referred to that clinic or a dentist that is. But I think for ease and to try to maximize the number of people you're servicing that that is going to get you, is keeping the community service, the bricks and mortar that's already in place, and add more.

Mr. Mike Harris: How much time left, Chair?

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

Mr. Mike Harris: Just quickly, to Middlesex-London Health Unit, Healthy Babies Healthy Children—amazing program. My wife used to administer some of that through Community Living up in North Bay.

I know Minister Flack wants to talk a little bit, so I'm going to pass it over to him.

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

Hon. Rob Flack: Thank you to all the presenters. Great to be here on this lovely, warm morning.

Specifically to the Middlesex-London Health Unit, having met with Dr. Summers and Emily in the past, I appreciate your time and I'm always here to listen and learn. A few questions as a follow-up: Just for everyone's understanding, what are your staffing levels today versus what they were pre-COVID?

Ms. Emily Williams: Through you, Mr. Chair, to Minister Flack: We started with a baseline of 336 staff. We expanded, at the peak of the pandemic, to 933 staff. We are now back down to what is likely to be our new baseline of just shy of 300 staff.

Hon. Rob Flack: Secondly, can you describe your permanent operating costs that have been added because of COVID? What are the added costs that you have today, your fixed costs today, that are permanent because of COVID?

Ms. Emily Williams: Through you, Mr. Chair, to Minister Flack, it's $1.1 million.

Hon. Rob Flack: Okay. Finally, what is the reason adjacent health units have given to not want to merge? And if they did, do you see consolidation benefits, service improvement benefits if you did so, and with which one?

Ms. Emily Williams: Through you, Mr. Chair, I'll start this one and then go to Dr. Summers. But initially, some of the hesitation has been with—

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

Ms. Emily Williams: —the dissimilarities between ourselves as a large urban-smaller rural mix in terms of the population we serve. Most of our neighbours have a very large rural component to their work, seeing themselves as quite different to the way we operate.

Dr. Summers?

Dr. Alexander Summers: Thank you, Emily. Through you, Mr. Chair, quickly: At this time, many reports over the last 20 years have identified that an ideal public health unit size is somewhere around half a million people in terms of an appropriate jurisdiction. That's what we are. It allows for us to build good relationships locally without being stretched too broad. In so many ways, we actually see ourselves as the ideal size to deliver public health services.

Hon. Rob Flack: Thank you.

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

It also concludes the time for the panel. With that, I want to thank each presenter and the supporting cast on the screen for preparing and being here to share your views with us this morning.

ANOVA

LONDON ST. THOMAS ASSOCIATION OF REALTORS

CHILDREN'S AID SOCIETY OF LONDON AND MIDDLESEX

The Chair (Mr. Ernie Hardeman): Our next panel is Anova: A Future Without Violence, London St. Thomas Association of Realtors and the Children's Aid Society of London and Middlesex.

Again, as we're approaching the table, we will remind them that each presenter will have seven minutes to make their presentation. I will notify you when there is one minute left. We ask you, as you start your presentation, to make sure that you give your name for Hansard to make sure we can attribute the comments to the right person.

With that, the first presenter is Anova: A Future Without Violence. The floor is yours.

Ms. Jessie Rodger: Thank you for creating this space. My name is Jessie Rodger. I'm the executive director of Anova.

Over the last four years, Anova has experienced an increased need in our community for our mandated services to support survivors and victims of intimate partner, gender-based and sexual violence. The last provincial increase to our base funding for our shelter programs was in 2021. The 14% increase in funds was meant to address needs in our anti-human trafficking work. Our sexual assault programs received their last provincial increase in 2023 of approximately 15%. We were able to add another full-time position to our Family Court Support Program with that increase.

1100

While those increases have been welcome, they haven't been enough to keep up with what our community needs from us. Our sexual assault counselling program still has a wait time of seven months. This means that a survivor has to wait half a year, at least, for counselling support to manage their trauma. This is seven months where survivors may not be able to work, go to school, show up for their kids or even participate in day-to-day activities.

In addition to this, we have seen a dramatic increase to our fixed costs at Anova since 2020. In 2019, our combined food cost for our two emergency shelters was $76,651; in 2023, that has increased by 53% to $117,637. In 2019, our hydro and water costs were $69,000 and change; in 2023, that increased by 30% to almost $90,000. In 2019, our gas costs were $16,765; in 2023, that rose by 45% to $24,355. If utility costs continue to grow at this rate, our ability to manage will quickly become unsustainable.

With dramatic changes in fixed costs, we have had to divert fundraising dollars to help cover basic needs. In the past, those dollars have helped us do pilot programming and cover costs for services to women and children. I'm fundraising for food, diapers, baby formula and hydro bills now.

There have been many conversations around reopening after the COVID-19 pandemic. We never closed our doors. Those of us who run violence against women services and

shelters stayed open through the entire pandemic crisis. We serve large catchment areas and answered more calls for help and support, to compensate for services that had closed their doors. It was our team that had to figure out how to deliver services during lockdown, manage heightened fears about outbreaks and implement universal precautions.

This has contributed greatly to the burnout we are seeing in our sector. Finding, retaining and supporting staff has become more difficult over the last three years. Rising prices, rents and inflation not only hit our clients, but they hit the employees as well. How are you supposed to be a helper when you can't take care of yourself? If we're not able to better support our staff with fair wages, comprehensive benefits and professional development, this sector is going to be bleak very soon.

We do appreciate the needed focus on women's economic prosperity that the current government has chosen to focus on, but I worry that focusing entirely on getting women into sectors traditionally dominated by men further marginalizes women. Women's work is valuable and often holds up a society. Working in violence against women shelters, delivering counselling services and advocating to end gender-based violence is a sector dominated by women. Their work is worthy of a decent wage and support, so please remember them.

The population of London has risen from just over 494,000 in 2016 to, in 2021, according to census data, 545,551. This growth has translated to an increased demand in services for Anova. Recent projections have shown that London is one of the fastest-growing cities in the country. We need to make sure we have enough resources to serve everyone in our community, not just the lucky ones who relentlessly call us at the right time to secure a bed, an appointment or a counselling session. Everyone who calls deserves to get the support that they need when they need it the most. We need to keep up.

Our data from 2023 shows us that 3,000 of the almost 10,000 calls to Anova's 24-hour crisis and support line were requests to stay in one of our two violence against women shelters. Of those 3,000 requests, about 150 were able to be given space. This means only 5% of the callers were given space at Anova. Turning away 95% of those calls is unacceptable. It's a failure, and it inadequately meets the needs of folks here in London. It's a lost opportunity to offer safety and prevent further harm or even death. Couple this with provincial increases in femicide, and there is a glaring need to be more proactive in how we fund gender-based violence.

From 2016 to 2017, there were 19 reported femicides according to the Ontario Association of Interval and Transition Houses. The most recent femicide list from 2022-23 had that number at 62 women and children. That's a 226% increase in five years. If we don't do something more, where are we going to be in another five years? I don't think we have the time or luxury to find out.

As our resources are depleting, we are on the cusp of having some very difficult conversations about the critical services and programs that we may have to alter or discontinue. The moral distress is growing, and the increased demand for service is not stopping.

So our ask to those who are in positions of creating our next provincial budget is to consider:

—a solid increase to Anova's funding for both our women's shelters and our sexual assault centres, by at least 20%;

—a one-time investment of at least 10% of our annual transfer payment agency allotment to manage the increased costs of inflation over the last four years;

—an increase in prevention dollars;

—an increase to invest in another full-time and part-time sexual assault counsellor, to reduce wait times from six months to two weeks in our—

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

Ms. Jessie Rodger: —sexual assault counselling program;

—an increase to our transitional housing and support programs so that we can avoid women and children having to go into shelter in the first place; and

—an increase to support staff stabilization, including comprehensive professional development and vicarious trauma support.

I would also point out the submissions from the Ontario Coalition of Rape Crisis Centres as well as the Ontario Association of Interval and Transition Homes. They have great sections that they have submitted as well.

Finally, we would ask that any investment about housing, addictions, mental health and justice be reviewed with a gendered lens and carefully consider the needs and strengths of women and kiddos when we're making decisions for our province.

I will end it there. Thank you.

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

With that, we'll go to the next presenter, the London and St. Thomas Association of Realtors.

Mr. Adam Miller: Thank you very much for the opportunity. That's a tough act to follow. Some of those numbers are pretty incredible, with the inflation of bills and expenses, so I feel for Anova, for sure.

The London and St. Thomas Association of Realtors, with the housing crunch that we have seen in the last year and a half—we certainly don't have much good news as well. It was, depending on which stat you look at, the worst year in housing in between 20 and 30 years of stats, so we've certainly felt the massive effects of the interest rate hikes. London and St. Thomas are hoping to round the corner, with a new stability of the interest rates on a hold or a pause.

What we have seen over the last year and a half was a rebound after a massive COVID crisis which shut down many industries and closed the doors to a lot of different companies. Real estate was certainly not one of them. We saw an absolute explosion in the real estate market through the COVID crisis, with an unhealthy spike of 40% to 60% in some of the growth opportunities. London and St. Thomas were certainly found by the greater Golden Horseshoe area, and we had a massive exodus from those markets down to

our market, in which we saw a growth of sale prices from the average sale price of about $425,000 up to about $650,000, and then, after the next year into COVID, up to the $800,000 mark.

The interesting part was that during that period of time, the $800,000 house was more affordable on a monthly rate than the $550,000 house is now, so we're having many of our London and St. Thomas area individuals having a hard time making their monthly payments on houses that they have lost $200,000 to $300,00 in value for.

There is lots of great news. We've had tons of great press and companies coming into the area, and we hope that that will spike in some of the new growth into the London and St. Thomas housing market.

One of our asks is the end of exclusionary zoning. It is an old practice with zoning in the area, where we need to see some diversity of changing the way people look at their property: turning it into garden suites or granny suites, depending on where you are and what you want to call them; converting double-car garages into living suites. We have both our new buyers and some of our senior owners who want to stay in their house and stay in the area where they've lived for the last 30 or 40 years, but certainly can create an opportunity for another housing unit on their property. Exclusionary zoning is an old practice that needs to be looked at on expanding and helping the London and St. Thomas area get different-style housing in the area as well.

Our second ask would be a loan guarantee for purpose-built rentals, affordable rentals and ownership projects. We have a lot of great builders and great developers in the city. Unfortunately, a lot of the building has been on a hard pause because of the market itself. "If you build it, they will come." Unfortunately, if you build it, no one is coming right now, so we're not seeing a lot of the activity that a lot of the builders would like.

But shovels in the ground six months from now is too late. We needed shovels in the ground six months ago, so that when the market does take a rebound, they are already in the process of being built or just finishing up. To wait for the market to rebound is an archaic practice and is not going to work well for the area, so what we need is a loan guarantee or a buyback program where the government is looking to help out developers and builders.

I know that's a hard pill to swallow for many people. They're looking at developers and builders and saying it's the government helping millionaires. That certainly is a factor. When COVID hit, builders and developers were making a great stride in their income. That's not the case now. That was short-lived, and so we do have to look at the ability of helping them make sure that they're getting the projects that we need in the ground, so that the general public can have some affordable housing in the very, very near future.

1110

Our last ask is the increased funding for skilled trades. We hear lots of stories in the real estate market of bricklayers making more money than doctors. Good for them. I've taught my kids how to build Lego for years; hopefully that translates them into bricklayers at some point in time.

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

Mr. Adam Miller: But we are shortly running out of a lot of incredibly skilled trades. So we need to start to reinvest, bring back high school programs and bring in the skilled trades that we need to build both houses, affordable units and new-style developments.

I will just to add one thing, the average sale of LSTAR, which is the London St. Thomas Association of Realtors—$77,000 of auxiliary spending in the first year of purchasing a home. So when the housing market is healthy, many of the markets around the house are also a healthy factor.

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

We now will now go to the third one, the Children's Aid Society of London and Middlesex.

Mr. Chris Tremeer: Thank you. Good morning. Good morning, Mr. Chair and committee members. My name is Chris Tremeer. I am the executive director for the Children's Aid Society of London and Middlesex.

I'm going to spend my time today to highlight two issues, two areas that are impacting health and well-being for children and families here in London and across Ontario. It's important to know that when child protection services are needed, it often means that other community services have not been available or able to address chronic health or social conditions that caregivers are experiencing. The Children's Aid Society, or CAS, is called to step in when the trauma, mental illness, addiction, food or housing insecurities have eroded parental capacity and put children at risk.

Firstly, today I want to speak about the lack of access to adequate mental health and addiction services both for adults and children. That's currently a driving force behind child welfare involvement in the province today, in London representing 50% of the families that we're working with. Some 33% of our families are struggling with mental health or addictions challenges for caregivers, and a further 17% of those families are struggling with a child's behaviour or parent-child conflict to the extent that the child is at risk of separation from the family or endangering other children in the home. We are seeing that these behaviours often arise or escalate from a lack of access to adequate mental health services for the child.

We acknowledge and applaud the government's investment in the child and youth mental health early-intervention programs, including the expansion to One Stop Talk and to Youth Wellness Hubs Ontario. These investments will provide supports to youth in their local communities and defer future, more intense pressures on the mental health and child welfare systems. However, there remains a significant gap in communities across the province for children whose mental health needs have escalated beyond what can be served by these prevention programs.

Our community-based children's mental health intensive treatment programs are not able to accept or adequately serve the most challenging youth for reasons of risk, program fit or complexity. These youth are not eligible for

secure treatment programs and they don't belong there, and they don't require acute hospitalization programs. The service programs they need are those from intensive treatment that have not been funded to keep up with the evolving complexity of mental health diagnoses, presentations and behaviours we're seeing in 2024. These programs are struggling to maintain staffing levels, impacted by pay rates for front-line staff. Programs have stopped admissions or are forced to hold empty beds. As a result, increasing numbers of children are being forced into the care of children's aid because their families can't access the services they need and are no longer able to manage the mental health behaviour or needs of the child at home.

In October 2023, London had six youth in care who were not otherwise in need of protection, but for lack of access to these services. Across the west region for the Ministry of Children, Community and Social Services, that number increases to 13. Across the province, you have seen media reports of youth living in CAS office buildings, hotels and unlicensed placements. Many of these are the youth that I am speaking about. There are no placements in licensed care or the mental health system to support these most complex and vulnerable youth.

In response, over the last 18 months, CAS of London and Middlesex has opened three agency-operated, therapeutic homes, with a fourth anticipated to come online in the next month. These homes are to both house youth and to provide supports to stabilize behaviour, to get youth to a point where they can be accepted into the mental health programs for treatment. This level of intensive investment and treatment support is not contemplated under the child welfare funding model and is causing significant children's aid budget pressures in London and across the province: $3.25 million for London alone and the west region costs are estimated at $18 million for this year.

We call on government to support incremental investment in the children's mental health sector to implement the recommendations from the March 2022 report from the complex mental health needs collaboration table. These recommendations will support improvements to the system to handle the more complex youth presenting in 2024 and beyond. We further call for incremental investments to children's mental health live-in treatment to stabilize staffing, enhance training and fund the necessary therapeutic and support services to enable these programs to serve Ontario's most vulnerable youth, and for budget relief for the children's aid societies who are providing care and support in the interim.

Secondly, I want to speak to Ontario's targeted adoption and legal custody subsidy program. This important program provides financial support to families in the amount of $1,035 a month for each qualifying youth adopted or placed through a legal custody agreement. The program is income tested annually and provides much welcome financial support to families that otherwise might be unable to commit to providing permanency for Ontario's youth. Since the program was announced in 2012, the government's funding policy for the program has shifted from fully funding the cost of these mandated subsidies to now funding 25%, with children's aid societies required to absorb the remaining 75% of the cost out of core operating budgets. The 2023-24 impact for London and Middlesex of these subsidies will exceed $1.6 million, and across the province, the agency-funded portion of this program is estimated to be $25.5 million.

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

Mr. Chris Tremeer: These are long-term financial commitments, mandated by government, as these subsidies continue until a youth reaches 21. They are also a vital support for the families providing permanency. Children's aid societies across the province are facing cuts in core protection work or compromising spending on prevention initiatives aligned with child welfare redesign to meet the financial obligations of this important subsidy program. We assert that permanency should not be at the expense of protection or prevention work, as we work to keep families and children together and safe.

We request the government make an incremental investment in the child welfare budget to return to a fully funded targeted subsidy program. This will ease the operating pressure on CASs while ensuring the additional investment flows directly to Ontario families, providing permanency for children and youth.

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Thank you for the opportunity to present on these two critical issues facing Ontario's children, families and CASs today. We can't afford not to make these investments in essential services.

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

We now will start with the questions, and we start with the independents. MPP Hazell.

MPP Andrea Hazell: Good morning to you three presenters. Thank you for coming in today and thank you for your detailed presentations.

I'm going to go to Jessie from Anova. Your presentation just tugged at my heartstrings. I am on page 3 of your presentation. I understand the population growth has impacted your services; I get that. I also look at your data, which is extremely disturbing: 3,000 of the almost 10,000 calls that you would get are 3,000 women asking for shelter. You could have only helped 150. That's 5%. You had to turn away 95%.

I have had in-depth conversations with women who can't get into shelters in Scarborough, in my riding of Scarborough–Guildwood. These women, when turned away, go back to their violent situation, and we know the outcome of that, or they will go to other shelters which harm them even more mentally, or they live in their cars with their children.

When I hear all of this—and we keep hearing all of this. This is a problem through Ontario, not just London. I think there were three deaths in London that are included in the 62, right? So would you call this an epidemic? That's my first question. Let's call it what it is because this is serious. We need funding to support this epidemic. And can you elaborate on your critical funding needs to support these

women? They are our vulnerable population and we need to do better.

Ms. Jessie Rodger Yes, I can answer. Through the Chair, would I say that intimate partner violence is an epidemic in the province of Ontario? Yes, I would. You can look at the numbers and see that there is an alarmingly high rate of femicide, of murder of women and children by their intimate partners or by their male family members, and it has increased exponentially since the beginning of COVID.

In COVID, during those times when we were in lockdown and people couldn't leave, we were having the most heartbreaking conversations with women about how to make staying with their abuser, staying in a really precarious situation, as safe as possible. We do a lot of harm reduction, but those conversations left a mark on our team and left a mark on the women that we were talking to.

When it comes to the critical services that we provide, our mandated service is just to provide a safe space. When you come to the shelter at Anova, there are three locked doors. Our security is based of off EMDC, the provincial jail that is in London. That's how safe our spaces are because that's what they need. So if we're not able to deliver services for those people who are asking, that's a major concern for me and I think it should be a major concern for everybody.

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

Ms. Jessie Rodger: I also think, critically, investing in prevention services before people need to call to have a space and shelter is also really important. Outreach services, prevention services, services for new parents, services for young kids, services for young boys, services for young men—if we do that pre-emptively, we're going to have less calls for space. So I think it's all connected. That's all I'll say about that.

MPP Andrea Hazell: Thank you for stating that for the record.

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

We will go to MPP Leardi.

Mr. Anthony Leardi: I'm going to address some questions to the representative of the realtors today. Mr. Miller, I want to start with some questions about development charges. Are you aware of what level of development charges are charged in this area, the area that you deal with?

Mr. Adam Miller: For the LSTAR? Yes, London is a little bit different than St. Thomas, but yes, I'm aware of development charges.

Mr. Anthony Leardi: Give us an idea of what the level of development charges is.

Mr. Adam Miller: To specifically talk about the London area, it's a tough question, because it's depending on the size of the lot and things like that. You're looking at your development charges being—probably, approximately, the average would be about $70,000.

Mr. Anthony Leardi: And a development charge is something that's charged to the builder, for example, when they build a new home, correct?

Mr. Adam Miller: Yes. The development charges go back to help with the creating of the sewer system that's going to be in the area, the sidewalks, the curbs, lighting systems and all that. It's charged back to the developer.

Mr. Anthony Leardi: The builder pays it upfront, and then rolls it into the cost of the home, right?

Mr. Adam Miller: Correct, yes.

Mr. Anthony Leardi: So, eventually, when somebody purchases the home, they pay the cost of the development charge.

Mr. Adam Miller: Correct, yes. The end-user, the final buyer—the development charge will be paid by them.

Mr. Anthony Leardi: So if a development charge is increased, that increases the purchase price of a home, correct?

Mr. Adam Miller: Yes.

Mr. Anthony Leardi: If a development charge is decreased, that decreases the purchase price of a home, correct?

Mr. Adam Miller: Fundamentally, that's how it should work.

Mr. Anthony Leardi: And the extra cost is paid by the purchaser and any savings is saved by the purchaser, correct?

Mr. Adam Miller: Yes.

Mr. Anthony Leardi: So if development charges are lowered or eliminated, that's not a bonus to the builder or the developer, right?

Mr. Adam Miller: No, it should be helpful to the end-user to make it more affordable for the buyer.

Mr. Anthony Leardi: Thank you very much.

I'm going to change my questioning now over to questions of the down payment. If you can put a down payment of 20% on a home, you will eliminate the necessity of having to apply through CMHC. Is that correct?

Mr. Adam Miller: That is correct.

Mr. Anthony Leardi: But if you put less than 20% down, then you have to go through CMHC?

Mr. Adam Miller: Yes.

Mr. Anthony Leardi: The Canada Mortgage and Housing Corp.—CMHC—give us an idea of what happens when somebody has to go through CMHC.

Mr. Adam Miller: Most of the mortgages that we are seeing go through the CMHC. Again, I'm not a mortgage expert, but they will pay—it's an insurance program. The mortgage is insured through the CMHC, so they do pay an increased percentage on their fee.

Mr. Anthony Leardi: So the purchaser will have to pay a fee, correct?

Mr. Adam Miller: Yes.

Mr. Anthony Leardi: Again, that's no bonus to the builder either.

Mr. Adam Miller: No. That has nothing to do with the development.

Mr. Anthony Leardi: Let's talk about the elimination of exclusionary zoning. I understand you primarily operate in the city of London. Is that correct?

Mr. Adam Miller: London and St. Thomas, yes. I guess from Grand Bend to Port Stanley would be an accurate area that we cover.

Mr. Anthony Leardi: I would presume that every time that question of zoning comes up, it's dealt with by the local municipal councils. Is that correct?

Mr. Adam Miller: Yes.

Mr. Anthony Leardi: Because zoning is a municipal issue. Is that correct?

Mr. Adam Miller: Yes.

Mr. Anthony Leardi: So when a municipal council is confronted with the question of exclusionary zoning versus non-exclusionary zoning, in your experience, what has frequently happened?

Mr. Adam Miller: I would say that we've seen a lot less pushback in the last year on the municipal level because the housing crisis has come to surface on all three levels—municipal, provincial and federal. So we are getting some co-operation, but we still do get old-school thinking on zoning: "What was good in the 1970s still should be good in 2024."

Mr. Anthony Leardi: Here is my experience as a former municipal representative: When you attempt to introduce a zoning change, which might create more housing or denser housing, the town hall or city hall is immediately packed by objectors. Has that been your experience?

Mr. Adam Miller: I would say in the last year we still get pushback, but it's mostly from one or two of the neighbours. I think we used to see where many would rebel against it, but if it's 30 at the town hall or two, it still holds the process up the same amount.

Mr. Anthony Leardi: When you say, "It holds the process up," what do you mean? By a day? A month? A week? A year? What are you talking about?

Mr. Adam Miller: I would say—yes, I just talked to a developer, and they're looking at probably an eight- to nine-month holdup.

Mr. Anthony Leardi: A builder who has to borrow money to build the building, preparing it for sale—what is a typical commercial rate for a builder?

Mr. Adam Miller: I'm not sure I'm qualified to answer that question. I would think you're probably looking at 5.5%—

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

Mr. Anthony Leardi: What you're telling me is now the builder has to carry the loan for an additional eight or nine months at perhaps 7%, 8% or 9%?

Mr. Adam Miller: Yes, for sure.

Mr. Anthony Leardi: And that is a cost to the builder?

Mr. Adam Miller: Yes.

Mr. Anthony Leardi: And then, eventually, who has to pay that cost?

Mr. Adam Miller: The end-user will probably eat that cost, yes.

Mr. Anthony Leardi: I submit that purchasers seeking to purchase a house, their first house, will have to eat the cost in higher purchase price when there's a delay at town hall or at city hall.

Mr. Adam Miller: Yes, I would agree with that.

Mr. Anthony Leardi: Thank you very much.

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

Mr. Terence Kernaghan: Thank you to all our presenters here today. It's good to see all of you again.

I want to start off with Anova. Jessie, I think you spoke about the moral difficulties that your folks are facing. I think turning away 95% of people who are seeking shelter should be something that gives the government pause. Would you like to see the government use some of its $5.4-billion slush fund to create more affordable housing and supportive housing and support organizations like Anova?

Ms. Jessie Rodger: Thank you for the question. Through the Chair, the short answer is yes. Housing is a critical part to the work that we do. We are having women and children have longer and longer stays in shelter. We have had, consistently for the last couple of years, more children than women in shelter, so we're having bigger families come and stay with us, so women with three, four, five, six children. Finding sustainable and affordable housing for them is difficult. It's going to be a longer wait in general, but we're having women stay in shelter with us for four, five, six months. Their risk reduces the longer that they stay in shelter, but there's nowhere for them to go. Then we have women calling with higher risk who need to be in shelter right away, but we're not going to kick out mom and kids when they don't have some place to go.

So being able to have affordable housing that is going to accommodate larger families is also really important. The urgency with which we need to address the housing crisis for the clients that we serve—it's on a daily basis we're seeing this. So any investment that could be helpful in that area would be greatly appreciated.

Mr. Terence Kernaghan: Understood. I want to thank you for your comments about women's labour, keeping these programs going, because that's something we hear all the time at committee, about how people with good hearts are keeping these systems functioning, despite financial disinvestment and financial neglect from the government.

I want to just, hopefully, have the committee focused on your quote. "How are you supposed to be a helper when you can't take care of yourself?" It really resonates and should with everyone who heard it. Can you talk about your workforce, some of the sacrifices that they make to help keep Anova running?

Ms. Jessie Rodger: Yes, I can speak to that. Thank you. Through the Chair, the team at Anova is much like a lot of the other teams from our sister shelters and sister sexual assault centres that we speak with. They come in and show up to work every day. Through COVID, there was a lot of having to come into work and not quite knowing what they were having to do. So putting on PPE or donning gowns, masks, shields, providing trauma-informed counselling services using PPE—not the easiest thing to do.

We have had a very high rate of staff who have had to take short-term and long-term leaves because of stress of the work. Having to turn away 95% of the calls is not only

difficult for the women on the end of the phone to hear, but it is incredibly difficult for our team to do that on an hourly basis. Couple that with the increased femicides that we've been seeing in London—we know these women, they're not strangers to us. We also had parts of our team really struggling with paying their own bills, and so coming to work and really focusing on trying to find somebody housing when they themselves are also struggling as well.

Oftentimes, a lot of this work is done on the backs of women. It's women supporting women, and it's not always valued as much as it should be. So any time there's an opportunity to talk about not just the incredible women we get to serve and support every day but also the incredible women who get to work and do this and deliver these services, we're always going to try to take that opportunity to really share how valuable they are and how worthy they are of a fair and decent wage and package.

Mr. Terence Kernaghan: Thank you so much for your comments.

I'd like to turn it over to LSTAR and Adam. I think we heard from the government a lot of blaming of local councils. They like to use the word NIMBY quite a bit. Do you think the province could step in and end exclusionary zoning across the board and actually deal with the problem that they would like to pin on local councils? Could the province step in and do this, actually do the heavy lifting to make sure that they actually do the right thing and end exclusionary zoning?

Mr. Adam Miller: I guess the short answer is yes, they could. The government can always step in and overrule the municipality. I think we're seeing some of that now. We're seeing a step forward with some of the ending of exclusionary zoning. It's a slippery slope: What's good for London might not be good for St. Thomas; what's good for Grand Bend might not be good for Port Stanley. So there still does need to be some local factor in there just to make sure that just because it does work or it can work that there could be a bit of abuse of power in some of the areas that way. So I think the government has to tread that fine line of walking over the municipality, for sure.

Mr. Terence Kernaghan: Sure. I also want to thank you for your comments. I know the government was trying to get you to make a statement about development charges. But you're quite right when you say the removal of development charges should be passed down to the buyer, but I think it's very clear here that the government could put steps in place to make sure it actually does. So I want to thank you for that.

My next questions will go over to the Children's Aid Society, with Chris. Chris, I want to thank you and your team for your dedication and all of the amazing work that you do. It's incredibly heartbreaking that when children's protection needs to happen it's actually happening because of a lack of supports within the community, when it should be an item of last resort. I want to thank you for talking about the root causes, the lack of mental health supports for adults, for children.

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

Mr. Terence Kernaghan: I wanted to ask, does it make any sense that the government has this legally mandated program of targeted adoption and legal supports, and yet it doesn't fund it properly? Would you like to see the government use part of its $5.4-billion contingency fund to fund its legal obligations properly?

Mr. Chris Tremeer: I think we'd certainly like to see the program fully funded. I'll let the government choose where they pull that money from, obviously. I think it's extremely difficult for families in the province who are not able to access services on the mental health side when they're hearing and reading those stories, and we've got agencies in our community saying, "We can't get staffing. We can't staff adequately to support your child." Parents are having to relinquish parental rights in an attempt to get services for their children, and the reality is that invokes our mandate as a children's aid society, but we're not a mental health agency—

The Chair (Mr. Ernie Hardeman): We'll have to finish that answer in the next round because we've run out of time.

MPP Shamji.

Mr. Adil Shamji: Mr. Miller, I was wondering if we could start with you, just a few questions. We've talked a little bit about potentially ending exclusionary zoning. We've heard some reservations expressed about that. I was wondering, are you familiar with the Housing Affordability Task Force?

Mr. Adam Miller: Yes, I am.

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Mr. Adil Shamji: This is a task force that was convened by the current government. Is that your understanding?

Mr. Adam Miller: Yes.

Mr. Adil Shamji: Did that task force recommend ending exclusionary zoning?

Mr. Adam Miller: I couldn't answer where it started. I'm sorry.

Mr. Adil Shamji: Sure, no problem. It did.

There was an article that came out just yesterday showing that the current government fell dramatically short in meeting its home building targets for 2023. They were about 25% short on their target.

Do you imagine that ending exclusionary zoning could help more homes get built faster?

Mr. Adam Miller: Yes, I do. I think it is a step in the right direction, in that case. We're going to see a slow increase of that because it is new for this area. Being somewhat familiar with the Toronto market, it's a little bit more popular there, where they're converting a section of their house of a double-car garage into a living space. So we're seeing that it has worked in other municipalities.

In this area, we need a couple of people to be the first to do it, and I think it will certainly take the pressure off some of the rental units and create some second units, for sure.

Mr. Adil Shamji: Thank you very much.

My next question I'd like to direct to you at Anova—and thank you for the important work that you're doing. As you may know, a few years ago, there was a really

tragic case in which three women were murdered in a horrific example of intimate partner violence in Renfrew county. There was a coroner's inquest that made 86 recommendations.

I was wondering, could you describe how some of the work that you do, if well-funded, could help to reduce and address the epidemic of intimate partner violence?

Ms. Jessie Rodger: Yes, thank you for the question. Through the Chair, I can answer that. Every day, we have the femicide list at Anova and it's something that is very present for us, and the fact that we are now at 62 confirmed names for this past year, we often think about what we could have done better. Each and every one of those deaths was preventable. Those deaths are preventable not just with having available shelter beds for women who need it, but it's also counselling appointments for women who don't have to wait seven months. It's also through having availability of an outreach worker to be able to talk about—before things get to a point where their home isn't safe anymore—how they can manage and adjust. It's about having opportunities for their kids to learn new skills and to be able to talk to somebody—

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

Ms. Jessie Rodger: —about what it's like to live in a family home where there's violence all the time. If we have a well-funded gender-based violence sector, we're going to see that femicide list be reduced. I think that's the ultimate point of the work that we do. And we know this not just because we have a wish, we have a hope, but we have data, we have research. We know that there are successful pieces of this work that happen when you invest in the gender-based violence sector in a meaningful and thoughtful and consistent way.

Mr. Adil Shamji: Great, thank you.

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

Mr. Mike Harris: Thank you, panellists, for being here. It's been certainly an enlightening morning so far.

Jessie, I just wanted to touch on a couple of things. I'm not sure how familiar you are with Women's Crisis Services and the sexual assault centre in Waterloo region, but they have a really interesting program where they're looking at upstream diversion. They have clinicians that are going out with police to calls for service where there's usually some kind of domestic violence that has taken place, and they're then able to look at early intervention—and you had just touched on it.

I was wondering if you were able to maybe comment a little bit on how that type of program could work with you, whether you're doing something like that, and whether or not it might fit in in your realm that you play in here.

Ms. Jessie Rodger: Thank you for the question. Through the Chair, I can answer. I have heard of that program and that's a great organization, and it's exciting to see that work happen. We don't have something that mirrors that. We work with London police pretty closely, but we don't have a program that exactly looks like that. I think we're always open to listening and learning, and seeing what other people in other regions are doing and seeing if we can replicate that in London.

I think part of our work—we think about diversion; we're also thinking about youth. We're trying to do more with kids, talking to young kids. We're also talking about how to reach women through—sometimes they're not super comfortable with talking to police or calling police; that's what we're finding through our crisis line. And so, finding opportunities to basically start the conversation at any point is really helpful.

But no, we don't have exactly that program, but I think that that's really important.

Mr. Mike Harris: Yes, I think they have seen roughly a 50% reduction in calls back to those same houses. I think the way that it works right now with a lot of municipalities, at least in Waterloo region, is that if you have one or two touchpoints in a domestic violence situation, you're then trying to get that intervention piece out there before it starts to become what we've talked about a little bit here already today.

Do you know what your relationship in that manner is like with the London Police Service? How are you liaising with them to try to get out there and reach more folks in the community?

Ms. Jessie Rodger: Yes, I can absolutely answer that. We have a good relationship with London police. I believe their IPV, or intimate partner violence, team is an audit team. They don't have officers that go out, so it's a little bit different in that regard. But Anova is really grateful to have a strong relationship with both the intimate partner violence team, as well as the sexual assault team. We are also part of the case review for unfounded cases of sexual violence, and have had some really great success in being able to help London police identify where things maybe have gone really well and where there could be some improvements, so that there can be fewer cases of unfounded sexual assault.

Mr. Mike Harris: When you say "audit system," that's where the incident will happen or what have you, and then you'll go later on and kind of look through and see, "Okay, there have been X, Y, Z cases. We're now going to go out and look at that"—how does that work?

Ms. Jessie Rodger: Yes, it is two separate things. With the intimate partner violence team, the audit, from what I understand—I'm not a complete expert, but their officers in that team don't go out to domestic violence calls. Those are meant for constables or any of the police officers that are out working in the city.

For the sexual assault team, it's the unfounded case review committee, which came out of—there was a Globe and Mail exposé that there was a sexual assault that was deemed to be unfounded, and so there was a lot of sexual assault centres in the province of Ontario that were able to work with their local police services to be able to review unfounded cases of sexual assault and give feedback to their local police service. London has enjoyed a really strong relationship with Anova and with that case review committee, so—

Mr. Mike Harris: What would you say is the ratio to unfounded versus founded right now in the community?

Ms. Jessie Rodger: Unfounded cases of sexual assault are deemed by the police, and that's when they say there's no space for them to charge anybody with sexual assault. So when a survivor goes to police and says, "I've been sexually assaulted," the police look into it and say, "Sorry. There's really nothing that we can do."

Mr. Mike Harris: So it's not necessarily that it didn't happen, it's just that there is nothing that they can do for that from a code perspective?

Ms. Jessie Rodger: There is nothing that the police would do in terms of making a charge. So, then, we're able to review those cases and able to give feedback to London police around, "You might want to try this," or, "Here you might have gone a little wrong," in that sort of situation.

Mr. Mike Harris: Sure. Gotcha.

Ms. Jessie Rodger: But I can say that we've been doing this since 2018, and we've seen improvements from the London police.

Mr. Mike Harris: I was just quickly looking through your page, but what's your budget right now?

Ms. Jessie Rodger: For the entire organization? We're just under $7 million annually.

Mr. Mike Harris: And you're asking for, I think it was, a 20% increase?

Ms. Jessie Rodger: Yes, $1.5 million overall.

Mr. Mike Harris: Let's be honest: 20% is quite substantial. What would that 20% increase be used for? I'm seeing staff salaries and different things on here. What about actual programming?

Ms. Jessie Rodger: For actual programming, that would be more programming for children in shelters. Like I mentioned, we have a massive amount of children in our shelters right now. We don't have a massive amount of children's programming to offer for them, so that would be something that we would be looking for.

More counselling services for women in shelter, more opportunities to create partnerships for people to come into shelter—that's a big piece of work for us that we would love to see more investment in and allows women to access services safely if they can't leave. And being able to keep up with—we are double staffed 24/7, so being able to make sure that our shelter spaces are always having enough staff to be able to take care of those spaces.

Mr. Mike Harris: Would you say your organization is more focused on the right now issues and not necessarily looking at those upstream issues?

Ms. Jessie Rodger: No. We also have a public education team and an education research wing of our work that I think has been really important. Part of that has been working with school-aged children, it has been working with young men and it has been working with—

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

Ms. Jessie Rodger: —young people to help them understand and be able to maybe correct behaviour before it begins. So—

Mr. Mike Harris: How is your relationship with the school boards?

Ms. Jessie Rodger: Strong, yes.

Mr. Mike Harris: Strong?

Ms. Jessie Rodger: Both public and Catholic, yes.

Mr. Mike Harris: That's good to hear.

That's it for me, Chair. Thank you.

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

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Ms. Peggy Sattler: Thank you to all of our presenters today. Chris, I wanted to start with you. You were in the middle of a response to my colleague MPP Kernaghan. But we met in the summer, and I talked about some of the families that I have been working with in London West who are in exactly the situation that you described. They have young people who have very, very serious and complex mental health issues and there are no services, no programs available for those young people. Their parents were advised that giving up custody to the CAS might be one way to get them into treatment, but as you point out, there really is no way that you can—you're not funded, you're not a front-line mental health agency to provide that kind of treatment.

I wonder if you can elaborate more on the kinds of budget pressures this creates for children's aid societies when you are dealing with this level of complexity among young people in our province.

Mr. Chris Tremeer: Thank you. Absolutely. Through the Chair, I think, as I was closing off with MPP Kernaghan—parents are relinquishing rights in a desperate hope that their child will be able to receive services once they become involved with children's aid, and as you've pointed out, we're not a mental health agency. We're in the queue with everyone else for those mental health resources in the community. We don't jump to the front of the queue. And the placements aren't there to handle these most challenging youth that are presenting.

This speaks to the recommendations that are in the report for complex needs that had gone to government in 2022. It was jointly done with the Ministry of Health and the Ministry of Children, Community and Social Services and includes recommendations to restructure parts of that system to be able to handle these more complex youth. Traditional mental health programs are often structured around eight to 10 participants. You can't combine eight to 10 participants with this level of need together in a room and expect that that program is going to go well. That's one of the reasons agencies are not able to accept these youth.

The other piece to underscore is that, from the government's own guidelines, Ontario-funded child and youth mental health services are provided under the authority of the CYFSA. They are not mandatory services but are provided to the level of resources available. That is the guidance to the mental health agencies. So when they have run out of resources, they stop taking the children. That doesn't shift our mandate as CAS. We've still got them, and we

have no ability to turn families away, which is why you see the reports of agencies struggling to house and find treatment for these youth. We don't have that same ability to design the exclusionary criteria, nor should we.

Ms. Peggy Sattler: So many of the budget pressures that CAS agencies like yours are facing could be alleviated if we had services elsewhere, where they should be—in other systems?

Mr. Chris Tremeer: In other systems. So in London, that is $3.5 million, and we're projecting out to $5 million, even, by the end of the year, in the child welfare budget to house and provide interim treatment supports to these youth that need a different style of placement. In the west region, that rises to $18 million. We're still compiling, as a sector, the province-wide data, but I would say it is in excess of $50 million worth of pressure on the children's aid budget envelope.

Ms. Peggy Sattler: Okay. Thank you very much.

I now wanted to ask Jessie from Anova some questions. Jessie, about 25 years ago, I actually worked at Women's Community House, which was an Anova predecessor. Certainly, I'm aware of the history of Women's Community House, which was created with fundraising dollars from a small group of women in the community.

The fact that we are back to using fundraising dollars to operate a shelter is appalling to me. The figures that you have provided in this report about the dramatic increase in basic costs, utilities and food that you're facing, and the fact that you're now having to fundraise for food, diapers, baby formula and hydro bills—it's unconscionable that the sector has been so underfunded that you've come to that point.

When you are only able to provide housing for 5% of the women and others who call Anova and are in need of shelter, I'm very concerned about what is going to happen if you continue to face those inflationary pressures and have to divert more and more donor dollars to those basic operating costs.

You talked about how your ability to manage will quickly become unsustainable. What are your options?

Ms. Jessie Rodger: Yes, I can talk a little bit about that, through the Chair. The thing about violence against women shelters and sexual assault centres is that one thing we know how to do is stretch a dollar. It is something that we're exponentially good at because we get so few.

We are starting to have these conversations in our organization about the fact that there isn't a whole lot to trim. We are now getting down to salary, so we are cutting everything that we can. We're having to have hard conversations about extras that we can have, whether it's for the women who we serve, the kids or even professional development for our staff. We're starting to have those conversations already. We're already trimming back as much as we can.

We once were able to, when a woman was leaving shelter and was moving into a new apartment or a new home—

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

Ms. Jessie Rodger: —we would be able to give her a package, give her some furniture, get her started. We can't do that anymore. And so I'm nervous about the conversations we're going to have to have around longer wait times, or if we're going to have to go down to single staffing on our overnight shifts. That was the last thing I wanted to have that conversation about, but we are getting very close to a point to have some really difficult conversations about how we can make sure that we keep our doors open and use and stretch every single penny.

Ms. Peggy Sattler: Just quickly: The end of your submission talks about the increased need for sexual assault centres to respond to a four-time increase in survivors contacting sexual assault services. What are you having to compromise on because of the funding pressures for sexual assault centres in terms of supporting survivors of sexual assault when there is that increased demand?

The Chair (Mr. Ernie Hardeman): We will never know; the time is up.

With that, the time is not only up for that question, it's also up for this panel. We thank you all for the time you have taken to prepare to be here this morning and to share your challenges with us. We hope that it will be of great assistance as we prepare the 2024 budget for the province of Ontario.

That also concludes our morning session this morning. I have a couple of announcements. Lunch for the members and staff is ready in the Windsor room, which is just around the corner from where we are here. We're also going to make every effort to get maintenance to look at the heating system in this building. I'm sure they must have one, so we hope that they can start it up.

Lastly, a procedural one I was going to say—I just noticed it this morning, and there's a solution to it: In the time as I sit up here, when I say, "One minute," it's very great, and we've been getting along well to use up that minute as we are. But I notice it also works very well if the speaker that is asking the question is going to quit in the last minute—we're not going to move to another speaker, I think that's not courteous to our presenters who know they are going to get a question they are not going to be able to answer. I will give that a try, and if the committee is dissatisfied with that approach, we can change back.

With that, we're recessed until 1 o'clock.

The committee recessed from 1204 to 1300.

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

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

COMMUNITY LIVING LONDON
TECHALLIANCE OF SOUTHWESTERN ONTARIO
CO-OPERATIVE HOUSING FEDERATION OF CANADA

The Chair (Mr. Ernie Hardeman): With that, we will now call on the first presenters: the Co-operative Housing Federation of Canada, Community Living London and TechAlliance of Southwestern Ontario. I believe we have three sitting at the table, so we must have three representatives from the organizations.

As you heard, you will have seven minutes to make your presentation. At six minutes, I will say, "One minute." Don't stop. Carry on, because you have one more minute to get your punchline in. At seven minutes, I will say, "Thank you very much for your presentation," and we'll go to the next speaker.

We ask you to make sure that when you start your presentation, you start with introducing yourself, to make we have your name recorded properly for Hansard and attribute the great comments you're going to make to the right person.

With that, we will hear from Community Living London.

Ms. Michelle Palmer: My name is Michelle Palmer, and I'm the executive director of Community Living London. Our agency, just to give you a little bit of history, supports over 1,000 people with developmental disabilities in London and we employ about 500 people.

Many of the people we support require intensive behavioural interventions, or they require ongoing supports for medical or mental health challenges. We provide 24-hour support in 32 residential locations in the city, and many of the people we support are aging and no longer have family members to assist with them. In addition to this, we also provide day supports for people who live on their own or with their families, respite for both children and adults, employment, independent living and supports that assist people to live successfully in our community.

For the past 30 years, we have received a total of 3.9% base funding increase. Base increases can be used for increased costs such as insurance, benefits, utilities and food, all of which have increased drastically, as everybody in the room is aware.

Although we recognize the funding commitments that the government has made over the years, they've been very specific—for example, expanding services—or with specific direction on where the funds can be spent, for example, wage enhancement. These funding initiatives are helpful, but they do not address the increasing costs for the ongoing operations of the organization. We've already developed innovative ways of managing this problem. For example, we created a non-profit back-office support organization in an effort to save administrative costs, but we're still going broke quickly.

I currently provide executive director services to four non-profit agencies in the developmental service sector so my expense can be shared amongst four agencies. That was in an effort to reduce admin costs and to make it manageable for people to keep providing the services that they provide. We also have finance, IT and human resources who are also providing all of that back-office support to four non-profit developmental service agencies.

There's nothing more for us to cut. The change has carried us thus far, but we now have run out of options; we truly have. One of our agencies has already had to reduce services to children who are technologically dependent and medically fragile. In addition to this pressure, we are also entering into negotiations with three of our four organizations, and we have nothing to offer our staff. We're already struggling with recruitment and retention, as are many others. We cannot be competitive with others who pay more and don't operate 24 hours a day like we do.

We have been doing everything possible to avoid service reduction, but without government assistance, at this point we're going to have no choice in the new fiscal year but to do so. This will put people with disabilities and their families at a loss and possibly at risk.

One of the sector's and government's greatest successes historically was the closure of institutions for people with disabilities, something everybody was very, very proud of. Yet this funding crisis is now putting us in a direction of having to look at larger group supports. How long before institutions are reopening because we can't afford to support people in the manner we're doing now?

The people we provide support to can't pay more. They get a total of $1,308 per month on ODSP. A 5% increase to base would cost the provincial government $111 million. If you add in an increase to Passport and ODSP, it's $145 million. We believe that's manageable in order to ensure the safety of the most vulnerable citizens in our communities. Equally important, we're asking for the development of an inter-ministerial task force to develop a sustainable funding model going forward so we don't have to come back year after year.

Thank you for your time.

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

We will now go to the TechAlliance of Southwestern Ontario. The floor is yours, TechAlliance of Southwestern Ontario.

Ms. Christina Fox: Good afternoon, everyone. I'm Christina Fox, the chief executive officer of TechAlliance of Southwestern Ontario. I have been inspired by the place for dreamers, innovators and world-changing ideas, and I'm pretty sure you will be, too. Thanks for inviting me today.

For more than 20 years, TechAlliance has empowered world-class ventures and fuelled growth in Canada's innovation economy. Imagine what the future of work will look like in another 20 years. We champion, coach and tell stories of businesses that are creating good-paying jobs for Ontarians while fostering a vibrant technology community of innovators, prioritizing accelerated venture growth and innovation across southwestern Ontario.

Like this government, Ontario's strong economic prosperity is a top priority for us. Headquartered in downtown

London, Ontario, and actively serving across the five counties of Middlesex, Lambton, Elgin, Huron and Oxford, we are the podium of record for technology companies, the lead voice for founders, innovators, tech talent, capacity-builders, angel investors and industry leaders and the centralized resource for southwestern Ontario's innovation economy, radically reducing obstacles and increasing speed to success for the most promising start-ups and highest-potential scale-ups spinning out prosperity right now.

TechAlliance is an important economic contributor to southwestern Ontario's economic development strategy, collaborating with more than 150 ecosystem partners, including Fanshawe College, Lambton College and Western University, while generating, commercializing and protecting made-in-Ontario intellectual property.

Southwestern Ontario is affordable. It has a population that is educated, technical and diverse. It has investable wealth and has ease of mobility to other parts of the country and the world. It's here where innovation thrives. Our region is globally impactful, with unicorns like 1Password, Info-Tech, Digital Extremes, Paystone, Big Blue Bubble, Voices and Carfax that have paved the way for the next generation of companies, like Renix, AutoVerify, Media Sonar, FluidAI, tbk, Odaya, Connexio, the Minery, Marlow, Front Line Medical, Apalo and Dibs, just to name a few.

Through our advisory services, our incubator accelerator and tech community experiences, we cultivate and steward companies of all sizes with access to capital, customers and ambitious talent. We're committed to a regional culture anchored in diversity and equity, with an all-women executive team. We're here for the long game.

Currently, TechAlliance and 17 other regional innovation centres, known as the RIC network, are in the midst of a renewed funding agreement with the Ministry of Economic Development, Job Creation and Trade. Of all of the funding allocated across the RIC network, TechAlliance only receives 3%, and all of the funding that all of us have has been frozen for 13 years, with zero inflation- or performance-related increases. Flat funding means TechAlliance cannot leverage match-funding opportunities for a three times or greater ROI like the better-funded RICs in Waterloo, Ottawa and Toronto.

It was our sincere pleasure to host the Honourable Rob Flack and the Honourable Vic Fedeli just this week, and we shared with them that after decades of growth, the greater London area has what it takes to be one of Canada's top tech ecosystems and a global innovation hub. TechAlliance punches well above its weight class for performance and happens to be the RIC with the largest geographic footprint.

Growing at twice the average rate in the country, London is the fastest-growing city in Ontario and the fourth-fastest in Canada. I think you know that. London ranked in CBRE's top 10 emerging tech markets in North America for the second consecutive year. That is not by accident. Reported by TECNA, Canada welcomed record numbers of tech talent migration to this region, and London was named number eight for the largest in-migration by city.

Built by founders and with a passionate and accomplished board of directors, alongside an incredibly talented team, at TechAlliance we've set ambitious targets to convene and continue to build our highly connected ecosystem that will deliver results for Ontario's innovation corridor.

Here's where things get real. Let me tell you about our return on your existing investment. Despite receiving only 3% of a total $21 million in RIC network funding, TechAlliance companies delivered over 30% of all FTEs across the active RIC clients across the network, demonstrating strong job creation for the region and for the province. TechAlliance supported well above the average number of companies across all 17 RICs and our companies accounted for 20% of all intellectual property filed and granted across all the RICs and for 10% of the total capital raised.

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Let me recap that: 30% of all FTEs coming from us; 20% of all intellectual property coming from us; 10% of all capital raised coming from us. How's that for ROI? Actively supporting more than 1,200 made-in-Ontario companies in the last five years, and given the substantial funding inequity that TechAlliance has faced since the inception of the network, imagine what more we could deliver if you increased our base funding beyond the 3%.

As this government prepares the budget, consider us your partner, driving a competitive and innovative Ontario. Bright minds with big ideas do come together at TechAlliance, with an unmatched spirit to solve global challenges and put this region on the map.

This leads me to my asks. First, to take our place amongst Canada's top innovation hubs, TechAlliance asks MEDJCT and the province of Ontario to implement an equitable redistribution of the existing total $21 million in funding for the RIC network in this contract renewal, granting $3.4 million each year to TechAlliance so we can actually deliver exceptional ROI for the province and secure match funding from other sources, for a three-times return for you. With additional investment by the ministry, we'll help exponentially more technology companies, create better jobs for Ontarians and provide more robust sector development and local longevity to support the concentrated strategic bet that you have made in a couple of multinationals like Volkswagen.

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

Ms. Christina Fox: The second ask is, local and autonomous support matters. TechAlliance fosters unicorns in the making in critical technology sectors like EV, ag tech and food innovation, advanced manufacturing, clean tech, quantum, AI, SaaS, gaming, life sciences and health innovation.

We ensure that London, St. Thomas and Sarnia, plus the rural and Indigenous communities in TechAlliance's geographic footprint, have the optimal conditions to thrive in the new economy. Last year, we supported 30% more start-ups than a nearby regional innovation centre that has six times more funding than us. We have the pulse of the local economy and we ask that you don't give permission

for other overly funded hub RICs to operate in our region and disrupt our healthy ecosystem.

In closing, TechAlliance operates with an infinite mindset focused on the moon shot that is achievable with the right champions. We will be among the top 10 ecosystems in Canada and remain there. It's happening; it's happening now. So the time is now for you. Be our champion. Invest more in us.

That concludes my remarks.

The Chair (Mr. Ernie Hardeman): We now will go to the Co-operative Housing Federation of Canada.

Ms. Mary Ann Hannant: Good afternoon, Chair, Vice-Chair and members of the Standing Committee on Finance and Economic Affairs. I'm Mary-Ann Hannant. I'm a board director at the Co-operative Housing Federation of Canada. I'm joined by Amina Dibe, senior manager of government relations.

CHF Canada is the national voice of co-operative housing. In Ontario, we represent 550 co-ops, home to 125,000 people. For over 50 years, co-ops have provided good, quality, affordable housing. CHF Canada is committed to providing education services, advice and support, government relations, enterprise services and cost-cutter and diversity programs to our members in conjunction with five Ontario regional federations.

I've worked in the co-op housing sector in Toronto for over 35 years and have seen first-hand the advantages of co-op housing. It includes affordable housing costs, which remain stable over time, quality living conditions and the ability to participate in the prosperity and growth of your co-op community. Housing co-ops offer an alternative to renting or buying for newcomers, seniors, young families and others needing better housing options than the market will provide. Across the country, including in Ontario, co-ops guarantee and preserve affordability in the present and future and provide security of tenure.

At the heart of cooperative housing lies a sense of community, which we greatly value and strive to preserve. We aim to ensure that individuals and families can remain in these communities for as long as they choose. No single policy lever can solve Ontario's affordability crisis, and no one actor can do it alone.

Thirty-five years ago, when I started work in the co-op sector, people attracted to co-op communities could apply for vacancies or spots on a waiting list. Today, people are lucky if they're able to get on a years-long wait-list. Every day, we feel the urgency of the great need that exists.

CHF Canada proposes four recommendations to preserve and grow co-op housing across the province so that more Ontarians can have a decent, affordable place to call home.

Ms. Amina Dibe: Our first recommendation is for the government to support co-ops in negotiations with municipalities as they reach an end-of-mortgage period. Amendments to the Housing Services Act, or HSA, were made to reflect a new reality for co-ops. These amendments reinforced the role of the 31 municipal service managers, who remain responsible for funding rental assistance to people who require it living in HSA co-ops once the initial mortgage is paid off and initial obligations end.

End-of-mortgage is an opportunity to transform and grow the sector. Negotiations between service managers and co-ops have begun to establish new agreements. In these new agreements, we want to see the protection of existing affordability, high asset management standards and co-ops empowered to plan and complete more capital repairs, renovations and retrofits. Additional considerations should also include support for the expansion of co-ops, mergers of co-ops and acquisitions. In particular, appropriate funding levels are needed to ensure that the RGI subsidy can continue to be provided.

Our second recommendation is to invest in a co-operative acquisition fund to empower co-op housing providers to convert affordable market rental into co-op housing. Canada loses approximately nine affordable rental homes for every unit that is built. In Ontario, between 2016 and 2021, the province lost just under 50,000 affordable units. A co-op acquisition fund would help maintain and preserve affordable housing. This can be accomplished with a two-year pilot with $25 million a year. A stand-alone fund explicitly for acquisition would help existing co-ops cover the gap of the debt the project could feasibly take on. We cannot afford to lose more existing affordable housing. An acquisition fund would help keep people in their affordable homes and in their communities for the long-term.

Our third recommendation is to create at least 250,000 non-market housing units by 2031. Of two million housing starts in Ontario between 1990 and 2021, only 0.4% was for non-market homes. We want to work with the government to fulfill the goal of building 1.5 million new homes—homes that meet the needs of all Ontarians.

To meet this objective, the province should prioritize non-market housing supply targets. The government could also modernize the OBC and other policies to remove any barriers to affordable construction; eliminate or reduce tax disincentives to housing growth, including removing the land transfer tax for co-op housing providers and expanding the affordability periods for development charge discounts and exemptions to at least 40 years; provide loan guarantees for affordable housing, including co-operative housing projects; and unlock underutilized land for non-market housing by entering into long-term land lease agreements, or providing the land at low to no cost.

And, finally, our fourth recommendation is to develop and fund a for-Indigenous, by-Indigenous urban, rural and northern housing strategy. Province-wide, 19% of Indigenous households are in core housing need, defined as inadequate housing requiring major repairs and housing costing more than 30% of household income.

This is an unacceptable reality which can be remedied by a comprehensive, funded housing strategy designed by and for Indigenous communities. As called for by the Ontario Aboriginal Housing Services and the Ontario Non-Profit Housing Association, this strategy is essential to tackle the housing inequality faced by Indigenous people and to address the enduring effects of racism, colonialism and intergenerational trauma.

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

Ms. Mary Ann Hannant: Ontario's housing and affordability crisis persists. Recent data highlights the staggering average rent in August 2023 reaching almost $2,500, yet our reporting on co-op housing reveals a promising contrast. One- and two-bedroom apartments are approximately 33% less than comparable market rents in cities like Toronto and Ottawa. Because of this resiliency, we are committed to sustaining and growing the co-op housing model.

To conclude, supporting co-ops as they transition from an end-of-mortgage world, building 250,000 new, non-market housing units, creating a co-op acquisition fund and funding a for-Indigenous, by-Indigenous urban, rural and northern strategy all align with CHF Canada's vision of co-op housing for all. We're ready to partner with the provincial government to fulfill this vision—a vision that provides stable, affordable, quality living conditions and well-being.

Thank you for your time.

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

We'll start the first round of questions with the government. MPP Byers.

Mr. Rick Byers: Thank you very much to our presenters. I really appreciate you making the effort to be here, and more importantly, the great work that you're doing in your communities, so thank you for that.

And maybe, Michelle, first to you: Again, thank you for the great work. I'm not familiar—I know the Community Living model, and we have some in our Grey-Bruce communities, where I'm from, but Community Living London—can you give me a sense of some of the history, how long you've been in the community and how things have changed in terms of your service model in the community? If you'd be good enough.

Ms. Michelle Palmer: Sure. That's a long answer, though—I'm kidding. We've been in existence for about 70 years. That's why many of the people we support no longer have family who is alive to support them, because they've aged with us. So we have adapted our services over the years to really meet the new needs of people supported.

It used to be, quite frankly, people who were fairly easy to support that were the priorities in our sector, and over the years, we're finding that we've got many people with dual diagnosis. So you've got a developmental disability combined with mental health issues or a development disability combined with significant medical needs, so their needs have expanded and enhanced much more rapidly.

The people who have become a priority now are those who require the highest level of support, quite frankly. Many people who only require a little bit of support, they just stay home with their families and the families assist in any way they can, or they use their Passport funding for that. So the people you'll find in Community Living Ontario organizations now are really, truly the highest, most vulnerable people in our cities.

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Mr. Rick Byers: Got it. Thank you very much. Again, thanks for that great work. You've mentioned a funding proposal of 5%. Can you remind us of where you get your funding from? From the provincial government, but do you do any other fundraising activity as well? I'm just curious about your funding model.

Ms. Michelle Palmer: Sure. So we receive our funding from MCCSS. We also do significant fundraising, which we use to fund things that aren't funded by government. For example, the people we provide support to live on, as I said, a very small ODSP amount. If they needed a house renovation or adapted equipment etc., we don't have funds for that, so we would use our fundraising for that.

We always call it that we're fundraising for wishes. The wishes are things you and I would take for granted in life, but unfortunately, the people we provide support to can't take that for granted. But that's how we offset costs that aren't funded.

Mr. Rick Byers: I certainly hear clearly your request. Thank you again for the services.

Ms. Michelle Palmer: Thank you for the question.

Mr. Rick Byers: Christina, maybe to you: In your business—and I am sure I'm the least tech-savvy person in the room—

Mr. Mike Harris: It's true.

Mr. Rick Byers: Exactly. I barely know how to turn on the phone, let alone use it.

But I'm curious. You mentioned in passing AI, and we hear a lot about the evolution of AI. Can you give us just a snapshot of how your organization sees this and how it may impact the provincial economy or broader and labour? Are we all going to be replaced by robots in the future? I'm just curious.

Ms. Christina Fox: Yes, I'm happy to share. Thanks for the question. We find fairly regularly that requests come in to our organization for me to sit on a panel and demonstrate thought leadership as it relates to AI. It is ever-changing. What might have been understood more deeply in October is different already today.

Generally, what happens is, when I'm asked that question, I ask, in context, is it because there is fear-based leadership about the impact of AI and job loss? Or, really, are we looking at having an abundance mindset of, what will AI do to unlock new opportunity for technical, diverse and professionally trained Ontarians that have the opportunity to shift their skill set into that area? Even a couple of years ago, there was a lot of talk about how robots and automation were going to take a lot of jobs. We will see a shift generally in the economy that will see a decline in some job creation, but we'll see an increase. That's why, even at the beginning of my set of remarks of, "Imagine what it's going to look like 20 years from now"—and then, with every single change and industrial evolution and economic evolution.

Things come out that we don't know that are coming. AI is giving us a bit of a look to the future of where AI can actually unlock creativity, unlock new opportunity and unlock autonomy for folks who are in work that can use

AI to better relate to their customer, to increase their revenue.

Certainly, AI has the opportunity to unlock job creation for really well-paying roles, but I think that we will see—and this is prophesizing, if you will—a very rapid shift to AI being a supporter and augmenter within companies that we would not have traditionally seen—I mean, think of even advanced manufacturing and the play that AI will likely have in any facility that we're building in this region over the course of the next several years.

Mr. Rick Byers: That's great. I really appreciate it.

I'll pass the rest of my time to MPP Dowie.

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

Mr. Andrew Dowie: Christina, I'd like to continue my line of questioning with you. Actually, I'm very fascinated with the regs. I'm the parliamentary assistant to the Minister of Economic Development, Job Creation and Trade, so Minister Fedeli says hi.

I can appreciate all the work that TechAlliance does to help prepare—as you just mentioned, helping advanced manufacturing, helping us get to a place where we can become more competitive and reshore some of the business that we've lost so that we can have the economic might here.

I'm wondering if you could elaborate a little bit as to right now how you're funded and what sort of tools do you see as being necessary to keep developing and growing the talent, so that we can continue to reshore our work to Ontario?

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

Ms. Christina Fox: That's a great question. I'll start first with the composition of our funding. I joined the organization about four years ago. At that time, I came in with a budget that was just north of $1 million. The great majority of that was funding by the Ministry of Economic Development, Job Creation and Trade and municipal funding that we've received from the city of London over a long period of time. We also have other revenue sources through events, sponsorship and membership.

Our base funding has more than doubled now, including some funding through FedDev Ontario. We've been a recipient on a couple of occasions, and right now we're in a significantly collaborative experience with other regional innovation centres that allows us to be focused on the green economy and to represent the founders.

Of that total amount of funding, though, about 38% of it is direct flow-through to companies. So when we think of the change that we've had in our operating budget, we—

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

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

Mr. Terence Kernaghan: Thank you to all our presenters here today in person as well as virtually.

I'd like to begin with the Co-operative Housing Federation of Canada, Amina and Mary Ann. Co-ops are communities. They're real neighbourhoods where people want to live, and co-ops have a proven track record of being able to stretch money as far as possible and are very well respected. I wanted to ask, what are the barriers that you perceive to the creation of more co-op housing?

Ms. Mary Ann Hannant: Sorry, I'm not sure which one of us is going to answer this, but I'll start, and you can chime in.

Thank you so much for the question. I think that the biggest barrier is funding. We know that construction costs, of course, have risen incredibly over the last few years. The federal government, in the National Housing Strategy, has put aside some money for development of housing co-ops, but, as I said in my remarks earlier, no one level of government can do this alone. It's going to take all levels of government working together, and so that's what we're hoping for.

Amina, I don't know if you wanted to add to that.

Ms. Amina Dibe: Yes. I think, just building off what Mary Ann said, it's money. I think it's coordination between the different levels of government that all play a part in building more housing and ensuring that people can have access to housing. Earlier, last week, the biggest co-op housing development in over 25 years across Ontario was announced in the city of Toronto, and so that's a huge positive sign for us, and we'd love to see more of that. We want to work with the province and other levels of government to make sure that we can do more of this, and it's not like this is a great announcement and then it never happens again. So, yes, it's certainly funding, and then helping us build more faster.

Mr. Terence Kernaghan: Absolutely. One phrase I hear with increasing regularity is that both the provincial government and the federal government need to return to their historic responsibility of providing that truly affordable housing and making sure that people have access to it. It is very much within their wheelhouse. I just want to thank you, and hopefully we'll work alongside co-ops who are the experts in the field.

Next, I'd like to go over to Michelle with Community Living London. Michelle, helming four agencies as executive director with all the other folks who are in finance, HR and IT, looking after four different agencies, what happens when you retire or any of those people retire?

Ms. Michelle Palmer: I'm not allowed to retire, Terence. There are going to be other people who can take on the leadership of what we're doing. I think we also will have to realize that we can't keep on doing this forever. We're working a lot in order to save money, so the organizations can invest in people with disabilities and can make sure that their services aren't cut, but we can only do so much in a day, and there's still only 24 hours in any given day.

Mr. Terence Kernaghan: This committee has heard from other folks who have said an investment in folks living with disabilities is an investment in the broader community, because it allows their participation within the community.

Ms. Michelle Palmer: Absolutely.

Mr. Terence Kernaghan: Also, all MPPs are receiving a significant amount of emails requesting that immediate

5% increase to developmental services, the base funding, the corresponding 5% increase to Passport services, as well as Special Services at Home. I wanted to also ask: How long, roughly, is the DSO wait-list for housing?

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Ms. Michelle Palmer: That's a really difficult answer because it's not done by how long you're on a list, it's done by priority. You could be on that list for 30 years and if you're not the priority in the community, you'll still be on that wait-list, whereas somebody else who, you know, let's be tragic and say their only caring parent passed away and they can't be left on their own, that becomes the number one priority really quickly.

It really is an impossible answer because it's not based on length of time waiting, it's based on how much of a priority you are for placement.

Mr. Terence Kernaghan: It's rather unfortunate that we have to wait until the untimely demise of a caregiver until people are given priority. What a pity that we're the richest province in Canada and yet that's what happens.

Ms. Michelle Palmer: It's a very sad state of affairs.

Mr. Terence Kernaghan: It is.

I wonder if you could briefly comment about wage parity with developmental services professionals and what impact that has within your organizations and the agencies?

Ms. Michelle Palmer: There is no wage parity amongst developmental service organizations at all. Each organization pays what they're able to. So, for example, with us going into negotiations with three organizations, we don't have the funding to offer anything. It's not going to be a pleasant set of negotiations this year. But there is no wage parity whatsoever. There's no consistency.

Mr. Terence Kernaghan: Absolutely. It must be frustrating when people are leaving developmental services to pursue careers without remuneration. What a loss because we need to keep those good people within that field.

Next I'd like to turn it over to TechAlliance with Christina. Christina, I just want to thank you for all of your work highlighting all of the fantastic work that's happening here in London, as well as southwestern Ontario. You've touched on everything, whether it was EV, ag tech, advanced manufacturing, gaming, life sciences—so many different things. You've also indicated that TechAlliance has 30% more start-ups than your neighbour that has six times the money. That's impressive. That's incredibly impressive.

I wanted to ask: In terms of the renewal of the agreement—the RIC network with the economic development, job creation and trade ministry—what's the timeline? Are you being given any sense of where you're at in that process?

Ms. Christina Fox: That's a great question. Our next fiscal begins April 1 and that's when the beginning of our next three-year term will happen.

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

Mr. Terence Kernaghan: Also, what are other ways in which the government can support the innovation economy?

Ms. Christina Fox: I would say every investment in start-up early-stage scaling companies—to invest in them is to invest in us, and to invest in us is to invest in them.

Mr. Terence Kernaghan: Understood.

Last, I think I just wanted to also point out: You mentioned, with $3.4 million, you can promise a three-times ROI. That's fantastic. Is that based on prior numbers? What is that based upon?

Ms. Christina Fox: Yes, I operate with data, always, and in coming to this organization four years ago, there was a lot of change that could happen, and has happened, as a result of focusing on business. We are a not-for-profit organization that operates like a scrappy start-up. We run lean; we take a look at how we attract talent to our own team—

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

We now go to the independent. MPP Hazell.

MPP Andrea Hazell: Thank you all for coming in and presenting today. I'm going to start with the Co-operative Housing Federation of Canada, and that's to Amina and Mary Ann. I heard you give some alarming stats and that really concerns me a lot. For the record, I just need you to explain that further. The numbers are the numbers. We all know that we are in a housing crisis. We know the vulnerable people, the low-income people are going to be suffering the most from these deficits.

You mention that you've lost 150,000 affordable units. Did I get that number right?

Ms. Amina Dibe: It's just under 50,000 affordable units between 2016 and 2021—deeply affordable units.

MPP Andrea Hazell: So what has led up to that? Because that is very concerning.

Ms. Amina Dibe: What's led up to it? So, this is for market housing, not co-op housing, but private market rents that are deeply affordable. Oftentimes, the developer, or if it's a REIT—a real estate investment trust—they'll want to sell off the asset because it's an older building and, for the most part, that's how deeply affordable rents have been lost or become not affordable any more.

MPP Andrea Hazell: So my follow-up question is, what accountability do you put on your organization when you start losing these numbers to negotiate for these new losses that you are experiencing?

Ms. Amina Dibe: The co-op model doesn't actually allow for that loss, which is why we want to expand it, because of the benefits. An acquisition fund, which is what we're pitching to the government, would help us ensure that when these real estate investment trusts do want to sell off their assets, we can be part of that solution, and co-ops that do have larger reserves or co-ops that are merging with other co-ops to join or combine their reserves are in a position to purchase those buildings with the support of different levels of government and convert it into the co-op model such that it basically is affordable in perpetuity and that people will be able to stay in their homes for as long as they want.

MPP Andrea Hazell: Well, I like the sound of that, but I want to move you to my third question. You mentioned

250,000 non-market housing units. What does that look like and how can you make that happen? Because in a report that I think came out yesterday, this government is not meeting its housing target for 2030 of building 1.5 million homes. We know there are a lot of agencies and municipalities and governments that have to come together to make this happen. How do you see your 250,000 target coming to life in all of this crisis?

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

Ms. Amina Dibe: Some of the things that I mentioned before, I think, like certainly funding for non-profit co-op developers—again, we can't take on the same level of risk that private market developers can and so we need that additional support from the government. I think some of the things that have yet to be implemented from the Housing Affordability Task Force report could really speed things up to achieve that goal of building 250,000 new homes, so more tax incentives for non-market and co-op housing providers—

MPP Andrea Hazell: I'm going to stop you there. What is one thing that you can do to press this government for support?

Ms. Amina Dibe: I think funding. Yes, funding would certainly be helpful and then we can do all those other things.

MPP Andrea Hazell: Thank you.

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

MPP Harris.

Mr. Mike Harris: Christina, I hope you're ready, given that I'm from Waterloo region, to answer some questions. So, listen, there are a couple of things that I just wanted to have you touch on. You were mentioning during your presentation unicorns, so for those of us—I come from the tech sector previous to this as well—around the table and maybe watching who don't really know what that is, give me a 30-second pitch on what a unicorn is.

Ms. Christina Fox: Generally, a unicorn is in excess of $1 billion in revenue. We look at unicorns-in-making when they are above $100 million in revenue and we work with a ton of them in this region.

Mr. Mike Harris: That's good. Thank you. You mentioned a few companies you are working with here locally—FluidAI, that name came up.

Ms. Christina Fox: Yes. Yesterday.

Mr. Mike Harris: We had a great celebration yesterday of FluidAI putting about $25 million into the economy, with a small chunk coming from the government of Ontario, to help create jobs. A lot of those, dare I say, will be in Waterloo region. But I'm glad to see that there is that cross-pollination and partnership between the hubs, incubators, alliances—WEtech down in Windsor, my colleague beside, and of course we have—Communitech is a huge tech hub in K-W, as well as the Accelerator Centre.

How do you work with the different organizations that are within that southwestern Ontario corridor? And I'll be honest: I'm actually fairly unfamiliar with your group so it has been great to hear a little bit more about it today. So how do you guys interplay and how does it all work?

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Ms. Christina Fox: I think it really depends a lot on the leadership of the organization and their appetite for collaboration. When I joined the organization, I couldn't imagine that there should be any kind of concern about supporting companies that come from across Ontario. We work with companies outside of Toronto. We work with companies in northern Ontario, and we collaborate very easily with others in other regions.

So when we speak about Windsor, Yvonne is one of my favourite people in the regional innovation centre network. We do a lot with them. They were born as a regional innovation centre, so we offered mentoring through our history to them so that they could achieve some of the outcomes that they have, but they've got phenomenal leadership.

We work very closely with Innovation Factory in Hamilton because they also have an area focus of medical sciences, life sciences and health innovation—myself and Dave, we were texting this morning about a whole bunch of different things.

Addressing FluidAI, when they were an early-stage company—we were fist-pumping yesterday. We were so excited about the announcement, knowing that we had significant attribution to their early days. And as often as companies can have support for multiple regional innovation centres, where there is advice and expertise that helps them along their journey, we're very open to that, a "no wrong doors" approach.

What we do like, however, when I spoke about local matters, when there are companies that are operating in London or have their founders in London, or have a headquarters or a branch in London, we really want to be able to drive value. We don't think that a company that's located in this region really should go to another regional innovation centre unless they offer something that we cannot offer.

In TechAlliance, with our history, we can offer, soup to nuts, just about anything that any kind of a company needs. If someone comes in from mining and forestry, we would definitely make a referral, but if there's a surge of forestry and mining tech companies in our region, we'd figure out how to support them in their entirety, whatever they need.

I think the key in southwestern Ontario is, a lot of leaders come together and find ways to operate so that it gives the best opportunity for Ontario companies that are commercializing and protecting their IP here.

Mr. Mike Harris: Yes, it's nice to see that collaboration, because I think that's one thing that—and it's interesting you say forestry and mining. There's actually a fairly thriving forestry sector in southwestern Ontario.

Ms. Christina Fox: Yes.

Mr. Mike Harris: More on the production side than the actual harvesting side, which is interesting.

I don't have a lot of time, so thank you very much for being here today. It's nice to see the tech sector represented in our budget deliberations.

I just wanted to pivot over to Community Living. I've had a lot of great conversations with the various Community Living organizations in and around Waterloo region. The one thing that they have consistently brought up over the last five years that I've really been interacting with them on is supportive housing and the lack thereof. I was hoping maybe you could fill us in a little bit on what things look like here in London, and maybe a little bit broader into some of the more rural areas.

I will say with my riding specifically, I'm about a fifty-fifty split between rural and suburban Kitchener. We hear a lot from our smaller municipalities, smaller towns that are 10,000, 15,000 or 20,000 people where they're having community members have to leave their home community—it could be half an hour, it could be an hour away—to then come into the city. So I'm wondering what it looks like from a landscape perspective here, and maybe if you could put that rural lens on it a little bit, it would be helpful.

Ms. Michelle Palmer: It's obviously changed drastically with the housing costs of late. London used to be quite an affordable city to live in.

We tend to look at investors instead of just renting from a landlord. So we form relationships with people who are willing to buy a house that will suit the people that we're going to be supporting. They have a say in which house is bought and then we end up with long-term leases with those people, which keeps our costs at a flat amount.

When we go to renew, sometimes we'll invest with fundraising dollars some upgrades to the home, and say, "We're going to paint the whole place or replace all the flooring for you if you'll sign us another tenure." So we've had very long-term successes in making these locations affordable by entering that relationship, instead of just a landlord who doesn't care if we leave tomorrow.

Mr. Mike Harris: Are you building any from-scratch homes at the moment?

Ms. Michelle Palmer: We haven't built a house in, gosh—

Mr. Mike Harris: When was the last time?

Ms. Michelle Palmer: —oh, my God, 10 years ago.

Mr. Mike Harris: Really?

Ms. Michelle Palmer: Yes.

Mr. Mike Harris: It's been that long. That's interesting. The way you're able to leverage some of the dollars, then, is to look at leasehold improvements in ways that you're improving the property etc. Is that a cost-offset piece for you?

Ms. Michelle Palmer: We also do have to sometimes offset the rent amount for people supported, though. Because even if you look at affordable housing in its definition today, for people who live on ODSP, it's not affordable. They can't pay $800 a month. They only get $1,300 a month, so we do have to offset the rent amounts for people or they would end up having to be homeless, quite frankly.

Mr. Mike Harris: Thank you.

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

Ms. Peggy Sattler: Thank you to all the presenters for coming here today to share your presentations.

I'm going to start with Michelle at Community Living London. As you know—I copied you on a letter—I had met with 18 families, all of whom have adult children with disabilities, and they shared some pretty heartbreaking stories about what they are dealing with on a daily basis in trying to provide the care that their adult children need. In particular, they talked about the lack of respite care. I had one family. Their son was 24 years old. They had not had any respite for seven years, those family members who were taking care of that young adult.

They also talked about the so-called wait-list for residential housing, which isn't a wait-list, it just prioritizes people on the basis of an emergency and urgent crisis that then gets them into housing, and how desperate it makes these families feel, as they themselves are aging and looking to have some kind of safe future for their children.

Your submission notes that in 2020, the Auditor General said that there were 34,000 people in the province waiting for developmental supports and services funded by MCCSS. In 2022, the auditor did a follow-up study which showed that that number increased to 39,000 people with developmental disabilities in the province waiting for services. You've asked for #5ToSurvive—a 5% increase to survive. Will that make a dent at all in this waiting list of 39,000 people in Ontario who are in desperate need of access to developmental services?

Ms. Michelle Palmer: No. Quite frankly, Peggy, no. Right now, the 5% to stay alive is basically for us to keep doing what we're currently doing. On top of that, there needs to be a plan to address the waiting list.

You speak specifically to respite. In London, there are 501 people waiting for respite services. That's just in London. In Elgin, there are 54; across the province, 20,000—just for respite. Again, these numbers are cumulative, so somebody might ask for respite but they might also ask for independent living supports or 24-hour supports, so they're not all unique individuals. But just to give a view, 20,000 people are waiting for respite in the province right now. So, no; the 5% is going to keep us able to continue supporting the 1,000 people we currently support.

Ms. Peggy Sattler: Thank you very much. Another part of your presentation that I think is really important—and you didn't get a chance to touch on it, but it's a page called, "The Case for Investing in Developmental Services." It talks about a modest upstream investment, how it is going to save the province significantly in downstream costs. I wondered if you could speak more about what happens when we don't provide those supports that people with disabilities need in this province.

Ms. Michelle Palmer: Right. I'll try to simplify it, because it's a really complex answer. For example, if there was a bigger investment in out-of-home respite supports, you're giving families a much better chance of being able to stay together. You're getting it so that families don't

have breakdowns; you don't end up with parents having health crises as a result of caring for their adult child for 50 years. Putting that investment in upfront, giving the families a regular routine break in the caregiving world, because it's exhausting, and you're more likely to see a reduction in requests for people then requiring 24-hour supports, which is far more costly. What happens is, these families continue doing this day after day after day, and they get exhausted, they get sick. Now they're the ones looking for emergency placement in a 24-hour support investment. We could have kept them at home.

Ms. Peggy Sattler: Yes, and I just want to emphasize for the government members over there: The 5% increase that you're asking for is just to maintain the current level of services.

Ms. Michelle Palmer: Correct.

Ms. Peggy Sattler: It's not even going to deal with this wait-list of 39,000 people in the province who need developmental services.

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Ms. Michelle Palmer: And, Peggy, if I can just add: Really, the only way we get vacancies is when somebody passes away. So you certainly don't sit here waiting for vacancies, right?

Ms. Peggy Sattler: Yes. Okay, thank you very much. How much time do I have?

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

Ms. Peggy Sattler: I want to go the Co-operative Housing Federation of Canada. I like your target, your goal of 250,000 new non-market units in the province. As the official opposition, we have proposed a public builder to jump-start the construction of those 250,000 non-market units that would obviously include co-op housing, supportive housing.

I wonder if you could speak to some of the concerns when you leave it up to the private sector to look at building non-market housing. Have we had any success with that in the province? And why is an increased government involvement in building non-market housing so important?

Ms. Amina Dibe: I'll start, and then, Mary Ann, if you want to jump in, feel free. Since I've been alive, at least, we've always partnered with private market developers to get co-op homes built. Co-op housing providers are not developers. they are people who live in the co-ops, and they just want to build more housing. So it's certainly not them who are doing the building.

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

Ms. Amina Dibe: I think that a lot of our members really live by the seven co-operative principles, one being autonomy and independence, so they do want to have control—not full control, but they do want to have a say in who is building their new homes. We are willing to partner with anyone—private developers or government—who is willing to come to the table and help us fulfill our goals of building more co-op housing.

Ms. Mary Ann Hannant: I'll just briefly add that we have partnered with private developers, but when we were doing this successfully in the past, in the 1970s, 1980s and early 1990s, it was with significant government funding along with it. Private developers are not willing to put enough money into seeing the housing gets built on its own.

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

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

Mr. Adil Shamji: I wonder if I could begin my first question to Michelle at Community Living London. If you could elaborate on any barriers that you are seeing in implementing and accessing more supportive housing in Ontario.

Ms. Michelle Palmer: Cost, quite frankly.

Mr. Adil Shamji: In terms of—

Ms. Michelle Palmer: Well, physical space, for one, but in order to expand our services—our services are driven by staff supports, so you'll have to have the funding and in order to expand what we're doing, we need more staff. Truly, we have the capacity of growing. We have the capacity of doing more, but we don't have the money. In a very simplified way, it's a funding issue.

Mr. Adil Shamji: And compared to the amount of need that exists in your community, how acute would you say your shortage in funding is?

Ms. Michelle Palmer: I don't even know how I would map out the numbers. In London alone, there are so many people waiting for services. We support 1,000 people in a range of services. There are thousands of people waiting for services. If I support 1,000 today and there are 1,000 still waiting, you're basically talking about doubling my funding. It's a huge issue.

I think the critical piece is that this is an issue that's been going on for years—as I said, 30 years of asks here. I've been with the organization that long, so I know it's real. We can track back to the same discussions over and over again. It's hit a crisis now where we've got tons of people without services, we've got agencies who can't keep their doors open, we're having services closed, so our 1,000 people could end up being only 800 people that we're serving because we can't keep doing it for everyone.

Mr. Adil Shamji: And I'm sure that those thousands of people who can't get access to that still call your offices every day and describe the, perhaps, desperate situations that they're in. What kind of stories are you hearing?

Ms. Michelle Palmer: We're hearing families having no choice but to drop their child off at emerg and refuse to pick them up—and they don't belong in emerg. They don't belong in a hospital. They're not sick; there's no treatment available for them. And it's not because families are neglectful. They can't do it anymore. It's dire. It truly is. And I always feel like I'm making a big deal out of something, and if people don't understand it, they think I'm being dramatic, but I'm not being dramatic. This is real.

Mr. Adil Shamji: So what you're telling me is that if adequately funded, you could provide timely care and more appropriate care and ease the pressure on our emergency departments?

Ms. Michelle Palmer: Absolutely. Not just emergency departments: In-house admissions to hospital, because

they don't just sit in emerg, they end up admitted because where else are they going to go? These are people that can't be put on the street. They can't go to a homeless shelter. They require 24-hour support.

Mr. Adil Shamji: Thank you for sharing that and for the amazing work that you're doing.

Amina, I was wondering if I could turn to you and just speak a little bit more about—

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

Mr. Adil Shamji: Could you share very quickly about some of the regulatory or legislative changes that you might like to see in order to help us promote more co-operative housing?

Ms. Amina Dibe: For sure, yes. Like I mentioned before, there are a couple outstanding recommendations from the Housing Affordability Task Force report that would significantly help all types of housing get built, but certainly non-market and co-op housing—again, modernizing the Ontario building code to remove barriers, allowing single-stair egresses in some of the more low-rise apartments would be significantly helpful, further eliminating or reducing tax disincentives—

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

That does conclude the time for these presenters and this panel, so we want to thank everyone who had spent all the time preparing your presentations and making the presentations today. I'm sure it will be of great assistance to us as we move forward.

LONDON HEALTH COALITION
CANADIAN PROPANE ASSOCIATION
THAMES VALLEY FAMILY HEALTH TEAM

The Chair (Mr. Ernie Hardeman): Our next panel is the London Health Coalition, the Canadian Propane Association and the Thames Valley Family Health Team. If you will come forward.

As with the previous ones, each delegation will have seven minutes to make a presentation. At six minutes, I will say, "One minute"—most of the time. Keep going; you will have until you get to the seven minutes, and then I will say, "Thank you very much," and we'll get on to the next presenter.

We do ask each one that speaks to make sure that you introduce yourself to make sure that we have the name for the great comments you're going to make to the right people.

With that, the first presenter will be the London Health Coalition.

Mr. Peter Bergmanis: Thank you, Mr. Chair, and to the members of the committee. My name is Peter Bergmanis. I'm the long-serving co-chair of the London Health Coalition, a public health care advocacy group tied with the Ontario Health Coalition.

After four decades of public hospital downsizing and restructuring, urgent action must be taken to resolve the clear and present crisis in health care. Twenty years of unrelenting austerity measures have taken their toll and have weakened Ontario's capacity to respond to public health predicaments. This province's descent to the bottom of the country on key capacity indicators in hospitals has been well documented. We're certainly the last in hospital funding; we have the fewest beds per capita in the country, as well as in OECD partners; and we have the fewest nurses per patient in the country. This is a true health care crisis.

With two teaching hospitals, London is a regional medical hub. However, it must be understood that over the past two and a half decades of London hospital restructuring that was very expensive at $1 billion in cost, the city has lost incalculable health care assets.

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Londoners have witnessed the closure of the London Psychiatric Hospital and the loss of a vital emergency department and intensive care unit at St. Joseph's Hospital. Losing the ICU and CCU effectively downgraded St. Joseph's Grosvenor campus from serving the community with the most medical beds in the city to that of an ambulatory care centre. The enormous South Street campus at Victoria Hospital has vanished.

Since 2012, London Health Sciences Centre and St. Joseph's Health Care London combined have been forced to make accumulative cuts of over $2 million, entailing the loss of hundreds of health care positions. Both facilities are suffering the consequences of deliberate systematic public hospital defunding. Under a seemingly endless restructuring regime, LHSC has shed a beloved cardiac care institute and a valued reproductive health clinic. Both are now in private hands. A vital home dialysis program is also under threat of contracting out. Such an enormous shift of health care dollars out of the public hospital system has had unfathomable consequences for hospital stability and ability to provide access to quality patient care.

Since the 1990s, over 18,500 public hospital beds have been ordered closed province-wide. Some 2,000 acute care beds have disappeared from service in the city of London and region alone. Approximately 80% of Middlesex-Elgin psychiatric beds have been permanently shuttered. Although housing approximately 1,000 to 1,200 beds, the LHSC chronically registers over 100% patient capacity. London's two remaining emergency departments are routinely filled, bursting with patients waiting an unacceptably long time to be seen and treated.

The city's urgent care centres are too woefully resourced and offer limited hours of operation. UCCs are no substitute and are not able to relieve the pressure on the strained hospital ERs. With over 1,200 ER department closures province-wide last year, many in nearby communities like St. Marys, the situation is not likely to improve without massive government intervention.

It is common practice at all London hospital sites to institute multiple annual OR closures or slowdown periods to conserve fiscal resources. Staffing shortages resulting in delayed elective surgeries have become normalized. St. Joseph's Health Care dealing with unfunded OR time is

forced to idle ORs regularly and begins winding down surgeries by 4 p.m. on weekdays.

Enterprising surgeons, however, seizing upon the diminished opportunity for public hospital OR time, moonlight in private, for-profit clinics, like the Advanced Medical Group, catering to those who can afford to pay to jump the queue while exacerbating the lengthening public wait time list. It's inexcusable that a public OR suite languishes while the province can finance for-profit health care. How can the private Don Mills Surgical Unit be publicly funded at an exorbitant profit premium, receive an over 270% increase in taxpayer dollars while public hospitals are closing existing ORs?

In the face of an existential crisis, citizens expect that their government spare no expense to preserve public health care. The Financial Accountability Office of Ontario, in its fourth-quarter analysis of Expenditure Monitor 2023-24, revealed that the Ontario government increased health spending by 2.3%. Unfortunately, with inflation running at 5% to 6%, the result is real dollar budget cuts.

London Health Sciences Centre is reportedly facing a $76-million operating deficit, and neither LHSC nor St. Joe's can afford to increase surgical capacity. Moreover, the FAO lays bare the rather mystifying spending priorities of the government. In the throes of the worst public health care crisis in a century, the Ford government is reducing monies for public health measures and public health agencies by $107 million.

The Middlesex-London Health Unit has been squeezed by this funding shortfall. Faced with the loss of $2.6 million to $2.8 million in operating funds, the public health unit has been forced to shed 17 staff, the majority of them 13 public health care nurses.

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

Mr. Peter Bergmanis: This is completely unacceptable. And then they're increasing, of course, their contingency fund by $2.5 billion. How is that not necessary money for maintaining our public hospitals?

We recommend the government must end its ideological war against public services and stop for-profitization of health care. It must end the needless wage suppression and pay up what is owed to its health care workers, the heroes, and also stop supporting for-profit agency nursing, because this is draining and siphoning key resources away from our public hospitals, as well as our other public partners in the community.

The long trend of downsizing and rationing Ontario's vital public health care services must end, and capacity expanded. We can't afford it—

The Chair (Mr. Ernie Hardeman): That concludes the time. Maybe we'll put the rest in in the questioning.

We'll now go to the propane association.

Mr. Jason Cooper: Thank you for the time today, everyone. My name is Jason Cooper. I'm a board member of the Canadian Propane Association, and also the director of business development for McDougall Energy, which the local London representatives will know as Dowler-Karn; it's part of that group, as well.

People who live in rural communities and off the natural gas grid know how important propane energy is for heating homes and their barns, to dry their crops and many other applications. Over the past few weeks, the importance of propane energy has been in the news. Because of that, Ontarians and Canadians who live in urban areas and have access to natural gas have begun to realize just how important propane is for those who live in those rural communities. The media coverage provides a good reminder about where and why we need affordable, low-emission propane as an important energy choice in rural Ontario.

C-234 provides exemptions for propane for agricultural applications such as barn heating, grain drying and greenhouses. While the bill was sent back to the House for review following Senate amendments, we continue to support the farming community in their efforts to have those amendments defeated and the bill passed in its original form. On the other hand, there will be a three-year pause in the federal carbon tax for carbon-intensive heating oil, but no similar relief will be made available for low-emission propane. The Premier and his ministers have been very vocal in pressuring Ottawa to include propane in any carbon tax relief plan that will make life more affordable for rural communities.

With respect to natural gas, propane can provide a fuel when there is a shortage of natural gas. One of our members reports, "We have seen a big increase in the demand for propane to back up or supplement natural gas infrastructure in Ontario. We are currently working on large installations for greenhouses and smaller agricultural installations like corn dryers, all with the same issues." These customers were not propane customers previously, but are now installing dual-fuel units because natural gas suppliers cannot meet the needs of their business. Frankly speaking, there isn't enough gas.

Minister Smith has noted an impact of continuing the federal carbon tax on propane, as well as natural gas. He said, "That means more money out of their pockets, Mr. Speaker, at a time when affordability is tough for people across Ontario." Affordable and low-emission energy should be a choice for Ontarians, whether they live in downtown Toronto or in Huron county, or other counties around our province that don't have access to natural gas.

We have filed our budget submission, which focuses on three main recommendations. The first: Work with Ontario's propane industry to establish a rural propane retrofit program that will incentivize Ontarians who currently use expensive and carbon-intensive heating oil to switch to the low-emission alternative of propane. Heat pumps are very popular, promoted heavily by governments and are featured prominently in low-carbon programs. However, they need backup energy in cold weather. Propane is the best energy source to support heat pumps for rural Ontarians.

Secondly, we also recommend that the 4.3-cent transportation tax on propane be removed. Propane is growing as a low-emission, affordable transportation fuel. It should not be subject to an extra tax at a time when the province

is reducing taxes on gasoline and diesel in order to provide relief from the high cost of transportation. Propane deserves equal treatment as gas and diesel.

Our third ask, the last recommendation, is that the government invest in research and development in biofuels. The CPA believes it's important for Canada to reach its net-zero targets by 2050, and an important part of this is making low-emission propane even cleaner through the development of bio and renewable propane. Thank you for the time.

The Chair (Mr. Ernie Hardeman): We now have the Thames Valley Family Health Team.

Mr. Mike McMahon: Thank you, Mr. Chair and members of the committee. I'm glad to be here. My name is Mike McMahon, serving as executive director of the Thames Valley Family Health Team. I don't serve patients directly. One of the only ways I can help our patients is by advocating for our teams who are able to provide those professional services across London and Middlesex county.

Today, we are one of five primary care organizations who serve London and Middlesex, and we serve 30% of the population with team-based primary care. Our 158 interdisciplinary professionals are working across London and Middlesex with 27 different primary care practices and in collaboration with 157 physicians and nurse practitioners.

My colleagues and I want to thank you for the investments that you've made in team-based primary care over the last 20 years. Having a trusted primary care health team that is familiar with you and your family throughout your lifespan in absolutely priceless, as I'm sure we would agree—at least those of us that enjoy that—and results in better outcomes and patient experiences. We know that millions of people in Ontario do not have the same experience and that translates very comparably here in London and Middlesex.

For example, here in Middlesex and London, 65,000 people do not have access to a primary care provider that they would call their own or that they are attached to—something that we say; 70%, or approximately 420,000 people in Middlesex and London, do not have access to team-based primary care or have tier-2 primary care access. Some 30% of people in Middlesex and London are rural residents, which means transportation and access to technology are among the barriers to receiving timely team-based primary care.

Ontarians get 70% of their health care services from the primary care sector, yet this sector is currently receiving just 5% of the provincial health care budget. I would like to contrast this with the most effective national health systems in the world, which invest upwards of 11% to 13% in their foundational primary care services.

I'm here to request that in this year's provincial budget, the Ontario government invest in primary care team wages so that we can sustain the teams that have been built over 15 years and that we do not lose staff that erode confidence that our community members have in their primary care services.

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Despite the rising cost of living and competitive job market, primary health care teams and community service providers had a 0% to 1.53% wage increase in 2023. For many, that's a 0% to 1.5% wage increase since 2018. This is in sharp contrast to the recent 11% increase for some hospital professionals and the 8% increase provided to emergency medical services. Our ability to serve patients by attracting and retaining skilled health care professionals is at stake. Our ability to expand team-based primary care to the 70% of Ontarians who do not have access is also at risk.

Our teams include nurses, nurse practitioners, registered dietitians, respiratory therapists, community support, outreach services, occupational therapists, psychiatrists, psychologists, mental health nurses and counsellors and pharmacists, all working with primary care physicians to serve the community. We're a team.

These professionals are an extension of the primary care physician or nurse practitioner and provide comprehensive care. The impact of this interdisciplinary work is, of course, extraordinary.

We changed the name, but let's take Janice, who suddenly became short of breath with any activity. Instead of calling 911, she contacted her nurse practitioner and was seen immediately. The respiratory therapist, who is part of the team, performed a spirometry test which showed that Janice had extensive lung damage and was diagnosed with chronic obstructive pulmonary disease or COPD. Janice was started on medication that same morning because of the access to team-based care, and was also offered the family health team's smoking cessation and COPD education programs. Within days, Janice was able to return to 70% to 80% of her normal activity, and Janice believes that intervention by the province's health care services and the family health teams saved her from hospitalization.

People who have had a continuous relationship with their primary care provider for years have a 30% reduction in hospital admissions. Investments in team-based primary health care bend the cost curve away from hospitals. As people wait for specialized services, our teams are often their first and ongoing point of contact. People count on these relationships from birth to death and through multiple generations.

Our ask: Team-based primary care providers and our colleagues across Middlesex and London are appealing for a look at compensation and a look at fairness in how we compensate our community primary care teams. The community and primary care sector is more than $2 billion behind on wages compared to peers doing similar work in hospitals and other sectors.

To honour our sector's compensation rates with industry standards, calculations have shown that Ontario needs to invest $500 million annually over the next five years. To keep up with inflation, suggestions are for an annual increment of 2.9% per year. Without a wage increase, we are struggling to recruit and retain the skilled professionals that people consider to be part of their care team, the care

team that will move them from higher risk in our health system to what they would enjoy, which is more time at home and enjoying a normal life.

Especially when combined with a shortage of family physicians, large numbers of family doctors who are reaching retirement age and growing community needs, team-based primary care can work with these priority populations. This investment will help us and help the system as we plan for expanding team-based care to the 70% of Ontarians who do not have access to primary care teams currently.

Our request illustrates that we can continue to help patients like Janice, as I mentioned earlier; ensure that our teams are equitably compensated; and recruit and retain skilled professionals. Team-based primary health care is a solution. It is a foundational solution to our Ontario crisis in health care.

On behalf of my local colleagues and primary care organizations in London and across Middlesex, we really appreciate the chance to come and present to the committee today.

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

We will start the questions. We'll start the first round with the opposition. MPP Kernaghan.

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

I'd like to begin with the London Health Coalition, with Mr. Bergmanis. Peter, this committee has heard from Dr. Andrew Park from the Ontario Medical Association. They've been talking about the crisis in primary care and how it holds the system together, and are advocating as well for greater home care. And yet, we've seen this government spending more and more dollars on privatization, rather than that publicly funded and publicly delivered care.

Ontario just issued waivers allowing Ontario's 140 hospitals to carry debt. This means that hospitals are able to take out now high-interest loans to address the funding gaps that have been largely ignored by this government.

Do you think that a cap on agency nurses would alleviate this cost pressure on hospitals? And do you think that health care is spending too much on allowing agency nurses to practise?

Mr. Peter Bergmanis: Thank you for the question, Mr. Kernaghan. I was also interested in what the Thames Valley Family Health Team was presenting here, because it's all related here.

As we know, the unconstitutional Bill 124 wage caps that suppressed health care wages in our institutional settings, like the big hospitals, are highly corrosive to what has been going on. Why so selective, as well? Because we do know that for-profit, private agency nursing has no such thing. There is no cap there. They are draining public dollars and resources away from our public health care system. The staffing that is required on a daily basis in, say, one of our stressed ERs—if they have to rely on that kind of money to supplement what is basically what should have been there all along, no wonder we're seeing these closures in smaller communities like, tragically, Minden, the most obvious.

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This is the kind of financial mismanagement that can't continue on. We have to ban the outright use of these agencies. They were never intended to be the bulwark that supports a public health care system. They're not useful to that purpose.

So, yes, if we eliminate the for-profit-driven private agency out of it or at least suppress them the same way they have been suppressing the public full-time workers, then maybe we'd have a beginning here. But, truthfully, we are wasting a lot of money going into premium payments to for-profit private agencies. Whether they be a clinic providing cataract surgery or whether they're an agency supporting staffing, that's all needless. Why are we going to these middlemen? We should be directly funding the public hospital system.

Mr. Terence Kernaghan: Understood. There's been a concentration with the government recently about these ambulatory clinics or these scaled-down ORs. Unfortunately, there is no control about whether these are private or for-profit or connected to the hospital system. I'm sure you know, here in London, we have the Nazem Kadri Surgical Centre, which is a scaled-down OR which has fewer staff, only the necessary tools, so it operates very efficiently, but it is publicly funded and publicly delivered. There aren't taxpayer dollars going into these private, for-profit pockets. It's also connected to the hospital. Would you say that these operating rooms and these clinics like the Nazem Kadri Surgical Centre are the ones the province should be emulating rather than taking taxpayer dollars and giving it to a few people in terms of profit?

Mr. Peter Bergmanis: Absolutely. I come out of St. Joseph's Health Care, hence why I was using that in my report. I worked in the OR for 30 years there. We are to the point where we literally don't have the staffing levels because we aren't able to fund the staffing that we need to be able to conduct surgeries that—we could reduce our wait time list for surgeries through the province just by adding even a simple couple of hours a day. We have idle ORs.

I referred to the moonlighting surgeons. Well, I happen to know some of them that came out of St. Joe's OR because they can't get funded OR time. So what are they doing? They're going to the advanced medical group—some of them are invested in it, in fact—and they actually are sending patients that they could have seen in the hospital but can't get OR time there and sending them to their own personal private clinic. And now they can also charge extra for upgrades to whatever the surgeries are, their outpatient work. ENT is very prominent in this.

All I can say is, why are we doing this? The ORs at St. Joe's are top-notch, world-class, yet every day, there's going to be an idle one because we can't fund it to run. And yet down the street, two blocks away, the advanced medical group—same surgeon—can make room for them to come in. Of course, there will be a little premium for them to have to do it there. What a waste of money and a

waste of the time of skilled surgical techniques that could have been done in an OR in the public realm which we have right now without building another tier of medicine whatsoever.

Mr. Terence Kernaghan: It seems rather fiscally irresponsible that the province has the existing infrastructure yet is actually using public money to recreate that infrastructure—

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

Mr. Terence Kernaghan: —just in order to enable a few people to profit off of people's health care using tax dollars to do so. That's concerning.

I'd like to move over to Mr. McMahon from the Thames Valley Family Health Team. Mike, I just want to thank you for your comments. Primary care does represent about 80% of health care, and Dr. Andrew Park has told this committee that it is the foundation of health care, and without access to it, it's a deep concern.

In your presentation, you talk about how team-based care considers the whole person. Does the Thames Valley Family Health Team—have you had to turn away patients who have tried to access care, and what kind of impact does that have on your organization?

Mr. Mike McMahon: We're not turning away patients, but what we're doing is we're looking ahead to say, if we can't fill positions, there is a point in time in the near future where service reductions will come from the lack of somebody to provide the service, or the lack of a qualified person to provide the service.

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

We'll go to the independents. MPP Hazell.

MPP Andrea Hazell: Thank you for coming in and presenting a very well-defined and robust presentation. I'm going to take my time with the London Health Coalition.

Peter, we hear your pain. We hear your suffering. It's all across Ontario. All the health organizations and agencies that are in, that are presenting, are really going through budget pressures. Really, how long are we going to be opening our doors to serve our Ontarians where health is concerned?

I want to draw your attention to your document because I really went through it. It's painful to read it. You mention Ontario ranks last in hospital funding; Ontario has the fewest beds per person of any province in the country. We're the economic engine of Canada. How is it possible that all of this is happening?

A humanitarian crisis exists in the Ontario public health care system, and I'm so sorry for the closure of your London Psychiatric Hospital and the loss of your vital emergency department and intensive care. Of course, all of that is impacting the services that you can provide. You even went on to say, "Approximately 80% of Middlesex-Elgin's psychiatric beds have been permanently shuttered." That's unbelievable.

And then I have CityPulse 24 on my phone and I just saw what popped up there. I thought I might mention it: The Ontario government will be allowing even more private clinics to perform surgical and diagnostic procedures in an effort to reduce wait times. So now we know where that funding is going.

Can you take some time and elaborate on one of your bullet points, which is the first one, and then talk about your budget pressures for 2024? You were recommending that the "Ontario government must end its ideological war against public services and stop the for-profit privatization of health care," and you just heard what came on my phone on CityPulse 24. I don't when it was announced and I don't know by who, but that's just what came.

Mr. Peter Bergmanis: Thank you, MPP Hazell. I appreciate the question

I might as well just redo my whole presentation because it's pretty well—those figures that first came out with the fewest beds in Canada, that's the Canadian Institute for Health Information. It's been well-known for a number of years and documented. This predates the pandemic. It's been a systematic defunding, literally my entire working career in health care—and that's 40 years—that I've witnessed a lot of this. That's why you see this chronological order of facilities that have closed, and that's over a 20-year period.

The restructuring commission back in the 1990s into the early 2000s, instituted by the Harris government, was responsible for a lot of those 18,500 beds—

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

Mr. Peter Bergmanis: —closing province-wide. And just to catalogue, in London alone we've had a generational shift in what our facilities are now. We literally have less now than we had a generation ago, and yet we have double the population and one of the fastest-growing populations in the province here in London, Ontario. We're overwhelmed. You probably see the homeless people out there, the addictions all on the streets right now. That barely existed a generation ago. We had psychiatric beds aplenty in St. Thomas and London—roughly about 1,500 beds at their height. Now we have a small amount. We have a crash unit—

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

MPP Harris.

Mr. Mike Harris: A lot of health care talk today, which is great. I want to talk a little bit about rural health care, so I thought maybe I'd start with you, Mike—a good name by the way. I'm not sure if you were here during the tail end of the previous presentation. We were talking to Community Living and trying to put a little bit of a rural lens on it. So I was wondering, from a health team perspective, if you were able to talk a little bit about rural health care, here in I guess it would be Elgin and Middlesex county more than it would be London proper, and how you're liaising with different community care clinics, and maybe touch a little bit on how large the actual coverage area is.

Mr. Mike McMahon: It's a great question. Thames Valley Family Health Team—and there's other family health centres in our region and community health centres—it's imperative that we work together, especially in the rural areas to collaborate to serve rural communities. The

challenge with rural communities is that if we happen, in north Middlesex, to locate ourselves in Parkhill, we could be 30 miles from somebody's home, and there's no team-based care, just by the luck of the draw, in their community. They have physicians, perhaps, but not a primary care team.

When we look at expansion of access to primary care teams, we're working with partners to talk about—regardless of the sign on the door. A sign on the door is not important to people in community. What they want to get is team-based primary care at the time that they need it for the health risk that they're encountering. In rural communities especially, how can we make ourselves present in the places where people go to for the services that they already receive with existing infrastructure? So buildings that are already funded and exist, services that may not have collaborated for years together but could collaborate and at least share a space to make, perhaps, a preventative care clinic.

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Coming out of the pandemic, preventative care and primary care—we're working on catching up right now. But if we can bring it closer to the places where people work, eat and sleep, we're going to do better. That's the care people expect anyway, because it is a tough thought for people in rural communities.

I live in Woodstock. It's mostly rural. I work with an organization that serves both rural and urban. There is a call for services to be made available closer to home. The only way we can do it is if we work together, the five organizations who I am talking on behalf of for London-Middlesex. We have to combine forces. But even together right now, all of us together only serve 30% of people in London-Middlesex with team-based primary care. That rollout stopped around 2014. So the health minister and the Ministry of Health folks are on the verge of expanding access to team-based care. It's on its way. And then we need to let that snowball roll down the hill.

Mr. Mike Harris: So 2014—obviously, that's a little while ago now. How can we help you, not just from, let's say, a dollars perspective, but whether it's regulatory stuff, red tape, just getting out of the way. How can we help you achieve those goals faster?

Mr. Mike McMahon: Ensuring that we reduce the unnecessary red tape that is present in multiple statutes around sharing information. Patients plead with us on the phone or through email that they wouldn't have to retell their story many times at many different providers. This causes an enormous amount of work also in primary care organizations because you have to retake all the information each time you meet somebody. That's an example of a place that has been, with good intention—

Mr. Mike Harris: Sorry, I don't want to cut you off, but we have limited time. How,, from an administrative burden, does having to retell that story and have it documented at, let's say, four or five different levels—how much of an administrative burden does that actually put on front-line staff?

Mr. Mike McMahon: There's no way to really—

Mr. Mike Harris: It's tough to quantify, I guess.

Mr. Mike McMahon: It's literally happening right now to one of out team members, as you and I are speaking. And then not to mention that a physician affiliate or partner or physician who doesn't even get to have access to a team would never even know that there's something like a history available or that this work has already been done by somebody, and then a small office physician and their reception and nurse have to do that all by themselves as well. We can solve that problem. We can work together to solve that problem, and family health teams—

Mr. Mike Harris: Sorry, how much time is left here?

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

Mr. Mike Harris: Just quickly, from a regulatory standpoint, then, what is standing in the way? Is it regulation? Is it legislation on that sharing of information? Is it more around privacy concerns? How does that work?

Mr. Mike McMahon: I think that information-sharing between organizations so that patients can have one source of their health record ought to be the standard. The different interpretations of privacy is part of the problem, but the separation of organizational data, with no way to pull that together, would take a massive effort. And it would be at ministry level to tell providers like me—I'm accountable; I serve at the pleasure of all of you, let's say, and the Ministry of Health—to say, "We are creating a medical record that is a single source for people that are having high-risk health care issues in the province of Ontario. End of story: We're moving in that direction and that's the way we go." And then everything would come along with it. But the more times we let another medical record pop up and start populating itself, the problem gets worse.

Mr. Mike Harris: Interesting.

We've seen previous governments get into a little bit of trouble with electronic health records. How do you think doing that now, looking back and learning some of those lessons, we can move forward to have that single piece of information that can then travel around with that patient?

Mr. Mike McMahon: I think that we're 20 years on from the eHealth crisis that happened a generation ago.

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

Mr. Mike McMahon: I toured Rhode Island health system. The Rhode Island health system is about a million people; the state and the health care insurers dropped a health information exchange on top of all the 71 EMRs that existed in the whole state, and that exchange pulls all the information out of everybody's EMRs.

Mr. Mike Harris: So, 71 different—

Mr. Mike McMahon: EMRs.

Mr. Mike Harris: —in Rhode Island?

Mr. Mike McMahon: In Rhode Island.

Mr. Mike Harris: Oh, wow.

Mr. Mike McMahon: And so, because I had the opportunity to experience it, I can offer you that example to say that somebody decided they were going to do that. And then, you can treat people with a customer service approach that you would expect because they know that you were just in the hospital and we can take the next steps

in terms of helping people to make the decisions with their health care.

Mr. Mike Harris: Okay, so, quickly, Chair, just to sum it up—

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

Mr. Mike Harris: That's it? All right.

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

Ms. Peggy Sattler: Thank you to all the presenters today. I'm going to continue with Mr. McMahon from the Thames Valley Family Health Team.

The information that you provided on salaries was really eye-opening—the fact that all of the health care professionals who work within a team-based care model have received a -1.53% salary increase.

You've talked about the benefits and the need to expand primary care, but as a result of that salary cut that is being experienced, are you seeing people leaving the system, which will have an impact on our ability just to maintain the current levels of team-based care that we're providing?

Mr. Mike McMahon: I think that I should correct for the record: That was a 0% to 1.53% increase.

Ms. Peggy Sattler: Oh, okay.

Mr. Mike McMahon: Because some of our colleague organizations have had to settle collective agreements and did have to offer a 1.5% increase. Even though we talked at a high level today about the 11% increase that hospital professional staff received when Bill 124 was declared to be unconstitutional, the differential rates of payment between hospital sector and community have existed for some time.

And so, for a mental health professional—I phoned a mental health professional at home after she decided to change employers and went to work at a hospital employer. It's very similar work, ambulatory care; people come and see the mental health professional, and it was about a one-day $32,000 increase in pay.

Ms. Peggy Sattler: Wow.

Mr. Mike McMahon: And that's the 11%. But when I say that much money, that's been growing for a long time, not just for the last six months. And so, people have to make that decision. As much as that person wanted to work in the community and continue to work in a family health team that enjoys really beneficial hours compared to hospital colleagues and staff, people are going to make the decision to leave and then we are out recruiting, and it's part of the administrative time that we spend away from the most important work.

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Ms. Peggy Sattler: Yesterday, the OMA was at this committee presenting, making their recommendations, and their submission projects that if the government does nothing, the number of Ontarians without a family physician is going to increase from 2.3 million to 4.4 million by 2026, which is staggering. Actually, they recommend expanding access to team-based care as one of their first recommendations.

But when you note that currently 30% of the population is served by teams, what is the target? What should we be aiming for in terms of access to team-based care in Ontario?

Mr. Mike McMahon: To say everybody should have access to team-based care is absolutely what I would want to put across to the committee, but making sure that within that access to team-based care, we look at, in a stratified way, whose risk level in terms of health is rising and that we can get to those folks before they reach a point where they need to be institutionalized or there's a high-cost intervention that's required for their health.

We want to keep people healthy at home, so team-based primary care that is being delivered through a population health lens—rather than being, like myself, fortunate to have a parent who was part of a clinic that became a team-based primary care clinic; I kind of inherited this amazing, tier-1 level primary care. My wife and five kids aren't with a primary care provider that has access to team-based care. But even for my wife and kids, if somebody had a rising health risk, team-based primary care should be able to pick that up, work with whoever the primary care provider is and look for an outcome that moves somebody back down the risk triangle and keeps them safe and healthy at home, rather than institutionalized—I don't know if that answers your question.

Ms. Peggy Sattler: I do want to turn to Peter Bergmanis from the London Health Coalition. Your first recommendation is calling on the government to stop the for-profit privatization of health care. You will certainly be aware of the experience in Alberta, and the research that was done there on the privatization of health care that showed that for-profit clinics don't decrease wait times, they actually increase wait times.

I wondered if you could talk a little bit more about why that is, why for-profit health care clinics are so dangerous to the provincial goal of reducing wait times.

Mr. Peter Bergmanis: It's important to frame this in terms of: Why do we have medicare in the first place, universal public health? It's because it was introduced six decades ago to eliminate the worst features of the for-profit medical system that we had here then. We had Canadians going bankrupt. We had Canadians losing everything due to exorbitant hospital bills because they had to pay out of pocket. It wasn't based out of need. We mirrored the Americans, who are suffering immensely to this very day.

To suggest that even thinking that private, for-profit—which requires a subsidy from the public to pay for that profit margin—is in any way going to help us is absolutely ludicrous. We've never seen it work anywhere, despite all the advancements that they like to project. Where does this work? It doesn't. It doesn't work in Alberta. It hasn't worked in any of the provinces that have made a second tier.

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

Mr. Peter Bergmanis: Ontario has the least amount of for-profit, believe it or not, in the system, and we are comparatively good at getting through our surgical wait

times. Why are we going to increase from a measly 3% portion of the health care budget, where there's a for-profit diagnostic system right now—why would we increase that and watch the strain, as we've seen in long-term care, which is now overwhelmed with for-profit motive, which we saw so many people die in? Why would we increase all the things that we escaped six decades ago and claim that's going to benefit anyone in our society, and waste the public dollar in the process of doing that?

So I don't think we're going to have any problem—

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

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

Mr. Adil Shamji: Thank you to you all of for your testimony this afternoon.

Mr. McMahon, I wanted to start with you and just ask a little bit about your family health team. Would you be able to clarify whether Bill 124 has impacted any of the services that you've been able to provide over the last few years?

Mr. Mike McMahon: Because of our funding for family teams, we can't run deficits. That's the law. It's really the law for everybody. However, in community, because we are smaller, the risk of having a financial crisis is much greater because of our size. We did not receive any new funding for salaries since 2018, and so our front-line service providers are being paid the same rates that they were paid when we implemented the last funding increase at the end of 2018, the start of 2019. So I would say that it didn't affect us directly, because there was no way for us to offer wage increases.

Mr. Adil Shamji: Even if Bill 124 didn't exist.

Mr. Mike McMahon: Even without it, but our staff team, through their professional associations, focused on Bill 124, but we weren't in a position to even offer 1% because it would have caused a financial crisis, because we receive funding, and then we pay it directly to the employees.

Mr. Adil Shamji: Understood. May I ask, what is the operating budget for your family health team?

Mr. Mike McMahon: Our operating budget is just shy of $14 million.

Mr. Adil Shamji: It's $14 million. That's a single family health team.

Mr. Mike McMahon: Yes.

Mr. Adil Shamji: The point that I'm hoping to impress upon everyone is that, if you talk to patients, family members, stakeholders, the Ontario Medical Association, primary care providers, whether they're family doctors or nurse practitioners, the one universal call that we hear is for more team-based primary care. And the point I want to make here is that we have a single family health team that has an operating budget of $14 million. If we want to have that ambition, to get primary care to everybody and even just a few more family health teams, we're going to need a bigger investment—a much bigger investment—than just $30 million, which is what was announced in the last budget. That $30 million will not allow the existing family health teams to be able to offer minuscule increases to their staff, for example. Thank you for that.

I wanted to turn to the London Health Coalition. Thank you for your remarks today. As you likely know, there was a press conference this morning announcing an expansion of diagnostic and surgical services out of hospitals, many of which will end up in private, for-profit clinics. We also know that yesterday there was a very significant report that announced our emergency department performance currently is the worst in our province's history. When the Minister of Health was questioned about that earlier today and was asked for her opinion on the crisis, her answer was specifically that the crisis in Ontario's emergency rooms is not a money or investment conversation or challenge. Do you agree with that statement? Do you have any reflections on that?

Mr. Peter Bergmanis: Reflections, yes: I worked in an ER for about 10 years earlier in my career, and a long wait in an ER back in the 1980s—

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

Mr. Peter Bergmanis: —was about two hours. Now it is completely routine to see in our ERs here that you could be there for eight hours. And this is London; this is not even an under-equipped, small ER somewhere out in a rural setting. It could be eight hours. If you're a psychiatric patient, you could be waiting for 20 hours—more—for admission, even, and then you're waiting in the hallway if you are admitted, for days on end, possibly. We had, back in the 1980s, almost unheard of ER closures in the entire province. I know we're not alone in the country, but 1,200 ER closures—

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

We'll now go to MPP Dowie.

Mr. Andrew Dowie: I'm going to let MPP Harris begin for just a moment.

Mr. Mike Harris: Just for the record, we have three people with five kids sitting around this table right now: myself, you and Mr. Bouma. You don't see that very often, so I thought that I'd get that onto the record for finance committee today. Over to MPP Dowie.

Mr. Andrew Dowie: Actually, my question—probably my only question because it's going to be lengthy—is for the Ontario Health Coalition. My local hospital CEO, David Musyj, appeared at this committee, and I want to just read from the transcript of what he told this committee, because from what I was hearing, what he's saying is not quite consistent with how you've described how the system works. So let's take his transcript—I'm hoping you can respond to it, if you don't mind.

I'll start: "A lot of attention has been made on the issue of creating community surgical centres. I appreciate some are skeptical. However, you don't have to look far to see one working and a massive success. Since 2020, we have the Windsor Surgical Centre in coordination and collaboration with Windsor Regional Hospital—in place to now handle some 6,000 eye surgeries a year. If it was not for creating the 2020 surgical centre, the wait-list would be close to 20,000 people. The only thing that

changed for a patient is the location of the surgery. Oh, you know what? I take that back. Actually, they don't which a charge parking. We do. It's the same physicians in the hospital; OHIP still works.

"This concept of upselling has been raised by those that unfortunately do not want to stick their neck out and would be the first to complain if the wait-list was 20,000 people. Can a patient pick a non-OHIP covered lens if they want to? Yes. I've been in health care for over 20 years. That's been around for over 20 years. Nothing's changed. Each political party could have made that change themselves. They had the opportunity. They decided not to. If you want a 100% covered lens, you get it.

"Another issue is this issue about having surgeries later in the day at hospitals' ORs. Sure, our ORs do reduce later in the evening, but for good reason. There's been many a study that indicates later-in-the-day surgery results in increased morbidity and mortality for patients. In talking to surgeons like Dr. Tayfour, he works all day, and asking him to operate at night is not good, let alone the age of a patient getting things like a cataract surgery to be done at 10 p.m. at night. Is that patient-focused?

"I can tell you we run our MRIs and CTs late into the evening. Our no-show rate is much higher than during the day. Is that a wise investment? Those that complain about community surgical centres—do they want us to start charging patients who fail to show up at night? I didn't think so.

1450

"So I can inform you that whenever Windsor Regional Hospital has asked for help in the last three years of this government, they've answered the call. This includes extra funding for hiring close to 500 more front-line clinical staff than we had pre-COVID, approximately 60 more medicine-surgical beds than we had pre-COVID. We got funding for lost revenue, funding to recruit more staff in the form of signing bonuses and the like. Nothing has gone unanswered."

So that was David Musyj, CEO of Windsor Regional Hospital, appearing in front of this committee. I'm hoping you can shed some light on how you see that to not be accurate based on your earlier comments.

Mr. Peter Bergmanis: Thank you, Andrew, for that information around CEO Musyj. I'm familiar with him as well and I'm very pleased to hear he's one of those CEOs who managed to get something out of the government, because the CEO at St. Joseph's Health Care, who has a cataract suite that is ambulatory in nature as well, doesn't have the capacity, apparently, to run past 4 o'clock every day if he wanted to. So Mr. Musyj and Roy Butler ought to get together and have a conversation on how he managed to do it.

Certainly, my experience in having cataract surgery through the public system has been excellent. The wait time was actually the eight months leading up to seeing the consultant, and part of the bottleneck there—it's not that there's not a plethora of private clinics around who are quite happy to upsell you if you are willing to pay. There's no need to, really. The cataract lens that's provided under OHIP is perfectly serviceable. I've enjoyed that benefit myself. But if you had a pool of surgeons that you could actually draw on, whoever's the first that can service the patient would be the one that would be drawn upon instead of having to have their own private list, which is part of our bottleneck issue.

I saw the consultant at St. Joe's Ivey clinic and, within a week's time, had a new lens put in, and not an extra cost whatsoever, and meanwhile, laser surgeons are out there asking for an extra $2,000 per eye that's not even necessary, and they're upselling. The very same surgeons working in a hospital are telling people to go to their clinic; supposedly they'll get in faster. I don't know. I think Mr. Musyj is painting a picture that's working well for him in Windsor, but it's not universal by any stretch.

Mr. Andrew Dowie: Thank you for that. I just would love to get your opinion, since this was some time ago now—and the Windsor Surgical Centre is in my riding, so I've been monitoring this for quite some time. I'm not hearing anything differently except a further reduction in the wait time for cataract surgery. So I'm wondering if you might be able to shed some light as to why Windsor's experience is so diametrically opposed to the experience of other communities.

Mr. Peter Bergmanis: I couldn't possibly begin to speak to what's going on in Windsor on that level. The fact is, it's also under a hospital umbrella, which is fantastic. I'm pleased to hear it is under a hospital umbrella.

Mr. Andrew Dowie: Okay. Thank you.

Chair, I'll pass the remainder of the time to—

The Chair (Mr. Ernie Hardeman): No, you can't pass it—

Mr. Andrew Dowie: Oh, no? Okay. All right.

The Chair (Mr. Ernie Hardeman): You're done? Thank you very much.

Thank you very much to the panel, all three, for taking the time to prepare your presentation and to come here to deliver it. We very much appreciate it, and I'm sure it will be helpful in preparing the budget.

VON MIDDLESEX-ELGIN COMMUNITY CORP.

MR. BRENDON SAMUELS

SOUTHWEST ONTARIO ABORIGINAL HEALTH ACCESS CENTRE

The Chair (Mr. Ernie Hardeman): As we're changing tables, the next presentation is VON Middlesex-Elgin Community Corp., Brendon Samuels and Southwest Ontario Aboriginal Health Access Centre. If you will take your seats at the table, and while we are getting ready, we'll point out that you will have seven minutes to make your presentation. At six minutes, I will say, "One minute," and at the end of the one minute, I will say, "Thank you very much for your presentation," and we will carry on.

The first presentation will be from the VON Middlesex-Elgin Community Corp. I believe we have them at the table there. We ask that before you start that you give your

name for Hansard to make sure it's properly recorded to the comments you are about to make.

Ms. Joy Bevan: Thank you to the committee. Good afternoon. My name is Joy Bevan. I'm a volunteer and past chair of the Victorian Order of Nurses, Middlesex-Elgin Community Corp. VON, as many of you know, has been around for over 125 years and is the oldest home and community care organization both in Ontario and Canada.

I'm also a retired nurse and former health care executive. This isn't in my presentation, but I should also say that most of my health care experience as a nurse and health care executive has been in the acute care sector. The reason I joined VON Middlesex-Elgin Community Corp. is because I see the need for a robust home and community care support system in our region and across Ontario.

I want to thank you for this opportunity to discuss the health care challenges we are facing in this area. The Middlesex-Elgin region continues to experience significant difficulties, as has been discussed, in accessing health care across all sectors, with nursing and PSW shortages particularly dire in home and community care. These capacity challenges are exacerbated by significant differences in wages for nurses and PSWs in home care versus other sectors. The scope of practice for nurses and PSWs is comparable across all health sectors, but the salaries are not. Staff are therefore leaving the sector for higher wages in hospitals or long-term-care settings.

I want to talk a little bit more about funding the sector more effectively. A 2021 Deloitte report projects a 53% increase in home care demand from 2019 to 2031 in Canada, with approximately 12 million Ontarians needing home and community care by 2031. We know that many people in our community want and need greater access to home and community care services so that they can safely stay in their homes for as long as possible. Providing these lower-cost, high-impact services will reduce demand on the hospital and long-term-care sectors and help stabilize the system, even as our capacity requirements across all sectors continue to grow.

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We believe that there is a compelling need to change how we view and fund the home and community care sector. VON is suggesting an investment of $1.25 billion over the next three years in the home care sector to reduce sector wage disparity, meet the ongoing inflationary and operational pressures and support innovative and scalable models of care.

Within the 2024 budget, we suggest the ministry allocates $553 million to the home and community care sector as a whole, allocated to provide rate increases and targeted wage increases for staff. This will help stabilize the sector and allow for the expansion of new and existing models of care, as well as system innovation. As well, with this stabilization of the wage gap between the home care and acute sector, we propose that home care can help to reduce unnecessary emergency room visits. As well, home care can help reduce the alternate-level-of-care patients who need home care or long-term care rather than a bed in acute care.

I would like to talk about supporting technology and innovation now. It is well understood that enterprise hospital information systems have enabled system transformation, new models of care and better health data. In the latest agreement with the provinces, the federal government has asked for increased accountability for spending and health data made available in return for increased funding.

Home and community care is still very much paper-based, and VON is in the process of building a $10-million technology solution, funded through private donations, to enhance clinical standardization and the delivery of care specifically at point of care, documentation of clinical interventions and outcomes, population health data and reporting for government and organizational efficacies, which include provider scheduling and billing etc., so back-office functions.

Technology solutions like VON Connect—and we are using the Alayacare platform—will transform the way we work and should be viewed as a funding priority for the government. It's very hard for a home care organization to raise $10 million as a charitable, not-for-profit organization, but we're doing it, but we need help.

I would like to talk about scale and spread of existing innovative models. Over the past year, the Ontario government has communicated a clear commitment to home care modernization. Legislation has been introduced to enable significant structural reforms. We know that Ontarians want to age at home with the clinical and support services that they require.

VON has been offering home care nursing clinics in this community for over a decade. These clinics are invaluable community resources and build regional home care nursing capacity by seeing twice as many clients as traditional home care models. Expanding community home care clinics and neighbourhood hubs that include adult day and assisted living programs—

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

Ms. Joy Bevan: —Meals on Wheels, transportation, home supports and caregiver respite will enable frail seniors to feel more comfortable and safe aging in place.

We've been impressed, I have to say, with this government's courage and desire to transform the system and ensure the home and community care sector is funded adequately. We are confident that you recognize that home-first strategies are integral to fixing a broken system.

I want to thank you for your time.

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

The next presentation is from Brendon Samuels.

Mr. Brendon Samuels: My name is Brendon Samuels. I am appearing as a witness before this committee to warn you about a storm that's brewing, the likes of which we are woefully unprepared for, and to ask for your help in keeping our province a safe, economically stable place to live. The focus of my recommendation today is on the urgent need for investment in climate change adaptation measures, particularly flood mitigation and green infra-

structure, that are vital to protecting people, property and the environment.

I am a PhD candidate at Western University here in London. I work in the environmental sector and serve in an advisory capacity to the municipal government. I advocate for policies that plan for climate change, protect biodiversity and support environmental stewardship. I am also, gratefully, a homeowner and I am currently paying off substantial damages from my basement flooding. I am an eager customer and service provider in Ontario's growing green economy.

I want to begin by telling you a story. Last year, I led a group of students on a project to restore the bank of a creek on our campus. We worked with our local conservation authority and Indigenous peoples to hold a public workshop where we planted hundreds of trees and shrubs and created a naturalized buffer along the bank of the creek, where only lawn existed before. This green infrastructure was installed in an area that's highly susceptible to flooding, where stormwater was eroding the creek bank, threatening the basement of an adjacent building and exacerbating pollution of the watershed.

Our planting cost us just a couple thousand dollars that we got through a grant from the university. As those trees we planted grow to maturity over the coming years, the services they provide and the potential damages that they help to avert will be worth much, much more. Indeed, according to the Canadian Climate Institute, for every dollar spent on adaptation measures today, $13 to $15 will be returned as benefits in the years ahead. We need to create more infrastructure like this throughout the province. The best time to start this work was yesterday, but it's not too late to start now.

As you may know, flooding is already the single most prevalent cause of public emergency in Ontario. It is the most expensive form of natural disaster in Canada, costing Canadians more than any other climate issue. This situation is getting worse: Floods are becoming more frequent and costly, and the strain on financial institutions is growing. The cost of home insurance in Ontario is skyrocketing. The infrastructure gap is widening as cumulative climate change impacts are not being met with investments to scale. Flooding is impacting water quality, damaging natural resources and infringing on the legal and treaty rights of First Nations who continue to suffer under boil-water advisories.

In 2022, the Auditor General published a value-for-money report on Climate Change Adaptation: Reducing Urban Flood Risk. The following excerpts were taken from the executive summary:

"The province is well aware of the need to do more to address this issue. No fewer than four reports and plans ... have identified specific actions that need to be taken to help Ontario reduce urban flood risk. Yet the province has never clarified provincial roles for addressing and coordinating actions needed to alleviate the risk of urban flooding, with the result that gaps in responsibility persist and actions and commitments have never been implemented....

"Several reports indicate that Ontario municipalities have been underinvesting in their stormwater infrastructure, resulting in a capital shortfall of several billion dollars. Of the 182 municipalities that incurred operating expenses relating to urban stormwater management in 2020, only 51 (28%) reported collecting revenue earmarked for urban stormwater systems. Federal and provincial grants for urban stormwater infrastructure varied annually over the past 10 years and totalled just $187 million, substantially less than the billions of dollars needed."

The audit concludes, "The province does not have effective systems and processes to reduce the risk of urban flooding, or to support and encourage municipalities and property owners to reduce ... risk."

Since this audit was published, the priority gaps it identified have not been addressed. In fact, over the past year, the government has taken actions that further undermine preparedness for flooding. For example, despite the audit finding large gaps in public awareness about flood risk, in March last year, the government voted down Bill 56, the Fewer Floods, Safer Ontario Act, aimed at providing public information about actions to mitigate flooding at home.

Recent changes to the Conservation Authorities Act severely restrict the supportive roles that authorities play in helping to mitigate flooding-related hazards. For instance, since Bill 23, authorities can no longer comment on natural heritage impacts of land use changes, and they have diminished capacity to support municipalities and landowners that depend on them for technical guidance. Whereas larger cities like London have dedicated staff and budgets for managing stormwater and flooding, smaller municipalities have less resources and can be highly vulnerable.

According to the Financial Accountability Office of Ontario report titled Costing Climate Change Impacts to Public Infrastructure, municipalities are projected to incur about four times greater a cost than the province.

In the absence of an adaptation strategy, climate hazards would add $4.1 billion per year on average to the cost of maintaining Ontario's public infrastructure in a state of good repair under a medium-emissions scenario. We could reduce those costs by as much as $1.1 billion per year with proactive adaptation. And yet, municipalities are struggling to mobilize funding for adaptation.

Here in London, we're currently working on our multi-year budget. This is an extraordinarily difficult budget cycle not only because of the economic conditions, but also since municipal finances were left battered by Bill 23's changes to development charge revenue and the province reneged on its promise to make municipalities whole again.

Last summer, the province released the first-ever climate change impact assessment report spelling out what impacts in Ontario look like today and into the future. The report provides overall risk scores for various indicators representing different sectors. It also assesses "resource availability," including financial, human and natural resources.

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

Mr. Brendon Samuels: I would call on you to commit to funding the adaptation priorities outlined in this 2023 provincial climate change impact assessment. We need to ramp up these investments and mobilize partnership research. Thank you.

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The Chair (Mr. Ernie Hardeman): Our next presenter will be the Southwest Ontario Aboriginal Health Access Centre.

Mr. Dave Remy: My name is Dave Remy. I'm the director of client care for the Southwest Ontario Aboriginal Health Access Centre. I've met a lot of you in person. I know a lot of you have come to the clinic, and I appreciate that. For those of you who don't know what SOAHAC, or the Southwest Ontario Aboriginal Health Access Centre, is, we were originally called an AHAC, which is an Aboriginal health access centre, which has since been changed to Indigenous primary health care organization. We'll stay that way until they change our name again.

We have five sites. We are all over southwest Ontario. I was just in our site in Guelph and Cambridge this morning; we have sites here in London, just right down the road; we are in Windsor; we are in Owen Sound; hopefully, starting a new site in Newbury as well; and then, on-reserve in Chippewa, just about 40 minutes from here.

I want to talk to you today about, first, the disparities of health that Indigenous people are facing right now. In the package that I provided you, you can see that within the population, we have increased rates of mental health and addiction, increased rates of diabetes, increased rates of COPD, and limited resources to deal with that.

Specifically, today, I am talking about our Owen Sound clinic. The clinic in Owen Sound is a very small clinic, probably one of our smallest. We have two big population communities out that way—the Neyaashiinigmiing community and Saugeen First Nation—and also the urban Indigenous population located within Owen Sound in the area. When I say, "the area," I am talking about Grey-Bruce, which is a massive area to cover.

Our resources in that area right now are half a physician. We have 0.5 of a physician, and then we have some nurse practitioner resources to deal with that. That is creating a massive health disparity in that area. We are unable to care for the population that we are mandated to care for.

So we are in a unique position in Owen Sound. We are actually on a reserve in Owen Sound. So we visit Neyaashiinigmiing; we visit Saugeen. A lot of our providers travel in that time. The amount of work we're able to do is limited, just based on those resources.

You can see that our numbers tell a story: 1,655 people access care with us—this information is about two years old; it takes us a little while to gather that data—and 49% of our clients need access to more than one of our programs. Our clients visit us roughly around 13 times a year. So when you think of yourself, how many times you visit your family doctor's office, our clients are seeing us 13 times a year, more than once a month, seeing multiple providers: our mental health team and our navigators, along with our primary care providers.

We are only able to serve 13% of Chippewa of Nawash, which is Neyaashiinigmiing, and Saugeen band members. That is a very limited amount, considering the care needed in that area. Some 44% people are waiting one to two years on our wait-list just to receive basic care. They are forced to access care in other ways, and I think we all know what "other ways" means: emerg, walk-in clinics, care that is episodic and not necessarily dealing with chronic conditions, which therefore ends people back up in emerg again.

Again, as we talked about, all this is being handled by 0.5 of a physician resource, which is very, very difficult to recruit. People want full-time work, and it's difficult to find bits of a physician to be able to handle our care. It also breaks up continuity of care, so they're seeing multiple different providers.

We've put a proposal in, and I'm sure there will be some questions with the expression of interest. We have put that proposal in. We are awaiting patiently to hear. Our ask is to go up to two physicians.

I would encourage you to look at the CHC model in the province. There are many CHCs out there, and I would ask you to look at how many of those CHCs are running with a one-physician model. I have not been able to find one. Most of them are in a multi-physician model. SOAHAC usually runs on a one-physician model, which is the case for all our clinics, and then our nurse practitioners. So we need health equity in that area. We are dealing with complex chronic conditions and we need physician help to be able to deal with that. We need our budget increased to be able to hire physicians.

With the limited amount of physicians and resources we have, I would ask you to look at how we're utilizing—so 5,000, almost 6,000 client encounters—that was during COVID. And I will express that during COVID, you saw many physician offices move towards a virtual model, where it was "call in and we will see you on screen." SOAHAC never did that. We were always seeing clients in person. We could not move to a virtual model. Many of our clients do not have the technology to access a virtual model and it doesn't work in terms of building trust and managing chronic conditions. We never closed. We were always open.

So 61% of our clients have had the breast screening and 70% the colorectal screening. We need to get that to 100%. It prevents people coming into emerg with chronic conditions. And 34% of our clients are diabetic, so that is a large part of our roster.

Within the package that you we provided, there are two client stories. I would really ask you to read those; I won't go through them here. They're really impactful stories, and they're stories that we see every day. We are a different type of family practice office. It's not uncommon for our providers—our nurse practitioners or physicians—to run into issues like food security or evictions within an appointment. I don't know how many of our family doctors deal with that; I know mine doesn't. But at SOAHAC, we do. So our providers, when they're dealing with food

security, can walk them down to a food hub and give them a box and send them on their way. Our social workers are there to deal with stopping evictions and preventing homelessness and working on implementing social programs.

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

Mr. Dave Remy: That's what makes SOAHAC different, and that's why we're worth the funding.

Our situation with Indigenous people in our area is not unique. There are stats there that show across Canada that there's an increase in specific diseases. We talked about diabetes, hepatitis C, asthma, mental health and addictions. We do a good job with our dollar. We're able to stretch that dollar. We're able to impact our client care.

I would ask you to read this proposal over. I have submitted it before. It is in for the expression of interest. I would encourage you to increase our funding in the Owen Sound clinic so we're able to meet the needs of those two communities and the urban population within Owen Sound.

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

We'll start the first round of questions with the independents. MPP Hazell.

MPP Andrea Hazell: Thank you for coming and presenting to us—a very detailed presentation. I'm going to go to Dave from the Southwest Ontario Aboriginal Health Access Centre. I want to draw your attention back to your presentation. What jumps out at me is the health equity. That means a lot to me from where I am coming from.

You mentioned in the presentation also systemic racism and prejudice and the resulting lack of trust in systems of authority, which means that Indigenous people are less likely to seek care and may not receive culturally safe care when they do. I want you to take some time and elaborate on that, because culturally aware care is very crucial in health equity. Can you elaborate on that a little bit more for me? How can funding help to bridge this urgent gap?

Mr. Dave Remy: I'll tell you a story: We had a client in our Owen Sound office who was accessing psychiatric care at the hospital. That client asked for an elder to be present and for our patient navigator, who's a position we have at SOAHAC who will travel and bring people to appointments and provide assistance for health literacy to be at that appointment. So that was arranged, and the client was at the appointment with the elder and with the navigator, and the psychiatrist who was meeting with that appointment asked both of those other people to leave and wouldn't continue the appointment unless it was a one-on-one conversation. That's what we mean by not being able to access culturally safe care. Our staff did leave, and the elder, but the client also left, because they did not feel safe to continue the appointment. So that disease then progresses and gets worse, and that person will eventually end up in emerg.

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It's no secret now that Indigenous people experience racism in hospitals. Hospitals are not a safe place for Indigenous people to go. They experience racism; they do not want to come back. SOAHAC London, down the street—although we are a primary care organization, there are some days when I'm in clinic and it looks like we're running a mini-emerg or a mini ICU. We're doing things that primary care clinics don't do because clients should go to the hospital with this condition but will not, so we manage it in clinic. The same can be said for our Owen Sound office, but it doesn't happen as often because we're not equipped to do it. When you only have half a physician, someone's not there all the time. Someone's not there five days a week who can manage these conditions.

That's just one story. There are hundreds of them that we can talk about, of people experiencing racism in hospitals. It's how SOAHAC tries to bridge that gap. We work with hospitals to provide education to staff, they do presentations, we provide access to the San'yas training, but it's really key to have somebody there sometimes, and that helps bridge that health equity gap.

MPP Andrea Hazell: I want to expand on that. You do need funding to bridge this gap, so what are you looking for? What are the figures that you're looking for that can impact this crisis?

Mr. Dave Remy: Sorry; you're asking about the numbers, how much we need?

MPP Andrea Hazell: How much, yes.

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

Mr. Dave Remy: We've put in for an expanded funding model of an additional $2.1 million. Within that there are physician resources, navigator resources and nursing resources. Again, we talk about physician resources, but physicians come with a workload, so if you just give a physician to an organization, there are more phone calls, there's medical admin, there's nursing, there's support that's needed to actually manage that patient load. So that's what we've added for our budget, and that also helps us with navigation services and even addiction services within that area.

MPP Andrea Hazell: Thank you.

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

We'll now go to MPP Byers.

Mr. Rick Byers: Thank you to all the presenters for coming this afternoon, and thanks for the positions you've taken. Certainly, we're listening carefully. We can't ask questions to you all, but we appreciate and assure that we hear you.

Dave, I want to continue the conversation, if I could, with you, because your presentation here is great and it talks a lot about Grey-Bruce, which is where I live and the region I represent.

In fact, I'm pleased to say I visited SOAHAC's office in Owen Sound. It's exciting to see it there, because it hasn't been there for that many years; it didn't exist before. So it was great to see first-hand the work that's being done in the community. It's very exciting. Thank you.

And Greg Nadjiwon, Chief Nadjiwon: As you've got in your presentation, I've met with the chief several times on other issues. I know he cares deeply about First Nations people in his community, as do I.

You mentioned the other SOAHAC locations around the province, including here in London. Maybe if you could

give me a comparison about the kind of services you deliver in London versus Owen Sound, or generally give me a sense of your operation here in town.

Mr. Dave Remy: Our original sites are probably Chippewa in London, and we just opened the new office in London. It has a lot of services.

The difference in Owen Sound is, we have more navigation support here. We have four full-time providers in London, one physician and three nurse practitioners, which is great for this city, but we could certainly make use of that in Owen Sound as well, as you know.

One of the differences between our London site and our Owen Sound site is there is no travel in London, right? We're in a downtown area, so our clients are able to access us. We're on the bus route. We provide transportation. That is certainly not the case in Owen Sound. You've been to our office in Owen Sound. They travel from Saugeen for that office, and Neyaashiinigmiing. Neyaashiinigmiing is probably about an hour, and Saugeen maybe 25 minutes. That's all time we have to pay for, right? That's all time that we use to treat people.

Also, in London, there are harm reduction services. We have one harm reduction worker who was provided by the province. We have addictions and mental health, so we're actually able to run groups for addictions and mental health and work on treatment—not just harm reduction, but actually focusing on treatment as well. We don't have that in Owen Sound. And we just added a Jordan's Principle navigator service there too.

It's much bigger here in London, because we've been here longer, but we're really advocating for Owen Sound because we know the two large communities that we support—that our quote from Greg Nadjiwon is actually from his first term as a chief, and then Chief Veronica came in and the band resolution letter, which is in the back of the package as well, the letter of support, is from when she was in term. Again, Chief Nadjiwon is a supporter of us and he's certainly excited to see us develop more.

Mr. Rick Byers: That's great. You mention the community health centre model, and in fact, I see a letter of support with the South East Grey Community Health Centre, which is in the community. I was on that board for three years before I was elected. I'm a big fan of that model and I think there's a lot of similarities between the model SOAHAC does employ and the CHC model, so that's terrific.

Mr. Dave Remy: Yes, we're very similar to a CHC model with the additional traditional healing and visiting healers. So there's a focus on traditional healing, Indigenous traditional healers, which wouldn't be at a CHC, but the rest of the model is similar, with the exception of the physician complement. They're generally higher at CHCs then they are at my IPHCOs.

Mr. Rick Byers: You mentioned, I think, Guelph, Cambridge, Windsor. When did those facilities open in the province? How long ago was that?

Mr. Dave Remy: The original London Chippewa, we celebrated 25 years this year. We had a celebration in the London office and all of our offices, so that was our oldest one. Our newest one is Cambridge, where I just came from, and we're just about a year and a half, two years into Cambridge. And then, I think, Owen Sound is 10 years this year, and Windsor is seven or eight.

Mr. Rick Byers: On the—I'm sorry; I'm Owen Sound focused here—on the transportation point you mentioned, was there ever consideration to have it farther north, closer to the First Nations communities there, do you know? I mean, something I can take away—I'm curious about that, whether you knew that.

Mr. Dave Remy: Yes. We're a bit unique in the Owen Sound area. Our mandate is generally urban Indigenous populations, which is why we're in Owen Sound. We don't usually go to the health centres on reserves because they have their own health centres to manage health care. We have a different relationship with Neyaashiinigmiing and Saugeen, where that's their preference. We take our direction from the community who wants SOAHAC in. That's why we travel to those sites, and that was the agreement that was made when SOAHAC come out there originally, 10 years ago.

Mr. Rick Byers: Got it. And do you also work with the public health authority there? I met with the doctor who runs it, and I know that he has a big focus on—

Mr. Dave Remy: We certainly did during the COVID outbreak and when running the vaccines. We have somewhat of a relationship with the hospital as well in terms of mental health services. As you know, the health care services are kind of limited out there, so you have to be able to work with partners. So, yes, we have good relationships with both those organizations.

Mr. Rick Byers: Great. I'm glad to hear the organization submitted an EOI last year when there was outreach from Ontario Health to a lot of communities. I see all the letters of support, so thank you for all that work you did to get those and submit the presentation. Have you heard anything?

Mr. Dave Remy: Nothing.

Mr. Rick Byers: Okay.

Mr. Dave Remy: It was supposed to be November, as far as I know, and then—I know that everybody put in a submission, right? So I don't know if they were expecting the amount of workload. I'm surprised they weren't, because everybody was looking for funding, so it's been delayed, but we have not heard anything from them yet. We keep asking, but there's just no—I think I met with the ministry about a month ago, but there was still nothing yet.

Mr. Rick Byers: Okay. And did you have an opportunity to outline your proposal to the ministry?

Mr. Dave Remy: Absolutely. We outlined—we submitted two and we're just waiting to hear back.

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

Mr. Rick Byers: Okay, great. Certainly, I will commit to following up. Like I said, I know Alex Hector from the CHC and I'll see if he's heard anything.

I really appreciate all the work you've done. Thank you for all this, thank you for presenting to the committee and thank you for the great work.

Mr. Dave Remy: Thanks so much.

Mr. Rick Byers: That's all, Mr. Chair.

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

Mr. Terence Kernaghan: Thank you to all our presenters. It's great to see you all again.

I'd like to begin my questions with Dave: 0.5 of a physician is outrageous. I'm amazed at what you've been able to achieve with that level, but obviously, that's something the government should and could rectify.

In your presentation, you talked about the existing wait times that clients who are currently rostered have to wait—seven to 16 days, or new patients have between 12 to 24 months. You're actually measuring wait times in years. What impacts did these have, both intrinsic and extrinsic, on patients who are waiting for care?

Mr. Dave Remy: Well, they have to seek care in other places, and the care they have to receive is either walk-in clinics or hospitals, who don't manage chronic conditions. If you have diabetes, that's something that you need regular bloodwork and regular follow-up with, and doing that at a walk-in clinic can be quite challenging. It's nothing with the physician, but it's hard to manage that care if you don't have a relationship with the physician.

1530

Even the last time I was at Owen Sound, there were two people walking in, asking about wait times and if they were able to access the services. We have to tell them, "We're actually full," and we haven't been able to do intakes in some time, because as you can imagine, the provider complement hasn't changed. It's just when people leave our list that we're able to add somebody else, and we try to do it as soon as we can, but there is a significant wait time, just based on the resources.

So really, it's about the follow-up. In the package, it talks about chronic conditions that we see in Indigenous populations. Those are not being able to be managed in an episodic care format. If you can manage them in that way, it's going to be very poor, until somebody ends up in emerg, and as we had just talked about earlier, emerg is not seen as a safe place, so usually it's very chronic by the time they get to emerg.

Mr. Terence Kernaghan: Absolutely. We're talking about an upstream investment here that is far less than an ineffective and more expensive band-aid that is unfortunately the situation that this has caused. Thank you very much for your advocacy and do keep us posted.

Mr. Dave Remy: Just to provide an analogy on that, Terence: What we want to do at SOAHAC is address the foot ulcer before we address the amputation, right? That's what we want to do. If you want to look at it purely on a cost basis, it's far more cost-effective to treat a foot ulcer than an amputation.

Mr. Terence Kernaghan: Very well said, 100%. Thank you for that.

I'd like to move over to Joy with VON Middlesex-Elgin. Joy, it's good to see you. I want to thank you for your advocacy. We've heard from quite a few other groups here at the committee about the need to make further and better investments into the home and community care sector. It's a vital part of our health care system, as you very well outlined. A nurse is a nurse is a nurse, and yet the province pays them differently, which is concerning. I believe that the Ontario Community Support Association said that PSWs in home and community care receive 19% less than acute care settings, 9% less than long-term care.

I wanted to know if you could tell this committee and explain to this committee: In situations where it's appropriate, why is home the best place for people to access care, when it's appropriate for that patient?

Ms. Joy Bevan: As I mentioned before, most of my career has been in acute care. The last position I held was at Grand River Hospital in Kitchener as associate vice-president for medicine services, and that was 10 years ago. I've been retired for 10 years. Our ALC rates were quite significant, and I helped to lead the home-first initiative at that time.

What we found is that there needs to be more—the home care sector is not able to meet the needs that the acute care sector needs to move patients out of hospital, and that's not because they're not competent; they're extremely competent, and they're able to provide the care. It's just that the wages in the home care sector—I believe that's significant, the pay equity piece or the wage parity piece.

If you think about it, in 2022, nurses would get paid about $11 an hour more in the acute care sector than in home care, so if you're trying to pay a mortgage, of course you're going to try to get a job where you're going to get paid more. Since the arbitration agreements came about, and even with the money that was finally received by the home care sector—in December, I might say; the last budget was in February. The sector received the money in December, and even though it helped us alleviate some of that wage gap, it just has continued to get—I can't even identify the dollar amount right now, because we really don't know the impact. But we know that it's increasingly difficult to be able to recruit and retain staff in the home care sector when we can't pay them what they deserve to be paid. A nurse is a nurse; they go through the same education. We have nurses who have been at VON for 25 or 30 years, but those are the ones who can afford to be paid less and love the job so much that they stay.

I don't know. Did I answer your question?

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

Mr. Terence Kernaghan: Yes, thank you.

Speaking with constituents and meeting with RNAO, who have spoken about people waiting for 28 days for basic wound care, which is concerning—not being able to access those supports because of government lack of investment.

I'll quickly move over to Brendon. I'm sorry there's only a minute left, Brendon. I want to thank you for men-

tioning Bill 23 in your presentation. The government would like the public to believe that the removal of development charges will be passed down to the consumer, this sort of trickle-down economics idea. Can you think of any economic model where that is true, where cost savings have actually gone down to the consumer?

Mr. Brendon Samuels: That's applicable to this example? Not really. I don't think that's what we're seeing happen. I think we have been left in kind of a limbo, waiting to find out if these finances are going to be reconciled. What we'll probably see happen is the taxpayers are going to end up paying the difference.

Mr. Terence Kernaghan: Thank you very much. It's obviously of deep concern, because when there are no guardrails—

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

We'll go to the independents. MPP Shamji.

Mr. Adil Shamji: Thank you to all of you for sharing your perspectives and expertise with us today.

I wanted to start with the Southwest Ontario Aboriginal Health Access Centre. By way of professional background, I'm a family doc and emerg doc. I've done a lot of my practice in Indigenous communities, mostly in northeastern Ontario. I have not worked in the southwest, although I did have the honour of visiting your Owen Sound location earlier this summer. At the time, I seem to recall that outside the clinic there was what looked like a brand new health bus that has been parked there for some time. If I recall correctly, it's because there isn't any operational funding for that. Is that correct?

Mr. Dave Remy: That's correct.

Mr. Adil Shamji: Are you even asking for that money right now?

Mr. Dave Remy: Yes, we are.

Mr. Adil Shamji: How much is that?

Mr. Dave Remy: It's part of the $2-million ask. It's going to help us operationalize that. That mobile clinic was a gift to us by Enbridge and the IPHCC. It came fully outfitted, but it's just the van. There are no operational dollars with it.

It made the most sense to operationalize that in the Owen Sound area, because of the travel and because we don't always have access to a health clinic, especially in Neyaashiinigmiing, which is certainly in need of help in terms of construction of buildings. So it made the most sense to bring it out there. That's why it's there.

Mr. Adil Shamji: So you've done your part. You've even got private partners on board. They have brought forward their own funds, and now the only thing holding you back is adequate support from the government.

Mr. Dave Remy: Yes. It comes down to choices at the end of the day. With half of a physician resource and limited nurse practitioner resources, do we put those on the road or do we manage what we—I mean, to add services that we have in Owen Sound without an operational budget doesn't work. So we've used the van when we've had to do existing work, like in Neyaashiinigmiing or in Saugeen, but it doesn't have necessarily an operational plan right now that could affect a lot of people.

Mr. Adil Shamji: I do have more questions for you, but very briefly I did want to turn to Brendon.

You spoke very eloquently about some of the challenges that we face about our lack of preparedness for climate adaptation and the risks that we face around flooding. You described how we've gotten to the state that we are in. Only in the last few moments, you articulated some of the things that we need to do moving forward. I was wondering if I could ask you to expand more on that.

Mr. Brendon Samuels: Yes, thank you. Unfortunately, I ran out of time.

In the climate change impact assessment report that I referenced, they provide resource availability, so they're rating the financial, human and natural resources that can support adaptation in the different sectors talked about in the report. In a number of these sectors, resource availability is rated as low.

The report also identifies specific infrastructure adaptation priorities: Given the huge breadth of things that we need to be thinking about, what does the report identify as the most important? Those include floor mitigation infrastructure and urban and rural stormwater management systems. These are both rated as high-risk. These have knock-on effects on some of the other items that are also at risk; for example, if you're not dealing with floodwater, you're also jeopardizing your buildings, your roads, your hospitals etc.

So I would say, and that is really the focus of my presentation today, that we need to be prioritizing funding for stormwater infrastructure, especially in smaller municipalities that cannot do this on their own without the province.

1540

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

Mr. Adil Shamji: Okay. Thank you very much.

Turning back to you, Dave, I wanted to ask: We know very clearly that Indigenous health trails far behind that of the general population. Funding your centres specifically, where there is Indigenous, culturally sensitive care: How can that make a bigger difference than just funding the hospital?

Mr. Dave Remy: Again, creating safety within an area where Indigenous people will come and actually access care will lead to better outcomes. People avoid emerg. There are just people who will avoid emerg until they absolutely have to go. I go back to the original example that I talked about. It's treating that foot ulcer before you're treating the amputation; managing that diabetic patient, so that they don't need anything further and they're able to manage it on their own. That's not going to be done at the hospital. That's not the hospital's role in a lot of those cases, and if you don't feel safe to go to the hospital, you're not going to go. You will let that condition develop until it's absolutely necessary and somebody takes you to the hospital.

I think that's what SOAHAC brings to the table. We offer that culturally sensitive care. Our providers may not

all be Indigenous, but they have access to Indigenous staff, Indigenous healers and Indigenous medicines right on site, and it makes a difference for clients.

Mr. Adil Shamji: Great, thank you.

The Chair (Mr. Ernie Hardeman): We will now go to the government. MPP Leardi.

Mr. Anthony Leardi: I have some questions for both of the health care providers here today. We've heard from some people who come before the committee, and they say, "The hospitals are poaching our staff." I'm shortening it, but it's, "The hospitals are poaching our staff." Then we hear from the hospitals, and they say, "We can't keep our staff." You're saying the hospitals are taking your staff; hospitalists are saying you're taking their staff. Any explanation for this?

Mr. Dave Remy: I was just in Cambridge and in the last three weeks, I have lost two nurse practitioners and two nurses to the hospital. I can't speak to what the hospital is seeing. They pay a lot more; there's no question about that. I mean, you can look at the grids in the hospital versus the grids for SOAHAC. I can show you the grids for SOAHAC. They're quite public. They pay a lot more.

When students are graduating their programs, they're graduating in debt, they're paying their OSAP and they have to make choices, they're going to chose the money, because that's how they pay it back. There's no difference in pension and benefits. It's the straight wage for us.

Ms. Joy Bevan: I think it's not that the hospitals are poaching or home care is poaching; it's about the economics. If you are a new graduate coming out of university and you get a good job at VON—say, at a home care agency—and you love the work etc. but you're having trouble paying your bills, you're going to go to a place that is able to pay you more.

I think the point that I'm trying to get across is that our health care system and the way we fund our health care system need to recognize what the community and home care can do to alleviate the problems that we have in the acute care sector: We can help keep people out of hospital.

We just had a good example about preventing that ulcer so that you don't need the amputation. Well, when a home care nurse is visiting someone on a regular basis and does a check of their feet, it may seem like a small thing, but it's huge when it comes to preventing that acute care admission and preventing someone going to the emergency department, waiting for a bed because they can no longer be looked after in their home. That's because we don't have the staff. The home care sector, period, doesn't have the capacity to pay staff enough so that we have enough staff, so that we can actually keep people out of hospitals.

If you do some reading, I believe the VON Canada submission has some examples about—from last year, anyway—the Denmark health care system, which is very proactive. In Denmark, home care is considered a priority for anybody who is over 65. You have someone who connects with you and ensures that your needs are being met, so that you can stay out of the acute care system, and even out of long-term care. We shouldn't have to go to long-term care just because we don't have the kind of family support systems that we used to have maybe 30 or 50 years ago, when families are living far apart.

Home care, visiting nurses, PSWs, people in clinics can help alleviate some of that need. So it's not that we're poaching from each other; it's that we can't afford to pay what is being paid in the acute care sector. I just heard, also, that the acute care sector is having a problem because the agencies are paying their staff even more. So there needs to be some recognition of the skill set that we have as health care professionals, and we need to enable our organizations to be able to pay people in an equitable manner.

Mr. Dave Remy: There are certainly differences in what budgets are provided for staff. Just in London in the last few months, we all heard of this LHSC scandal, where they were spending $500,000 to send executives on trips. What I could do with $500,000, the amount of clients I could see with $500,000, I can't even describe. I mean, that would be an amazing gift to an organization like SOAHAC, who could then translate that money into more client care, more patient care.

When you hear that in the news—you know, you're on your way to work and you're hearing of $500,000 for half a year to do trips—it's mind-blowing to me. I can't imagine getting that type of budget when we have such gaps. I'm sitting here today trying to get more than half a physician to treat clients in Owen Sound.

Mr. Anthony Leardi: The reason I asked that question is because I think it's an issue we need to explore, because it seems to me that a lot of what's being discussed here is, "Well, I heard this, and I heard that," or "It's based on what I've been told," and I don't know if we have anything that can actually confirm where the staff are going.

You've given us an example, and I think that's quite a logical example, and you've given us examples, and I think those are quite logical examples, but we hear in every sector that there's a desperate need for labour, for talented staff. We hear that from every sector, not just the health care sector. We hear it in every sector, including the construction sector, the banking sector and the retail sector. We hear it from every single sector: They need more workers.

And so I'm wondering if this is simply an across-the-board symptom of what's going on across the board, not specific to any sector, including the health care sector; not specific at all, but rather, endemic in every sector is the desperate need for more workers across the board.

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

Ms. Joy Bevan: I believe that this problem of recruitment and retention is happening across the board, in all sectors, but it's clear that in the home and community care sector, we are not able to pay our staff at the same level as the acute care sector.

Mr. Anthony Leardi: It seems to me, then, that the solution is supply; we just need more people—

Ms. Joy Bevan: We need more people, and we need to pay them equitably. We need to recognize the skill set that a nurse has, no matter where he or she works.

Mr. Anthony Leardi: Well, there are differences in every sector; that's for sure.

I don't have any more questions, Mr. Chair.

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

Ms. Peggy Sattler: Thank you to all three presenters this afternoon.

I wanted to begin my questions with Joy from VON. I have to say that one of the slides that VON included in previous budget submissions was around the different costs to the provincial treasury, funding home care versus funding long-term care versus funding hospital care. I was able to quickly look that up: It's about $103 a day to provide care for a patient through home and community care services, $201 a day in a long-term-care home and $730 a day in a hospital, so certainly not just very much from the patient's perspective but also from a dollars-and-cents perspective, it makes a lot of sense to invest in home care services. So I really appreciate your advocacy and you coming here today to impress upon the government the need to deal with the crisis in staffing in our home care agencies.

I noticed that the budget submission from the Ontario Community Support Association—and VON is a member of that organization—in that $533-million ask that you have brought to us today, it talks about the need to immediately invest $77 million for retroactive pay increases to prevent wage disparities from worsening as a result of Bill 124 arbitration awards. I wondered if you could explain that a little bit more about the impact of Bill 124 and how this is going to widen that pay gap that we've been talking about if the government doesn't immediately come to the table with some additional dollars.

Ms. Joy Bevan: As I explained before, there is about an $11 wage gap in 2022 between the hospital care sector and the home care sector. That was before the arbitration agreements were recognized and achieved. Even though we did receive some monies in December—and I think that money is starting to flow; I'm not sure if it's completed flowing. But because of the arbitration agreements and 11% raise, that gap has just widened even more. I can't give you a dollar figure on that because they're still working on trying to figure out what that dollar figure is going to be, but it is huge. It impacts our ability to recruit and to retain staff.

There are many things that the government has been doing to try to help mitigate some of those staffing shortages such as helping to work with colleges around getting international nursing people—I think even physicians—to be able to work. Supply and demand—that's part of the problem, but it's the fact that we're not able to pay people what they deserve and what they should get. Being a health care professional, you should be able to choose where you work and get paid for your expertise and to be able to pay your bills and your mortgage at home, so it's pretty clear.

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I know when I graduated many years ago—I'd be telling you how old I am if I told you how many years it was, but the problem is not new; it has just become worse. I think it has become more of a problem because we have more elderly people. We have more people who need to be served. We're looking at building long-term-care facilities, and I'm not saying we shouldn't build the long-term-care facilities, but we should be looking at how we can best support people in their homes and keep them safe and looked after independently in their homes. That's where people want to be.

Ms. Peggy Sattler: Thank you for that.

I wanted to ask a question of Brendon. Brendon, I very much appreciate your advocacy on environmental issues. Your submission, I think, really points out the reality that we are in a climate crisis in this province, in this world, and we need to act urgently to deal with the crisis.

Your submission today focuses on flood mitigation and the adaptation priorities that you are urging the government to move forward on immediately. Can you elaborate a little bit more on why you are focusing specifically on flooding as the environmental priority that you would like this government to focus on?

Mr. Brendon Samuels: Absolutely. Thank you for the question. As I think I alluded to earlier, flood risk intersects with a lot of the other vulnerabilities that we see in Ontario's infrastructure, and many of the solutions for flooding, particularly green infrastructure, have many other co-benefits that can help with adaptation to extreme heat. For example, overheating in buildings is going to become an increasing concern.

Biodiversity loss is another major issue that we should be dealing with in Ontario and the climate crisis is absolutely going to exacerbate that. When we create green infrastructure properly, such as the riparian project—

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

Mr. Brendon Samuels: —I talked about on our campus, we're taking care of biodiversity at the same time.

I have personal experience with flooding. I go to a school where our campus is in a floodplain. My own basement flooded earlier this year. I don't think a lot of homeowners realize that your home insurance doesn't cover that, and you're looking at about 40 grand in damage that you're paying out of pocket. This is going to become prohibitively expensive for Ontarians. It's really something that authorities need to take seriously. We've been kicking the can down the road for a number of years. The writing is on the wall. This all has to be paid for at some point.

I would point to the Financial Accountability Office of Ontario's report on the shortfalls and the costs of doing nothing. There's an appendix table, appendix number 9, where they look at no adaptation versus proactive adaptation versus reactive adaptation, and across the board, proactive adaptation is the cheapest. If we just do these things in advance, if we're needing to service infrastructure anyway, let's get on it and save some money for later. This is going to impact future budgets otherwise.

The Chair (Mr. Ernie Hardeman): Thank you very much. That includes the time for that question, and it concludes the time for this panel. Thank you very much for taking the time to prepare and come present to us today, and helping us with our deliberations for the 2024 budget.

LONDON PUBLIC LIBRARY

CANADIAN MENTAL HEALTH ASSOCIATION THAMES VALLEY ADDICTION AND MENTAL HEALTH SERVICES

ALZHEIMER SOCIETY OF ONTARIO

The Chair (Mr. Ernie Hardeman): With that, we will move to the next presenters: the London Public Library, Canadian Mental Health Association Thames Valley Addiction and Mental Health Services and the Alzheimer Society of Ontario, if they will come to the table. As with the others, the instructions are the same: There are seven minutes for the presentation. At six minutes, I will say, "One minute." At seven minutes, I will say, "Thank you."

With that, we do ask each presenter to state their name for Hansard, to make sure we are recording properly and that the person giving it is attached to the presentation that was given. I believe we have one virtual on the screen, so welcome. The instructions are the same virtually and being here.

With that, the first we're going to hear from is the London Public Library.

Mr. Michael Ciccone: Good afternoon. I'm Michael Ciccone. I'm the CEO of the London Public Library, just across the way here. I'm here today representing not only Londoners, but all Ontarians, as a spokesperson for the Federation of Ontario Public Libraries and the Ontario Library Association. Thank you very much for having me today.

Public libraries are Ontario's farthest-reaching, most cost-effective public resource. They are engines of innovation, entrepreneurship and local economic development in Ontario communities of all sizes. According to the 2022 Ontario public library statistics:

—four million Ontarians have public library cards. They rely on local public libraries to connect to their communities, to work, to learn, to find or train for a job and to connect to their community and government services;

—2.4 million Ontarians use their public library every week, and double that number visit our websites;

—67,000 Ontarians per week attend programs at their library;

—2.2 million books and other items, be they physical or digital, are borrowed from libraries every week;

—12,000 patrons across Ontario use library computers per day; and

—52,000 patrons per day gain access to the Internet through library wireless services.

The organizations I represent have three provincial priorities. The first is a province-wide solution to the delivery of digital resources and tools. Two years ago, the province provided a $4.8-million grant to provide high-speed Internet to over 100 rural communities, and we were very, very appreciative of that. In some cases, this is the only Internet in a community, making public libraries the sole destination for people to get online.

Building on that foundation, we seek your support in empowering Ontarians with resources and tools needed to succeed no matter where they live through the creation of an Ontario digital public library. This service would provide province-wide access to a common set of online resources and tools that would include in-depth job and career skills training, language learning, live tutoring, homework help and health and information resources. Alberta and Saskatchewan already have a model that works well, and the Ontario public libraries are proposing something very similar.

There is substantial evidence from larger libraries across Ontario that are lucky enough to have budgets to allow them to subscribe to some of these tools, including London Public Library, that these resources and tools are heavily used. For many Ontario libraries, especially those in small and rural jurisdictions, subscriptions are cost-prohibitive. People are denied access to these resources simply based on where they live. By leveraging volume purchasing and delivering this service through an existing public library infrastructure, the Ontario digital public library could provide a core set of high-impact digital resources to every public library and every Ontarian at an overall cost savings of up to 40% when compared to what libraries currently pay by subscribing individually.

Every library in Ontario would benefit. Small libraries would be able to deliver access to these tools perhaps for the first time. Larger libraries can reinvest money into other services and needs, such as addressing the needs of their IT infrastructure and guarding against cyber attacks, like the one that LPL recently experienced, or adjusting the security and safety of their patrons and staff. We are requesting $15 million to support a proven model of service delivery that would make a tremendous difference in so many Ontario communities.

Our second priority is the First Nation Salary Supplement. Of the 133 First Nations communities in Ontario, only 39 have public libraries. Public libraries are destinations for these communities, sometimes the last gathering place for where their languages, stories, culture and artifacts are stored. As you know, public libraries rely on municipal grant funding to fund their operations, and these are not available to First Nations public libraries. Often, they have to rely on one-time grants, and this is not sustainable. Librarians running these institutions have to make choices between the books and resources they provide or their salary, and their salary is far below living wage. Ultimately, they have to make a choice: staying in their community below a living wage or leaving to support themselves and their families. This forces First Nations public libraries to close. With an annual $2-million invest-

ment, we can ensure First Nations communities across Ontario can continue to collect the stories of their culture and have a community gathering place.

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Our third priority is to increase the provincial funding for public libraries. Public libraries are grateful for the continued support through the Public Library Operating Grant, or PLOG, but unfortunately, the allocated amount has not been increased in over 25 years. Ontario public libraries are a key community gathering place that support job creation, job skills, education, literacy and serve our most vulnerable communities. With so many competing priorities, libraries are asking for an increase to the operating grant so that we can continue to support all Ontarians.

Thank you for your time.

The Acting Chair (Mr. Will Bouma): We will now move on to the presentation from the Canadian Mental Health Association Thames Valley Addiction and Mental Health Services.

Ms. Pam Tobin: I'm Pam Tobin, and I'm the CEO of the CMHA Thames Valley Addiction and Mental Health Services. On behalf of the CMHA, I'd like to thank you for the opportunity to address the committee and to share the mental health and addiction needs in our community.

We're one of the largest CMHA branches in the country, serving over 17,000 clients every year. Last year, the provincial government demonstrated a commitment to community mental health and addiction care by providing a 5% base increase, and we would like to thank the government for that. It was the first infusion of infrastructure funding for our sector in more than a decade, and it really helped us to balance our budgets while continuing to provide high-quality care.

But as the demand for our services and the complexity of our clients continues to grow, so does the wage gap between our sector and other health sectors. We urge the government to maintain momentum this year by providing another round of stabilization funding for the community mental health and addiction sector. Without stable funding, we cannot keep pace with the need in our community.

London is facing a dire health and homelessness crisis. The number of individuals experiencing homelessness has reached approximately 2,000 people. That's double the number from before the pandemic. At least 250 people have died on our streets over the past four years. Our municipal partners have worked really hard to create an innovative community response to this challenge. The plan includes creating connections to community mental health and addictions services to ensure that these individuals have the supports they need.

Individuals experiencing homelessness are often the most complex to serve. While not all individuals experiencing homelessness have a mental illness, we do know that they're more likely to have poor mental health than the general population. But it is difficult to fully support our partners with these initiatives when we have such limited resources and we're struggling with the health human resources crisis.

Providing quality mental health and addiction service for Ontarians requires incredibly dedicated staff, yet when compared to others doing the same job in other health sectors, my colleagues are often paid 20% to 30% less, resulting in a high staff turnover. We're currently managing a staff vacancy rate of about 23% and we continually lose talented people to other sectors who pay more.

Additionally, new programs are often coupled with escalating staffing and operating costs that continue to strain our resources. Take, for example, the recent funding from withdrawal management beds for Elgin county. We certainly appreciate the government's funding for this program, which is greatly needed in the community; however, the funding only covers operational costs. We supplement the difference with our current budget allocations to ensure quality care for our clients. Likewise, many of our programs are dependent on grants, donations and in-kind gifts to sustain optimal service delivery. This includes My Sister's Place, a drop-in centre for women which received more than 34,000 visits last year.

The lack of secure funding prevents us from long-term planning. This issue isn't unique to our branch. A compensation survey released on behalf of CMHA and our partners found that the community health sector is behind on wages by more than $2 billion compared to staff doing similar work in other areas of health care. This needs to change by closing the gap in pay, which brings me to our formal pre-budget ask.

The community mental health and addictions sector requires a 7% increase in funding of $143 million annually to address these challenges. This includes a 5% in stabilization funding to help us bolster services while managing the health human resource crisis. The remaining 2% of our ask, or $33 million, comes in the form of a new provincial, three-year community supportive housing innovative fund.

We can appreciate that the government is focused on more affordable housing across the province, but it also needs to include more supportive housing. Supportive housing helps to reduce homelessness and connects service users with wraparound mental health and substance use supports. Evidence shows that supportive housing models can help a person's journey to recovery from a severe mental health issue. It's also a fraction of the cost when compared to hospital or correctional institutions. But the latest data indicates that the average wait time for supportive housing across the province is 300 days. In our area, the average is about 184 days.

A new community supportive housing innovation fund would provide capital and operating dollars for the development of innovative and evidence-based models of housing with supports. The fund would be available for initiatives led by community mental health and addiction sector experts who have strong partnerships with other social service providers. It would also enhance the Ministry of Municipal Affairs and Housing Homelessness Prevention Program to get more people housed and ensure that they have the support that they need.

It's important to note that investing in mental health and addiction care serves to limit unnecessary hospital visits.

Our sector is proud of the work that we do to provide appropriate community care pathways for clients and help to reduce the strain on our colleagues in the emergency room. Our work is in line with the last Auditor General's report, which recommended strengthening the community care sector to support our hospital system.

For example, our mental health and addictions crisis centre serves as an efficient and effective alternative to the emergency department, offering 24/7 walk-in and referral service, as well as police and ambulance drop-off. The crisis centre served more than 10,000 clients and diverted 4,792 hospital visits this year alone.

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

Ms. Pam Tobin: Our work has a broad impact in many areas of our community. With stabilization funding to strengthen evidence-based programs and an increase in commitment to supportive housing, our sector can improve outcomes for individuals in our community.

In closing, I'd like to thank the committee for taking the time to hear from us and the other stakeholders in our community, and I look forward to your questions.

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

Our next presentation will be the Alzheimer Society of Ontario.

Mr. Kyle Fitzgerald: Good afternoon, Chair Hardeman and committee members. Thank you for the opportunity to appear before you today. My name is Kyle Fitzgerald. I'm the director of government relations and public policy with the Alzheimer Society of Ontario. I'm joined onscreen by Carol Walters, CEO of the Alzheimer Society's Southwest Partners, which provide services through Elgin, Oxford and Middlesex counties, including London, where we are today.

January is Alzheimer's Awareness Month, recognized across Canada and internationally as an opportunity to reflect on the challenges faced by people living with dementia, and their care partners. I encourage you all, and anyone watching at home, to visit ourconnectionsmatter.ca, to learn more about dementia signs, symptoms and prevention.

By the end of 2024, an additional 67,000 Ontarians will have developed dementia. There will be, by that time, a total of 316,600 Ontarians living with dementia, including those without a diagnosis, and over 185,000 care partners will provide over five million hours of unpaid care to someone living with dementia each and every week this year in this province, depriving Ontario's labour force of the equivalent of 130,000 full-time jobs.

Dementia costs Ontario $30 billion a year and we have no provincial leadership dictating where that money is spent. We have stumbled into a reality where the only place to get care is a hospital emergency department. Unsurprisingly, people living with dementia now account for half of all ALC days in Ontario's hospitals. That means that we're losing 3,000 beds each and every day, just under 10% of our overall bed capacity, because we are failing to provide support to people living with dementia at home.

Community supports make up less than 2% of the overall health budget, and we have stretched that as far as it will go. Base funding increases last year, the first in a decade, still leave a gaping hole between compensation for home and community works and those in the hospital sector.

Refusing to support people with dementia and care partners at home does not mean that their care needs go away. Instead, they go to the one place that can't say no: their local emergency department—or their not-so-local emergency department. This is an inefficient, expensive and wasteful approach, and one that provides worse outcomes at higher cost.

The four recommendations put forward in our pre-budget submission should be seen as the minimum the provincial government can do to slow the steadily deteriorating quality of dementia care in Ontario. Our provincial dementia strategy, accompanied by a central coordinating body overseeing spending on dementia care, would regain some control over a disjointed system and bring Ontario in step with peer international jurisdictions. This would also be a bipartisan success. Bill 121, which proposed a provincial dementia framework, passed second reading with all-party support.

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It is within this government's power and in this government's interest to make a provincial dementia strategy one of its defining policy legacies. As part of this strategy, we are calling for $3.4 million in additional funding for First Link, a fund which would support nearly 7,000 further Ontarians ever year, and funding which was promised in 2019, but never delivered. First Link has been shown to avoid one hospital visit per three clients served based on health card data. This funding ask would save over $1 million more than it costs in avoided hospital utilization.

The status quo for dementia care is not working. It is not working for Ontarians living with dementia and their care partners, who are not receiving anything near the care they need to stay at home and are turning to overburdened hospitals as a result. It is not working for care providers who are leaving for better pay and working conditions elsewhere, and it is not working for taxpayers, who are spending $30 billion a year on stopgap measures, with very little to show for it.

To share more about how this is being felt locally, I will now turn to Carol Walters, CEO of Alzheimer Society Southwest Partners. Carol, over to you.

Ms. Carol Walters: Thank you, Kyle. Good afternoon.

Our call to action is that no one living with dementia goes unsupported. We face two major risks: meeting demands of an increasing dementia population and the risk of not obtaining sufficient funding to sustain operations.

The Ministry of Health only provides 50% of our operational need, and the remaining 50% must be obtained through community support. There are 14,000 people living with dementia in our region, with projected growth to 18,630 by 2030. We receive, on average, 150 new referrals in a month, and we've never experienced such growth in need. In the past, we met this demand with the

financial support of our community and our over 430 volunteers. We have now squeezed all that we can out of our Ministry of Health 50-cent dollar, and our wait-lists are growing.

To sustain operations, we need to fundraise $2.4 million a year, in addition to ministry funding. The tough economic times have made it impossible to meet this financial target. Due to insufficient ministry funding, 52% of our staff positions are funded through donations. This year, we have had to remove five staff positions and one management position to meet our budget, thus impacting service levels.

Kyle did an excellent job outlining our need and our priorities. Critical programs like First Link care navigation, that connects families with services they need, are at risk with one third of our staff in this program being supported by fundraising.

Generous donations and Ontario Health West one-time funding allowed us to place dementia resource consultants in the emergency departments of three hospitals in our region. Now, non-acute patients with dementia can return home with supports needed instead of landing in a hospital bed. While we are grateful for one-time funding, it does not form part of a viable financial plan, putting successful programs like this at risk.

We face significant financial risk using funding to support operations.

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

Ms. Carol Walters: We are forced to balance increasing need and decreased funding. With adequate ministry funding and continued community support, we are confident that we could meet the growing demand.

It is time to make it right. The essential programs we provide contribute notable savings to enhance efficiencies within the health care framework. These programs reduce emergency room visits and hospital admissions, postpone admission into long-term care and deliver indispensable education and support. Your investment in the Alzheimer Society will have a significant health system impact. Thank you.

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

We'll now start with the questions. MPP Harris.

Mr. Mike Harris: Michael, let's talk libraries.

Mr. Michael Ciccone: Sure.

Mr. Mike Harris: I've participated in a couple of these hearings around the province. I'm not a permanent member of this committee, but when we're going all across the province we try and spread the love, if you will, and have different members take part so that we can get a little better sense of what's happening in different parts of the province.

I've now heard from a rather coordinated effort from the libraries across Ontario.

Mr. Michael Ciccone: Some of the language may have been similar.

Mr. Mike Harris: Yes, exactly.

One of the things that's obviously come up quite often is the notion of this more holistic provincial online library. Where I'm from—I'm from Kitchener—the region of Waterloo operates our libraries in our townships; we have four townships. And then each city—Waterloo, Kitchener and Cambridge—operates their own libraries respectfully in their municipalities. Each of those library systems has some kind of current online component.

I guess the question is—I assume that is the case in most libraries, if not all at this point across the province. How can we accomplish this without having to reinvent the wheel? Because there has obviously been a lot money and time that has been dedicated to setting up these individual online components. How can we coalesce them together and look at a way to move that out across the rest of the province?

Mr. Michael Ciccone: I do have some background in terms of collections, which usually falls underneath that portfolio. I haven't been there in a while, but I can say that, if we decided, as a province, to approach the vendors that provide these resources, bringing that up would not be that difficult. For instance, some of the databases would probably just do it by IP authentication. Wherever you logged in from in Ontario, you would be able to get to those databases. It actually makes it simpler because, in general, when you're trying to get into these databases, you're authenticating through your public library. That requires, in some cases, a licence to get into your system in order to authenticate to make sure that you're a member of that library. That would all go away with a provincial approach.

Mr. Mike Harris: So if you were to take a provincial approach, it would then make the individual ones redundant, I would assume.

Mr. Michael Ciccone: Redundant, yes, absolutely. Obviously the vendor needs to be paid, but I think, in the past, they've been willing to forgo that for a larger customer base.

Mr. Mike Harris: Sure. But that one vendor would be doing all of the province. I'm assuming there are multiple vendors for different municipalities.

Mr. Michael Ciccone: Yes, there is absolutely. I—

Mr. Mike Harris: From a framework perspective, you would have to figure that out, but it could be done.

Mr. Michael Ciccone: Yes, absolutely. Again, all these libraries are dealing with these vendors one-on-one. This would be an opportunity to have one group dealing with each of the vendors.

Mr. Mike Harris: So who would become the online library? How would that be administered?

Mr. Michael Ciccone: You know, I don't know for sure. My guess is, and it's just a guess, it would be the Ontario Library Service.

Mr. Mike Harris: Okay.

Mr. Michael Ciccone: Because they're doing some of that now, where they're negotiating for consortium pricing, but it's still individual purchasing.

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Mr. Mike Harris: I just look at it like—we've got four different library systems in Waterloo region. That doesn't make a lot of sense as it is.

Mr. Michael Ciccone: It does not.

Mr. Mike Harris: Yes. But I think about the fact that they would then fight about who would be the ones to take charge and make sure that the region's interests are represented in that.

Mr. Michael Ciccone: As you can see by our coordinated effort here, we actually work very well together. Libraries are very collaborative when it comes to things like that, if it means saving money and if it means getting access to the people in Ontario.

Mr. Mike Harris: And what about from a municipal standpoint? Because, like you said, the libraries are funded by the various municipalities, with funding sometimes—well, most of the time—from various other levels of government as well. So how do you envision that funding model working, then? If there's a provincial arm that's taking over the online piece, they'd be funded separately than the brick-and-mortar libraries?

Mr. Michael Ciccone: The savings are significant, but not so much at the municipal level that we would say, "Oh, my God." There are still digital resources that we would have to do individually based on the licensing, like, for instance OverDrive and Libby or something like that. Anything that reflects what you would think of as taking out a book in the digital world—

Mr. Mike Harris: Which is the Libby system.

Mr. Michael Ciccone: —which is the Libby system—would not qualify for this. It would be more of the research, LinkedIn and things like that, where—

Mr. Mike Harris: So you would still have your individual library systems doing the in-and-out of books through Libby—

Mr. Michael Ciccone: Some of those digital resources, yes.

Mr. Mike Harris: —but then there would be another system on top of that from a provincial standpoint, is what you're saying.

Mr. Michael Ciccone: It would be a substitute for what we're doing now, which is an individual approach.

I'll just give you an example. If I were to go to the London Public Library right now to go to a research database that we provide, I would have to put in my library card number and my PIN, and that would authenticate in our system. If the province would take over administration of that, I would just go in and I would be in, because it's IP-authenticated. The vendor recognizes the IP for Ontario, and I'd go straight in. I wouldn't have to authenticate with my local public library.

Mr. Mike Harris: I just would hate to see two systems being built out that would step on each other.

Mr. Michael Ciccone: It won't. They already exist, and they wouldn't step on each other. This would just basically be taking some of the digital resources and putting them into this consortia-level approach, which would make it easier for everybody and save the library, the province overall and municipalities some money. And that money could be put toward other aspects of areas that we're struggling with.

Mr. Mike Harris: How much time is left, Chair?

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

Mr. Mike Harris: Just quickly over to CMHA: We had a lovely presentation from one of your colleagues in Welland last week, and I've gotten to know Helen Fishburn very well in Waterloo region; she does a phenomenal job. One of the things that we talked about was upstream investments, and I was wondering if you maybe had a—I know we don't have a lot of time here, but 30 or 40 seconds just to talk about a couple of key things that you view—

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

Mr. Mike Harris: —that could go into the Ontario budget funding model, that could help with some of those more upstream issues before they become, obviously, larger problems downstream.

Ms. Pam Tobin: Thanks for that question. I think first and foremost would be staffing. We can't deliver on our services and programs in a timely manner without the staff to do so.

Mr. Mike Harris: Okay. That seems to be—as MPP Leardi alluded to, I think in our last presentation, staffing across the board is something that has been a bit of a challenge over the last little while in many, many industries.

Ms. Pam Tobin: That's right.

Mr. Mike Harris: I think of skilled trades as a huge example of that—not that we're conflating the two. But I think human resources is certainly a challenge, and making sure that we have credibly educated people that are doing those jobs is going to be an important piece in the future.

I know we're out of time, Chair. Thank you.

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

Mr. Terence Kernaghan: Thank you to our presenters here today, as well as those virtually.

I'd like to start off with the London Public Library. Michael, I know it has been a very difficult time with the cyber attack, and I just want to extend my condolences to all of the people who are working on the team. I know it has been a tremendously difficult time.

But I want to thank you for your presentation on behalf of Ontario's libraries, because libraries do look into the future. They provide countless possibilities. They are at the heart of future work, skills development, economic development. Many presentations have shown how this is a cost-effective investment that the government could make, and I do hope that they will finally listen, because I know it's something that's been happening year over year. It has been many years that the province has neglected Ontario's public libraries.

I also just wanted to thank you because you indicated that while you have access to these resources, you are also advocating for those people who do not, as well as the First Nation supplement. I just wanted to thank you very much for that; I think that's very good of you.

For my questions, though, I wanted to ask: Pam, in your presentation, you spoke about the 20% to 30% wage gap. I think it's something that the government shouldn't dismiss, say that there are problems within every sector. We know that people are moving in health care especially from one sector to another. You can actually track where

these people are going because of the disparity. Could you explain for the committee: When you have a new hire, could you explain the financial implications of training that person up only to have them leave? What does that look like for the organization?

Ms. Pam Tobin: Well, it's very demoralizing for all of the staff and leadership. It's quite extensive and costly for the human and financial resources to on-board new staff, only to have them leave. One of the challenges that we have is we have a very passionate and dedicated staff. That's one thing that I've really noticed since joining CMHA. The people who are coming to work for CMHA are interested in supporting clients within the community. CMHA does that really well. Often, when we have staff leave, and they say that they have to leave because they're getting better wages elsewhere, it's also demoralizing on them.

It is an ongoing cycle, and it's one that consistently changes. We're sitting now at a 23% vacancy rate. It puts a lot of increased workload on the existing staff. We're not able to be innovative any longer with our current budget. We're at capacity for innovation. Right now, we're just able to deliver on the services that we've set out to do.

Mr. Terence Kernaghan: Understood. So it's not a mystery where people are going; you know directly that they're telling you they're leaving to pursue another avenue.

I wanted to commend you on the ask. I think it's very wise that you're looking for that 7% increase, considering 5% for wages but also 2% for that community supportive housing innovation fund. I also think it's quite smart that you've looked for capital as well as operational dollars within that ask. Can you speak to the importance of supportive housing and how that changes lives?

Ms. Pam Tobin: Supportive housing is critical to the health and wellness of our community. When I look at the work that we do, we have over 1,000 supportive housing units, and we have more than 20 programs and over 130 staff who are providing services to supportive housing. Supportive housing also provides wraparound services to keep people housed. It directly impacts the health and homelessness initiative that's in London right now. It keeps people off the street, and it keeps people healthy and happy. I think that that's, again, critical to the success of the work that we do.

Mr. Terence Kernaghan: Absolutely. I'm glad to see the greater understanding of people within the community, recognizing that homelessness is a cause of mental health exceptionalities. Mental health exceptionalities do not cause homelessness, which is often the judgmental pose that can be taken.

Next, I'd like to move over to Kyle and Carol. I want to congratulate you on an excellent presentation. You've shown what the impacts are of the government not looking forward and considering what is happening with the aging population as diagnoses of dementia are increasing within the community and what that costs our system as well. I'd like to apologize that the funding that has been promised from 2019 has not flowed. That has got to be a little embarrassing for the government members. It's unfortunate that you have that expectation. You would take them at their word, and you would expect that they would make good on their promise, and unfortunately, that money hasn't flowed.

But I also wanted to—if you could explain for the government, Carol, the great work that the First Link care navigators do, how they help families and how they help those who have received the diagnosis of dementia.

Ms. Carol Walters: Yes. The First Link care navigator is probably the first person that anyone coming to our organization will meet with. They certainly sit with the family, both the care partners and the person living with dementia, and determine not only what services they need at the Alzheimer Society but what other community services would be helpful for them.

We have noticed since the pandemic that the cases that are coming to us are much more complex than they ever used to be. We have many of our clients who also require services of CMHA, addiction services, so again, our team connects the individuals with those services so that they're not having to just get a whole bunch of pamphlets and try and navigate it on their own. They are directly connected to what they need to be able to live well at home and then start the programs at the Alzheimer Society to learn more and set expectations as to what to expect through the dementia journey. So it is an extremely critical role. They're very well connected throughout the community.

Mr. Terence Kernaghan: Absolutely, and they do wonderful work making sure that people aren't met with closed doors but with open ones.

I must say, it is disappointing that you have to fundraise to pay for the necessary staff. I hope that the government will listen to this, realize that you've had to cut positions because those ones were fundraised for, and they could address this with their $5.4 billion—

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

We'll go to the independents. MPP Hazell.

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MPP Andrea Hazell: Thank you for coming in and presenting. It's great to meet you. I want to touch on the London Public Library—a lot of your folks have been with us presenting and they've done a fantastic job, so if we do not get it right, there's a problem. With the cases that your organizations and libraries presented, I hope we don't see you next year back at pre-budget consultations and you get the funding that you desirably need.

I'm going to go to the Canadian Mental Health Association. Pam, thank you for your presentation. I want to look more into your 7% increased funding that you're asking for. I guess where you're getting pressures on your budget is the managing of your operations, including your human resources crisis that you're going through, right? And coupled with that, you're also managing a vacancy rate around 23% and then you continue to lose talented people. Is that 5% and that 7% enough to get you through 2024 to 2026 so you're not back at the table next year asking for funding? Because this is a crisis.

Ms. Pam Tobin: Absolutely. We would take more money for sure, but we want to be mindful that there's only so much money to go around and there are other people who also need funding as much as we do. However, we are at a crisis moment in time where the 5% base funding would enable us to continue the programs that we have. If we don't get the 5% funding, we will see an increase in wait times and we'll see fewer clients served. We won't stop our services, but it will be harder to deliver on those services.

When we look at our vacancy rate, the 5% increase in base funding would help us to stabilize our workforce. The 5% funding that we received this past year—it was the first in a decade, but we were able to use those funds to put towards staff to help stabilize our staff. So that number of 23% would have been much higher had we not received that 5%.

Supportive housing is critical to keep people housed and to provide those wraparound services to clients, and I think 2% is a nominal amount to keep people housed. When we look at the cost of having people at the emergency department, it far exceeds all of the services that we provide within the community to keep people out of the emergency department. So I think our ask is quite reasonable. Is 7% enough? We could always do with more to expand our services. This is to keep us in operations and to keep us delivering the services that we've committed to deliver.

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

MPP Andrea Hazell: So, in the worst case scenario, which one will you put on top if you have to put the first? Is it the 5% or the 2%?

Ms. Pam Tobin: It would be the 5% base funding.

MPP Andrea Hazell: I agree with you.

Ms. Pam Tobin: If we had to pick one—I would be hard-pressed to pick one, but if we had to pick one, it's the 5% base funding in order to enable us to keep our operations going.

MPP Andrea Hazell: Thank you for putting that on the record.

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

Mr. Rick Byers: Thank you to the presenters for being here this afternoon and for the work you do in your communities.

Perhaps I'll start with Kyle and Carol. Thank you for your presentation and your work. You comment about the ALC beds that patients are occupying. I didn't appreciate the significance of that number. Can you give me some sense of that trend over years? Has it been increasing? The province has made changes to ALC beds in recent years as well and how they're used, but I wonder if you could just comment on what you've seen in terms of your clients' use of those beds over the years and how that's been changing.

Mr. Kyle Fitzgerald: So, I'll start and then maybe put up Carol, if she wants to add—for the local context.

Province-wide, it's 50% of ALC days, so that works out to about 3,000 beds. That's been fairly consistent across the province. I'm aware of some regions where it's actually in the 70% range.

What we're seeing is hospital emergency departments have been involuntarily inserted as part of the admissions process to long-term care, so individuals who are at the end of their everything are having to call 911 and be admitted to hospital because they're so low on the wait-list to long-term care, because ALC status has been designated as a higher priority for long-term-care admission.

What we're seeing is folks that are waiting years to get a long-term-care bed are not able to get support at home. It's usually actually the caregiver that burns out—and that's putting it lightly—the caregiver that breaks, and when that person is unable to continue to provide care, it's usually a single crisis situation that will lead to them going to hospital. And once you enter the hospital system, the number one predictor of you being admitted to hospital if you're someone living with dementia is, have you been admitted to hospital before? Once that first admission happens, it starts a downward cycle and it's very, very difficult to keep that person at home.

But I'll turn it over to Carol—if you have anything to add on ALC rates here.

Ms. Carol Walters: We're very similar in ALC rates locally. Our program dementia resource consultants in the emergency department that's been recently implemented is only a pilot project until the end of March. Within the first month and a half of putting it in place, we're seeing a significant diversion rate.

As Kyle said, many times it's the sick care partner that has burned out or just can't do it anymore at home—this program comes with dollars to support respite care. If it's overnight respite that's needed—the care partner needs to get a good night's sleep a couple of times a week—we can support that, or if it's during the day that the care partner just needs time to go get groceries and things like that, we can support that through this program.

There was a pilot project prior to this one in the Brant and Norfolk area with incredible results. We're anticipating we're going to see the same from the hospitals that are up and running through the pilot till the end of March. We just need funding to continue this. It can't be a program that stops. It's critical that we continue it. It's critical for the whole health care flow, both with long-term care as well as the ALC beds.

Mr. Rick Byers: Okay, great. Thank you very much. Thank you for all you're doing.

On the funding side, I'll disagree with my colleague from the opposition: I think the fundraising you're doing in the communities is fantastic and engages you with the community, in my opinion. In fact, on the 29th, I'm one of the judges for a Soup's On contest run by Alzheimer's in Grey-Bruce. It's a fantastic event and really a great way—last year, we tasted about 25 different soups, so I'm looking forward to that. But thank you for all that work. I know it takes a lot of effort, but it's so important.

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Maybe, Pam, we'll go to you now. Again, thank you for the work you're doing. CMHA is very active in the Grey-

Bruce community, too, an organization in Owen Sound. Can you give me a sense: Is it fair to say that—perhaps both organizations—you're part of the primary care network in the community? How do you work with other primary care providers in the community that you're working in?

Ms. Pam Tobin: We have a lot of strong partnerships in the community. We partner with the hospital. We partner with grassroots organizations and everything in between. We're seen as a leader in the community for community-based mental health and addiction services, so we have a lot of partnerships.

If we have somebody who might reach out to us to ask to partner, we will extend our resources to support them in however we can. So there is not just one way in which we support primary care, but there are many different ways in which we support them. It depends on how the ask might come to us, but we're always there to support and partner with primary care.

Mr. Rick Byers: Got it. Thank you. And relating to that, each community is going to be different and is going to have different partners playing different roles. I must confess, that makes it challenging for government to assess the funding requests that come, frankly, because, as I said, each community is going to be different and have the organization play a different role. I know you've made an ask here—and I certainly appreciate that, and we take that on board—but how can we best assess the needs of different communities and different organizations? There is no easy way to do it. I don't know if you have any thoughts on that that you can offer us.

Ms. Pam Tobin: CMHA is an expert in community mental health and addiction services. We are the expert in the community. We are not 9 to 5, Monday to Friday; we're out on the streets, 24/7.

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

Ms. Pam Tobin: We have staff everywhere, all the time, to provide mental health and addiction services. That's what makes us unique in the system, and we partner well with all levels of health care. I think that that's what makes us different.

Mr. Rick Byers: And the association speaks on behalf of all the different organizations to government. Do you feel there is a good dialogue there with the Ministry of Health and ministry of mental health and addictions?

Ms. Pam Tobin: Oh, absolutely.

Mr. Rick Byers: Good.

Ms. Pam Tobin: Yes, very much so.

Mr. Rick Byers: Okay. Thank you so much. Thank you to you all.

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

Ms. Peggy Sattler: Thank you very much to all of our presenters today, and Carol online.

I want to begin with Pam and CMHA. During your comments, you noted that many of your programs are dependent on grants, donations and in-kind gifts, and you mentioned My Sister's Place, which receives more than 34,000 visits a year. I've visited My Sister's Place numerous times and talked to the women who use the services there, and I have seen the incredible impact of My Sister's Place. I wondered if you could elaborate on some of the challenges for an organization when you can't fund something like My Sister's Place through stable base funding, but you have to rely on grants, donations and in-kind gifts?

Ms. Pam Tobin: The amount of effort that we have to put into raising funds to keep programs such as My Sister's Place open is incredible. It far exceeds any funding that we would receive to keep the doors open. We have a fund development department who spend a considerable amount of time on that.

My Sister's Place is really a part of London's community, very much so. We receive such positive feedback on the work that we do there and the services that we provide to the women. We see so many women there who benefit from our services every day. We could expand those services, as well, but we just don't have the funding to do so.

It's extremely stressful knowing that the funding for My Sister's Place is donor dollars. There is no funding that we receive to keep that program open from any of the other sources. It's 100%—well, it's about 80% donor dollars, so yes, it's extremely stressful in order to keep the programs running.

Ms. Peggy Sattler: In your official pre-budget consultation submission, one of the programs that you highlight is the COAST program, and you note that "London is one of the only comparable size cities in the province without dedicated funding to support a police-health co-response model" such as COAST.

Now, given the evaluation data that corroborates the effectiveness of the COAST program right here in our community, have you ever gotten an explanation from the government as to why they would not provide permanent funding for COAST in the London area?

Ms. Pam Tobin: No, we have not.

Ms. Peggy Sattler: Nothing? Okay. Well, we'll keep trying.

I now want to go to Kyle and Carol with a couple of questions. Kyle, you began your presentation by talking about the annual cost of dementia in this province, over $30 billion annually. I'm interested in knowing how much of those costs is preventable or avoidable if we were to move forward with the recommendations that you have included in your submission: renewing Ontario's dementia strategy and creating a central body, with funding control, to provide strategic direction. If we do those kinds of things and move forward with some of your other recommendations, can we help shift that $30-billion cost of dementia?

Mr. Kyle Fitzgerald: Oh, 100%. I think, actually, right now, that the next six months are the best opportunity we've ever had to change how we care for people living with dementia. We're on the verge of having a treatment for Alzheimer's disease, which we've never had before.

We are so unready for it, it is frightening. It takes anywhere from 12 to 18 months to see a specialist to get a

diagnosis of dementia. By that time, you're no longer eligible to receive the treatment. It must be administered early, in the mild cognitive impairment or early Alzheimer's disease stage. If we're not able to catch people quickly, this opportunity is going to pass us by.

Research out of the University of Southern California showed that we could save $9.9 billion over 20 years through these treatments. That's net, so the cost of the treatment is included. We would save almost $10 billion. However, we're not well positioned to take advantage of that, because we don't have a dementia strategy, because we don't have the capacity to keep people at home and because a lot of Ontario seniors don't even have family doctors, the most basic form of care.

Ms. Peggy Sattler: Carol, did you want to elaborate on that?

Ms. Carol Walters: Certainly a lot of the services that we provide, not only at the Alzheimer Society, but community support services, do have a direct impact on the health care system. Reducing hospital visits, reducing people in hospital beds and ALC beds, delayed entry into long-term care—all of those things save money to the health care system. But we need an investment in community services, in organizations like the Alzheimer Society, so that we can keep people at home longer.

Ms. Peggy Sattler: And going back to the exciting research developments on this treatment that is imminent in the province, are you hearing from the Minister of Health and the government? Do they share your excitement? Do they understand the importance of preparing for this treatment to be available, and can you elaborate about what we need to be doing to be able to leverage this opportunity?

Mr. Kyle Fitzgerald: Maybe I'll take your second question first and hope my time runs out before I get to the first one. It really falls into early detection and diagnosis, infusion capacity and monitoring capacity.

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

Mr. Kyle Fitzgerald: We need to be able to detect and diagnose Alzheimer's disease, so that requires specialists and primary care. We need to be able to infuse these treatments—they're infusion-based, which means we'll need about 96,000 infusion appointments per year in Ontario just in the first year alone. As well, we need MRI capacity. These treatments in the US require four MRI scans in the first year to monitor for adverse effects. That would be about 16,000 MRI scans in Ontario. We don't have 16,000 available MRI scans, so one of our recommendations is to make effective use of existing clinical MRI capacity—which are not being used around the clock, and unfortunately, I don't think that concern is fully appreciated. Some of our stakeholders—we've seen other organizations raise that, and we've seen media interest, but that hasn't yet been reflected.

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

Mr. Adil Shamji: For the Alzheimer Society: The protocol that you just described, in terms of four MRIs in the first year—I understand that CSF analysis and that kind of thing is all involved. How impactful are these disease-modifying drugs in terms of influencing the course of mild cognitive impairment, or early Alzheimer's?

Mr. Kyle Fitzgerald: It's important to note that there are currently three treatments for Alzheimer's disease in Ontario, but none of them actually modify the course of the disease. The treatments being considered right now by Health Canada and the ones that have been approved by the US FDA and in Japan have been shown to reduce cognitive decline by about 27% over 18 months. So it's not a cure; it's not a silver bullet. However, when you're at the stage of your dementia where you potentially only have a few years left, 27% more time works out to potentially four, five, six months of enhanced quality of life and memories with your loved ones. So, on an individual level, it's quite impactful, and on a health system level, as well. If we were able to delay the onset of symptoms by five years, Ontario would avoid a million cases of Alzheimer's disease over the next 30 years. So, at a health system level, if we're able to get these treatments to people and delay the onset of symptoms until, frankly, they pass away from other causes, we would avoid a million cases. That would cut our expected case increase by one third; right away, we've saved ourselves 33%.

Mr. Adil Shamji: I note from your pre-budget submission that there's a call to review or fund lumbar punctures, CSF analysis and PET scans. I've always been able to order those things when I've needed to, or to perform them when I've needed to. Can you elaborate a little bit on that?

1650

Mr. Kyle Fitzgerald: For diagnostic purposes, for Alzheimer's disease in particular—the only way to get a diagnostic PET scan for Alzheimer's is through a clinical trial, right now. That used to be funded up until 2019 or 2020, I believe; it was delisted. So, currently, you're not able to order that for the purpose of diagnosing Alzheimer's disease, outside of a clinical trial.

Mr. Adil Shamji: Thank you very much.

For the Canadian Mental Health Association: We face, unfortunately, a rampant addictions crisis. We have an epidemic of people seeking mental health treatment. Can you elaborate a little bit more on how—sure, the base funding, but then also the additional 2% that you're asking for can help us make more of a dent in those crises?

Ms. Pam Tobin: The 5% base funding provides us the opportunity to continue with the services that we provide. If we don't receive the 5% funding, the wait-lists will be longer and fewer clients will be seen, escalating the crisis that we're already in.

Supportive housing also provides wraparound services to clients and keeps them housed. Even though unhoused people don't necessarily have a mental health illness, we know that mental health does suffer when faced with issues of food insecurity or homelessness.

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

Ms. Pam Tobin: So the supportive housing will keep our clients housed and provide services around individual clients, to provide the supports that they need, and to meet

them where they are. I think that's so important in the work that we do, to make sure that we're addressing the crisis that we're in. Without this funding, we will not be able to do any of that.

Mr. Adil Shamji: Just very briefly, because our time is almost up, can you speak to the demands that we're facing in this community for your services—maybe the length of the wait-list or the number of people who are calling?

Ms. Pam Tobin: The length of the wait-list depends on the program. Since the pandemic, in particular, the delivery of services and the complexity of each client that we're seeing—

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

With that, that concludes the time for this panel. We want to thank all of you for your presentations and for taking the time to prepare them and come and present them to us today.

PHSS MEDICAL AND COMPLEX CARE IN COMMUNITY
POWELL HOLDINGS
YWCA ST. THOMAS-ELGIN

The Chair (Mr. Ernie Hardeman): Our next presenters will be PHSS Medical and Complex Care in Community, Powell Holdings and YWCA St. Thomas-Elgin.

As with the previous panel, if you were here for the instructions, it's a seven-minute presentation. At six minutes, I will say, "One minute." At seven minutes, I will say, "Thank you."

We do ask each presenter, whether virtual or at the table, to state their name at the start of their presentation to make sure that we can attribute the great comments to the right name.

We're going to start with PHSS Medical and Complex Care in Community. The floor is yours.

Mr. Brian Dunne: Good afternoon, everyone. My name is Brian Dunne. I'm the CEO of PHSS Medical and Complex Care in Community.

Chair Hardeman, Vice-Chair Fife and members of the committee, it is my pleasure to speak to you today on behalf of the entire PHSS community.

Established in 1988 by London-area families, PHSS is a unique not-for-profit organization dedicated to providing care and supports across Ontario for individuals with developmental, medical and complex needs at home and in their communities.

PHSS supports more than 300 Ontario residents across more than 75 locations, in communities like London, St. Thomas, Owen Sound and Ottawa.

PHSS is funded by the Ministry of Health, the Ministry of Children, Community and Social Services, the Ministry of Housing and Home and Community Care Support Services. The organization is governed by a board of directors of 16 members.

The individuals we support are served via day supports, respite, 24/7 residential supports or in co-operation with families in their homes, through the You at Home program. The You at Home program is a new and growing service for PHSS, and we are now bringing our person-centered approach to support 35 Ontario families in each of their homes.

As a provider of care and support to both persons with developmental needs and persons with medically complex conditions, PHSS is also proud to be one of the only Ontario providers supporting individuals requiring long-term ventilation, or LTV, in the community. These individuals are normally cared for in hospital ICUs, where the average cost of support can exceed $3,000 a day. PHSS is able to support these individuals in the community, greatly enhancing a person's quality of life while achieving substantial system cost savings.

We've helped numerous Ontario families in managing the direct funding they receive from MCCSS, and we provide education to communities on the Passport Program. We are a strong partner in pushing forward the government's Journey to Belonging transformation agenda.

We are currently in the midst of reaccreditation with Accreditation Canada, which will provide the government of Ontario with greater levels of assurance as to the quality of care and support we provide.

We are also proud to be members of five Ontario health teams across the province, including Oxford, Grey-Bruce, Elgin, Huron Perth, Middlesex London.

As we continue to expand in the eastern region, we look forward to continuing to engage with the health and social care service partners in that area.

Members of the committee, over the last decade, base increases to funding for community health and social care organizations have been minimal. PHSS, more than most providers, has been able to withstand these pressures. We're one of the few health and social care organizations to expand services in recent years, and through the COVID-19 pandemic. However, PHSS is deeply concerned about the financial situation of our system and that of the health and social care sectors in particular.

Government has made significant investments to the tune of a 5% annual increase for mental health and addictions. While welcome news to many, these investments in no way touch community agencies like PHSS or the people we support.

1700

It is here in Ontario communities that we can prevent social isolation and provide the care and support necessary to keep these issues from escalating. It is here that we can provide the support to individuals with medically complex needs that will keep them out of our ICUs and long-term-care homes. It is essential that the government begins to recognize the impact of failing to adequately fund the community health and social care sectors.

PHSS has a long history as a trusted partner with government. We are here to be part of the solution. It is in that spirit that we now ask the government of Ontario to begin to address the intolerable pressures in the health and social care sectors, with an adjusted increase reflecting the current costs, with similar funding levels in the years to come.

We would also like to request that government take additional steps to ensure the greater availability of one-time funding to its trusted partners as they seek to develop the electronic records and cyber security capacities the government requires of them. Additionally, the government must address the funding requirements to maintain ongoing repair, maintenance and infrastructure costs, including building code and fire code requirements, to ensure the safety and security of our most vulnerable citizens. The availability of this targeted funding is insufficient to ensure that expanding services like PHSS are able to meet the demands of providing services in 2024 and beyond.

PHSS thanks the committee for its consideration and due diligence. We will be pleased to answer any follow-up questions the committee may have.

The Chair (Mr. Ernie Hardeman): Our next presenter is Powell Holdings.

Mr. Peter Watson: First of all, I'd like to thank the Chair and all you honourable MPPs for listening and asking great questions.

I represent a growing community of factory-built construction materials. This is an answer to the government's request for a quota of homes to be built—

The Chair (Mr. Ernie Hardeman): I would just ask you to do your name first.

Mr. Peter Watson: Absolutely. My name is Peter Watson. I own a company called Response Generators. It's a research and marketing firm.

My interest is to try to help along the government to provide middle-class families, first-home buyers, immigrants and, certainly, students with affordable housing. So that's my mission. It's something new, as you've probably realized from the press. There's a growing concern that we require up to 1.5 million houses, or more, by 2030. London itself has a quota of nearly 4,000 homes in 2024. I don't have statistics to mark against how many more that is than previous years; however, it must be a fair amount against what we normally build here.

I'm going to try to define prefab homes against modular homes. Prefab homes are built in factories, and generally they're built by robots—CNC machines that are automated, working in the wood material. Also, modular homes are restricted by their ability to be transported on highways, so they can only be a half-wide kind of thing, and generally they don't go over two storeys, whereas prefab homes can be multi-family dwellings. The only restrictions are pre-built into the roof trusses, the floor panels and the wall panels that are part of the construction material.

By definition, prefab is exactly what it sounds like, and it's assembled by robots, so right away, some of the characteristics of prefab construction would be speed. Loose lumber construction takes many, many weeks to frame a house, whereas prefab can be built in under a day. The robots are able to make the panels, the floors, the roof trusses, all against a CAD program from the builder or developer, and this reduces the time to build by 30% to 40%. That's the first significant milestone and part of my interest in getting that point out.

Lower cost is the second characteristic, and speed of factory construction where weather is not a dependent factor—it's inside. Also, it gets the builder to the market quicker so he doesn't have a long-running construction loan, because, literally, his construction components are built in a day, delivered to the site the next, he needs one framer to build the interior/exterior walls and then the crew would of course assemble the roof trusses and the floor. It lowers the construction cost, is the bottom line here. Also, it improves the cash flow for the builders, so they're in and out much quicker than what is referred to as loose lumber.

The other part is low waste. Robotic prefab construction produces very low waste materials. Of course, wood is sustainable, so we've got a sustainable element that they turn over to either agricultural or other organizations that use the extra cut-off lumber. But it's very minimal, because of the computerization.

A fixed move-in date for the buyers or renters: Because they're able to move quickly, they can actually firm up the move-in date. I myself got stuck in my last home because I moved in close to December and the building trade normally takes a couple of weeks off, so you're literally stuck with their holiday. But here we've got a fixed date that the buyer or renter can work to.

Tradespeople shortages: Prefab requires one framer, whereas on-site construction with loose lumber requires many framers and a lot of time. Time is money, and so that's one of the four or five benefits of prefab construction.

Now this isn't the first time that Canada has solved a housing problem with prefab.

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

Mr. Peter Watson: Way back in World War II, the returning troops needed houses, and they either were bringing a bride back with them or they required housing. So the government at that time produced various floor-plans. I recall them as Kernohan homes, or they've been referred to as strawberry boxes: We're going back to that. It worked beautifully in the Second World War here in London, around Wolseley Barracks. There are all kinds of tiny houses that are great. Either they have a cottage roof or a regular truss roof, and they're really—

The Chair (Mr. Ernie Hardeman): Thank you. We'll have to put the rest in the questions part, because you're out of time.

We will now go to the YWCA St. Thomas-Elgin.

Ms. Lindsay Rice: Yes. Good evening, everybody. My name is Lindsay Rice. I'm the executive director of the YWCA St. Thomas-Elgin. We are a member association of YWCA Canada. There are 30 of us across the country, and we are proud to be empowering women and girls every day.

Tonight I come to speak with you about our crisis of housing and the desperate need for affordable housing, particularly for our most vulnerable, including women and youth under the age of 25. It is estimated that homelessness costs our country between $4.5 billion and $6 billion annually. Break that down: We know Ontario is a big price tag of that. We also know that the annual cost of hospitalization for an individual experiencing homelessness is

over four times higher than that of a person housed, and the time to act is now to build affordable housing because the costs have almost increased by 20% over the past year. We need to build now.

1710

I've had several conversations with Associate Miniter Rob Flack. He's very well aware of our Project Tiny Hope. We are working to build 40 tiny houses in St. Thomas. We have a request to the province of Ontario to come on board and help us build. We have purchased 21 King Street in downtown St. Thomas. We have fully remediated this downtown property. It was a brownfield. What a great example of a build, turning over a brownfield into housing—supportive housing, nonetheless. It is 2.1 acres, and we are proposing 40 tiny houses. I love the segue of this panel, which way this is going.

We have a serious crisis in St. Thomas-Elgin of folks experiencing homelessness. We currently provide housing at the YWCA to 51 adults and youth. This property will help us nearly double that.

These tiny houses have been beautifully designed by Doug Tarry Homes. They are one of our primary partners within this project, and they are a renowned home builder in the St. Thomas community. They have also been a key donor to this project. One of the amazing pieces of our project is the opportunity to create gift-in-kind donations to this bill to bring down the affordability and cost associated to building. You can't do that with an apartment building as easily.

In our case, we have donors coming to the table who want to provide roofing for tiny houses. They want to provide siding. They want to provide windows, fridges, flooring, carpeting. It's phenomenal what we can do when we have a community of partners that want to come help solve this issue, and we want the province to be part of this solution as well.

Part of our plan with 40 tiny houses is that we will be hosting a race of home builders. This is an innovative idea that home builders can come together and build tiny houses with sweat equity, again bringing down our labour costs and decreasing the costs associated to building affordable housing. You cannot do that with an apartment building.

Our houses are going to be small, but they are going to be hosting individuals and families, from youth ages 16 to 24 up to all senior ages. We look at this as an opportunity for all levels of government to come together.

We have a commitment from the city of St. Thomas of $3 million, and we have some seed funding from CMHC. We will be also applying to CMHC for a co-investment mortgage and grant. We are ready to go. We are shovel-ready. We have done our groundbreaking ceremony. All services have been put into the ground, and we are ready to build. We just need the remaining funds from the province of Ontario.

This is our site plan. We are utilizing 2.1 acres of property in downtown St. Thomas. As you can see, we have singles, townhouses and semis. We also have a large program house—large by standards; it's not that large, but larger than the tiny houses—in the middle of the property that will be home to activities, one-on-one counselling services, group-based activities around financial literacy, employment services, economic stability and food security. All of the residents will receive housing-based case management from the YWCA, and the community will really be building a sense of belonging and decreasing loneliness of folks who are living within the tiny houses.

Doug Tarry Homes will also be utilizing a type of prefabricated build so that the speed and efficiency of the homes going up can be that much more efficient and affordable for the YWCA to build.

Our project has many benefits. We are going to be having all of the units built to a net-zero-ready standard, with the goal in the future to include solar power so that we can be fully net zero.

All of the rents, of course, are going to be affordable and deeply affordable. We are extremely concerned about the rising rental rates in the St. Thomas community for one-, two- and three-bedroom units. Particular attention is going to be given to women and youth.

Overall, the cost of our project is just over $14 million. That is including the purchase of the property, the development charges, the construction, the site prep etc. Our proposed funding sources include the province of Ontario, with the goal of receiving $2.5 million for this capital project to come on board with other investors. We have raised over to $2.3 million and we're on our way to closer to $1 million of gift-in-kind donations. We continue to have that number increasing, which is amazing, particularly because of our innovative strategy to collect home builders into a blitz build race.

Today, we are requesting, again, $2.5 million from the province as one of the solutions that can build affordable housing in St. Thomas-Elgin—40 tiny houses, 66 individuals of all ages building safety and security for years to come, and it's going to be a huge media opportunity.

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

Ms. Lindsay Rice: We're going to be having a large event circulating around the three-day-long weekend blitz build. We want to have multiple volunteers, spectators, all hands on deck for these builds of these tiny houses, and we want to get this done quickly so that we can start housing more people. Because, in fact, St. Thomas is gearing up for the new Volkswagen battery gigaplant, and we have an even more escalated need for affordable housing in our community with this new adventure and economic prospect.

Thanks for your time.

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

We start the first round of questions with the official opposition. Mr. Kernaghan.

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

To you, Peter: I'm very well aware—and it's something that the opposition has tried to convince this government of—of the importance of resuming its historic responsibil-

ity for the provision of truly affordable housing. You think about that greatest generation who came back from the war and how that gave rise to the baby boomer generation and the economic prosperity that was generated as a result of making sure people had that safe place to call home, an asset that they could pass down to their family. I think your comments are really quite interesting.

I did want to ask: Have you done any cost analysis? How does the prefab construction in a factory environment affect the cost as opposed to building piece by piece on site?

Mr. Peter Watson: That's a good question, Terence. My assumption would be that it's a time thing. Time is money. The robot cranks out an entire home in half a day, whereas you've got a crew of framers that are building loose lumber on a building site, so that time is compressed.

Also, we're waiting to see what the federal government will come up with in terms of the plans. The days of the original strawberry box houses—tiny kitchens and very small cupboards and that kind of thing—probably won't cut it in today's world, but your idea of tiny homes is great.

I should add too that Powell Holdings is making the move to invest in London to build a wall panel factory here. They already have the roof truss and floor construction site in Watford and so the missing part is the wall panels. They're planning on leasing for the first two years while they build the factory, so they're dead serious about prefab.

The other part in this equation is St. Thomas has Element5, which is a company that also makes prefabricated wall panels, not roof trusses, and I think they make floors and laminated beams and that kind of thing. And then, even our own Copp's Buildall is doing backyard homes, which is great. So we've got basically three prefab factories in the London CMA.

Mr. Terence Kernaghan: It's really a fascinating approach, and I think we need to take a look at many different modes to address the housing crisis, given that we've seen the province and the federal government not create enough affordable homes; they got out of the construction of them in the mid-1990s. I think the gap, if you go year over year, is about 1.2 million homes if they continued at that rate and the stated gap is 1.5—I mean, the numbers aren't too far off.

1720

Mr. Peter Watson: Well, yes. I should add too that this idea of prefab is relatively new, except it's an old idea. Eaton's and Sears did it at the turn of the century. So you can see some very cute houses that were good houses. Then we did it again with the Kernohan homes right after the Second World War, and they're doing it again now.

I'm waiting to hear and see what the plans are like. My role will be to help convince the developers and the builders that this is a good idea, get on board and let's go. Then the other part is to convince the homebuyers or renters that this is a really advantageous thing for their family needs. So that's my interest in prefab.

Mr. Terence Kernaghan: Thank you very much for all your excellent comments.

I'd like to move over to Brian with Participation House. I just want to thank you for all the fantastic work that you and your team do for the community.

This presentation—I was quite struck when you take a look at your words there. Participation House has worked extremely hard to maintain your status as one of the government's most trusted partners. It summarizes how I think a lot of the presenters have felt here today, trying to keep their vital services operating in Ontario. Can you share with us: What would it look like for all of the people that you serve if you had all of the resources that you needed from the Ontario government?

Mr. Brian Dunne: All of the resources we need? I think that's a very broad question, because there are many challenges around the population that we serve, and it would vary depending on the community. We need to take into account the partnerships that that would include, which would be our hospitals, our primary care facilities, our private and public partners, which would include housing. So it's a broad question. But at the end of the day, it would mean that the people that are on waiting lists and the people that are currently supported across the province would be living good lives in their local communities.

Of course, that's what we all want, whether we are 15 or 50 or 70 or whatever. I haven't met anybody yet that really chooses to go into a particular place other than in their community. So it would mean that we start to build those healthy communities, which I think is the goal of the Ontario health teams, which I have hope for, that that will be the case, that local planning will be a part of that and that local decisions and priorities will become part of it as well.

I think there are opportunities to do that. The risk, of course, is that we don't look at community, and I think one of the things that I've learned through COVID, in particular, is that the focus was on hospital and long-term care—

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

Mr. Brian Dunne: —but a lot of people with very complex needs were supported in the community through COVID in a very good way. However, the community services are not considered a sector. So I think the rules and the resources are not distributed in equitable fashion around the three important sectors we have.

Mr. Terence Kernaghan: Understood.

Lindsay, just quickly I want to thank you for an excellent presentation. It's brilliant. I think it's a really wise idea to address the current issues. Will the municipality be helping with service outcome for all of these tiny homes?

Ms. Lindsay Rice: We have completed the underground servicing, and we've used our own cash and donations to complete that, yes.

Mr. Terence Kernaghan: Who is responsible for the program space? Will that be the Y?

Ms. Lindsay Rice: Yes. We will own the property and operate the programs and services.

Mr. Terence Kernaghan: Wonderful. I look forward to the next stage of the project. I think it's fascinating.

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

MPP Andrea Hazell: Thank you guys for coming in and presenting to us—very detailed presentations.

I want to start with PHSS and Brian. I must tell you, today we had approximately nine health care providers, organizations or associations presenting to us. What you have put forward in this document is not new. It's really music to our ears throughout today with the presentations. So I want you to take some of my time and detail or elaborate your budget priority pressures for 2024-25.

Mr. Brian Dunne: I think our infrastructure pressures are pretty significant. This past year, just as an example, our insurance has increased by $100,000, and that's because of the market. Because of our contracts, we had to re-evaluate our homes that we operate and they brought them up to market value, so that created an additional $100,000 just on our insurance. The cost of hydro, cost of transportation—every infrastructure cost has increased, and there hasn't been a base increase in the last 10 years. So you're working on 10-year-old resources, so it's put great pressure.

Of course, the last thing we want to do is to compromise the supports and services that we provide to the folks who we have made a commitment to to provide the best supports possible long-term. We're in this for the long haul. We don't have a discharge policy because we believe that when people live well in the community in their homes—and that's the message we give families—it's our responsibility.

So we've increased our fundraising. We're trying to buy our own vans because the transportation system in terms of the paratransit system in this community and other communities—different names—are not adequate and they're not responsive. The folks we support may need to go to the doctor this afternoon, and if you have to make a booking three days in advance, it doesn't work. So you have to have a parallel system, and that costs. Insurance costs on vans have increased.

Just those infrastructure costs alone have really, really put pressure on the system. We've managed it well in our organization, but I know across the system, it's not the case because they've not been able to withstand it.

MPP Andrea Hazell: Thank you, Brian, for that, and thank you for putting that on the record.

I'm going to move over to YWCA. Lindsay, thank you for your presentation—very upbeat, energy, passion. You mention affordability, housing and the homeless crisis, and then you said, "The time act is now," and I love it.

The tiny 40 homes that you're trying to build—I want to ask a question around that. And thanks for the groundwork because that is efficient. You talk about gifts-in-kind, donations—you've already received that. You're working with a lot of community partners—congratulations. You've already secured $3 million invested and you've got investment from CMHC and some management grants as well.

My question to you: If this government did not give you your $2.5 million, what happens to the 40 people you're preparing for?

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

Ms. Lindsay Rice: They would be 20 years older by the time they got housed and much worse off. The time is now. We need housing today. And our community has raised a significant amount of funds—over $3 million, plus a commitment from our municipality of $3 million. CMHC is able to offer a mortgage of about 2.6% plus a grant of about another $2 million. So the federal government is putting up their money, but we need the money from the province to fill that funding gap, so that all levels of government can be part of the solution together.

MPP Andrea Hazell: I needed you to put that on record. Thank you.

Ms. Lindsay Rice: Okay. Thanks.

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

Mr. Mike Harris: Thank you very much. You guys are rounding out the deputations for the day.

Lindsay, I'm very intrigued by the proposal you're putting forward, and I want to give you a little bit more time to talk about some of the nuts and bolts. I'm from Waterloo region. I don't know how much you had a chance to hear earlier today, but Waterloo region's been known for being very proactive and very visionary in regard to a lot of these types of programs that are being put forward, but I haven't actually seen anything like this come to fruition in Waterloo region yet. We've talked about it. We do have some shelter spaces that have been built out in a similar way, but not like this. So there's a few things—and I want to follow up with you a little bit after, if that's okay.

Ms. Lindsay Rice: Absolutely.

Mr. Mike Harris: A few things I'm interested in: The first is planning with the municipality. How did that come about and—I see the eyebrows being raised, so I'm sure it was tricky. Tell us a little bit about it.

Ms. Lindsay Rice: St. Thomas-Elgin—our municipality is consolidated, and so the YWCA has had a long history of providing services with public funding through this city and the municipality.

We started conversations about growing affordable housing back in 2018. This project has been worked on for several years and they have been an amazing partner. They have tried to move red tape where they can move red tape; they've tried to move things faster if they can move faster. They have been a phenomenal partner. I can't say enough about them.

1730

Mr. Mike Harris: Our government recently announced that, essentially, there would be an ability to have townhomes built in pre-existing communities. I thought that was a great tool to be able to have in the tool box for many municipalities. How has that helped speed up some of the process over the last year since that was announced?

Ms. Lindsay Rice: January is when we went for our zoning and bylaw change, because the neighbourhood

wasn't set up for that type of zoning. It was just processed and done. It was a really easy, seamless way to go through the channels. The city council and the mayor were set up and understood how things worked, so when we presented our site plan and the need for the changes to the zoning, there were not any issues.

Mr. Mike Harris: With this being a brownfield site, how was it during the remediation process and working through some of that? And who were the key partners in getting those things done?

Ms. Lindsay Rice: It was very expensive from my perspective, but it was necessary, because it gave us a prime location, also giving the urban downtown of St. Thomas a facelift. So it had many meaningful reasons why we wanted to remediate that property: not only to provide housing, but then to also help revitalize part of the downtown core of St. Thomas.

Doug Tarry is the person who came to the YWCA saying, "I provide full market houses. We build houses; we sell houses. I want to be part of the affordable housing solution. What can I do?" And so, we brainstormed and came up with this scenario. The brownfield piece was a little bit worrisome, but through our work with Doug Tarry Homes, we were able to then hire the right people through eXp, do the work, do all the processing and get the ministry to—

Mr. Mike Harris: Lindsay, when you say "expensive," would you say that it was overly burdensome and that there was a lot of regulations that added to that expense?

Ms. Lindsay Rice: Yes, I would.

Mr. Mike Harris: How do you think, from a provincial standpoint, we could help reduce some of those barriers so that other organizations—and yourself, maybe in the future, if you're looking at replicating this—might be able to move forward with, of course, keeping some environmental regulations in place, but helping reduce some of those cost barriers?

Ms. Lindsay Rice: The Ministry of the Environment seemed to have a lot on their plate, so we were just one of their pieces in a very large portfolio. That process took a very long period of time and the communication I had with them was excellent. They were great people, but they were just part of a system that was a slower system. So maybe more human resources associated to that team would allow more projects to get through more efficiently.

Mr. Mike Harris: What about looking at something that would be—now, I'm just kind of blue-skying this—dedicated to these types of projects, where you could have one portal where organizations that are looking to build truly affordable housing across the province could go, rather than getting lumped in with all the other housing initiatives that are taking place across Ontario?

Ms. Lindsay Rice: If affordable housing could be prioritized in that way, that would be fantastic, but it's not going to help us if we don't get the capital dollars.

Mr. Mike Harris: Okay.

How much time left, Chair?

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

Mr. Mike Harris: What would you say is the biggest challenge that you've had throughout this process? Where have you butted your head up against a wall and said, "Man, I don't know if we can get this done"?

Ms. Lindsay Rice: I think we would have people in houses today if we had had the capital funds come to us when we asked for them two years ago. We've been asking for a long time to receive capital dollars. As I said, the process with the municipalities seemed very smooth. The Ministry of the Environment was great; they just had a lot of projects on the go, and the remediation work—you know, you just go through that process. Really, if we had the funding, we would be housing people today already.

Mr. Mike Harris: And just quickly, what are the criteria to be able to move into one of these homes? How are you selecting those folks?

Ms. Lindsay Rice: We're partnering with our city because we already have a coordinated access system and a by-name list, so we're not creating another list for folks. We are going to be integrated into the existing system, so that the folks with the need are already being supported first.

Mr. Mike Harris: Great. Thank you.

The Chair (Mr. Ernie Hardeman): To the opposition. MPP Sattler.

Ms. Peggy Sattler: Thank you to all of our presenters today.

Brian, thank you for the work that you do at PHSS. I certainly have worked with you over the years and have seen first-hand the value that your organization provides to the community and especially to the people that you support.

I was following along with your presentation with the written materials that you provided, and you skipped a paragraph here that talks about the "intolerable pressures" that the health and social care sector is facing, and that if the government doesn't come up with some funding that reflects current costs, and similar funding levels in the years to come, this would be catastrophic to the many committed leaders across this sector. Those are strong words, "intolerable pressures" and "catastrophic impact" if the sector doesn't get some funding recognition from the government for the issues that you're facing. Can you elaborate a little bit more about how dire the situation is within the sector which you've actually said earlier is not really a sector, but agencies like PHSS?

Mr. Brian Dunne: There are a number of agencies across the province that are currently facing deficits and they've had to close programs. If that happened on a larger scale, and it can, if infrastructure costs continue and other costs—human resources, because of course that's a huge issue everywhere—people will obviously be having to be placed in places that they don't need to be in, and probably inappropriately and at a much greater cost. For us, most of the folks we support would probably be in the hospital. Many other folks would probably go to long-term care. So, again, it's just going to shift the pressure somewhere else.

But it is also about people living well in community and they have a right to do that. So we need to be mindful stewards of all of our citizens in ensuring that the most vulnerable in our communities are also cared for in a way that we want to be cared for if we were in that situation, which may very well happen to us as we age or if we have some other catastrophic thing happen to us. It's going to mean that a lifestyle that people have currently, or wish to have, will not be available to them going forward. The activities that they're familiar with doing, the lifestyle, the community they are in may all change. That, to me, is catastrophic. It's catastrophic to even think about it from just an ethical perspective. Ethically, I think we need to look after our citizens the best we can within the resources we have. So we need to plan differently maybe.

Ministries need to work together; that's a constant concern. As a multi-system partner, it's challenging working with different ministries that have different rules, different expectations and different funding methodologies because we, as one entity, have to work within a framework of being fair and equitable across our system. If one ministry gives some resources and the other one doesn't, I can't give you a dollar, Peggy, and Mr. Hardeman nothing, because I'm going to have a big labour issue. So I think the ministries themselves need to work together in partnership and look at community as a whole rather than individual ministries. I know you've heard from service providers that are funded from a single ministry and they certainly have their issues. But each ministry might be a little different, so I think each ministry needs to go back and look at how best they can manage to fund supports and services from a community perspective. That would be maybe a little different depending on the community. Certainly, things that are happening in Grey-Bruce might be very different than are happening in Haldimand–Norfolk.

Ms. Peggy Sattler: Yes, and thank you for that.

Earlier today, we had a presentation from Community Living London. I mentioned at the time that I had met with 18 families with adult children with developmental disabilities. Many of them were getting service from CLL but many also from PHSS. Those families really emphasized the shortage of access to day programming. These are families who have their adult children with disabilities living at home with them, and they can't get access to day programs. They don't have enough Passport funding to pay out of pocket for the day programs that are available. They can't get respite care.

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Can you talk about some of the wait times that you are aware of and the frustrations of the families who you deal with, with regard to accessing these services?

Mr. Brian Dunne: Certainly, we see that on a daily basis just in our own group, but I know across the province there are many family groups that call us looking for some kind of advice about how they might manage in their current situation, and some of these are becoming crisis situations. So if there isn't something—and sadly, again, when systems don't work together and collaboratively—when you're in the school system, you get a lot of supports; when you graduate, there's nothing. So if you are a single parent with a child with significant needs, to suddenly have to do the 24/7 work—at least you had the school system break; you have nothing now.

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

Mr. Brian Dunne: And you may also be pulling together three or four little jobs to try to survive. So that's a crisis in the making, and what will probably happen is that person will wind up in emerg and be in the hospital system, and the parent probably also. So not only have we created one problem; we've created two for the system, whereas an upstream intervention for both probably would have been great for that family, but also would have saved the system a whole lot.

Ms. Peggy Sattler: Thank you.

The Chair (Mr. Ernie Hardeman): To the independents, and MPP Shamji.

Mr. Adil Shamji: Thank you to all of you for your comments this afternoon. I wanted to begin my questions with PHSS. I have no doubt you're familiar with the ALC phenomenon that we're experiencing across our health care system, where medically stable patients who could be discharged from a hospital unfortunately can't, because there isn't an adequately supported environment for them to return to. It is one of the major drivers for elevated wait times in our emergency departments, and a reason that people wait so long for an in-patient bed.

How can your organization help to combat this ALC phenomenon, and how could additional funding assist you in doing so?

Mr. Brian Dunne: I have to say that that's not just a funding issue. We've had 10 years, or maybe 15 years, of formal partnerships with five hospitals, with home and community care, with respirologists etc., to take people who have chronic mechanical ventilation, who are the highest-needs medically in our system, who block ICU beds. It works because there was funding put into the community, but also the partnership. Without the partnership, you cannot do this.

And so, there needs to be a coming-together of these different disciplines to look at the person as a whole person, so that everyone's on that team. It works for us because the hospital will respond immediately if we have a need, respirology will and primary care will. So I think part of it is that it's a funding issue, for sure, but it's also a capacity issue of building the skill set within the community.

We've been good at this as an organization, but we're probably one of the only organizations in the province that have taken that approach. There are very, very few situations where we couldn't support somebody, if the partnerships are in place and if the supports are in place.

The partnerships also include housing, because housing is a very important component, but it's not just housing; it has to be accessible, affordable housing, and that's a whole other challenge. That's where we can also bring in the private

partners, because we have been very successful when we work with private developers who have embraced what we do as an organization, who embrace what we do as supporting people and are long-term partners with us.

So I think there are a number of things. Yes, funding is one piece of it, but building the partnerships and government encouraging those partnerships to happen, I think, will help greatly in how that can be streamed, because we know that there are a number of people in hospitals who don't need to be there, who could be well-supported. This is not an Ontario thing. This is a worldwide phenomenon.

But, again, I go back to that we have two sectors, health and long-term care, but we have not focused on community as a sector and funded it and given it the tools adequately. Part of that is legislative. I can tell you that there are all kinds of barriers from legislation in every ministry that are catastrophic to work with, to be honest. The building code is an example of one; the fire code is another one.

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

Mr. Brian Dunne: So I think all of those—we need to have a really serious conversation, interministerially, about how we have an approach that is collective in our thinking so that these barriers are eliminated.

Mr. Adil Shamji: Perfect. Thank you very much.

Lindsay, turning to you very quickly: Thank you for sharing about your exciting tiny home project. I know in many cases the success of these have been dependent not just on the capital funding to build the homes but the operational funding for wraparound supports. Can you speak to that a little bit?

Ms. Lindsay Rice: Yes, those are the two budgets that change almost on a daily basis, depending on what the mortgage interest rate is and what the affordability rate is for our apartments. So we continue to monitor that, and we have a long-term plan for our operations so that they will be sustainable based on the affordability of rents that are coming in because of the offsetting revenue that we would get upfront for the capital.

The Chair (Mr. Ernie Hardeman): Thank you very much. That concludes the time. We look forward to success with that.

We'll go to MPP Byers.

Mr. Rick Byers: Thank you very much to all the presenters—very interesting way to end our day here in London, I must say.

Maybe Peter, starting with you, I'm very interested in hearing about your business. Is it fair to say that you're in the early stages of this? Maybe give me context on where you are and how your conversations are going with other partners in the industry to develop this affordable housing model.

Mr. Peter Watson: I'm happy to do that. Powell Holdings is actually the owner of Moffatt and Powell. They have seven outlets that are affiliated with Rona now, so they're a force in the province. Watford Roof Truss has been in business for a very long time and was a former client of mine, so I'm aware of the factory and its capabilities. I'm just intrigued with the concept of prefab and CNC machines milling wood, the plan, in a CAD form, building door openings and window openings in advance, and then the rest of the fabrication is the actual stud walls, which would be then covered with drywall or other materials.

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This is just an interesting time, and I want to be a conduit to help the manufacturers, of which there are a number of really good ones out there that are making beyond-net-zero walls. They have three different levels that you can go to: moose, reindeer and snow owl are the names, and it's all the R factor of the walls that they're building. In the case of Powell, the walls that they build will be two by four, two by six, two by eight, so they've got different levels in there too.

It's just an interesting time. I'm sort of a student of, "What's the trend? Where's the pain in the building trade, in the housing industry, in the rental industry, and how do I facilitate that?" So Powell had bid their work. Regrettably, we didn't get the contract, but that doesn't mean I hadn't done a lot of pre-work on prefab construction. I did a lot of pre-work, and there are other companies here that will require help. Element5 in St. Thomas is a 137,000-square-foot robotic plant—so it's kind of interesting.

I just want to help facilitate this now because I was intrigued with the war houses. I lived in St. Thomas and they were all over St. Thomas. So I'm waiting to see what the federal government's plans are—and, of course, Ontario too—in terms of how to take that to market, how to get the developers to step up, how to fundraise so that the land acquisition isn't a barrier. Hopefully in London, the red tape will unravel, to the sufficient position that we can actually get this done. We've got a quota of 4,000 houses, so it's not insignificant. So I'm just pushing it along now. I've done deep studies into Timberline, which is a company I think in Ohio. There's another one I've forgotten the name of now, but they both are robotic plants making prefab. Powell had gone down and studied what they were doing and how they were doing it, and the robots and so on. It's an emerging thing, and we need to step on the gas pedal, don't we, Lindsay.

Mr. Rick Byers: Well, yes. You may have found a customer to your left there.

Mr. Peter Watson: Where's my card?

Mr. Rick Byers: Lindsay, I want to ask you, because I must say we all have YWCAs and YMCAs in our communities. I've never heard of one that's building homes, so very interesting. What prompted this initiative that you've started, a very exciting one, it seems several years ago now?

Ms. Lindsay Rice: So we often do get confused for the YMCA, so it's lucky when a community has both in their city. YWCA in St. Thomas—we started providing housing in 1928 with a 21-bed women's residence, which still exists today in downtown St. Thomas. We've added to that a men's residence, four youth houses for all genders, a family transitional home and some scattered side apart-

ments throughout St. Thomas and Elgin. So we really know what we're doing when it comes to affordable housing.

Mr. Rick Byers: Do you own these facilities that you've described?

Ms. Lindsay Rice: Some we own, some we have had leases with.

Mr. Rick Byers: Very exciting.

Ms. Lindsay Rice: Yes.

Mr. Rick Byers: I don't know whether—is that Rob Flack's office? Is this land right near where his office is—

Ms. Lindsay Rice: It's probably about a five-minute walk in St. Thomas.

Just to note, the plans that we are using—all of the building plans, all of the electrical, the HVAC and everything—Doug Tarry Homes is offering as open book to every other community in Canada, so that you're already ahead of the game and you don't need to invest those dollars into that framework. You can take the plans and run with them.

Mr. Rick Byers: Wow. Well, very exciting. We hear your request very clearly—

Ms. Lindsay Rice: It's $ 2.5 million.

Mr. Rick Byers: Yes, we got the number.

Ms. Lindsay Rice: Thank you.

Mr. Rick Byers: Over to you Brian—a quick question. There's an organization called Participation Lodge in Hanover, not in Owen Sound. I don't know whether that's the same organization or not, but I'm curious about the Owen Sound presence that you've got. I represent the area, and maybe briefly describe some of the activities you've got up in that community.

Mr. Brian Dunne: We support some younger folks there. The Participation Lodge is a facility of 30 beds, maybe, I think. We don't have a facility. Our locations are homes or apartments or whatever. It's very community-based.

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

Mr. Brian Dunne: In Owen Sound, two young women live together. We support them. We provide community supports to other folks. We have our You at Home program, which is funded through home and community care, which is in-home family supports for transitional age youth who are mentally fragile. It's a very popular program. It started here with families, and it's growing right across the southwest now. So our presence is growing. Our approach is different. We do it from a community perspective, and we are a part of the community of providers in Grey-Bruce.

Mr. Rick Byers: That's great. I'll follow up and connect with them directly, but we appreciate the work you're doing. Thank you all so much.

That's the end, Mr. Chair.

The Chair (Mr. Ernie Hardeman): You're right: It is the end. The time is up. With that, that the time is up for this panel too. I want to thank the panel for taking the time to prepare and come here and present some interesting ideas and things that need to be looked at as we prepare the 2024 budget for the province of Ontario.

I also want to thank the committee, because I have here a motion that says about the adjournment. I want to say that it is one minute before 6, and the agenda says we're supposed to adjourn at 6 o'clock. So I want to thank you for keeping us on time. No, we're not going to give you any more time. Thank you.

Thank you very much. The committee is now adjourned until 10 a.m. on Thursday, January 18, 2024, when we will resume public hearings in Cambridge, Ontario.

The committee adjourned at 1759.

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