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Pre-budget consultations

Chair: Soo Wong
Clerk: Katch Koch

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Hansard Reporting and Interpretation Services
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ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON FINANCE AND ECONOMIC AFFAIRS

COMITÉ PERMANENT DES FINANCES ET DES AFFAIRES ÉCONOMIQUES

Wednesday 21 January 2015

Mercredi 21 janvier 2015

The committee met at 0900 in the Radisson Hotel, Sudbury.

PRE-BUDGET CONSULTATIONS

The Chair (Ms. Soo Wong): I am going to call the meeting to order because we have a very tight schedule. Welcome, everybody, to Sudbury for the pre-budget consultations 2015.

ORCHESTRAS CANADA

The Chair (Ms. Soo Wong): The first witness today is coming to us by conference call. Mr. Jones, are you on the line?

Mr. Matthew Jones: Good morning. Yes, I am.

The Chair (Ms. Soo Wong): Good morning, Mr. Jones. My name is Soo Wong. I'm the Chair of the committee. With us this morning are the following members from the government side: Laura Albanese, Joe Dickson, Ann Hoggarth, Eleanor McMahon and Daiene Vernile; from the opposition party: Jim Wilson, Vic Fedeli and Monte McNaughton; and from the third party: France Gélinas and Catherine Fife.

Mr. Jones, you have a total of 15 minutes for your presentation this morning, followed by five minutes for questioning. This round of questions will begin with the official opposition party. You may begin any time. When you begin, Mr. Jones, can you please identify yourself and the organization you represent? Thank you.

Mr. Matthew Jones: Good morning, everybody, and thank you very, very much for the opportunity to speak to you. My name is Matthew Jones. I am the music director of the Timmins Symphony Orchestra. I also am proud to be the music director of the Kitchener-Waterloo Chamber Orchestra, and I am a proud board member of Orchestras Canada, which is the service organization that oversees the national picture for orchestras across the country. I'm really here with my Timmins Symphony hat on to speak to you today and to impart some information about orchestras in Ontario that we are very proud of and working very hard for.

To begin, certainly orchestra musicians and the industry acknowledge the financial realities that Ontario is under, so we blanket a context of that over all that we say. But I am here to acknowledge the critical importance of Ontario public funding to the arts and to symphony orchestras, and just how important it is for us to be able to leverage that funding to do the great things that are going on in our communities.

Ontario boasts 55 symphony orchestras within its borders. That is unprecedented anywhere else in the country. It is a fantastic community of musicians who are actually all working together to promote culture and art in Ontario. We spend about $67 million in our communities in total; 70% of that money goes toward salaries and fees and paying musicians. Actually, I'm proud to say that I am indeed a musician who pays taxes. So it is an important part of the economic engine that symphony orchestras—we boast.

I really want to impress upon you that symphony orchestras are, by and large, the largest cultural organizations within their communities, and that we truly are not making decisions within a vacuum. We are looking to our communities and looking to serve as well as we can. I can certainly share many examples of that with my orchestra here in Timmins. We have a music school, for example, that is associated with our organization. We teach about 150 hours of lessons a week. We had to move that operation from an outlying building because our local gold mine wanted the gold that was underneath it. We have managed to bring that part of our organization into our downtown core, where we now contribute to the cultural vitality of downtown Timmins. We were able to reduce our costs in doing this, which was absolutely fantastic, mostly because of a community partnership that our orchestra developed with a business downtown, a business that is also looking to position themselves as a cultural entity within the community. It happens to be a local coffee shop that promotes live music and wants to be the go-to place for culture. We partnered with them and got a wonderful opportunity to have space from them in their upstairs.

I should also point out that Trillium funding made the renovations of that space possible. We now live on a beautiful second-storey floor of this coffee building. You open the windows in the summertime and you can hear the music out on the street—the students' lessons taking place. It's absolutely fantastic. The result of all of this energy is that there's so much potential that is embedded in that part of our operations that it is just wonderful.

We also look to our community to partner with other organizations like the museum, for example. They are now our box office. The Timmins Symphony Orchestra

is driving its audience into their business. It is a natural fit, of course. The museum has done a wonderful job of caring for our box office, and they benefit from our clients going to their space to purchase their tickets. I happen to know that we are equally benefiting from their clients knowing about us and seeing us in the community.

We also partnered with the local cathedral. We have sought greater efficiencies for our concert-producing opportunities, and we now have a great partnership with the local cathedral. Our money now goes to yet another community cultural entity, and there's a great cost savings. The benefit for us is awesome acoustics and a wonderful ambience and environment for our concerts.

Finally, another partner that I would like to highlight that the symphony has actively sought out is the city of Timmins itself. We made sure that we had a voice and we participated fully on the recent Timmins 2020 strategic plan. Embedded within it is a culture plan. I personally sat on the steering committee for that part of the entity. So we are contributing to the broader cultural dialogue in our community. We are helping to steer it. We also embedded, in our own recent strategic plan, some of the elements of that Timmins 2020 cultural plan so that we are aligned with our municipal government as we are moving forward.

This is a wonderful opportunity for us, but it also showcases just how embedded in the cultural communities of cities and towns across Ontario symphony orchestras really are.

The government of Ontario has contributed just over $4 million to symphony orchestras specifically, across the province. It's about 6% of a typical orchestra's revenue base, so it's not much, but we are able to leverage that funding to get corporate sponsors on board—our local donors—and it is of critical importance.

When we come to recommendations moving forward, Ontario investment in the arts needs to be sustained, with a view to growing it commensurately with the economy. Orchestras have done a great job, and I hope you appreciate that they have really worked hard to match the context—the financial realities—as we've gone along: ebbing and flowing with the economy.

It's such a different story in Canada than it is in the United States, where those two lines are very divergent. In Canada, it's incredible to see how carefully the revenues and expenses of orchestras have matched the reality of the economy. That is partly because in Ontario, we have the Ontario Arts Council, which is helping us and guiding us to police those expenses. They are watching very carefully. The result is, we have a very healthy and responsive orchestra sector in the province. For a relatively small investment in the orchestra world, there's a great deal of economic growth that's available to Ontarians.

The Ontario Arts Council, in the opinion of orchestras, is the best vehicle for arts investment. It does a great job with, frankly, inadequate resources. Over the years, the Ontario Arts Council has really transformed itself as well. It is also lean; it's efficient; it is able to make tough decisions. I happen to know that the Ontario Arts Council has the respect of MPPs. I have visited you in your offices and talked to you about the Ontario Arts Council, and I have not met anybody who did not have respect for the Ontario Arts Council. You should also know, though, the Ontario Arts Council has great respect within the orchestral community as well, and more broadly within the cultural community.

0910

So the Ontario Arts Council has transformed itself into this lean, efficient operation and it works hard to respond to growing numbers of applicants. It, frankly, is a victim of its own success. It is at the point, I think, of diminishing returns. We have to be careful, moving forward, and I hope that, if anything, we put the Ontario Arts Council and Ontario public funding on the radar screen for you as MPPs when you consider the budget, moving forward.

I mentioned the great potential that we have here in our school of music and what we are doing in Timmins. We can also be cursed with potential, and I would prefer not to be cursed.

That concludes my portion, and I'm absolutely happy to answer any questions.

The Chair (Ms. Soo Wong): Thank you, Mr. Jones. This round of questioning will be from the official opposition party. Before I start that, I want to recognize our colleagues Cindy Forster and Monique Taylor from the third party, who are joining us.

Mr. Fedeli, did you want to begin the questioning for this round? You have five minutes.

Mr. Victor Fedeli: Thank you very much. Matthew, how are you?

Mr. Matthew Jones: I'm very well, thank you, sir.

Mr. Victor Fedeli: Good. It's Vic Fedeli here. I'll be asking you a couple of questions.

Thank you, first of all, for all of the history that the Timmins symphony has had with our North Bay symphony. We've had some beautiful trade-offs where we head up to Timmins and you head down to North Bay, so we've had a little bit of fun and we have enjoyed—it's different than our usual hockey rivalries that we have in the north. So it's always pleasant. I know I've enjoyed hosting the mayor and the symphony folks. So thank you very kindly for your past work.

I also want to comment, on a positive note, Matthew, on your partnerships. Throughout the north especially, Matthew, we have found that that's how we need to make things work. You partner with the museum; you partner with the cathedral; you partner with the city of Timmins. This is exactly the kind of thing that we need to see more of, and I think it serves as a model for many other organizations, just to know that it's not always a handout; it's a leg up. You work hand in hand with people like the museum for equal benefit. I just think that's a super way for you to be working and I just want to acknowledge that.

You talked about the point of diminishing returns with the Ontario Arts Council. Can you just expand on that for a moment? I wasn't quite sure I got the entire point.

Mr. Matthew Jones: Sure. We have just recently been notified by the Ontario Arts Council—who, by the way, have had stable but non-increasing funding since 2009, and we all appreciate that that is like getting a cut. What has happened is that all of us who benefit from funding through the Ontario Arts Council have been told that if we write an application this year that is as good or even better than the application that we sent in with them last year—it is an annual process for us, by the way—we are looking at a 5% cut, guaranteed, across the board. So it has come to the point for the Ontario Arts Council where, in order to satisfy their mandate, they are having to make some really tough decisions, and we are all having to participate in the responses to this situation.

Mr. Victor Fedeli: I appreciate that, Matthew.

I'm going to steal a line from my NDP colleagues who chatted yesterday with the symphony representing the Fort Frances area. They talked about the fact that they run their symphony like a business. Would you agree that you run your symphony in a businesslike way as well?

Mr. Matthew Jones: Oh, absolutely. If anything has occurred for not-for-profits, in my personal opinion, in the last even five years, and for sure 10, it is that the business acumen that we have been required to show in terms of business plans and expense profiles and the whole nine yards has increased a great deal. It has put, in all honesty, a great deal of pressure on boards of directors to really get their governance acts together. I'm happy to say that in Timmins we have a very talented board that has that business side of it on it. But, absolutely, we are business first.

We have just created a value proposition for the symphony orchestra that we are prepared to share with our community and our corporate sponsors that shows the benefits and the economic drivers that the symphony helps to promote and where the money comes from and where it goes—the whole thing. It really is a business plan. Actually, I would like to also say that all those partnerships and all of those things that the Timmins Symphony has developed—really, at its core, everything that we do is designed to answer the question, "Why should you support us within the community?"

Mr. Victor Fedeli: Excellent. Then, as a business, would you be equally concerned with higher taxes, increased red tape? When we think about the upcoming pension tax or the upcoming carbon tax, are those taxes that we should be taking a message back to the government that this will affect your sales or this will affect your operation of your own business; the skyrocketing energy rates? Is there any message that we can take back to the government regarding the high cost of doing business and the high cost of business that affects your customer base or your clientele? Is there any particular message?

Mr. Matthew Jones: Absolutely. The cost of doing business, on the expense side of our operations, has consistently increased. It is absolutely true. The shrinking economy has made it hard for us to make up the difference. I will suggest that I have great anxiety about our organization's capacity to produce an artistic product—

The Chair (Ms. Soo Wong): Mr. Jones, our time is up, so thank you for coming before the committee. If there is any additional stuff you want to submit, please submit it to the Clerk by next Friday, 5 p.m. Thank you so much for joining us this morning,

Mr. Matthew Jones: Absolutely a delight to talk to you all. Thank you.

CANADIAN MENTAL HEALTH ASSOCIATION, SUDBURY/MANITOULIN

The Chair (Ms. Soo Wong): Our next witness is the Canadian Mental Health Association, Sudbury/Manitoulin branch. Welcome. Come on in. As you heard earlier, you have 10 minutes for your presentation and five minutes for questions. This round of questioning will be by the NDP. Please identify yourself and your organization for Hansard purposes. You may begin.

Ms. Patty MacDonald: I'm Patty MacDonald. I'm director of operations at Canadian Mental Health Association, Sudbury/Manitoulin branch.

Ms. Marion Quigley: I'm Marion Quigley. I'm the CEO with the Canadian Mental Health Association, Sudbury/Manitoulin.

Ms. Patty MacDonald: Thank you, Madam Chair, and honourable members of the committee. On behalf of the individuals served by the Canadian Mental Health Association, Sudbury branch, I want to thank you for the opportunity to appear today. I will begin with a story to highlight the profound impact that certain decisions and system transformation is having in our community.

This is the story of one woman. She could be any one of us—our mother, our sister, our daughter. We will call her Pauline, which is not her real name. Pauline is an individual living with mental health challenges who lived in a long-term-care setting until she was finally able to access housing in her own community. Housing and other supports in the community contributed to Pauline being able to receive the services she required and avoid being hospitalized.

However, in less than a year, she was diagnosed with cancer. Facing serious health challenges, she went into treatment. Fortunately, she was able to go home sooner, thanks to having a home with housemates and supports both at home and in the community to return back to. As part of her hospital discharge, we were able to engage with community supports such as the slow-paced rehabilitation program at Extendicare York, North East Community Care Access Centre nursing and homemaking, and Red Cross for transportation support, just to name a few.

For Pauline, access to housing which was closer to home in Sudbury and closer to her family helped them to help her while she received treatment.

This story is one example of how we are working with our partners in alignment with one of the Ontario government's central initiatives: putting patients at the centre, the right care, right place, right time. Though our vocabulary for individuals accessing our services may differ from that of other providers, we are all working for the same population: patients, clients, individuals experiencing mental health challenges. They need all of us to continue to innovate in changing how we offer services.

0920

We understand and are experiencing that more and more stories like Pauline's have positive outcomes when there is collaboration across sectors. The World Health Organization states that the social determinants of health are the conditions in which people are born, grow, live, work and age. At the local municipal level, the city of Greater Sudbury's Housing and Homelessness Background Study highlights prominent factors contributing to homelessness in Sudbury. These include mental health issues and many other factors experienced, such as family and relationship breakdowns; unemployment; conflicts with the law; obstacles to accessing suitable housing; and evictions for various reasons.

Housing challenges are powerful determinants of health for these individuals. Without suitable housing and the supports that individuals require day to day, it is sometimes virtually impossible to help individuals gain or return to mental health. Housing providers know that persons with mental health issues may have difficulty adhering to the rules of social housing buildings and may also lack the life skills to maintain a household. Evidence shows that communities where individuals enjoy mental health, resilience and inclusivity are strong, sustainable communities.

We are partnering with service providers across governments and across systems in our communities. We sense that the Ontario government's leadership on collaboration will require service providers to enter into a new phase of development to the benefit of the work—who look to us in their times of greatest need.

Collaborating on shared responsibilities across government—one of Ontario's key priorities—has been a discussion point in our circles for some time. We have experience in this type of initiative and look to our government and ministry leaders to continue to support us in this complex work. We know that the delivery of coordinated, timely and quality services—the next phase of the mental health and addictions strategy—will require this type of partnering.

Collaborating has enabled us to meet our commitments to getting results with new funding. One example is our successful partnership through our Community Mobilization Sudbury program. This program is a community partnership representing key sectors in the human services system, such as health, children's services, policing, education, mental health and addiction, and municipal services—the collective efforts of 19 partners coming together around a common need and desire to build multi-sectoral and collaborative mechanisms for responding to situations of acutely elevated risk. It is recognized that the CMS model is an investment of resources upstream in the coordinated prevention of negative outcomes, rather than a downstream response to harmful incidents once they have occurred.

These early interventions have demonstrated the potential to reduce the need for more intensive and enforcement-based responses, such as hospitalization, arrests and apprehensions. Some 75% of mental health care happens outside of the formal system. Across sectors, service providers are being asked to move forward on social and affordable housing.

Our agency is one of the largest providers of housing for individuals experiencing significant mental health challenges in our community. We have been able to make strides in this area thanks to our funders and the support for innovative solutions brought forward by our staff members, the community and our partners. For individuals living with mental health challenges, the idea of being able to access services through community hubs, as the government of Ontario is now asking of our municipalities, sounds promising. Though this may not meet all of the needs of our clients in rural and remote areas, we are looking forward to being part of the evolution of this concept.

We know that at least one in three residents of northeastern Ontario experiences a mental health issue in their lifetime. Based on nationwide estimates and 2012 population figures, the annual economic cost of mental illness in the northeast is $730 million. Of great concern is the fact that approximately 3% of the population actually has a severe and persistent mental illness.

When we consider that individuals with severe mental illnesses are also more likely to be homeless, it makes sense that our local statistics show that 36% to 51% of homeless people in Sudbury also experienced mental illness. They are homeless for longer periods of time and have less contact with family and friends. They encounter more barriers to employment and are in poorer health than other homeless people and individuals living in poverty.

We appreciate the opportunity at this time to highlight the need for additional supports, and in a variety of housing options, for persons with mental illness.

Studies show that in our area there is a need for an additional 350 supported and supportive housing units for persons with mental illness in Greater Sudbury and the districts of Sudbury and Manitoulin. Though positive changes are clearly occurring, the individuals we serve continue to struggle with access to services, partly due to the fragmentation and silo realities of the varying systems. They may encounter this when trying to access counselling and treatment and affordable housing, and especially in times of crisis and potential suicide.

We, as service providers, must learn and be supported to collaborate and combine our resources to continue and multiply the instances of positive change occurring for our population. The decisions we make, the resources we are able to provide, and the face-to-face services we

deliver contribute to healthier lives for individuals living with mental illnesses, and at times the impact is as profound as the prevention of a death by suicide or other preventable means.

Vern Harper, whose son Vincent was found dead in an alleyway this summer and whose story made national headlines due to the video which unfortunately surfaced, shares that he was a good person. He just got lost on the way. Vincent Harper struggled with substance abuse and was in fact homeless.

The Sudbury/Manitoulin branch of the CMHA supports government initiatives and infrastructure enhancements aimed at the following outcomes for all persons living with the high risks that come hand in hand with mental health challenges and illnesses: increased community supports and services; sufficient affordable, safe housing; care and community services as close to home as possible. Where additional mental health and addictions funding is given to a community agency to provide supports in the community, it is crucial that the infrastructure be able to sustain services such as cost-of-living increases to employees, support services, heat, hydro and rent, and remain viable—

The Chair (Ms. Soo Wong): Ms. MacDonald, can you wrap up, because we want to get some questions from the NDP.

Ms. Patty MacDonald: The government has highlighted the importance of enhancing mental health and addictions services in the action plan for health care and the 10-year mental health and addictions strategy. At this time, we are still striving to support individuals and communities struggling with the gaps in services and supports. Whenever our branch announces new housing opening, there are approximately 30 people lined up at the door, hoping they will be one of the fortunate ones. It is our vision, however, that all the people we serve will participate in a healthy society. We strive for this through our mission to continually improve community-based mental health systems to facilitate the well-being of all.

On behalf of the individuals we serve and the board and staff of CMHA, we look forward to continued capacity enhancements and services for all people facing mental health challenges now and in the future.

The Chair (Ms. Soo Wong): Thank you. Ms. Fife, do you want to begin the questioning? Oh, Ms. Gélinas.

M^me^ France Gélinas: Thank you for presenting, Ms. MacDonald and Ms. Quigley. It's always a pleasure to see you. We have some guests from out of town. We welcome them with a warm welcome at minus 27 this morning.

Just to put it in context, you and I both know that we have homelessness in Sudbury. Can you quantify it a bit for guests who may not know our community as well as you and I?

Ms. Marion Quigley: Yes. Within the city of Sudbury, we have a homelessness issue, as most communities do in the north. We provide an Out of the Cold shelter on a temporary basis, currently until the end of March. People can come in and not have to identify, which is different from regular shelter services, and can be intoxicated when they come into the shelter. We have supports. We have a transitional home. We have rent supplement programs, as do several other communities in the north.

I'm not exactly sure what else—

M^me^ France Gélinas: How many people would you say are homeless at any point in Sudbury?

Ms. Marion Quigley: Probably about 600. We do a count on a regular basis. Six hundred is probably high, because that's taking into account people using shelter or temporarily couch surfing, those kinds of things. We don't have the exact numbers, but around that.

0930

M^me^ France Gélinas: But we've had a study in our community and we count them on a regular basis—

Ms. Marion Quigley: Yes, and the count is actually coming up on January 28—next week.

M^me^ France Gélinas: Yes, but I wanted our guests to understand that homelessness is real here, and the way to solve homelessness is through housing. What would you need to make sure that those people have a home—so that the homeless find shelter and a real home to make their own?

Ms. Marion Quigley: I think there's a variety of housing options that people have to have. It's about choice for individuals. Right now we're working with several partners; you can't do housing in your communities without partnering. That's a given. You can't keep going to the government and asking for more money. We need to show that the money we're putting into health care—and housing is part of our health care. It's showing that individuals have better quality-of-life outcomes. We're having less stress on emergency services and less stress on hospital ED departments. But we need to have more rent supplements, more individual housing options and more shared living options and transitional homes.

We're very fortunate that across northern Ontario you're seeing more of these recovery homes through the government—the transformational housing money from the old homes for special care. All of those options are really making a difference.

Unfortunately, it's just that younger and younger people are becoming homeless. Older people who have addiction issues are having difficulty keeping housing because of their addictions. In Sudbury we're working with a group of partners to look at managed alcohol programs, and that's going to be developing a 15-bed harm-reduction residence.

The Chair (Ms. Soo Wong): I'm so sorry, but the time is up.

Thank you so much for presenting today.

HABITAT FOR HUMANITY ONTARIO GATEWAY NORTH

The Chair (Ms. Soo Wong): Our next witness is Habitat for Humanity Ontario Gateway North. Good morning. Welcome.

Ms. Ellen Frood: Good morning.

The Chair (Ms. Soo Wong): Can you please identify yourself and all your colleagues for Hansard purposes, as well as your position? That would be really helpful. This round of questions will be from the government side. Thank you. You may begin any time.

Ms. Ellen Frood: Thank you. I'm Ellen Frood, the CEO of Habitat for Humanity Ontario Gateway North. With me today is Laura Redman, who is our regional community manager, and Lise Rheault, who is executive director of the Habitat for Humanity Sudbury chapter of Ontario Gateway North.

I'd like to start quickly by just making one acknowledgement, and that is of Vic Fedeli, over here, who actually was one of the original founders of Habitat for Humanity in North Bay. I just want to say thank you for that, Vic. It's always nice to know that you're here at the table.

Habitat for Humanity is a non-profit organization. Our vision, very simply, is a world where everyone has a safe, decent and affordable place to live. Our mission is to mobilize volunteers and community partners in building affordable housing and promoting home ownership as a means of breaking the cycle of poverty.

What I find very interesting is that Patty, presenting from Canadian Mental Health, is talking about some of the very same issues that we come to the table with. It's about homelessness and affordable housing.

On September 1, 2014, Habitat affiliates from north Simcoe, Orillia, Muskoka, North Bay and Sudbury joined together and created the new region called Ontario Gateway North Habitat for Humanity. Joining us also, as a new chapter, was Parry Sound. We actually are moving up into the Timmins area and are speaking with some people now. That covers about 231,000 square kilometres: lots of rural areas and lots of great gaps and spaces. It's very unique—we're not an urban centre—in the work that we do.

Our homes are very simple. They're approximately 1,000 square feet. We build with all-new materials. We are a Tarion-registered home warranty builder. I always want to make sure that people understand that. We don't draw the materials out of our resources, basically, and our families contribute 500 hours of sweat equity into the building of their own homes. What that translates to, just so you know, is about three months of work. Three months of work for a single parent with a couple of kids: That's a pretty large contribution. It is not insignificant. The families don't move into their homes until such time as they have completed the sweat equity.

When I look at the agenda, I see so many similarities. I see people from health professions, from mental health, doctors, nurses and housing people. I see that the builders' association is presenting today. So it sounds to me like you have a bit of a common theme coming from all areas when you are speaking with people.

I do want to highlight what happens with—in particular, our interest is the investment in affordable housing funding. Clearly, we're appealing to you to lobby with the feds to make sure that that source of funding is continued past 2019, actually.

In the investment in affordable housing funding, what happens is that local service managers will take the funding and administer it in their own regions. There is no one way that it is done in any region. For example, in Orillia a couple of years back, they were receiving $50,000 per door. In Muskoka, we were receiving $10,000 per door. In north Simcoe, they received nothing. Sudbury? Nothing.

They make decisions on the kind of housing. Some of it is the existing rental stock or creating rent subsidies. Some of it—a very small portion of it—is down payment assistance grants. We're looking to say that the difference in affordable home ownership is very dramatic.

We do have some packages that are coming to you afterwards which will include statistics, and if we have time, we'll say them. But I'll just give you some differences. In the IAH funding, contractors are actually given funding to assist with building affordable homes. It ranges from about $50,000 up to $150,000. Again, it depends on the area where it's coming from, but if a contractor builds an affordable home—I'm going to just use some basic round figures. I would say it's approximately $150,000 that it might cost a contractor to build one affordable home. But if you gave Habitat for Humanity $150,000, we would be able to build three homes. With the three homes, because we depend on the communities that we work in and the contributions of the community—donations, donated labour, sweat equity from our families. So it's very affordable.

When a contractor builds an affordable home, they are required to keep it for 20 years and manage rent and what have you. They are also able to increase that rent every year as dictated by the government through rent increases. In the case of a Habitat home, our homeowners never pay more than 25% of their income. If their income rises—we check with them every year—then their mortgage payment will go up. If their income drops, their mortgage payment will drop accordingly. So we make sure that it's always affordable.

The impact of a low-income family going from probably paying 60% to sometimes 80% of their income on rental housing to 25% is enabling them to stay in their community, to own a home, to invest more. They buy more in the community. They do all sorts of things that reinvest. So it's beyond a social return on investment.

By the end of 20 years, Habitat would have been able to build, with that first $150,000 investment, approximately 18 homes over a 20-year period. So we have one home at $150,000, and we have three Habitat homes at $150,000. Over 18 years, we've built 18 homes. Those 18 homes are generating somewhere in the area of $100,000-plus in mortgage revenue, which we are required to roll back into building more homes. Every time we build a Habitat home, we reinvest that mortgage revenue into the building of more homes. So it's a self-sustaining model in many ways.

Now, if we just said, "Give us $150,000" and said, "See you. Bye"—well, I'm going to tell you, "No. I'd like to see $150,000 every year," so we can build those three homes every year and have three times the number of homes.

Again, there are many, many differences in terms of what rental does. Because the local service managers are able to control that, then we don't really have much of a say. So, as I say, in some areas, like the Cochrane district, they have invested all of their money in rental housing and none in home ownership.

We, by the way, receive no government funding at all. What we're hoping is that the government will look to Habitat as an exception, or affordable home builders such as Habitat. I'm not going to use us as the only one, because we're not the only ones out there. But to say rather than streaming funding to the local service manager directly, that Habitat become a delivery partner—what that helps is to fund the continuing housing crisis. What it does, effectively, is remove a layer. So, as a partner, the funds come directly to us, and we're able to address the priority needs of the organization, rather than tying it specifically to one home in particular.

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Other things that we're looking for are to track and measure the outcomes of the current IAH funding. I know that each of the service managers is required to provide a report, and they've all done the 10-year report, but I'm not really sure who's monitoring it in terms of community impact. I'd love to see what the impacts are, because we do know within Habitat that the home ownership model is very, very different than rental. Rental housing basically lets somebody continue to live in poverty, bottom line. A Habitat home enables somebody to build equity in a home, to have more money.

We've seen in our Habitat families kids going to university for the first time. We've seen generational poverty being broken through Habitat home ownership. We've seen gentrification of neighbourhoods as Habitat homes are built in some of the pretty tough-looking areas in cities. Other people are coming forward and volunteering, working with the community, and all of a sudden the other homes are planting flowers, building fences and starting to make the whole neighbourhood look nice. It is a huge gentrification. It's a movement. It's a community movement.

We're looking for any surplus land that the government might have. I mean, there could be something that has been designated as parkland. I heard about one recently—something designated as parkland right beside a park. How silly is that? Let us build homes on some of these properties. If there's real estate that we could maybe take, renovate and turn into condos, consider us. Think of us in those ways.

Embed inclusionary housing into the Planning Act. Access to housing is a basic human right. It sounds kind of silly—lots of us have never had to really think about that, right?—but again, for the low-income people and people with mental health issues that Patty referred to, it's always an issue, and it contributes to poor health. Continue, obviously, to advocate with the federal government for continuation of the national housing plan.

We do have, as I said, a few stats. I don't know, Laura, if you could take a second—

The Chair (Ms. Soo Wong): This round of presentation is up, so I need to go to the government side for them to ask questions. Okay?

Ms. Ellen Frood: That's fine.

The Chair (Ms. Soo Wong): All right. So, Ms. Hoggarth, begin the questions.

Ms. Ann Hoggarth: Thank you very much, Ellen. I want to tell you how wonderful the Habitat for Humanity program is. I watched as a single mother and her two young daughters moved into—it was a renovated spot, but it was just beautiful. Those two young girls were so excited to have their own rooms and to have their own home. It makes such a difference to their self-confidence, and the mother was just on cloud nine. It is a wonderful program. We know our Premier goes out and works with Habitat for Humanity, as do many of the MPPs, so we value this program very much.

I wanted to ask you: Do you find that the investment in affordable housing funds is helpful in achieving your organization's objectives?

Ms. Ellen Frood: Well, not now, at the current level, because it's regulated by local service managers, which is why we're looking to stream it away from IAH funding and directly to Habitat and other affordable housing providers, taking a layer out so that we have consistency across the province in how those funds are used for housing in all areas.

Ms. Ann Hoggarth: Okay.

The Chair (Ms. Soo Wong): Ms. Vernile, you had a question?

Ms. Daiene Vernile: What is your preference? Tell us what it is that you would like to see.

Ms. Ellen Frood: What we'd like to see is for the investment in affordable housing and home building—the home ownership piece; not the rental stock—to flow through a different stream, directly to the housing providers, so to Habitat for Humanity in our case. Rather than sending the investment in affordable housing funding to local service managers, it would flow directly to us as a builder.

We are, as I say, a builder and a developer. If you look at us from that perspective, we actually don't really fit in the rental-market model that most of the IAH funds are supporting.

Ms. Daiene Vernile: In August 2014, our government made a very ambitious announcement that it wants to end chronic homelessness. Share your thoughts on that, if you can.

Ms. Ellen Frood: Well, I applaud that, because it is generational and it is chronic. I truly believe that, through home ownership, we will see an end to it far more quickly than by sustaining rental models in communities. We are taking people out of geared-to-income housing already. We're empowering them to build lives and build

communities, to have better health for their kids, better health for themselves and better job opportunities.

And we reinvest all the dollars back into the communities that we build in, so it's beyond a social return on investment; there is also a financial return on investment, as well, throughout the Habitat model.

The Chair (Ms. Soo Wong): Ms. Hoggarth has more questions. Two more minutes, that's it.

Ms. Ann Hoggarth: Would you mind explaining who gets to be a candidate? Because I always thought it was the poorest of the poor that got to be a candidate, and that is not the case. Could you explain that for us please?

Ms. Ellen Frood: I'll tell you a little story first, quickly. Millard Fuller, who's the founder of Habitat for Humanity Canada, had a group of people together and he said, "How many people in this room have never had a default on a mortgage?" There were a bunch of people who stood up, you know, pretty proud of the fact that they have never had a default. Millard Fuller looked at this group of people and he said, "Well, if you've never had a default, you're not reaching far enough into the poverty pool." So we are about low-income families and we are about creating systemic change.

Our families have to meet three criteria: One is need. The other is ability to pay. The third is willingness to partner. Willingness to partner is the 500 hours of sweat equity. Need is defined by many things. Oftentimes it's mould, mildew, health issues, a requirement for accessibility, kids with autism who need a little space of their own to go to, those kinds of things. The ability to pay is based on three years of previous income and what we look to be as a sustainability of income going forward. Will they be able to continue to support a mortgage payment as they move forward?

I want to let you know that the minimum mortgage principal amount that a family can pay is $250. So if you assume that the property taxes are $250, that means that that family's minimum amount that they would pay on a monthly basis would be $500 a month.

I asked Lise here the other day, "What's rent go for approximately?" What I heard was maybe a one- or two-bedroom for $1,100 or $1,200 and up. When you have a three- or four-child family, people are living in very crowded quarters.

The Chair (Ms. Soo Wong): Thank you very much for your presentation today.

Ms. Ellen Frood: Thank you.

NOOJMOWIN TEG HEALTH CENTRE
SHKAGAMIK-KWE HEALTH CENTRE
N'MNINOEYAA ABORIGINAL HEALTH ACCESS CENTRE

The Chair (Ms. Soo Wong): Our next witness group is Noojmowin Teg Health Centre. I hope I said that correctly. We'll have some witnesses come forward. I did say it properly? They're going to tell me how to properly say this name. I don't want to say it—

Interjection.

The Chair (Ms. Soo Wong): Exactly. I'm going to mess the name up.

Good morning, ladies. Welcome. Can you please identify yourself and your organization, to make sure we pronounce it correctly? Welcome. You have 10 minutes for your presentation. This round of questioning will be from the official opposition party. Welcome. You can begin any time. Thank you.

Ms. Pam Williamson: Aaniin.

Remarks in Ojibway.

Pam Williamson, Noojmowin Teg Health Centre—it's on Manitoulin Island. Thank you.

Ms. Gloria Daybutch: Good morning. Gloria Daybutch, health director for the N'Mninoeyaa Aboriginal Health Access Centre. We service First Nations people from Sudbury to Sault Ste. Marie, including the aboriginal population residing in Sault Ste. Marie.

Ms. Angela Recollet: Aaniin. Boozhoo.

Remarks in Ojibway.

My English name is Angela Recollet and I'm with the Shkagamik-Kwe Health Centre.

The three of us here today are representing the aboriginal health access centres in the province of Ontario.

Ms. Gloria Daybutch: Thank you for this great opportunity. As we know, First Nations aboriginal people in Ontario are a wounded people due to the historic trauma. I'm not going to get into the historic trauma, but we know that it's legislation, it's practices and it's policies that have left our people living with generational post-traumatic stress disorder. If we do not transform the effects of this trauma, we will continue to transmit this stress disorder within generations. As it goes from one generation to the next generation, it worsens.

We will not have improved health outcomes without relational healing that will make us whole. Wholeness comes from our culture, and we know culture is not an individual. Culture is a set pattern of behaviours, artifacts, languages and values that we hold. It's the therapy of our culture that will make us whole as a community.

The Ontario government, back in 1994, developed the aboriginal health policy. They recognized that we also have a culture of sameness. This sameness meant that we need our doctors. We need nurse practitioners. We need our physiotherapists and occupational therapists. But they also recognized that we have a culture of differences. In that, they gave us funding for our traditional healing services. Out of the aboriginal health policy, 10 AHACs were founded to address the complex impacts of colonization and intergenerational trauma and play a powerful role in the healing, the health and the wholeness of our aboriginal populations. AHACs' ability to deliver services through integration and to look at traditional counselling—addictions, mental health, spiritual health—really have been the key agents of positive change in our aboriginal First Nation communities and aboriginal populations in Ontario.

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For us, as aboriginal health access, culture is our therapy. Through this approach, AHACs have earned the trust and credibility of the populations and the people that we serve. We do this through working through collaboration to offer a wide range of programs and services that address the physical, emotional, mental and spiritual needs of aboriginal people.

As a result of this increasing demand for services and programs, the AHACs grew from 1995 to 2005. By 2005, the demand for AHAC services outpaced the funding levels. By 2007, it was clear that there was a financial crisis. Continuing to the present day, wait-lists grow and centres are struggling to keep up with our demand for services. Despite these major changes, Ontario's 10 AHACs continue to operate as community health services and spaces that offer a sense of belonging and access to aboriginal programs and services for healing and holistic health.

Ms. Pam Williamson: Just to continue on, it was really felt that it was important to give you a sense of the enormity and the uniqueness of the conditions that we are working in and the unique populations that we are serving. Just to bring you back to the executive summary, we are asking for a targeted investment of $10.1 million.

Giving you some background, going to page 2, part two, AHACs and the ministry history: In 2011, the AHACs appealed to be transitioned from the Aboriginal Healing and Wellness Strategy to the Ministry of Health and Long-Term Care. They were moved, specifically, to the negotiations branch. Since that time, it has been noticed that the core funding received by AHACs is substantially lower than their CHC counterparts, the community health centres. CHCs serving similar numbers of clients and in similar geographic areas typically receive substantially more funding than AHACs. These models are often compared because they are both community-governed, mature, well-established models of primary care with interprofessional teams; focus on marginalized populations; and offer holistic health services beyond strictly illness treatment. The median budget for a CHC in Ontario is $3.1 million, whereas the median budget for an AHAC in Ontario is $2.3 million. Given the similarity in service volumes and the models of care, the core inequities facing AHACs in relation to their CHC counterparts is crippling.

In October 2014, a new development: We were moved from the ministry's negotiations branch to the primary health care branch. The goal of this change was to align the AHACs to a more appropriate team within the ministry. This move is expected to allow for improvements and consistency with reporting requirements while recognizing the uniqueness of the AHAC model.

Since the transfer in 2011, the ministry has acknowledged the AHAC underfunding issue and made repeated commitments to address inequities. They committed to conducting a funding parity review in order to address the systemic funding inequity within the sector. This commitment, which is now four years old, has yet to materialize.

Part three, highlight of AHAC challenges: The chronic underfunding of AHACs has posed significant challenges. The first one that we want to talk about is human resources challenges. Due to underfunding, AHACs are often unable to staff their centres at appropriate levels. This means that staff in the centres face greater personal and professional burdens because they're required to do far more with far less. Others are funded through a patchwork of funding sources. AHAC staff are consistently facing the challenge of delivering high-quality holistic health care services with inadequate personnel due to insufficient funding.

Further to the lack of parity and equity in the area of compensation for health care professionals, AHACs face large shortfalls in the overall staffing types and numbers required to deliver appropriate services and programs to the aboriginal community. AHAC EDs are forced to make difficult decisions in terms of resource allocation required for staff compensation and benefits versus resources required for other operations, equipment and supplies.

Another challenge has been data support and information management, which is the one that is kind of stuck in our craw right now. The CHCs, over the course of their 40-year history, have developed a robust information management strategy and have a strong reporting infrastructure. Most CHCs have the capacity to work meaningfully with data for performance measurement, quality improvement, business intelligence and accountability purposes. CHCs were funded to move onto a common electronic medical record and have been supported by their LHIN to create and adopt a business intelligence reporting tool called BIRT. BIRT helps them ensure data quality and assurance; enables them to benchmark performance against each other and provincial averages—I'm trying to hurry; automate standard reports, including accountability reports; use data for clinical, operational and resource planning; drill down, which is important to us, for root cause performance analysis; and generally enable analytics for higher-quality services and greater efficiencies and effectiveness. Most CHCs have centre-level personnel called data management coordinators to oversee this critical work. Finally, they have shared regional decision support specialists to provide regional and provincial data support.

We are comparing ourselves to CHCs because we are in the same membership under the Association of Ontario Health Centres.

Where am I?

The Chair (Ms. Soo Wong): You have one minute.

Ms. Pam Williamson: I have one more minute.

We don't have that. That is a very critical point.

What is the impact on our programs and services? Because of these inequities, we are having to make decisions about what we are going to be funding. It's a case of effectiveness versus providing professional services that the communities are needing.

I'm going to turn it over now to—

The Chair (Ms. Soo Wong): Ms. Williamson, your time is up. I think there may be questions from the opposition party asking you to elaborate some of your points.

Mr. McNaughton, can you begin?

Mr. Monte McNaughton: Great. Thank you very much. I'm sure, with some of these questions, you'll be able to finish your presentation.

I'm just curious: Where do you think the $10 million should come from? Within the system, do you see where there—

Ms. Angela Recollet: On behalf of the 10 AHACs, let me quickly just summarize. Ontario is a gem, if you don't realize yet, because we're the only province that has aboriginal health access centres. This is something that this province should be quite proud of. The amount of work that goes into servicing a population that is often forgotten has excelled—and excellence in health provision is provided by the 10 AHACs.

Historically, when the AHACs began, they were under the Aboriginal Healing and Wellness Strategy. This was an effort that was embarked on by leadership, both First Nation leadership—and Métis and Inuit—and leadership of the provincial government. At that time, it was under the Ministry of Community and Social Services. The AHACs, in our evolution, tried to make the transition to the Ministry of Health so that we could have the same access to equity when it came to primary health care. We are now under primary health care, the Ministry of Health and Long-Term Care, under the interprofessional health care branch. We were, in that transition, under the negotiations branch. As you can see from my colleagues, there have been strides made to meet equity, to be at par with our partner CHCs, but we're nowhere near. We're always doing far more with far less.

Ms. Gloria Daybutch: And to answer your question, I think the funding should come from the same way—the ministry is looking at reallocating from resources like hospitals and physicians and putting it into community-based programs. Where we meet the front-line people is at primary care.

Mr. Monte McNaughton: That's great. You said you've had to make some tough choices. Can you explain what impact those choices have had in your community?

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Ms. Gloria Daybutch: We've had to lay off nurse practitioners in order to fund our EMR, because we do know that the electronic world that we have to move into for more accountability, for efficiency, for client safety and for client care—so we've had to make some hard decisions because we can't do both.

Ms. Angela Recollet: So we're asked to implement the EMR system, and we've done that, with grave disparities to the community that we serve. The province has asked us to implement these services without any resources to support them, and then it goes back to impacting on the direct service delivery for the people that we're all here to support.

The Chair (Ms. Soo Wong): Mr. Wilson.

Mr. Jim Wilson: As a former Minister of Health, I came in at 1995 and I think you started up in about 1994, and it was a great program. We had the privilege of expanding it, and you are good value for money.

It's unusual for the government to ask other organizations to take from their capital account, which would be your electronic records computers and data entry and that, and dip into your health services, like nurse practitioners. Do you want to explain a little further the unfairness of that?

Ms. Angela Recollet: If you could explain it to us, that would be wonderful. So let's start there.

Mr. Jim Wilson: At least you have it on the record, because it is highly unusual that they would do that.

Ms. Pam Williamson: Our systems are pretty flat-lined, with not a level of support that we need for administration. We do really focus—the focus is on the services, and basically we get funding for services; we don't for administration. So there is more accountability being asked of us, in terms of being able to provide better data. We're very much interested, because this hasn't been an area that they have had a lot of access to before, so it is unique that we are able to provide good data or that there is a collection of aboriginal health data that can be compiled. But in asking us to be able to come up to a level with a system and without the supports, without the financial ability to do it—you have to understand, that really has been a struggle for us. We are doing really well, but it is at a cost.

Ms. Gloria Daybutch: I'd just like to add that there is no population in Ontario—AHAC EDs—who want to see the statistics go down in terms of the poor health outcomes of aboriginal people more than we do, so we want that data; we want that proof. We want to be able to say that we are making that difference in Ontario, so we do need that data information, and unfortunately something else is going to have to suffer, so we'll have to see less people. We could do a lot more if we had additional resources, but we do need that data. We know the importance of making a difference.

The Chair (Ms. Soo Wong): Ladies, thank you so much for your presentation, and thank you for being here, as well as for the written submission.

ODSP ACTION COALITION

The Chair (Ms. Soo Wong): Our next witness is the ODSP Action Coalition. While we're waiting for the next witness, can I just remind—

Interjections.

The Chair (Ms. Soo Wong): Ladies? Mr. Fedeli?

I just remind everybody in the committee that if there are any questions for the researcher, please write them down so that before we adjourn we can submit them to staff. I heard some questions from Mr. Wilson to the witnesses this morning, so if there are any questions that you want to follow up on—because this committee has the authority, as the report comes forward, that with any

outstanding questions, the staff can support those comments. Am I correct, Mr. Koch?

The Clerk of the Committee (Mr. Katch Koch): Yes.

The Chair (Ms. Soo Wong): Okay.

The next witness is the ODSP Action Coalition. Please come and join us. Welcome and good morning. As you heard earlier, you have 10 minutes for your presentation and five minutes for questions from the committee members. Please identify yourself and your position with that coalition. This round of questions will come from the third party.

Ms. Chris Cosby: Thank you. My name is Chris Cosby. I'm a community legal worker and paralegal at Sudbury Community Legal Clinic, and I've been a member of the action coalition for over 10 years.

I must apologize. I'm still convalescent from an illness over the holidays, and I may have to pause to catch my breath, though, in view of that 10 minutes, I'll try very hard not to.

The action coalition has a number of concerns, of course. I intend to address two principal ones and a corollary, with your permission. The first issue is the ODSP rates. At present, after a prolonged freeze of the rates from 1993 to 2005, when the increase was finally made—the rates were frozen. Since then, they've gone up at 3%, 2% and, more currently, 1%. Currently, for a single recipient, which is the maximum of ODSP recipients, the full monthly income, if they're receiving everything, is $1,187.46. This includes tax credits and the Ontario Trillium Benefit, as well as full ODSP.

ODSP shelter for a single recipient is $479. That's supposed to cover the cost of rent. The average rent for a one-bedroom apartment in Sudbury is $741, which means that a portion of the basic needs allowance, which is $607, has to be used for rent. This can be even worse if, as with many apartments, utilities are not fully included. The one that is normally not included is electricity, and we all know that the rates are not going down.

Now, the basic needs allowance, $607, is supposed to cover everything but shelter—that is, food, clothing, transportation, cleaning supplies, personal supplies, seasonal costs such as winter clothing and boots, and telephones, which were deemed unessential in the 1950s and are still deemed unessential in 2015. There is no coverage for that particular utility.

The nutritious food basket cost for a single person in Sudbury is $278 per month. Add that to a rental of $741, on average, and it leaves $163 for all the rest of the basic needs. How is anybody going to cover all their needs, other than food and shelter, with $163 a month?

Now, there are a number of effects of the rates that are very difficult for people. One, for example, is that a great many people decide to share their accommodation costs, to find a two-bedroom apartment and have two people move into it, which is rational. It does mean that you have a better quality of living and a slightly better apartment. However, I have one current client who made that decision six years ago. He and a friend, who had both found themselves evicted at the same time back in 2008, decided to move in together and share costs. He notified ODSP that he was doing so. His friend was not a recipient, but a low-income working person. Six years later, they are being told that they are spouses. Apparently, one of the reasons for that is that they've succeeded in getting on with each other for six years. If they weren't friends, it wouldn't have worked, obviously. Spouses they are not, but what's going to happen with that, I do not know.

Another, much sadder example: I was in hospital over Christmas. When I got home, I sent my daughter out to buy the supplies I needed, the various foods that I had to have while I was recuperating. Around the same time, an ODSP recipient, a friend of the gentleman who was supposed to come with me today but couldn't, was also released from the hospital. Unlike me, he would spend his money when he got it, at the beginning of the month. He got home to an apartment where all the fresh food had spoiled during his hospital stay. He was able to obtain nothing except a little from the food bank. I understand that the cause of death is that his illness recurred. He died.

The rates must be brought to some kind of reality. While there has been a recent social assistance review, the provincial government has never, under any provincial government, reviewed the adequacy of the rates in comparison to the actual cost of living. That simply has to be done. People who have lived the experience, ODSP recipients and former recipients, should be among those on any such review committee.

Another issue is that for the past two years the 1% increase to ODSP has applied only to the recipient, not to any dependent adults. Dependent adults are expected to find work, and they deal with Ontario Works rather than with ODSP. This does not take into consideration the very many cases in which a dependent adult, either a spouse or an adult child, has to stay home to look after the disabled person. In one such case, a young—well, to me, she seems young. A woman of about 42 recently lost her right leg. She suffers from cerebral palsy and diabetes, and it was the good leg that they took. Her recovery is going to be very slow and very painful. Her spouse has no option but to stay home and look after her. She requires care 24/7. How is he supposed to go and get work? And yet, their income is pretty low.

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The second issue: Please note that the ODSP income support directive 6.1 states that the basic needs benefit is intended to assist with the cost of food, clothing, transportation, personal needs and other non-shelter-related items. Directive 6.2 makes the same statement regarding shelter: assistance for shelter costs up to the maximum amounts available.

If ODSP benefits are intended to assist with the cost of living, why is almost all other income received by ODSP recipients deducted from the ODSP income? Canada Pension Plan disability deducted; Canada Pension Plan early retirement deducted; employment insurance deducted; and any support payments of any kind—they're

gone. So where is the "assist with"? The only income that is not deducted 100% is earnings.

People who can work and are on ODSP work. The idea that people choose not to work—the commonest thing I hear on intake from people coming in to open their files is, "I'd give anything if I could go back to my job but I just can't do it anymore." Once people are on ODSP, the majority of them—barring, perhaps, the ones over 60—do look around to see if there's something they can do. People don't like to be idle and they don't like to feel worthless, and that is very much the feeling that the system gives them.

Last year the government announced that people would be permitted to retain the first $200 that they earned. This was to encourage people to seek employment. It was a good move. We would suggest that $200 is perhaps a bit less than should be considered as the amount exempted. So $200 and then they get to keep 50% of the remainder of their earnings. Some manage to work their way off ODSP; most still require at least some support, but people do feel a great deal better about themselves if they earn some of their own living, and they do not need to be punished into doing so.

But what's happening now? There has been for some time now a $100 work-related benefit that people who are on ODSP and are working are entitled to get. In the 2014 budget, it was announced that the work-related benefit and the employment and training start-up benefit and the employment transition benefit—all three mandated benefits—are to be cancelled and, instead, there is going to be a discretionary benefit, which people will receive if their worker thinks they ought to, in a total amount of $1,800 per year. This will go principally to people who—

The Chair (Ms. Soo Wong): Ms. Cosby, can you wrap up?

Ms. Chris Cosby: As fast as I can; okay.

Discretionary funding does not replace mandated benefits, and to say that your worker can decide whether you deserve to get a benefit—this is just not acceptable. The removal of mandated benefits has happened before—Community Start-Up.

Now, on behalf of the coalition—and this is my wrap-up—I'm requesting that the following issues be addressed in the 2015 budget: an immediate significant increase to ODSP rates, and in order to bring the actual purchasing power up to what it was in 1993, a raise of nearly 25% would be needed. Reinstate the work-related benefit instead of cancelling it for most people as of June, and make no further cuts to mandated benefits until such time as the rates have increased to adequacy. Finally, in order to ensure that the rates are indeed adequate and remain so, establish an independent panel to review the rates compared to the actual cost of living and make recommendations for rational and fair criteria to determine levels of income support. The experts on such a panel should include people with disabilities and social policy experts.

There is one other little detail. People who can work and get off ODSP do so, and I'm walking proof. I got off in 2003 and I'll never look back, and I've paid off the overpayment that I acquired while working part-time for two years. I got off in spite of the program, not because of it.

The Chair (Ms. Soo Wong): Thank you very much. For this round of questions, Ms. Forster, do you want to ask the questions?

Ms. Cindy Forster: Thank you, Ms. Cosby, for being here today. I'm glad you raised the issue of the changes in benefits out of the 2013 budget and the fact that it's the government's intent to actually cut the $1,200 a year that ODSP recipients get, $100 a month, which would have assisted them in getting to work, perhaps, to buy some new clothes or to take a bus or to buy a lunch while they're out working. But the impact of cutting that money will directly impact the $200-a-month clawback piece. Do you see this as a detriment for people on ODSP to go out and seek work?

Ms. Chris Cosby: I think that people who are able to work will still seek work, but I think this will make things far more difficult for them. I understand that the government's position is that part of that $200 that they are allowed to keep can be used to replace the work-related benefit. What kind of poverty reduction strategy is that, please?

And I have lived it. Things have improved since my time—I got off, as I say, in 2003, and that was before the election—but there is no real help from ODSP itself in seeking work unless it's something like seeking accommodation for someone who is deaf, blind—one of the more obvious disabilities, shall we say. But if you are suffering from a physical disability that is not of that type, and you're not in a wheelchair—again, that's one of the more obvious ones—then there's just nothing for you.

People with mental health issues—not all people with mental health issues are able to work, but some can, and they want to. The idea that there are employers lining up, just waiting for them—I would like to meet those employers, please.

Ms. Cindy Forster: The goal of the $200 clawback provision that the NDP negotiated with the government in that round of budget was supposed to assist people—

Ms. Chris Cosby: And it did.

Ms. Cindy Forster: —and to perhaps lift them a bit out of poverty, and it did. But the changes to these employment benefits are actually going to negate any of that.

Ms. Chris Cosby: It's certainly going to much reduce the good effect of the $200, which should be increased in any case. On top of that, people lose the right of appeal. If you have a mandated benefit and you're denied it, you have a right to appeal that decision. If it's a discretionary benefit and you are told, "No," well, you can ask for an internal review and you usually get, "It's still no."

The Chair (Ms. Soo Wong): Ms. Cosby, thank you very much for your presentation. If there's any written

submission after today, please send it to the Clerk by next Friday.

Ms. Chris Cosby: The action coalition has done a written submission. Unfortunately, due to my illness, I didn't have time—

The Chair (Ms. Soo Wong): That's okay. Thank you very much for your presentation this morning.

OLIVER PUBLISHING INC.

The Chair (Ms. Soo Wong): Our next witness is Oliver Publishing Inc., Mr. Callum James. This round of questions, sir, is from the government side. You have 10 minutes for your presentation. Please identify yourself for the Hansard. Thanks.

Mr. Callum James: My name is Callum James. I'm the vice-president of regulated professions for Oliver Publishing. Good morning.

I represent Oliver Publishing, a Toronto-based provider of Canadian financial service education. We have competed as a private business for over 30 years, providing regulatory training in financial services both in Ontario and nationally. We are one of a number of financial service educators who train aspiring professionals to obtain their licences and financial designations. Much of what we teach focuses on policies and regulations.

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We are also entrepreneurs and investors, and we're keenly aware of the economics of the marketplace. We are therefore able to understand education policies from their inception through to their ultimate economic impact in our markets.

From our unique viewpoint as educator-entrepreneurs, we would like to share some recommendations that we believe will encourage economic development, innovation and more efficient regulation. These five recommendations are not just suitable for our sector, but for any sector that relies on individual licensees who are supervised by an Ontario regulator or self-regulator.

(1) Recognize licence training for the professions as a key component of Ontario's labour strategy. We strongly agree with the minister's statement in the fall economic statement that "Investing in skills will help foster a dynamic economy, stimulate innovation and increase prosperity for all Ontarians."

Ontario invests over $1 billion annually in employment, training and labour market programs. However, this number does not include the millions of dollars spent annually by people who enrol in regulator-approved programs to earn a professional licence. These highly motivated individuals are not asking for financial support. They are investing hundreds and even thousands of dollars of their own money to prove their readiness to future employers, or to earn the right to become self-employed.

Licensee candidates also invest their precious time. If we combine initial licence training and continuing education, the learning activity required in professional licensing represents one of the largest adult training frameworks in the country in terms of the number of people affected and study hours. All that these learners ask is that the path leading to their new career and to best practices is as efficient and economical as possible.

The government of Ontario, through streamlined regulation and more competitive education policies, has an opportunity to help highly motivated workers transition to become professional licensees. This will lead to a higher-skilled workforce and open up many more ancillary job opportunities.

(2) Recognize the potential contribution of Ontario's knowledge workers who specialize in professional licensing education. Chapter IV of the 2014 Ontario Economic Outlook and Fiscal Review calls for the province "to invest in the skills and talents of Ontarians to help them compete globally and to meet the demands of a rapidly evolving economy."

Ontario is already a leader in Canada in terms of the number of its professional instructors, instructional designers and subject matter experts. Many of these knowledge workers are already aligned with specific professions. Ontario is also home to dozens of post-secondary educational institutions that are training specialists in adult learning, distance education and cutting-edge learning technologies. For example, as I speak, there are bachelor of education candidates in a class just 10 minutes away at Laurentian University who could well be leaders in regulated professional training.

It's essential that the role of the private sector in providing education and training programs to regulated professions be preserved and enhanced. Having third-party, regulator-approved private sector companies deliver education and training services removes the conflict between industry and standard-setting bodies. It decreases costs and administration within the regulatory bodies and it also promotes private sector job creation and innovation.

(3) Encourage regulators to establish and maintain centralized public proficiency standards while refraining from taking the role of educator. Proficiency standards for professions are essential to protect the public. They codify the knowledge, skills and other competencies that individual licensees are expected to possess or perform. Proficiency standards serve as blueprints for educators. They not only streamline regulation, they reduce the burden for businesses and learners by allowing them to focus their development efforts. The government should seek opportunities to eliminate situations where regulators rely on more than one proficiency standard or where standards are owned by vendors rather than the people of Ontario.

(4) Remove any economic incentive for regulators and self-regulators to form anti-competitive policies. Regulators should regulate their respective industries, not participate in the marketplace of their licensees. Technically, regulators and self-regulators should not profit from their policies, since they're supposed to operate on a cost-recovery basis, but it would be naive to ignore the fact that regulators are always under pressure to reduce costs and become self-funding where possible. We ask

that before regulators engage in any new revenue-generating activities, especially those that compete with the private sector, that the government first review their regulatory impact.

We acknowledge that there are legitimate reasons for regulators to ask for new fee-generating opportunities, for example, to maintain proficiency standards and exams. However, without close supervision, there is the danger that regulators will choose the most expensive and burdensome approach. Allowing competition between education vendors is the single most effective tool for ensuring efficiency in licensing education.

(5) Encourage Ontario's regulators to adopt existing best practice standards. The business of professional licence education is not unique to individual Ontario markets. In many cases, regulators in other industries across Canada, and internationally, have already pooled their collective regulatory wisdom to create standards for ensuring quality in licence education. Organizations such as the Association of Real Estate License Law Officials not only set the highest international standards for quality in licence education, but they also provide self-funding, accreditation services that encourage reciprocity and reduce the cost of regulation for members.

Ontario's regulators should avoid creating new standards in isolation from their community of peers. Our commitments under NAFTA and AIT require that the government of Ontario adopt the most widely accepted standards whenever possible. This isn't just good business; it enables Ontarians to benefit from a greater transfer of intellectual capital. It makes us smarter as a province.

Let me share a practical example that touches on the principles behind our recommendations. It's also a case where regulator gears could mesh far better with government initiatives. In the fall economic outlook, the Minister of Finance announced an important initiative to review the adequacy of the regulations and proficiency standards for all of Ontario's financial advisers and financial planners. In the meantime, FSCO has stated it will enter the financial services marketplace as an education service provider in January 2016 and exclude current education providers.

It would make sense, from our point of view, to delay FSCO's entry to the market just until the minister's expert committee has had an opportunity to provide its recommendations for a more integrated approach for financial service education. Otherwise, there is the danger that FSCO will engage in activities contrary to the recommendations of the minister's expert panel.

Finally, I would like to invite you to share the future we envision for professional licensing education. We see Ontario as a hub of instructional design excellence and as a net exporter of innovative training. This vision can only materialize in an open and fair marketplace. We believe in a future where everybody benefits: regulators, educators and, most of all, the public.

Thank you for your time and consideration.

The Chair (Ms. Soo Wong): Thank you very much. This round of questions is from the government side. Ms. Vernile, do you want to begin?

Ms. Daiene Vernile: Thank you very much, Callum. Thank you very much for coming and speaking to this committee today, and for sharing your thoughts and your concerns about your industry. In my region, Waterloo region—I'm from Kitchener Centre—we are very well familiar with the insurance industry and your concerns.

I'd like to ask you: What is your current relationship, your company's relationship, with FSCO?

Mr. Callum James: Our relationship is improving. There's a new person leading FSCO who we are in contact with, and it's a much closer relationship than it has been previously.

Ms. Daiene Vernile: And has the Financial Services Commission of Ontario been willing to meet with you? Tell us about those meetings.

Mr. Callum James: Yes, they have. There are initiatives that FSCO undertook that were largely in isolation of stakeholders like ourselves in terms of the recommendations that were made. We're having an opportunity now, at this point, to be able to talk to FSCO about these. The challenge at this point is that the train is on the track, and it's headed this way; meanwhile, there's an expert panel being struck this year to go this way. We hope that they're going to meet up, but it's very difficult to serve two purposes, two directions. We would like it to actually be combined into one, and therefore we've asked for a delay, to make sure that both the government initiative and FSCO's initiative are brought into alignment.

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Ms. Daiene Vernile: Have you been able to suggest any alternatives or any innovative solutions to this conflict?

Mr. Callum James: Yes. Actually, we have been making recommendations all the way through. We actually indicated we are prepared to pay to fund the services that are required. We have continually put forward alternative models, but all of them have been rejected so far.

Ms. Daiene Vernile: Okay, well, regulators are concerned about having everybody in Canada in step and making sure that insurance agents are adequately trained. Will you be participating in the government's mandate to review FSCO?

Mr. Callum James: Yes, we will. We actually have participated; every opportunity we've been given, we have participated in. Whether it's contributing to national standards or whether it's participating on committees, we are happy to participate.

Ms. Daiene Vernile: As you mentioned, we are continuing to consult with stakeholders, so I hope you will be a part of that.

Mr. Callum James: I will look forward to it.

The Chair (Ms. Soo Wong): Two more minutes. Does anybody have a question? Ms. Albanese.

Mrs. Laura Albanese: I simply would like to thank you for presenting to the committee today and for making

us learn more about this aspect that is quite important, especially as we look to the future of Ontario, as you pointed out.

As my colleague MPP Vernile said, I would encourage you as much as possible to be part of any possibility—FSCO review or any other committee—and continue participating and bringing forward your views and your concerns.

Mr. Callum James: Thank you.

The Chair (Ms. Soo Wong): Thank you very much, sir.

ONTARIO MEDICAL ASSOCIATION, DISTRICT 9

The Chair (Ms. Soo Wong): Our next witness is the Ontario Medical Association, district 9: Dr. Stewart. Good morning, Dr. Stewart. Can you identify yourself and your colleague for Hansard purposes? You have 10 minutes for your presentation. This round of questions will be from the official opposition party. Welcome.

Dr. James Stewart: Excellent. Thank you, Ms. Chair. This is Mr. Richard Rodrigue, who is a regional manager with the Ontario Medical Association responsible for districts 9 and 10.

Good morning; thank you for the introduction. My name is James Stewart. I am a family and emergency physician from North Bay, Ontario. I operate a family practice. I do corrections medicine and work with the North Bay Regional Health Centre providing emergency services. I also function as an assistant professor with the Northern Ontario School of Medicine.

I'm very pleased to be able to come and speak to you today. We need to discuss the importance of a well-funded and sustainable health care system in Ontario and specifically for Sudbury and the surrounding communities.

As you may know, recently, following months of negotiations, the Ontario Medical Association was dealt a take-it-or-leave-it offer from the government of Ontario. They threatened that if the OMA didn't agree with their cuts, they would move ahead without us and cut even deeper. The OMA said no, and that is what the government did; they cut even deeper. Over the last 12 years, as a profession, we've tried to work in partnership with the government, and this is not a partnership.

In my role as the director for district 9, I represent the Sudbury region. I also represent 34,000 doctors and medical students through the province.

Today, I am calling on the government of Ontario to adequately fund our health care system, which is facing pressures from growth in patient numbers and needs. I want to take a few minutes to explain why the decision is so critical to understand, as we believe the government's recent actions have serious implications for our patients and our families across this province.

One of the building blocks of a healthy economy is clearly a healthy population. The fact is, Ontario's population is growing and aging. But the government has decided to fund less than half—less than half—of the additional care that will be needed. They don't even want to pay for new doctors to treat existing patients who are struggling to access the care they need. This is not right, and we cannot support this.

By the Ministry of Health's own estimates, demand for medical care will grow by at least 2.7% per year—that's $307 million per year—due to population growth in Ontario, an aging population that needs more complex care and the need for new doctors to treat existing patients who currently can't get timely access to the care they need, yet the government is only willing to fund 1.25%, or $142 million. Big discrepancy: 2.7% is the need, 1.25% is the fund. Looking back over the past five years, historically, growth for medical services has increased by an average of 3% per year.

Why has this happened? It's not because doctors have gone out and advertised for more patients. Let me repeat why it is: It's happening because our population is growing and aging. More care and more complex treatment is needed because of the growing and aging, and more care and complex treatment is being delivered across the province. And the government needs to know this is increasing—and also does know that it is increasing.

Every year, 140,000 new patients come into our health care system in Ontario. To put that into perspective, that's roughly the population of Prince Edward Island coming in each year.

The issues facing the health care system in Ontario are amplified here in the north. The North East LHIN, which includes Sudbury, has a higher than normal provincial percentage of seniors, daily smokers and adults who are obese. With each of those factors comes a much higher prevalence of chronic diseases such as diabetes, high blood pressure and arthritis. These chronic conditions place a high burden on the health care system and reduce the quality of life for those who suffer with these conditions.

I mention this because recent physician service agreements in British Columbia and Alberta demonstrate how those governments have accounted for the changing needs of their populations and have made the changes necessary to fund the required system growth. However, in Ontario the government is shirking its responsibility to fund the medical needs of its population. That is especially the case given circumstances in the north.

New doctors are needed right here in Sudbury. The reality is that Sudbury currently has approximately 19,000 unattached patients without access to primary care, including children and the elderly. That number increases to 57,000 once we start looking throughout the North East LHIN. With the government's imposed agreement, the situation is going to get worse.

Relative to the province, the North East LHIN also has a higher percentage of First Nations people. These cuts affect funding for aboriginal health access centres, rural medical incentives, and the ability to recruit and retain doctors in northern and remote communities, all of which will impact patient care for First Nations people in Sud-

bury, the North East LHIN, the North West LHIN and all the communities within.

Ontario's doctors offered the government a two-year freeze on our fees. This stands today. This means no increase in the fee paid for physician services, from a standard assessment with your family doctor through to any of the most complex of surgeries. All the OMA is asking is that the government accept its responsibility to fund new doctors to treat the patients we have today and provide the extra care needed to treat Ontario's growing and aging population.

Ontario's doctors understand and acknowledge the economic challenges facing the government. A freeze on fees and a government commitment to fund growth are the right things to do in today's economic climate. In 2012, Ontario doctors accepted a 5% cut in fees. In doing so, we also helped save $850 million in the system—$850 million. We did this then because we could make the cuts in places that would have minimal impact on patients. Now, less than three years later, the government wants to cut another 4% from medical services. This pattern is clearly unsustainable. It is unrealistic if we want the best care for our patients and if we want the best doctors available in Ontario. This pattern is a race to the bottom. It's not right, and we cannot support it as an association and a profession.

Moreover, it is important to acknowledge that OHIP billings are calculated before expenses. For example, doctors' rent for office space, staff salaries, office and medical supplies, and equipment are paid for by the physician through OHIP billings. Doctors are also employers. In fact, each doctor employs roughly four full-time people in their community. In all, we employ about 96,000 people in the province, in full-time jobs. The government's attempt to demonize doctors by equating billings with salary is quite unfair and quite underhanded.

The government cuts are real. Last week, the government took a 180-degree turn in the wrong direction. I personally was astonished to see that the biggest part of the cuts the government is imposing is focused squarely on family practice, specifically at our group- and team-based models of delivering primary care.

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These are the models that we have spent the last 10 to 12 years on building, to develop and improve access and quality of care for Ontarians. Now the government is dismantling them, taking us back to a time when millions of patients couldn't find a family doctor, students did not want to become family doctors and doctors were leaving the province in droves. When government imposes these terms, doctors will do everything we can to limit the impact that these cuts will have on our patients, but make no mistake about it: There will be negative impacts to patients in Ontario.

Our message is very clear: We want the government of Ontario to fulfill its obligation and responsibility to Ontarians and fund the unmet needs of our current population and the natural growth to provide care to our aging and growing population. Patients in Ontario, and especially in the north, deserve this from our government.

I'd be happy to take any questions.

The Chair (Ms. Soo Wong): Thank you, Dr. Stewart. This round of questions is for the Conservatives. Mr. Wilson is going to begin the questioning.

Mr. Jim Wilson: Yes, thank you, Dr. Stewart, and thank you to the Ontario Medical Association for your brief.

As a former health minister, I think people find it hard to believe that any government would not fund new doctors, which would be against the Canada Health Act, and that people won't be served because of the stubbornness of the government, but you're saying exactly that. What are they going to do, cap doctors? Because you're often accused of ramping up the number of patients you see to make up for income shortfalls. So is the government proposing to cap how many patients you can see, and are we going to have unemployed doctors in the province?

Dr. James Stewart: There are two questions in there. We have unemployed doctors in the province, currently, and it isn't specifically a cap in the sense that people would know as caps, but the funding requirements of 2.7% to meet the growing and aging population in these populations—the government is underfunding that by 1.45% in that they are only going to provide 1.25%. There is obviously a differential between those two.

In addition to a 4% reduction in fees, the government's position has been that that will be the limit on the physician services budget. Anything that goes beyond that will be a recovery at year 3 against the physicians.

Mr. Jim Wilson: So you'll be sending a cheque back if you go over?

Dr. James Stewart: We'll be sending a cheque back. And the flip side, potentially, to this is that, wanting to be partners in the health care system, we have very little control over what the spending will be on some of those initiatives that may develop over the next three years that would be outside of physician control, in addition to growth and utilization—

Mr. Jim Wilson: You mentioned the north; you mentioned Sudbury already has access problems—access to physicians. That will get worse and people will wait longer. Will that be some of the effect?

Dr. James Stewart: When you're not meeting the needs of the patient population and the growing and aging population, and you're setting up detractants for people to participate in primary care and family medicine and/or eliminating programs that we've worked so hard to try to develop to improve access, the natural outcome could be that.

Mr. Jim Wilson: Thank you. I think Vic's got a question.

Mr. Victor Fedeli: Thank you, Dr. Stewart, for being here today. You talked about the 19,000 unattached patients in Sudbury. I've understood the number in North Bay to be 12,000. Do you have any insight into that number?

Dr. James Stewart: Thank you, Mr. Fedeli. It was about 10,000 about three or four years ago, when we were working on the recruitment initiatives within North Bay. Since that time, we've lost three physicians who had fairly substantial practices to retirement, to passing away and to illness, that sort of stuff. So I would imagine that we're probably at that number or a bit beyond.

Mr. Victor Fedeli: In your opening statement, you talked about the government adequately funding our health care system, facing pressures from growing patient needs. How does the firing of 40 health care practitioners in Sault Ste. Marie yesterday and 75 health care practitioners in North Bay this month achieve that goal?

Dr. James Stewart: I wouldn't know. You're much more in tune with what's gone on in the last day or two in those areas, so I couldn't answer that.

Mr. Victor Fedeli: We've often talked to seniors who are suffering because physiotherapy cuts in homes—have gone from 100 sessions of physiotherapy down to four sessions a year. So if you have a hip or a knee surgery, and you're now limited to one hour a week for four weeks, those seem to be some of the real cuts that are being made—diabetes testing strips that have been cut, or cataract surgeries that were cut 39 days last year.

Are you aware of any of the other cuts that have been affecting seniors and families throughout the north specifically?

Dr. James Stewart: Certainly those would be some of the ones that were most obvious.

I can't think of other significant ones off the top. In the proposals that the government is looking to legislate or is looking to impose unilaterally, we will see some things around access through family health teams—physicians, that they're able to participate in group models that work in team-based care, which is now starting to show that it has some greater benefit to patient care in the community. So I anticipate—although I can't speak on the past—in the future, we may see some of that.

The Chair (Ms. Soo Wong): Thank you so much for your presentation today.

Dr. James Stewart: Thank you.

ONTARIO NURSES' ASSOCIATION

The Chair (Ms. Soo Wong): Our next witness is the Ontario Nurses' Association: Pamela Mancuso. Welcome. Good morning. Pamela, can you identify yourself as well as your position with the Ontario Nurses' Association for Hansard? You have 10 minutes for your presentation. This round of questions will be from the official third party. Thank you.

Ms. Pamela Mancuso: Thank you and good morning. I'm Pamela Mancuso. I'm a registered nurse and I'm vice-president for region 1, which covers from North Bay all the way to the Manitoba border, of the Ontario Nurses' Association, known as ONA.

I've been a registered nurse for—actually, more than 27 years; it's almost 30. I've worked in a variety of roles, including front-line nurse and clinical instructor at the college. My last position before coming on the union was district stroke coordinator out of the Sault Area Hospital.

ONA is Canada's largest nursing union, representing 60,000 registered nurses and allied health professionals, as well as 14,000 nursing student affiliates, providing care in hospitals, long-term-care facilities, public health, community clinics and industry. I'm here today to speak on behalf of the registered nurses who are extremely concerned about the announced cuts to RN positions in 2015 in northern hospitals and the resulting impact on quality care for our patients.

As advocates for our patients, registered nurses must speak up and bring this information on the impact of underfunding our hospitals to light. The public has the right to know what is going on with respect to the care they will lose as a result of nursing cuts in their local hospitals. Overall, Ontario has 71 RNs per 10,000 population, compared to 83.6 RNs per 10,000 in the rest of Canada. This ratio is the second-lowest in Canada. This creates a significant gap in RN care for Ontarians who are in the hospital.

This morning, I want to focus my remarks on why we need more registered nurses in our hospitals to meet the increased care needs of our complex and unstable patients. While the need for more RNs in our hospitals is growing, hospitals are cutting RN positions, which can be traced directly to years of frozen base operating funding and the current funding model in place.

Right here in Sudbury, Health Sciences North has notified us that we will be losing as many as 34 full-time-equivalent RN positions. The plan is to eliminate full-time positions in critical care, mental health, surgical, and emergency. Other areas of the hospital will see reductions in hours, such as the birthing centre and the OR. Bed closures in the surgical unit will mean that additional positions will be affected as well.

Further cuts announced or expected in northern hospitals include 20 RN positions in the Sault Area Hospital, as the revenue of $5.5 million is less than planned, including $1 million in renal endoscopy reductions, and funding for hips and knees reduced by 9% and 4.5%. The hospital is planning $10 million less in funding for next year and likely more cuts. The elimination of 20 RN positions will affect patient care areas such as medical, rehab, renal and complex continuing care.

Ten RN positions at Timmins and District Hospital are to be eliminated to address an $11-million deficit for this year and next. In addition to closing 26 beds, affected patient care areas will include chronic care, dialysis, obstetrics, intensive care and emergency. Out-patient rehab services have already been significantly reduced since November 2014. Because Geraldton District Hospital no longer offers obstetrical services, all expectant moms must now travel to Thunder Bay from 37 weeks of gestation until delivery. This does cause considerable financial hardship, and some of them take the risk of actually having an emergency delivery done there. There is no operating room, and an emergency would likely mean an extremely negative impact on mom and baby.

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Lake of the Woods District Hospital in Kenora has announced that it is facing a $1.2-million cut to their budget, which is a 6% reduction, so we expect that we'll hear word of layoffs there, as well. North Bay Regional Health Centre has announced cuts of 75 positions, including 16 RN positions. Temiskaming Hospital in New Liskeard has announced cuts to address a $1.4-million deficit this year; as a result, 15 positions will be eliminated throughout the hospital, with six of those being full-time RNs.

While hospitals are cutting RN care, there are numbers of studies that clearly show the strong relationship between higher RN staffing levels in hospital and improved patient outcomes. Studies also show that decreasing RN staffing has a negative impact on patient health outcomes. Higher levels of RN staffing in hospitals are essential to care for patients with complex and unstable conditions, as the previous speaker spoke about. In the north, we have very many complex senior patients in this population. Adding one patient to a nurse's average caseload in acute-care hospitals is associated with a 7% increase in complications, a 7% increase in patient mortality.

Higher RN staffing is associated with a range of better patient outcomes, reduced hospital-acquired pneumonia, nosocomial bloodstream infections and other complications, and reduced length of stay. And yet in Ontario, three years of frozen base operating funding for hospitals has resulted in the elimination of millions of hours of RN care. Since January 2012, 1,700 RN positions have been deleted—we track all our jobs, just so you know. This means that more than three million hours of nursing care have been eliminated from our communities in this period, completely ignoring the evidence linking RN care to improved patient health outcomes.

I can tell you that studies show that adding RN staffing achieves significant cost savings, as well, by reducing adverse outcomes, lengths of stays and by avoiding patients' deaths. Additional RN staffing mitigates complications through early intervention and leads to more rapid patient recovery, saving lives along the way. Funding at less than the combined rate of inflation and population growth has put enormous pressure on hospitals to adopt short-sighted and risky measures to balance their budgets, including the elimination of RN positions, not replacing RN positions when they become vacant and substituting RN positions with less-qualified staffing.

As a result, ONA is calling on the government to restore hospital base operating funding to at least cover the cost of inflation and population growth. We are calling for a multi-year nursing human resources plan, to make significant progress in reducing the gap in the RN-to-population ratio between Ontario and the rest of Canada. Registered nurses at the Sault Area Hospital, for example, had to speak out previously about their ability to care for emergency patients to the standards that are required of them by their regulatory college, because of their shortage of staff.

We recognize that the hospitals are trying to operate under serious fiscal restraint, but as registered nurses we have to speak out on behalf of our clients and try to provide the best and safest care for our patients. The findings from a study using a nursing outcomes database, for example, show that it takes not only the right number of nursing staff for every shift to ensure safe patient care, but also the right skill mix of expertise and experience. And yet, RNs' share of nursing employment in Ontario has been falling consistently over time, from 77.4% in 2004 to 70.8% in 2014. This is a troublesome trend given the extensive research on the clear benefits of higher RN staffing on better patient outcomes.

We know from research literature that fewer RNs and fewer RN hours will result in more patient complications and higher mortality rates for patients. Short-sighted funding decisions and budget staffing reductions are costing the health system in dollars and morbidity. It is time for the Ontario government to step up for hospital patients in northern Ontario. Increased base operational funding for hospitals is essential to properly staff to meet the care needs of our acute patients and a comprehensive human resources plan for RNs in our hospitals must be developed. Thank you.

The Chair (Ms. Soo Wong): Thank you for your presentation. Ms. Gélinas? Oh, Ms. Fife is going to ask the questions.

Ms. Catherine Fife: Thank you very much. Thank you very much, Pamela, for the presentation. One of my questions was actually going to be around the flatlining of hospital budgets for four years and what the impact of that is, but I think you were very articulate in explaining the negative impacts on patient care. I think, actually, all of us are probably seeing that in our respective ridings.

Recently, though, in the media, the issue of nurses' safety has come up, because, as you point out, patient care is becoming very complex. Work hours and shift work contribute to that. What should the government do in this budget to help keep nurses safe so that they can actually care for patients in the province of Ontario?

Ms. Pamela Mancuso: It would be nice to have security at every hospital, but we know that that's not possible. There are many small hospitals that would never be able to fiscally afford that. But I think that part of the problem is that a lot of our client loads that have been released from other facilities—and not really properly followed—come into the hospitals, and they're very volatile and unstable. If you don't have a nurse right at the door to do that assessment, then they slip through the cracks and then something happens, and the escalation occurs.

If you look in the paper you'll see that many, many of our nurses are being attacked, stabbed, and we under-report—we know that—so the numbers are probably five or six times higher than what is being reported. At the end of the day, a lot of nurses think it's part of their job. The patients are sick; it's not their fault, and they don't report. But it's nobody's job to go and be injured or not

come home, as we've had several of our nurses do—not come home.

So that's a bigger question. Right now, ONA's concern is trying to get the right skill mix back into the hospitals and making sure that if this patient requires an RN, then they have an RN. That should be what we are looking at—look at the base funding, look at what our population growth is and what the complex needs of the patients are, and have the right skill mix. That's what we're there for.

Ms. Catherine Fife: So there's a recurring theme here this morning around the overall health of the community and how it impacts—and many of those complex needs end up in a hospital instead of, for instance, home care, if you will. I know that the government, of course, is in the process of reviewing home care and the role of CCACs in that sort of mix. You also represent care coordinators in these 10 CCACs. Right?

Ms. Pamela Mancuso: Yes, we do.

Ms. Catherine Fife: So do you think that direct public home care delivery through CCACs would allow for improvement in continuity of care for patients? Because we're going to have to find some creative options to alleviate the pressure on hospitals in this province.

Ms. Pamela Mancuso: Well, they certainly help coordinate it because there aren't enough nurses in a hospital to coordinate anything; they can barely get through their shift. So we need to have somebody coordinating the care, and that needs to be someone who understands the care. But I will tell you that a lot of communities have cut so many services that there isn't a lot of care to coordinate out there anyway. So, at the end of the day, we're robbing Peter to pay Paul instead of having a very intensive review of what is required.

Looking at the North East and North West LHINs, they have extensive elderly clients with multiple complex needs. We need to be looking at those types of things. The services are vastly different across the province, as I've found out.

Ms. Catherine Fife: Yes. We heard the same thing in Fort Frances yesterday as well. I think, actually, that's why it's so good that this committee travels to the north—

Ms. Pamela Mancuso: Thank you.

Ms. Catherine Fife: —because the issues are intensified up here because of a lack of resources and accessibility.

Ms. Pamela Mancuso: I'll give you an example: My husband just had to go to Sunnybrook to get a referral. We live in Sault Ste. Marie.

Ms. Catherine Fife: And he had to go to Toronto to get a referral?

Ms. Pamela Mancuso: He had to go to Toronto to get that referral.

Ms. Catherine Fife: Because that makes a lot of sense.

Ms. Pamela Mancuso: It doesn't make sense to us.

Ms. Catherine Fife: No.

That's it for me. How much more time?

The Chair (Ms. Soo Wong): One more minute. Ms. Forster?

M^me^ France Gélinas: No, I will take it.

I certainly appreciate very much you coming in today. When you say that as one more patient is added to your caseload, 7% more complication and mortality—give me an example. What does that mean?

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Ms. Pamela Mancuso: Okay. So if you were a nurse in renal dialysis, your patient load could be three patients to one. Renal dialysis patients are multi-complex patients and you're dialyzing them. Quite often they code. If you add one more patient to that load, it's putting all those patients in serious risk. Or if you're a critical care nurse and you're 2 to 1, one of them could be a ventilator, the other one's usually very, very sick. You're not in ICU unless you are very ill. Sometimes they add one more patient: "It's not as heavy but you can take it. Four more hours."

This is what we're saying. You have to look at the complexity of the patients and not just assume that, "We'll just add one more to your caseload."

M^me^ France Gélinas: On a regular medical floor, what would be the ratio?

Ms. Pamela Mancuso: Every model is different in every hospital. They try different models to try to reduce their costs, but if you're on a heavy medical floor, a nurse may have four patients. Two of them could be stroke patients. On top of that, you'll have two other patients—could be a hip, could be something else. She's responsible for everything for that patient: meds, bathing, making sure everything is done, tests, getting them transferred, doctors, everything. That's her responsibility. If you add one more to her—she's only there for eight hours. How much more can you do? That's reality.

The Chair (Ms. Soo Wong): Ms. Mancuso, thank you very much for your presentation. If you have any more written submissions, you can send them to the Clerk.

Ms. Pamela Mancuso: There will be a written submission by the Ontario nurses in Toronto.

The Chair (Ms. Soo Wong): Thank you.

SUDBURY AND DISTRICT HOME BUILDERS' ASSOCIATION

The Chair (Ms. Soo Wong): Our next witness is the Sudbury and District Home Builders' Association. Welcome. Ms. Higgs, you have 10 minutes for your presentation. This round of questioning will be from the government side. Please identify yourself for Hansard, and your position with your home builders' association. Thank you.

Ms. Laura Higgs: Thank you. Ms. Chairman, members of the committee, good morning. My name is Laura Higgs and I'm the executive officer of the Sudbury and District Home Builders' Association. Thank you all for making the trip to Sudbury and giving us an opportunity to speak on the upcoming budget.

The Sudbury and District Home Builders' Association is proudly affiliated with both the Ontario and Canadian home builders' associations. We are the voice of the new housing, land development and professional renovation industry in Greater Sudbury. Our association has 95 member companies.

Here in Sudbury, the residential construction industry is vital to our local community, as it is in every community. We support over 3,000 jobs in the new housing and renovation sectors, paying $165 million in wages. The total annual investment value of the sector represents $345 million across the Greater Sudbury area. Similar to many communities across our province, we are experiencing a slowdown in our market; however, our renovators seem to be doing a little better.

Throughout Ontario, the residential construction industry supports over 322,000 jobs, paying over $17 billion in wages and contributing over $43 billion to the provincial economy. We not only support jobs in construction in the skilled trades on-site, but also jobs for planners, engineers, architects and suppliers of construction material, whether from manufacturing to the retail end. I think it's important to note that our industry differs from the mining or automotive sectors in that we don't just operate in a few specific communities in Ontario, but that we support jobs and investments in communities throughout Ontario, from Sudbury and northern Ontario to Fort Erie, and from Windsor to Ottawa. We really are an Ontario-wide industry.

While I mention these stats and figures, it's important to keep in mind that we are talking about people's homes, which represent a roof over a family's head, and is often the single largest investment a family will make.

Our industry remains concerned about the broader economy as some sectors have not fully recovered from the recession. The mining sector, for example, has experienced layoffs and reorganization; some retail and grocery stores have closed; and many of our members have delayed or cancelled projects. When consumers are not confident, when they don't have a job or lack job security, they don't buy a new home or renovate their existing home. That is why my deputation today is going to focus on infrastructure, job creation and the underground economy.

The Sudbury and District Home Builders' Association strongly supports a coordinated infrastructure investment towards strategic projects, based on clearly defined priorities. We believe that the expansion of core infrastructure—that means roads, bridges, transit, and water and waste water—in support of a growing economy and a growing population should be a key priority for the provincial government.

It is also important to ensure that the province has in place a long-term asset management plan to ensure ongoing maintenance and a state of good repair for Ontario's existing infrastructure. We also believe that the housing affordability choice should be recognized and measured as one of the priority outcomes of the public infrastructure investment.

Investments made by the public sector encourage additional private sector investment and job creation for our members. We acknowledge the investment in Highway 69 south and the recent announcement of support for the Maley Drive project. These are great examples of partnerships between the public and private sectors that produce dividends through new jobs, economic growth and stability.

Greater Sudbury is 3,267 square kilometres in area, making it geographically the largest municipality in Ontario and the second largest in Canada. That is a lot of infrastructure to build and maintain and a challenge to finance for a city of 160,000 people in northern Ontario. As you are aware, local infrastructure projects are in part funded through development charges. These charges have increased in Greater Sudbury from about $3,000 in 2009 to just under $15,000 in 2014. That's for a single-family home. Over the next four years, these rates will increase yet again to just over $17,000. It is an unfair burden to new homeowners who finance infrastructure through their mortgages, and it negatively affects affordability, perhaps even preventing young families from purchasing a new home.

We recommend that infrastructure investment be more strongly coordinated among all levels of government. This would provide greater stability and predictability for what projects are going to occur and when. This will allow for the private sector to plan our projects and target our investments to better align with new and upgraded public infrastructure facilities.

The government has committed to an ambitious 10-year, $130-billion infrastructure plan, with $14 billion of that targeted towards transportation improvements outside of the GTA. We are looking forward to Sudbury receiving its fair share. We recommend a process by which projects meet criteria that will enhance productivity and support economic growth identified as priorities and, finally, that the government outline a schedule to provide certainty for citizens and businesses in Sudbury. This will help our community to become an investment-ready community. We need to ensure greater alignment and collaboration between the public and private sectors in terms of investment and planning policies to pre-zone and pre-designate for growth.

The home builders' association here in Sudbury also represents the professional renovation sector within the region. Our members must abide by a code of ethics, and we promote and direct our consumers to our national association's Get it in Writing! campaign. Having a written contract gives you control over your renovation or construction project and is a good way to protect yourself and ensure long-term satisfaction. While you can never guarantee perfection, we tell consumers that they can take control of a project with a written contract and use available information and tools to put them firmly in the driver's seat.

I'd like to quote Finance Minister Charles Sousa's fall economic update: "When businesses don't pay their fair share" of taxes "they disadvantage other businesses that

do follow the rules." Often businesses that do not pay taxes also ignore rules that protect employees and ensure that products are safe and reliable.

I'd like to highlight that the renovation sector isn't a small part of the provincial economy. It represents over $23 billion in activity across Ontario, which is even larger than the new home building sector. We believe that it is time to take serious action to combat the underground cash renovation economy. Through our association, the Ontario Home Builders' Association, we would like to work with the government on an underground economy task force.

I'd like to share a couple of ideas with you. A consumer-focused tax credit similar to the expired federal government's home renovation tax credit would be an excellent tool to combat the problem of the cash economy in the renovation sector. I say this because it isn't just the businesses that are the problem. Many consumers seek out cash deals to avoid taxes. It does take two to tango, and I think we need to incent good behaviour by offering a tax credit to those who collect receipts from legitimate businesses and to submit those to the Canada Revenue Agency. Again, I'm sure most people in this room know someone who took advantage of the tax credit or perhaps they themselves did. It was a great tool to encourage the use of legitimate businesses, and on the back end, it provides an information-sharing opportunity, through which receipts can be collected through the CRA.

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This brings us to our second recommendation: The government should examine additional measures that would enable better information-sharing across government ministries, agencies and jurisdictions to detect and target underground builders and renovators. I can tell you that the WSIB has an information-sharing agreement with the CRA, Canada Revenue Agency, and we need more of this type of information-sharing between government agencies. We need a stronger system in which information collected by the revenue agency and other agencies can be cross-referenced to catch underground operators. The collection of more renovation receipts through a reno tax credit is a great first step to assist in this initiative.

Lastly, we would like the government to consider province-wide campaigns to raise public awareness of the negative impact of the underground economy in the home renovation industry. In fact, this isn't just about government revenue; this is about consumer liability and risk, as well as the health and safety of workers and the potential for shoddy workmanship. I'd encourage all of you to visit our website, sudburyhomebuilders.com. We have a section on the underground economy with a very well-done advertisement put out by the CRA two years ago in Atlantic Canada, warning consumers about the perils of hiring a renovator to work for cash. Please check out the ad. It would be very helpful if the province would be able to work with us to provide a similar campaign.

In closing, I'd like to thank all of you for your attention and reiterate our core themes:

We support continued provincial investment in core infrastructure.

We support a permanent home renovation tax credit to combat the underground economy.

We support greater information-sharing agreements to combat the underground economy.

We are seeking a role on any provincial task forces or stakeholder groups to look at the underground economy.

Thank you, and I look forward to any questions you may have.

The Chair (Ms. Soo Wong): Right. From the government side, Ms. Albanese, do you want to begin the questions?

Mrs. Laura Albanese: Sure. Thank you very much for your presentation and for highlighting the work that your organization does throughout the province, both on the builders' side and on the renovators' side.

I guess the first thing I would like to mention: I took note of what you were saying in regard to the underground economy. I will be tasked this year by the Minister of Finance to conduct a consultation and produce a report to the minister later on this year on the underground economy—or revenue integrity, as we call it. So I appreciate the ideas that you have, and I do understand that you would like to have a role in that, but I don't know if we will have a task force as of yet. We will keep you updated, and I will take a look at your website as well.

Ms. Laura Higgs: Thank you.

Mrs. Laura Albanese: I understand that you're also working with Tarion to identify some loopholes in—

Ms. Laura Higgs: Yes, we are. It may be true across northeastern Ontario, but definitely in the Sudbury area, when we look at permits for new construction homes, just a little more than 40% of those permits are issued to private individuals who intend to build their own home. That's absolutely fabulous, nobody has a problem with somebody building their own home, but we don't believe that that many people know how to build their own home, so we're concerned that that work is being done by part of the underground economy as well. So we do work with Tarion. We've been able to facilitate information-sharing between municipalities and Tarion so they share that information about all permits that are issued. Further, we're working with Tarion to perhaps in the future drill down more in terms of those private permits and be able to identify repeat offenders.

Mrs. Laura Albanese: Okay, that's good. I had just one more question. I know that the home builders' association has been very vocal in the past in regard to the College of Trades. As you know, the government has appointed Tony Dean to review that. What have you been hearing from your members?

Ms. Laura Higgs: Well, the Sudbury home builders' association wrote a letter directly to Mr. Dean requesting that he come to Sudbury so that we might be able to present our feelings on that. Certainly, it's always a good idea

to educate and recruit people to work in skilled trades in our province and, indeed, in our country. I think we support that.

Our concerns, however, with the College of Trades centre around the increased regulation and bureaucracy within all of the trades in that sector. Furthermore, we are very concerned that it further pushes the public to engage in the underground economy. So while there may be some pluses there, there are some minuses as well.

The Chair (Ms. Soo Wong): I heard that Ms. Vernile wants a question. There's one minute left.

Ms. Daiene Vernile: Do you want one more, though?

Mrs. Laura Albanese: I just wanted to know the comments about the review: That has been welcomed by your members?

Ms. Laura Higgs: Indeed. It was very well welcomed by our members, yes.

The Chair (Ms. Soo Wong): One minute.

Ms. Daiene Vernile: Thank you very much, Laura. I have a very deep and abiding respect for your industry. My father owned a small construction company in Toronto for many years. When I say "small," it was just him. I spent many happy evenings and weekends working with him rather than staying at home and cleaning the house with my mom.

Ms. Laura Higgs: Lucky you.

Ms. Daiene Vernile: I would like you to talk a little bit more about this issue of the underground economy, because it's very pervasive. Some people might think that you're getting a deal if you're getting Fast Louie down the street to build your deck rather than hiring somebody who's paying taxes. How great of a problem is this?

Ms. Laura Higgs: It's a great problem. It's a great problem on many levels within our province. First of all, that person who's building the deck maybe isn't licensed to be a renovator in our city of Sudbury, let's say. They probably don't have business liability insurance; they probably aren't paying their WSIB, so they're not a firm that's enrolled in the WSIB, which means, at the end of the day—and there are lots of technicalities here, but at the end of the day, they are the employee of the homeowner. If something happens to those individuals or that individual while they're there, that homeowner is at significant liability, and they are not aware that they're at this liability.

The other aspect that's more of a municipal factor is that generally, permits are not issued for that type of work. In Sudbury, a permit is needed to build a deck. When things are built, even if you do something structural in your house, and permits are not done, that costs the homeowner; it costs the province—

The Chair (Ms. Soo Wong): Ms. Higgs, can you wind up? Because we're almost there. We've finished the time.

Ms. Laura Higgs: I think at the end of the day, it puts the homeowner and the consumer at risk.

The Chair (Ms. Soo Wong): Thank you for your presentation. I noticed that you didn't submit anything in writing. Can you share with us what you just presented to the committee and leave it with the Clerk?

Ms. Laura Higgs: I can, yes.

The Chair (Ms. Soo Wong): That would be great. Thank you very much for your presentation.

Ms. Laura Higgs: Thank you.

DR. JAIRUS QUESNELE

The Chair (Ms. Soo Wong): Our next witness is Jairus—is it Quesnele? I hope I didn't say it wrong. Welcome. Can you please identify yourself? You have 10 minutes for your presentation. This round of questions will be from the official opposition party. Thank you.

Dr. Jairus Quesnele: My name is Jairus Quesnele. I'm a local chiropractor and a clinical science specialist. I just relocated back to Sudbury. I was faculty at the Canadian Memorial Chiropractic College in Toronto and also was a chiropractic resident of the World Health Organization a few years ago.

I'd like to speak to you this morning—and also, thank you for having me speak to you on this important issue. The government has been implementing its action plan for health care to strive towards an increasing, high-performing, patient-centred, sustainable health care system, ensuring that Ontarians have access to the right care at the right time in the right place. Within the health care context in Ontario, there is a musculoskeletal challenge.

I'd like to speak on four brief issues that come to mind. The first is that musculoskeletal issues are pervasive. It's estimated that 11 million Canadians over the age of 12 are affected by a musculoskeletal disorder. As its population ages—which we can't stop—these burdens are going to continue. Up to 80% of people will experience low back pain in their lives, and nearly 20% of Ontarians report it to be chronic.

Number two: Musculoskeletal patients are high consumers of system resources. In 2006-07, about 23% of Ontarians saw a physician for a musculoskeletal disorder; 33% saw a specialist like an orthopedic surgeon. Musculoskeletal disorders represent 27% of all ambulatory visits to physicians in Ontario. Chronic low back pain patients are frequently referred for surgical consultations despite 90% not being proper surgical candidates. Still, 84% of these require advanced imaging.

Musculoskeletal injuries pose a significant economic burden. The Public Health Agency of Canada found that in 2008, direct costs for musculoskeletal care in Ontario were almost $2.4 billion, and direct costs for low back pain were greater than $390 million.

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Musculoskeletal disorders, according to the World Health Organization, are the leading cause of work-related time-loss claims and account for 40% of lost-time claims and 50% of all lost-time days registered with the WSIB, and low back pain represents a majority. Musculoskeletal conditions impact complex patients. The prevalence of co-morbid conditions is continually rising, and as our population ages, this burden will become more

pervasive. Adults suffering from multiple chronic conditions, like diabetes and heart disease, also suffer from musculoskeletal conditions. These contribute to pain, limit mobility, prevent patients from engaging in their active phases of care and ultimately exacerbate existing conditions.

We believe chiropractors can help. Chiropractic care improves patient outcomes. There are numerous high-quality systematic reviews, meta-analyses, other things like clinical practice guidelines among RCTs—randomized control trials—that show the efficacy of chiropractic care in decreasing pain, increasing physical functioning, and disability improvements. This is further amplified when combined with medical care.

Access to chiropractic care reduces system costs. Research has shown that low-back-pain patients who had access to chiropractic care versus those who did not had 30% to 40% fewer back-related costs, hospitalizations, back surgeries and required medical imaging. A recent case study conducted by the Ontario family health team found out that when a chiropractor is included in the team, prescription medication and the use of narcotic medications were reduced by more than 50% and the median number of physician visits reduced from 2.5 to one.

Chiropractic care also produces high levels of patient satisfaction. We know, from many different sociological studies along with Ministry of Health and long-term-care projects, this to be true—not just true, but they're very high.

I'm a local chiropractor. I've been in practice for about five years, and I'm a clinical science specialist and also a researcher. I'm fortunate to have had many experiences working with interprofessional health teams and professional research teams in academic environments and have seen first-hand the impact that interprofessional teams have on health care and the important roles that chiropractors play. Our practice is situated in a multidisciplinary sports setting here in Sudbury, and I often see cases of complex low back pain, neck disorders, headaches, neuromusculoskeletal conditions and other sports-related medicine conditions.

Although I've recently relocated back to Sudbury, I've taken my experiences from the GTA and around the world. I've worked diligently to build bridges with local GPs, medical specialists and other health care providers in Sudbury. It has become very clear to me that the role of the chiropractor within multidisciplinary and interdisciplinary settings in northern Ontario is increasingly important. I've noticed that in the north, patient rosters are further overloaded, physicians are overworked and burdened, emergency visits and specialist wait times are way too long. Patient complexities are mounting. Access to care is also often insufficient, and costs are rising. To suggest this is a complex problem is an understatement.

Many of my patients suffer from chronic conditions like diabetes, respiratory conditions and cardiovascular conditions, and I've seen the first-hand complexity of managing these patients. I've had many conversations with local medical doctors, physicians, nurse practitioners and others about the burden not only carried by these individuals because of their problems, but also the burden it places on the care provider and the health care system. Often, pain represents a major barrier to effective treatment for these individuals. Physicians want to empower their patients but are finding it increasingly difficult to do so because of pain. The cycle continues and more pain continues to persist, their physical health remains unchanged, disability and impairments further continue, and this compounds the problem. It takes time for the GP and results in the ordering of potentially unnecessary diagnostic tests which help to figure out their pain and bring answers and relief to their patient. The system is taxing and needs support.

My experiences within interprofessional settings have given me good insight into how these complexities can be better managed. I've had the unique experience of working at St. Mike's Hospital as a chiropractor, and I've seen, aside from the very positive clinical environment there in the family health team, outstanding outcomes. Patient care was efficient and enabled the GPs to focus on their patients. The strong relationships between the general practitioners and the chiropractors equated to less diagnostic tests being ordered and, subsequently, less referrals for surgical consultations. The chiropractor would perform a thorough assessment, make evidence-based recommendations and treatments, and these are all communicated back to the GP. This undoubtedly saved time and money and bolstered patient satisfaction, along with outcomes.

Further, while in the GTA, I've had the opportunity to work with surgeons—spine surgeons and other musculoskeletal surgeons—in their assessment clinics. I was there to learn, but also as part of their decision-making process for triage. It was often a frustration to the surgeon that patients who would wait several months for this consultation would only find out that they were inappropriately referred; they were not proper surgical candidates. It results in further long wait-lists and delays for patients who do require surgery. Unfortunately, these cases are plentiful, and they had previously consulted with their GP on many occasions and had gotten several other expensive diagnostic tests. To contrast, these patients could have been evaluated in an evidence-based assessment by a chiropractor and many of these unnecessary referrals to specialists and MRIs been dramatically reduced.

I could speak literally ad nauseam about the number of cases that I get that end up in the emergency department, recurring emergencies that are musculoskeletal in nature and are easily diagnosed and treated, and yet this continued problem persists. It's very expensive, not only for the ER visits and physician time but also medical imaging.

To address these challenges, the government—and we are happy about this—has been rolling out the Low Back Pain Strategy since 2012, including two very important projects: the Inter-professional Spine Assessment and

Education Clinics and Primary Care Low Back Pain Pilot projects. In working with chiropractors and other providers on efforts to improve the way the system manages low back pain, positive results have already been demonstrated.

In addition to the Low Back Pain Strategy, in the fall of 2013, the government authorized interprofessional primary care teams to employ chiropractors, but additional funding is necessary for this to happen.

There are opportunities to further leverage the use and expertise of chiropractors, reducing unnecessary health expenditures while improving patient outcomes and access to care. We hope that you will continue your commitment to enhance low back pain and musculoskeletal care. Specifically, we think there are two ways that are important—

The Chair (Ms. Soo Wong): Can you just wrap up?

Dr. Jairus Quesnele: Sure. These are the two, and then I'm done.

The first is that we recommend that interprofessional primary care teams be funded to hire chiropractors to support comprehensive musculoskeletal programs. This will promote immediate improvement in musculoskeletal care and low back care in team settings.

And we urge you to ensure there is funding for a province-wide rollout of comprehensive low back pain models of care based on the results of the Interprofessional Spine Assessment and Education Clinics and the Primary Care Low Back Pain Pilot projects.

Thank you.

The Chair (Ms. Soo Wong): Thank you. I think this round of questions will begin with Mr. McNaughton.

Mr. Monte McNaughton: Great. Thank you very much. My questions are simple: What's the ask as far as money? How much is this going to cost?

Dr. Jairus Quesnele: I can't specifically speak to that. My association will be speaking to that in due time. But currently the government has given $2.3 million for the Primary Care Low Back Pain Pilot project to ascertain whether this is going to be cost-effective. Based on the preliminary results already, it appears that the government has saved $15 million, which is significant, considering the pilot projects haven't really even unfolded a great deal.

I'll speak to that a little bit more as well. In these independent spine assessment clinics, with chiropractors taking leads, they've noticed that—these are secondary levels of care. So patients who are complex and can't be managed by their physician or chiropractors are referred for these consultations instead of being referred for surgery or surgical consults. They have noted that out of the 3,000 who have been referred, only just over 200 have needed a surgical consult or medical imaging, a significant savings, and it's only a snapshot.

Mr. Monte McNaughton: So you're saying the government needs to fund having chiropractors in doctors' offices, essentially?

Dr. Jairus Quesnele: Yes.

Mr. Monte McNaughton: How many chiropractors would have to be hired? I mean, this would be a significant investment.

Dr. Jairus Quesnele: Well, I think that your information will come directly from these pilot projects, and so you will get an understanding of (a) how many chiropractors are going to be needed to bring down that cost overall for medical imaging and surgical consults. I don't have a specific number in mind of how many chiropractors would be needed, but these are pilot projects. There are seven sites—

Mr. Monte McNaughton: Okay. I was going to ask you that.

Dr. Jairus Quesnele: There are seven sites currently, but we want that, once the findings come through, we'll have good, sound evidence to say, "This needs to be amped up."

Mr. Monte McNaughton: Will your association be presenting to the finance committee?

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Dr. Jairus Quesnele: They will be, yes.

Mr. Monte McNaughton: Okay. So we'll have that dollar amount before the budget—

Dr. Jairus Quesnele: Yes, and I can echo that to them.

Mr. Monte McNaughton: Okay. Thanks.

Dr. Jairus Quesnele: Thank you.

The Chair (Ms. Soo Wong): Mr. Fedeli, do you have a question? Two minutes.

Mr. Victor Fedeli: Thank you very much. As someone who has been to chiropractic since probably the 1970s—

Interjection.

Mr. Victor Fedeli: Well, when I was first thrown from a snowmobile and then secondly thrown from a horse, if you really want to know my medical history. I have had great need—thank you—for chiropractic.

Can you talk to us just about the changes in how you're paid and who pays you today versus some time ago? Would you mind, in about the minute that's left, just give us—

Dr. Jairus Quesnele: Yes, I'll give you a snapshot. Generally, billings are reimbursed through a third-party payer, so insurance companies will pay, or it's fee-for-service and you pay for your service. Those are generally the two.

There are other unique models. Some of the teaching clinics in Toronto operate a little bit differently based on some collaborative funding projects. And within the family health care teams, it's also structured a little bit differently.

In contrast to previous OHIP cuts since 2004—there was a stipend that the government would cover; I'm sure you're fully aware of that. In Alberta I believe that they are now reintroducing that stipend back to seniors. That might be a really interesting pilot project to try as well, based on our increasingly aging population and the musculoskeletal demand—

Mr. Victor Fedeli: When the cuts were made, did people stop using chiropractic?

Dr. Jairus Quesnele: Initially there seemed to be a bit of a blip. This was right when I was sort of considering going to school to be a chiropractor, so those questions were kind of prominent in my mind. There seemed to be a blip but it didn't seem to affect the numbers of chiropractors in subsequent years to follow.

That being said, only about 10% to 12% of the population see chiropractors regularly—

The Chair (Ms. Soo Wong): Thank you very much for your presentation. I'm sorry, the time is up.

Dr. Jairus Quesnele: No problem.

The Chair (Ms. Soo Wong): Thank you for your presentation.

AV TERRACE BAY INC.

The Chair (Ms. Soo Wong): Our next witness is AV Terrace Bay Inc., Mr. Giovanni Iadeluca. Right?

Mr. Richard Groves: I'll save you—

The Chair (Ms. Soo Wong): You'll say it better than me. That's okay.

Mr. Richard Groves: No, you got the name right, but I'm speaking on behalf of Giovanni. My name is Richard Groves.

The Chair (Ms. Soo Wong): Okay. Welcome. Can you please identify yourself and what your position is? You have 10 minutes for your presentation. This round of questions will be from the official third party. Welcome.

Mr. Richard Groves: My name is Richard Groves. I'm the vice-president of AV Terrace Bay. I'm in charge of fibre supply and government relations. I'm speaking on behalf of Giovanni Iadeluca, who is the CEO.

I want to thank you for the opportunity to speak to you about some of the many challenges facing our business in the broader forest industry today. These challenges all present an opportunity for the province to have a positive impact on the industry, in some cases without even spending any money.

Interjection.

Mr. Richard Groves: Like those ones? I tried to bring something good.

First I'll speak to the importance of the provincial roads funding program to the forest industry across Ontario and then speak briefly about two challenges much more unique to AV Terrace Bay: the Chinese anti-dumping tariff that poses a significant challenge and the forest tenure system.

The forest industry has faced many unprecedented challenges over the past seven years but has begun what we hope is an equally unprecedented rebound. While many hurdles surely lie ahead of us, we are optimistic that we can decidedly overcome those through continued and, in some cases, increased support from the province of Ontario.

To give you a bit of profile of who AV Terrace Bay is, the Terrace Bay pulp mill was purchased by the Aditya Birla Group in July 2012 and was restarted in October 2012. The mill was previously owned by Kimberly-Clark, Neenah Paper and the Buchanan Group of Companies and had undergone a number of lengthy shutdowns and CCAA proceedings, which most recently resulted in the sale of the facility to AV.

The mill was purchased as a world-class producer of northern bleached softwood kraft but with a commitment and aggressive plan to convert the facility to the production of dissolving grade pulp used in the manufacture of rayon. As a forester, I now say I'm in the clothing business, not the wood products business.

The Aditya Birla Group is the world's largest producer of DG pulp with 22% of the global market share, marketed as Birla Cellulose. AV Terrace Bay is part of that group, which has three pulp mills in Canada.

AV employs directly at the mill 385 employees; in the woodlands, 375 employees; and then the indirect jobs added up were accountable for 3,800-plus employees—people.

AV makes the following annual contributions—this is where we help you. Our payroll is $34-plus million. Our fibre purchases are $70 million. Our charges to the government are $11 million for wood alone, and other purchases in northwestern Ontario are $41 million. We have made a significant impact in a short time frame. We also have a capital investment of $75 million and are planning on spending another $250 million.

The first item I wish to highlight with you today is the importance of your continued support for the provincial roads program. We have heard support for the program from all of the major provincial parties, which certainly asserts the significance of the continued growth of the forest sector in northern Ontario. The Ontario government has long recognized that the province should pay a proportionate share of the cost of building and maintaining infrastructure in forest areas, because infrastructure provides many other benefits to the public.

Forest access roads are utilized by other industrial partners, particularly in the mining sector. They also provide benefits to the provincial economy. They are utilized by government and utility providers to bring services to remote areas. They are utilized by emergency services to access remote communities and camps. They are also used by aboriginal communities and members of the general public in pursuit of recreation, hunting, gathering, trapping and other traditional and cultural activities. This road infrastructure is becoming a significant long-term asset of the province of Ontario.

A prime example: This year alone, we've had two closures of the Trans-Canada Highway. Our road system saved people driving hundreds of kilometres, and they were implemented immediately. We shut down the haul to make sure that people were driving safely and could do that. We are used by the province of Ontario.

The current program was established in 2006 and was provided annual funding of $75 million. Since that time, funding has dropped nearly in half, to $37.9 million, as of 2014. Harvest volumes are now showing a slow increase across the province, meaning more road construction and

maintenance requirements, while funding has significantly fallen from the original commitment. This drop has had a double impact on AV Terrace Bay, who are trying to re-establish forest operations in an area already receiving limited provincial roads funding support due to the depressed harvest of the previous mill ownership. The distribution of funds is based strictly on a five-year rolling harvest of each management unit, which disadvantages new entrants to the province without an established history of harvesting.

AV Terrace Bay was extremely pleased to hear Premier Wynne's commitment to increase funding to approximately $60 million for 2015-16 and 2016-17. To put this in perspective, our company expects to spend nearly $13 million on road construction and maintenance activities in the upcoming 2015 fiscal year across our woodshed. If the increase to $60 million in the provincial program is realized, we have estimated that our reimbursement will be only a third of that, so we're still going to spend a significant amount of money after the $60 million. We encourage the province to consider returning the program to at least $75 million per year in future years, understanding the challenges in front of you today.

The province has an opportunity to show continued leadership and commitment to northern resource-based communities by continuing their support for maintaining and developing the forest road infrastructure that provides access to resources for a variety of users. The benefits and strengths of the provincial roads funding program are well recognized across the north, and should be considered an investment in northern prosperity.

The second item I wish to draw your attention to today is the Chinese anti-dumping tariffs on dissolving grade pulp, and the resulting challenge being put forth to the World Trade Organization. The AV Terrace Bay facility was purchased with a commitment to convert to production to DG pulp at an investment of $250 million. While this commitment is still in place, it has been greatly complicated by the Chinese anti-dumping tariffs imposed since the mill purchase. Although our facility would be highly dependent on internal consumption, much of this business interest is located at our processing facilities in China, to which these tariffs would still be applicable. In addition to this, since China is the world's largest consumer of DG pulp, the proportion of our production that would be sold externally would also be heavily influenced by the Chinese market.

In late 2012, Chinese DG producers petitioned the Chinese government to carry out an anti-dumping investigation against DG producers in Canada, the United States and Brazil. Under the direction of the World Trade Organization, the Ministry of Commerce of the People's Republic of China carried out that investigation. Based on the analysis completed, the Chinese government imposed country- and facility-specific tariffs on DG imports from the three aforementioned countries. AV Terrace Bay was not specifically included or considered in any of the sample analysis, despite providing voluntary responses, and have been levied a generic tariff that we believe is not nearly representative of our cost structure and economic considerations. AV Terrace Bay is certain that the anti-dumping investigation was not completed in compliance with the requirements of the World Trade Organization anti-dumping agreement.

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When the AVTB mill was purchased, dissolving grade pulp had reached what was thought to be a fairly stable price of $1,000 a ton. This was down from an unsustainable peak when prices rose above $2,000 a ton. The price of DG is now at $860 a ton, but new Canadian producers like AV will be faced with a 24.7% tariff on top of that. This in Canada would net $645 a ton, marketplace. In contrast, NBSK, which is the product we're now producing, sells at about C$1,000 a ton and is cheaper to produce.

The AV Group, among other Canadian DG producers, has petitioned both the federal and provincial governments to challenge these tariffs with the WTO. AV Terrace Bay understands that the federal Minister of International Trade has already commenced a World Trade Organization challenge of the anti-dumping duties. We are asking that the province continue political and financial support of this challenge. Our company is optimistic that these duties can soon be eliminated, along with related concerns over the significant and long-term investment being made to convert our facility.

The final item I wish to speak about today is wood supply certainty—as indicated by my title, probably my primary focus—its importance to industry and its effects on our current business operations.

To the forest sector, wood supply security is business-critical, and this security is largely driven by the forest tenure arrangements that are in place. The forest industry, overall, was pleased to hear the commitment and direction with respect to forest tenure modernization from the province through former Minister of Natural Resources David Orazietti in 2014. This direction, however, did not alter the tenure position of AVTB, which currently resides directly within the new provincial forest tenure test models established by the Forest Tenure Modernization Act. AVTB is the largest company in the province to have no sustainable forest licences or direct management authority on any portion of the large land base from which it sources wood fibre.

Although this was recognized at the time our group purchased the facility, wood supply commitments were made to AV by the province that we have not seen realized to date. After two years of discussions and negotiations, two of the three tenure models which will encompass nearly three quarters of our committed wood supply are still not nearing completion. Tenure uncertainty and interim arrangements as a result of these pilot projects have significantly increased our costs and continue to put our business at competitive risk.

If we can solve this, I will put wood to work, which will generate taxes, and if you look after the road system, it will provide us the competitive advantage to stay in business. Thank you.

The Chair (Ms. Soo Wong): Mr. Groves, thank you so much. This round of questions is from the third party.

Ms. Fife, do you want to begin the questions?

Ms. Catherine Fife: Yes. Thank you very much, Richard, for coming and sharing some of the concerns of your business, and also of the economy of the north, really. Many of the topics that you've touched on today are very similar to what we heard at Fort Frances yesterday. In particular, the Ontario Forest Industries Association made some compelling cases.

The security around fibre supply, wood stock, is absolutely, I think, an eye-opening experience for those of us who are on the committee, because clearly you are making an investment in the north, and there was an understanding that you would have wood supply. You must let us know, through comments, how to best deal with the situation that you're currently in, that you do not have a sustainable forest licence.

Mr. Richard Groves: I need the government to deliver on the obligation it committed to when we signed the deal to purchase the facility, which means you need to convert the existing forest management units into what they call enhanced sustainable forest licences. That's my issue. Because that has not happened, our mill came down to two days of inventory on January 1. We almost shut the facility down totally because we had no wood supply. I should have harvested an additional 200,000 metres before that, which would have employed more people and generated more revenue. But the issue is I had, and I'm still at—now I breathe carefully—eight days' worth of wood. Normally, I would have 38 days' worth of wood in the mill yard today. Those are my challenges, and that's why Giovanni is not here and I came in his place.

Ms. Catherine Fife: Can you explain, though, to the committee, what is the barrier?

Mr. Richard Groves: The barrier is that the government started a process. I believe the objective and the intent was great, and I believe once this gets completed, it will be functional and will deliver what we need. But a lot of expectations were set with a variety of people, a lot of discussions happened, and they haven't come to a conclusion. That's the issue. The government leads the process, so I have to sit on the sidelines as the government goes through the process to get it completed, and the interim measures that were put in place didn't make wood available. I need what was set to be done, and that's been my discussion, as of this morning, with the Minister of Natural Resources and Forestry's office. We need to have it happen.

Ms. Catherine Fife: Okay. That's good for us to hear because we can take that message back.

Could you also comment on industrial hydro rates in Ontario compared to neighbouring jurisdictions, and what you would do to make Ontario industrial hydro rates more competitive? Of course, you need the wood first.

Mr. Richard Groves: That part is a little harder because I'm the wood guy. The province of Ontario has some of the highest energy costs anywhere and we need to deal with some of that. The package that was put together at our particular facility is not as great as if you were in Quebec—in Quebec, I'd be paying a third of what I'm paying here—but it was enough to make the business flow. Again, it's all part of, the devil is in the details. Continually having those energy rates that were committed to us flow into the future—they need to be solidified and clearly laid out. The energy rate that we have—like I said, part of the deal to come to Ontario—is good, but the details need to be there to make it happen long term. It's the NIER Program, and all those programs have a life expectancy. They need to be sorted out and delivered long term.

Ms. Catherine Fife: The barrier of not having a sustainable forest licence—because you're a wood guy, I'm going to go back to the wood. What is the future for the company if those licences are not secured?

Mr. Richard Groves: The biggest issue—and I just came from my budget presentation. The company came to Ontario because it had wood and water. Wood was reasonably priced but they could access wood. India doesn't have wood, India doesn't have water. They had two of those things. But if they don't materialize, then they will not continue with the investment.

The Chair (Ms. Soo Wong): Mr. Groves, thank you very much for your presentation.

ONTARIO HEALTH COALITION, SUDBURY CHAPTER

The Chair (Ms. Soo Wong): Our next witness is the Ontario Health Coalition, Sudbury chapter. Welcome. Can you please identify yourself for Hansard.

Ms. Felicia Fahey: I'm Felicia Fahey.

The Chair (Ms. Soo Wong): You have 10 minutes for your presentation. This round of questioning will be from the government side for five minutes.

Ms. Felicia Fahey: I represent the Sudbury chapter of the Ontario Health Coalition. We are a citizens' group made up of volunteers trying to protect and improve public health care systems here in the Sudbury region. We work to ensure that health care services are provided based on population need under the principles of the Canada Health Act. We are a non-partisan organization dedicated to protecting health care and ensuring that public policy regarding our health care system is democratic and equitable.

Some of the things that we're trying to deal with: Cuts have been very significant and detrimental on patient access to care here in Sudbury and in our region. In the 2013 budget, hospital global funding was frozen. A 0% increase in the face of increasing inflation means real dollar cuts and real cuts to care. Sudbury has seen devastating cuts to hospital beds, despite the fact that there is a need for the services.

In addition, the Ontario government has announced plans to further cut hospital diagnostics and surgeries and contract them out to private clinics. The evidence shows

that this plan will result in higher health costs, increased quality concerns, worse staffing shortages and increased requirements for oversight and monitoring of all of these private clinics.

We urgently need health care cuts to stop and we need the government to reinstitute sound planning to meet our community's need for health care services. There has been no needs assessment, bed planning or regular health system capacity planning since the 1990s. As a result, we have been subject to ad hoc cuts and severe rationing of access to needed care. While we have seen severe downsizing of our hospitals, at the same time, wait-lists for long-term-care placement are extremely long and patients have been sent to long-term-care homes not of their choice and far from home and from their loved ones. Home care is an excellent service, but it's inadequate to meet the complex needs of patients off-loaded from our hospitals.

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If there is one message that we can convey today, it is that hospital funding needs to be restored. The cuts must stop. Health care services need to be based on sound planning and the ability to meet the needs of community members.

We would like to draw your attention to the Auditor General's findings on the high cost of privatized P3 hospitals. The auditor reported that if new privatized P3 hospitals and other P3 projects had been properly managed and built publicly, the province would have saved $8 billion. This finding serves to underline the fact that the hospital cuts are a budget choice, not a necessity. The privatization is not saving money; it is costing us billions. It should be stopped, and the savings should go towards improving access to public, non-profit health care and for the needs of all.

We have a few recommendations. First of all, stopping private clinics: Private clinics, including diagnostic and surgeries from our local hospitals contracted to private clinics, need to be stopped immediately. Hospital care should be integrated and provided under the safety and public governance of our local hospitals. Private clinics, whether nominally non-profit or not, are not safe. They threaten single-tier public health care, and they drive up the costs. This is bad public policy, and it must be stopped.

I'm not in the health care system. I am a mom of two girls. I am a community member. We got involved with the Ontario Health Coalition because we wanted to make sure that our health care system stayed intact, the system that we grew up with, the system that our grandparents fought for. We have a state-of-the-art system that we don't want to lose.

One of my girlfriends entered the health coalition with me because she fears that her daughter is going to die of diabetes. She is a single mom, and she has no money. Keeping up with Morgan's health care costs is literally breaking her. She's paying over $600 a month in diabetes funding—her blood work, her tests. She's going to these private clinics. She went in last year to get celiac testing done, because Morgan couldn't breathe some days, and they told her that it was going to be $150 for the blood work. She broke into tears at the private clinic, not realizing that if she had just gone to the hospital, it would have been free. These services need to be free for people when they're free through our public system—and they're not telling people that that's happening. That's wrong.

The government's plan to cut public hospital services and contract them to private clinics bears close resemblance to the English government's contracting of public hospital services to private clinics. In the UK and other jurisdictions, including Canada, multiple reports and many studies report lighter caseloads and evidence of cream-skimming by private clinics, leaving the more expensive and heavier caseloads to the public, non-profit hospitals while depriving hospitals of resources. When we have clinics that are doing things like colonoscopies, and then when they have a problem with it, they send it back to the hospital—even though we don't have the resources at the hospital now because we've been sending funding to the private clinics—that's absolutely ridiculous.

We see it here all the time. We have people who are reporting this back to us. When we did our study back in April, we had over 5,000 people just here in Sudbury volunteer to come in to vote on a referendum to stop public cuts. It wasn't an electoral vote where they were mandated to come out and vote; this was something that they chose to do because they care about our system. They need to keep it.

Recommendation 2, hospital cuts: After eight years of hospital funding increases that have been set below the rate of inflation, hospital cuts are very severe, and access to vitally needed hospital services has been compromised. Hospital funding needs to be improved and stabilized. There needs to be a moratorium placed on cuts to hospitals and services and expanded user fees for seniors.

In the 2014 budget, funding for hospitals was frozen again—less than inflation—forcing more and more cuts. Hospital base operating funding was held to a 0% increase in 2014-15. It has been held to less than the rate of inflation since 2006. Budget constraints on hospitals have resulted in damaging cuts to needed services. Ontario has the fewest hospital beds per capita of any province in Canada by far. Our province has the highest level of hospital occupancy of any jurisdiction for which we could find data. In fact, hospital overcrowding in Ontario is at dangerous levels. Continual pressure on hospital budgets has meant cuts to needed services across Ontario. Offloading and privatization of hospital clinics and services are detrimental to patients.

Sudbury has been impacted by the inadequate levels of hospital funding. In recent months, our hospital has been operating at more than 100% capacity, meaning that all of the beds are full and patients are waiting for admission to beds. The emergency department has been backlogged,

and long waits have left patients in substandard conditions.

My grandmother had a fall. She lives in Kitchener, and she's 94 years old. We decided that we were going to move her up to Sudbury. Up until last October, she was still driving. She chose to give her driver's licence back. She was maintaining her own home, and after the fall, she just couldn't do it anymore. She moved in with my mother and ended up having a mini-stroke in January. She sat on an emergency stretcher in a hallway for three days because there were no beds. The cuts have to stop.

We're a humane society, and I understand that there are budgetary restraints, but it can't be on health care. We've cut and cut and cut, and we can't cut anymore. It's really just that simple. There has got to be a way to make this better. When we have 94-year-old women, who have extreme dignity, sitting out in the open, watching people walk by and stare at them—that's where I had my limit. It wasn't just because it was my grandmother—because we spent three days in there, watching it happen to 50, 60 other people waiting.

Just last week, my daughter passed out at high school. We didn't know what it was. She was brought in by ambulance to Health Sciences North and sat in a hallway on a stretcher bed waiting for five other ambulances to unload because they had no beds for them. That's a crisis. She was fine, but I don't know about those other four.

Long waits for long-term health care: According to data from the NE CCAC, there are almost 1,000 people on wait-lists for long-term care in Sudbury. This further underlines the fact that the hospital cuts must stop.

The Chair (Ms. Soo Wong): Ms. Fahey, can you please wind up your presentation so that there can be time to ask questions?

Ms. Felicia Fahey: Absolutely. We're also asking for P3 hospitals to be cut—stopped and no more funding put into them. We've seen through the Auditor General's report that it's just not working. I think that our program and our health care has worked for many years, and I think that it's time that we start remembering why our grandparents fought to have the system that we do and to be proud of it and to stop cutting it.

The Chair (Ms. Soo Wong): Thank you very much. This round of questions: Ms. Albanese, do you want to begin the questions?

Mrs. Laura Albanese: Yes, I will start. I want to thank you, first of all, for being here today, for your presentation. I am familiar with the work that the Ontario Health Coalition does. I know that this is the Sudbury chapter. I'm more familiar with the Toronto chapter, but in any case, I know that you keep, I guess, a keen eye on the policy of the government and on any shift, in trying to ensure that the government remains committed and accountable to the people of Ontario. I want to thank you for that. I know that your goal is that: to protect—

Ms. Felicia Fahey: Absolutely.

Mrs. Laura Albanese: —and to improve our public health care system. I can assure you, we all are very proud of our health care system, and we want it to continue to be what it has been for generations. I recently became a grandmother, so I would like to preserve it for generations to come.

One question that I had was: Have you seen any difference in the investment that, for example, the province has made with funding to the small and rural hospital fund? Has that helped in any way?

Ms. Felicia Fahey: Like I said, I'm not in the health care system, so as a mom or a patient coming through—

Mrs. Laura Albanese: And you know, we've been trying to shift also to get more help in the community, and this has been one of the issues.

Ms. Felicia Fahey: Right. You've got to remember that here in Sudbury, up until about five years ago, we had three hospitals functioning. Building one giant hospital, regardless of whether somebody thought it was a brilliant idea or not, meant less beds. We had three functioning hospitals with staff in all of them. All of them were full back then.

As somebody who lives in the region, it's not working. It doesn't matter how much funding is going in to these smaller clinics; it's still not there. We don't have a lot of smaller clinics here to begin with, and they're not providing the same amount of care. Like I said, when I was talking about celiac testing, when you're going in there and you're being charged user fees—I mean, we're already paying taxes on top of the user fees. All of that should be included, right? So I don't think that it's working. I don't think that we are seeing, as members of this society, an increase or any further efficiencies with the funding system that's going on right now.

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Mrs. Laura Albanese: Okay. I know that you have given us a list of recommendations, so thank you for that. I don't know if any of my colleagues—

The Chair (Ms. Soo Wong): I think Ms. Vernile has a question. There are two minutes left for this round.

Mrs. Laura Albanese: And then Mr. Dickson, apparently, has a question.

Ms. Daiene Vernile: I just want to ask you: That time that your grandmother was waiting for three days in the hospital, in the hallway, as you described—was she getting health care at that time? Was she being attended to?

Ms. Felicia Fahey: Yes, she was being attended to. It's more of a dignity question. I mean, when you're 94 years old and you're getting your care done in the middle of the hallway—it's the same as with my daughter last week. My daughter has huge anxiety around needles. They put the IV in in the middle of the reception room. I know, myself, I pass out when I get needles. She's normally in tears and trembling when anybody gives her a needle. This was the first time she had ever had an IV put in. They did it with somebody right beside her who had just been in a car accident with his child in the car, and was in crazy tears. That did not help her anxiety. That did not help her calm down with the fact that they were coming through with a needle this long, poking it in her,

where she had not even drapery around her to keep her calm. So, no, it's not working.

The Chair (Ms. Soo Wong): Okay. I only have one minute. Mr. Dickson, you wanted to ask a question?

Mr. Joe Dickson: Thank you, Madam Chair.

Thank you for your presentation. Well done. I know I've heard some of your presentations in previous years and they're very—

Interjection.

Mr. Joe Dickson: I'm so used to not speaking too loudly because I didn't think my wife wanted to hear me.

I'd like to thank you very much for your presentation. Do you receive any funding to assist you in the good work that you do as an advocate for care?

Ms. Felicia Fahey: No.

Mr. Joe Dickson: You're on your own.

Ms. Felicia Fahey: I'm on my own.

Mr. Joe Dickson: Okay. By the way, I thank you because there are a lot of items that they're going to take back to review at health in the budget process.

You talked about wait and backed up and so on and so forth, and I just wondered if you were aware that according to the Fraser Institute, which is a right-wing think tank out of the west coast, that Ontario has gone from the very worst province to the very best province in the number of wait times that there are per capita. It's quite an accomplishment, but it doesn't end there. There is still more to do, and we're onside with you with that. Thank you ever so much.

The Chair (Ms. Soo Wong): Ms. Fahey, if there are any comments, can you just put them in writing and submit them to the Clerk—

Ms. Felicia Fahey: Absolutely.

The Chair (Ms. Soo Wong): —by next Friday?

Ms. Felicia Fahey: Sure.

The Chair (Ms. Soo Wong): Thanks so much for your presentation.

Ms. Felicia Fahey: No problem.

The Chair (Ms. Soo Wong): Thank you.

CANADIAN FEDERATION OF INDEPENDENT BUSINESS

The Chair (Ms. Soo Wong): Okay, folks, the next witness is the Canadian Federation of Independent Business. I believe there are two individuals coming to present.

Welcome. Good afternoon. You have 10 minutes for your presentation. This round of questioning will be coming from the official opposition party. Can you please identify yourself and your position with the Canadian Federation of Independent Business?

Mr. Plamen Petkov: Absolutely.

The Chair (Ms. Soo Wong): Thank you.

Mr. Plamen Petkov: Thank you, Madam Chair. Good afternoon, ladies and gentlemen. It's a pleasure to be here in Sudbury and present CFIB's pre-budget recommendations for the Ontario budget 2015. My name is Plamen Petkov. I am the Ontario vice-president at CFIB, and I'm here with my colleague Nicole Troster, who is a director for provincial affairs in Ontario, as well.

We have a brief presentation for you. I think it's just being distributed. We're going to walk you through some of the slides that we have prepared and then we're going to leave some time for questions as well. So I'll turn it over to Nicole to walk you through some of the initial slides.

Ms. Nicole Troster: Great. Thank you for giving us the opportunity to be here.

The Canadian Federation of Independent Business, as many of you may know, is a not-for-profit, non-partisan organization that represents 109,000 small and medium-sized businesses across the country, 42,000 here in Ontario. Each week, our sales representatives meet with our members—about 2,000 members a week—and that gives us credibility in representing our members.

The other thing that gives us credibility is the fact that we base all of our recommendations on the surveys that we do with our members. The feedback that you will see in our presentation is based on first-hand feedback from small and medium businesses.

The other thing that you should know about CFIB is that we're fully funded through memberships. We don't receive any external funding from government or anybody else.

If you flip to slide 3, you'll see that CFIB represents businesses from every major sector of the economy, from retail to construction to agriculture.

On slide 4 you'll see, based on survey results, that—again, any of the recommendations that are in this presentation are based on feedback from our members. When we asked them about the most important issues in their business, you'll see that total tax burden is the most important concern of business owners. That includes payroll taxes, for example. The second most important concern is red tape and regulation, followed by government debt and deficit, then workers' compensation.

If you move to slide number 5: We regularly survey on taxes and things like that. We've asked our members many, many times about affordability and retirement savings, for example. You'll see on the chart that we've surveyed both business owners and working Canadians on the issue of being able to save more for retirement, and the answer is very similar. Some 61% and 65%, respectively, say that they cannot save more for retirement.

As a result of the lack of affordability, you'll see that the majority of small business owners actually oppose any kind of mandatory pension plan contributions. However, there is broader support for voluntary options.

Mr. Plamen Petkov: With that information in mind, I'd like to direct you to some of the recent research that we have done, specifically on the proposed Ontario Retirement Pension Plan. As soon as we got the first glimpse of what that plan could look like in May of last year, in the first budget, we went directly to our members to get their reactions. As you can see, overwhelmingly, 86% of small and medium-sized business owners in On-

tario are opposing the implementation of a mandatory Ontario Retirement Pension Plan.

There is a good reason for that. On slide 8, we look at some of the consequences that small business owners will have to face if such a plan is in fact implemented starting in 2017. Most business owners, almost 70%, indicated that they would have to freeze or cut salaries; over half would have to reduce jobs; and over half would have to reduce investments in their business. I would just like to direct your attention to those three very important consequences that we should expect to see if, in fact, this plan comes into effect in 2017.

In addition to our members' opinions, we have also conducted a series of economic analyses, and we have put some of the findings on slide 9, where we have looked at the broader impact on the economy—not just on the small business sector, but on the Ontario economy. We found that the ORPP will cost 160,000 person-years of employment in the short term, it will increase the unemployment rate by 0.5% and it will reduce wages in the longer term.

Most importantly, it will take 40 years of solid contributions from employees and employers to attain full benefits. That fact was really news to our members. I'm sure it is news to Ontarians, as well. It's a very long period of time before you actually get the full benefits prescribed under the ORPP. In addition to that, because it's a separate plan, it will require a new remittance system, in addition to the remittance system that currently exists under CPP, which we believe is going to increase red tape significantly in this province.

We have met with Minister Sousa. We have met with Minister Hunter. We are participating in the ongoing consultations on the ORPP. We will be preparing a way more detailed submission on the ORPP and sending it to Minister Hunter in the next two weeks, but we wanted to use this opportunity, with representatives from the three parties here, to once again really raise the importance and the grave concerns that our members and the broader small business sector have about this potential mandatory pension plan.

We believe that there are better options for retirement savings, where government can actually help. That's on slide 10. We believe that government should focus on the areas that it controls best—controlling government spending and reducing taxes—to help Canadians and help small business owners get that extra financial capacity that Nicole talked about in the beginning, which simply does not exist right now, not just for small business owners, but also for their employees.

Ms. Nicole Troster: Moving on to red tape, on slide 11: Red tape is a hidden tax on productivity. Consequently, it's the second most important concern of business owners, as I mentioned before. You'll see in this chart that close to 40% of small business owners indicated that they agree with the statement that they may not have gone into business had they known about the level of burden of government regulation. You'll see another 42% who may or may not have gone into business. This is really indicative at which point red tape is a deterrent for running a small business in Ontario.

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On slide 12, you will see the specific areas. Given the influx of new occupational health and safety requirements in the last year and a half, it's no wonder that small business owners indicate that workers' compensation and occupational health and safety are by far the most burdensome areas. The government really has to work on streamlining regulatory requirements to help businesses to comply. That's a win-win situation for all parties involved.

Businesses also find requirements related to HST and employment standards as particularly burdensome. That being said, there has been some progress on red tape, which will take some time to translate into savings for small businesses.

In particular, recently the Ontario Legislature unanimously passed the Burden Reduction Reporting Act, or Bill 7, which will require the government to identify, report on and reduce unnecessary burden. This is a good first step in understanding the size of the regulatory problem in this province and then being able to address it accordingly. We recommend that any kind of reform initiatives include all public service and arm's-length agencies to really capture all of government's burden on small businesses.

On slide 14, we shift over to government debt and deficit, and we see that inflation-adjusted government spending has far outpaced population growth. Small businesses expect the government to balance the budget by 2017-18 as promised. In order to do so, the government should not look to introduce new taxes—any kind of new taxes, including a carbon tax. Instead, it should reduce spending to meet fiscal targets.

Mr. Plamen Petkov: Finally, I would just like to direct your attention very briefly to the issue of workers' compensation, as that is in the top four priorities for members, as identified earlier in the presentation.

In 2008, the government passed Bill 119, which is a bill that now requires business owners, operators, directors and independent operators in the construction sector to pay WSIB premiums on their own earnings in addition to what they already pay for their employees. That has a huge cost impact on small construction companies and on independent operators. We estimate it's about, on average, $6,000 per company. As a result of that, we asked our members—on slide 16—how they are planning to cope with this added cost. Almost half would have to raise prices, 30% would cut their own compensation and 20% would downsize their business.

One of the recommendations that we have for this committee and for the government is to repeal this bill as, from our perspective, it really does not meet the objectives that it set out to achieve. The purpose of this bill, when it was introduced and passed, was to tackle the underground economy and to improve workplace safety. It has not achieved any of that. If anything else, we are

seeing that, actually, more businesses are tempted to go underground to avoid this cost.

On the last couple of slides, you are going to see a list of our recommendations. I'm not going to go over those, just to give some time for questions.

The Chair (Ms. Soo Wong): Mr. Fedeli, do you want to begin the questions, please?

Mr. Victor Fedeli: Thank you very much and welcome. So on this ORPP, do you think that people realize that it's money that will come off of their paycheque and money that will come from their employer as well? Or do you think people think it's government money they are going to receive?

Mr. Plamen Petkov: Well, I mean, we have surveyed members, and based on some of the information that we have passed to them—and obviously there has been some debate on this—our members, or employers, understand that they have to bear some of the cost, or half of the cost. I'm not quite sure, though, that the average Ontarian actually understands that this is going to be money coming from their paycheque. I think they are going to realize that after they see that deduction in 2017 onwards.

I think there is a big education component here that is missing from the whole debate on things such as, it is not a free plan; it is not something that the government is giving to the people; and there's also the fact that it's going to take 40 years of contributions to actually get the benefit.

Mr. Victor Fedeli: I understand that 86% oppose the ORPP.

The consultations that you've had with the government—you've mentioned you've had consultations. Did it come up—about the fact that companies with defined contributions must pay into this? Because that seems to be something new or something that we've only heard recently. Did that come up?

Mr. Plamen Petkov: In our discussions, both in our meetings with Minister Sousa and Minister Hunter, and also in the public consultations, the only thing that we were led to believe is that these consultations are currently taking place in terms of what is going to be considered a comparable plan. We don't know if a defined contribution or RRSP plan or potentially a PRPP plan would be exempt. That's actually in our recommendations. One of our key recommendations is to have such plans actually exempt from ORPP. But at this stage we don't have any clarity in terms of which plans will be exempt.

Mr. Victor Fedeli: Were you aware that when Kathleen Wynne was first elected as Premier she asked the Ministry of Finance what the effect of this payroll tax would be, and they informed her that for every $2 billion taken out of the system it would cost Ontarians 18,000 jobs? Is that something that you've come across?

Mr. Plamen Petkov: I think there were some media reports on this, if I'm not mistaken, before the last election in Ontario. We have seen that. I think that was more linked towards the new revenue tools that were up for debate at that time. So we have seen those statistics. From our perspective, on this specific issue, on ORPP—it doesn't matter what you call it or whether you call it a tax. I know that the government calls it an investment. From our members' perspective, it is something that has to be paid from the payroll. When you're a small business owner and when you have a limited budget, that money has to come from somewhere. You cannot just absorb it. Unfortunately, what we think is going to happen is that this is going to come from cuts in their labour force, from reducing hours and from freezing wages, just like you saw on that slide. So it is money that has to come from somewhere. In a small business you don't have the luxury of having that much cash lying around.

The Chair (Ms. Soo Wong): Mr. McNaughton, I heard you wanted some questions. There are two minutes left.

Mr. Monte McNaughton: Great. I just have a couple of questions. First, thanks for all the work you do in standing up for small businesses in Ontario and across Canada.

I wondered if you could put it in context—because all MPPs hear across the province about how expensive it is to do business in Ontario. Can you put into context where Ontario is versus the other provinces?

Mr. Plamen Petkov: I think it's fair to say that when we come here and talk about the burden of, let's say, a potential ORPP, or when we talk about increasing payroll taxes, I think it's very important to know that these are things that are not happening individually or one-offs. It's a combination of things.

So if you're a small business in Ontario, over the last year you've paid higher hydro rates. If you are in the skilled trades, you now have to pay into the College of Trades. If you're in the construction sector, you have to pay $6,000 more to comply with a legislation that's in place and doesn't really deliver on what is meant to be.

So it is really a combination of different charges that, as a small business owner, you either have to take from your payroll, meaning reducing your labour force, or you have to pass it on to your consumer, meaning raising prices. If you keep raising prices you're not going to be competitive and you'll be out of business pretty soon.

Over the last week or so, we saw reports of big companies, multinational chains, exiting Canada and Ontario because they are not competitive. They cannot stay competitive. The same is valid for a small business. If you start raising your prices to absorb some of these costs, you're not going to make it too far.

The Chair (Ms. Soo Wong): Thank you very much for your presentation.

Mr. Plamen Petkov: Thank you.

ONTARIO COUNCIL OF HOSPITAL UNIONS

The Chair (Ms. Soo Wong): Our last witness for today—I understand from the Clerk that we have the Ontario Council of Hospital Unions instead of the On-

tario Health Coalition. I believe Mr. Michael Hurley, the president, will be here to present.

Mr. Hurley, you have 10 minutes for your presentation. This round of questions will be from the official third party. You may begin any time. Thank you.

Mr. Michael Hurley: Thank you very much for the opportunity to present today and thank you for agreeing to change the presentation. The health coalition had difficulty making this hearing because there was a public meeting last night in Leamington about the closure of the obstetrics unit at that hospital. That's a dynamic that's occurring across Ontario, but if we just look at what's happening in northeastern Ontario for a moment, with very deep cuts in the Soo hospital, which originally had tried to close or significantly downsize some of the satellite hospitals that it had in its orbit to make up for its budget problems—it couldn't do that, deamalgamated, and now has to deal with those problems it has.

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The Timmins hospital has had deep cuts and bed closures. Temiskaming Hospital has closed half of its operating room hours. The North Bay hospital just announced the closure of eight psychiatric beds, some of those forensic psychiatric beds, and the elimination of 80,000 nursing team hours. Sudbury has had ongoing cutbacks to continuing complex care and to the hospital here, which is one of the most overcrowded hospitals in Ontario.

Unfortunately, that's just a pattern of the kind of cuts we see across Ontario, with the threats of hospital closures in communities as diverse as Richards Landing, but also in Trenton and in Welland and in Niagara-on-the-Lake and in Penetanguishene, where the hospital is closing, and in Dunnville and in St. Marys and in other communities across Ontario. Small, rural hospitals are very much under threat, and the larger hospitals are downsizing significantly.

The Auditor General has estimated that the amount of funding that hospitals require on a yearly basis needs to increase by about 5.8% because they're required to provide drugs free to all in-patients, and the costs of those drugs is escalating at a rate consistently over 10%. But also, despite the recent initiative of the government, doctors' salaries ballooned by almost half a billion dollars, as you know, last year. Then there are medical technologies. So hospital costs are actually under greater pressures than the economy in general, but hospitals have been effectively frozen for three years now and are expected to be frozen for another two. The hospital association tells us that they expect that the cuts will be much worse in 2015 than they were in 2014, and of course they are very, very significant.

As the health coalition mentioned earlier, the government has made choices around some of the decisions it has made with respect to hospitals; for example, on the capital side, as was mentioned, the private-public partnership initiatives which the Harris government approved in its first mandate and which the Liberal Party said that they would cancel the contracts for in the election that saw the Liberals replace the Conservatives. In fact, that hasn't happened. The number of P3 projects has ballooned despite the fact that it was known, even during the Harris years, from the British Medical Association journal studies of P3s in Great Britain, that in fact the cost of those hospitals would be about 30% higher and they would come with significantly fewer beds and staff—doctors, registered nurses, other staff all down the line.

One of the cost pressures that's particularly acute for the North Bay hospital is that it was built as a P3, and so in addition to the cost freeze that it has, it also has to deal with the fact that it has the most expensive infrastructure of any hospital, aside from the Royal Ottawa or the William Osler, to contend with.

The Bank of Canada announced a prime interest rate cut today. Ontario is the beneficiary of falling gas prices. Ontario is the beneficiary of a falling Canadian dollar. I've been to maybe a decade of gloomy finance committee hearings where everybody knew the situation facing Ontario was a pretty bleak one as we staggered out of the last recession. But the Ontario economy has actually started to outperform a number of its peers, and in some other areas—the Ontario economy is the beneficiary, for example, of increased federal transfers, almost half a billion dollars more than was the case. I know we need more, absolutely, and we need to have pressure on the federal government to honour and extend the health accord at a federal level. Absolutely, we need to deal with the question of federal transfers, but Ontario has a revenue problem which is causing it to starve these institutions, and the revenue problem can't be resolved unless we deal with the taxation issue.

It was a little bit risible to hear the presentation before me, because Ontario has been very, very generous to business with respect to taxation at a corporate level. That generosity has not been extended to their employees. I think that it is a good initiative of the government, in fact, that a pension plan is coming for those employees who, if the government did not take the initiative to create one, would wait forever for small business and corporate Canada to create one for them. It simply hasn't happened.

We're calling on the government to end the funding freeze on hospitals: to recognize that it's having a significant impact in restricting access, that it's just not tenable and that, in fact, Ontario cannot continue to fund that service at $281 per taxpayer less than any other province in the country. We're also asking you to reconsider your P3 building program for the hospital sector; it saddles institutions which are cost-pressured with enormously expensive infrastructure and is simply a very lucrative opportunity for business to feed on a service which should absolutely be provided on a not-for-profit basis.

Thanks so much for the opportunity.

The Chair (Ms. Soo Wong): Thank you, Mr. Hurley.

For this round of questions, Ms. Gélinas, do you want to begin the questions?

M^me^ France Gélinas: Absolutely. Thank you so much for coming. I'd like to drill down on some of the cuts that

you have made public and what you figure will happen to the care that those people receive.

Let's start in North Bay, with the closure of eight mental health beds. You come from the business. You live it day in, day out. What's your best guess as to what's going to happen to people who need mental health care when those beds are no longer available for them?

Mr. Michael Hurley: Well, I think they're going to be medicated and sent home, but these are people, Ms. Gélinas, who, as you know, when they present at a hospital in a stage of acute psychiatric illness, sometimes require for their own safety or the safety of others some temporary institutional care. The ongoing downsizing of these beds has created a shortage of these places, and not only in North Bay; there's a shortage in psychiatric units across the province.

M^me^ France Gélinas: The government would tell us that those people are better cared for in the community. It sounds pretty good.

Mr. Michael Hurley: Absolutely.

M^me^ France Gélinas: What's the reality like?

Mr. Michael Hurley: You know, there's a great quote which I'm happy to be able to read to you—it's very short—from a study by the British National Health Service, looking at deinstitutionalization and the closer-to-home theory. They set up a commission to study it, and they titled this "Magical thinking and Messiah concepts."

"The commission was concerned about the prevalence of magical thinking in current policy and politics, which regards providing more integrated care for older people with frailty closer to home as being a 'silver bullet' to slay the demon of poor care. We described this as a Messiah concept."

They talk about all of their other failed initiatives to pretend that community care existed when it did not. There simply has not been an investment comparable in the community sector, as you know, to provide the pick-up either for the loss of acute-care, complex-continuing-care or alternate-level-of-care beds, or for the psychiatric beds which have closed.

M^me^ France Gélinas: We talk a lot about the 5% of people in Ontario who are using a lot of the health care services. Would you describe the people using those eight beds that no longer exist as part of this group?

Mr. Michael Hurley: I really don't know about that. It's a personal tragedy that any one of us is afflicted with the kind of illnesses that require hospitalization. I wouldn't wish that on anybody. If there is a segment of the population which uses hospitals more than others—for example, elderly people—then that might be a logical expectation of what happens to the human body after a lifetime of living and working. So it shouldn't come as a shock, right?

The Chair (Ms. Soo Wong): Ms. Fife, do you want to ask a question?

Ms. Catherine Fife: Thank you for the presentation. I wanted to just touch on—and thank you for raising the issue of P3s and the privatization agenda. The auditor's report should have an impact on the way that capital and operational funding is flowed to hospitals.

Can you talk broadly about the privatization agenda of this government and how it's affecting health care in Ontario?

Mr. Michael Hurley: Absolutely. Of course, CUPE represents the staff who work in hospitals, so, admittedly, we have a bias, for sure. But what we see is, first of all, the privatization of infrastructure, the privatization of many of the support services, like materials management, like food services; in some cases, housekeeping, even though housekeeping has clearly been identified as a service that should not be privatized, at least in Britain, because of the implications for the safety of patients. But there's also pressure now to privatize clinics and to move them to free-standing clinics which will do surgeries like cataracts and other surgical procedures. Our concern around that really is that these services are co-owned by doctors at the outset, can be purchased by corporations and will inevitably lead to gouging of the public through user fees. But also, there are significant quality concerns in moving services away from hospitals that have an emergency department to a free-standing facility which doesn't have one, albeit it's only a fraction, a sliver of—

The Chair (Ms. Soo Wong): Mr. Hurley, can you wind up, please?

Mr. Michael Hurley: —of the population that goes into some acute episode when they are being treated. But there are people who routinely die in the United States, which causes the US Congress to suspend funding for those clinics in the United States for a period of time.

The Chair (Ms. Soo Wong): Thank you, Mr. Hurley, and thank you, everybody.

Mr. Michael Hurley: Thanks so much for having me.

The Chair (Ms. Soo Wong): Before we adjourn, I just wanted to let everybody know that the Clerk has informed me that the presentation from Ms. Higgs from the Sudbury and District Home Builders' Association has been submitted to him, so we will get copies tomorrow.

All right. We will be adjourning to Ottawa. Thank you.

The committee adjourned at 1231.

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