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Standing Committee on Finance and Economic Affairs

Comité permanent des finances et des affaires économiques

Pandemic and Emergency Preparedness Act, 2022

Loi de 2022 sur la préparation aux pandémies et aux situations d'urgence

2nd Session
42nd Parliament

Tuesday 5 April 2022

2e session
42e législature

Mardi 5 avril 2022

Chair: Ernie Hardeman
Clerk: Michael Bushara

Président : Ernie Hardeman
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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON FINANCE AND ECONOMIC AFFAIRS

COMITÉ PERMANENT DES FINANCES ET DES AFFAIRES ÉCONOMIQUES

Tuesday 5 April 2022

Mardi 5 avril 2022

The committee met at 0900 in room 151.

The Clerk of the Committee (Mr. Michael Bushara): Good morning, honourable members. In the absence of the Chair and Vice-Chair, it is my duty to call upon you to elect an Acting Chair. Are there any nominations? Mr. Bouma.

Mr. Will Bouma: I would nominate Mr. Kanapathi.

The Clerk of the Committee (Mr. Michael Bushara): Does the member accept the nomination?

Mr. Logan Kanapathi: Yes, please.

The Clerk of the Committee (Mr. Michael Bushara): Are there any further nominations?

There being no further nominations, I will declare the nominations closed and Mr. Kanapathi elected Acting Chair of the committee.

PANDEMIC AND EMERGENCY PREPAREDNESS ACT, 2022

LOI DE 2022 SUR LA PRÉPARATION AUX PANDÉMIES ET AUX SITUATIONS D'URGENCE

Consideration of the following bill:

Bill 106, An Act to enact two Acts and amend various other Acts / Projet de loi 106, Loi visant à édicter deux lois et à modifier diverses autres lois.

The Acting Chair (Mr. Logan Kanapathi): Good morning, everyone. I call this meeting to order. We are meeting today for public hearings on Bill 106, An Act to enact two Acts and amend various other Acts.

Please wait until I recognize you before starting to speak. As always, comments should go through the Chair. Are there any questions before we begin? Seeing none, I will now call on the Honourable Prabmeet Singh Sarkaria, President of the Treasury Board.

TREASURY BOARD SECRETARIAT

The Acting Chair (Mr. Logan Kanapathi): Minister, you will have 20 minutes for your presentation, followed by 40 minutes of questions from the members of the committee. The questions will be divided into two rounds of 7.5 minutes for the government members, two rounds of 7.5 minutes for the official opposition members, and two rounds of five minutes for the independent members. The floor is yours.

Hon. Prabmeet Singh Sarkaria: Good morning. Thank you very much, Chair, for the introduction. Also, thank you for the opportunity to present here before the honourable members in this committee.

I want to first start off by thanking—as we passed second reading of this legislation, I also want to thank the members from both parties for supporting second reading.

I'm looking forward to my opportunity here to be with members of the opposition and government members to speak about Ontario's Plan to Stay Open.

It is my pleasure to address this committee and present the Pandemic and Emergency Preparedness Act. If passed, this legislation will help us to build on our progress to date and maintain our momentum to ensure Ontario is ready and resilient for the future.

As we all know too well, the past two years have been unlike anything that Ontarians have ever experienced. One day we were reading about the first positive case in Canada, and the next day our health care system was on the brink.

Very quickly and early on in the fight against COVID-19, one thing became clear: Historically, Ontario had not done enough to protect and prepare the province for a crisis. Everyone on this committee was impacted as a result. In only a few weeks, patients in need far outnumbered the hospital spaces available to care for them. Front-line workers were forced to put themselves at risk because there was limited supply of PPE available. Ontarians had to scramble for resources just to keep their loved ones safe. Anxiety, angst and unease weighed on everyone as the crisis prevailed across the province.

That is why our government got to work right away—to address the long-standing problems plaguing our system. We made significant and important investments in priority areas, including our health care system. We moved swiftly and safely to protect the people of Ontario, and we are continuing to build on this progress.

That is what the Pandemic and Emergency Preparedness Act is all about. If passed, this legislation will make sure that Ontario is well equipped to deal with any future emergencies or threat to the lives and livelihoods of Ontarians. It represents our plan to stay open, the first complete post-COVID-19 pandemic preparedness plan in Canada.

Esteemed members of this committee, the Pandemic and Emergency Preparedness Act is built on the following three pillars: (1) expanding Ontario's health workforce;

(2) shoring up domestic production of critical supplies; and (3) building more hospital beds. There are also several initiatives and legislative pieces that fall outside of these pillars, which exist in another category of their own. Together, these initiatives constitute and complement the pillars of our plan and are specifically designed to protect our progress by increasing capacity in Ontario's health care system, strengthening government-wide coordination for emergency response, and streamlining policies that are necessary to safeguard Ontario for the future. It is my pleasure to briefly outline these pillars of the plan today.

The first pillar, which speaks to Ontario's health care human resources—represent exceptionally skilled, committed and well-trained professionals. But for years, the province didn't invest in the staffing necessary to make the health care system work as best as possible. That is why the first pillar of the Pandemic and Emergency Preparedness Act details the expansion of Ontario's health workforce. Our government is working to ensure that our health care heroes are well equipped with adequate health human resources.

Earlier this month, committee members might recall that the government announced an investment of $763 million to help retain nurses across the health care sector. These funds are providing Ontario's nurses with a lump sum retention bonus incentive of up to $5,000 per person. Through this support, we are helping to stabilize the nursing workforce and build a stronger, more resilient health care system in Ontario.

Our health care system has been Ontario's first line of defence throughout the COVID-19 pandemic, and we have the opportunity to ensure it remains the best line of defence in any future emergency or pandemic. But a world-class health care system is simply not possible without our front-line health care heroes, who are, quite simply, the very core of our system.

Ontario's Plan to Stay Open gives us the means to continue bolstering our health human resources in several ways. Let me give you a few examples.

Our plan includes the expansion of medical schools across the province, to which we are adding 295 postgraduate and 160 undergraduate seats over the next couple of years. This represents the biggest expansion of Ontario's medical seats in more than 10 years.

Through the plan, we are also addressing barriers for individuals looking to be registered with the health regulatory colleges, including internationally trained professionals. Eliminating these barriers will help to address staffing challenges. It will enable talented, resourceful individuals to contribute to the workforce—individuals who will be able to use their training and expertise for the benefit of the people of this province.

0910

Another initiative within this pillar of the plan is the new Ontario Learn and Stay Grant. The grant is intended to provide crucial financial support to post-secondary students who enrolled in high-priority programs related to health, human resources and other critical care positions. It would also enhance the health care sector in the province's north through the commitment from graduates to work in underserviced communities. Tracking to launch next spring, this program represents the Ontario-wide innovation and resiliency we are working towards.

Along with the Ontario Learn and Stay Grant is a Community Commitment Program for Nurses. This new program is specifically designed to place new nursing students in communities of greatest need across the province, to ensure that our system meets the needs of every community across Ontario. Through this program, an investment of $81 million will go towards full tuition reimbursement to 3,000 nursing graduates over the next four years. In return, these graduates would pledge to work in the communities in need for a minimum of 24 months, with 1,500 starting in early 2022-23. Together, the Ontario Learn and Stay Grant and the Community Commitment Program for Nurses will help us to grow Ontario's health workforce.

The COVID-19 pandemic also revealed red tape within the health care system that, if reduced, would advance Ontario's health human resources and how they work together. This is an important part that starts with improvements in amending the Personal Health Information Protection Act from within this omnibus legislation. Amending it will better integrate Ontario's health teams and allow them to finally work as one coordinated team wherever they provide care.

These examples are only some of the ways our government is applying the lessons learned during the COVID-19 pandemic. We know that securing Ontario's preparation and readiness for the future does not end here.

The second pillar speaks to shoring up domestic production of critical supplies. After years of pressures facing the health care sector, many of Ontario's life sciences firms have left the province. For years, the sector was not receiving the resources and support it needed to prosper. That is why the second pillar of the Pandemic and Emergency Preparedness Act specifically concerns shoring up domestic production of critical supplies. Our government is reinvigorating the province's life sciences industry with a new strategy that is vital to increasing that production. Ontario has the largest life sciences sector in the nation. It provides 66,000 well-paying jobs to this province. This strategy will allow medical technology companies to produce much-needed life-saving solutions such as vaccines right here in Ontario. The strategy will help Ontario finally close the gaps that the COVID-19 pandemic exposed and the province's inability to nurture innovation in the health care sector, and develop the medicine and therapies to improve and save lives.

A key part of protecting the lives of Ontarians is having the resources to do so. But when the pandemic emerged, our government was left to find that the province's stockpile of PPE was expired and depleted under the previous government's watch. This left us dependent on foreign supply and unstable supply chains. That is why our government is working hard to foster the capacity needed to produce critical supplies right here in Ontario. As part

of our plan to stay open, we created the made-in-Ontario PPE and critical supply and equipment program to secure Ontario's supply chain and make sure that the province has access to the PPE and goods needed to stay safe. With this domestic support, we will have both a robust way of maintaining Ontario's stockpiles and the tools needed to monitor their quality going forward.

To continue supporting domestic businesses, last April our government committed $50 million to launch the Ontario Together Fund, in the wake of COVID-19's first wave. This fund enables businesses to develop the ideas and solutions that will prevent the spread of COVID-19 while they retool their operations to help produce much-needed PPE. This initiative is yet another example of how our government is meeting and anticipating the needs of Ontario through our plan to stay open.

In addition to supporting the province's manufacturing capabilities, another key aspect of shoring up our domestic production of critical supplies is creating a comprehensive process to secure safe and stable food. That is why our government is taking further steps to build the agri-food sector needs into our emergency preparedness planning. We are delivering on this commitment by proposing amendments to the Ministry of Agriculture, Food and Rural Affairs Act. These amendments would specify that the ministry's mandate includes providing advice and programming related to stabilizing and safeguarding our food supply. Updating the mandate will help us to grow sector capacity, build a strong labour force, and nurture an environment that builds a resilient supply chain from farm to fork.

Our third pillar consists of building more hospitals and hospital beds. Long before the pandemic began, capital investment in Ontario's hospitals failed to support the demands of this growing province. Ontario was left with a health care system that was unable to address the immediate and urgent needs that came with the pandemic. That is why the third and final pillar of the Pandemic and Emergency Preparedness Act and the plan to stay open pertains to building more hospital beds.

Let me give you some examples of the record investments our government has made, and will continue to make, in Ontario's health and long-term-care infrastructure.

In March 2021, we provided over $1.2 billion to help Ontario's public hospitals recover from financial pressures created and worsened by the pandemic. This funding made sure that Ontario's hospitals could continue to provide the world-class programs and services that Ontarians rely on.

In January 2022, we announced an investment of $125 million to add more than 500 critical care and high-intensity medical beds to create capacity and address any new wave of COVID-19 cases.

In addition to these investments, our government has committed to making progress on our plan to add 3,100 acute-care and post-acute-care beds and the capital plan expansion. The expansion features over 50 major projects that would add 3,000 new beds over the next 10 years. We are also committed to investing $30 billion over the next 10 years in hospital infrastructure projects across Ontario.

The actions we are taking and investments we are making are creating more hospital capacity and positioning Ontario to respond to any emergency now and into the future.

0920

Beyond the pillars I have just outlined, there are select initiatives and legislative pieces that are also key parts of our plan to stay open. I will overview a couple of those right now as well.

The COVID-19 pandemic caught the world off guard, and the uncertainty that came with it only worsened its effect. That is why our government is equipping the province to detect and prevent threats that could put us in such an unknown position again. This will happen with our Wastewater Surveillance Initiative, which is one way to help achieve this. This program began in 2020 as a response to the pandemic. It uses waste water sampling, combined with clinical and public health data, to help public health units recognize potential outbreaks and enable more timely decisions. However, it doesn't only pertain to the COVID-19 virus. It can also be used to learn more about detecting other diseases of concern, and therefore help us to anticipate any potential threats and prepare accordingly.

To briefly highlight another initiative—when it came time to reference emergency protocols in response to the COVID-19 pandemic, our government was left to find that there were no up-to-date emergency protocols in place. In fact, the 2017 Auditor General's report revealed that under the previous government, Ontario's emergency planning had not been updated since 2006. This cost the province dearly throughout the darkest days of the COVID-19 pandemic, and as a result, the lives of Ontarians hung dangerously in the balance. That is why our government is creating a sound emergency preparedness plan. The plan is composed of much-needed amendments to the Emergency Management and Civil Protection Act. These amendments are designed to bolster the province's overall capacity to plan and provide the province with the tools needed to constantly monitor for new threats from around the globe. It is absolutely critical that the government is able to have access to every possible lever, to respond to any emergency or threat that might endanger the people of this province.

The Acting Chair (Mr. Logan Kanapathi): Minister, you have one minute to go.

Hon. Prabmeet Singh Sarkaria: Thank you, Chair.

Gathering this information and developing fulsome plans will ensure Ontarians stay safe, stay healthy and stay open.

Esteemed committee members, it has been my great pleasure to outline the three pillars of the proposed Pandemic and Emergency Preparedness Act, which include, once again, expanding Ontario's health workforce, shoring up domestic production of critical supplies, and building more hospital beds, as well as the initiatives that complement and constitute these pillars. While we are making significant progress, we will never forget the dire circumstances that brought Ontario so close to the brink,

and never again will our government leave the people of Ontario in as precarious of a position as previous governments did.

This announcement is part of our government's plan to ensure that Ontario remains vigilant and ready for the future. It is one way that all of you, the people of Ontario, will hold us accountable, and it is one of the ways in which we will support our front-line health care heroes. Together, we will ensure that Ontario is always prepared, because we can never go back to the way things were before.

The Acting Chair (Mr. Logan Kanapathi): Thank you for your presentation.

This round of questioning will start with the official opposition. MPP Mamakwa.

Mr. Sol Mamakwa: Meegwetch, Minister, for your presentation.

Over the last few years, you hear these things that governments say—and they say the good things. Sometimes the words that are spoken make me want to cross the floor and join you guys over there and do the good things.

Mr. Michael Mantha: But then you wake up.

Mr. Sol Mamakwa: But then I wake in the dream, and—

Mr. Michael Mantha: It's a nightmare.

Mr. Sol Mamakwa: —and I realize it's a nightmare.

In all honesty, I think, as a First Nations person, as an Indigenous person, that that thing has been done to us for hundreds of years—where settlers will say the good things and do something else.

Towards the end of your presentation, you spoke about hospital beds. I know that in far northern Ontario, when we talk about infrastructure, when we talk about access to hospital beds for the fly-in First Nations I represent in far northern Ontario—is there any consideration? Or would you consider having an actual hospital on-reserve so we don't have to leave our communities to come to Toronto, to come to Thunder Bay, to come to Sioux Lookout?

What is the appetite of this government to have on-reserve hospital services?

Hon. Prabmeet Singh Sarkaria: Thank you very much, MPP Mamakwa, for that question.

Our government, since the outset of this pandemic, has recognized that there are certain regions and areas of this province where there is an inequity of health care. We have been working towards fixing those issues, especially with respect to the lack of capacity across the province. So we will definitely take into consideration the needs and the requests by members like yourself and First Nations communities from across this province.

I think one of the things we heard quite a bit about during our conversations with members in the north, First Nations communities and others was the lack of access to doctors in the north as well. That is why you see, through this plan to stay open, a significant investment in NOSM, almost doubling the number of medical students, almost doubling what they currently have. So that recognizes the needs of our communities, and we want to build upon that. We want to make sure that there are enough doctors there. We want to make sure that there is an opportunity for them to serve in their communities. That's one of the things that is really critical about this plan, and we'll continue to build upon that.

We also have programs like the community commitment program in this, which will reimburse—for example, with respect to some northern communities, there isn't a pool of accessible talent, sometimes, or individuals who want to work or stay in those communities. We want to make sure that those who commit to those areas and regions actually have their tuition paid for as well, to make sure that those areas in the north are better served.

Our government will continue to work with stakeholders across our province, our First Nations community and, MPP Mamakwa, yourself as well, as we develop our historic infrastructure investment over the next 10 years. It's an over $30-billion commitment to build health care infrastructure, and we will do that by working with our communities across all of Ontario to deliver on that. We look forward to working with you as well.

Mr. Sol Mamakwa: Meegwetch. Thank you, Minister.

I know that schedule 5 of Bill 106 goes in the right direction to ensure that Ontario has an adequate supply of PPE in the event of another crisis. However, schedule 5 fails to recognize that group purchasing organizations that award contracts to PPE-producing companies currently have no oversight or accountability. In other words, it is a free-for-all for these organizations. They are incentivized to give large, international companies lucrative contracts, knowing that the commission they earn will be higher. In the end, who loses out? Small and medium Ontario-based companies.

At the outset of the pandemic, Ontario had a significant shortage of PPE. Nurses were wearing garbage bags in an effort to protect themselves. Ontario companies had the means to efficiently produce life-saving PPE, but they weren't allowed to; they weren't awarded the contracts.

Can the government please tell me why schedule 5 lacks oversight and accountability measures for the group-purchasing organizations?

The Acting Chair (Mr. Logan Kanapathi): You have one minute, Minister, to answer.

0930

Hon. Prabmeet Singh Sarkaria: I'll answer that very quickly, within a minute.

MPP Mamakwa, I appreciate that question.

The intent and purpose behind this legislation is to make sure we never find ourselves in the position we were in in March 2020. We're going to build commitments into this that will ensure that there is public reporting of how much PPE, whether it be in our stockpiles or procured by government, is domestically purchased and domestically made. That's a core commitment of our government, because we know that in that time of need, we were waiting for planes to arrive from different parts of the world, and some were held up at borders because jurisdictions didn't want to give up their supply. Our government is going to change that. There are significant production facilities that have been set up all across the province to ensure we have a good critical supply—

The Acting Chair (Mr. Logan Kanapathi): Thank you, Minister.

This round of questions will go to the independent member.

Ms. Mitzie Hunter: Thank you, Minister, for your presentation.

It is really important that after an emergency—a global pandemic—we have this discussion in terms of what needs to be improved and what lessons we have learned. I certainly know that I was part of a government that did that very thing during the 2013 ice storm that hit Ontario.

My riding of Scarborough–Guildwood has been a COVID hot spot since the beginning and throughout the 25 months of the pandemic, and my community has felt the neglect of this government in terms of a lack of priorities for key things. It's not because of lack of resources or money; the federal government has funded 85% of our pandemic response, so we know that it's not about the resources. In fact, this government chose to leave $5.6 billion in unallocated accounts, as well as in reserves, instead of flowing that money to areas that are needed to shore up Ontario's emergency response—because we're still in an emergency; we are still in the pandemic.

This has really hurt a lot of areas. I want to identify some of those areas, because it requires a whole-of-government approach. We can't just look at one area; we have to look at all areas.

The call to lower class sizes, from the very beginning, to keep schools safe and to keep students and educators safe while protecting their ability to learn—the government refused to do that.

When you look at aspects like long-term care—I remember standing in this Legislature on March 11, asking the government to really protect the most vulnerable when it comes to what we thought at the time was a respiratory virus. I did that because of my experience very early on with SARS. Scarborough was the first place that someone was diagnosed and ended up dying of SARS, and so I made that appeal to this government to protect long-term care.

And we know what happened to the elderly and the most frail and the most vulnerable: They were not protected. When we talk to those who work on the front lines of care—the workers in long-term care really felt that the government was very slow to bring along PPE and infection programs, to protect them. I remember television news covering workers in long-term care wearing garbage bags, very early in the pandemic, because we were trying to understand this virus. Some of those actions were made by your government, and you need to be responsible.

The cuts to public health very early on by this government really hurt our ability to prepare—$300 million out of public health. If we had invested that or kept their budgets the same, they would have been better equipped and better prepared for the scaling that had to happen.

So my question to you, Minister, is, do you believe that, as we're reviewing Bill 106, it is a whole-of-government response that is required? Frankly, I would even push that further to say it's a whole-House response—because when you're dealing with an emergency, you want information from every source so that you can protect lives and keep Ontarians safe.

Hon. Prabmeet Singh Sarkaria: Thank you, MPP Hunter, for that question.

After 15 years of neglect of our health care system, our government was moving very quickly and swiftly to ensure we changed that. When we talk about long-term care from 2011 to 2018, only 600 beds were made in this province. That is a significant reason why we are investing over $6 billion to build 30,000 new beds across the province. It was the lack of investment by the previous Liberal government that left areas like Scarborough and Brampton without access to health care. We invested immediately over 3,100 surge beds—

The Acting Chair (Mr. Logan Kanapathi): Thank you, Minister.

This time we are moving to the government members. MPP Cuzzetto.

Mr. Rudy Cuzzetto: I want to thank the minister for the excellent work that you have done on this bill.

I go back to the previous government, the neglect from—George Smitherman has even admitted that their government cut funding, and Kathleen Wynne has said that they cut funding for health care during their time in government.

One thing that I was struck by, when the pandemic first hit, was how Ontario was totally unprepared for this. I know our government has made significant investments to protect the health and safety and well-being of Ontarians.

Minister, what was the state of Ontario's readiness when the pandemic first hit us in 2020?

Hon. Prabmeet Singh Sarkaria: I think you understand the position that the previous government, after 15 years, whether it was freezing hospital budgets across the province, whether it was not having enough health care workers—our government stepped up right away, when we had to.

One of the key commitments that is being made through this piece of legislation is making sure that our PSWs and DSWs have a permanent wage enhancement. After years of being neglected, after years of being a systemic issue within the PSWs and DSWs—of the inequities that they faced—our government, under Premier Ford's leadership, addressed that and made that temporary wage commitment permanent.

When we look at health human resources, we are now making the largest increase of medical doctors—trained professionals—in the province's history. Whether it is building a new medical school in Scarborough, whether it's building the first one in the GTA in over 100 years, or whether it's doubling the amount of doctors who will be in the north, these are very important investments that we are making.

I think the most important investments that we are making in addressing the structural challenges that the previous Liberal government left us with are in health care capacity.

Since March 2020, we've added over 3,100 new beds into the system—acute-care and post-acute-care beds,

critical care beds. Those are very important investments when we look towards how that can help the people of the province today. It has helped in delivering better health care services for those individuals and their families anywhere across the province. These 3,100 beds are spread out across the province.

To ensure that we are never in a situation like this, we are undertaking a historic investment and expanding capacity for hospitals as well. We're building hospitals all across the province.

I know we're building the largest hospital in all of Canada, and I believe it's in your riding. I know, MPP Cuzzetto, you've been a champion for that project. You have advocated for it, after the previous member and the previous government neglected Mississauga and the needs of Mississauga. You have always stood as a champion for that city and the health care needs.

0940

When you look at a city like Brampton, which I represent—almost 700,000 people living in a city, and we only had one hospital. It is our government that is committing to a second new hospital for that city, after years of being ignored.

Peel has some of the fastest-growing cities, both Mississauga and Brampton, in all of Canada.

The commitments and the investments that needed to be made by the previous governments weren't—this plan ensures that we will. And we'll continue to build upon that, and we'll always be prepared.

Mr. Rudy Cuzzetto: Thank you very much, Minister, for being there to build the new hospital in Mississauga–Lakeshore.

That hospital was built in 1958. I was even born there. I won't tell you the year that I was born, but it was not too long after 1958.

It will be the largest hospital in Canadian history, so I want to thank the Treasury Board and our government for wanting to build that type of hospital in Mississauga–Lakeshore, which was neglected for 15 years by the previous government.

Minister, can you talk about the importance of introducing this bill now? What has the province been doing, and why is this a critical time to table this legislation and launch a plan to stay open?

Hon. Prabmeet Singh Sarkaria: Thank you very much, MPP Cuzzetto, for that question. You're right; now is the time to introduce and pass this legislation. I was very appreciative of the members of the opposition for supporting this bill on second reading as well.

I think it's important to understand that the pandemic really brought light to the long-standing systemic issues, the decades of neglect and chasing priorities by other governments that didn't serve the people of Ontario in their hours of greatest need.

What I think is so important is to make sure we build upon the progress that we've made. Last year's public accounts showed that there is no government in the history of this province that has invested more for the people of this province than this government has. We invested over $19 billion to keep the people safe in Ontario—$19 billion. That included, whether it be health care investments, investments to our municipalities, investments to long-term care—across the board, we made significant investments and took decisive action.

So we need to make sure this legislation is enacted and we move forward. We have a plan to stay open. We're the first jurisdiction in all of Canada to put forward a plan to stay open, and it's important. We can't make the same mistakes that were made in the past, which was to ignore long-standing issues, whether it be in our health care system, whether it be in our—

The Acting Chair (Mr. Logan Kanapathi): One minute left.

Hon. Prabmeet Singh Sarkaria: Thank you, Chair—whether it be in our health human resources. This is a commitment to ensuring that we continue to do that, and that we continue to build upon all the work we have done in the past.

Ontario leads the country with respect to having some of the highest vaccination rates. We've delivered a lot of—I think over 135 million rapid test kits, and I know MPP Smith was a big part of championing rapid tests across Ontario and making sure that everybody had access to them. Ontario has led the way.

We've got to make sure that we continue to build on that progress, secure the challenges that we see before us, and ensure that, whether it be through legislation or government investments, we never have ourselves in this situation again.

The Acting Chair (Mr. Logan Kanapathi): We are moving on to the official opposition.

MPP Mantha, please go ahead.

Mr. Michael Mantha: It's nice to have the minister with us this morning, from the Treasury Board.

Minister, you shouldn't be surprised by some of the questions that I've been asking you. I hope you did your homework—because it's going to be in regard to a discussion that we actually had last week. It's in regard to the supply of PPE that we need in this province. I'll take you through a little bit of history.

The province didn't have the proper supplies, or the supplies that we had had actually expired, and we didn't know what we were going to do with the supplies and so on. "Are we going to throw it away? Are we going to recycle it? What are we going to do with it?" So we made a decision: It's better to issue it out and use it than to not have it. A lot of what was provided was limited in supply. And you're right; we were scrambling to make sure that we had some supply.

This is not me saying this; the media is out there and there are plenty of pictures. These are some of the N95 masks that the Premier was photographed with, delivering to some of the agencies. These were produced in China. These are some of the masks that were delivered in the schools, and these were delivered, again, by the Premier. These were produced out of Vietnam. Some of these were also issued.

But this is where the crux of the problem is: The media has reported, and health science has reported very

accurately on this, that the difference between these and the N95s—although this one is being produced in China, this one is being produced here in Canada—is significantly, significantly different. I'll explain why: These have a bare minimum of protection for individuals who wear them. However, the N95—the evidence shows that it is three to five times better at protecting individuals, with those masks. I do understand that these are being produced at four companies here in Ontario. One of them is Primed in Cambridge. Brockville, I believe, is producing some of them. There is Canada Masq in Richmond Hill. And there is Viva surgical or Viva—they're producing them in Scarborough. However, these are not what we need. Don't get me wrong; each level of protection that we have is going to help. But we know that it's the N95s that are going to statistically have a much better outcome in this pandemic that we're in.

We have producers here in Ontario. Actually, the producer—one of the presidents of it—is Matthew Owl. He's from First Nations Procurement Inc., in partnership with Dent-X Canada. They are producing both masks, but I want to talk about these ones, which are needed. They are a stone's throw away with their stockpile that they have here, just down the street in Vaughan.

Can the minister provide me with an explanation as to why we have not looked in our own backyard and provided an opportunity for future procurement and security of our PPE that we need, and even purchased one single mask out of First Nations Procurement Inc.?

Hon. Prabmeet Singh Sarkaria: Thank you very much, MPP Mantha, for that question.

I do want to direct you towards the Personal Protective Equipment Supply and Production Act that's being put forward through this legislation. We recognized that at that time, in March 2020, there wasn't an adequate supply of PPE. There was expired PPE, and then we were reliant on foreign jurisdictions for that PPE. But through this legislation, we will have annual reporting on PPE and CSE; centralized supply, which will include information about the quantity, the quality, origin of production; and we will make sure that we are bringing transparency and ensuring that the stockpile is maintained. When we speak to the origin of production, this is to ensure that we have domestically procured and domestically made PPE. That is the core of what this legislation is aiming to ensure—that we don't make the same mistakes as previous governments did.

We also put forward the Ontario Together Fund, which invests over $50 million to help those companies that needed to retool, that wanted to help produce PPE, or had those innovative technologies that supported us during that very difficult time.

So we're going to continue to ensure that Ontarians are protected against future unforeseen emergencies by maintaining that healthy and robust stockpile, and we're going to make sure that we have the opportunity to continue building upon the stockpile that we have and being—

Interjection.

The Acting Chair (Mr. Logan Kanapathi): MPP Mantha.

0950

Mr. Michael Mantha: Minister, that's where I want to get down to: Ontario Together. Under Ontario Together, there was Mohawk Medbuy and other entities that were there to help with securing some of the supplies that we need. This is where the problem is: Ontario Together and that process could not pick up a phone and return a single call as to the problem that was identified either in cost or in the quality of this particular product.

Chief Glen Hare, out of the Chiefs of Ontario, actually contacted the government and said, "What's going on? We have these two companies that have opened up, one on Wiikwemkoong First Nation"—

The Acting Chair (Mr. Logan Kanapathi): You have one minute left.

Mr. Michael Mantha: —"and the other one in Sagamok First Nation, who have applied, who have hired 40 individuals at each plant. Can you provide us with an explanation or a return call so that we can address either the quality or cost need?" Nothing was returned. These are individuals who didn't request any money from this province, who have self-invested into their companies and are looking to do more. Can you provide them with some type of an explanation as to why not one single mask has been purchased from either of their plants?

The Acting Chair (Mr. Logan Kanapathi): Minister, you only have 14 seconds.

Hon. Prabmeet Singh Sarkaria: Thank you very much for that question, MPP Mantha.

We have had the opportunity to speak to this previously. You've raised this multiple times, but we'll undertake to get you a response on that.

The Acting Chair (Mr. Logan Kanapathi): We are moving to the independent member. MPP Hunter.

Ms. Mitzie Hunter: Minister, this morning you spoke about the shortages in the health system. There are a lot of questions I could ask you about that, but I want to make a comment regarding the increasing of the supply of medical student positions, because that directly affects my community in Scarborough, and it is something that I welcome. I was one of the individuals who helped the University of Toronto Scarborough campus, along with the Scarborough Health Network and others, to put forward that proposal, because of the shortage of primary care doctors in our community, and just the benefit of having residency locally would help our students locally. So I do want to say that that is something I have supported at every stage, and continue to support, because we really do need to see communities like Scarborough produce doctors and contribute to the medical professions. So that is something I appreciate. I am wondering how fast—you are the Treasurer of the province—and is that something that you are going to move through? I'm a bit disappointed that the number of seats is less than what the university wanted, but I do think it is a good start to get the Scarborough medical academy going.

Hon. Prabmeet Singh Sarkaria: Thank you very much, MPP Hunter, for that question.

It is so important for us to ensure that we are able to have the care, especially in our communities. A lot of

times, we have communities that require culturally appropriate, culturally sensitive care. So ensuring that whether it be communities like Scarborough or whether it be communities like Brampton—which are very diverse and have a wide range of communities from all over the world who live in those cities.

I think it's very important to have the ability to train doctors and health care professionals through those schools, to ensure that we have, whether it be residents, surgeons or family doctors—I think we can all look to our communities and see that there are a lot of people who need family doctors. That is what this is addressing. It's the largest expansion of medical seats, not only in places like Scarborough and Brampton, but across the entire province, to ensure we have more doctors and health care professionals across the province. It's very important for us.

Our government is about getting it done. We knew that there was a need to get more doctors. We didn't talk about it; we got it done. We knew there was a need to build more hospitals in the province of Ontario; we're getting it done. We're building those hospitals, and we're going to make sure that there are enough doctors to train the people in those hospitals as well, because that's really important, especially in communities like Brampton, and especially in communities like Scarborough, as well.

The Acting Chair (Mr. Logan Kanapathi): You have one minute left.

Ms. Mitzie Hunter: I'm just wondering about that need to be flexible during an emergency. Bill 124 is one where—we've heard from nurses and we've heard from a lot of front-line health care professionals saying that it's hurting their profession, that we're actually losing very experienced nurses who feel, frankly, disrespected because they are not able to bargain freely. Why has this government refused to repeal Bill 124?

Hon. Prabmeet Singh Sarkaria: Nurses are the heroes of this pandemic. They have gone above and beyond to serve in our hospitals. That is why our government recognized, just three weeks ago, the incredible commitment that they have made towards our hospitals.

There are issues with respect to retention. We invested over $760 million to give nurses and health care professionals a $5,000 retention bonus. Early on in the pandemic, they got pandemic pay. And we have increased and made permanent the PSW wage enhancement pay—

The Acting Chair (Mr. Logan Kanapathi): Thank you. Moving on to the government members: MPP Crawford.

Mr. Stephen Crawford: I know that we've touched a little bit on some of the lack of resources—health facilities, for example—and servicing in northern Ontario. There have been a lot of regions that have been neglected by the previous Liberal government, and your region of Brampton is one of them. Certainly, the north has been neglected. We know, as legislators, how important it is to ensure Ontarians have equitable access to health care.

It's very hard to attract individuals to some of these more northern and remote communities. I know the plan to stay open includes the Ontario Learn and Stay Grant. I thought you could tell us a little bit more about how that will help recruit, and, importantly, retain health professionals in some of these neglected parts of Ontario.

Hon. Prabmeet Singh Sarkaria: Thank you for that question, MPP Crawford.

The Ontario Learn and Stay grant is really addressing one of the core issues at the heart of the challenges that our health care system is facing. This is going to be a $142-million investment by this government. I will break it down into two components. So $81 million of that investment will be made to expand the scale and scope of the Community Commitment Program for Nurses. This calendar year—2022-23 and 2023-24—we'll see up to 1,500 nurse graduates each year who will now receive full tuition reimbursements, in exchange for committing to practise for two years in an underserviced community. This is to recognize that there are significant challenges in the north, in some communities, in having those health care professionals. I'm sure there are some members in our committee, whether it be MPP Mantha or MPP Mamakwa, who have also probably experienced those things in those communities, and I know they likely will welcome changes and programs like these to ensure that we do have enough nurses, we do have enough health care professionals in those areas to serve those communities.

1000

The Ontario Learn and Stay Grant also builds upon that. The second component of it is the ability to target health professionals in other—we'll likely start with nurses, but we'll also have the opportunity, in consultation with medical professionals across the province, to target other specific programs, if needed, to ensure that they get the access, or if there is a shortage of another health care workforce, that they have an opportunity to tailor programs and reimburse tuition payments from that perspective as well.

We're going to continue to build upon the progress we've made and make sure that we have an adequate amount of health care professionals in this province, because we know that it is critical for our plan to stay open.

Mr. Stephen Crawford: How much time, Chair?

The Acting Chair (Mr. Logan Kanapathi): You have four minutes left.

Mr. Stephen Crawford: That's great. I appreciate that.

We were elected on a campaign in the last election to secure more hospital capacity and end hallway health care. COVID came along, obviously, and unfortunately put us in a weak position, because Ontario had among the lowest beds per capita not only in Canada but North America and, in fact, the developed world.

Right now, we have a backlog of critical surgeries because we did not have a lot of beds. Can you tell us how this plan will address this chronic shortage of beds and help to finally address hallway health care here in Ontario?

Hon. Prabmeet Singh Sarkaria: Thank you very much, MPP Crawford, again, for that great question.

One of the other pillars of our plan to stay open is ensuring that we build more hospital beds and we build

more hospitals. We've spoken to some of the historic investments we're making in communities like Windsor. They're getting a new hospital. We're looking at communities like Brampton, Mississauga—across this province, significant health care investments through our capital infrastructure plan.

I think one of the other very important points to note is that since March 2020, our government has increased the acute-care and post-acute-care beds and critical care beds by 3,100. If we break that down, that is the equivalent of building almost an additional five hospitals across this province. We did that in the span of the past two years. And in doing so, we also have supported our nurses through ensuring that we invest over $342 million with respect to retention, upskilling nurses—over 8,000 PSWs being able to access that $342-million investment, supporting those PSWs. So that really speaks to the immediate term of what we did with respect to hospital capacity, after inheriting a system that was left on life support by the previous Liberal government, after a decade of underfunding, underinvestment and cuts to our system.

Moving forward, I think it's very important for us to ensure that we continue to build on that progress and ensure we have more health care capacity and health care beds across the province.

The Acting Chair (Mr. Logan Kanapathi): You have one minute left.

Hon. Prabmeet Singh Sarkaria: Thank you very much, Chair.

Over the next 10 years, we have committed to building over 3,000 new beds. That's approximately a $30-billion capital investment across this province, and that's significant. Not only are we building those beds, but at the same time, we're going to ensure that we have the physicians to staff those beds; that we have the specialists within those hospitals, whether it be for surgeries, whether it be for cancer care, whether it be for other medical needs; that we have the health human resources. That's why this plan significantly builds upon that to ensure that we have enough nurses, we have enough PSWs, DSWs, by giving them that historic increase and making it permanent. So we'll continue to work on that and build on that very important progress.

The Acting Chair (Mr. Logan Kanapathi): Thank you, Minister, for your presentation, and thank you for your time.

This concludes our business for this morning. The committee is now recessed until 3 p.m. this afternoon.

The committee recessed from 1005 to 1500.

The Acting Chair (Mr. Logan Kanapathi): Good afternoon and welcome back. We are continuing public hearings on Bill 106, An Act to enact two Acts and amend various other Acts. Please wait until I recognize you before starting to speak. As always, all comments should go through the Chair, please. Each presenter should also state their name for Hansard before they begin to speak for the first time. The Clerk of the Committee has distributed committee documents, including written submissions, via SharePoint.

As a reminder, each presenter will have seven minutes for their presentation, and, after we have heard from all three presenters, the ren yomaining 39 minutes of the time slot will be for questions from members of the committee. The time for questions will be divided into two rounds of seven and a half minutes for the government members, two rounds of seven and a half minutes for the official opposition members, and two rounds of four and a half minutes for the independent members. Are there any questions from the committee members?

COMMUNITY LIVING TORONTO

WeRPN

MR. NICOLAS SMIT

The Acting Chair (Mr. Logan Kanapathi): I will now call on Community Living Toronto. They are in person. Please come forward and state your name for Hansard. Welcome.

Mr. Brad Saunders: It's good to be here in person.

The Acting Chair (Mr. Logan Kanapathi): Please state your name for Hansard. You may begin now.

Mr. Brad Saunders: I'm Brad Saunders, CEO at Community Living Toronto.

Mr. John Yakabuski: It's good to have you here.

Mr. Brad Saunders: It's good to be here.

The Acting Chair (Mr. Logan Kanapathi): Please go ahead.

Mr. Brad Saunders: I'm here this afternoon to provide my full support and the support of our organization to make the temporary wage enhancement permanent for developmental services workers in Ontario.

Community Living Toronto supports over 5,000 people each year, and we work every day towards building more inclusive and welcoming communities for people with developmental disabilities so they have a place where they belong. That's our mission. Many in our workforce are represented by CUPE Local 2191, and I really value the leadership and perspective that they bring to our work each and every day. Not surprisingly, the last two years have been the most challenging in our 74-year history.

I want to share with you a few thoughts on why we are so supportive of this wage enhancement becoming permanent.

We provide supported living for about 600 people. Living situations range from staff occasionally providing support to a person living in an apartment on their own, to those with complex medical needs requiring 24/7 personal care in congregate living spaces of four to six people. We have a workforce of about 1,300, and about two thirds of those staff are direct support professionals working in homes and apartments across the city of Toronto. Our direct support professionals are supported by a seasoned group of supervisors and managers who are hands-on leaders, never hesitating to roll up their sleeves and get the job done.

On March 17, 2020, with Premier Ford's declaration of a state of emergency, the focus of our entire organization

moved from inclusion and belonging to safety and wellness, to keep an invisible enemy at the door. To give you a sense of scale, over the past two years we have managed 1,671 situations involving COVID, suspected or confirmed outbreaks, with people we support. That's 1,127 staff situations, 544 with individuals we support. We also managed through 92 outbreaks in our various locations around the city. It was a continual cycle of testing, staff isolating, retesting and managing situations. The demands have been enormous.

But there's also another story, and that's one of dedication and compassion, one in which every day throughout the pandemic staff at Community Living Toronto and DSWs around the province just kept coming to work. The people they supported needed them to, and they answered the call. They did so with good humour and a commitment to safety. They did so because of who they are, because that is what needed to be done.

Every day, staff left their homes and families and came to work to support some of Ontario's most vulnerable citizens. They donned masks and face shields, gloves and gowns, and worked 12-hour shifts keeping people safe. This is who we are. This is why we do what we do when we're called upon.

Ontario should be proud of our developmental services workforce.

But this being the Standing Committee on Finance and Economic Affairs, there's also another story, and that's the story of return on investment. At Community Living Toronto, we tracked quite closely the impact the temporary wage enhancement had on our workforce and were amazed at what we saw: a dramatic reduction in sick time, a reduction in last-minute shift cancellations, a reduction in turnover, as well as an increase in overall staff engagement and satisfaction—this at a time when we would have expected to see the exact opposite. For our staff, the people who do the work, it also meant more economic security, the ability to give up a second job. More than 60% of our staff, going into COVID, had a second job to be able to pay the bills every month. They were not required to work as much overtime, and they were able to create a much better work-life balance. For our workforce, this $3 an hour represents between a 10% and 14% increase in salary.

I would like the committee to note—and a note of caution, while we are waiting on the details of how this funding will roll out: Staff have become accustomed to receiving a net $3 an hour on their paycheques. It does not currently include costs such as vacation, benefits, sick time, retirement funds. Everything except hours worked is not included. If that's not compensated for as money flows out, staff are going to be in for a disappointment. We wouldn't want this to become a bad-news story. The actual implementation could be somewhere north of 20% more than the actual $3 an hour.

While this addresses pay equity issues, which have been a significant issue for this sector for decades, investing in some positions and not others is creating realities for agencies that will skew their pay equity grids and matrices, which will cost organizations going forward.

Having said that, this investment is needed. To give some context of the economic situation for our staff, our last four-year agreement settled for two years at a stipend of a few hundred dollars for each of the first two years, followed by a 0.75% increase, followed by a 1% increase. For our sector, Bill 124 was aspirational. We have never been able to provide increases that would keep pace with the cost of living. When we settled our collective agreements, we were not given funding to augment those amounts that we were having to pay on staff. We were simply left to our own means to figure out how to cover these salary increases, with no increases net to our funding. This is, frankly, unsustainable.

I would urge governments to commit to never again having wages for our sector and other sectors across the province lag so far behind as to make the system fragile and vulnerable.

The Acting Chair (Mr. Logan Kanapathi): You have one minute left for your presentation.

Mr. Brad Saunders: Thank you.

I find it remarkable that I'm here today discussing the merits of such a significant and welcomed investment in direct support staff. It will make a difference. I really applaud Premier Ford's personal commitment to make this $3 permanent, and I'm glad to be here to watch it in the process of coming to fruition.

The Acting Chair (Mr. Logan Kanapathi): Thank you for your presentation.

Next, we will call WeRPN, the Registered Practical Nurses Association of Ontario.

Ms. Dianne Martin: Good afternoon. My name is Dianne Martin. I'm the CEO at WeRPN, the Registered Practical Nurses Association of Ontario. I want to thank the members of the committee for giving me the opportunity to speak here today about Bill 106, the Pandemic and Emergency Preparedness Act, 2022. It's always an honour to speak on behalf of Ontario's registered practical nurses, or RPNs, and today is no different. This bill is extremely important to our members.

In our province, we have more than 50,000 registered practical nurses, which makes them the second-largest group of regulated health professionals in Ontario. Those nurses are experts in nursing practice. They are leading innovators in leading positive change at the point of care, and they are passionate about ensuring that their patients, residents and clients always have access to the highest-quality care our system can offer. In fact, 95% of RPNs work in roles that provide direct face-to-face care for Ontarians.

This means that RPNs have been on the front lines throughout the COVID-19 pandemic. They have been in our long-term-care homes doing everything in their power to protect our most vulnerable seniors. They have been in hospitals, working every day to ensure that despite the tremendous toll of the pandemic, patients still receive the level of care they deserve. They are the front-line heroes so many have spoken about.

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We appreciate the government's commitment to funding the Ontario Learn and Stay Grant and the Nursing Education Initiative, as well as actions to begin addressing barriers faced by foreign-trained nurses when trying to register and practise in Canada. These are important initiatives.

However, I am hearing from RPNs every single day who tell me that they are feeling overwhelmed and undervalued, and one important piece of Bill 106, schedule 7, stands to make problems potentially worse, unfortunately.

The government has announced that it will use schedule 7 of this bill to make permanent a $3-an-hour wage increase for PSWs and DSWs. I want to be really clear that RPNs fully support this pay increase for their colleagues. That is a really important thing. What our members can't understand is why that pay raise is only going to be available to their colleagues but not to them. RPNs are often the direct supervisors of PSWs in long-term-care homes, and this wage increase has left many of them earning just barely more and in some cases less than the colleagues they supervise. RPNs work with an increasing scope of work, legal liability and accountability to a professional college, compared to the PSWs with whom they work. This lack of recognition from the government for the work that RPNs have done and continue to do is extremely distressing. Our organization is already seeing the number of RPNs working in long-term care beginning to decline, and the proposal to increase PSW wages but not RPN wages is sure to make that problem worse. At a time when our province is just beginning to emerge from a global pandemic into a human resources crisis that sees us desperate to recruit new nurses, the government has announced their intent to take an action that could potentially and maybe inadvertently make the problem worse. Thankfully, it doesn't have to be this way.

There is a simple solution to not only reduce the number of RPNs who are leaving our long-term-care homes and our hospitals—and by the way, at the same time we're trying to increase substantially, by 27,000 care providers, the staffing in long-term care, the numbers of RPNs are significantly dropping, and we are struggling to attract new people to the profession. The solution is to pay RPNs a fair wage that is appropriately matched to the skill and value they bring to Ontario's residents, patients and home care clients. When the regulations under schedule 7 of Bill 106 are drafted, make sure that RPNs are included in the $3-an-hour increase as well.

The government will say that they've already taken steps to recognize the work that nurses have done throughout the pandemic by offering a one-time retention bonus of $5,000. While this will serve to offset the expenses incurred by nurses through and because of the pandemic, the simple reality is that this is in no way enough. Nothing short of a permanent wage increase is going to enable us to successfully retain RPNs or attract new ones to the profession. It's a one-time payment, and it doesn't even equal $3 an hour for a full-time staff member.

If the government is truly committed to addressing the health human resources crisis that our province faces, if they are truly committed to ensuring that our seniors in long-term care get the highest level of care possible, if they truly are committed to treating front-line health care workers with the respect they deserve, then there is only one path forward: Pay nurses what they deserve, and use schedule 7 of the legislation to extend the $3-an-hour wage increase to RPNs.

Thank you again for giving me the opportunity to speak today. I look forward to your questions.

The Acting Chair (Mr. Logan Kanapathi): Thank you.

I will now call on Nicolas Smit. Please state your name for Hansard, and you may begin now.

Mr. Nicolas Smit: My name is Nicolas Smit. I have the honour of being the only Canadian working on President Biden's new task force working on PPE and PPE supply chain strategies for pandemics and biological threats. I've also had the pleasure of working with the White House, as well Democrats and Republicans in the House and Senate, since January on PPE pandemic problems. However, I first started solving pandemic issues in Canada in March 2020, when I worked with MPP France Gélinas to get the province to look into and eventually recommend elastomeric respirators as N95 alternatives, to solve the N95 shortage crisis for our health care workers.

In November 2020, I convinced the Ontario Nurses' Association to take the province to court using my resources. The province quickly settled that court case in less than a week, which led to several new improvements in health care worker safety.

For a pandemic and emergency preparedness plan to be successful, we need to be able to act quickly, before the problems occur and get exponentially worse. We need to be able to rely on the tools needed when we need them. A pandemic plan needs to include all the major problems related to the virus, not just hospitalizations and deaths. Long COVID is extremely prevalent, with studies showing that around one in three people get long COVID.

While vaccines are great at reducing hospitalizations and death, they cannot prevent infection or long COVID, which is why in July 2021, the CDC recommended that people start using masks to stop transmission, no matter their vaccination status. Surgical masks can be held tightly in place with mask bracers, giving those wearing them protection from airborne transmission in addition to droplet protection. Our health care workers and others are only given loose-fitting surgical masks without bracers. Instead of using the best masks and working our way down to the ones that offer the least amount of protections when better masks aren't available, we've been using the masks with the least protections and rarely going up to N95s, or the more protective elastomeric respirators, which have been readily available for years.

To be ready to react to pandemics, it is important to have a well-stocked PPE stockpile, which should include a combination of surgical masks with bracers, N95s and elastomeric respirators that can be immediately distributed

on a moment's notice. The big bonus to elastomeric respirators is that they can be safely reused for several years, and the filters only need to be replaced once a year. Some hospitals in the US are still using the same ones they used for H1N1. And while N95s expire after three years, elastomeric respirator filters expire after five.

The more elastomeric respirators we buy now, the less masks we'll need to buy in the future. For example, if you buy one million elastomeric respirators now, that's one million individuals in Ontario who will immediately have the best protection possible for the next few years, and then those respirators can be put in storage at the end of the pandemic and kept for future emergencies, resulting in less need for additional mask purchases for the provincial stockpile. Had the province used the stockpile of 100,000 elastomeric respirators they bought in July 2020, they would have rarely needed to buy more surgical masks or N95s since that time for health care workers.

Two of the biggest failures to date that continue to be repeated in the US and in Canada are the failure to support domestic PPE manufacturers, and elastomeric respirators being locked up while also refusing to let the public know about the government recommendations to use them.

Having PPE made domestically is a luxury we will soon lose. Two years ago, Canada had no domestic PPE capabilities. A year ago, Canada had enough domestic PPE to be completely self-reliant. Yet almost all PPE is bought exclusively from non-Canadian companies. Canadian manufacturers have offered to provide enough N95s and elastomeric respirators to keep everyone in the province fully protected from transmission. However, the province has refused to buy masks that aren't from 3M, an American company, so our domestic manufacturers are now closing or are significantly reducing production levels.

Allowing the remaining domestic PPE manufacturers to go under will mean a return to problems like we experienced in 2020, when Canada had to rely on China, which stopped exports just as Canada desperately needed them. If we want to be able to rely on quality and effective PPE, now is the time to ensure we support our domestic manufacturers, so that they continue to have the PPE needed for this wave and any future waves we face.

At first, health care workers and other government employees were told that they couldn't have better masks due to shortages. The mask shortage was declared over a year ago. However, employees are now told that they don't deserve, nor do they need, better masks, despite the government having them readily available.

In my hometown of Sudbury, Health Sciences North has been in outbreak since 2021. This not only endangers health care workers but also forces hospitals to cancel surgeries, life-saving procedures and tests.

An even bigger failure than the collapse of the domestic PPE industry is elastomeric respirators. Health care worker unions have repeatedly asked for them to be distributed to health care workers, so they can finally put an end to health care workers getting infected. Unions have explained that they provide much higher levels of protection than N95s, can be safely reused for years, are more comfortable, plus are the most cost-effective respirators available. However, they're not being used in any meaningful way.

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In his testimony to the Ontario long-term-care commission, Mario Possamai, the lead SARS investigator, explained that the biggest failure by the Ontario government during the pandemic was the lack of urgency in getting elastomeric respirators to health care workers. Mario provided similar testimony on July 6, 2020, in the House of Commons.

In June 2020, after getting the province and federal government to recommend elastomeric respirators as N95 alternatives, I was able to get Ford's office to launch an internal investigation into health care workers being actively prevented from using them due to the lack of awareness about the new Ontario Health and Health Canada recommendations to use them.

On June 29, 2020, David Morgado, Ford's executive assistant, let me know the results of the investigation. David said that the province bought 100,000 elastomeric respirators from 3M and that they would all be distributed to hospitals and long-term-care homes within weeks. Combined with the 22,000 elastomeric respirators hospitals we already had, the additional 100,000 was enough to have kept every health care worker in Ontario fully protected from transmission since July 2020.

When the province received the 100,000 respirators, France Gélinas let me know that the province decided they would keep the stockpile in government warehouses since the province was under the assumption that health care workers wanted to stay in surgical masks. When unions found out months later that the province locked them up for future pandemics, they started fighting to get them distributed. However, the government still refuses to distribute them, despite twice telling MPP John Fraser that hospitals could easily access the stockpile and use all the elastomeric respirators they want to.

Had Ontario businesses known about elastomeric respirators, they could have used them to stop workplace outbreaks and the large economic damage workplace outbreaks cause.

The Acting Chair (Mr. Logan Kanapathi): You have one minute left.

Mr. Nicolas Smit: Not mentioning elastomeric respirators publicly and in Parliament has resulted in the problems going undetected by journalists. Health critics like France Gélinas and John Fraser will hopefully be able to use public pressure to get the stockpile distributed and get answers as to why Ford's office thought it was better to keep health care workers at risk than use the stockpile they bought to eliminate the risk of infection.

It is not too late to significantly improve our current pandemic and emergency preparedness to get us through the pandemic while minimizing the economic and health impact. Without fixing the current problems, we will be left even more unprepared for future pandemics and emergencies, and we'll keep repeating the same mistakes over and over, with worse results each time. I hope you

can take the time needed to investigate these problems and consider these things in future plans to quickly get ahead of, and be prepared for, future pandemics and emergencies, no matter how bad they get.

Thank you for your time.

The Acting Chair (Mr. Logan Kanapathi): Thank you for your presentation.

This round of questions will start with the independent member. You have 4.5 minutes for your presentation and questions. MPP Hunter.

Ms. Mitzie Hunter: I want to thank the three presenters for taking the time to join us here.

I'm going to start with WeRPN, the registered practical nurses of Ontario. I want to begin by thanking you for your incredible work and the work of your members. I happen to have a loved one who is in the care right now of some wonderful nurses. They're the ones who are always there when I visit. I really value the care, the professionalism. I feel that you're essential to a good health care system.

When you talk about the government's lack of consideration of the classes of work within the health care system—we support personal care workers getting a wage increase and bumping that up. Certainly, the Ontario Liberals support making that permanent. It's something that really does need to happen. However, when you're looking at one sort of band, you have to look at how it affects those who are next to it. So the compression that you're experiencing is unfortunate, given the fact that everyone has to work together in the one setting.

If you could just speak a little bit in terms of what is helpful to your members—you did say applying that $3-an-hour increase, because then the nurses would sort of increase along with the personal support workers, and you think that's a way to start. Are there other aspects that you want the committee to consider at this time?

Ms. Dianne Martin: I think the most important thing to recognize with the wage compression is that RPNs are nurses, and while they're no more important to the care of people, as you know, than PSWs, they do provide nursing care, which requires a great deal more education and a great deal more legal accountability. As they go closer and closer to PSWs in wages, instead of closer to the RNs, which is the group of people who hold the role most close to the RPNs, there becomes very little reason to stay.

Some have gone to work as PSWs to make the same amount of money—or a very similar amount—without anywhere near the pressures. Others have said, "I can week in so many places in society these days, as the need for all kinds of workers increases, that I just can't give that much of myself"—which is what nurses are doing these days—"to not be recognized."

The Acting Chair (Mr. Logan Kanapathi): You have one minute left.

Ms. Dianne Martin: I've heard it said in Hansard—a sort of rationalization that nurses have eight steps of pay for them to get to the top, so they're getting pay raises yearly, but that's RNs. RPNs actually only have three levels, and within two years of graduation they have hit the top pay level and are reliant on the pay increases that they get through negotiation to be able to manage the cost of living etc., or they fall back. So they've been spending many years now falling far behind where they should be in wages.

Ms. Mitzie Hunter: Thank you for bringing this so clearly to the committee.

I want to thank Brad, as well, for all the work you do with Community Living. You definitely do great work in my community in Scarborough, and I really want to say thank you for that.

The Acting Chair (Mr. Logan Kanapathi): We are moving on to the government members. MPP Yakabuski.

Mr. John Yakabuski: Thank you very much to all the presenters today.

I'm going to start with you, Brad Saunders, and thank you very much for joining us today and for your presentation.

I've been around long enough to remember when the way we treated those with developmental disabilities in our society was a far cry from what it is today. We're certainly grateful for the changes.

I remember, growing up, that I started grade 1 at the same time as a young boy who was really, really struggling. I think he was only there for grade 1, and then he disappeared. He was taken away to Smiths Falls, to Rideau Regional. I remember getting in touch with him again once he was an adult and I was running a hardware store in little old Barry's Bay. Jimmy and I would chat every morning because he'd be out at 7 o'clock and I'd be out at 7 o'clock cleaning up in front of the place and making sure we were ready to open those doors. Those were some of the best conversations I ever had, because he was such a sports fan. He could tell you who scored all the goals the night before, who hit the home runs and all of this—great conversations. I'm grateful that we have a community living system—because he returned to Barry's Bay as an adult—that has changed the lives of so many.

I have a nephew who is 41, who is in the community living system. Our daughter, who is also 41—I shouldn't be telling you ages—worked in it, and now she is working for the board of education. She spent years working with autistic children. She was a specialist in that regard.

So I do want to thank you for the work that you do as an organization—but all of the people who have dedicated so much of their lives.

In those organizations, we have DSWs. That is the bottom of the pay scale, basically. I spent 15 years in opposition and almost four now in government meeting with those workers and their representatives—and how they were challenged with difficulty negotiating with the government at the time for 15 years about being recognized for the work that they do.

The pandemic exposed a lot of weaknesses that were pre-existing, but it has given us an opportunity to pause and reflect on where the impacts are in our system and what we can do better.

1530

You talked a little bit today, Mr. Saunders, about the wage enhancement. Can you give us more on making it

permanent for DSWs and PSWs? Can you give us a little more meat on that bone, if you would, about how this is going to impact the lives of those workers and, by extension, the lives of every client that you serve in Community Living?

Mr. Brad Saunders: Thanks for your comments. I really appreciate the personal experiences that you've had. That's great to hear.

When I knew I was coming here, yesterday afternoon I sent an email out to our staff and said, "Tell me how this $3 an hour is going to impact you as an employee." I was planning to incorporate some into my time, but there were so many that it was hard to pick and choose. But it's a significant impact—anywhere from a supervisor saying, "My son got married, and I was able to put aside a few extra dollars towards that wedding," to somebody saying, "I could quit my second job," which I sort of talked about. The impacts are vast.

What we find with the $3—again, I think of it in terms of an investment. It's people choosing this career and then being able to stay in this career and make a go of it. When we're giving relatively anemic increases of a few hundred dollars a year, or less than a third of the rate of inflation, it's not an attractive job to get into and to stay in.

I'd encourage governments, as you said, to really take the pause and look at how we got to where we got to. It was decades of underpaying staff and not funding organizations—to be able to do that. This three bucks is a nice correction, but we would do ourselves a disservice to not consider how to continue that in the future and invest so that for the next pandemic, the workforce is strong, the organizations are strong and the families are well supported with workers who work in their home.

Mr. John Yakabuski: Well, I can tell you that it takes a special person to work in that field. I have these conversations with Heidi, our daughter. Heidi would say that she doesn't want my job, but I conversely say, "Heidi, I couldn't do your job." It takes a special person to be able to do that, and we're grateful for all of those people.

Mr. Brad Saunders: Yes. I cannot say enough about our workforce.

Mr. John Yakabuski: Thank you so much for being with us today.

The Acting Chair (Mr. Logan Kanapathi): MPP Cuzzetto.

Mr. Rudy Cuzzetto: I want to thank Brad for being here. I was reading here that your organization has been around since 1948, and you have 80 locations—well, pretty well—in the GTA. I want to thank you for all the work that you're doing in the community.

I'm involved, in Mississauga–Lakeshore, with DEEN Support Services, which does this type of work to help people with disabilities. As well, we're trying to bring in the first-ever YMCA abilities centre into our riding. What we're trying to do is train Paralympians in this facility. It would be right at the corner of Lakeshore and Mississauga Road, at a new development that's happening there. I've been working very closely to get this into our riding, because it would be good if we could do that for the future for the people in the province Ontario.

I want to talk again about the $3-an-hour enhancement. Will that help retain and hold our PSWs in this field?

Mr. Brad Saunders: In developmental services, it's DSWs, but I take what you mean.

Absolutely. We have tracked this fairly closely. The pandemic was obviously a different time—

The Acting Chair (Mr. Logan Kanapathi): You have one minute left.

Mr. Brad Saunders: Sure—so what's a regular turnover rate pre-COVID versus post-COVID? Our experience has been, if you provide a living wage and people are able to earn an income that they can live off of, they're more likely to stay and progress through an organization. So it absolutely will help with retention.

Mr. Rudy Cuzzetto: How much time do we have?

The Acting Chair (Mr. Logan Kanapathi): You have 51 seconds.

Mr. Rudy Cuzzetto: Okay.

On our RPNs: Will you help us lobby the federal government for funding to increase our funding to our health care system in all the provinces across Canada to 35% from 22%?

Ms. Dianne Martin: I think that we have a really solid understanding that the ability provincially to fund our health care system is—

The Acting Chair (Mr. Logan Kanapathi): Thank you. I'm sorry to cut you off.

At this time, we are moving on to the official opposition members. MPP Michael Mantha.

Mr. Michael Mantha: Nicolas Smit, be prepared. I'm going to be coming back to you, because you were singing to my ears.

Brad, my son is a DSW up in Sudbury. Prepare yourself, because he's going to be going somewhere in that field. I took a few notes here—that dedication and passion is something that I learned from my son and his teachers as he was growing up to through school. The impact is going to impact my bank account—giving him those increases. Anyway, it does take a special person to get into that field, and I recognize a lot of the benefits that they bring not only to their clients but to the community as a whole.

Dianne, repealing Bill 124 would be a huge step, which isn't included in this bill. And yes, a front-line worker is a front-line worker is a front-line worker, and you definitely deserve those increases, as does everybody else in this province.

Nicolas, my friend, I want you, in a 30-second elevator version, to tell me—I don't know if you can see me, but I want you to describe the benefit of this particular mask, what it does and what it doesn't do.

Mr. Nicolas Smit: It's more what it doesn't do. It doesn't protect from airborne transmission. The sides leak. They're not a tight fit, which is why health care workers have been asking for N95s and elastomeric respirators—because it has a tight seal. It does provide some droplet protection, but so do N95s and elastomeric respirators.

The surgical masks can be useful. But you need to pair it with a mask bracer so that it does seal, so that there are no edges around that can let the air in and out.

Mr. Michael Mantha: When you talked a little bit earlier about the actual supplies that are available in the province—this is an N95 mask that is being produced by FNPI, First Nations Procurement Inc. They're a branch of Dent-X Canada. They're producing those masks in both Wiikwemkoong First Nation on Manitoulin Island and in Sagamok First Nation on the North Shore and at Dent-X here.

Would you be surprised if I told you that I was standing in a warehouse with between four million to four and a half million masks that are available to this government—in order to make them available to not only our hospital staff but to our visitors who come into hospitals, long-term-care homes and each and every student in this province?

Mr. Nicolas Smit: I'm not surprised. This is actually a common problem. Eclipse Automation's CEO, Steve Mai, warned CTV News in February of last year that the same thing was happening to his company. He had, I believe, 15 million Health Canada-approved N95s, and the Canadian and Ontario governments didn't want to buy them, even though they were being made in Ontario. They only wanted to buy 3M N95s from the Brockville plant because of the contract they signed. There was even a June 22, 2021, Ontario Health internal meeting called a "knowledge exchange," where they explained that hospitals in Ontario want to only fit-test health care workers on 3M respirators going forward. So it's going to be more common than not in the future.

Mr. Michael Mantha: I want to describe to you what happened to me when I went to a hospital. I was wearing my N95 mask, which is not only safer for me but for those around me. I was disarmed. I was told to take it off and put on a mask that doesn't protect me at all, and I was told that this is the policy that is being imposed at all of our hospitals in Ontario, at all of our long-term-care homes. We are being disarmed, and we are putting our loved ones and those who are most at risk in danger. Why are we doing that?

Mr. Nicolas Smit: It's because the government guidelines allow you to go to the minimum. Most people don't realize that N95s and elastomeric respirators offer the higher levels of protection.

The other danger, besides just going to another mask, is that when you remove your mask in the entrance of a long-term-care home, for example, or a hospital—the virus can stay suspended in the air. So not only do you risk yourself putting on a more dangerous mask that won't protect you, but you're also exposing yourself to a fleeting exposure of COVID. It no longer takes 15 minutes to infect an individual; it could take mere seconds to infect somebody, and that person doesn't even have to be in the same room, since the air can linger for hours.

Mr. Michael Mantha: So if we have these masks that are available, and it has been known—and just so you know, for your information, I've been raising this for months now. I've provided a mask to each and every one of the MPPs inside the Legislature, to security, to Hansard, to the Clerks, to the Speaker of the House. They've been provided to each and every individual in this House. They are there. They're available.

Why wouldn't the government even reach out or return a call to let this Ontario company know, "We have a problem with your price," or "We have a problem with your quality." One way or another, the company would be able to address the question, but if there are no questions that are being asked—why is that? Why wouldn't we look at what is being produced, a stone's throw away from us, that would significantly change the spread of this particular virus, not only in Ontario but across this country? Why aren't we taking those steps?

1540

Mr. Nicolas Smit: It's very important, even, for example, when it comes to teachers. Teachers can really benefit from using those FN95 masks from Wahnapitae First Nation and Sagamok First Nation. It's not just health care workers who can benefit.

Every single government employee should be given an N95, at a minimum, and then government employees will no longer have to worry about getting infected and bringing that infection home to their families—because not only when they bring it home to their family do they infect their partners and children, but that ends up continuing the cycle of transmission because those kids bring it to school, and their spouses or partners bring it to their workplace and continue it.

So protecting workers with N95s, at a minimum—especially government employees, when the government is responsible for their safety—is going to help stop a lot of community transmission in addition to workplace outbreaks.

Mr. Michael Mantha: Interestingly enough, the supply that the government did have—

The Acting Chair (Mr. Logan Kanapathi): You have one minute left.

Mr. Michael Mantha: Okay. This will be more like a statement.

The government provided over 900 dental facilities or businesses with N95 masks, free of charge. Would you not think that it would have been beneficial to provide them to those students who, when they went back to school after March break, were concerned about being exposed from long exposures—as far as being away from the schools and then coming back and gathering in those incubators? But those N95s were not provided to students. Are the lives of students not as important, are the lives of our seniors not as important as dental offices? I'm not taking away from dental offices; those are important as well. But do you not think, when we have an Ontario-made product here, available to us—why wouldn't we have made that available?

Mr. Nicolas Smit: Absolutely. We have the means to make schools safe, so why don't we?

Mr. Michael Mantha: Thank you very much. I really enjoyed our discussion.

The Acting Chair (Mr. Logan Kanapathi): We are moving to the independent member. MPP Hunter.

Ms. Mitzie Hunter: I want to see if I can go back to WeRPN, just for a little bit of clarification around the foreign-trained nurses and how they can be incorporated. I know that the government introduced a recruitment, but I also recall that there was concern that the hours that these workers were providing was not going to be counted towards their accreditation certification, even though they were being supervised in learning and participating in the health care field. Can you speak to that and what your stance is on bringing some of these resources into a system that, perhaps, is short right now?

Ms. Dianne Martin: We have traditionally made it very, very difficult for foreign-trained health care workers to become regulated in our province. What you're talking about is the pressure of the number of hours needed, and sometimes in a limited time, because they are going to have to go back to their old country if they don't become registered in a certain period of time.

What we've been advocating for and what I think all of us have been working on is a streamlined process to become registered in the province that recognizes knowledge and experience, and tests skills, so that people can become regulated and safe to work in our province in a much more rapid fashion.

Ms. Mitzie Hunter: Do you believe that the province has given the right support to make that happen, at this stage?

Ms. Dianne Martin: Well, I've heard various support and various committees, but I haven't seen a close alignment—I think we are being allowed to move forward with these things, and I do think that they will come to fruition. I think there has been great work done at the national level, to set some standards at that level. Those are trickling down to us here, as well. And I'm not feeling huge barriers in making those changes right now.

Ms. Mitzie Hunter: Thanks so much for the work, Dianne, that you and your members are doing. Please extend that appreciation.

Nicolas Smit, I want to thank you for your passionate presentation and for providing this committee with—we are talking about emergency preparedness, and the role of masks and who gets them and who doesn't is really important.

This morning, the minister was present before the committee, and I had a chance to say that I know that in the long-term-care system, for instance, at the beginning of the pandemic, they were not easily able to get the appropriate PPE, including masks and other types of protection, while we were trying to diagnose what was happening with this virus. We know that the elderly were the most vulnerable, and many of them were passing on, very tragically and unfortunately.

The Acting Chair (Mr. Logan Kanapathi): You have one minute.

Ms. Mitzie Hunter: The role of masks and PPE is really important, and the knowledge of how to use them correctly is extremely important. So thank you for being here as well today.

And, of course, Brad Saunders, whatever we can do to support DSWs in the incredibly important and valuable work that they do in this province, including recognizing that they are front-line people who are working as well—I think that is also very important. So thank you for that.

The Acting Chair (Mr. Logan Kanapathi): We are moving on to the government members. MPP Cuzzetto.

Mr. Rudy Cuzzetto: I'm going to return to Dianne from WeRPN. I'm sorry I couldn't finish the question there. I want to thank you for all the work that you do as well.

At one time, the federal government used to support health care in the provinces 50-50; now it's down to 22%, and we have to supply 78% of it. We've asked the federal government to increase that to 35%.

Will you help us lobby the federal government in that support so we can get more money for health care in the province and all across Canada—because all Premiers are asking for the same thing.

Ms. Dianne Martin: Thanks for giving me a chance to finish that answer.

We definitely get the connection between that transfer payment from the federal government to the provincial government. Certainly, we have been and will continue to be vocal in ensuring that that particular transfer payment from the federal government is adequate to provide the health care we need.

Right now, our system is really pressed to be able to have enough care providers and pay them appropriately. However, I do believe there is an opportunity, even with what we have now, to pay nurses appropriately.

But, yes, we will always be looking at that transfer payment and giving comment on it. The numbers you've given me today—I can't say that we have looked at those particular numbers, but we have always understood the connection.

Mr. Rudy Cuzzetto: I want to thank you for joining us to lobby the federal government for that funding to help health care and to sustain health care moving forward.

The bridging of education grant: RPNs will receive up to $10,000 a year in financial support. As well, the program is expected to graduate 2,900 RPNs by 2024: 700 for the home and community care sector and 2,200 for the long-term-care sector. The program is expected to graduate 1,250 RNs by 2024: 900 for the home and community care sector and 350 for the long-term-care sector. Do you think doing this will help us retain more RPNs and PSWs and everything across the board?

Ms. Dianne Martin: The answer is yes. I think it gives a bright future to people who are thinking, "I don't even know, really, what I can sustain anymore." When they see the bright future of being able [*inaudible*] career trajectory that is very promising, it will retain people. In fact, many of the initiatives—no one initiative will retain nurses. Many initiatives are needed to retain them. But one initiative will cause them to leave, and that is not paying them adequately for the education and the work they have to do.

So while we think the BEGIN program is great—and so do nurses, by the way, and PSWs—we've had a lot of uptake in that program, particularly RNs to RPNs [*inaudible*] the numbers if we don't fix the situation.

1550

Mr. Rudy Cuzzetto: Thank you very much for that answer.

I'll go back to Brad from Community Living Toronto. What other things could we do to help move this forward much better for DSWs?

Mr. Brad Saunders: I mentioned in my remarks that $3 an hour has been in place for a couple of years now. DSWs have become used to seeing the $3 net per hour worked into their paycheques. If it's simply rolled over, outside of the emergency order, into our base budgets and distributed amongst staff, that will create some implementation issues for us that I hope government considers—one being the mandatory employment-related costs: CPP, EI, the sorts of things we all have to pay. There are different levels of retirement or pension funds that need to come out of that—union dues, that type of thing. It can't just be three bucks; it should be three bucks plus mandatory costs if we want to see that impact for workers.

The other thing: As a commitment to an ongoing commitment to our sector, to other public sectors, PSWs, whatever it might be—there are not two tiers of public service. If you're in one part of government delivering a particular type of service, your wages are—1%, 2%, 3%—keeping pace with inflation, but if you're in other sectors that are deemed less valuable, less important, you're not getting increases that are even matching 1%. So that would make a huge difference in making the system more sustainable.

Mr. Rudy Cuzzetto: How much time is left?

The Acting Chair (Mr. Logan Kanapathi): You have two minutes and 30 seconds.

Mr. Rudy Cuzzetto: Does anyone else have questions?

The Acting Chair (Mr. Logan Kanapathi): MPP Will Bouma, please go ahead.

Mr. Will Bouma: Thank you, Chair, and through you, I'd like to thank all the presenters for coming to us today. I really appreciate your time and your dedication. I'm so fascinated to hear the insights from people who work on the ground in these different situations, and to hear exactly what you have to say to this committee.

I'll start with Mr. Saunders. What are the lessons learned in your organization from COVID that you would like to bring to us moving forward?

Mr. Brad Saunders: Great question.

We're still just coming out of it, so some of the lessons learned are still to be documented and categorized.

We did a couple of things right out of the gate. We were early in giving our staff increases that were not funded—we didn't know where the money was coming from at the time, but we thought it was important to show staff that we were behind them and we had their backs. We covered some costs around people not being able to take public transit. People will remember early on that we didn't know what was going on. We communicated a lot with our staff. We really showed them that the work they were doing was valued. We made sure we had PPE when it was very hard to get.

The Acting Chair (Mr. Logan Kanapathi): You have one minute left.

Mr. Brad Saunders: The investment in staff and putting forward that effort, that energy, really pays dividends, and the people we support benefited from that. We did not see the negative impacts in other sectors in our sector because of the way we were structured and a number of other factors.

Mr. Will Bouma: Dianne, do you have anything to add in the last 20 seconds or so we have left?

Ms. Dianne Martin: One of the big lessons is that we found out how human care providers are and how they're so engaged in the quality of care, the provision of quality care, that they were traumatized when they were faced with not being able to be the very best they could be. It gave us a new insight into who care providers are, and they have my thanks every day for that.

The Acting Chair (Mr. Logan Kanapathi): We are moving on to the official opposition members. MPP Mamakwa.

Mr. Sol Mamakwa: Meegwetch. Thank you, Brad, Dianne and Nicolas for your presentations.

I'm Sol Mamakwa, MPP for the riding of Kiiwetinoong, which is in far northwestern Ontario.

I think one of the things that I see happening with this rapid legislation process that we see happening—as First Nations people, we've always been taught to do things carefully. If you're going to build it, take the time to build it right.

Dianne, I know that this bill is this government's way of fulfilling its promise to increase wages of PSWs. However, we see that the bill says nothing about increasing the pay for registered practical nurses, who have also worked tirelessly, especially during this pandemic.

Can you articulate what this government can do to ensure that RPNs are also paid fairly for the important work that they do?

Ms. Dianne Martin: Well, of course, ultimately, all people in Ontario should be able to negotiate their own wage levels with their employers. But outside of that, and more immediately, I think that recognizing the impact this particular situation has on wage compression between those two—and the fact that it is cited to me as the one reason that RPNs are leaving these days. It isn't worth it to them to stay, with the incredible workloads and trauma they see, when they are losing people and working in a way that they can't—they have too many patients assigned to them, because there are so few nurses. They can't provide care in the right way, and it's the last straw. That solution can happen immediately in this bill, in the regulations—if they were to include RPNs in that.

But ultimately, I'm looking forward to the day when we return to negotiating our wages in a way that recognizes everybody's input into those negotiations.

Mr. Sol Mamakwa: So that would help—if the government repealed Bill 124?

Ms. Dianne Martin: Oh, yes. I think for many people—not just nurses and PSWs and DSWs. I think it would be impactful for many professions who are feeling a real pressure these days in the face of inflation and those sorts of things, when they are facing Bill 124. Ultimately, yes, that needs to be the goal for all of us.

Mr. Sol Mamakwa: When we talk about the impacts on patients, the Ontarians we provide service to—how does this continue to impact the patients we serve?

Ms. Dianne Martin: Do you know why we don't talk about that as much? It's because it hurts too much.

I have a daughter who's a nurse, and she'll come home and tell me about the day she's had, where she had to take care of twice as many patients as she usually does. The pain in her eyes when she describes the bits of care that didn't happen, that provide dignity and care to others, breaks my heart. That's what I hear from all sorts of nurses—the tremendous trauma they have when patients are in need of the basics of comfort, and they cannot provide it because of the shortages of staff. We actually don't talk about it as much as we should because of the pain involved. That is our purpose for being there, and that is where the trauma is coming from.

Thank you for asking that.

Mr. Sol Mamakwa: Thank you for that answer.

Brad, maybe you can answer that question as well—the impact on patient care, the impact on patients themselves, the people we service, on the increase for the PSWs?

Mr. Brad Saunders: Individuals with a developmental disability who we supported across the city had a really tough time during COVID-19—unable to leave home, in places where parents weren't able to visit. We found that the impact was pretty significant. We did as much as we could virtually—staff giving people tools; we did deliveries of boxes and fun stuff—but as was said, the impact on staff was traumatic. We had five people lose their lives through COVID: two of our staff members and three individuals we support. To still see people rally and come to work and get behind that in a very scary time was remarkable.

So I agree that trauma is going to be something that we'll have to deal with, and people resetting to a new normal. We'll have to deal with that as it comes. But we're certainly expecting to see more of that within our workforce and with people we support as well.

1600

Mr. Michael Mantha: How much time do we have left?

The Acting Chair (Mr. Logan Kanapathi): You have one minute and 30 seconds.

Mr. Michael Mantha: That's perfect.

Nicolas, can you please make an effort to reach out to my office so you and I can connect? I would really like to have some follow-up discussions with you. My name is Michael Mantha. I'm the MPP for Algoma–Manitoulin. Please reach out to my office. We need to have further discussions.

Dianne, 50,000 RPNs across the province—a lot of them feeling the pressures, a lot of them feeling the disrespect.

Do you have any statistics in regard to how many RPNs have actually decided to walk away (1) because of the burnout; (2) because of disrespect; and (3) just because of everything that has been put on their shoulders with their additional duties and their scope? Do you have those numbers?

Ms. Dianne Martin: A year ago, our surveys showed us that 34% were considering leaving the profession. We believe that it's quite a bit higher now, just because of the resignations that come through our membership, across our desks, and their reasons for leaving. We're getting ready to repeat that survey—but a year ago, 34%.

The Acting Chair (Mr. Logan Kanapathi): Thank you.

A reminder to all presenters: The deadline for written submissions is 7 p.m. on Wednesday, April 6, 2022.

ONTARIO EQUAL PAY COALITION

NORTHERN ONTARIO SCHOOL OF MEDICINE UNIVERSITY

CANADIAN ASSOCIATION OF PPE MANUFACTURERS

The Acting Chair (Mr. Logan Kanapathi): I will now call on the Ontario Equal Pay Coalition. Please come forward.

Welcome. Please state your name for Hansard purposes. You may begin now.

Ms. Fay Faraday: I'm Fay Faraday. I am the co-chair of the Ontario Equal Pay Coalition. It is a coalition of businesses, professional organizations, labour organizations and community organizations that has, since 1976, been the primary advocate for pay equity in Ontario. I want my submissions to be focused on schedule 7.

What I want to say off the top, just so you get the highlights, is that schedule 7 of Bill 106 is unconstitutional. It violates public and broader public sector workers' charter rights to freedom of association. It violates women workers' charter right to equality. It eliminates workers' rights to challenge government interference with their pay. And it eliminates fundamental pay equity rights by defining pay equity obligations of the government out of existence. Instead of repealing Bill 124, it doubles down on this. And all of this has been presented in a way as if what is happening is a gift to women. The government has, in the Hansards, in introducing the bill, said that this is to enable RNs to get their one-time $5,000 retention pay, and that it's to enable making the $3 pandemic pay permanent for PSWs. But what it doesn't tell you—and it wasn't apparent anywhere in the Hansard—is that in order to do that, they're ripping up pay equity rights. And they're doing that a week before Equal Pay Day, which is next week, on April 12. In the current arc of how this is proceeding, this bill will be introduced on Equal Pay Day, which is an added insult to women.

What we're asking is that schedule 7 be repealed. What I want to emphasize is that the government does not, in any way, need schedule 7 in order to make the payments indicated to women. What it needs to do is repeal Bill 124 and then exercise its budgetary power, which it already has, to make the wage enhancement grants, to ensure that the services in the broader public sector that have been relied on so heavily during the pandemic are funded at an appropriate service level, and that the workers who are doing the work are being funded at a level that provides them with living wages.

ad, what's important to emphasize is that the bill introduces a compensation package which is entirely to be developed in regulation, which gives the government unilateral power to distribute wage increases to occupations as they choose. What they've done by Bill 124 is stopped unions from being able to negotiate pay increases, and they are giving themselves unilateral power instead to distribute that. That is the very definition of an unfair labour practice. The government has introduced provisions here that prevent workers from challenging it in any form, giving themselves to the power to engage in unfair labour practices, and removing the liability for doing so.

More importantly, they also define out of existence pay equity obligations. What they've said is that they'll give increases to folks. Right now, if you see my lower hand that's down by my chin, that's the PSWs in the broader public sector. Here they are in the hospitals. The gap between them is the existing pay equity gap. They're the comparators for each other. If they both get a $3 increase, the size of that gap is exactly the same. But what the government has done—it has said, "For these folks who are at the lower level, that $3, we're going to pretend that it shrinks the gap." But it doesn't.

What they've done in that is defining out of existence a pay equity debt that it owes to women, but it does it in a way that's not confined to this situation. It carries that forward. It overrides the Pay Equity Act, which has always said that those kind of wage enhancements which are necessary to retain workers are excluded from pay equity calculations, that any general bargaining increases are excluded from pay equity calculations, because they don't shift the gap at all. The government is using this opportunity to give women what appears to be compensation for the pandemic but in exchange is eviscerating their pay equity obligations. That is a continuation of over 20 years of attacking pay equity in the broader public sector. This is a human rights remedy, and the government is depriving them of a systemic human rights remedy for wage discrimination.

The government tried to repeal this, back in 1995. A charter challenge was brought, striking down that legislation. The government's next response was to decide it wasn't going to fund it. Another charter challenge was brought, finding that the government had to actually pay that. And the government has spent the last 15 years challenging this in negotiations before the pay equity tribunal, all the way up to the Supreme Court, which, last year, said, "No. You actually have to pay—

The Acting Chair (Mr. Logan Kanapathi): You have one minute left for your presentation.

Ms. Fay Faraday: Yes. The Supreme Court of Canada, last fall, told the government, "You have to pay pay equity wages. Those women in the broader public sector who are getting less need to be brought up to their comparator." The government's response is to define that gap out of existence rather than actually paying the money.

What we're calling for is that Bill 124 be repealed—that schedule 7 be repealed and be replaced by a provision repealing Bill 124 in its entirety. The government can make these payments to workers using its existing budgetary power and does not need to rip up collective bargaining rights or pay equity rights in order to do it.

The Acting Chair (Mr. Logan Kanapathi): I will now call on the Northern Ontario School of Medicine University to please come forward.

Welcome. Please state your name for Hansard. You may begin now.

Dr. William McCready: I'm Dr. William McCready. I'm a professor of medicine and vice-dean of clinical relations at NOSM University. Thank you for the opportunity to speak before you today to address pandemic and emergency preparedness.

Founded in 2002, NOSM has much to show for its short history. The university's unique distributed community-engaged learning model has grown into something extraordinary. This model includes strong ties and engagement with remote, rural, Indigenous and francophone communities. It features partnerships and collaborations with more than 100 organizations in more than 90 communities and with more than 1,800 clinical, human and medical sciences faculty dispersed across all of northern Ontario. NOSM has produced 780 MDs; 55 self-identify as Indigenous, and 165 self-identify as francophone. In addition, 692 residents have completed NOSM programs. More than half of these health practitioners have stayed in northern Ontario, with a majority establishing their practices in Sudbury and Thunder Bay.

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The health care needs of the northern population are complex—having the most vulnerable, unhealthy population of any geography in Ontario. We have the highest rates in the province for addictions, mental health issues, cardiac disease, cancer and diabetes. We also have an aging population and a life expectancy that is, on average, two years lower than the rest of the province, and a high number of Far North and remote First Nations communities who face food insecurity, long-standing boil-water advisories and high rates of chronic diseases. This is the perspective I bring to our topic today.

The COVID pandemic took the world by storm and proved that our health care system was not prepared for a crisis of this magnitude. We have learned a thousand lessons with every pivot that we have made, but the reality is that we can do better. There will certainly be another pandemic, and we must be better prepared, beyond the obvious need for adequate PPE. The solution is greater than the sum of the parts. PPE, sustainable health care

resources and a flexible system that adapts to the needs of our community are required.

Despite NOSM's success, we know that northern Ontario is dangerously short of doctors; more than 300 are urgently needed. Our daily news is peppered with stories about overworked physicians, exhausted and frustrated, leaving communities after trying to hold it all together. Urgent care clinics have been cancelled because of the lack of human health resources. Some emergency departments are hanging on by a thread, the doors barely propped open by a locum or two.

Our First Nations communities are at a severe disadvantage in northern Ontario. There are more than 100,000 people who self-identify as Indigenous, and there is a marked inequity in the impact that this pandemic has had on these peoples.

By any fair and decent standard, the health care picture in northern Ontario has always been extremely fragile. It is well time that we build a solid foundation to prepare ourselves for the future.

On March 15, 2022, the government of Ontario announced the expansion of medical education across the province. With this announcement, NOSM University will see an added 30 medical degree and 41 residency spots over the next five years. Increasing the number of undergraduates and postgraduate medical education positions at NOSM University is a great start in addressing the physician shortage, but more is needed. Ontario needs a sustainable workforce, of which medical education and training is critical. Clinical education must be considered an integral component of a sustainable health care system, and physician resources are required to enable high-quality, accessible care in the context of a teaching-and-learning health care system in which learners are trained by those same physicians who provide equitable, high-quality care.

Medical residents are also an integral part of the health care system. As new physicians working towards their independent practice, they continue to learn a variety of specialized knowledge and skills, and they often serve as teachers for medical students during their clinical clerkship.

Since COVID-19 changed the world as we know it, our residents had to adapt in every possible way. Hands-on training was more difficult, access to surgical procedures diminished, redeployment to areas of critical need—often outside their scope of speciality—impacted their training, all the while having conditions, guidelines and directives changed on the fly. Loss of training in their primary specialty and redeployment to areas of critical need may have doubly impacted their educational and clinical work.

The concept of an integrated teaching and clinical service workforce is the key to the future success of sustainable health care delivery for the region and to building a more resilient health care system.

The Acting Chair (Mr. Logan Kanapathi): You have one minute left.

Dr. William McCready: Thank you. NOSM University has been incredibly successful in providing health care leaders and physicians in northern Ontario, where the need is the greatest. We will continue to build a flourishing physician workforce for northern Ontario, locally integrated with the health care system and connected to a regional network, with permanent care as the strong foundation, and supported by robust, accessible speciality services across all of northern Ontario.

In summary: (1) we need to be better prepared for the next pandemic; (2) it must go beyond the obvious needs of adequate PPE; (3) Ontario needs a sustainable workforce, of which medical education and training is critical; (4) the expansion of medical school seats, as it has been announced in March of this year, is a major step in the right direction; and (5) NOSM University has been incredibly successful in providing health care leaders and physicians to northern Ontario, where the need is greatest.

Thank you for your attention.

The Acting Chair (Mr. Logan Kanapathi): Thank you.

Next, I will call on the Canadian Association of PPE Manufacturers to please come forward.

Welcome. Please state your name for Hansard purposes. You may begin now.

Mr. Barry Hunt: I'm Barry Hunt. I'm the president of the Canadian Association of PPE Manufacturers. I would like to thank the committee for the kind invitation to present to you today.

The Canadian Association of PPE Manufacturers, or CAPPEM, is made up of 30 Canadian-controlled private corporations—SMEs—who answered the government's call to action to produce PPE here in Canada. Twenty of our members are located right here in Ontario. SMEs make up 99% of the Canadian economy and employ 90% of the private workforce—10 million Canadians, with four million of them right here in Ontario. SMEs are the economic engine of Canada, and we are here to help.

Ontario has shown great leadership in support of domestic manufacturers. Several Ontario PPE companies were recipients of Ontario Together funds, and some Ontario companies received provincial contracts for the supply of PPE, and we're thankful to the province for both. We've had very productive dialogue with MGCS over the past year and are now hopeful that the Personal Protective Equipment Supply and Production Act in Bill 106 will result in building a strong PPE industry here in Ontario.

You may remember that, at the start of the pandemic, the National Emergency Strategic Stockpile had expired and our N95s had been destroyed. Canada had no domestic PPE manufacturers, because Canadian hospitals only buy PPE from multinationals that source from foreign countries. That needs to change. Canada was desperate to buy PPE, but the multinationals couldn't deliver when we needed it most, because China and the US—the world's major producers of N95s—had banned exports. We were forced to overpay to buy foreign products of dubious quality in a fierce global competition.

At the federal government's request, we set up our own PPE industry in Canada almost overnight. We even had to create our own CSA national standard for N95s because

Canadian companies were banned from US NIOSH certification. Two years later, the US has still not allowed one Canadian company to get NIOSH approval. When the chips are down, we simply cannot rely on foreign countries or multinationals to protect us.

CAPPEM was created to ensure Canada would never again be vulnerable to foreign countries or multinationals for the supply of PPE.

Innovation drives Canada's economic growth, and nowhere is this more evident than here in Ontario. There has been more innovation here in the PPE industry in the past two years than in the previous 50 years worldwide. In Waterloo region, where I'm from, we've created world-first easy-breathing nanofiber filter materials, compostable fiber materials, and new highly protective elastomeric N95s that look like cloth masks. For Canada's new, very own N95 standard, CAPPEM lobbied hard to specify the easiest-breathing, highest-performance requirements in the world, because we make the easiest-breathing, highest-performance N95s in the world. Ontario health care workers deserve the easiest-breathing, highest-performance N95s in the world, and now it's up to us to find a way to work together to make that happen.

CAPPEM has also developed the world's first industry standard for bioaerosol masks—a brand new category to protect the general public and health care workers from virulent airborne disease. A bioaerosol mask is light and easy to breathe through, like a surgical mask, but offers the fit, seal and airborne protection of an N95.

There is no national stockpile today of masks suitable for protection of the general public against virulent airborne disease. We believe this is a major failing in emergency preparedness. Fourteen major variants of concern, with progressively increasing transmissibility and vaccine escape, have already emerged, and more are on the way. We need to prepare for the very real possibility that we may someday face a more lethal virus, now or in the near future. Canada's eight-week stockpile of N95s would be gone in eight days if this were to happen, and we have nothing in our national stockpile to provide to millions of children.

We believe Ontario could, and should, take the lead in being the first major government in the world to procure, distribute and stockpile bioaerosol masks to protect their citizens.

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The federal government invited multinational companies to manufacture N95s here on Canadian soil, with plants bought and paid for by Canadian taxpayers. 3M and Medicom were given sole-source contracts in the order of $600 million to sell in competition against Canadian SMEs. This undermines the entire domestic Canadian PPE industry. Hospitals, which have been buying foreign PPE for decades, gave long-term contracts to the same multinationals that now lock out Canadian companies for many years to come. The federal government promised to buy PPE from Canadian innovators but now says they no longer have an appetite for PPE procurement, and that health care is a provincial responsibility. So now we're counting on Ontario to lead provincial PPE procurement in Canada for both government and health care. Where Ontario leads, others will follow.

Over 100 Canadian companies answered the federal government's call to action, and 70% of them are now out of the PPE business. Many are now bankrupt. Others are on the way to bankruptcy.

The remaining CAPPEM companies, committed to a sustainable PPE industry, can produce 10 times more product than the 3M and Medicom contracts put together. But we need orders from government and from health care. A sustainable domestic PPE industry is absolutely the right thing for Ontario, to protect our economy, our health care system and our 14 million citizens. It has overwhelming public support, and now it needs government support to make it a reality.

Canada was unprepared two years ago for a virulent airborne pandemic; we are still unprepared today. The Public Health Agency of Canada believes that we are now well-situated with N95 respirator domestic manufacturers; I can assure you we are not. Canadian companies have been locked out of federal and hospital contracts for two years now.

We need to support our domestic PPE industry now—

The Acting Chair (Mr. Logan Kanapathi): You have one minute.

Mr. Barry Hunt: —with centralized provincial procurement, or it won't be there when we need it. We need Ontario's business. We need Bill 106. Thank you.

The Acting Chair (Mr. Logan Kanapathi): Thank you for your presentation.

This round of questions will start with the government members. MPP Ghamari.

Ms. Goldie Ghamari: Thank you for your presentations, everyone.

I'm going to spend my time focusing on some of the statements made by Dr. William McCready.

Dr. McCready, it's great to see you. Thank you for joining us today. I'm really glad that you're speaking about NOSM today, because as parliamentary assistant to the Minister of Colleges and Universities, this has been something that we have been working on, and I can say it's such a pleasure to see how the school is thriving and expanding. So I just want to talk a little bit about that.

Part of this legislation that we're introducing is to ensure that our government is able to make sure that Ontarians across the province—and especially in northern and rural Ontario—have access to health care and doctors.

As an institution which will be welcoming new medical students in the near future—can you please tell us a little bit more about how NOSM plans to help strengthen Ontario's health care system?

Dr. William McCready: NOSM, of course, is extremely happy to become NOSM U—just a very short time ago, on the 1st of April—and we're very grateful to the government for proclaiming our act in a timely fashion. In fact, my dean would have been here today to talk to you, but we're having our first inaugural board meeting to pass our first bylaws, as we speak. So we have great plans. We

see the future as a collaborative one, where we collaborate with northern institutions and northern communities.

We try to find the right students to enrol in our new university—students who will stay in the north after training. We know that if you come to our school and do your residency with us, you have about a 70% chance of staying to practise in northern Ontario, so finding those students who want to do that is our main goal. We want to try to become more sophisticated about our entry criteria, in trying to select those individuals, and we want a wider variety of residency programs to be able to keep our students here. We have quite a number of them, but we also lack quite a number. Very often, some of our students will go elsewhere for residency, and that decreases the chance of them coming back. We know that if you do both, you come back 70% of the time—and only about 50% of the time if you only do undergraduate and/or postgraduate. We really recognize that as a big opportunity to retain people—if we've got more residency programs.

We believe that the 41 new residency spots—some of those will go to expanding our residencies as we move forward with the royal college to certify them. We're hoping to start such programs as radiology, for instance, too, and that will provide a bigger opportunity.

Ms. Goldie Ghamari: I want to focus and unpack a statement that you made which I think is really critical. You spoke about student retention in the north.

Ensuring that northern Ontario continues to have strong access to health care is a priority for our government.

Would you be able to tell us a little bit more about how NOSM is working with northern communities to ensure that doctors educated in the north stay in the north?

Dr. William McCready: We have an associate dean of workforce planning in our school, Dr. Sarah Newbery—many of you may have heard her presenting at various functions—who is working with communities to understand the need better, and to try to help retain these individuals in the north.

We're starting, for instance, a rural medical stream, where students are able to identify very early in their undergraduate career that they're looking at a rural career, so they've got special training and special exposure to rural environments and teaching.

We're also starting a stream for Indigenous learners, who will be identified early in the course of their undergraduate education—that they want to try to potentially earn the skills they need to go back to Indigenous communities.

From an educational point of view, we're trying to select the right people who are suited to go to these places, we're trying to provide them with a clinical and learning environment that encourages their interest, and we're looking to the government to help to provide a work environment that will be attractive to them to stay. That's also going to be a crucial part of it. If the work environment is not attractive, then people will go elsewhere. Right now, the market is so heavily laden to underservice that a medical physician can go virtually anywhere in Ontario to work.

Ms. Goldie Ghamari: I'd like to have a bit of a conversation about the expansion of the number of students. Currently, there are 64 undergraduate medical education seats and 60 postgraduate positions. We recently announced—on April 1, actually—that NOSM will receive 30 additional undergraduate seats by 2026 and 41 additional postgraduate positions by 2027. This seems to be happening very quickly. NOSM became an independent institution right away, and now, all of a sudden, our government is working with NOSM to increase capacity so that more students can be educated and stay in the north. Do you think something like this would have been possible if NOSM was not independent? Or do you think there would have been more bureaucratic red tape layers? Is everything a bit more streamlined in the university now that it's a separate institution?

Dr. William McCready: Yes, I believe so. The only way we're going to be able to accommodate these students, especially in their clinical years, is to distribute them—

The Acting Chair (Mr. Logan Kanapathi): You have one minute left.

Dr. William McCready: —in a more equitable manner across the north. I think that the opportunities of being a stand-alone university, where we don't have to worry about the niceties of our host institutions, will be most helpful in ensuring that that happens.

Ms. Goldie Ghamari: I take it that everyone in the north is pleased with our government's decision to make NOSM a stand-alone university to support the health care system in the north.

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Dr. William McCready: We are ecstatic.

The Acting Chair (Mr. Logan Kanapathi): We are moving on to the official opposition members. MPP Sattler, please go ahead.

Ms. Peggy Sattler: Thanks to all the presenters for appearing today before the committee.

I am going to address my questions to Ms. Faraday, the co-chair of the Equal Pay Coalition.

Certainly, your presentation raised some very serious concerns about the impact of schedule 7 on workers' charter rights to freedom of association and on women workers' charter rights to equality in the workplace. I wondered if you could expand a little bit more on what the impact would be of this legislation, given the undermining of these charter rights.

Ms. Fay Faraday: First of all, this is an omnibus bill, and there is nothing in schedule 7 that is about pandemic and emergency preparedness. I just want to make that very clear.

What this does is, it's setting up this shell that will be filled by regulations, a shell of a compensation enhancement program. There are no details about it. It gives the government the authority to put pay increases in for any occupation, anywhere, temporary or permanent. That's a real problem in a context where the government has been talking about accountability and transparency. There is no transparency about what that program means, what it will consist of, what the extent of the powers will be. Right now, it's a blank cheque.

The government says that for any funding that is paid out under that compensation enhancement plan, if there's a pay equity debt that's owed, that payment will be deemed to be made for the purpose of achieving pay equity or maintaining pay equity. That completely overrides the collective agreement. It overrides the provisions in the Pay Equity Act.

What I also want to make clear is that achieving pay equity in the Pay Equity Act is defined as a process of negotiating the value of compensation, of pay, in occupations with a union, so to unilaterally deem this as having achieved or maintained pay equity also explicitly overrides those existing legislative obligations to negotiate this with the exclusive bargaining agent, and that's obviously a real problem. With Bill 124, they've created this ongoing power for the government to intervene in a pay structure explicitly where there is no agreement between the employer and the union. So right now, they've capped unions' ability to bargain in the public and broader public sector under Bill 124, and even though unions have been asking for these increases to pay that the government is now giving, they've refused to let them bargain them. They're giving them—appearing as a handout—right before an election.

What this provision does by creating this compensation plan and this ongoing power is that, even after Bill 124 is either struck down as unconstitutional or expires, they're going to continue to have that statutory power to interfere in wages and override collective negotiations; to make them moot by simply saying, "Well, we're not going to negotiate that," and then unilaterally give it. That is a very dangerous provision that not only gives them a continuing opportunity to interfere and increase wages where and when they want, over the bargaining wishes of the union, but it also then defines those payments as being pay equity adjustments, even though they do nothing to close that pay equity debt I was talking about. So if everybody in that classification goes up, the gap hasn't changed at all.

They're basically saying, with this legislation, "We're going to give you your one-time $5,000; we're going to give you your $3 an hour—but only to the jobs who we say get it, not to everyone who has actually been at risk on the front lines during the pandemic. And we're going to pay you with money that we already owed you." So if there's an existing $5 pay equity gap—that's not out of line; it's actually smaller than many gaps—they already owe workers $5, and they're saying, "We're going to give you $3, and we're going to pretend that we've paid you pay equity. Even though we've given everybody $3, we're going to say that we now only owe you $2." It's like stealing from Maria to pay Marisol. It's like the women are getting paid with the money that they're already owed, and it's being treated as if it's somehow a gift, and in the process they lose their bargaining rights and they lose their pay equity rights.

Ms. Peggy Sattler: You have a concern about the constitutionality of this legislation, as well as the constitutionality of Bill 124. Can you expand a bit on why this bill is unconstitutional, in your opinion?

Ms. Fay Faraday: Under section 2(d) of the charter, there is a right to freedom of association, which includes the right to belong to a union, to negotiate collective agreements—

The Acting Chair (Mr. Logan Kanapathi): You have one minute left.

Ms. Fay Faraday: —to go on strike.

What this does is—it's an explicit end run around the union. It says the government can give out money, even without the agreement of the union, which is a key union-busting tactic. And then they say, "There's no way you can challenge us doing that, and it's, by definition, not an unfair labour practice," even though in the law it is.

In terms of the equality issue, the people who are going to be affected by this are predominantly in female occupations, and they're being affected specifically in their pay equity remedy, which is a human rights remedy for sex discrimination in pay. So they are having their human rights remedy for systemic sex discrimination being defined out of existence, with no opportunity to challenge it, and that will affect their pay going forward, forever.

The Acting Chair (Mr. Logan Kanapathi): This round of questions will start with the independent members. MPP Hunter.

Ms. Mitzie Hunter: I would like to continue on with Ms. Faraday of the Ontario Equal Pay Coalition.

Did the government consult with you on the equal pay impacts in terms of this schedule 7 and Bill 106, in terms of how this legislation will impact women and will impact the whole movement towards pay equity? Did you receive any consultations?

Ms. Fay Faraday: No, we have not been consulted at all. We only found out about it when the announcement that it was going to committee came out. This was rushed through at lightning speed—between Tuesday and Thursday. The announcement of the hearings came out on Friday, and we had to respond on Friday about—no, we have not had any negotiation on it.

In fact, this is directly contrary to the litigation that the Ontario Equal Pay Coalition was involved in with the government. The government and employer groups were taking the position that they don't have to maintain pay equity in the broader public sector. We had to go all the way to the Supreme Court, before the Supreme Court said, "No, government and employers, you've lost this case. You have to maintain pay equity in accordance with the act." And instead of doing that, what they're doing is defining their debt out of existence. But it's still there, right? Women are still being underpaid. That's why they're leaving; that's why they have a retention problem.

So, no—exactly contrary to being consulted. This runs right against what the court has ordered must be done. It's a tactic, like I said, that has been going on since 1995. The government keeps trying to negate the pay equity rights of women in the broader public sector simply because it costs money. The Supreme Court has said that you can't use women as the shock absorbers of your economy; you can't build an economy on the backs of women by giving them discriminatory pay. But that's what they're doing, and this

doubles down on it and gives them the opportunity to do that going forward, even when Bill 124 [*inaudible*].

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Ms. Mitzie Hunter: I would agree with you. I believe that this government really does not consider pay equity for women and gender parity when it comes to legislation. I was in this very committee when, in 2018, the government struck out the enactment date of the Pay Transparency Act that was coming into effect on January 1, 2019, and there was no discussion. It just cancelled the enactment date and, therefore, that legislation is just sitting there now and not being enacted, not doing the work of closing the pay equity—the gender imbalance that exists.

I do want you to—

Ms. Fay Faraday: There had been extensive negotiations prior to that introduction.

The Acting Chair (Mr. Logan Kanapathi): One minute.

Ms. Fay Faraday: They said that they needed more negotiations. It hasn't really happened. Nothing has happened. We should have had our second annual pay transparency report this May.

Ms. Mitzie Hunter: So how has Bill 106 harmed women, and what are the solutions?

Ms. Fay Faraday: If it is passed in this format, what it means is that it's going to, again, deprive women of, collectively, millions of dollars of pay equity debt that they are owed by the government, and it will continue to erode both their collective bargaining rights and their pay equity rights. It will override collective agreements, and it will undermine their ability to negotiate pay equity properly under the rights that exist right now in the Pay Equity Act. All of this is being done by stealth. None of this was mentioned when the bill was introduced, none of it—

The Acting Chair (Mr. Logan Kanapathi): Thank you. I'm sorry to cut you off.

This round of questions will start with the government members. MPP Crawford.

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

I'd like to start my question with the PPE manufacturers. Thank you for all the work you've done through, obviously, a very difficult time—as it has been for a lot of individuals and industries living through COVID. Your industry has really been on the front line of it.

I want to start with a very general question at the outset. How will this particular act impact the PPE companies that you represent? I think you mentioned you had 30 companies, 20 based in Ontario. I know I've got some great companies in Oakville; I'm not sure if they're members of your organization—but certainly involved in the PPE. So I'm just curious to get your take on that.

Mr. Barry Hunt: We're very hopeful that Bill 106 will be transformative for our industry.

As I mentioned, the playing field has been tipped in the wrong direction by both the actions of the federal government—certainly, all good deeds have unintended consequences. So we're struggling right now to find a way into health care and into government procurement because of long-term contracts that have been given in both. The federal government gave long-term contracts to multinationals, and the health care systems have done the same thing.

There are three buying groups right now for health care, Mohawk Medbuy, Plexxus and HealthPRO, which basically represent 100% of the hospital purchasing in the country for thousands of line items—Band-Aids, tongue depressors etc.—and they've treated PPE in that same manner, as well. We have long-term contracts that extend until 2025 and 2028 throughout the country, which prevent Canadian companies and Ontario-based manufacturers from participating in that health care market where most of the PPE is purchased. So billions of dollars' worth of PPE is being purchased now under a long-term contract that Canadian companies and Ontario companies are not allowed to participate in. We're hopeful that Bill 106 will allow central procurement for the province to be able to supply not just provincial departments and organizations and agencies, but also hospitals.

We have great products that we have invented at the request of the federal government. We've invested a lot to create these great products. We have brand new standards now for these products, and we need to find a way to get those to market, not just for our business, but to improve the lives of the health care workers and people in the public sector who wear PPE today.

Mr. Stephen Crawford: The goal of our government has been to produce product in Ontario and, obviously, we want to be able to sell it in Ontario. We want to sell globally, but we want to sell in Ontario.

The percentage of forecasted PPE that will be produced here in Ontario over the next 18 months, I believe, will grow exponentially. Is that correct?

Mr. Barry Hunt: Yes. We could also produce far more here in Ontario than Ontario could ever use. We can supply the rest of the country, and we can supply enough for export.

Mr. Stephen Crawford: In essence, how would you contrast the difference in support from the federal government in terms of building and developing and supporting our industry versus the provincial government here in Ontario?

Mr. Barry Hunt: There are really two areas of support. The support for innovation and standing up in industry initially—the federal government did participate in innovation through the ministry of innovation, science and economic development. Then, there is the second piece, which is procurement. There has been no procurement from the federal government whatsoever, to date, from Canadian manufacturers.

Again, we found a lot of support here in Ontario initially to help some of the companies stand up—new businesses—in PPE. We've certainly found a lot of positive dialogue with MGCS towards a future where we can supply to the province from Ontario manufacturers.

Mr. Stephen Crawford: Obviously, our preference is to buy locally manufactured products, because it's money

back in our communities. We also have a fiduciary duty to get the best product and the best price, as does everybody.

Could you explain and give a sense as to how competitive we are here in Ontario, both in price and in the quality of the product that we manufacture, to give people assurances on that side of it?

Mr. Barry Hunt: Well, the quality is second to none in the world. We lobbied very hard against multinationals—one multinational in particular—to improve the performance requirements for N95s here in Canada when we wrote our standard. Our standard is a NIOSH-plus-plus-plus standard. We introduced two new levels of breathability, which is the first time any country in the world has done something like that. So we have very high-quality products.

We've very competitive price-wise, especially when you look at the economic impact back to the local economy. But even without that, we in Ontario have automations second to no one in the world and quality second to no one in the world. So we're able to compete on a level playing field. When you consider labour practice, for example, in your procurement, we can compete with anybody in the world.

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

The Acting Chair (Mr. Logan Kanapathi): One minute and 30 seconds.

Mr. Stephen Crawford: Again, we want to produce, manufacture and purchase here in Ontario. That's certainly our goal. But is there export potential for these manufacturers?

Could you give us a quick sense as to if other countries are protectionist or there are barriers there—particularly in the United States?

Mr. Barry Hunt: The US is protectionist, absolutely. But our goal is to export all over the world, which is one of the reasons we focused on quality, quality, quality.

Every country has to be known for something. Obviously, China is known for cheap prices. We want Canada to be known for high-quality, high-value products and innovative products. We have products now that are light years ahead of what other countries are producing, and we would like to find an international market for those.

Mr. Stephen Crawford: That's great. We'll leave on that positive note.

The Acting Chair (Mr. Logan Kanapathi): At this time, I'm moving to the official opposition members. MPP Peggy Sattler.

Ms. Peggy Sattler: I'm going to return to the Equal Pay Coalition and Ms. Faraday. You were concluding your remarks in the last round with a comment about the lack of transparency and the fact that these changes are being brought in by stealth as part of a bill that is supposed to be about pandemic preparedness. Can you give us a sense of what categories of women workers we're talking about? What specific occupations might be affected by this attack on pay equity rights?

1650

Ms. Fay Faraday: Well, the legislation says that the compensation enhancement program is "for the purpose of supporting the provision of public services," so that's a very wide definition. That would be workers in the public sector and in the broader public sector. To the extent they've been talking about nurses and PSWs, those are workers who are both in the direct public sector and in the broader public sector.

The broader public sector is the wide range of child care workers, violence-against-women workers, addiction services workers, long-term care, elder care, home care—all of the different elements of the care economy that make life possible, from cradle to grave. Those are all care work professions that are predominantly female. We know, through decades of academic expertise and litigation and jurisprudence, that the more female-dominated an occupation is, the more it is associated with women's care work, and the larger the pay equity gap. That has been confirmed again and again, including by the Supreme Court of Canada.

So what the government is doing is saying to those women, "We're going to take another run at that, because we don't want to pay it. We're just going to define it out of existence, and we're going to define it out of existence in terms of—we're going to shrink your human rights remedy, but we're also going to do it in a way where we define it as having met the obligation to negotiate," which it doesn't do, clearly. It's a unilateral act, and they've said that they're deeming it to have achieved pay equity.

Under the Pay Equity Act, achieving pay equity is specifically defined as going through the negotiation process with the union to identify the value of the jobs, the pay of the jobs and to identify the gaps. So they're taking on for themselves the unilateral ability to decide that explicitly without the agreement of the union.

Ms. Peggy Sattler: I'm going to turn it over to my colleague MPP Mantha.

The Acting Chair (Mr. Logan Kanapathi): MPP Mantha.

Mr. Michael Mantha: I want to go to Mr. McCready. I'm going to be having a meeting with the North Shore health group tonight. One of the issues that we're going to be talking about is doctor recruitment and the challenges we have.

Right now, the models of care or the models of funding are just not meeting the needs of doctors, who are very much interested in coming to northern Ontario. One of the reasons why they're interested in coming to northern Ontario is how NOSM had prepared them—when you are going through the NOSM process, you are trained as being part of the team, where you have a network that surrounds you. Right now, what we're seeing is that the old models that are being used in many communities in northern Ontario, which initially attracted doctors there, are actually hurting that process.

We're scrambling for doctors for our hospitals and so on, and right now, primary care is basically non-existent in many communities because there are no community doctors there. One of the results is having greater placements from NOSM.

I was wondering, what is the challenge from NOSM's perspective as far as getting more placements for students

in northern Ontario? I think that would address a lot of the needs that are there.

Dr. William McCready: Absolutely. It's a two-edged sword. If you're under-resourced from physician numbers in a community and then you ask the few doctors you have, who have a very busy clinical schedule, to now take on a learner, that's an added strain to them. It takes more of their time. What we try to do is put a resident there, and then we can add a student. But we can't always do that. It's a vicious circle, in many ways, when we're under-resourced.

So for smaller communities—do you know what? You were absolutely correct. In days gone by, you attracted, in northern communities, the hard-working doctor who put his nose to the grindstone and worked 60, 70, 80 hours a week, looked after his patients. That model of care is gone. The modern generation of physicians doesn't want to work like that. They want the team-based care that you've talked about. They want to have a contract that gives them time off, that gives them time for continuing medical education. Those models are ultimately very important to retention and recruitment.

So there's kind of a process here where we have to get to a critical mass of numbers, in a given community, where we have some redundancy.

Everybody likes to quote what I call the Marathon miracle—where Marathon, at one point, recruited two extra doctors, compared to what the ministry's contract called for, and they were able to self-locum. They were able to give themselves time off, take a little less money. That was very helpful.

The Acting Chair (Mr. Logan Kanapathi): You have one minute left.

Mr. Michael Mantha: Okay.

Mr. Hunt, in your comments you said that, presently, the stockpile of PPE that we have here in Ontario—and I'm not sure if you were specifically indicating the masks and what masks. You say that supply would be gone in a matter of eight days?

Mr. Barry Hunt: Yes. The stockpile that we have now is primarily for health care applications and front-line workers; it's not for the general public. If we get a lethal variant or a new lethal airborne virus sometime and we need to protect our citizenry, there is no stockpile for that.

Mr. Michael Mantha: So what type of masks is that supply? Are those the N95s?

Mr. Barry Hunt: This is a new category we call a bioaerosol mask—invented here in Canada. It's a lighter weight. It's similar to a surgical mask. We've written an industry standard for it—

The Acting Chair (Mr. Logan Kanapathi): Thank you. I'm sorry to cut you off.

The next round of questions goes to the independent member.

Ms. Mitzie Hunter: I want to thank all the presenters.

I'm going to go back to Ms. Faraday, because I do want to hear—it seems to me that Bill 106 is supposed to be dealing with the emergency preparedness overall for the pandemic response, and then sort of hidden in here is a bill that really threatens, first of all, collective bargaining rights for female-led professions and gender equity. So I want you to talk to us about solutions that you see. That's what committee is for. We're supposed to be listening with both ears—and I really direct that to the government members at this time. What are the solutions to fix this?

Ms. Fay Faraday: What schedule 7 does is, it tries to carve out a little exemption to Bill 124 but then retain all the privileges of Bill 124 of being able to suppress bargaining and have government unilateral action and interfering in wage-setting.

The resolution is really simple: The current contents of schedule 7 should be repealed and replaced with a section that says that, on the date of royal assent of this act, Bill 124 is repealed in its entirety. That's all you need.

Like I said, the government already has the power to make wage enhancement grants. It has done that repeatedly over the decades. It doesn't need to undermine collective bargaining rights; it doesn't need to undermine pay equity rights in order to do that. They have the power, and it's their regular budgetary power, to set the allotment for the broader public sector and the public sector. That's their core power right now. At the very least, sections 5, 6, 7 and 8 need to go. But honestly, the entirety of schedule 7 needs to be replaced by "Bill 124 is hereby repealed."

1700

Ms. Mitzie Hunter: Just before I go to my next question, I want to thank Mr. Barry Hunt, who is here on behalf of the PPE manufacturers. Thank you for your work and contribution in keeping us all safe.

In the short amount of time that I have left, I do want to ask Dr. McCready—I'm very much thinking of my colleague MPP Michael Gravelle, MPP for Thunder Bay–Superior North, who just announced today that he's undergoing cancer treatment once again but hopes to run in the upcoming general election. I'm sending him my best. He has been a friend and colleague, certainly, for the nine years that I've been here. I needed to say that, Chair.

Perhaps Dr. McCready could say how it is going in terms of one of the original intentions—of Indigenous recruitment and retention of doctors in the north. I know that when Premier McGuinty launched the Northern Ontario School of Medicine in 2005, this was one of the core aspirations—as well as, of course, francophones, French-speaking as well. How is it going when it comes to those goals?

Dr. William McCready: Overall, we've retained about 60% of our learners, both graduates and undergraduates, in the north. Really, that's very successful in many ways.

Michael Gravelle has been a long-time friend of the medical school, as well. I'm sad to hear that he's struggling again with an illness. I've seen him recently in the parking lot of a local market that we both frequent, and he certainly didn't look very well, so I wish him well.

The Acting Chair (Mr. Logan Kanapathi): A reminder to all presenters: The deadline for written submissions is 7 p.m. on Wednesday, April 6, 2022.

CANADIAN FEDERATION
OF INDEPENDENT GROCERS

MS. ADRIENNE TELFORD

DENTEC SAFETY SPECIALISTS

The Acting Chair (Mr. Logan Kanapathi): This is the final group of presenters for this evening. I will now call on the Canadian Federation of Independent Grocers. Please come forward.

Welcome. Please state your name for Hansard. You may begin now.

Mr. Gary Sands: Good afternoon. I'm sorry I have to appear virtually. I was on another Zoom call a few minutes ago.

Chair and members of the committee, thank you for the invitation to appear here today. My name is Gary Sands. I'm the senior vice-president of the Canadian Federation of Independent Grocers. Just as background, there are approximately 6,900 independent grocery stores in Canada, and in some provinces—such as this one, Ontario—independents account for close to 60% of all the retail grocery stores in Ontario.

Some of you may have read the op-ed I wrote in the Toronto Star a couple of weeks ago on the subject of food affordability. For those of you who did read that, please forgive me for repeating some of the points I made in that article.

Ontario is a tapestry. It's woven together from a myriad of urban, semi-rural, rural and sometimes remote communities, and we need to bear in mind that in many of those rural and remote areas, an independent grocery store is, more often than not, the only grocery store in that community. That context is extremely important when we talk about issues of food affordability, fair supply, uneven fluctuations in the cost of inputs, labour shortages and spiralling costs of things like trucking and fuel.

Over the course of the last two years, dealing with the challenges of a global pandemic, the supply chain is probably experiencing what could best be described as combat fatigue. We have weathered catastrophic flooding in British Columbia, resulting in significant damage to infrastructure in transportation corridors. Omicron followed up with another blow as it ripped through the supply chain, causing widespread labour shortages. In roughly the same time frame, we had the so-called freedom protesters set up blockades at some of our critical border crossings, resulting in more supply disruptions and delays and, for our members, higher costs. Of course, the most recent hit will soon be felt as a result of the invasion of the Ukraine by Russia, which we know will also significantly impact costs for a range of products. Also, an Ontario avian flu is now popping up as an issue.

Some of us could be forgiven for thinking Vladimir Putin and the Four Horsemen of the Apocalypse were trying to forge new careers in the food industry.

The cumulative impacts to the entire supply chain that arise from these challenges are not always borne entirely equally. We know that for many of our members, they're seeing cost increases from suppliers in the range of 25% to 30%, and they're seeing trucking costs more than double.

Again, going back to my earlier comment about independents being the only grocery store in many Ontario communities, we have to remember that food security for those areas is very much predicated on the ability of those grocers to access fair supply and at affordable prices. This is particularly important during emergencies.

Based on the shared experiences of the last two years, governments and industry, I believe, recognize that they need to collaboratively work together to develop long-term solutions to systemic issues and vulnerabilities that have become very apparent in our supply chain. CFIG has fought very hard in the last two years to secure fair supply for some essential products—not equal supply, but fair supply. We have brought our concerns forward to the federal government and to all of the provinces on that issue.

Minister Thompson's office and the Premier's office have both, I have to say, been very receptive to hearing our concerns, and they have been very engaged with us in discussing these challenges, and we appreciate that. So the proposal to help ensure a safe and stable food supply by requiring regular reports on the province's security of food supply and contingency planning is something that we very much support and we feel reflects a response to concerns we have been raising about fair supply.

As well, I cannot overemphasize the importance of the Ontario Food Terminal to independent grocers, the supply chain and the Ontario communities they serve. I mentioned the self-described freedom protesters blockading border entry points. This has a very serious impact, particularly in off-season months, on product coming into the terminal. There were even rumours of potential blockades being set up at the terminal itself. So we also strongly support the proposed measures that would allow for the creation of temporary alternate locations for part or all of the Ontario Food Terminal operations during an emergency.

Again, in our view, the government has listened to what we and other food industry stakeholders have raised as concerns, and we think the response is appropriate and warranted.

The Acting Chair (Mr. Logan Kanapathi): Thank you for your presentation.

Next, I will now call on Adrienne Telford from Cavalluzzo LLP. Please come forward.

Welcome. Please state your name for the purposes of Hansard. You may begin now.

Ms. Adrienne Telford: My name is Adrienne Telford. I'm with the law firm Cavalluzzo LLP. I have worked closely with a number of unions fighting for pay equity rights of women workers in the health care sector, including many of the women who work in nursing homes and hospitals, and who have been on the front lines of the province's pandemic response. I'm here this evening in my personal capacity as a lawyer who practises in the areas of labour and human rights, including pay equity rights.

I thank the committee for the opportunity to speak to schedule 7 of Bill 106. In my limited time, I'd like to focus on two areas of concern. The first is the lack of transparency in the bill, and the second is how the bill purports to circumvent fundamental human rights. And then I'll close by summarizing recommended amendments, time permitting.

First, the lack of transparency: From a transparency and good governance perspective, it's concerning that schedule 7 of the bill does not contain any details of what the government is purportedly promising for workers. The substance of that promise is going to be determined unilaterally by regulation, as set out in section 11 of schedule 7. The bill doesn't define key terms such as "compensation enhancement program," and the bill is silent with respect to crucial details such as who gets the wage enhancement, when they will get it, how much it will be, and whether it will be permanent or temporary. All of these details are left to the government to determine unilaterally by regulation. In short, the substance of the deal will be written and adopted and potentially amended and revoked at the executive's sole discretion, without legislative oversight and with no guarantee that the workers' representatives will be at the table in a meaningful way.

On the other hand, the few details schedule 7 does provide are deeply concerning from a human rights perspective. It purports to insulate from legal challenge the substance of the wage enhancement program, the terms of which will be determined by the government unilaterally, and it purports to override important labour and pay equity rights. So not only is schedule 7 anti-democratic from a transparency and good-governance perspective, but it is also anti-union and, perhaps ironically, anti-worker.

1710

This brings me to my second point, which is that schedule 7 of Bill 106 represents a Faustian bargain for women workers. On the one hand, it purports to promise a wage enhancement for some workers but not all, with the details left to government to decide; while on the other hand, it purports to circumvent important human rights protections set out in legislation such as the Pay Equity Act and the Labour Relations Act, among other pieces of legislation.

Focusing first on pay equity, section 6 of schedule 7 purports to deem permanent wage enhancements to be for the purpose of pay equity without necessarily requiring the employer to adhere to the requirements of the Pay Equity Act. By doing so, it potentially circumvents important protections under the Pay Equity Act with respect to which wage increases are or are not appropriately characterized as pay equity adjustments. Wage enhancements traditionally are treated as general wage increases and not pay equity adjustments.

Furthermore, by singling out only some workers for wage enhancement and not others, schedule 7 will potentially exacerbate wage inequities within the workplace. It's not just the PSWs and the DSWs who are deserving of wage increases; it's all of the predominately female workers, including registered practical nurses, activity aides, dietary aides, cooks, housekeeping aides, and I could go on—all of whom have had their working conditions in the nursing home severely impacted by the pandemic. All of them deserve a fair wage. All of them deserve compensation free of systemic gender discrimination, and yet, section 5 of schedule 7 purports to prevent a tribunal like the Pay Equity Hearings Tribunal from requiring the employer to extend that wage enhancement to other employees who are equally deserving.

The fundamental precept of pay equity is equal pay for work of equal value. This necessarily entails a pay-equity-compliant relationship among the different jobs within a workplace. Yet the wage enhancement program, by singling out some workers for wage enhancement and not others, will potentially exacerbate these wage inequities, and at the same time schedule 7 purports to insulate such discriminatory treatment from challenge.

One of my key take-home points would be that there are very important mechanisms under the Pay Equity Act for identifying and redressing systemic discrimination and compensation of women workers, including in the nursing homes and the hospitals. And if the government wants to help those vulnerable women workers, we shouldn't be overriding these important pay equity and human rights protections. Instead, we should be focusing on removing the barriers that these workers face in enforcing their pay equity rights, including long systemic delays before the Pay Equity Hearings Tribunal, including preventing employers from evading their pay equity duties for years on end—

The Acting Chair (Mr. Logan Kanapathi): You have one minute left for your presentation.

Ms. Adrienne Telford: Thank you—and, when necessary, providing funding to employers to enable them to satisfy their pay equity obligations.

In my final 40 seconds, let me just say this: There are similar issues when it comes to labour rights. Section 5 of the act purports to override collective agreements, something the Supreme Court of Canada has found to be unconstitutional. It also excludes unions from a meaningful role in negotiating the wage enhancement program and prohibits workers and their representatives from making complaints to an expert labour board or arbitrator with respect to the program. Finally, it doesn't repeal Bill 124; rather, it just carves out a small exception to what we would suggest is unconstitutional legislation—

The Acting Chair (Mr. Logan Kanapathi): I'm sorry to cut you off. Thank you for your presentation.

I will now call on Dentec Safety Specialists to please come forward.

Welcome. Please state your name for Hansard, and you may begin now.

Mr. Claudio Dente: My name is Claudio Dente. I'm the president, co-founder and CEO of a company called Dentec Safety Specialists, located in Newmarket, Ontario. I'm going to share with you my journey. I hope the information I provide will help the committee members to

understand how to prepare for the next one—as I am involved in the United States with the various levels of government that you will see.

I've dedicated my entire professional career, spanning 40 years, to the manufacturing and design of personal protective equipment; most notably, respiratory protection. In 2014, I purchased my supplier, located in Kansas, that manufactures reusable respirators that were primarily intended for the industrial sector. I have been representing their products since 1987, and I've been selling respiratory protection since 1980—so yes, I'm old. I believe I'm qualified as an expert to talk about respiratory protection.

We are a Canadian family-owned-and-operated company, with manufacturing operations in the United States. Our facility is NIOSH-certified, and our products are Health Canada-approved as well.

I worked through all the pandemics since SARS in 2002, and I've witnessed first-hand supply challenges for PPE throughout them all. During those pandemics, we experienced sharp increases and declines in cases that did affect the supply chain, but not to the extreme that we are experiencing with COVID-19. At the end of the other pandemics, we as a society never took the initiative to prepare for the next one—the one that we're in now. We must take action now and do what we can to prepare to finish this one, but there's another one looming on the horizon.

Over the last two months, I've been involved in meetings with Mr. Tim Manning, national COVID director to the White House, for preparedness planning for the next waves. In the fall of 2021, I testified at congressional hearings from their small business committee, chaired by Congresswoman Sharice Davids. The purpose of my testimony was to explain what a company of my size and my specialty had to deal with going through such a COVID surge. It was difficult and demanding. But what they're doing, as the government, is asking the people like us, "What do we need to do to prepare for surges and for the next pandemic?"

We learned that COVID is a particulate aerosol that can travel great distances. It travels in many directions. There have been examples of nurses and doctors who have passed by patients, wearing surgical masks, and contracted COVID.

In October 2020, the CDC updated their guidelines for elastomeric respirators. They also said, "Do not use a respirator with an exhalation valve, as it can cause the spread of the virus." They also asked the market to create a reusable elastomeric respirator without an exhalation valve, which is what I'm wearing here.

You have to understand that before this call to action, this kind of respirator didn't exist. They state that when using a filter on a mask that is encapsulated in a protective housing like you see here, the filter can last, conservatively, up to a year. I hope you understand that statement.

The new messaging in 2021 from health experts in Canada and the United States was to wear a tight-fighting NIOSH-approved N95-type respirator, but yet there is a higher level of protection that's more economical and safer.

I've asked both the provincial and federal governments for funding to set up manufacturing in Newmarket to produce the reusable respirator that you see here, and communicated with several members that you've seen here in the documentation. I also met recently with the procurement director for the provincial government, Mr. Doug Kent, and explained and wanted to introduce him to this type of a product.

While I've been advocating for the use of reusable respirators in Canada for two years—and you heard Mr. Barry Hunt talking about his variation—the following summarizes the change in direction that I want to make you aware of that is happening in the United States: In March 2022, 100 top health experts advising the White House, including Dr. Osterholm, issued their own pandemic preparedness plan called A Roadmap for Living with COVID. The group's leader, Mr. Emanuel, estimated that it will cost $1 billion or more to fully prepare the nation for future variants and pandemics, and they're taking the measures. The link in this document will take you there. Here are some highlights of what they're saying:

Workers in high-risk settings need access to reusable respirators.

There should be a robust domestic respirator manufacturing industry to ensure sufficient supply for health care and high-risk settings, with capacity to ramp up production during respiratory emergencies such as another pandemic or surge.

The national stockpile should be replenished with reusable respirators.

1720

The supply chain of respirator manufacturing must be considered a national and economic security priority. Where necessary, domestic manufacturing capacity for respirators must be assured.

Health care workers must be provided with respirators such as elastomeric half-mask respirators for the rest of the pandemic.

Innovative designs of elastomeric respirators are available, many without exhalation valves, as you see here. They should be made available to workers and required in health care settings.

After these recommendations led to reusable respirators, we were awarded a contract to the US government for 125,000 masks and half a million replacement cartridges, for which we completed delivery last week.

A reusable rubber half-mask without an exhalation valve should be added to the solution, not only disposables and so forth. Why? Because it provides an airtight seal the virus can't get inside when fitted properly; it's less expensive—considerably less expensive, but I'll show you momentarily; environmental savings and impact on waste is even more astronomical; and it's far more comfortable.

The Acting Chair (Mr. Logan Kanapathi): You have one minute left for your presentation.

Mr. Claudio Dente: There's a chart in here where we explain, if we issued 160,000 health care workers in Ontario one disposable respirator per person per day

versus issuing our respirator, the numbers are that we're going to save in a 90-day period $8 million, and we're going to reduce waste by 286,000 pounds. If we extrapolate that over the period of a year, it's going to be $32 million and 1.1 million pounds, and that's just for one respirator per person per day for 90 days. If we move that to five per person per day, we're going to save $65 million, 1.4 million in waste, and we are going to save $262 million for the period of a year. There's testing data and science all behind it.

Thank you very much for your time.

The Acting Chair (Mr. Logan Kanapathi): This round of questions will start with the official opposition members. MPP Peggy Sattler.

Ms. Peggy Sattler: Thank you to all the presenters—very, very different issues that you have raised today regarding this bill.

I want to direct my questions to Ms. Telford from the Cavalluzzo law firm. You have raised some very alarming concerns about the impact of this bill on human rights and the Pay Equity Act and workers' rights. I wanted to give you an opportunity to finish off your presentation—you were in the middle of a sentence regarding Bill 124 and the fact that this legislation does not repeal Bill 124, and I think you were going to say something more—and then I don't know if you got to the recommendations that you would want to make as to how we can address these issues that you have identified.

Ms. Adrienne Telford: Thank you for that question.

Yes, I was cut off. I was saying that Bill 124 should be repealed in its entirety due to, from our perspective and the unions' perspectives, that it's an unconstitutional interference with freedom of association and collective bargaining rights.

When I take a step back and ask myself what the solution is to the problem of women workers who are in precarious work, lower-paid jobs in nursing homes and other sectors of the economy, the solution to the problem already exists. They are in the Pay Equity Act. They are in the Human Rights Code. They're in the Labour Relations Act. The problem is one of enforcement, as was mentioned before, and systemic delays before the Pay Equity Hearings Tribunal. There are many ways employers can evade their pay equity duties. So if the government truly has a desire to ensure fair and equitable pay for these women workers, then let's look at the problem of enforcing the rights that already exist.

Sadly, I think schedule 7 will result in protracted legal challenges that will be costly and distracting to everyone involved, including the government, employers, unions and workers, and it's going to result in uncertainty and delay in getting the money into the pockets of the women workers who deserve it.

My recommendation in terms of proposed amendments would be—well, let me first urge this committee to seek and obtain a legal analysis from your Ministry of the Attorney General of the constitutionality of schedule 7 prior to passing it. Furthermore, I'd recommend removing sections 5, 6 and 8 of schedule 7 altogether and adding another provision which makes very clear that schedule 7 is not intended to abrogate or derogate from the fundamental human rights of workers, including their rights in the Pay Equity Act, the Labour Relations Act, the Hospital Labour Disputes Arbitration Act and the Crown Employees Collective Bargaining Act, and so on and so forth—to make it crystal clear here that those rights continue to exist regardless of any wage enhancement program. And finally, as I mentioned, repeal Bill 124 in its entirety.

Ms. Peggy Sattler: Thank you very much for those recommendations.

The government may claim that this legislation is going to help reduce the wage gap or somehow contribute to achieving pay equity. Will this legislation have that effect? Will it do anything to close the wage gap for women workers?

Ms. Adrienne Telford: It is so difficult to say, because, as we often say, the devil is in the details, and all the details are going to be in the regulations.

What I find concerning is that we basically have this skeleton of a schedule, which—what I see in there are just protections to insulate from legal challenge, whatever the government ultimately decides to do. To me, that is a red flag. Why does the government need to insulate the wage enhancement program from challenge under pay equity legislation, under labour relations legislation? I have deep concerns that it's going to exacerbate the pay equity gap, particularly because it's going to have a disruptive impact within the workplaces where some workers are being singled out for wage enhancement and not others, as well as the problem of those who are receiving the wage enhancements—well, typically, those are treated as a general wage increase. They're not about pay equity. Any pay equity adjustment is additional and must be added to the base salary and the compensation.

So while there are huge question marks in terms of what the wage enhancement program is going to do and what impacts it's going to have, there are some serious red flags in this legislation which, to me, all point towards eroding and evading the human rights and pay equity rights of women workers.

Ms. Peggy Sattler: You said in your presentation that what the government should be focused on is removing barriers to achieving pay equity rights. Can you elaborate a bit more on what those barriers are that need to be removed?

The Acting Chair (Mr. Logan Kanapathi): You have one minute left.

Ms. Adrienne Telford: Thank you.

It's a problem of enforcement. There are many ways that employers evade their pay equity duties, and—I'm speaking from experience—it's very challenging to hold employers to account before the Pay Equity Hearings Tribunal. There are systemic delays within the tribunal. They're under-resourced, they're understaffed, and there are so many elements to the pay equity exercise which an employer can use, basically, to challenge, to delay. In

some instances, we have employers who have delayed maintaining pay equity in their workplaces for nearly two decades now.

The Acting Chair (Mr. Logan Kanapathi): We are moving to the government members. MPP Smith.

Mr. Dave Smith: I'd like to start with Mr. Sands.

You've come in and talked about what it's like for independent grocers to get access to some of the produce, for example, that they would be selling. Could you expand a little bit more about that? Most of the people who would be watching this—the four or five who are watching this live—would have no concept of how an independent grocer would operate or where the food would come from before it actually shows up on your shelves.

1730

Mr. Gary Sands: It can be very complex. It's a challenge. A lot of people think that we only eat in Toronto or Ottawa or the big cities, because they sometimes lose sight of the challenges we have in getting food across the province. For instance, in the off-season, we depend on about 70% of our fresh produce and vegetables etc. coming to the Ontario Food Terminal. If that gets blocked off—as it did at the border crossing at Windsor, for example—you're almost choking off about 70% of the supply of fresh produce to many, many communities in the province.

There are so many challenges I could talk about. For example, in Ontario, the two biggest wholesalers of food for independents are Loblaws and Sobeys. So for independent grocers, you're buying from your competitor, and that's a challenge that's almost unique to Canada.

As well, we found during the past two years—I don't know if I'm answering your question, but just to expound on the difficulties we face—that fair supply became a real issue for many independent grocers in communities across Ontario—across Canada, but I'll stick to Ontario—

Mr. Dave Smith: If I could jump in, I really would like to get you to elaborate on that. You mentioned Sobeys and Loblaws. Effectively, you have to buy wholesale from your competitor, who is providing for their own stores first and foremost. When there's a shortage, then, it's logical that Loblaws and Sobeys would provide their corporate stores with everything they need first, and then the independent grocers would be the secondary or the afterthought. That's the type of thing that I don't think the average person in Ontario truly understands.

Mr. Gary Sands: No, they don't. You hit it right on the head. We found that during COVID we were seeing, particularly when certain essential supplies were in high demand, that we were getting shorted on many of those products. I don't know whether to point the finger at the wholesaler or the supplier, because we also did find cases where suppliers were making special deals with larger players and just cutting off the independents all together for supply. I'm talking about everything from hand sanitizers to even the jars that are used by Indigenous communities for storing meats and preserves.

We also got a couple of ministers across Canada sending us messages encouraging us to tell our members to not limit the quantities of eggs, so we sent back to those ministers pictures of the empty shelves of the independent grocery stores where the eggs were supposed to be, but we had none. When customers walk in, they're puzzled as to what the heck is going on. "Why don't you have that?"

We have an overly consolidated food industry in Canada, so we're constantly struggling to stay on the playing field. We're never going to level the playing field, but fair supply can turn into an issue of food security, and that's one of the reasons why we're very supportive of the elements of Bill 106 that the minister has put in which we think help address some of our concerns.

Mr. Dave Smith: I have a significant agribusiness sector in my riding, so a lot of my residents truly understand some of those challenges.

With respect to schedule 3, the Ontario Food Terminal Act, why would this be something that would be important—the ability to move that food terminal, if we had to on an emergency basis? How is that going to help the supply chain for an independent grocer like yourself?

Mr. Gary Sands: I can tell you what would happen if the terminal had been blockaded. That is a critical lynchpin—it's a jewel that we have here in Ontario—that allows local producers and processors in this province to get their product onto the shelves of independent grocery stores. That is just so important to the whole supply chain. And for the independents—if they don't have access to those products at that terminal, where do they go? There are a lot of those local, smaller producers and processors who don't have the infrastructure to be able to do the direct store delivery etc. And independents, conversely, don't have these big warehouses in their community. So that is just a critical linchpin in the supply chain. Cut it off and there are going to be food security issues right across this province.

Allowing for the opportunity to have alternative locations available—I can't overstate how important it is. I'm really not being partisan. I'm just commending the minister and government for recognizing that. It's something we've been asking for.

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

The Acting Chair (Mr. Logan Kanapathi): You have one minute and 21 seconds.

Mr. Dave Smith: I'm going to quickly pivot, then, to the gentleman from Dentec.

Your mask is something that—I've seen similar things, having done a significant amount of drywall myself. It's very similar to a lot of the drywall masks—but you mentioned about the exhale valve, I think?

Mr. Claudio Dente: Correct.

Mr. Dave Smith: Why isn't that something that would have been removed previously? Why was it that it took the pandemic for someone to say that we need to make this kind of a change?

Mr. Claudio Dente: I've been selling that type of respirator—this is a modification where we plugged up the

hole. Basically, that's what we did, and we made some other modifications. But this pandemic caused me—and I've been in the business forever—to do a direct comparison of this versus disposable, because you think, "Oh, man, this is big. It's heavy. It's uncomfortable and more expensive." When we did our testing, I did thermal temperature testing that I've included in the report and so forth. This is far more comfortable than wearing a disposable respirator. So we're at a point where it's a complete mind shift. People have to understand that wearing this thing is not uncomfortable.

Mr. Dave Smith: But the exhale valve, in particular?

Mr. Claudio Dente: That I can't tell you. I've been through all the pandemics. It has never come out to this point. But I think it's because of the severity of COVID and the spread of it—

The Acting Chair (Mr. Logan Kanapathi): Thank you. I'm sorry to cut you off.

This round of questions will start with the official opposition members. MPP Sattler, please.

Ms. Peggy Sattler: I want to return to Ms. Telford to ask about her recommendation that the government review schedule 7 with lawyers from the Ministry of the Attorney General as to the constitutionality of that schedule.

Can you elaborate a bit more as to why you have these concerns about whether schedule 7 would meet the test of constitutionality?

Ms. Adrienne Telford: I think there are two primary concerns. First, it appears to be a violation of section 15, equality rights. Section 15 provides for substantive equality for women, and in recent jurisprudence from the Supreme Court of Canada, including in 2018, that includes pay equity rights for women. By interfering with those pay equity rights and insulating that interference from challenge, it potentially has the effect of substantively discriminating against women workers. So that, to me, is a clear prima facie violation of section 15 of the charter.

The second key problem is section 2(d), freedom of association under the charter. Freedom of association protects workers and their union representatives from substantial interference with their collective bargaining process. A collective agreement is the product of that collective bargaining process, and here in schedule 7, it says that, basically, these wage enhancement programs can override those collective agreements; in other words, the fruits of the collective bargaining process. Second of all, it says that the wage enhancement programs can be imposed, even without union agreement. So freedom of association is really about protecting workers' voice, their choice to be represented by unions and to have those unions representing their interests vis-à-vis employers and entities with more power, including the government.

From my perspective, there are two constitutional infirmities in schedule 7: section 15, equality rights, and section 2(d), freedom of association, collective bargaining rights.

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Ms. Peggy Sattler: Thank you for that response.

I know my colleague would like to ask a question. MPP Mantha.

The Acting Chair (Mr. Logan Kanapathi): MPP Mantha, please go ahead.

Mr. Michael Mantha: I'd like to go to Mr. Dente.

I take it you know what you're talking about when it comes to masks, right?

Mr. Claudio Dente: I think I do.

Mr. Michael Mantha: On a scale of 0 to 10, let's say, the one that you're wearing right now is the 10, which is the Cadillac.

Mr. Claudio Dente: Correct.

Mr. Michael Mantha: What is this?

Mr. Claudio Dente: Zero.

Mr. Michael Mantha: Zero. This is what people are being recommended, by government, through policy—that people are required to wear when they're entering a long-term-care home or when they're going into a hospital.

Let me describe the scenario to you—we talked a little bit earlier. This is an N95 mask. It's made by Dent-X and First Nations Procurement. I wear this mask. When I go to a hospital or a long-term-care home, I am being disarmed, and I'm being asked to put this on to go into the hospital.

Mr. Claudio Dente: You are.

Mr. Michael Mantha: How is this protecting me?

Mr. Claudio Dente: It's not.

Mr. Michael Mantha: It's not?

Mr. Claudio Dente: No. What this gentleman here asked about, the exhalation valve, think of—wherever it doesn't seal, air exits the mask, right?

The Acting Chair (Mr. Logan Kanapathi): Please speak through the Chair.

Mr. Claudio Dente: I'm sorry. Okay.

As I was saying, a mask of that nature doesn't provide an airtight seal like this type of mask does. It absolutely allows air to exit the mask in a number of different ways and different directions, but it also allows you to suck in the air. With a virus as infectious as COVID, that's the hazard. We've never had this issue before. We've never experienced a virus of this nature.

Mr. Michael Mantha: So this particular type of mask, or even these cloth masks that we're wearing—on a scale of 1 to 10, how is this protecting me?

Mr. Claudio Dente: No disrespect, Mike, but that mask is not an N95 respirator.

Mr. Michael Mantha: No; I know it's not. This is actually what was provided to our students in our schools. Actually, there was lots of media that reported it. This is a mask made in—oh, jeez, I said it earlier—Vietnam. These were delivered to our schools by Premier Ford.

This is also referred to as an N95 mask. These were produced in China, and these were delivered to some of the health care facilities that we have here in Ontario.

It just baffles my mind as to—if we are aware of all these things and we do know the difference between what an N95 mask is and how it will serve and protect the public, why are we continuing to put our loved ones and

our health care system in harm's way by continuing to tell people to disarm themselves and put this one on, when there is zero protection from this?

The Acting Chair (Mr. Logan Kanapathi): You have one minute left.

Mr. Claudio Dente: My belief is that it comes down to sheer volume—of being able to supply the general public. As you see from when I spoke of the report on what the US is doing, they are categorizing the level of risk—the highest level of risk is health care workers and front-line workers; they also talk about the food industry and so forth—to allow the companies to continue to operate and work. Give them this type of a product that's reusable, and it will take the consumption requirement out. The next level is to give a proper N95 respirator to the other communities, to protect the schools, to protect other levels of businesses and so forth.

Remember, we're going through a very big shift here in thinking and strategy. What we have to do is get our minds away from what we used to do. That's the challenge that I think we're all having.

The Acting Chair (Mr. Logan Kanapathi): This round of questions will go to the government members. MPP Will Bouma, please.

Mr. Will Bouma: Thank you, Chair. Through you: I appreciate the conversation this afternoon. I want to take a moment, because this appears to be the last round, to thank everyone for coming today—I really appreciate it—and also for the questions from my colleagues on both the opposition and government sides. It has been an interesting afternoon.

Just to keep the conversation going with Mr. Dente a little bit—because I'm intrigued by it, and we've been talking a little bit about that. Not to be adversarial at all—and maybe that's just TV shows; I'm no expert on this—but a surgeon will still wear a surgical mask when he's doing surgery. You've stated here in committee, which will be in the Hansard, that that provides zero protection. I was wondering if you could comment on that and the prevalence in the medical community of still using surgical masks while doing surgery. When you say zero, does that also include a situation like that?

Mr. Claudio Dente: Yes. If an individual surgeon provides surgery and is asymptomatic, there is a serious risk that the patient could contract the virus.

To give you an example of what has happened, because it has been around for a long time, the FDA—which moves very slowly; I think it was May of last year—made the statement that they were allowing the use of this type of reusable respirator for surgical settings. That has never happened before.

Again, this virus caused this mind shift change—to develop a higher level of protection that we didn't know was there before. The gentleman here asked about the exhalation valve. The reason is that, normally, the exhalation valve allows you to blow hot air out of the mask, and we have flappers inside these cartridges that seal when you breathe out. But what we're doing now is, we've sealed the exhalation valve and removed the flappers. We're breathing in and out through the filter. We didn't think that was possible before, but it's very possible—and you can see I'm purposefully wearing it, because I can communicate with you.

Mr. Will Bouma: Yes—a little muffled, but I really appreciate that.

I'm a volunteer firefighter in the county of Brant, and we wear SCBA, obviously, so I'm aware of how the valves and everything work.

Do you do research and development at your company, and can you describe some of that work?

Mr. Claudio Dente: If you use the example of the call to action by the CDC in 2020, I have been selling an enormous amount of my regular respirator with an exhalation valve, because we make an N95 filter—that's what I have here—and we've been making it for many, many years. So when the call to action was, "You've got to get rid of the exhalation valve," I said, "Oh, no. What are we going to do?" I'm the individual who thought we could modify our existing mask; it wasn't a major modification.

We have our NIOSH-certified lab in our facility in Lenexa, Kansas. We have preferred status with NIOSH because I'm a 40-year customer. You heard Mr. Barry Hunt talk earlier about Canadian companies not able to get NIOSH certification; I can flip the switch. When I told them about what we were working on, NIOSH told me, "As soon as you're ready to come to market, let us know." They approved our product in three weeks. We got the federal government contract in another four weeks. So that's the status that we can provide.

Mr. Will Bouma: That's something that I'd like to hone in on a little bit more.

We do incredible research and development in so many medical technologies in the province of Ontario. I've been in the MaRS building and I've seen technologies where they hope to be able to implant living cells into brains to cure things like Parkinson's—and I believe that work is ongoing right now. I've seen ultra-accurate ultrasound devices that surgeons can use while they're doing surgery on a prostate, to guide them exactly to where the suspect area is while they're doing a biopsy. Yet so often, somewhere between that research and development phase—which I think we do a pretty decent job of supporting. But when it comes to the commercialization of that technology, that's where we fail.

You said you can get approvals in three weeks. What is the experience like provincially and federally? And in the dying seconds here—because I don't know how much time I have left—

The Acting Chair (Mr. Logan Kanapathi): You have three minutes and—

Mr. Will Bouma: Oh, we've got lots of time then.

I'm intrigued by the differences in your experience, working on both sides of the border, as far as the commercialization of new products, new R&D and the acceptance of those things in the markets—the difference between Canada and the United States.

Mr. Claudio Dente: You have to understand, I purchased a business—I was in the respirator business for many years, manufacturing, so I bought their R&D. God bless the people in Canada who stood up, like Mr. Hunt, and started from ground zero. I have approved vendors that I have to have, according to my certification with NIOSH, that are already filtration specialists. I have a bank of people for different levels—I have N95; I have R95; I have P100. So I can bring that technology up here.

The challenge or the thing that COVID caused was a sudden reaction. It's a call to action, and we need suppliers or companies that can stand up and make melt-blown, and we need companies that can make the scrim and the other parts of the components of the filtration material. I'm already there.

I know Mr. Hunt well. We've talked a great deal. He referred to the CSA certification for disposable respirators—it doesn't have anything to do with reusable—and he mentioned that it has the lowest level of breathing resistance as a standard that NIOSH doesn't have. Well, Barry tested my respirator, and our filtration media already surpasses that requirement.

So the challenge is, you've got people starting up again—God bless them for doing it—but there's already a bank of people who have filtration expertise, and we're already working on some other materials as well.

Mr. Will Bouma: I'm intrigued by that. I've been pestering a few people for a while that we need to have a life sciences strategy in the province of Ontario, and I was so glad to see that announced by our Minister of Economic Development, Job Creation and Trade.

In your opinion, having been in the industry for a long time and going through COVID now, how critical is it that we have, specifically in Ontario, a life sciences strategy that can make sure that we have PPE and have that kind of sovereignty over that sort of equipment in the province of Ontario?

The Acting Chair (Mr. Logan Kanapathi): You have one minute left.

Mr. Claudio Dente: What I'm understanding from your question is—can the life sciences group develop new materials and so forth? Right?

The science behind N95 filtration has been around a long time. The other thing that people are trying to work on, and some people have it, is a killing agent or an antibacterial process that can be put in the filter so the filter can filter the virus. But the issue is, can it kill the virus on contact? Why the CDC says our filter can last up to a year is because the virus is embedded into the filter—you can't touch it manually. Overnight, it dries, it dissipates, and it dies. So the theory about killing the virus on contact is not as important.

Mr. Will Bouma: Is it critical that we develop and grow these technologies here, locally, in Ontario?

Mr. Claudio Dente: Yes, sir.

The Acting Chair (Mr. Logan Kanapathi): Thank you to all the presenters for your presentations.

As a reminder to all the presenters, the deadline for written submissions is 7 p.m. on Wednesday, April 6, 2022. The deadline to file amendments with the Clerk of the Committee is 12 noon on Friday, April 8, 2022.

The committee is now adjourned until 1 p.m. on Wednesday, April 6, 2022, when we will continue the public hearings on Bill 106.

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

The committee adjourned at 1754.

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