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Comité permanent des finances et des affaires économiques

Pre-budget consultations

Consultations prébudgétaires

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43rd Parliament

Tuesday 3 December 2024

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Mardi 3 décembre 2024

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Tuesday 3 December 2024

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 3 December 2024

Mardi 3 décembre 2024

The committee met at 1000 in the Senator Hotel and Conference Centre, Timmins.

PRE-BUDGET CONSULTATIONS

The Vice-Chair (Ms. Catherine Fife): Good morning, everyone. Welcome to Timmins. Hello. My name is Catherine Fife. I'm the Vice-Chair of this committee, and I'm calling this meeting to order. We are meeting to conduct public hearings on pre-budget consultations 2025.

Before we begin: Due to weather concerns, the hearings in Manitoulin Island have been cancelled. Is there agreement from the committee to allow presenters scheduled in Manitoulin Island to appear virtually for hearings scheduled in Timmins or in our next location, which is Kenora? Do we have consensus? Thank you very much.

For those who are appearing, please wait until I recognize you before you start to speak. As always, all comments should go through the Chair. As a reminder, each presenter will have seven minutes for their presentation and after we have heard from all three presenters, the remaining 39 minutes of the time slot will be for questions from members of the committee. This time for questions will be divided into two rounds of 7.5 minutes for the government members and two rounds of 7.5 minutes for the official opposition members.

CANADIAN MENTAL HEALTH ASSOCIATION COCHRANE-TIMISKAMING

SENSENBRENNER HOSPITAL

TIMMINS ACADEMIC FAMILY HEALTH TEAM

The Vice-Chair (Ms. Catherine Fife): I will now call on the Canadian Mental Health Association Cochrane-Timiskaming, to begin. Please introduce yourself for Hansard before you start.

Mr. Paul Jalbert: Hi everyone. My name is Paul Jalbert. I'm the executive director with the Canadian Mental Health Association Cochrane-Timiskaming branch. Thank you for the opportunity to address this committee. CMHA Cochrane-Timiskaming proudly serves communities from Timmins all the way south to Latchford and all the way north to Cochrane. We work daily to help people living with and impacted by mental illness and addiction by providing supports and services on their journey to recovery. Our services intersect with issues of homelessness, poverty, criminalization and food insecurity, all of which contribute to further deterioration of mental health.

Simply put, we need funding in three focused areas. The ask is that we need an investment of $33 million per year over the next four years simply to stabilize the system. We need $60 million per year over the next two years for operational funding for supportive housing units, and we need $20 million to expand crisis hubs.

I spent the better part of last week trying to figure out what I could possibly say to this group that you haven't already heard. I know it's a tough question to answer, but I'm going to try. Maybe it's that we continue, right now, to lose on average more than seven people per day to opioid-related deaths in this province, and the situation, according to the stats, is even more acute in this community in Timmins. Maybe it's that in the last two years of available data for the Cochrane district of ED opioid poisoning deaths, only two of those individuals were unhoused.

Maybe it's the rise in visible homelessness and encampments in our communities, with an estimated 1,400 encampments across the province, more than 350 people living and experiencing homelessness in our region and over 200 in Timmins. Maybe it's that supportive housing is by far the cheapest and the most effective way to support individuals who are unhoused. It costs about $72 a day to support a person in community, while compared to how in hospital, you're looking somewhere around $486 a day, or in a correctional facility, $365 a day. Maybe it's that our staff are paid 20% to 30% less than their peers in other sectors of health care.

We really are on the precipice of some type of health care reform. Either it's with intent and we plan it, or really it's going to be a faltering collapse that will lead to sicker Ontarians and likely draconian austerity measures. We can restructure the system and plan for integrated, asynchronous care, or we can believe that institutional care will be fixed by simply doing more of the same.

CMHAs across the province are a foundational part of health care, and we're starting to crack under the increased strain on our sector. These challenges are echoed by many of my colleagues across the province. Some of them are having to cut positions and change their service delivery as they face deficits. Our sector reduces emergency and hospital care costs and decreases the burden on the legal and criminal justice system. I'll give you an example: At the beginning of the pandemic in 2020, CMHA Cochrane-Timiskaming established a mobile crisis program in the

Timiskaming district. The assumption at that time was, with social distancing and isolation, we'd likely get an increase in 911 calls related to mental health, which will put the emergency department of the hospital under burden, and OPP. When we started off, essentially, 19 out of 20 of those calls that were received ended up with a trip to the emergency department. We established a mobile crisis program, we addressed the needs and today, we're floating at about 7% of those calls ending up with a trip to the emergency department.

So what do you get for $33 million, I guess, is probably one of the key questions. The impact of having our staff being paid 20% to 30% less than peers in similar positions in the rest of health care is that we have a higher turnover rate. Vacancies remain open for longer, we incur the cost of recruitment, we incur the cost of training and other organizations who then can come and collect some of our staff reap the benefits of that—and that doesn't even speak to the client care issue.

We often have people come to our door on likely what is one of the worst days of their lives. They've already talked to their friends, they've already talked to their siblings, they've already been to their primary care physician, and they're coming into us to help them. We establish a rapport, we establish a relationship and we cannot maintain the staff. They leave. That relationship now has to be renewed with somebody else. This is not a simple task.

The system needs greater coordination, and I agree: Integration is one of the ways to do that, but right now, integration—there are no funds to plan integration between organizations. There are no funds to do the implementation between organizations. There are no funds to cover the legal costs of an integration. The IT infrastructure, the wage disparities that occur when you bring organizations together, and technology—there has to be an investment in technology.

We have to help people before they get sick or before their symptoms get worse. If we do that, their location of care changes and then you make material changes to the cost of health care overall and you increase improved outcomes for clients.

What about the $60 million for supportive housing? Well, we work hard to keep people in recovery, divert them from hospitals and correctional facilities which are the costliest forms of care. We can't achieve that without supportive housing. So there's a component around stock; there's a component around the supportive housing, the operations of it.

The Vice-Chair (Ms. Catherine Fife): You have one minute left.

Mr. Paul Jalbert: If there's something that I said today that leaves a mark, really, please, let it be that we're urging this government to commit to a five-year plan to stabilize the community mental health care workforce, that if the province is committed to improving the mental health and addictions care of Ontarians, it needs to fund services appropriately, and that's that $33 million a year to stabilize the system. Our staff are supporting increasingly complex clients that are dealing with addictions, mental health issues, are unhoused, whether through incarceration or hospitalization, and we need the supportive housing funds to help them.

I appreciate the opportunity to share the challenges and needs of our community during these dedicated consultations.

Thank you for making the time to hear me today.

The Vice-Chair (Ms. Catherine Fife): Next, we're going to move on to Sensenbrenner Hospital from Kapuskasing. I would ask the presenters to please state your name for Hansard. Please go ahead.

Ms. France Dallaire: Good morning. France Dallaire, CEO at Sensenbrenner Hospital.

Dr. Jessica Kwapis: And I'm Dr. Jessica Kwapis, chief of staff at Sensenbrenner Hospital.

Are you able to see my screen?

The Vice-Chair (Ms. Catherine Fife): Yes, we can.

Dr. Jessica Kwapis: Thank you very much also for the opportunity to present this morning. We'd like to talk to you about the obstetrical access crisis in northern Ontario. This is a province-wide issue across the north, and there's also particular needs at Sensenbrenner Hospital at this time.

I want you to imagine that you have to travel over 500 kilometres to reach a hospital that can deliver your baby, or that you're not even sure if you want to have another baby after the stress of having to travel for your first. Imagine even risking your life to travel to a location where your baby can be born.

In 2022, Christina Osmond, a pregnant woman, was killed in a crash on Highway 11. Her unborn baby also died. Her friend Brooke was in the car, and her unborn baby also died. She did survive but required a lot of time in intensive care. These are the risks that women take every day who have to travel for labour and delivery obstetrical care.

1010

Here in the slide, you can see that in 2021, there were over 1,200 women who had to travel more than one hour to receive labour and delivery care. Up to 207 of them had to actually travel more than four hours for labour and delivery care. This is a pretty consistent number across years, and in fact, it's increasing as additional services close.

Why is this a problem? We know by data that has been collected in British Columbia and some preliminary data in Ontario that there's a 1.8-times increased risk of stillbirth if you have to travel for your labour and delivery care. There's a 2.3-times increased risk of preterm births. There's longer NICU stays—almost double the number of days in NICU if you have to travel more than two hours for care—and three times the risk of perinatal mortality if you have to travel more than four hours for labour and delivery care.

In this map, you can see the spots that are highlighted in red. These are the remaining rural programs in northern Ontario that offer labour and delivery care. There are huge gaps in between. The blue centres are the larger sites that also provide care. At these red sites, care is provided by family doctors who have obstetrical training, many of them volunteering their time to be on call 24/7 for Ontario. Twenty years ago, there were 20 of these red dots across Ontario; now there are only nine. There have been closures of a couple of services even in the last couple of years.

One of the services that closed last year, in June 2023, was Hearst. They had had an active obstetrical program for many, many years. Now Kapuskasing is the only community on this 800-kilometre stretch of highway between Timmins and Thunder Bay that is still offering obstetrical care for women. This is the distance of travelling to and from Toronto to London, Ontario, two round trips. Imagine how many hospitals there are in between Toronto and London, Ontario, that actually offer obstetrical care. In this distance, there is one place, and that is us in Kapuskasing. Is this equitable access to care? Is this care at the right place at the right time? Clearly not.

We know, based on estimates, that about $5.76 million per year is spent in travel costs for these women, the average being $4,750 per pregnant woman who has to travel for health care. These women are advised to relocate to a larger community at 37 weeks' gestational age so that they're not caught in a community without care when they go into labour. You, yourself, probably experienced or observed some of the challenges with travel during the wintertime. That is a real concern for these women, who sometimes can't even get out in time if they haven't relocated beforehand.

This money represents lost wages. It represents both looking after the home front as well as housing in a hotel for up to two weeks, which is the average amount of stay for women who relocate for obstetrical care. This also doesn't cover the cost of emergency transfers, such as EMS and Ornge, and these are significant costs that we will detail later in a written submission.

Also, to emphasize, EMS, even if they were able to transfer a pregnant woman emergently to a centre that has care, are then leaving their community. The one rig that's available to their community is now going elsewhere, and if someone has a heart attack or a stroke or an overdose in the home community, there is no ambulance to respond to them.

We also know that there's a 2.9-times increased infant mortality rate in these rural communities with high proportions of Indigenous communities. There are several of these communities within this 800-kilometre stretch as well throughout northern Ontario. This clearly needs to be addressed based on the Truth and Reconciliation Commission action point 19, which recommends focusing on indicators such as infant mortality and maternal health.

What are we asking for? It's a twofold ask. First, it's a local solution. We need crisis mitigation and assistance to stabilize our programs so that Sensenbrenner Hospital doesn't have to close so we can keep this program open for women in this corridor of Highway 11. We're also asking for funding to create an organization and an entity to address the obstetrical crisis across rural northern Ontario for rural partners.

Sensenbrenner Hospital has been emerging as a leader in our region. We're providing obstetrical and surgical care as well as dialysis care, chemotherapy, visiting specialist care, home care, among others for the entire region.

The Vice-Chair (Ms. Catherine Fife): You have one minute left.

Dr. Jessica Kwapis: So we need support for a plan that we've put in to the Ministry of Health for an alternate payment plan to stabilize physician coverage. This needs to happen immediately. This amounts to about $570,000 a year to stabilize the program so we don't have to close.

We're also asking for a long-term solution and funding in the amount of around $500,000 to organize and develop a strategic plan over the next few years to address this crisis across all of northern Ontario. This would be a joint effort between the maternal child network, Ontario Health, our hospital, the Marathon Family Health Team, NOSM University and other partners.

If we look at Your Health: A Plan for Connected and Convenient Care, these issues address many of the pillars that have been introduced and these are not occurring right now in so many of our communities, so please help us to keep our mothers and our babies alive.

Just to note: Many of the statistics came from this report from the Northern Policy Institute a couple of weeks ago.

The Vice-Chair (Ms. Catherine Fife): Thank you so much for that.

Next, we will hear from the Timmins Academic Family Health Team. Mélanie, please go ahead and please introduce yourself for Hansard.

Ms. Mélanie Ciccone: Hello. Bonjour. My name is Mélanie Ciccone, and I'm the executive director at the Timmins Academic Family Health Team.

I'm just trying to multitask as I get the screen up and going, and it looks like it's working, so, great.

The Timmins Academic Family Health Team is funded by Ontario Health, and we receive funding for about 38 positions within our family health team, which is comprised of nurse practitioners, registered nurses, registered practical nurses, social workers, a dietitian, a psychologist, as well as our administrative staff. We're affiliated with the White Pines Family Health Network, which is a group of 29 physicians.

There are various primary care models across the province. So we're a FHT that's affiliated with the FHN, and the physicians are not part of our staffing. We provide services primarily to patients of the FHN, but some of our programs and services are offered to the entire community. We have offices in Timmins but also provide primary care services to the community of Gogama.

We were quite happy to hear about the appointment of Dr. Jane Philpott as chair of the new primary care action team with the goal of connecting every Ontarian to primary care services within the next five years.

If we look specifically at Timmins, we have 23,245 patients that are enrolled or rostered to a primary care provider, whether it be a physician or a nurse practitioner. But our calculations show there's still about 5,000 to 10,000 patients without primary care access, or not connected to a primary care provider in Timmins. Our family health team was successful in obtaining additional funding to expand our primary care services, but that still won't reach all of the individuals in our community. So for the government to be able to reach that goal of connecting everyone in five years, there definitely needs to be further investments in the expansion of primary care teams, and hopefully with the goal of adding to the current structures, and where there's no current structures, creating new primary care teams.

As Paul also mentioned, we are having health human resources issues within our sector. There is a report that was done, which was called the Ontario community health compensation market study. The goal of that study was to look across health care sectors to get a benchmark of what the salaries and wages look like, and it was determined that there is a $2-billion wage difference or a shortage compared to peers that are doing similar work in schools and hospitals. So our staff are definitely underfunded for the work that they're doing, and if we continue to look at how primary care is being put at the centre of a lot of objectives or of primary care networks and Ontario health teams, there needs to be a substantial investment in primary care.

Last year, our turnover rate was about 18%. We're having difficulty retaining our skilled professionals. We're training them and then they're moving on to other, more competitive sectors. When we're onboarding staff, that adds cost to training, it's time-consuming and it impacts our patients that are receiving services. We're also having difficulty attracting people to our sector that are qualified and skilled.

So what's the impact on staff? We have staff that are sharing with us that they're accessing the food bank. With the increased cost of living and us not having had a cost-of-living increase, they are needing to make ends meet and are accessing the food bank or working multiple jobs. That's adding strain on their families and work-life balance. Staff share, when they're departing, that they're leaving for wages, but also our limited health and dental benefits. This year, our health and dental increased by 13% and we don't have further funding to cover that, so we're needing to make our budget balance. Our team is working short-staffed; when there are vacancies, that has an impact on team morale and burnout. We're also hearing in the news about physicians feeling overburdened; that has an impact on their practices too. We don't have a model where we can have an on-call list to call someone in when we're short-staffed.

1020

What's the impact on patients? It's quite huge and significant. If we're not filling vacancies or we have a high turnover rate or we're hearing from other organizations that they're not filling vacancies to be able to increase staff wages, there's an impact on patients. They're needing to wait longer for services, they will need to go to the emergency department to access services and their continuity of care is interrupted.

And our staff are not working to the top of their scope. If our staff are covering for other individuals—for example, a registered nurse is unable to run our Well Baby program and the nurse practitioner is covering for them—that's impacting the nurse practitioner to be able to work at full scope of diagnosing and prescribing. Also, if the goal is to connect every Ontarian to primary care, if we don't have a full team and we're not compensating them as we should be, physicians and nurse practitioners will not be able to enrol as many patients.

It's also important to continue investing in digital health capacity and data integration. We're very appreciative of the one-time funding that we've received for digital health solutions; however, this funding does need to be made permanent. As we work in a team concept—we work closely with the physicians and we share our electronic medical record; that's our charting system—if there's funding for family health teams or primary care teams, there also needs to be funding made available for the physicians.

Our recommendation moving forward is that we are in complete agreement that every Ontarian deserves timely, coordinated access to comprehensive care in their community. We want the government to support policies that prioritize investments in health human resources, the expansion of primary care teams and increased resources for digital health. What the investment in health human resources looks like is $430 million, so $86 million annually for five years, which will help us recruit and retain our staff.

The Vice-Chair (Ms. Catherine Fife): You have one minute left.

Ms. Mélanie Ciccone: Also, other sectors have been impacted by Bill 124. There have been investments made in other sectors to help compensate for that, and we would ask for the same for our staff.

Thank you for this opportunity.

The Vice-Chair (Ms. Catherine Fife): Thank you very much to all presenters.

This first round of questions will go to the official opposition. MPP Kernaghan?

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

I'd like to begin with CMHA Cochrane-Timiskaming. Paul, I want to thank you for your words and for your question about addressing what the committee potentially has not heard. I believe this committee has heard quite a bit, but I would say the difference does make one wonder whether their inaction on what they've heard speaks to the fact that they have not listened. How can you retain staff in this sector when people are paid 20% to 30% less compared to the same job?

Mr. Paul Jalbert: It's incredibly difficult, and we do see that we have a higher turnover rate. For example, CMHA Cochrane-Timiskaming is likely around a turnover rate of about 16%. It's huge.

What we're noticing is two bits: People aren't just transitioning to other jobs in health care; we're seeing individuals leave the field, period. An example: Mining is big in the north. We're losing staff to mining. As strange as that might sound, that's one of the occurrences that we're having.

The other component that I'd highlight is the clinical impact of having such a high turnover rate. As I mentioned, building clinical rapport—building a relationship with the individual that you're providing services to—is critical. The ability to support an individual with good outcomes is a function of the strength of the relationship that we build with them. That's the impact.

What can we do about it right now? What we see CMHAs across the provinces doing is we see them transitioning from looking for individuals who have a suite of abilities to looking to identify a task that is critical to address. But the challenge becomes, if that task is critical to address, where do you situate the other tasks? The challenge is, if

you have somebody who is dedicated to doing this specific task, if for whatever reason they go on a leave—and the leave could be a parental leave; it could be a health care leave—how do you replace that individual? How do you absorb that through the team? And we're living this right now. The example is, in Timiskaming, we have two positions around seniors' mental health that we can't fill. We are not able to recruit. We have two nurse practitioner vacancies that have been over 12 months here in Timmins alone. Our primary care service is comprised of two nurse practitioners. It's not hard to fathom what that impact is. Thank God that we have a family health team next to us that have been incredibly supportive of the work that we're doing. But it is incredibly challenging.

I haven't touched on staff morale—the morale of staff when somebody leaves the team. The critical care that needs to occur so we do our best to spread the work over to really focus on what is the most urgent, but there are clearly impacts.

Mr. Terence Kernaghan: It's a disturbing situation when we're only able to address the most pressing need and not all of the contributing additional factors.

I noticed in your request that, again, CMHA is requesting funding for supportive housing. Can you comment on the importance of supportive housing and what happens to people when they don't have a safe home with those supports?

Mr. Paul Jalbert: Supportive housing, in many ways, we identify as the first mental health intervention. In order to provide effective treatment, somebody needs a safe place to live, so it's critical in our outcomes.

In a recovery journey, people will typically, particularly around addictions, have moments where their treatment is quite successful, and there are moments where there might be some stumbling that occurs. But that has to occur when the individual can go to sleep at night in a safe and supportive environment, where we can develop things like activities of daily living. It's a fancy way of saying the things that are required on a daily basis to maintain housing.

Things that we do, for example, right now are how to be a good tenant. Depending on where they're at in their stay in supportive housing, we can go, and we do go, for example, on a daily basis, because if we don't at the outset, which is the most critical part when somebody transitions from being unhoused to housed, some of the things that we observe in our community—and I'm sure this happens in other communities as well. Apartment takeovers: Somebody gets an apartment and all of a sudden, people kind of—you have some friends come over and then these friends' friends might come over; these friends' friends aren't really friends, and then, all of a sudden, you're not actually living in your apartment anymore because it's been taken over and it's being used for other purposes.

Mr. Terence Kernaghan: Absolutely. I think as well, Paul, you've spoken about the 17,700 ER visits that you've managed to divert with CMHA, and I think the costs associated with that are significant.

I think as well, $72 a day for community services that you provide as opposed to the $486 per day in the hospital or $365 in the correctional sector—the cost savings are enormous and profound, and speak to why this request that you are making for this five-year plan would make a tremendous difference.

The Vice-Chair (Ms. Catherine Fife): You have one minute left.

Mr. Terence Kernaghan: I'd like to now move over to Sensenbrenner Hospital. I just first wanted to state that the tragedy of Christina and Brooke and their children Colton and Grace is incredibly disturbing.

I did want to ask: What are your thoughts about the province making changes to allow hospitals to carry a deficit?

Dr. Jessica Kwapis: France, do you want to answer that?

Ms. France Dallaire: I think the reality is that we have at Sensenbrenner carried a deficit for the last few years, at least since the beginning of the pandemic. But it's very difficult for our organization to plan for services in that context and to really address the needs of our community.

The Vice-Chair (Ms. Catherine Fife): I'm sorry, can you just state your name for Hansard, please?

Ms. France Dallaire: Oh, I'm sorry. France Dallaire, Sensenbrenner.

The Vice-Chair (Ms. Catherine Fife): Thank you.

Ms. France Dallaire: So have I answered your question? I think we're—

The Vice-Chair (Ms. Catherine Fife): You're going to get a chance in the second round. There's another 7.5 minutes. I'm sorry about that.

1030

Now we're going to move to the government side. MPP Hamid.

MPP Zee Hamid: My question is for Mr. Jalbert from CMHA. Thank you for the presentation; it was really helpful. You were talking earlier about diverting people from costly emergency department visits. Can you talk a bit more about how you've done that in detail, and how you plan to do that in the future? As well, a follow-up question I might as well ask now: Can you talk about some of the things that are unique to Timmins in this area?

Mr. Paul Jalbert: How do we divert? One of the examples I use is mobile crisis in Timiskaming. The idea is that we co-respond with OPP to calls made for mental health and addiction purposes, and then we can plan for care from that point. So, again, it's asynchronous at the time they need, the location they need, and we can move. That's one of the strategies that we can use.

The other strategy that we use is we have case management services that create plans for individuals that can look at some of the triggers, some of the situations that may lead towards having to access emergency departments, and develop plans on what we do in those critical moments.

What's unique to Timmins? There's a number of them. For example, in 2018, what at the time was the local health integration network—now Ontario Health—commissioned a needs-based planning study that identified services that are required for a comprehensive treatment model for addiction services. What it identified particularly in this region

is that there are services that—never mind they don't have adequate capacity; they don't exist in this area. If people are going to access this service, they have to go out of region. That should be part of health care.

I'll give you an example. The technical term would be enhanced-complexity addiction treatment. That's a fancy way of saying a day program or an evening program for addiction services. It's not available in Cochrane. It's not available in the Timiskaming district either.

When you say intensive service, what this means is daily contact for probably about 10 to 15 hours a week per client, so it's intensive. It is typically understood as a step down from an in-patient service like a treatment bed or withdrawal management bed, or a step up from what you'd consider your typical case management. It doesn't exist, so what happens is that individuals who could benefit from that service—one of two things happen: They either go into an in-patient service, which is way more costly and doesn't have as good outcomes as could be—to be fair, individuals living with addiction are by far, the majority of them, employed and housed, which means as an in-patient not in the community, it's not just more costly, but they have to take time away from work and take time away from the house if they have kids or whatever. That's one of the uniquenesses: that suite of services we don't have.

The second thing is, we have one of the highest opioid poisoning deaths in the province. That's a really heartbreaking statistic. This is my community—my kids live here—and we don't want to see that go on. Part of a comprehensive solution is treatment, and we can't keep staff. We need the help. We really do.

The Vice-Chair (Ms. Catherine Fife): MPP Dowie.

Mr. Andrew Dowie: I want to thank all the presenters for being here with us today. This is actually my third time here in Timmins, and I want to applaud everyone in Timmins who have been advocating so well for your community, and also the broader Timiskaming–Cochrane area.

My first question is actually to Paul once again. In looking at the CMHA's work and your role in the services delivered—we heard two years ago the call for action. In the budget of 2023, there was the largest base funding increase in over a decade, so certainly, I think, the committee heard the call at that point in time. So now, as we're two years later and we still see the same struggles, I'm wondering if you might be able to share with us what role CMHA plays in addressing the issues. Are you part of the first response, or is CMHA part of the first response to mental health issues, or is someone else taking those tasks on, for example, the police or EMS or the hospital?

Mr. Paul Jalbert: Here in the Cochrane area as first responders?

Mr. Andrew Dowie: Yes. You've got the mobile crisis response team. Is that something that you operate directly? Is that an after-hours service? What does that look like in terms of your operations?

Mr. Paul Jalbert: In the Timmins area specifically, mobile crisis is a service, but it's operated by the Timmins and District Hospital. In Timiskaming, we operate the mobile crisis program. But let's be fair; we pivoted quickly in 2020 in order to address what we anticipated was going to be a rise in needs with the isolation.

We've been successful at applying for funding but not on a renewal basis, so every year we apply for mobile crisis funding, for example, typically through the Ministry of the Attorney General and whatnot, and then we've been successful. That being said, it doesn't come without the pressure of—you typically get the notice that you've been successful somewhere around October or November, and you've been incurring cost hoping that's going to come as of April 1.

I'm hoping I'm answering your questions. Those are some of the roles that we play.

Mr. Andrew Dowie: Thank you.

The Vice-Chair (Ms. Catherine Fife): You have one minute left.

Mr. Andrew Dowie: A question for the Timmins Academic Family Health Team: Mélanie, thank you for your presentation. I'm hoping you might be able to share a lit bit of what does the team look like, and is there is a specific kind of position that is difficult to recruit for here in the region?

Ms. Mélanie Ciccone: Yes. Great question. Our team has multiple locations, so some of the locations, our staff are in our own offices, but in other locations, our staff are in physicians' offices. Our main offices have at least one RN, one RPN—so a registered nurse, a registered practical nurse and a nurse practitioner. The positions that we're having trouble recruiting—at the moment, we have three nurse practitioner vacancies, so that is similar to what Paul has expressed, too, for his team. It's a huge need in our community.

We are aware of funding opportunities for nurse practitioners; we have applied twice for Grow Your Own NP, and twice we've been unsuccessful because we had temporarily filled one of our positions on a temporary, part-time basis so we could continue to provide care in the community of Gogama, so we didn't meet the criteria, and then again this year didn't meet the criteria because one of our staff is taking the program part-time instead of a full-time basis.

The Vice-Chair (Ms. Catherine Fife): Thank you very much. That concludes this round.

We'll now move to the official opposition for another seven and a half minutes. Please go ahead.

Mr. Terence Kernaghan: I'd like to allow Sensenbrenner Hospital to finish. I know we cut you off at the last moments of your discussion. Is there anything else you would like to add?

Dr. Jessica Kwapis: If you could unmute France, I think she was going to finish what she had been saying.

Ms. France Dallaire: I think my only comment was that it's very difficult for us to plan and organize services in this type of context, with the budgets, like Paul had just mentioned, when they're approved at the end of the year. Obviously, if we have more information on our financial capacity then we can address the needs of our communities much better.

Dr. Jessica Kwapis: If I can just jump in: We are taking a risk every time we make additional investment. We're trying to position ourselves at Sensenbrenner as a hub to provide services for this region that otherwise is uncovered, but we're funded as a small hospital that's funded to look after its own catchment area. So we really are taking a leap of faith and hope that there's going to be some increase in our funding, and running deficits such that we almost don't make payroll. That is a very scary place to be, and yet we're still passionate about keeping services open so that our community isn't completely uncovered.

Mr. Terence Kernaghan: Absolutely, and I think your indication of 20 obstetrical centres down to nine is a clear indication that the government needs to do more to stabilize programs such as those available at Sensenbrenner.

I think, as well, in January 2024, when the government allowed deficits to be carried and issued waivers, forcing some hospitals to possibly take out high-interest loans, is a very clear indication that the province is not funding health care appropriately; it's a clear admission. It ought to be unthinkable.

1040

I'd like to move over now to the Timmins Academic Family Health Team. Family health teams are models of care which are exemplary. They consider all aspects of a person, whether it's their mental, physical or lifestyle, as well as other health factors, and address the entirety of a person. I wanted to know: Would you be able to comment on FHT funding and when was it last updated?

Ms. Mélanie Ciccone: The last time wage and salaries was addressed was about four years ago. It started in 2017 to 2021; there was an increase to salaries and wages. Unfortunately, though, by the time that happened, the request that we had made, it didn't bring us to actual wages. It was too far behind. We have received an additional increase in our operational budget, but that was one time for two years. So these commitments are nice, but it needs to be rolled into our yearly funding, because we're not sure if we're going to get it in the future.

Mr. Terence Kernaghan: Absolutely. The province has indicated, quite rightly, that it wants to expand family health teams across the province. But does it make much logical sense to expand them when they're not funding them appropriately at this time?

Ms. Mélanie Ciccone: It's a very complicated issue. Yes, we do need the expansion of primary care teams, regardless of the model—if it's family health teams or community health centres. However, we can't not look at the wage issue, because if we're expanding teams, we need to be able to recruit for those positions. There's a lot of investments being made to increase the amount of nurses that we have across the province, but we need to be able to attract them to our field.

Unfortunately, we may foresee having vacancies if we can't fill those positions, which is what we're experiencing right now with the increase of funding we've received. We're, right now, unable to recruit two nurse practitioners through that funding stream.

Mr. Terence Kernaghan: Absolutely. I also wanted to discuss wage parity. It's something that this committee has heard year upon year upon year. In fact, in the 2024 pre-budget consultation report, authored by this very committee, it recognized that numerous stakeholders identified the issues with health care human resources and retention due to wage parity, and the need to address it. Unfortunately, no action has been taken by the province. Do you want to see fairness for health care sectors and make sure that people are paid appropriately?

Ms. Mélanie Ciccone: Absolutely, yes. Fairness across community health sectors and bringing our wages comparable to similar work that's being done in other sectors is a definite need for us.

Mr. Terence Kernaghan: Excellent. I wanted to also ask: How does access to primary care through FHTs, for instance, realize cost savings for the province?

Ms. Mélanie Ciccone: In multiple ways. It diverts people from the emergency department. We've heard, through Paul, how much it costs to offer services within the hospital. Having people access services within their community decreases that cost. Also, it helps us to work on preventative care, right? A cancer screening, for example—we are able to do that through our primary care offices. People are not presenting to the emergency department for preventative care, and unfortunately, we're getting people when they're sicker and it's taking longer to treat them.

Mr. Terence Kernaghan: Would you like to comment specifically on access to diabetes care as well?

Ms. Mélanie Ciccone: Yes, diabetes care is a definite need, especially in northern Ontario, in the Cochrane district. I believe, last time I looked, we do have one of the highest diabetes rates across Ontario. So it is a definite need.

We do have some good local partners that offer programs and services for diabetes, such as Misiway as well as the Timmins and District Hospital. But when we look at digital health solutions, it's so important for us to be able to communicate. Ideally—I know the province has said they're working towards it—but one system to be able to document so we're able to access notes, and patients are not stuck telling their story over and over, would be a huge improvement as well.

Mr. Terence Kernaghan: Absolutely. Having to tell your story over and over again, in many cases, can often lead to further trauma or further negative health outcomes.

You mentioned, Mélanie, about staff having to access food banks.

The Vice-Chair (Ms. Catherine Fife): You have one minute left.

Mr. Terence Kernaghan: What kind of impact does that have on people who work using food banks alongside the people that they serve?

Ms. Mélanie Ciccone: Our staff are so courageous in being able to share their story with us. It takes a lot of courage to be able to share those vulnerabilities with each other. It's definitely hard. It's saddening that our staff are having to access food banks. It's also sad, across the province, there are issues with minimum wage and things like that that patients are having to access the food bank as well. But when you look at it, we're funded by the province of Ontario and we're not funded—our staff are not receiving a high enough salary that they can live off of that salary.

Mr. Terence Kernaghan: Thank you very much.

The Vice-Chair (Ms. Catherine Fife): Going to the government side: MPP Hogarth.

Ms. Christine Hogarth: I just want to thank all of you for being here today, and thank you for your hospitality here in Timmins. It's nice to have the fresh air when we come here. I always love being up in the north. Just so you know, I do represent the riding of Etobicoke–Lakeshore, but I am a northern girl myself, from Thunder Bay, Ontario, so I understand the vast geography that we're dealing with. I know we're very fortunate in Toronto to have access to health care by subway, by cab or by driving. We understand the vast geography around here, and it's not so easy listening to the stories of—I can't imagine travelling down that highway pregnant or in labour. That is a difficult position to be in.

Some of the work we have done in northern Ontario—the first thing is, it was a PC government who brought in the medical school in Thunder Bay, which has made a difference. I know you see the results not just in Thunder Bay, but across northern and northeastern Ontario. Maybe I can ask you to expand upon what that has done for your communities. We have added extra seats. When we're running out of doctors, it's not to cut those seats in medical schools, as the former Liberal government did. We actually increased those seats in northern Ontario, because sometimes—you always move for two reasons: It's either love or money. When you're in the north and you see how beautiful it is, you might find that partner and stay here, so we certainly want people to stay in our beautiful northern communities.

First, if I can ask you—all the impact that the northern Ontario medical school has had on your communities and the expansion of the seats, how will that help you moving forward? I know retention and getting those people is a problem all across the province, but especially in northern Ontario. Maybe we can start with you, Paul. We'll go in the order that you spoke. Have you seen a difference, with the medical school being in northern Ontario, with having physicians, nurse practitioners etc.?

Mr. Paul Jalbert: In Timmins alone, I think we have over 14,000 orphan patients, so it's critical that we bring in primary care physicians and nurse practitioners who can help support with that. And, yes, NOSM has been critical in feeding that need.

I'd also say we also have to—we are in a technological revolution in terms of health care. Within the next decade, we're going to go from a diagnostic model to a predictive model of health care, or at least the leading health care systems in the world will be able to do that, which means that they're going to be able to predict with a fair degree of certainty which illness you're going to have in which period of time in the future, and then you can start preparing for that. If we're going to do that, we have to rethink about how we do health care. Technology has to be a fundamental part of that.

I'll give you an example. A lot of us have wearable devices that take your blood pressure. You wear it and then you can check your blood pressure for the past month. You can say, "Hey, when these things happen"—when you're sitting in front of an assembly and your blood pressure tends to go up, maybe that's not the best for your health, and you want to pay attention to that. Or we can use a traditional model, where we make the appointment, we go see a primary care physician, and we get our pressure checked at one point in time, and we make medical decisions based on that.

Now, is primary care important? It's a cornerstone of health care—it has to be, and NOSM is supporting that need—but I think we have to go a little bit further, too.

Ms. Christine Hogarth: Does anybody else have anything to add about NOSM, or did Paul fill in all the good stuff?

Ms. Mélanie Ciccone: If I can just quickly add: In Timmins specifically, we're looking at an additional 15 physicians in primary care, as well as 25 specialists, so NOSM is making a difference. A number of physicians in the White Pines Family Health Network have graduated from NOSM. It is great news that we're adding additional seats. The impact of that will take a number of years before we see any, and there is a greater issue where there is a need right now, as well, to be addressed.

Ms. Christine Hogarth: Absolutely. Jessica, did you want to add something in?

Ms. Jessica Kwapis: I echo what Mélanie just said, and also to add: Certainly Kapuskasing has definitely benefited from recruiting NOSM graduates here. Physicians also need to be retained here and so wage parity, even for physicians—okay, we're graduating family doctors, but most of them are not going into obstetrics because it's challenging, it's stressful and it's not attractive as a model for being paid. So that's part of what our proposal is, to improve the compensation for physicians to actually make them want to do obstetrics.

1050

And then there are just so many other issues as well. Doctors themselves are part of the solution, but they're not the whole solution. That's why we also need to take a broad look at the entire system and bring all the partners together to find a solution. But NOSM is absolutely a great addition and continues to be a critical part of this problem.

Ms. Christine Hogarth: Amazing stuff. Paul, you mentioned technology—I have a doctor's appointment today at 11:15, on the phone. So, interesting: Technology is changing and I can take my appointment here in 10 minutes and it's easy.

One other question and this one's actually for Jessica: You mentioned $500,000 for a plan, and I'm wondering how your plan—you said you want to do a strat plan. How do you plan on integrating that with Dr. Philpott, who started her job yesterday, I believe? How do you see that integrating?

Dr. Jessica Kwapis: Primary care is absolutely a part of the solution as well. Actually, Sensenbrenner is taking on an initiative right now to stabilize our region for surgery and obstetrics. Stabilizing primary care is also a part of that objective. I do believe that there should be a synergy between what's happening with primary care, as

well as what's happening with obstetrics. Specifically though, the issues, again, are not just primary care. It's emergency transfer—

The Vice-Chair (Ms. Catherine Fife): There's one minute left in this question.

Dr. Jessica Kwapis: —it's virtual accessibility to specialists in larger centres; it's opportunities for continuing medical education for physicians and nurses providing this; it's educational hubs to keep people's skills up in low-resource and low-volume environments. So I think the primary care initiative is one of many that needs to be brought together to look at this problem.

Ms. Christine Hogarth: Wonderful. I think with Dr. Philpott in place to work with all teams, especially in northern Ontario, but across the province, of course, just to make sure that we do fulfill the commitment of—I think her goal was a family care practitioner near their home within the next five years. So she has a big job to do, and I see all of you will be willing participants in her study. Thank you all very much for your time today.

The Vice-Chair (Ms. Catherine Fife): There's only 10 seconds left, so I want to thank all presenters. Really good questions and thank you for making the trip here to Timmins.

WEENEEBAYKO AREA HEALTH AUTHORITY

TIMMINS PUBLIC LIBRARY

TIMMINS FAMILY COUNSELLING CENTER

The Vice-Chair (Ms. Catherine Fife): We are going to be moving on now to the next set of presenters. We have two individuals from the same organization in-person. Is there agreement to allow both presenters to sit at the witness table?

Interjection.

The Vice-Chair (Ms. Catherine Fife): In total, there was five. Two will be coming up—this is from Weeneebayko. So four in-person, altogether, if we have enough chairs. It's all good? All right.

If those from the Weeneebayko Area Health Authority are here, please come up to the table. The Timmins Public Library are appearing virtually, as will Jessica Horne. And, Timmins Family Counselling Center, please make your way up here. We don't bite.

Welcome. We have enough chairs at a budget consultation; that's a good thing.

We're going to start with Weeneebayko Area Health Authority. Please introduce yourselves for Hansard before you begin speaking. You have seven minutes.

Mr. Jack Hutchison: Good morning, everybody. My name is Jack Hutchison. I'm the senior vice-president and chief operating officer at the Weeneebayko Area Health Authority, or WAHA. I'm here today with Lynne Innes, our president and CEO. We are an integrated health organization, providing care to the six communities of the western James Bay coast for all phases of life. Our organization provides acute, long-term care, primary care, mental health, community health programs and a paramedic service.

We, like all health providers, are facing an unprecedented financial challenge, particularly with agency nursing and physician locum costs. Given our geographic location and the transient nature of our workforce, WAHA has historically relied on agency and locum staffing to ensure safe, effective and efficient patient care services. Like our broader health system, this reliance was exacerbated during the pandemic and has only increased. The increased need has resulted in further operational pressures as the cost of agency hours has risen as organizations across the province also become more reliant on them.

At WAHA, while we have made great strides with recruitment and, more importantly, retention, we are developing and have strategies to ensure that we become less reliant on agency staff, but we also recognize that they will be a key component of our staffing models for the near and medium term. In discussions with our peers in the northeast, this seems to be the case. While we recognize that Ontario has made great progress in supporting the health system with planning, new services and programs and an unprecedented amount of redevelopment projects and is working diligently to address recruitment and retention within health human resources, there must also be a system-level approach to agency and locum staffing to ensure that organizational spending is sustainable and that providers are able to continue to deliver safe and high-quality patient care services.

This issue is the same within our physician group. At WAHA, we are funded for 18 full-time physicians and currently we have eight. Only four of those are able to work in our emergency departments. Our staffing model within this group requires physicians to work both emergency shifts and primary care shifts, with those primary care shifts occurring across each of our six communities. The shortage of physicians has left some communities with gaps in primary care services as well as a dramatic increase in costs to fill our emergency shifts with locum physicians. Currently, we're paying $3,500 per emerg shift to a locum physician, and recently another hospital in our region was offering $7,000 a shift.

Let me be clear that we support other organizations' efforts to provide care in their community, but this is unsustainable and has created an environment where hospitals are competing for providers and not systematically planning services to meet the needs of the residents of northeastern Ontario. It also creates a system where physicians are incentivized to leave their full-time employment with WAHA and work as locum physicians as they get more flexibility, more time off, higher compensation and more flexible scheduling. At WAHA, we are beyond grateful to our physicians who have stayed and the dedication and care they provide to our communities.

In comparison to other hospital organizations, over the last three to four years, we have performed stronger, financially speaking. This year, though, we are forecasting a $16-million deficit, which is the same number we're anticipating to spend on agency nurses and locum physicians,

with a $9.2-million premium on agency nursing alone. Physician and nursing shortages are also resulting in a lack of primary care in our region, as we stated, especially at Weeneebayko. I informed you of our model of practice within physician services; however, there's also a need for further investment into primary care nursing and increased funding for primary care nurse practitioners. With only having eight physicians out of 18, as well as the strain that this staffing places on ensuring that we have our emergency department shifts covered, our communities are not receiving full primary care services and visits, which could be offset by further funding of nurse practitioners in the northeast.

Last year I know the government invited organizations to apply for primary care funding, and we were informed that an unprecedented number of applications were received. We submitted a fulsome proposal which outlined significant gaps in our region and a plan to begin addressing them. We were provided for funding for a primary care team; however, it was significantly lower than our request, resulting in continued gaps experienced by the people of the James Bay and Hudson Bay coast.

To put this into perspective, our population health team recently completed a research project on mortality, and 59% of the people we serve do not live past the age of 65. Yes, you heard that correctly: 59% compared to 22% for the rest of Ontario. Our population has an overrepresentation of diabetes and cancers and a lack of access to primary care. An investment in this area would not only provide organizations like ours with the ability to be innovative in scheduling and models of staffing, but it would finally begin to address the inequalities in access faced by our organization.

There are other considerations that WAHA asks Ontario to make when determining and allocating health care funding, specifically around the uniqueness of our organization. We were established through the merger of a provincial and a federal hospital and have grown into an integrated local health system that serves all six communities across the 400-kilometre span. Moosonee and Moose Factory, where our headquarters are based, are accessible only by train, with Moose Factory, on an island, only by water and helicopter. Fort Albany, Kashechewan and Attawapiskat as well as Peawanuk are only accessible by air, and all six communities rely on seasonal ice roads to deliver goods and services.

1100

Despite the clear remoteness not experienced by other organizations, the funding model for health services remains the same as the rest of the province despite the increased costs of delivering care, shipping supplies, getting patients out, bringing staff in and even travelling between our sites. WAHA has asked and are continuing to advocate for a remote funding formula to account for these costs.

The Vice-Chair (Ms. Catherine Fife): You have one minute left.

Mr. Jack Hutchison: We're grateful for our relationships with Ontario and the government and the investments they've made in our region, and these issues of agency nursing, locum physicians and primary care have devastating impacts on ours and other health organizations. We're encouraging the government to develop a coordinated and systematic approach to dealing with agency nursing costs, locum physicians and health human resource deployment programs, as well as other tax incentives and wage strategies to attract health practitioners to northern Ontario.

We thank you for allowing us to appear today and look forward to our feedback in the next budget.

The Vice-Chair (Ms. Catherine Fife): Next we'll hear from the Timmins Public Library. Please go ahead, and please introduce yourself before you speak.

Ms. Carole-Ann Demers: I'm Carole-Anne Demers, CEO of the Timmins Public Library, a member of the Federation of Ontario Public Libraries. Thank you for letting us join today's 2025 pre-budget consultations.

Public libraries are important to help economies grow and thrive. I work with amazing librarians every day who help people. Our library aims to build community and inspire change, and our services are all about the people.

Millions of Ontarians depend on libraries for free services which help them: to learn and develop new skills; to find jobs; to connect with people, community and government resources; to access leisure and educational resources for kids, teens, adults and seniors; to use computer stations and access the Internet—a service that the majority of us take for granted, but for a homeless person, we are the only go-to.

Oftentimes, the public library in a smaller town is the only place in town where patrons can get one-on-one help with email, government forms and help to connect with social service agencies that are only available online.

Libraries support teachers and parents, and foster a love of reading in children and develop their literacy skills at home and in the classroom.

Public libraries are simply a place to connect with others, which we know is such an important thing in people's lives today, whether it be a senior participating in a book club, storytime moms and dads sharing parenting information, a shy and lonely teenager who has the opportunity to participate in a fun coding program that connects them to other youth or a newcomer participating in a conversation circle making them feel welcome in their new city. Public libraries are a place where everyone is welcome and inclusivity is a priority.

Libraries adapt to community needs, but challenges like the pandemic, inflation and rising demands are making it increasingly difficult.

Your government has supported libraries by increasing funding for First Nation libraries and by installing or upgrading broadband connectivity at over 100 public libraries. We are very thankful for those investments.

Today, Ontario libraries are advocating for critical, targeted investments that will stabilize our public libraries and ensure that all Ontarians, no matter where they live or learn, will continue to have access to modern, cost-effective resources and services they have come to rely on through their local public libraries.

In 2024, digital resources are a key part of any public library. The difficulty we are facing is that some communities cannot provide services and resources at the same level as other municipalities, creating an uneven playing field for residents based on their location.

The Federation of Ontario Public Libraries is proposing a new provincially funded resource, the Ontario digital public library. I'll tell you a bit more about that.

These digital resources would help with job skills, language learning, tutoring for kids, health information and more. Examples of these include: LinkedIn Learning, which would cost our library $8,000 to $10,000 based on our population; national and international newspapers online, which would cost $5,000 to $10,000 for our library; Ancestry Library Edition for those researching their family tree; live tutoring and homework help for our kids; legal forms and templates; and so much more.

These resources are expensive, especially when libraries have to buy them on their own. Most families can't afford to pay for them either. This has created a big gap: Larger-city libraries can afford these digital tools, while smaller-city libraries and libraries in rural, northern and First Nations areas often cannot.

Following successful models already established in Alberta and Saskatchewan, Ontario has an opportunity to leverage its purchasing power, saving up to 40% compared to libraries purchasing these on their own, to establish a provincially funded digital resource. An annual provincial investment of approximately $15 million for the Ontario digital public library would ensure equal access to high-quality tools to all Ontarians, either in the library or remotely from home.

Also a priority: Ontario's public libraries are advocating for increased provincial funding to meet evolving community needs. My colleague Jessica Horne from the Cochrane Public Library will speak about this priority. Thank you for time.

Ms. Jessica Horne: Hi, everyone. I'm Jessica Horne, CEO of the Cochrane Public Library, and I'm very happy to be joining you all today representing medium- and small-sized northern Ontario libraries. We are continuing to emphasize the need to increase the annual provincial funding for Ontario public libraries, which will be used to address critical shared priorities, both government's and libraries'.

Unlike most sectors in the province, Ontario's public libraries have received no increase in provincial operating funding for over 25 years. Due to the inflation during that time, the value of the province's investment in public libraries has decreased by over 60%. To put that in perspective, the $3 that would have gotten you a large cup of coffee in 1996 would only get you a small cup of coffee today.

The Vice-Chair (Ms. Catherine Fife): You have one minute left.

Ms. Jessica Horne: While the majority of our public library budgets are municipally supported, the provincial portion of our funding is critical. This funding supports our budget and also sends the message that libraries are an important priority for the province. The ask is that Ontario public libraries get an extra $25 million every year to help with these priorities, which are:

(1) Supporting economic recovery through job training and skills development: Library staff are helping people write their résumés, and they are helping them do online training for a new job or helping them set up appointments with social service organizations in town; and

(2) Helping address the impact of mental health and addictions: Library staff sit on community wellness committees, support the local health unit initiatives and connect people with rides to their medical appointments.

We offer these resources to everyone in the community, regardless of their background. The people who really need it most, like seniors, newcomers, working families and those in vulnerable states, know that they can access these things for free at the library; however, we're having a hard time providing those resources on our limited budgets.

As always, we support early literacy in kindergarten through grade 12 success—

The Vice-Chair (Ms. Catherine Fife): Thank you very much, Jessica. That concludes your time. I'm sure there will be some questions for you.

We're moving on now to the Timmins Family Counselling Center. Please go ahead, Tania, and please introduce yourself.

Ms. Tania Duguay: Hi. My name is Tania Duguay. I'm the executive director at the Timmins Family Counselling Center. Thank you for giving me the opportunity to speak with you today.

Timmins Family Counselling Center is a non-profit agency that provides counselling, clinical counselling and psychotherapy to individuals and families in Timmins and the surrounding area. Our services are unique because we fill the gap in the system of care, often serving the most vulnerable and meeting the diverse needs of our communities, including low-income, Indigenous, women, men, youth and individuals of all gender identities. We don't only serve the clients who are funded under ministry-funded programs, but we also help anybody who comes and reaches out for support, and we tailor our approach to meet each person's unique experience and goals.

Our organization provides clinical counselling, so our service is different from crisis intervention. We do the early intervention and we also do the continuity of service. How I explain it is that if somebody breaks a leg and they have a cast, that's the crisis, and you attend the needs right away. Then, after they take the cast off, they go to physiotherapy to regain the mobility and the strength in their leg to be able to walk again and return to their normal daily activities.

So what we do is, the intervention is like the physiotherapy, so we're after the crisis. We offer services to help them find coping skills, build resilience, and when they're faced with life challenges again, they have all the skills and the tools to be able to address that and not fall back into crisis mode.

1110

Today, I'm here to speak to you about two urgent issues: One is addressing gender-based violence by offering or having funding for early intervention for men. The other one would be the human resource crisis, so pay equity.

I would like to begin by discussing the critical needs for increasing funding for early intervention for men to address gender-based violence. Right now, we focus a lot on the women, the survivors—the needs, the crisis, the housing, that support, counselling for women—but we are missing one big piece and it's the early invention for men.

There are not a lot of services for men. If they have services, they have to pay for it, or they're really not tailored towards the needs that they do need. A lot of men will come for services because they want to be a better father, they want to be a better partner, better community partner; however, finding that support is very difficult. There are a few services that are available to help men address harmful behaviour, develop healthy relationships and break the cycle of violence. By focusing after the fact, just to support the survivor, we're really missing one big piece, and it's to address the men and give them those supports.

Gender-based violence—know that there is a high cost on the province of dollars; there is a high cost on health care, law enforcement, social services, not to mention the emotional and social toll on families and communities. By broadening our approach and giving early intervention to men, we'll be able to reduce these costs but also save lives and help to build healthier and happier families.

So one ask is to increase the funding for early intervention for men as a way also to address gender-based violence.

The other ask that we're talking about is the human resource crisis. There's been a high turnover, a lot of burnout, and the family counselling centre has been living a lot of that, where we have really qualified staff that come in and then they move to a higher pay. We do hire qualified staff. They went to college, they did university, they invested into their career, their profession, they have the skills, we give all the training, and they do amazing work, they're supporting clients in their healing journey, they're changing lives, but the low wages do not equal the value or reflect the work that they do, even in community care. So what happens is they move or they go to other sectors like hospitals, education, and they do similar work or the same work that they do at the family counselling centre but with a higher wage, and now they feel that their work is valued. What they do equals the pay, so that value is very important. We also know that when qualified staff leave, it has a ripple effect on the delivery of the quality of service, as well as the cost in the recruitment and training on the centre.

So the other thing that I'm advocating for is pay equity so that the pay reflects the value of the work that the staff do. By doing that, we're ensuring that these workers are compensated fairly; we'll help stabilize the workforce, improve service delivery and reduce recruitment and training costs. This is also an investment in both the people who work in this sector as well as the families, individuals and the services that we offer.

The Vice-Chair (Ms. Catherine Fife): You have one minute left.

Ms. Tania Duguay: That's pretty much my conclusion. Thank you for your time and consideration.

The Vice-Chair (Ms. Catherine Fife): We'll begin with seven and a half minutes of questions from the official opposition. MPP Kernaghan, please go ahead.

Mr. Terence Kernaghan: I'd like to begin with Jack and Lynne from WAHA. Thank you for your presentation. I believe that you had indicated that you will be facing a $16-million deficit. How does that play out? What kind of impacts will that have for WAHA to be operating under that deficit?

Mr. Jack Hutchison: Like every organization, we're going to do everything we can to not reduce service delivery. But if it continues and there's no long-term plan, then that means potentially reduction in services, but certainly a reduction in workforce. It may mean reduction in travel and we're not able to go between sites.

We're worried that we're going to be where the group that spoke ahead of us is, where we're barely making payroll. That's the trend we're going to be headed down if there's no long-term solution. I know there are some long-term solutions from the government in place. Those won't be impacting us for at least a few years, so we need something more sustainable now.

Mr. Terence Kernaghan: Having a $16-million deficit does really speak to the inadequate funding that you're receiving, because it seems as though you're not able to meet the needs of your community based on the funding that is being provided. You spoke to the really large proliferation of agency nurses, something that we've seen across Ontario and how that has changed since the pandemic, as well as the increased cost of locum staffing.

You recommended a system-level approach. What would you like to see the province institute in that?

Mr. Jack Hutchison: In an ideal world, there would be regulated salary caps on what agencies can cost. The other is, potentially, a deployment plan, so whether that's in the northeast or the northwest or province-wide, having a strategy where there are health professionals that can be deployed to organizations requiring staffing, or just more investment into the programs that are existing or new programs, for example the Learn and Stay program for health professionals, tuition forgiveness or reimbursements. I know one thing we discuss frequently is that physicians have tax incentives for serving and working in underserved areas—perhaps opening that up to other health professionals.

Mr. Terence Kernaghan: I think agency nursing is always going to be necessary in northern Ontario, but as you say, there does have to be reasonable limits. The province can certainly address those.

I'd like to now move over to the Timmins Public Library. It's near and dear to my heart; I'm a former teacher-librarian.

You spoke about the 25 years since the province has addressed their funding, and you've spoken quite well about how the actual funding that they've provided has decreased as a result of inflation. How much does the municipality fund the library as opposed to the province?

Ms. Carole-Ann Demers: Currently, it has been 95% of our budget, and I would imagine now, it's probably closer

to 97%. The municipality basically has to pick up the pieces because of our funding model.

Mr. Terence Kernaghan: It seems a common theme: We see shortfalls from the province, and others are expected to fill that gap.

Can you discuss how public libraries support STEM learning? Hopefully this will get their attention.

Ms. Carole-Ann Demers: Absolutely. Jessica can also chime in there.

For ourselves at the Timmins Public Library, we have a monthly STEM activity at our branch. That has been very popular. Every month, we advertise that we're going to be doing some type of STEM event.

As well, we have, of course, our collections—a lot of them are geared to science.

For the kids, we have special programs, drop-ins, that kind of thing. We have a Lego challenge, and we had an engineering challenge at one point where we built cardboard houses with the engineering association, that kind of thing. Those are always in our plans when we're developing programs for kids.

Jessica might have additional—at the Cochrane library.

Ms. Jessica Horne: As a much smaller library and municipality, we don't have the funds to keep up with the newest kinds of technology and STEM programs. It costs a lot of money to have Raspberry Pi, to have circuit-building programs and to have 3-D printers that can do what people need them to do. We're not able to keep up with that demand. We don't have the manpower to do the training that it takes to offer these programs. So while there's all of the desire to do that, we are limited as a smaller library in what we can do for that.

Mr. Terence Kernaghan: Understood. What will happen if public library funding is not stabilized?

Ms. Carole-Ann Demers: What happens across the province is that we end up losing staff, for the smaller libraries especially. That also results in less hours open to the public, and as I've described, the library's a really important place for a lot of people. So if you're starting to reduce services, that's where it affects the people.

1120

Mr. Terence Kernaghan: Absolutely. In some smaller communities, it is basically something that stands in for a constituency office, with the supports that we provide.

Ms. Carole-Ann Demers: Yes.

Mr. Terence Kernaghan: I also wanted to know if I could hear your comments—it seems as though there are different areas of the province where there's inequity based on your location. Would you like to discuss those?

Ms. Carole-Ann Demers: Basically, the inequity is the funding model. Different municipalities will appreciate the services of the library more than other municipalities. And then, it all boils down to the funding that the municipality has. Depending on the number of households, they only have so much money to go around. I think it depends on the council, it depends on how good of a job that library is doing at promoting themselves and making sure that every resident in that community knows the value of the services that we offer. I think it depends on the municipality. I see some that are struggling, some that are one-person libraries. They're struggling.

Mr. Terence Kernaghan: So it would really seem that if the province chooses not to step in, they would really be letting down northern, remote and rural communities because of this continued inequity that they are fostering. Thank you very much for your comments.

The Vice-Chair (Ms. Catherine Fife): You have one minute left.

Mr. Terence Kernaghan: I will just say, your comments about asking for $25 million a year, it's something that we have heard at this committee year after year after year. I look forward to the committee hopefully addressing this and listening this time. I want to thank you and all of the people who work for the public library system for being on the front lines with mental health supports. Did you want to speak about the lack of supportive housing that we see in our province?

Ms. Carole-Ann Demers: Supportive housing?

Mr. Terence Kernaghan: Yes.

Ms. Carole-Ann Demers: That's not really my area of expertise, but I can tell you that the library is a place where everyone can go to provide a warm space. During the day, definitely, we have a lot of homeless folks that are using the library, they are using the computers, they are sometimes just using it as a place to sit because we are a warm space. At the same time, we're hoping that—

The Vice-Chair (Ms. Catherine Fife): Thank you very much. I'm sure you can get in more questions in the second round.

Moving forward, MPP Smith, please go ahead.

Mr. Dave Smith: I'm going to start with WAHA, if I could. A couple of things that you pointed out: You were formed as a merger of the provincial and federal hospitals. Does the federal government still provide any funding at all?

Mr. Jack Hutchison: They provide some funding. We have a formation agreement that they're obligated to. They're also funding a portion of our redevelopment, but it's not been costed to inflation, so we still receive the same amount we've been receiving for 15 years.

Mr. Dave Smith: It's an interesting model. You've got acute care, long-term care, primary health and paramedics, if I understood correctly. I haven't seen another model quite like that, so it's very unique and I think that's fantastic. Do you run into trouble on the agency side because you're trying to get somebody who, potentially, is a nurse on the primary care side, but then you need to have somebody who's in as a paramedic? Or is it simply the nurses that you're looking for at the moment for the agency side?

Mr. Jack Hutchison: For agency, it's mostly registered nurses.

Mr. Dave Smith: A proposal has come in to me from one of the health care providers in Ontario to create a regional set-up for what effectively would be agency nursing. I'm not familiar with your operations, so I don't know whether or not this is something that would work. The concept is five or six hospitals that would be within a reasonable distance, which, I get, is very different in different

parts of the province. I say that because my riding is larger than every other riding combined that is here in the room. I'm the size of Prince Edward Island, but I'm small compared to some of the geographic areas that you take.

Is it feasible to create something within our existing health care system where nurses—I'll use hospitals as an example because it's easy, everyone understands that—who are part-time at one hospital could submit their names and have a pool, then, within, say, five or six hospitals, and rather than go to an agency to bring a nurse in, they could offer up those shifts to nurses from other hospitals? They would simply move from hospital to hospital, knowing that, perhaps, they don't want to be full-time, but maybe they want to pick up an extra shift on the weekend or an extra shift through the week because they're doing something else. Is that something that would be reasonable in your region?

Mr. Jack Hutchison: I think, for sure, it would be; it would have to be nuanced. We did have a partnership with Health Sciences North in Sudbury. We had an agreement where they would provide us nurses and their nurses would earn seniority with their bargaining unit. So there's an advantage to working elsewhere—and we have not been successful, just because they're so short-staffed. So, in concept, yes, but—

Mr. Dave Smith: In practicality, probably not at the moment.

One of the things that we recognize is that there is a shortage of human health care resources. When you look at doctors, our population has increased every year. We had a reduction in the number of residents' positions almost 10 years ago now; that would have added 450 more doctors to Ontario.

I've said repeatedly that it doesn't take a rocket scientist to figure out that if your population is growing, you need more doctors and more nurses and so on. It's something that is a challenge for us on the family health physician side. It's anywhere between five and seven years for a doctor to go through school. So we made that increase in our first budget in 2019. Universities didn't actually add the spots until September 2020 simply because of their cycle to be able to do it. So the first cohort of doctors will actually graduate this year from it.

Again, I'll come back to it: It shouldn't have taken a rocket scientist to figure out, as the population was growing, you needed to add more doctors. The challenge that we face at the moment is that it is five to seven years for someone to go through medical school.

Do you have any suggestions on how we could expedite that without reducing the level of education, without producing doctors who are at a lower quality? Is there anything we can do to speed that up so that it doesn't take five to seven years for a doctor?

Ms. Lynne Innes: I certainly think that there are opportunities for growth and innovative modelling with the existing nurse practitioner program—

The Vice-Chair (Ms. Catherine Fife): I'm sorry; could you just introduce yourself, please.

Ms. Lynne Innes: My apologies. Lynne Innes, president and CEO of Weeneebayko.

I certainly think that there are opportunities to have a path or an education stream, especially for a nurse practitioner who's working in remote communities because they essentially are the one-stop health care access point to about 15,000 people in our region.

So having a pathway that shortens that education, as well as—we've heard time and time again—international physicians, but trying to get them over here and going through all of the paperwork is—

Mr. Dave Smith: Brutal.

Ms. Lynne Innes: It is.

Mr. Dave Smith: Absolutely. I'm not going to disagree with you on that one. I know, locally, we've had some challenges bringing in international physicians. If you are trained in the United States, it's a little bit easier; if you're trained in the UK, it's a little bit easier, but if you come from any other country, for whatever reason, the College of Physicians and Surgeons seems to want to go through that whole—re-litigate, almost, whether or not someone is qualified. I personally don't know how we make the adjustment on that and get them in faster without the College of Physicians and Surgeons coming forward and saying that, yes, someone who is trained in another country is still pretty good.

Again, I'll use a local example: I have a gentleman who grew up in Peterborough, didn't get into an Ontario medical school, so he went to the Bahamas. He did all of his residence in Michigan. I would think that, if you cross the border between Ontario and Michigan, it's not a significant drop in the quality of physician. He could practise medicine. In June, when he walked across the graduating concourse, in Michigan—

The Vice-Chair (Ms. Catherine Fife): You have one minute left.

Mr. Dave Smith: —and yet, it took us nine months to get him registered here in Ontario. He was living at home with his parents. A great set up—it would've been fantastic for us. We just had that challenge. I know, in northern Ontario, you have a more significant challenge because you have to bring someone up here and convince them to come up here.

It's kind of ironic, because last night, when we were coming in from the airport, our taxi driver was an engineer. He was a mechanical engineer who moved to Timmins from India because he wants to work in the mines. But we wouldn't recognize his credentials right away—again, the Professional Engineers Ontario are the ones who decide on that.

We've got people who want to come here; we just have to convince the agencies and groups who do the certification to speed that process up.

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The Vice-Chair (Ms. Catherine Fife): Moving on now to the official opposition, MPP Kernaghan.

Mr. Terence Kernaghan: I'd like to turn to the Timmins Family Counselling Center and Tania. I want to thank you very much for your comments about the importance of early intervention and it's cost-effectiveness as opposed to crisis intervention. I hope that the committee takes those under advisement.

You also spoke about gender-based violence—just quickly. Would you like the province to name this as a crisis of men's violence against women? Do you think it's important that that being explicitly stated?

Ms. Tania Duguay: A really good question—now, how I want to answer it and how many people want to hear about it might be two different things. But, no, I really feel that early intervention for men is very important altogether. I think it will have a good outcome on gender-based violence; however, it is important to give services to men as early intervention as counselling.

I feel that men, even boys, they go through—they have trauma. They go through violence—emotional, physical, sexual abuse. They grow up, they get to 18 years old, and there are no services for them after that. Where do they go? They have to pay for services, and they fall into the cracks. After that, they have learned bad coping skills—so how to cope with that anger, that anxiety—and then it might come to violence. Once they go into the system, then they have the PAR Program and they can have access to services again, but they had to get to that point to have services.

How about if we are able to give them services before we get to that point? This is what is important, because I think after a certain age, boys and men fall into the cracks, because they have to pay for services and not everybody has the funding to pay for service. We pass a lot of men under United Way funding, donations that we receive from the mine. We take that funding to help them out.

A lot of people—when I first started in 2003, the male population seeking services was very, very minimal. Now if I look at my stats, I have 49% is women and 41% is men seeking services, because they want help. They want to be a better person. They want to know how to cope better with their stress. They want to know how to cope better with their anger. They want to make better choices. I think it's just, overall, that giving services to men will have a benefit through being a better person—and, too, one of the resulting outcomes would also be to help with gender-based violence.

Mr. Terence Kernaghan: Absolutely—and whether you consider all of the lives that will be impacted as a result of not addressing the root cause. But I think you've spoken quite effectively about how the province really needs to address the root cause rather than the symptoms.

I would like to speak now about the health care human resources crisis, particularly wage parity. I think your comments about how people are being paid low wages within certain sectors as opposed to other sectors, where they have similar work but a higher wage—specifically, you said, "Work is valued and that pay reflects the work that people do."

This committee itself, in their pre-budget consultation report from 2024—I'd like to quote from that and then just hear your comments—"Another common request for investment heard by the committee related to health human resources. The committee heard gratitude for recent wage enhancements, but witnesses raised concerns about those professions that did not qualify and about the ongoing legal challenges to Bill 124.... Many of these witnesses asked for a health human resources strategy focused on recruitment and retention that would also deliver wage parity. Several witnesses suggested that current wage differences resulted in some employers—notably in home and community care and primary care—losing staff to other better-paying sectors."

Would you like to speak about the importance of paying people what they're worth for the job that they do?

Ms. Tania Duguay: How it would be very important is, there will be less rotation in staff and just feeling valued. They went to college, they went to university, they invested—they paid a lot of money and invested into their profession, if it's psychotherapy, social worker, registered social worker. And then they come to work at a lesser wage, and they're doing extremely wonderful work. I think by giving that value to their work, it's going to help just with feeling better. I think with the increase—we can't follow the increase of society and how everything went up in cost. Just to be able to give that, as well as, for an agency, the cost of training—we invest so much in training. We pay for couples therapy training, and then we do trauma training and we do all of that. Then they're with us for a year or two, and then they move onto a higher-paying job doing the same work and then we have to start all over again.

This disrupts the clients as well, because now they have to change therapists. They have to start all over again. The quality of care is affected and we have frustrated clients who are just frustrated because they changed therapists three times in one year. This is not good-quality service. How can we say we give quality service, if every time they come in they have a different person?

It affects the cost of training, the cost of retention—just being able to recruit those qualified therapists is so hard, especially in the north. We cannot find those qualified therapists. I don't know where they go. They graduate university and college and they're certainly not in the north. It's very hard and costly for the centre, so it has a whole ripple effect all over.

The Vice-Chair (Ms. Catherine Fife): You have one minute left.

Mr. Terence Kernaghan: If we can get the government to admit that pay reflects the value of the work that people do, then really, it makes one think that the province doesn't value the work that you do by allowing wage disparity to continue. Do you think that the province needs to admit that wage disparity is causing a crisis for people, for organizations and for health care quality across the province?

Ms. Tania Duguay: I certainly do, yes.

Mr. Terence Kernaghan: I did want to quickly ask: You work with survivors of sexual assault. Do you see an impact with the backlog in the underfunded justice system?

Ms. Tania Duguay: What do you mean? Sorry.

Mr. Terence Kernaghan: Do you work with folks who are seeking justice within the courts, but are not able to receive it because of cases being dismissed because time has run out?

Ms. Tania Duguay: We do a bit. We don't really support the victim in court, so we usually see them after court to help them with support and go through their trauma—

The Vice-Chair (Ms. Catherine Fife): Thank you very much. That was good.

Going to the government's side. MPP Saunderson, please go ahead.

Mr. Brian Saunderson: I want to thank all of our presenters today for coming to give us your thoughts about our upcoming budgeting process, which is very important.

My first question is for WAHA. In my riding of Simcoe–Grey, we have three hospitals, and all three are going through capital requests. It's a long process, but what we're hearing from our local family health teams is they also help to drive recruitment. I know our health care system is far more than bricks and mortar, but bricks and mortar are an important aspect of it. My understanding is that WAHA and the government of Ontario have awarded a $1.8-billion fixed-price contract to get a new Far North hospital built. I'm wondering if you can just speak to us on how that's going to change service delivery up here, but also how that might change your recruitment efforts.

Ms. Lynne Innes: Certainly moving from a 75-year-old hospital to a brand new facility, I'm sure, is going to help recruitment. It's also going to be the hub and spoke in reaching everybody along the James Bay and Hudson Bay coast, so spanning 400 kilometres to the hardest to reach. There are always going to be issues with access to care, as well as delivering that care in a timely fashion. But our difficulty is not having an appropriate funding model to be able to deliver the services that we need to to the hardest to reach in the province.

Mr. Brian Saunderson: This year's budget had a $45-million investment to expand the Northern Health Travel Grant Program. Has that impacted how your patients can get access to the services they need?

Ms. Lynne Innes: I'm going to say 95% of the patients that we serve are First Nations, and not all of them are able to capitalize on or to utilize the travel grant system. Probably 10% can utilize it, but it's not enough. Because of our location, the cost of a plane ticket just to get to Timmins is $3,000 return, so the northern travel grant doesn't even come close to compensating for what the actual cost is to receive specialized care.

Mr. Brian Saunderson: Did you want to add anything?

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Mr. Jack Hutchison: Just with the travel grant as well, a lot of it is a reimbursement system, so people have to put that money out and then wait a long time to get the funding back. We were informed that we could apply to be an agency that administers the travel grant; the issue with that is we have to then front the funds and get reimbursement.

So if there's work to do there, that's definitely something organizations like ours could be interested in, but just having to front that and then wait months and months and months to recoup that cost is not sustainable.

Mr. Brian Saunderson: It's a challenge.

My next question is for Tania. We have at Queen's Park now a justice policy standing committee which is looking into intimate partner violence, and we've gone through two stages of our hearings, so I was very interested in your comments abut proactive upstream investments in making sure that we break the cycle, because we're certainly hearing to date about the cyclical nature of gender-based violence and intimate partner violence.

One of the programs—this government has implemented a pilot project in Hamilton in the high schools, Coaching Boys Into Men. So the high school coaches are being counselled on programs and counselling they can provide to their young athletes to try and address this problem.

I'm wondering if you could just go into some detail about the programs that you're thinking of initiating if you were to get the funding through the budget or through some other mechanism to help educate boys, and men, and provide them the services, because we're certainly hearing that men at risk are having trouble accessing the services before something traumatic happens.

Ms. Tania Duguay: There's one thing that comes to mind: In Nova Scotia, they have an intervention line for men that seems to be working very well through counselling services. I think they're all paired up throughout Nova Scotia and they help each other out and they work in collaboration within different agencies. So having that, but as well, just offering funding to offer that individual counselling, that counselling when men are seeking help, so that they have access to those services right away and not be put on the wait-list, or if they don't have the service, they won't even reach out. It takes so much to reach out, and then to say, "Oh, I cannot pay for service," or "Okay, well, you'll fall under different funding"—it just takes so much just to make that phone call, and then having to jump hoops over hoops just to be able to have that service that could just be offered and give them the tools that they need at the time that they need it.

We're also talking about couples counselling to help them as well. Doing couples counselling—group or couples counselling, was something that we've talked with the family services agencies about. I'm part of the members for Family Service Ontario as well, so we're all working in collaboration to be able to extend our resources, and if anything comes our way, we can all work together and share those resources so we can attend to the men's needs as Ontario, as well as a community.

Mr. Brian Saunderson: Thank you. Those are my questions.

The Vice-Chair (Ms. Catherine Fife): There are still two minutes left. MPP Barnes, please go ahead.

Ms. Patrice Barnes: I just wanted to have my question also for Tania. We're talking about intimate partner violence, and I don't know if you—did you have a chance to participate in that round table at all that is happening at Queen's Park right now?

Ms. Tania Duguay: No.

Ms. Patrice Barnes: The government had announced another investment of $162 million for organizations that wanted to do a lot of the things around preventative measures. Did you get a chance to apply for any of that either?

Ms. Tania Duguay: Is that the gender-based violence, the big funding that was—

Ms. Patrice Barnes: Yes.

Ms. Tania Duguay: I did not apply as an individual centre because I know it's very hard to be recognized as a

small centre in Timmins to have funding, so what we've done is we've applied through Family Service Ontario—

The Vice-Chair (Ms. Catherine Fife): Just one minute left.

Ms. Tania Duguay: There are people in Toronto that are doing a collective funding ask for men, for couples, and I piggybacked with them, so if there's funding, it will be trickling down our way as well. So that's how we—

Ms. Patrice Barnes: How much time left?

The Vice-Chair (Ms. Catherine Fife): You have 30 seconds.

Ms. Patrice Barnes: I have a question for the libraries—thank you, Tania.

We're starting to recognize the difference, that we need to differentiate between urban and northern, and we see that where we have done the funding for Indigenous communities. I wonder if you want to talk a little bit about—maybe we need to start doing that as well just for libraries. Whereas in the urban sectors you might have a lot more overlapping of services, like what you're doing now, employment services, helping with resumes and that sort of stuff—

The Vice-Chair (Ms. Catherine Fife): Ten seconds left.

Ms. Patrice Barnes: Quick response

Ms. Carole-Ann Demers: I think just maybe looking at the funding model that has not changed in all these years—25 years it has not increased—but also looking at how it's allocated.

The Vice-Chair (Ms. Catherine Fife): I want to thank all presenters—really good conversation. Your time is really appreciated.

This committee stands recessed for lunch. We'll return at 1 o'clock.

The committee recessed from 1145 to 1300.

QUILTS FOR SURVIVORS
EAST END FAMILY HEALTH TEAM
CANADA NICKEL CO.

The Vice-Chair (Ms. Catherine Fife): We're back here for the afternoon—welcome, everybody. For the new folks who haven't been here, this is pre-budget consultations.

Just for the members: We don't have an update regarding Manitoulin, but Vanessa is working on that right now.

Just as a reminder, all questions come through the Chair. Each presenter will have seven minutes, and then we will rotate between the official opposition and government members.

Without further ado, please start. First, we will hear from Vanessa from Quilts for Survivors. Please identify yourself before you start speaking, for Hansard. Please go ahead.

Ms. Vanessa Génier: My name is Vanessa Génier. My spirit name is Summer Sky Woman. I'm from Missanabie Cree First Nation and I'm the CEO and founder for Quilts for Survivors. Quilts for Survivors started as a grassroots initiative. Over 6,300 quilts have been gifted to date, supported by a growing network of volunteers, sponsors and staff.

I'm honoured to present the 2025 financial plan for Quilts for Survivors. Our mission is to create comfort and healing through the making and gifting of quilts, a small but powerful gesture of care and solidarity for survivors. Our vision is bold: to see that every living survivor receives a quilt, a tangible symbol of love and support. In today's presentation, I'll outline our achievements, plans for 2025 and the opportunities we have to grow with your support.

One of our top goals for 2025 is to strengthen our team. Currently, we have three dedicated staff members: myself, Katherine Jeremiah as studio manager and Kendrick Jeremiah as studio assistant. To meet the growing demand and improve our operations, we hope to add two to three more staff members. These roles include a longarmer to speed up production, an executive assistant to manage administrative tasks and a volunteer coordinator to enhance volunteer engagement. These additional positions will ensure we maintain a steady workflow, increase quilt output and send out more quilts to survivors in a timely manner.

This year, we've seen a remarkable 54% growth in funding and donations compared to 2023. This progress reflects the deep commitment of our supporters and the increasing recognition of our mission. Grants provide nearly half of our revenue, with the remaining coming from generous donations, sponsorships and our annual sewing retreat, which added additional revenue this year. At the end of the 2023-24 fiscal year, we carried over a surplus, much of it allocated to wages, ensuring sustainability for our organization.

Our largest expense is wages, which is critical for sustaining our skilled and dedicated team. Quilting is labour-intensive, requiring significant time and experience to create each quilt. Our second-largest expense is shipping, as 90% of our quilts are sent directly to survivors, highlighting the importance of logistics in fulfilling our mission. As we grow, continued support is essential to meet these operational costs and sustain the impact we're making in survivors' lives.

For the 2024-25 fiscal year, our project budget is $375,000. Of this, $90,000 will come from grants, with the remainder covered by donations, events and sponsorships. Project expenses include $30,000 for materials and supplies, and $60,000 for shipping. Shipping costs may rise due to the ongoing Canada Post strike, prompting us to explore more cost-effective options, especially for reaching isolated First Nations communities.

Payroll is at $200,000. It is our largest expense. This includes not only our current staff, but also the addition of new hires, such as a longarmer, executive assistant and volunteer coordinator, to meet the growing demands of our work and reflecting the labour-intensive nature of quilting and the importance of our skilled team.

Our expenses include insurance, interest, maintenance and repairs, and ensuring our operations must run smoothly. We are extremely fortunate to have a studio space provided rent-free for five years by the Anglican church, which significantly reduces our overhead costs.

Our funding streams include grants from organizations such as the Ontario Trillium Foundation, Apatisiwin, the Ontario Arts Council, the Canadian arts council, Mushkego-

wuk Council, Ontario Power Generation and other generous supporters.

To maintain and grow our impact, we have specific funding needs for 2025. We require $160,000 for payroll, which will support four to five employees, including new hires like the longarmer, executive assistant and volunteer coordinator. We also need $75,000 for shipping to cover 2,500 quilts, with an estimated shipping cost of $30 per quilt. This assumes that no volunteers ship their own quilts.

Despite our positive growth, we face challenges related to grants. The grant application process is often time-consuming and uncertain, with delayed response times and restrictions that limit our flexibility. Additionally, the scope of many grants is limited, and conditions attached to these funds can make it difficult to retain staff or hire new team members. We also face barriers in employment and training funding, with a limited recruitment pool and conditions that do not always allow us to keep our current staff. Addressing these funding needs will help us sustain and expand our operations, ensuring we can continue supporting survivors and achieving our mission.

As we close, I want to emphasize that our 2025 financial plan is a critical step in strengthening our ability to support survivors through creative healing and community connection. With your help, we can reach more individuals, provide more resources and deepen our impact in ways that truly matter. Together, we can empower survivors to rebuild and thrive, offering them the healing and support they need on their journey.

The Vice-Chair (Ms. Catherine Fife): You have one minute left.

Ms. Vanessa Génier: This is not just funding. It's a tangible way to participate in truth and reconciliation, making a real difference in the lives of those who have endured so much. We invite you to join us in this important work. Your support allows us to continue and grow our mission, ensuring that more survivors receive the comfort and healing they deserve.

This is our dedicated team: myself as the CEO and founder, Katherine as the studio manager and Kendrick as the studio assistant. We're hoping to hire some more staff as well, all Indigenous, and our board is also all Indigenous women.

For any inquiries or if you'd like to learn more about how you can support our work, feel free to reach out. You can find us on the web at www.quiltsforsurvivors.ca, or just google us; there are lots of news articles about us.

The Vice-Chair (Ms. Catherine Fife): Thank you very much, Vanessa.

Next, we'll hear from East End Family Health Team. Please introduce yourself before you start.

Ms. Katherine Harvey: I'm just going to share my screen here.

Hi, I'm Katherine Harvey, executive director of the East End Family Health Team. Thank you for hearing me today for your pre-budget consultations. I'm happy to be here to share about our team and some of our asks for the pre-budget consultation.

A little bit about our history: The East End Family Health Team was established in 2006. We did begin in 2004 as the East End Health Network, and this year we actually celebrated 20 years of service. It was a great celebration.

As you can see by the map, we are located in South Porcupine, and we service patients who predominantly reside in the east end of the city of Timmins. Definitely, South Porcupine is its own community—it has its own grocery store, schools and other community centres.

What's unique about our team—and I'm sure you've heard about other family health teams—is that we are a BSM model. What that means is we're a blended salary model, and we actually employ physicians at our site.

We are also a community-sponsored model, so, actually, what that means for us is that we're hosted by Northern College, which is the college located in South Porcupine. We are also very proud about that partnership and connection. We service approximately 1,500 rostered patients and also unattached patients, including the students who are supported by our college—that's approximately 1,000 students; also, we have other unattached programs for counselling etc.

Our team here is pictured. We have, like other family health teams, medical receptionists, registered practical nurses, registered nurses, registered psychotherapists to do counselling, nurse practitioners and physicians. Compared to other teams, we are small, but we are mighty, and we are proud to service our small community.

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I'm also happy to share that we were recipients of the expression of interest to expand and enhance interprofessional primary care. We actually finished hiring for those positions, so we have an additional two full-time nurse practitioners and one full-time mental health counsellor.

Our core services are, as you can guess, primary care at its roots, primarily through nurse practitioners. Our team is unique in that even though we are a family health team, we actually just hired a physician. We've had a physician vacancy for well over a year. And this physician that we hired is only a 0.2 FTE, so he works one day a week, so we still need to recruit physicians. As everyone here knows, there is a physician vacancy, and we're trying our best to recruit and provide care to those in our northern community.

Our four nurse practitioners service those 1,500 patients, and they do so very, very well. Our patients are very proud to have care received by nurse practitioners. We do know that more work needs to be done to recognize the care of nurse practitioners and also to let the public know about the care nurse practitioners can provide. Hopefully, nurse practitioners can formally enrol patients. That is a hope that we have for the future so that we can better track care, so that it's not only physicians who can enrol patients.

Our other services include follow-up care after a patient has been discharged from the emergency department or an in-patient setting; immunizations; Well Women program, so preventative care screening; aging well programs; hypertension management; diabetes management; foot care; counselling and psychotherapy; as well as telemedicine, or OTN.

As you can see, that's a comprehensive list of services. The downside is that not every patient in our community

can receive these services. It is quite heartbreaking when we see our wait-lists just steadily increase. Every day, our receptionists are receiving dozens of phone calls from patients who want access to services because they've been dropped by one of their physicians who are retiring. A number of physicians have retired in our community. The one in the east end of the city, for example, has approximately 3,000 patients who are going to be dropped. Actually, they probably have been; the physician was retiring at the end of November. So these patients are coming to our doors and asking for care, and we can't meet the demand. It's heartbreaking to see patients with cancer diagnoses, or diagnoses that haven't been met although their health is decompensating and there's not the primary care to help.

And that is it: Our priority is our patients, their families and our community. I hope everyone can see the illustration on the screen here: They're health care workers holding up a floorboard with a family on top. That's primary care. That's what primary care means. We support families, we support individuals and we support communities. If people cannot access primary care, that very foundation crumbles, and patients and communities suffer.

We lay the foundations for health, and it's necessary for that one individual to access preventative care so, for instance, cancer is caught early—that they can have families, they can continue to work and contribute to their communities and their societies. So we really need to all work together to make sure our primary care foundations are strengthened. I know that's not only a priority for primary care but for each and every one of us in this room, as we are all affected by this.

The Vice-Chair (Ms. Catherine Fife): Katherine, you have one minute left.

Ms. Katherine Harvey: So what are our specific challenges? Well, staff turnover, particularly, in our case, medical receptionists, who are one of the lowest-paid staff members; filling temporary positions as well, like sick leaves and maternity leaves; as I said before, recruiting physicians to work in primary care; and meeting the needs of our community—attachment is key.

So what am I asking for today? Please consider helping our staffing challenges by helping to close the wage gap between the primary care sector and other health care sectors. The Eckler report was released. It's well known that there is a discrepancy there, and there are so many recommendations already put out by AFHTO, the Association of Family Health Teams of Ontario, to help meet these needs. So I hope that you look at those reports and see the work of AFHTO and primary care to help meet that wage gap.

We would also like to see greater investment in digital health tools and support when using these tools—

The Vice-Chair (Ms. Catherine Fife): Thank you very much. We'll probably get to some of those other stats through the questions. Thanks, Katherine.

We're going to move on now to Canada Nickel Co. Please introduce yourself for Hansard.

Mr. Pierre-Philippe Dupont: I'm Pierre-Philippe Dupont. I'm vice-president of sustainability at Canada Nickel Co. Good afternoon, Chair and committee members and fellow presenters. It's great to join you today to discuss how our Crawford nickel project can advance Ontario's economic and environmental priorities while addressing the growing global need for critical minerals.

Over the next few minutes, I'll outline the opportunity our project represents, the alignment with provincial and national strategies and the specific support required to keep advancing it efficiently.

Our company was founded in 2019, and we've become a leader in advanced mining exploration with a focus on nickel. Our main asset, the Crawford project, is located in the heart of the Timmins nickel district.

We are currently advancing key development activities in the Timmins region. This includes low-impact mining operations, downstream processing facilities and groundbreaking carbon sequestration potential. The rock that we mine at the Crawford project has the capacity to spontaneously react to atmospheric conditions to sequester and store CO_2. Our innovative IPT carbonation process leverages this natural phenomenon, making Crawford a net-negative CO_2 contributor. For every tonne of nickel produced, we can store 30 tonnes of CO_2. At full capacity, Crawford could store 1.5 million tonnes of CO_2 annually, positioning it not just as one of Ontario's largest nickel mines but also its largest permanent carbon storage site.

Our project has already gathered strong support from globally recognized partners such as Anglo American, which is one of the five biggest mining companies globally; Agnico Eagle, which is the largest mining company in Canada; and Samsung.

The Crawford mine is scheduled to begin production by the end of 2027. Once fully operational, Crawford will generate over $1.5 billion in average annual gross revenue at peak production, increasing Ontario's mineral production value by an impressive 15%. We will create more than 1,300 full-time jobs, which is kind of important with the announcement that you heard yesterday about Glencore closing its Kidd facility in the Timmins area in 2026. In short, Crawford will become the highest-value mine in Ontario and the largest nickel mine in Canada.

As many of you know, nickel is essential to modern life, found in everything from smart phones and infrastructure to food processing and military equipment. Growing at 10% annually, nickel demand outpaces most other base metals.

Last week, Canada Nickel achieved a significant milestone with the submission of the impact statement for the Crawford project with the Impact Assessment Agency of Canada. This marks an essential step forward, keeping the project on schedule to secure final permits and make a construction decision by the end of 2025. It is also the first mining project to reach this point since the Impact Assessment Act was modified in 2019, which really shows the challenges involved in advancing mining projects in Ontario. We are grateful that both the federal and provincial governments have prioritized critical minerals as vital to Canada's economic growth and clean energy transition.

This support has also enabled NetZero Metals, our subsidiary, to plan North America's largest nickel processing facility in Timmins using Crawford's carbon storage

technology to produce low-carbon alloys. Production is set to begin by 2027.

To ensure Ontario remains competitive in the global market, it is essential to explore strategic incentives that attract foreign investment. Other jurisdictions, like Indonesia, the largest nickel producer, have introduced robust financial incentives to support nickel mining and processing. For example, Indonesia offers corporate tax holidays of up to 20 years; HST exemptions for imported and domestic capital goods; and local government tax reductions ranging from 50% to 100%.

Canada Nickel has outlined key recommendations to help advance the Crawford project, support Ontario's electric vehicle and battery supply chains and stimulate local economic growth.

We suggest to increase the Ontario mining tax processing allowance and align it to what Quebec is actually offering. Quebec is offering a 75%-to-20% model; our model in Ontario is 65% to 8%. This adjustment could deliver $655 million in tax savings and incentivize local processing activities. We also suggest to introduce a tax holiday, provide a corporate income tax and Ontario mining tax holiday to offset significant upfront costs. For the Crawford project, a 10-year tax holiday could generate approximately $800 million in early cash flow, enabling faster project development. We also suggest to adjust the Invest Ontario program—so explore changes to support funding for long-lead items and studies for NetZero Metals's downstream processing facility, as well as identify near-term funding opportunities aligned with provincial priorities and program objectives.

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Government support in these areas will signal confidence to private investors, helping to attract additional private sector funding. This is particularly important as shifts in the investment landscape and limited regulation on short-selling, compared to other jurisdictions such as Australia, have enabled global hedge funds to exploit Canadian junior stocks.

Additionally, the move to index funds has left TSX Venture stocks without critical funding, reducing returns for junior mining companies and their investors.

The Vice-Chair (Ms. Catherine Fife): You have one minute left.

Mr. Pierre-Philippe Dupont: To address these challenges and support the long-term sustainability of junior mining companies, we suggest—and I think we've provided a deck with very detailed options to address the short-selling aspects, so I'm not going to go through these. But we have multiple options that should be—and we're already discussing with the government on this, but multiple options to address this issue.

These measures will enhance market transparency, protect investors and ensure the TSX Venture Exchange remains a sustainable platform for raising capital and supporting economic growth in our sector. Thank you.

The Vice-Chair (Ms. Catherine Fife): Thank you very much for all presentations.

This round of questioning will go to the government side. MPP Dowie, please go ahead.

Mr. Andrew Dowie: I want to thank all the presenters for speaking today. I think where I'd like to start would actually be with the piece on the family health team. Thank you so much for your presentation. What you've described can be replicated across Ontario in terms of what's the best path forward for primary care.

I saw, just in doing some homework, that the two Timmins family health teams received $1.3 million this past September combined. I believe that Timmins Academic received a more substantial part relative to East End, but it's projected that 10,000 more people will be able to be serviced from that funding. I'm wondering if you might be able to speak a little bit to what impact would that funding deliver. Beyond the number of people served, what will it allow you to do to help improve primary care here in the community?

Ms. Katherine Harvey: Thank you for the question. We do receive $470,000 with the EOI funding, and we are already seeing, actually, the benefits of that funding. For example, we did recently fill all of our positions, so two full-time nurse practitioners as well as one full-time counsellor, because of that funding—just speaking to the nurse practitioners, we're able to take patients off our wait-list. I think at our peak, we were at 800 patients on our wait-list. We've seen that go down considerably.

Also, with the physician who's retiring in East End, we're actually helping to take on 500 of his patients. Those are some of the benefits we are seeing right now—and with our counsellor that we hired, because we know mental health is a priority, particularly for those without insurance—private insurance through work, for example—to access counselling and psychotherapy. Our counsellor services patients without that private insurance—for instance, students who need it and members of our community.

Mr. Andrew Dowie: Thank you for that. Chair, I would like to follow-up just with another question. What would a patient load be for a nurse practitioner, for example, in your clinic?

Ms. Katherine Harvey: The load that we say for nurse practitioner is 500 to 800 patients. Now, we do that range because the experience of a nurse practitioner varies. For instance, a new NP, new grad, we start at about 500 patients, and then as they develop their practice and get familiar with, or comfortable with, clinical skills, then the goal is to reach up to 800 patients.

Mr. Andrew Dowie: Just to conclude–then I'll pass it on to MPP Hogarth—once you get to the 800, are there other professions that are part of the family health team that can help you enhance that ratio, or is that really an upper limit? For example, nutritionists, dietitians or just other members of the health team.

Ms. Katherine Harvey: Yes, I think so. The benefits of having the interprofessional care team is that, for example, a lot of our work, for nurses, is through medical directives, so they're able actually to—instead of that patient seeing an NP in an appointment, they see a nurse, and the nurse is able to actually help do the work that otherwise, without a medical directive, the nurse practi-

tioners would do. So that helps. It definitely helps climb up to the 800 patients.

Mr. Andrew Dowie: Thank you.

The Vice-Chair (Ms. Catherine Fife): MPP Hogarth, you have four minutes left.

Ms. Christine Hogarth: Katherine, if you don't mind, I want to continue some questioning. We had some health deputants earlier today, and we were talking about the northern Ontario medical school and how that's helped bring physicians to the area. But we also have our Learn and Stay grant, which includes full tuition reimbursement for coming to stay in an under-serviced community for two years. Has that helped your community? I know that we have added more seats to our programs because we need more physicians. Can you just expand upon that and how that's helping your community?

Ms. Katherine Harvey: These new initiatives are great, and I think they're going to help our community. For the East End Family Health Team, it's particularly challenging because we actually do not have a full-time physician. So a lot of the new opportunities—for instance, training an internationally trained physician at our team—can't happen because we just don't have a physician physically on-site full-time.

But we are seeing, even in our students, this interest to go study medicine—to know that there's positions that are going to be available at our team. We've had physicians and students tour our team, and they're like, "This would be a great place to work." But, again, it's like—let's get them, right? Four years, we have to wait, probably, but the sooner, the better.

Ms. Christine Hogarth: We certainly want our students to come back home and work in the community that they grew up in, because there's nothing better than that. Thank you so much for the work you do.

Vanessa, I just wanted to say thank you for the work you do. It comes from the heart, and you can certainly tell that when you're speaking. I'm just wondering if you've taken advantage of some of the programs that the government is offering to help out. I know we have a Northern Ontario Heritage Fund stream. Have you had the opportunity to apply for that type of funding?

Ms. Vanessa Génier: We have applied for some. We've been denied for some and then there are still avenues that we haven't explored due to the fact that we have such a small team. We rely heavily on volunteers; however, you don't want volunteers doing that type of work, so a lot of that falls on my shoulders. So we're always looking for ways to access different funding.

Ms. Christine Hogarth: Wonderful. We also have a Trillium fund that may help you as well. And our government has launched the Indigenous Economic Development Fund and the Indigenous Community Capital Grants Program; it's $3.2 million and $6 million for Indigenous businesses, communities and organizations to help develop infrastructure, create growth plans and support access to skills training. That, as well, might be an avenue you might want to search out, and we can certainly have a conversation after to help you out, because the work you do is just amazing and I just want to thank you for that.

How much time do I have left?

The Vice-Chair (Ms. Catherine Fife): You have one minute left.

Ms. Christine Hogarth: Maybe back to our health teams there: I just wonder if you can expand—we talked about, in the fall economic statement, making a historic $80-billion investment in health care, but also recognizing there's more to do. Where would you like to see our government focus in the 2025 budget? I know that we have a vast geography here in northern Ontario. You are unique, then—southern Ontario, where we have access to doctors' offices across the street or on a subway ride. Any input you'd like to share with us today that we can take back?

Ms. Katherine Harvey: I think I would say that the expression of interest that that project and that initiative—amazing, great, to expand our team. I think also we cannot forget about the existing teams and to support those teams. Also, financially, we know that our teams haven't received a budget increase for salaries, HHR, in a long time—

The Vice-Chair (Ms. Catherine Fife): Thank you very much. That concludes this session, but you'll have another opportunity to answer that question.

Please go ahead, MPP Kernaghan, for the official opposition.

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

I'd like to begin with Vanessa. Vanessa, I just wanted to thank you for this thoughtful and meaningful work that you're engaged in. You spoke about creative healing and community connection and how your work empowers survivors. I also wanted to recognize that that's a tremendous amount of work to create 6,300 quilts. That's quite something.

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I just wanted to possibly change tactics a little bit or ask you a question that you might not have come prepared for. Earlier this week, the government voted against MPP Sol Mamakwa, the MPP for Kiiwetinoong—his call to recognize September 30 as a paid statutory holiday. Do you think it's important for the government to recognize this as a day for reflection, for recognition of residential school survivors?

Ms. Vanessa Génier: Personally, I have some issues with the National Day for Truth and Reconciliation. As an intergenerational survivor, it was my government that hurt my ancestors. We need to do more than let our public servants get a day off. I think they should step into the shoes of an Indigenous person. They should have to take cultural training or something a little bit more than just a holiday, as we know people have chosen other things to do. As an Indigenous person, it's a little hard to grasp.

So what our organization does is we host our annual sewing retreat purposely over the National Day for Truth and Reconciliation and Orange Shirt Day to give people somewhere where they can give back to the people that the day is supposed to honour.

Mr. Terence Kernaghan: Excellent. It makes a great deal of sense. This is ongoing learning. It's not as though someone can complete training and be done forever; it's

something that must be completed, possibly annually. Thank you very much for that.

Next, I'd like to move over to East End Family Health Team. Katherine, I wanted you to possibly express some more support for nurse practitioners. You spoke quite a bit about them. How are they helpful to address the primary care crisis, and how do they support interprofessional primary care?

Ms. Katherine Harvey: I'm happy to speak about nurse practitioners. I myself am a registered nurse, and so I have a deep appreciation for nursing and the power of the nurse practitioner. They can very much help solve the health care crisis in Ontario. They are well positioned to attach patients to primary care. I think we have to recognize that more.

For example, right now I'm reporting to the ministry. One of my requirements is to report how many patients are enrolled; that number would be zero if I reported how it was asked. In fact, it's 1,500, and it's because those are NPs rostering patients. We need to recognize that and track that, so that we can better track attachment in Ontario.

Mr. Terence Kernaghan: Understood.

An earlier family health team spoke about how the current funding that is applied to family health teams reflects 2017 values. Does this 2017 funding affect you, considering you're with a blended salary model?

Ms. Katherine Harvey: That's an interesting question. It doesn't specifically affect us because we're BSM in that case, because physician salaries are actually unrelated to our base budget. That's actually covered instead by the Ministry of Health and not Ontario Health.

However, we can say that, yes, it still affects everything. The operations of our medical receptionists, our nurses and our nurse practitioners—those are covered by the base budget. They don't have increases. That affects the whole operation in that there's staff turnover. People can leave and find other work where they've had increases. And then physicians who would be employed might see that it's not as efficient of an operation as possible, because staff leave, and with that the knowledge, so it's almost starting from scratch sometimes.

Mr. Terence Kernaghan: Absolutely. And what happens to the continuity of care when there is such a high rate of staff turnover?

Ms. Katherine Harvey: It depends where the turnover is taking place. It's particularly problematic if it's with primary care providers. So nurse practitioners, when they leave, that's when a lot is a struggle. But the efficiency of our operation definitely suffers if, for instance, the people at the front—the medical receptionists—turn over, because they're handling the phone calls, they're getting that information to the primary care provider. That's why I'm advocating for an increased wage for medical receptionists, for example, who are very important to that operation.

Mr. Terence Kernaghan: Absolutely. One of the things that the official opposition brought forward was recognizing what the Ontario Medical Association had to say about the administrative burden that is placed on primary care physicians, as well as their teams. It would free up an additional two million spaces for Ontarians to have that access to primary care.

Would you like to speak to the administrative backlog that primary care physicians face?

Ms. Katherine Harvey: Yes, for sure—so much paperwork. We see that slogan, "Patients Before Paperwork," but we have to make it that that's actually true.

We see a lot of technologies—although they're helpful, sometimes they actually create additional struggles and challenges so that it actually increases admin burden.

That was related to one of my other asks: Help us have support people to know how to work technologies, so that we can be efficient in them and not take up more admin time. Pretty much, we say 40% of a nurse practitioner or primary care provider's day is spent in admin work, which is considerable. That's almost 50%.

Again, we see things like, for example, doctors' notes required from workplaces, and then that taking up time—tons of paperwork to fill out for disability applications etc. Streamlining these processes would certainly help decrease that burden, and then off-loading some of the burden to other staff as well, when possible.

Mr. Terence Kernaghan: And to think that with that high level of education and training, to spend that time with paperwork seems a little bit misplaced.

The Vice-Chair (Ms. Catherine Fife): You just have one minute left.

Mr. Terence Kernaghan: I also wanted to say: How does primary care and how do family health teams realize a cost savings for the province?

Ms. Katherine Harvey: I like that question; I lit up with that question: because it's upstream. We have to look at upstream, and that's what primary care is. We catch problems early, we catch disease early, so that, later on, there's not hospital admissions, that we can prevent cancer, time off work, disability, years of life lost. That's why it's so important to invest in primary care now so that there's less cost to the province later on.

Mr. Terence Kernaghan: Prevention rather than treating.

Ms. Katherine Harvey: That's right.

Mr. Terence Kernaghan: Thank you very much.

The Vice-Chair (Ms. Catherine Fife): Thank you very much.

Now on to MPP Anand on the government side. Please go ahead.

Mr. Deepak Anand: I want to start by thanking all the presenters. I want to say thank you to Vanessa—such a heartfelt presentation you gave. Often, we talk about, "Only the wearer knows where the shoe pinches." And I always say: Even somebody thinking beyond is lip service, because only the wearer knows where the shoe pinches. You're so right.

I want to talk about the great work that you're doing through Quilts for Survivors—amazing. I am actually a graduate from sustainability, and I always love the opportunity that you're providing for these artists to take their art out, and then sharing with everybody. I noticed that right now—because of the model that you used, because this is from your heart—it is only for the survivors, and you're

trying to heal them a little bit, maybe. That's what I would say. Probably because of that, there is no revenue. I want to share this—a request to you is that this education environment, healing is important, and it should be your first priority. But somewhere, people like us—or the others also—they need education and awareness also.

Maybe opening up this model—and I'll tell you, urban eye care was one great example. What they were doing: They have two separate entrances where they care for the eyes, one paid and one unpaid. So they'll take that paid—some of the revenue that comes helps to pay for the unpaid ones as well.

MPP Hogarth talked about a lot funding, and there is funding, and we encourage you to get that funding, because the more funding you get, the more quilts you will make, the more healing you will do, the more artists will be able to get their art out. This is great. But maybe add a little component of revenue, out of 10—maybe two, three, or four, whatever you think—to begin with. Put it for sale—not just for the revenue, but for the education and awareness also.

I thought I'd give you just a small suggestion. Any thoughts on that?

Ms. Vanessa Génier: We don't sell our quilts. However, if organizations and businesses wish to give a substantial donation, we can offer a quilt that's not made with fabric that was donated to give to survivors; we make sure of that. I've done that several times. Shingwauk is part of Algoma University. It's where my great-grandparents went. It has a quilt that we made for them that honours the 85 nations that sent children to that school. That's one way to bring in money.

We are also looking at forming a social enterprise where we'll have a quilt shop and we'll sell quilting supplies, and hopefully that will also bring in volunteers. Those are some of the ways that we're—

Mr. Deepak Anand: So Connecture in my riding has a similar model, wherein they actually help women learn how to braid, and then, through braiding, they get into entrepreneurship, and then they start up—something that you can think of. We have PA Barnes from the Ministry of Labour, where we have the Skills Development Fund—and that subjective term as well.

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Quickly, I want to talk to East End Family Health Team. Katherine, I quickly just want to ask you—I notice there's a lot of trouble having the human capital here working. So in terms of technology—we're in 2024; compare 20 years back: What do you think of technology helping, supporting, the locals here? Where can government help and support—in 30 or 45 seconds, because I have to pass it on.

Ms. Katherine Harvey: Thank you for the question. There are great technologies coming out to support primary care physicians and nurse practitioners. The thing is we can receive these technologies, but we don't have someone to help us learn how to effectively implement it. For example, I'll have a technology introduced—great—and then it's sometimes me as the executive director trying to understand it and then making sure other staff get training in it. So it's very piecemeal instead of having someone dedicated to help us implement it in the way that works for our team.

We do have this in terms of QIDSS, quality improvement decision support specialists. You may have heard of them. A lot of teams actually have a QID support person—but it's more like a QIDSS. We need more support like QIDSS, and more time dedicated to individual teams. For example, the QIDSS that we have, we see very, very sparingly because they support other teams as well, so we need more of that.

The Vice-Chair (Ms. Catherine Fife): MPP Saunderson.

Mr. Brian Saunderson: Chair, how much time do I have?

The Vice-Chair (Ms. Catherine Fife): Two minutes and 40 seconds.

Mr. Brian Saunderson: First of all, I want to thank all the presenters for coming today and sharing your input and insight.

My question is to you, Pierre-Philippe. This government has been working very hard on developing the Ring of Fire collaboratively. We've made changes to the Mining Act, and you made mention of how your mine has been one of the few recent new mines to come online in the province, if not the first. We've also been making significant investments, about $4.1 million, in five mining supply and service projects in northeastern Ontario. So it's been a focus of this government to be able to put ourselves in a position where we're harvesting the critical minerals for EVs so that we're supplying both mining and the manufacturing—so right from pulling it out of the ground to putting it in the parking lot.

I'm wondering if you can speak to us about how our investments in the five mining supply and services projects in northeastern Ontario is impacting your sector and what do you see as the opportunities coming out of that?

Mr. Pierre-Philippe Dupont: Obviously, every dollar that you invest in the junior mining space is going to be well received. Just to give you an example of the scale of what we're doing—for this project so far, we invested approximately $200 million into just getting that project into the feasibility study stage and permitting stage. Now, to move this project forward, we're thinking—the scale of what we're talking about here would be the biggest space metal mine in Canada. The investment requires about $2.5 billion.

The Vice-Chair (Ms. Catherine Fife): One minute left.

Mr. Pierre-Philippe Dupont: So obviously if you're talking about $4 million, you put that in perspective. At some point, if you want to push forward some of these projects to actually feed and get the whole domestic supply chain, it would be good for different governments to invest a little bit more and support the drill mining space a little bit more for these companies to be able to push those projects forward. Just for us right now, the scale of the investment that we need is a couple hundred million to get this thing going at the same speed that we've been working.

I'll give you an example: We got a letter of intent from Export Development Canada of US$500 million, and another governmental entity provided US$350 million as debt. So we're basically moving into this phase where we

need people to get involved a bit more to see these projects moving forward.

The challenge is that if those projects fall into the hands of major mining companies—

The Vice-Chair (Ms. Catherine Fife): Thank you very much. I'm sorry, I have to cut you off there, but perhaps we may get it through the second round of questions.

Please go ahead, MPP Kernaghan.

Mr. Terence Kernaghan: I'd like to turn over now to the Canada Nickel Co. Pierre-Philippe—very impressive statistics about the Crawford project and how it's a net-negative CO_2 producer.

I wanted to ask how mining companies today are fostering relationships with First Nations communities. Could you please touch on the importance of free, prior and informed consent?

Mr. Pierre-Philippe Dupont: That's very important for us. It's part of our ethos, I would say, in the company. Right now, we're working with six Indigenous groups: Taykwa Tagamou Nation, Apitipi Anicinapek Nation, Mattagami, Matachewan, Flying Post First Nation as well as the Métis Nation of Ontario. We're building very strong relationships.

As part of the impact assessment process, we have a chapter in the impact assessment that's dedicated to each of the nations. We actually provided funding for the nations to do their own studies. So it's not us that did the studies and asked them to validate what we've done; they actually fed their own studies into the process. So they all did their own traditional knowledge in the new studies as well as socio-economic studies.

We have very good examples of partnerships that we've put forward with nations. We are actually working right now with Taykwa Tagamou Nation. Taykwa Tagamou Nation has a joint venture that will build the power line required to feed Crawford. It's a 40-kilometre power line that will connect Porcupine to the project, and, basically, we're a client. They will build the power line and provide us with the power, and we'll basically pay as a client. For them, it's very structuring. We're talking about 40 years, the life of a mine, so it's revenues that will go into the community for the next 40 years.

We're working on other pieces of the project. As I mentioned, it's a $2.5-billion investment, so there's a lot of work, lots that can be shaved off the project and given to First Nation partners to basically take these pieces and provide us with the services. That's the kind of model that we're working on right now with the nations.

For us, it has been very, very important. I'm meeting with the Wabun Tribal Council tomorrow for a full-day meeting, for example. We're spending a lot of time and energy in building these partnerships and collaborations. We're not talking about informing right now; we're talking about partnering and collaborating with the nations.

Mr. Terence Kernaghan: Excellent. That's wonderful to hear.

You also spoke about how government investment signals confidence, which spurs the private investment. What would happen if the government does not show confidence for the sector in this way?

Mr. Pierre-Philippe Dupont: I would say we're seeing a huge shift right now in the mining space. With the Inflation Reduction Act coming online and the need for domestic products, we're using terms that we didn't use for 20 years. We're the biggest nickel mine in the Western world—the Western world. We didn't use that before. We're competing with China, Russia. Right now, the IRA, the Inflation Reduction Act, is providing some funding for companies, actually, that came across the border, so we've seen a few projects receiving some dollars.

I'm seeing right now, in the last couple of weeks, some European funds actually financing mines that are in development in Quebec. There's a huge competition for critical minerals, believe me. If Germany, for example, invested in mines in Canada, they will want to make sure that the offtake goes to Germany. This is what we're talking about.

This is what's happening in the space right now as people are competing for resources and, for example, nickel. There's not enough. There's not enough to achieve our goals for electric vehicles, especially in North America, where nickel is actually responsible for the range. So the more nickel you have in a battery, the longest range—I don't know if you can say that, but the more range you will get. So it's especially important for North America. If you buy an EV in Paris, you maybe do 100 kilometres and you're fine, but in Timmins, not so much. You need range.

Mr. Terence Kernaghan: Understood.

Next, I'd like to move back to Vanessa. Vanessa, you mentioned that there's an all-Indigenous staff and board. Could you speak to the importance of having Indigenous leadership in these spaces?

Ms. Vanessa Génier: Sure. The work that we do is healing Indigenous communities, whether it's First Nation, Métis or Inuit. It's important that it's done our way, by us. I think that's really important.

An elder was offered quilts for survivors, and she refused them, because she said, "We don't want white people's quilts." The guy assured her. He goes, "She's not white; she's Indigenous"—or not fully Indigenous. My dad's white. He goes, "But it's coming from our people, for our people," and that, to her, was very important. So I take that knowledge back. It's very important that we look after our people and that we pay our people for the healing.

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Our volunteers are any race. We're open to everyone. We're a very safe space, but I think when it comes to leadership and management of the organization, it's important that it's Indigenous-led.

Mr. Terence Kernaghan: Wonderful. A lot of the work that you do is focused on the survivor community, but I also wanted to give you the opportunity to speak about the impact that your work has on the local community.

Ms. Vanessa Génier: One local volunteer came in and learned how to quilt. We also teach how to quilt. If you don't know, we'll teach you. We offer classes. She said that working in a lawyer's office, she had such a negative outlook on Indigenous people, because she only saw them at their worst, when they were needing legal advice and help. They were dealing with the court system.

The Vice-Chair (Ms. Catherine Fife): One minute remaining.

Ms. Vanessa Génier: She had a very negative outlook, and when she came and met us and worked with us, it totally changed the way that she now sees Indigenous people and she has a high respect for the work that we do.

A lot of other volunteers have said since they heard of Kamloops and the unmarked graves—and we know they're looking up on the coast—people are looking for somewhere to put their grief, somewhere to put their frustration with not knowing. I hear that a lot: "We didn't know." Now they know, so I said, "What are you going to do about it?" and they're like, "I'm going to make you some quilts" or "I'm going to buy some thread" or "I'm going to give you some fabric" or "Here's five dollars" or something like that. All that helps. That's how we become allies and how we work together.

Mr. Terence Kernaghan: Katherine, you have the last few seconds. Which priority does the government need to address for the growing wage disparity across health care sectors?

Ms. Katherine Harvey: Sorry, I missed the first part of the question.

Mr. Terence Kernaghan: Wage disparity for health care professions from the different sectors within health care.

Ms. Katherine Harvey: Yes, absolutely. Our ask, and I think any family health team will say it's their ask, is that wages increase across HHR.

The Vice-Chair (Ms. Catherine Fife): Okay. Thank you very much. That was a good statement at the end. Thanks to all presenters.

NORTHERN COLLEGE
TIMMINS BOWHUNTERS AND ARCHERS INC.
TIMMINS CHAMBER OF COMMERCE

The Vice-Chair (Ms. Catherine Fife): We're going to move forward now with our 2 p.m. slot. I see some people have just entered the room. We're going to give you a chance to get settled. This includes Northern College, Timmins Chamber of Commerce and Timmins Bowhunters and Archers Inc. Thank you very much, folks.

To committee members, we have two individuals from the organization in person. Is there agreement to allow both presenters to sit at the witness table? Yes.

While people are taking their seats, I'll just give the committee an update. As you know, we had to cancel Manitoulin for tomorrow. One presenter has cancelled, two have scheduled for Kenora and we are still waiting for three more. This would take us to 3 o'clock on Thursday.

Welcome to our presenters. Before you begin, I would just ask that you introduce yourself for Hansard. We will begin with Northern College. Mr. Dumas, please go ahead.

Mr. Mitch Dumas: Hello, my name is Mitch Dumas. I'm president and CEO of Northern College. I'm here to present two projects that we would like the government to possibly fund or help support. I'll go through my notes quickly since I only have seven minutes.

The first project is a health sciences wing: a $40-million project, 40,000 square feet. Northern College is known across the province for its amazing health sciences and emergency services programs. The college has built the Integrated Emergency Services Complex, which is a one-of-a-kind facility in which policing, paramedics and firefighting are taught within a learning complex that is shared with an active volunteer fire department, Timmins police and Cochrane District EMS.

Northern has seen many of our graduates stay within our communities across the region to work within these fields. The same is known of our nursing programs, from practical nursing to registered nursing at Northern College. The college has an amazing track record when it comes to our nurses passing their provincial examinations and then going on to play major roles in our area hospitals and resident care facilities.

With the need for more health care professionals, not only within Timmins but across the region, to Temiskaming Shores and James Bay coasts, Northern College is wanting to build this health sciences wing, which will not only have amazing labs and classrooms for our existing health sciences programs, but also introduce new programs that will fill the gaps across the region and province when it comes to specialization in diploma health sciences and degree health sciences fields.

Program opportunities that we're exploring to have in this new facility include dental assistance, dental hygiene, gerontology, ultrasound and X-ray technology, as well as pharmacy technician and much more. These are all in high-demand areas and high-study areas. When students leave the region to study these programs, they usually don't return. Having these programs in the north will allow youth to stay and to attract youth from across the province to come and study, with new grads looking to stay and work in health-related fields in the north.

Northern will look to build and grow our collaboration with university partners to deliver more degrees in the north, and this facility will give us the opportunity to do that. The proposed health sciences wing will also have office clinical space, and doctor and residents research opportunities with our innovation and applied research team, with opportunities for potential new partnerships with NOSM.

As mentioned above, building such a dedicated health science wing will allow Northern College to have a talent pipeline needed to help the staffing requirements and shortages at the Timmins and District Hospital, Temiskaming Hospital, Blanche River Health and Weeneebayko General Hospital and our other hospitals, clinics and treatment centres across the north of Ontario.

The second project is a multi-sports complex. This is a $10-million project. Northern College is proposing to build a multi-sports dome, along with an attached field house and fitness centre. The multi-sport dome will allow Northern College to have a state-of-the-art facility to attract students to stay in the north, and to come north to study post-secondary. A multi-sports dome would allow Northern to have multiple intramural sports for students, with varsity sport options to compete in the OCAA. Not only would this be a recruitment incentive for the college, but it would also

be a retention piece for student success. While this facility would be great for students in the aspect of physical and mental well-being, it would also allow Northern to develop new programs within sports, health science and business.

The multi-sports dome will be a great community and regional facility for all residents to use year-round when it comes to youth and adult sports and activities. Northern College would also have an amazing venue with space to host major events and conferences. When it comes to being a recruitment and retention piece for the college, it would also be a recruitment and retention piece for regional industry partners when it comes to attracting workers to fill the gaps within our region, from doctors, nurses, to tradespeople and skilled workers in various sectors.

Amenities highlighted in this facility would be a $90,000-square-foot collegiate athletic turf field for high-performance sports and community recreational use. So we'd have artificial turf, meeting Ontario Soccer Association-approved artificial turf pitch, along with removable dividers to allow three smaller soccer play surfaces, cricket, Frisbee and/or flag football, lacrosse, baseball or golf. There would also be a rubberized track flooring for track and field. There would also be a rubberized sports flooring that would accommodate either two regular-sized volleyball courts or two tennis courts or two basketball courts or pickleball courts.

Attached to the dome would be a 6,000-square-foot clubhouse that would house a fitness centre, change rooms, a boardroom, office space as well as food and beverage vending machines. Such a facility would also allow tax relief to our Timmins residents and lower future financial investments as the city of Timmins looks to build a multi-sport arena and pool facility. Therefore, we would take away some of those—the hard surface sports, we would take care of.

Northern College will be consulting with our four regional school boards, five hockey associations, two NOJHL teams, tennis association, cricket club, Timmins Porcupine Minor Soccer, Hollinger and Spruce Needles golf clubs, Real North Athletics, Timmins Running Club, Timmins Selects Basketball Club, Timmins Porcupine Badminton Club and other sport clubs and associations to speak to year-round training and league opportunities for athletes. This amazing facility will allow our athletes and teams to be competitive across the province as there will be a 365-day per year facility in place for them to train.

The Vice-Chair (Ms. Catherine Fife): You have one minute left.

Mr. Mitch Dumas: Existing programs such as police foundations, paramedic and pre-service fire students would be using the facilities to train. We would also look at including new programs, such as sports and recreation management, therapeutic recreation and strength and conditioning management.

These two projects are in the design phase right now with architects. They are proposing a $40-million budget for the health sciences wing and a $10-million budget for the sports dome.

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We did apply to NOHFC for $2-million funding for the sports dome. We have passed our first phase and we're just looking to see what that will progress to. We're also looking to FedNor for funding, but we'd like to see the province contribute as well.

The Vice-Chair (Ms. Catherine Fife): Thanks very much, Mr. Dumas.

Next, we'll move on to the Timmins Chamber of Commerce, and I'll give you one-minute notice when you're almost finished.

Mr. Tom Faught: I do have another representative still coming in. Did you want to do the bowhunters first?

The Vice-Chair (Ms. Catherine Fife): We can buy you some time for sure.

We can move forward with the Timmins Bowhunters and Archers. Please introduce both of yourselves as you speak.

Ms. Carole Larche: I'll stand up.

The Vice-Chair (Ms. Catherine Fife): No, no. You can still sit. We're not going to make you work harder.

Ms. Carole Larche: I don't mind.

My name is Carole Larche. This is Allan Moyle. I'm a club member. Allan Moyle is the rangemaster—not ringmaster but rangemaster—for the Timmins bowhunters and archery club.

We thank you for the opportunity for inviting us to do this presentation. Our objective here is to hopefully get financial support for our clubhouse foundation repair and replacement of our storage shed.

If you look at the handout that I've given you, on the back, there are pictures of the buildings: the clubhouse as well as the storage. The clubhouse, the main structure, was built in 1983, as well as the storage shed. The clubhouse is a 600-square-foot building and primarily built with pine lumber. The current condition is below average. The foundation has gradually deteriorated over the past 40 years, and this improvement is used mainly for shelter.

Our goal is to remove and replace the existing concrete block foundation with a new pressure-treated wood foundation and interior timber cribbing or with the installation of helical piles and steel beams.

The storage shed was also built in 1983. It's a 20-by-24 building, primarily built with lumber. The condition is also below average. We hope to reconstruct the shed or alternately purchase a 10-by-20 trailer structure to secure our 3-D targets.

About the club: We've been a non-profit organization, founded in 1983. I'm very proud to say that we are the only independent clubhouse in northeastern Ontario. We're not affiliated with a gun club. We're in close proximity of the city of Timmins and we are recognized as a unique destination for visiting archers.

We are dedicated to, and we do promote, the sport of archery in our community and the surrounding areas. We do place a strong emphasis on archery and bowhunting education. We strive to promote safety all the time, responsibility, respect for nature and the conservation of our natural resources. We currently have a sustainable membership of 70 members. It ranges from youth, seniors, ladies—and we maintain our clubhouse. We have 3-D big and small animal targets. We operate year-round.

We usually host an annual 3-D fun shoot, which attracts participants from southern Ontario and across from northwestern Quebec. This is our major fundraiser. We usually participate in our annual sportsmen's show, which draws a lot of people, where people can try the sport of archery.

Our funding request—we are requesting up to $50,000 to help with the following costs: for the clubhouse foundation repair, $30,000; the storage shed replacement, $20,000.

Our future goal, sustainability and community engagement: We continue to offer our clubhouse and range to interested community groups. We have great partnerships with the Timmins Native Friendship Centre, Mushkegowuk tribal council, local sports organizations. We maintain an active membership to recruit members in the promotion of the sport, and we want to keep securing our 60 3-D targets, which is a huge financial cost to our club. Above all, we'd like to provide our clubhouse shelter and ambience as a significant advantage.

One story I'd like to share with you is, we have a single mother with three young children. She approached me earlier this fall and told me that we were the only sport organization to accommodate her and her three young children. Whereas, because our clubhouse is under a lock and key, we've provided her with a key. She goes and takes her three kids, brings her snacks. She says that the clubhouse offers shelter, they feel safe and they feel sheltered.

Our clubhouse is steeped with history. It's built strong. It's unique, like I was saying, and we feel strongly that if anything should happen to our clubhouse, it will be a sad day.

Our oldest archer is Mr. Vic Vien, and he's 87 years old. This is why we are doing this: because of people like him, and how we want to keep this, and we want to share our beautiful clubhouse with other non-profit organizations as well.

The Vice-Chair (Ms. Catherine Fife): Thank you so much, Carole. You still have one more minute left. Did you want—Allan, can you please you introduce yourself?

Mr. Allan Moyle: Yes. Thank you. Allan Moyle.

The clubhouse was built and maintained by volunteers for over 40 years. Some of the older folks are still around—

Ms. Carole Larche: Including you.

Laughter.

Mr. Allan Moyle: —and we're getting more and more youth involved. We've come up with a family membership a few years ago, and now families are coming in and bringing in the little kids, the big kids and those types of things.

If it comes down just because of age, it would just be a tragedy. There's so much history in terms of archery in Timmins, and we'd like it to be there for the youth as they get older.

We've done everything with volunteers. The blood, sweat and tears that went into that for over 40 years has happened, and volunteers have just been such great people. We're just worried that that foundation is going to give and the clubhouse is going to be gone.

The Vice-Chair (Ms. Catherine Fife): Thank you very much, Allan. Thank you, Carole.

We will now move on to the Timmins Chamber of Commerce. You have seven minutes. If you could just please introduce yourself before you start to speak—but it looks like you're going to start, Thomas.

Mr. Tom Faught: Yes, for sure.

My name is Tom Faught, and I have MJ Filo on the end of the table with me. I am the president of the Timmins Chamber of Commerce. Since 1949, The chamber has represented our 650-plus members with respect to local, provincial and federal government policy while actively addressing educational, civic, social and economic issues.

Today, I am here to discuss the 2025 pre-budget considerations which were developed in consultation with our members and collaborators, outlining several key priorities, including infrastructure investments, immigration and workforce development and business support and innovation.

Infrastructure investments in the north: For Timmins, investment in housing and infrastructure is essential to attract and retain businesses, create jobs and enhance quality of life. Improved infrastructure can lower transportation costs and increase efficiency for local businesses, making them more competitive in the market. A significant investment in housing infrastructure is essential to tackle the housing shortage and affordability crisis in the region.

Recommendation 1 is based on housing. We ask that you address the housing shortage in Timmins through targeted funding for affordable housing and essential infrastructure like water, sewer and public transportation. Recognizing Timmins in Ontario's housing strategy can unlock development opportunities and address unique challenges like seasonal workforce demands and geographic isolation. Infrastructure investments such as water, sewer, roads and public transportation are crucial for new developments and enhancing regional connectivity, facilitating trade and improving access to essential services. Investing in trade-enhancing infrastructure and resilient supply chains will strengthen Ontario's economy.

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Recommendation 2 is based on telecommunications. Northern Ontario faces significant barriers to reliable telecommunication services, hindering business growth and access to essential services. Despite government efforts to expand broadband access, investments in cellular networks are also needed to address gaps along the supply chain routes, which can cause delays and safety issues. We urge the government to prioritize northern Ontario in infrastructure investments, streamline regulations and expedite cellular infrastructure deployment and encourage innovative technologies like 5G+ and 6G. Public-private partnerships can also help accelerate the rollout of necessary cellular connectivity solutions.

Workforce attraction and development: A key concern among members is a shortage of skilled workers due to an aging population, youth out-migration and low birth rates, creating a significant skills gap. This issue must be addressed by industry and government to keep northern Ontario businesses competitive. Failure to resolve this could lead to decreased productivity, reduced economic growth and deter new investments, worsening the region's economic challenges.

Recommendation 3, based on immigration: To address the critical labour shortages in northern Ontario, we ask to consider allocating 3,000 of Ontario Immigrant Nominee Program spots specifically to northern Ontario. By mirroring the success of the Rural and Northern Immigration Pilot program, we can attract skilled immigrants to our region and stimulate economic growth. This initiative would not only help fill essential positions in key sectors such as health care, education and infrastructure, but also enrich the communities with diverse cultures and perspectives.

Recommendation 4, based on health care: Northern Ontario faces a health care crisis due to physician shortages, long wait times and limited services. The government should expand upon its original investments in team-based primary care models, such as primary care health teams, to improve access to underserved areas. Expanding funding in both virtual and in-person services ensures equitable health care access, while embracing digital health technologies can enhance efficiency and provide specialized care to rural communities. Prioritizing these investments will address immediate health care challenges, support mental health and strengthen the productivity and well-being of the regional workforce.

Recommendation 5, post-secondary funding: Invest in post-secondary education through increased multi-year base funding for post-secondary institutions and implement recommendations from the blue-ribbon panel report. Collaborating with post-secondary institutions and industry to fund more work-related learning opportunities, especially in sectors facing labour shortages like construction, manufacturing and emerging technologies can fill skilled labour gaps across the province. This includes supporting initiatives that provide training, upskilling and reskilling opportunities for workers in high-demand sectors such as mining, technology and health care in northern Ontario, ensuring that Ontario has a skilled and competitive workforce capable of driving economic growth and prosperity for generations to come.

Business support and innovation: Northern Ontario has a unique economy prone to boom-and-bust cycles. Our economy largely depends on non-renewable natural resources, and we must balance the need of sustainability of our economy with the sustainability of the communities. As businesses across Ontario continue to recover from the economic impacts of COVID-19, supply chain disruptions and changes in consumer behaviours, it is imperative that the government continue to contribute to the overall economic health of businesses and entrepreneurs across the province.

Recommendation 6, sustainability: Promoting research and innovation to facilitate Ontario's clean energy transition along with exploring investments in various clean energy and low-carbon sources will be essential for securing a sustainable future. The Ontario government can support the initiatives in renewable energy projects, energy-efficient initiatives and clean technology research. Investing in clean energy can stimulate job creation in sectors such as manufacturing, installation and maintenance of renewable energy systems and supporting local economies by reducing energy costs and increasing energy independence.

The Vice-Chair (Ms. Catherine Fife): You have one minute left.

Mr. Tom Faught: Recommendation 7, targeted business supports: Northern Ontario businesses face unique challenges, including economic cycles, supply chain disruptions and the need for technological adoption. The Ontario government should provide financial incentives for innovation, workforce training and supply chain risk management. For example, adjusting the beer tax to a hexilitre-based system would ease pressure on the craft brewers, enabling reinvestment and job creation. Tailored tax reforms and targeted incentives for key sectors like mining, forestry and manufacturing will strengthen the competitiveness, drive growth and build economic resilience across the region.

Recommendation 8, Indigenous economic reconciliation: Continue to provide Indigenous businesses and entrepreneurs with direct support and financing to contribute to the actionable reconciliation and economic development initiatives. This includes funding for business development programs, training and mentorship—

The Vice-Chair (Ms. Catherine Fife): Thank you very much. That concludes your time. You may be able to get to some of those recommendations through questioning.

This round of questions will start with the government side. Please go ahead, MPP Barnes.

Ms. Patrice Barnes: Hello, Mitch. My first question and conversation is for you as well. Thank you for bringing it forward. I know Northern College does a lot of great work in the north, as well as some of the partnerships that you have in Toronto and the urban centres.

I would just flag that, some of the feedback that we had here today, I would think to probably expand into midwifery. That might be another good one. We've heard that there are a lot of shortages of obstetricians, and that would probably be a good piece as well.

I wanted to flag, for the centre that you're building, that it would probably fall under the SDF capital funding model that is available. It's open right now. I know you're familiar with the SDF training stream that was out earlier. Now, there's a capital stream that helps you to build training facilities, that is open, so that would be one of the areas that I would probably explore to see that opened November 29. I would look into that stream. I don't know if you would get, necessarily, funding for the whole $40 million, because I can't remember exactly what the limitations are around how much you can apply for, but I think one of the best places to start would be there in regard to that.

It would align with a lot of the things that are important around health care for us, around really providing resources in the north, especially around health care, and to be able to build that facility would really be upskilling, so you would be covering a lot of different pieces of that. You're talking about nurses. You're talking about paramedics. I know you do some of the PSW training as well, and adding midwifery—just a hint—would probably be a good one as well. I think that would be one of the fastest places to start in regard to getting funding for that as well.

For the recreation facility, that might be a little harder to get funded under the government stream. We had the

Community Sport and Recreation Infrastructure Fund that was opened. That closed October 29, I believe it was, so that might be a little trickier in regard to the funding piece.

I would say the same thing for the bowhunters and archers association. That would also be one of those places that you could look into funding for, because that funding model did repair, it did upgrade, it did new builds as well. I would keep my eye open for that opening up as well.

There's also Trillium funding—and this is for you as well, for Northern College. The Trillium fund does have three different levels of funding. They have the seed, the grow and the expand, I think—seed, grow, build or expand—three different levels of funding models that would cover both of those projects that you have put forward in regard to upgrading. I know Northern sort of has a framework already because you've worked with government in regard to the funding piece. But for bowhunters and archers, I would say probably reach out to your MPP office and just connect with them and see if they can help you navigate that piece around the Trillium funding or anything else that might come up. Because these are, like you said, important pieces within the community, and you don't necessarily want to lose them. Those would be my primary recommendations for both of you.

Mr. Allan Moyle: May I ask a question, please? Maybe I can't.

The Vice-Chair (Ms. Catherine Fife): You can respond.

Ms. Patrice Barnes: Response? You have a response for me?

Mr. Allan Moyle: I just wanted to make sure. Thank you. I'm sorry; I'm out of order.

You'd mentioned the Trillium, but I just wanted to make sure that the first thing you had said—did we get that, Carole?

Ms. Carole Larche: Yes.

Ms. Patrice Barnes: Ontario Trillium fund and the Community Sport and Recreation Infrastructure Fund, yes.

Mr. Allan Moyle: Thanks so much.

Ms. Carole Larche: Thank you.

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The Vice-Chair (Ms. Catherine Fife): There's three minutes left. Who else? MPP Anand, please go ahead.

Mr. Deepak Anand: My question—not really a question; maybe a comment, I would say. I want to say thank you again to all of you for coming here—Ontario Trillium fund is what you need to know.

I want to talk to the Timmins Chamber of Commerce. I actually had an opportunity to visit yesterday, at DJB Mining and Timmins Mechanical Solutions, two of your members. They were actually talking about something very similar to what you said but, technically speaking—I mean, we criss-cross the whole province. We hear the same things: Housing is an issue; infrastructure is an issue; SDF; OINP program; physician shortage; post-secondary funding; promoting R&D and supporting businesses. It's not just limited to Timmins, and that's why this government is investing into all these programs. That's why we invested into infrastructure. That's why we have many of our bills on housing.

My question is more so—I've been to Timmins for the first time. I see it's a hidden secret. When I think of northern communities, I think of communities—there is not enough infrastructure in terms of serving the community, wherein I see it in almost every store here. I saw health care here. I saw even a Sikh temple here. I saw a lot of culturally sensitive restaurants here. I think, in my opinion, all these things—definitely the government needs to work and the government actually is working, but more than that I think Timmins is a hidden secret.

I'll tell you my story. I have the exact opposite story. In my riding of Mississauga–Malton, 11,000 new people come to the riding every year.

The Vice-Chair (Ms. Catherine Fife): One minute left.

Mr. Deepak Anand: Most of the time when you're looking for human capital, you probably look either international or you look at the people who just joined Canada. I think, rather than looking at that, look for somebody who's been here for three-to-five years. When you're new, you're trying to survive. Once you're here three-to-five years, you know the cultural sensitivity, you know how to survive but you want to leap to the next level.

Are there any suggestions that you can give to the government on how we can help to support to get you that human capital?

Mr. Tom Faught: Just to start with your first remarks: We want to be the loudest and the strongest. I do understand that this is the same across the province, but it is good that you're recognizing in Timmins that we are bringing up these issues. We want to be the loudest and strongest when it comes to this. Timmins is unique in the sense that we do need a lot of skilled labour and workforce, mostly to—

The Vice-Chair (Ms. Catherine Fife): Thank you. I'm sorry. I'm going to have to cut you off there, but you'll get another round of questioning.

Moving over now to the official opposition: Please go ahead, MPP Kernaghan.

Mr. Terence Kernaghan: Thank you to all our presenters here today. I'd like to begin with Mitch from Northern College. I was looking at an article from January 2024, which indicated that Northern College had 80% of the total student body coming from abroad. How will Northern College deal with the loss of international students? Is there going to be an increased need for provincial investment?

Mr. Mitch Dumas: So 80% includes our private partner in Toronto; it's not necessarily just in Timmins. That number was actually 55% to 60%. We did lose 30% of our enrolment from international because of the policy changes so we will look at adjustments internally to balance our budget—obviously, we have to present a balanced budget. That will happen next year, for sure—not to the extent of other colleges down south that have to do significant cuts. We've been more conservative, I guess, in our spending over the last few years. Even though we had a private partnership in Toronto, we didn't rely on it to balance our books really. With the increase in salaries over the last five years with the lack of increase in funding—although the $1.3 billion was announced this year, only one third of that was going to colleges; the rest was going to universities. Being the smallest public college in

the province, we're not getting very many dollars. It's all going to be an internal adjustment for us, for sure.

Mr. Terence Kernaghan: Understood. It is unfortunate that Ontario ranks the last in Canada for post-secondary funding. We would have to increase expenditures by 45% in order to be second-last. It is also a pity that the government didn't listen to its own blue-ribbon panel, which recommended twice the amount that they ended up allotting, but they pat themselves on the back for it. However, I digress.

I did want to ask, Mitch: How do sports facilities, such as the ones that you were calling for with this increased investment, help the health, educational outcomes, community identity and economic prosperity for areas like Timmins?

Mr. Mitch Dumas: Internally for the college, our recruiters that go down south on an annual basis hear from students, "What are your extracurricular activities that you have available at your college?" We're limited; all we have is a gym. So having this sports facility will give us more opportunities to expand our offerings, to even go into intramural or varsity sports. We don't even have any varsity sports right now. This will give us an opportunity to explore that going down the path.

We also hear from industry, where they're trying to recruit staff, and oftentimes they ask: What is there to do in Timmins? And again, we have a lot of things that we offer in Timmins; this would just be added. If somebody's child plays soccer down in Toronto and they wanted to recruit them to be a physician in Timmins, that child can continue playing sports now, because we'll have those facilities available to them. That's what we're looking for. It's really a community facility.

Mr. Terence Kernaghan: Excellent. We see in southern areas that there is going to be an impact on the amount of domestic students that colleges are going to be able to accept. Are you going to see those sorts of impacts with current funding pressures from the government?

Mr. Mitch Dumas: Can you explain that a little bit further first?

Mr. Terence Kernaghan: Yes. With current funding, such as it is for colleges, they're having to close programs—you said it yourself. Is Northern College facing those similar sorts of pressures?

Mr. Mitch Dumas: We are exploring that, for sure. As we have fewer international students, we will have to reduce section sizes or possible programs that are no longer available. The CIP list, the code list that came out, there are a lot of programs that are not on there; business programs, for sure. So we'll be downsizing those programs, for sure, and then we're hoping to get the federal government to increase that CIP list so that we have more programs available. Trades, as was mentioned, is really big in the north, and the majority of the trade programs are not on the CIP list.

Mr. Terence Kernaghan: I see. So by limiting the number of international students, that's also going to have an impact on domestic students and domestic enrolment?

Mr. Mitch Dumas: Of course.

Mr. Terence Kernaghan: Understood. Thank you very much for that.

Next, I'd like to move over to Timmins Bowhunters and Archers. Carole, you shared a lovely story about the young mother with her children coming to visit the clubhouse. Would you also like to describe the other sorts of folks that typically use your clubhouse?

Ms. Carole Larche: I, two years ago, for personal growth, took an instructor's course for beginners to teach beginner archery, and my personal goal was to promote the sport of archery and expand it to the ladies, the women. I was very successful. I didn't anticipate the outcome, but it was a huge success. I'm hoping to promote that and also teach the youth—apart from the general public, primarily the youth, the seniors and the women, the minority groups.

Interjection: The city of Timmins—

Ms. Carole Larche: The city of Timmins, yes. We hosted, the city of Timmins, a wellness day, and the city of Timmins employees came to try the archery, and it was very successful, it was very well-attended. And we have the Scouts, and we have the Timmins ringette for team building.

The Timmins Native Friendship Centre, I have partnered up with, also, to teach the ladies about archery. It's very successful. It's slow, steady, but it's very successful. Hopefully it will be with the clubhouse. We want to use the clubhouse as a centre to host these types of events or seminars or sessions.

The Vice-Chair (Ms. Catherine Fife): One minute left.

Mr. Terence Kernaghan: I see. I just wanted to also congratulate you on the only club with an independent clubhouse. I can tell you folks are quite proud of this, as you have every right to be.

I did just want to clarify for the committee: What you're seeking is money to rehabilitate the foundation only; you're not asking for an entirely new clubhouse or anything along those lines. You're trying to protect what is already there and maintain it for future generations.

Ms. Carole Larche: Absolutely.

Mr. Allan Moyle: Well said. Thank you.

Ms. Carole Larche: If I may add, because we are located within the city of Timmins, we have to pay municipal taxes, which costs us about—it used to cost us $3,200 a year. In addition, a land use permit for the use of crown land for the range: That's an extra $670 a year. In 2019, I applied for a request for a consideration for the municipal taxes and was able to decrease that to about $2,000.

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Over the years, we were able to save enough money, and we bought over $9,000 of 3-D targets, of equipment. So we are working hard—

The Vice-Chair (Ms. Catherine Fife): Thank you very much. That concludes that section.

Now we'll move to the government for another seven minutes. Please go ahead, MPP Dowie.

Mr. Andrew Dowie: I thank all the presenters today, actually—three very fascinating presentations.

First, I want to start with Northern College. I'll have to respectfully disagree with my colleague opposite: Ontario's funding for post-secondary is the second best in the country.

Obviously, we've got some work to do, but we dispute our figures, very clearly, on that.

I wanted to ask of Northern College—given how many students I've met every time I come to Timmins, how proud they are to be students here, whether they're at the college or here for university. They're very attracted to Timmins and the student experience here. I was wondering if you might be able to share a bit about what is part of your magic elixir and what makes you attractive to students, especially international students, who have chosen Timmins and are choosing to stay in Timmins because of the service you provide.

Mr. Mitch Dumas: That's confidential.

Mr. Andrew Dowie: Okay. That's good.

Mr. Mitch Dumas: You know what? It's the small class sizes, I think, that makes a big difference, because the teachers that are teaching these students actually know these students. They can help them. You know what I mean? It's not just help in class, but it's help just in general in the public. If they have trouble getting downtown or they have trouble with groceries, we support our students wholeheartedly, not just in their education but in their total experience here. I think that makes the difference. They're not just a number.

Ms. Carole Larche: Excuse me; I'd like to add that we are graduates of the college also ourselves, and proud of it.

Mr. Mitch Dumas: So am I.

Interjection: Proud alumni.

Mr. Mitch Dumas: Yes.

The Vice-Chair (Ms. Catherine Fife): Are you done?

Mr. Andrew Dowie: I have one follow-up, actually.

The Vice-Chair (Ms. Catherine Fife): Go ahead, and then we'll move to MPP Hamid.

Mr. Andrew Dowie: We'll pivot to the chamber of commerce. It's related to the topic, because skills development is something that's very important. A lot of employers, especially in southern Ontario, indicate that they don't have a confident workforce coming in. I wanted to understand from the chamber what sort of strategies do you see government playing a part in to help support workforce development? Certainly, supporting our post-secondary institutions is important, but are there initiatives that we're missing out on right now in terms of ensuring that there are employees for those that want to establish a business right here in Timmins?

Mr. Tom Faught: I think you've just said it best. It's partnerships with the post-secondary institutions, recognizing the needs and having industry-focused programs. It's exactly that. It's those partnerships.

The Vice-Chair (Ms. Catherine Fife): MPP Hamid, please go ahead.

MPP Zee Hamid: Thank you all for your presentations. By the way, Northern College made an impression on my 17-year-old, who wants to come here. But I'm hoping to keep him local. Life's expensive.

Ms. Christine Hogarth: Parents.

Interjection: Meddling.

Ms. Christine Hogarth: Meddling parents.

MPP Zee Hamid: Hey, man, if I'm paying for it, I get a say.

My question is for the chamber of commerce. In your presentation, you had mentioned what makes a lot of rural economies and northern economies unique compared to southern Ontario. But can you tell me a bit more about Timmins specifically and the surrounding area? What makes this place unique compared to other places in Ontario?

Mr. Tom Faught: I think we have a sitting member in the House that screams that every time you guys are in session. It's critical minerals. "We've got what the world wants" is exactly his phrase.

I heard it best at an Ontario economic summit I was at last week: We have the resources in the ground, and we have the final buyers, essentially, or the final plants, but we don't have anything in between. We're stuck as to how to get that out of the ground, what we need is to get rid of the red tape to get that out of the ground. And kudos to the government; you are working towards that, and you are doing a great job, but that just does have to be spoken about quite often.

MPP Zee Hamid: Thank you for that. A follow-up question related: Ontario added something like 200,000 jobs this year. Related to your answer, what are some of the ways that a government can keep the momentum going the rest of 2024-25 and beyond in terms of creating new jobs?

Mr. Tom Faught: I think the northern Ontario immigration programs that you guys did have and then reopened again are extremely helpful. We could use more in terms of direct immigrants to the area, however that is a step in the right direction.

MPP Zee Hamid: Excellent.

So, Northern College, which—again, my son might possibly go there. I don't know what these kids plan on—

Interjections.

MPP Zee Hamid: You mentioned class sizes, you mentioned funding and all the other challenges facing—can you talk about some of the government funding that come in different programs? I know that there was a College Equipment and Renewal Fund, there was a school of mines instrumentation program, a campus welding program and other streams like that. So in addition to just general funding that the government provides, are there other streams that are valuable that we should look into more?

Mr. Mitch Dumas: So, yes, you mentioned CERF. So CERF is specifically for equipment—College Equipment and Renewal Fund—and then there's FRP, Facilities Renewal Fund. So we definitely benefit from those. We get roughly $2.2 million from FRP and roughly $150,000 for equipment. Now, keep in mind that a manikin in a nursing program is almost half a million dollars, so if we're going to buy that, we would have to fund a majority of that ourselves if we were going to use the CERF funding. Even when it comes to repairs or roofs—a roof is over a million dollars now, just a small section. So, again, FRP funding doesn't go very far.

We also get—now I'm drawing a blank on what it's called. Small, Northern and Rural Grant is what it's called, and that's been in place, I think, since 2012 and has never

increased once. Sorry; it's increased once, where we got a million dollars one year, just a lump sum, added onto it. And then this year the ministry decided with their $1.3-billion announcement that we would get additional funding under the Small, Northern and Rural Grant. We got $47,000. So it's pocket change. And then we get special funding for different employment options and those types of things, but it's just funding that goes directly to expenses. We don't make any money on that; it's just to provide a service.

The Vice-Chair (Ms. Catherine Fife): One minute left.

MPP Zee Hamid: So I have two follow-up questions. I'll just ask them together, because we have very little time left: One was regarding labour shortages. What more can we do to help that, specifically when it comes to northern post-secondary institutions?

Mr. Mitch Dumas: So you can give me $40 million to do my health wing, and then I'll be able to offer more programs in the north so people can stay in the north and then work in the north. That is ultimately what I want.

The Vice-Chair (Ms. Catherine Fife): It's a good pitch.

Mr. Mitch Dumas: Sorry; that's a simple solution.

The Vice-Chair (Ms. Catherine Fife): There are 20 seconds left.

MPP Zee Hamid: Okay. So, real quick: What other challenges are specific to northern post-secondary education that more urban centres might not face?

Mr. Mitch Dumas: Well, we're probably facing it, but it's the moratorium on entrepreneurial activity. That needs to be lifted ASAP, because that is the only way for us to make money now, because we're not getting extra funding and our students are declining, international students are declining. We need other opportunities to make money, and that's how we're going to make money.

The Vice-Chair (Ms. Catherine Fife): Moving on now to the official opposition: MPP Kernaghan, please go ahead.

Mr. Terence Kernaghan: Thank you, Chair. My next questions will—

The Vice-Chair (Ms. Catherine Fife): Sorry; one second.

There's a procedural issue. One delegation that we were supposed to go see tomorrow has agreed to come virtually here at 3 o'clock, and this is the Manitoulin Central Family Health Team, so I just need consensus that we can take this one last meeting. Are we okay? Thank you very much.

Please go ahead. Your time will start now.

Mr. Terence Kernaghan: Thank you very much, Chair.

I'd like to move on to the Timmins Chamber of Commerce, with Tom and MJ. I want to thank you for your presentation. You started off with one of the most important things that the government can do right now, which is to tackle the housing crisis that we're currently facing. We know there were many recommendations from the Housing Affordability Task Force. Your request for targeted funding for affordable housing I think should be well received. Unfortunately, right now the government has really struggled. They've really deeply struggled to build housing. I think housing starts are the same as 1955.

We were very proud to bring forward legislation for the government to return to its historic responsibility to create that affordable housing along with co-ops and non-profits and municipal partners, something that has been done with the Homes for Heroes program, post World War II. I think of Premier J.P. Robarts, who formerly held the seat that I am in, a Conservative Premier who built 70,000 permanently affordable units. However, that plan has been called socialism and communism, unfortunately, by this government. But I just want to thank you for making that request for targeted funding for affordable housing.

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I wanted to look towards your second request, which was for telecom. Recently, the Premier made a $100-million commitment to Starlink. I wanted to know, how will that $100-million investment affect northerners? What kind of affordability will that provide for them?

Mr. Tom Faught: I actually have Starlink at my cottage, so I'm a personal example of that. We're looking more for connectivity within the supply chains—being highways. When you're driving from even within the city limits, you can lose cellphone service, but more so than that, if you drive down to Sudbury, you've got a good hour and a half where there's no service.

That's where the safety aspect comes in and the supply chain issue comes in. If Highway 144 gets shut down, there's literally no detour and you're stuck there for—it could be 12 to 20 hours, whatever it is. That's more our stance on the telecommunications.

Mr. Terence Kernaghan: As a Starlink customer, will that $100 million realize any benefit for you? Will you see a cost reduction as a result of that government expenditure?

Mr. Tom Faught: Personally, I'm already established with it, so it would have been an equipment acquisition if I hadn't been established. Where I do have it personally, there will be other people there that will probably apply for it, so it will make a difference for them.

Starlink's technology is only going to get better and better, so there will be a point where—and they're already starting—there is a mobile application to it, where you can put it on service trucks, you can put it on transports, and they can maintain connectivity throughout the supply chains.

However, Starlink only has a certain capacity, so if everyone tomorrow adopted Starlink, who is to say whether their capacity could handle it? But with time, their technology will be good—it will.

Interjection.

Mr. Terence Kernaghan: Dave Smith, it's not your turn. Settle down.

I also want to thank you for your recommendations about health care. Expanding on team-based primary care models is something this committee has heard again and again, although those family health teams are struggling with funding that is based on 2017 numbers. They're trying to expand it, but expanding an unfair system is rather interesting. But I think you're absolutely right, we need to improve access to underserved areas.

Thank you also for mentioning the blue-ribbon panel report. Experiential learning is one of the best modes we

can have to help develop the youth of tomorrow into future work.

You mentioned easing pressure on craft brewers, and I think that's something we've seen the province do, reduce the 6% tax on wine production. Do you have any opinion on craft distilleries? Right now, they face a 61.5% tax from the province. Have you worked with any craft distillers within your work in the chamber?

Mr. Tom Faught: We haven't locally, but I have heard through the OCC of other distilleries that have brought up that exact issue, yes.

Mr. Terence Kernaghan: Absolutely. It's crippling when the small distillers are paying the exact same tax. There's no sliding scale. Whether you're a major producer or you're a small one, you're paying the exact same tax, which is so hard to make a go of things when you're just the little guy.

I think you were cut off for your eighth point, which was Indigenous economic reconciliation. Would you like to take time to finish your point on that?

Mr. Tom Faught: Sure. I was also cut off before I was going to mention all the good stuff that you guys have been doing too. Do you want me to go through all that stuff?

Laughter.

Mr. Tom Faught: I was almost ready to buy their extra minute of time just to get through this point.

I can't remember where I left off, but I have:

This includes funding for business development programs, training and mentorship. Collaborating with Indigenous communities to identify and address barriers to economic development and support Indigenous-led initiatives and enterprises to create sustainable economic opportunities.

Mr. Terence Kernaghan: Recently, the federal government—I believe it was in their 2023 budget—made changes allowing for employee ownership trusts, something that I think the province should also be helping in buttressing those federal changes—exempting the first $10 million of capital gains tax, for instance, on businesses that sell to their employees within that model.

The CFIB currently estimates that over three quarters of small businesses will be sold within the next 10 years as a result of the aging demographic and the baby boomer generation. Would you like to see the province offer more incentives so that employees are able to continue that community wealth building by purchasing from their employer who's selling their business?

Mr. Tom Faught: That's a fairly broad question or remark. Absolutely, anything helps, by all means. But, you know, there are a lot of other challenges associated to buying businesses in today's environment. Cash is relatively cheap so there so there are a lot of large businesses that are purchasing up these small businesses.

The Vice-Chair (Ms. Catherine Fife): One minute.

Mr. Tom Faught: It comes to the tune that the existing business owner doesn't really want to be active in the business anymore. They just want to sell it and walk away, right? But whatever actions can be taken to support transition and to keep it a small business would be totally helpful, absolutely.

Mr. Terence Kernaghan: Absolutely. You know, we see a lot of deep pockets with hedge funds and multinationals wanting to purchase these. I think it's incumbent upon the province to make sure that they're maintaining that community wealth by allowing employees to purchase because when they do so they can also mitigate job losses during economic downturns. They also keep that wealth hyper-local by employing those people, keeping those businesses within the community. I'll certainly be in touch with future plans.

The Vice-Chair (Ms. Catherine Fife): Thank you very much and thanks to all presenters. I wouldn't mind using a crossbow right about now. That would be fun. I guess it looks quite cathartic.

We're going to recess until 3 o'clock so our 3 o'clock delegation can get online. Once again, thank you very much for being here today.

The committee recessed from 1446 to 1500.

MANITOULIN FAMILY HEALTH TEAMS

The Vice-Chair (Ms. Catherine Fife): Good afternoon and welcome to the finance committee pre-budget consultations. I'd like to welcome Manitoulin Central Family Health Team. Thank you for accommodating us and the weather. You have seven minutes to proceed. Please introduce yourself before you start entering your presentation. Please go ahead.

Ms. Judy Miller: Good afternoon. My name is Judy Miller, and I am the executive director of the Northeastern Manitoulin Family Health Team, and with me virtually today is Lori Oswald, the executive director of the Manitoulin Central Family Health Team. Sandra Pennie, our other executive director of the Assiginack Family Health Team was unable to join us, due to the change in time. Together, we are representatives of Manitoulin Island primary care, located in a rural, remote area in the northeast. We appreciate the opportunity to address this committee as part of the 2025 budget development process.

Primary care is the cornerstone of health care. Primary care is the backbone of a high-functioning, sustainable health care system. Research demonstrates that access to primary care teams not only leads to longer, healthier lives for individuals but is also vital to the community they live in. Effective primary care helps keep patients healthy, reducing pressures on hospitals when timely high-quality care is available. However, for this system to function as intended, primary care must be adequately supported.

Currently, many Ontarians rely on the fragmented care at walk-in clinics or the emergency department because they can't find a primary care provider. Meanwhile, family health teams are struggling to attract and retain skilled staff. We see this especially in the north. We urge the government to consider the following three recommendations.

First, address the significant wage gap in community health care. In rural and northern communities, wage disparities within primary care create inequities and worsen recruitment and retention challenges. The November 2023 Eckler report, Ontario Community Health Compensation

Market Salary Review, found that the compensation of the benchmark jobs in the community health sector is lagging relevant to the market median and the broader public sector, and the Ministry of Health-funded rates are notably significantly below market rates. These gaps are driving skilled professionals, including nursing practitioners, nurses, mental health providers, dietitians, physiotherapists and support staff away from their primary care roles. They often move to higher-paying positions elsewhere, leaving critical vacancies that jeopardize patient care.

For example, rising living costs mean many primary care staff are struggling to make ends meet. Some rely on food banks to feed their families, request remote work to save on commuting costs or they can't afford winter tires due to a lack of even a cost-of-living increase as current salaries made by health care employees decrease in value. Without wage parity, we risk further staff shortages, service cuts, longer wait times and greater reliance on emergency departments.

Our proposed action to you: Reduce the wage inequities to attract and retain skilled professionals and align primary care wages with other sectors and adjust for cost-of-living increases.

The second recommendation is to mitigate retention and recruitment challenges in rural and northern communities. Attracting and retaining health care workers in remote areas, like Manitoulin Island, remains an ongoing struggle. We are unable to recruit health care providers as they are unable to relocate to our community due to the extra financial burden of the high cost of living, the uncompetitive wages and no funding for reallocation. Wage disparities and financial pressures discourage professionals from relocating or remaining in these communities, and the high turnover negatively impacts patient care. For instance, a health care receptionist earns a comparable wage to a grocery clerk but faces significantly more stress and responsibility. Without competitive salaries, it becomes nearly impossible to fill crucial roles in primary care teams. Our proposed action is to provide competitive compensation that reflects the demand of primary care roles and introduce return-of-work incentives to encourage health care workers to serve in the under-serviced area.

The last recommendation is to address the impact on patient care and access. Staffing shortages caused by wage inequities directly affect patient care. Reduced access to timely primary care leads to a higher mortality/morbidity rate, increased emergency room visits and greater inequity in comprehensive health care for northern Ontario communities.

The provincial goals of improving access, reducing wait times and strengthening health care capacity cannot be achieved without addressing this wage gap. Our proposed action is to expand primary care teams in under-serviced areas to provide culturally appropriate, comprehensive care and to prioritize sustainable funding to prevent service cuts and ensure consistent care delivery.

Our call to action is that the status quo is not viable anymore. To ensure the future of Ontario's health system, immediate action is required to support primary care teams and the vital services that they provide. We recommend investing in primary care to address wage inequities that align with provincial priorities for access wait times and system capacity. We want to collaborate between the Ministry of Health and primary care teams across the northeast to develop long-term solutions for staffing challenges and inequitable access. We want to ensure that health care workers can continue delivering high-quality care without undue financial hardship.

The Vice-Chair (Ms. Catherine Fife): You have one minute left.

Ms. Judy Miller: Conclusion: By addressing wage gaps, improving recruitment and retention, and expanding access to care in under-serviced areas, we can build a stronger, more sustainable health care system together that supports the professionals who are committed to caring for Ontarians today and into the future.

I thank you for your time and attention, and welcome any questions.

The Vice-Chair (Ms. Catherine Fife): Thank you very much. This round of questions, we will start again with the government. MPP Smith, please go ahead.

Mr. Dave Smith: Because this is the finance committee, one of the things that we have to take a look at is what the cost would be for it. What would you suggest would be an appropriate salary range for one of the health care workers?

Ms. Judy Miller: Every single one of them—one benefit of primary care teams is that it's rolled out with the same grid across the entire province. The Eckler report speaks clearly to what those rates should change, so the NPs' rates should now go from this level to this level.

Mr. Dave Smith: And what level should they go to?

Ms. Judy Miller: For now, $149,000 for a nurse practitioner.

Mr. Dave Smith: Okay.

Ms. Judy Miller: We're funded at $122,000. But the Eckler report is clearly the guide that we felt would give us a reasonable increase, including some cost of living.

Mr. Dave Smith: Thank you, I appreciate that.

In terms of recruitment, one of the things that we've heard is that we have a challenge with simply the volume of health care workers. We know that there's a shortage across the province right now. If we increase the salary as you're suggesting, how is that going to improve the recruitment if, at present, everyone else is being paid at a very similar rate? Does the increase in salary—is it going to make it easier for you or is there something else that we should be doing to look at how we bring someone to one of the more remote or one of the more rural areas?

Ms. Judy Miller: I'm going to turn this question over to my colleague here, Lori. Go ahead, Lori.

Ms. Lori Oswald: Hi. It's Lori Oswald from Manitoulin Central Family Health Team.

Currently, we are losing nurse practitioners to privately followed organizations. There is quite a bit of benefit from working in a team environment, such as the primary care family health team model. Right now, we have nothing to

argue against these people leaving. We have nothing to be able to offer them in terms of an equitable, comparable salary.

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So a lot of these people are not leaving because it's just about the money; they want to stay, but they can no longer afford to. I can't go to my colleagues and say that you need to stay and still need to access the food bank and take care of your families that way. So if we can be comparable then I think our retention and recruitment are going to dissipate because we're going to become more attractive.

Mr. Dave Smith: So one of our challenges still is that there aren't physically enough bodies. If we address the salary side of it, is there anything else that we need to be taking a look at to say, "This is how we attract someone," specifically to a more rural or more remote area?

I live in Peterborough–Kawartha. I'm actually in the township of Douro-Dummer. We're lumped in with Scarborough. Scarborough doesn't have a problem attracting health care workers. I have much more of a problem attracting health care workers because in the township I'm in there's only 3,800 people and it's 700 square kilometres. So it's not quite as attractive as going to, say, Scarborough, where you've got a lot of other things that have nothing to do with your job that make it as an attractive thing.

The challenge that all of us face then is when we look at the more rural areas, more remote areas, it's not just money. There's something else that people are looking for to go to those areas. I know that it is much more difficult to attract someone to a northern Ontario health care centre. So if I take the money aside and I say, "All right, everyone is getting paid exactly the same amount," I still have an issue with attracting someone to northern Ontario; I still have an issue with attracting someone to a more rural area or a more remote area. Remote areas are even worse than rural for attraction.

So what types of things should I be looking at then to entice someone to say, "The quality of life in Manitoulin Island is going to be far better than the quality of life in the city of Toronto because X, Y, Z"? What kinds of things should we be looking at that way?

Ms. Judy Miller: Look at some relocation costs, just like we've done with Geraldton and places where we've recruited physicians. We've provided a sign-up bonus of some relocation. We've assisted in trying to get them selling their house in southern Ontario and relocating them with some relocation costs. Those are things a lot of employers in the private sector have done, and we think that those areas have worked.

With a commitment, though, that you move to Manitoulin, and you have a five-year signed agreement—no different than growing your own—that you're committed to this community—because the community and the ministry have helped to relocate you. And you're right, they love the island. But as Lori stated—I've got a nurse practitioner who is from the island, who's right now living in St. Catharines. She's trying to sell her house to come and work here, and we're doing everything we can—even with, "Come in for $2,000 because you signed up for this and signed this contract." Things like that really matter to people because they have those heavy-burden costs just to relocate.

Mr. Dave Smith: I appreciate that. We also have challenges when it comes to physicians, not just nurse practitioners.

Ms. Judy Miller: I'm using that as an example because it has seemed to have worked in some locations.

Mr. Dave Smith: Where I'm going with it though is—in your model, is it team-based, where we have some physicians, some nurse practitioners, some nurses, and there's a sharing of responsibilities on it? How do you think that we should be expanding that so that we're reducing the challenge for someone to get health care but they're getting the appropriate level of health care? What should we be looking at for a mix between the different health care professionals?

Ms. Judy Miller: I think within the documentation that we will be sending you, there are a lot of potential clinics that are team-based care.

The Vice-Chair (Ms. Catherine Fife): One minute.

Ms. Judy Miller: Having an opportunity for people to join—even when we see our NOSM students and our med students, they want to join in a team. They don't want to sign up and be their own practice and have their own overhead—huge—by themselves. They don't have the business knowledge of how you set that up.

What attracts people is an interdisciplinary team approach. There are communities that we know that don't have that. There's still the mom-and-pop shop, and there's not even incentives for them to move towards being part of an OHT or a discussion with that because they have no concept of how team-based care and team coordination of services works.

So if we're moving towards an OH model, we need to put some money into areas that people will—again, even if they're mini-teams. They don't have to be full blown but have a nurse; have a receptionist; have an RPN; have a social worker. It just really adds—

The Vice-Chair (Ms. Catherine Fife): Thank you very much. That concludes that section.

Now we'll move to the official opposition. MPP Kernaghan, please go ahead.

Mr. Terence Kernaghan: Thank you to Judy and Lori for presenting to us virtually; we very much appreciate it. While we would have preferred to see you in person, we appreciate your flexibility in seeing us in this virtual manner.

I also want to thank you because you've tipped the balance today. Before you presented, only half of delegations today talked about the wage disparity crisis that this government has fostered and created and ignored. So 50% of delegations today talked about the unfair pay scales for health care workers. Other delegations also spoke about the Eckler report, but what you've done is that you've made it more than 50%.

I think your comments about health care workers having to visit food banks is one that this government really needs to pay attention to and to address. In fact, in the 2024 pre-budget consultation report, this very committee noted that many delegations were talking about the unfair treatment

that the province has towards health care workers in terms of pay scales. You've mentioned how the Ministry of Health-funded rates are significantly below market rates, as pointed out in the Eckler report.

I also wanted to ask: In terms of the family health team model, we've heard from other delegations today, who have spoken about how family health teams are funded with 2017 numbers. Would you like to speak to the difference in costs between 2024 and 2017, in terms of funding?

Ms. Judy Miller: They're actually 2016-funded. We had our R&R funds; we got those rolled out and that was based on a 2014-to-2016 grid. Not that we weren't happy, but we need to be—the Eckler report is as close to a grid review as it can be.

In addition to that, there's not been any change in the operating budget. I can tell you, my cyber insurance went up from $3,000 to $9,000 so nobody hacks me. There's never been an operating cost—at this time, we're barely managing, and I'll let Lori speak, but it's the wage of a body. I can't give care if I don't have a nurse. It will never match a hospital grid. It will never match that.

The Vice-Chair (Ms. Catherine Fife): Lori, you had your hand up. Did you want to respond?

Ms. Lori Oswald: I just wanted to say that, in that whole time, even though we received the R&R funding the wages have not increased. We are now getting to the point where minimum wage has increased, other places have increased, and we continue to remain the same. That doesn't just do financial burden; it's also insulting from a moral perspective. These individuals give their heart and soul to our patients—I'm sorry, I can't do this without being emotional. We can't be here without the patients, and for them to go: "You know what? I don't really care. I'm giving my heart and soul. I could go somewhere else and have less burden and have less challenges in my job compared to what I'm trying to do every day." But they stay because of the loyalty, or they go because they can't afford it. And I can't say to my team member, "You have to stay and we're going to pay you less." But how do I argue?

Mr. Terence Kernaghan: Absolutely. We heard from delegations who felt that health care workers had been ignored, taken for granted. They're either looking into going into another sector or they're leaving the field entirely. But I think your words that it's insulting from a moral perspective really should hit home with this government. They ought to address them, with addressing wage disparity that they have ignored for many, many years.

How does this impact overall longitudinal health in patient care when you have a crisis of retention and recruitment?

Ms. Judy Miller: We get a turnover rate, and then the patient has developed a relationship with that provider and they're gone. You have someone who's suffering from cancer and they have to retell their story to a brand new nurse practitioner. The layer of stress, both for the provider as well as the patient—that's what I see the impact on. As Lori has said, many of the staff stayed on for a long time, just because they're committed to their patients. But any turnover of any—not to mention the advertising costs we have, not to mention the training costs we have. That impacts on—and Judy Miller has to work the front desk, because I don't have a receptionist. Those things happen, and it's very stressful on the group.

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Mr. Terence Kernaghan: The province is also trying to create this greater, broader use of family health teams across the province. Do you find it insulting that you're not being paid properly and yet the government is actually trying to expand these as well? Does that make any sense to you—that you're not being treated fairly, you're not being treated equitably, and yet they're trying to create yet further, more examples of unfairness across the province?

Ms. Judy Miller: It won't work, because as you expand more, there are less people to recruit, and they're challenged. So you're going to set up more teams, but then what happens? How do you fill them?

The other thing to think about, just going back to the last comment that you made, is that the relationship between health care providers and their patients becomes one of the most intimate relationships they ever have in their lives. There are lots of things that you end up telling your health care provider that you don't tell your spouse. So when all is said and that person then says, "See you," and you have to tell the story again—where is that level of trust? How many patients are going without care because they have to retell their story or they haven't got to the level of trust to say, "This is my problem, and I really need you to help me out here"? And how many of them are not getting their tests done because—"I don't have anybody who's going to look at them, anyway, so why am I getting it done?" So—

The Vice-Chair (Ms. Catherine Fife): One minute left.

Ms. Judy Miller: —the health of our population that we serve. So the impact is significant. And it's not just about health care workers; it's ultimately about our patients.

Mr. Terence Kernaghan: Very excellent points.

How is primary care and family health teams—how is that an upstream investment that actually realizes cost savings down the line for the government?

Ms. Judy Miller: It actually saves money, because we're getting you to the right provider at the right time for the right care. Instead of always going to a physician because I have a sliver or I have an owie, a nurse can look at that for a fraction of the cost. The services that are provided in team-based care are at zero cost to anyone. It's based on the salaries that are given, where a physician—you are then charged per visit, as an exam. So it's very economical—

The Vice-Chair (Ms. Catherine Fife): Thank you very much for that testimony.

Going over to the government side: MPP Hogarth.

Ms. Christine Hogarth: Ladies, thank you very much for accommodating our schedule. I really do appreciate you being here. Please pass along to your other team member our apologies that we couldn't make our way to Little Current. I was looking forward to going back there. I haven't been there for years. My in-laws had a cottage on the lake there, and it's a beautiful spot, for sure.

Thank you very much for your presentation today. We've heard a lot about health care in the north.

Our government takes health care—such a priority for all of us. The day before yesterday, Jane Philpott started to help, making sure that we have—working with groups like yourselves to make sure that we have a family health care practitioner for everybody. It's going to take some time. She has given a timeline of five years, so we certainly hope—and give her as much support as we can to make sure that's happening. And I see some nodding heads, so I'm sure you're active participants—when she gives you that call to say, "How can we help?"

The north is very special to me. I grew up in northern Ontario, and I lived here most of my life, up until 1995. I understand the vast geography that we have here in our communities.

One of the things that we found important, as a government, when we opened up the northern Ontario medical school back—I guess that would have been 25 years ago. We had the idea, and then it was opened later on, which has allowed us to have more doctors practising. I certainly see it in Thunder Bay and Sudbury. I know there are some coming up your way.

We also have the Learn and Stay program, where we will pay for your tuition, but we want you to stay and invest in that community. What we really want is people to see the beauty of these communities and stay and raise their families and be active participants in the community.

I currently live in Toronto now, but the north is so beautiful—we always consider it a hidden secret to many, and sometimes we don't want to share that, especially in the summertime, when the lakes and the sun is shining so brightly.

I'm wondering if you can expand upon how Learn and Stay or the medical school in northern Ontario—how has that helped recruit people to your community, or has it?

Ms. Judy Miller: One area, if I were sitting in your chair, respectfully: We would support Grow Your Own. There are many times that we've had physicians' children living in these communities fit the criteria for school, and they get shipped to Thunder Bay, which is fine. They got into school. But there's no priority like we do priority for our Indigenous submissions or our francophone submissions. There needs to be a Grow Your Own so people can come back and work in their rural communities that they want to work in. That's why they've applied.

I always had that discussion with NOSM, and we need that more. The new grads do not want to be generalists. They do not want to be the family doctor that does the emerg and does the manor and the nursing homes and their clinics. No, no—they want to be either hospitalists or they want to just work emerg. So we got creative in some ways to try to attract that à la carte type of person. Having some incentives for individuals here—sure, that works, but that's not what's in their heart anymore, that entire general medicine.

The other thing that I find—no disrespect, but if you get to know me, I tell you how it is—the reality is, the incentives that are coming out for the RNs—you get a brand new RN grad and we can give them this $35,000 blah blah blah. That has insulted all of my nursing staff who have been with me for 36 years. They can't get a wage increase, but if I turn around and post for an RN, I can get this incentive. In some communities, in some areas, when you haven't got the wage parity up and running, the incentive, again, insults the existing team members that are bringing in this nurse who is making this much more money and getting this bonus to sign. So sometimes they can be dangerous and backfire on the existing system.

Ms. Christine Hogarth: So are people signing? When you mentioned they're getting the bonus, are you signing nurses with that bonus?

Ms. Judy Miller: Right at this time, I'm not out recruiting a nurse. The entire northeast network, there are 29 family health teams and we would love to work with you. We meet on a regular basis. They've had some situations where nurses have applied looking for that, but they're having a hard time because they've had senior nurses still with them now that are threatening to leave.

Ms. Christine Hogarth: But you have your complement?

Ms. Judy Miller: For the RNs, I do.

Ms. Christine Hogarth: Okay, great.

I noticed a hand up top there. Did you have something you wanted to add?

Ms. Lori Oswald: I just wanted to add: You were asking about the Northern Ontario School of Medicine and whether or not that has been useful for us, and I would say no. We cannot compete with the incentives that are offered by other places. We have a low economic patient base here, and therefore the communities cannot afford to add the hundreds of thousands of dollars that are the incentives that are going out to entice physicians.

I would also say, we also get denied the Grow Your Own. We feel like we can't win for losing. Even if we do apply, we're denied. When we ask for the resources that we feel are efficient and effective in the areas that we serve, we're not getting them. And so, I have to say, we are a huge component and take a lot of learners here, and we have nobody that has turned around and taken this on. We've taken learners from all disciplines: nurse practitioners, dietitians, physicians, the pharmacy, the PA system—nothing. So how do we compete? We cannot.

Ms. Christine Hogarth: Well, you certainly want people who love the community, because they'll certainly stay and, as I said, raise their family there.

Just a quick question about technology: We have technological advancements. It's important in the medical field, your ability to service your communities in new and innovative ways, and I'm wondering if you can identify any unique challenges of your ability to adopt and implement technologies in your fields. How is that working for you?

The Vice-Chair (Ms. Catherine Fife): One minute left.

Ms. Lori Oswald: We are a huge proponent of using AI. We have EMR systems. We've implemented a lot of new technologies, but we also have challenges with cellphone coverage and bandwidth and those sorts of things.

Once we move to all this great IT—Access and Ocean and all of those things—we're also reliant on that. Can people work remote? Yes and no. When the system goes down, we don't have a copy of anybody's EMR system. so, you know what? It's got its pros and its cons. We don't really have backup. If somebody's going to come and fix it, they're coming from a long way. We end up figuring it out ourselves.

The Vice-Chair (Ms. Catherine Fife): You have eight seconds left.

Ms. Christine Hogarth: I just wanted to say thank you for your time. Thank you for your opinions and the conversation. I think it goes a long way, and we'll certainly take your comments—

The Vice-Chair (Ms. Catherine Fife): Now we're going to go over to the official opposition. MPP Kernaghan, please go ahead.

Mr. Terence Kernaghan: No further questions, but thank you very much for presenting today.

The Vice-Chair (Ms. Catherine Fife): Excellent. Thank you very much to everyone, to the entire committee, and thank you to all our presenters this afternoon.

As a reminder, the deadline for written submissions is 7 p.m. on Wednesday, February 5, 2025.

The committee is now adjourned until 10 o'clock central time on December 5, 2024.

The committee adjourned at 1530.

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