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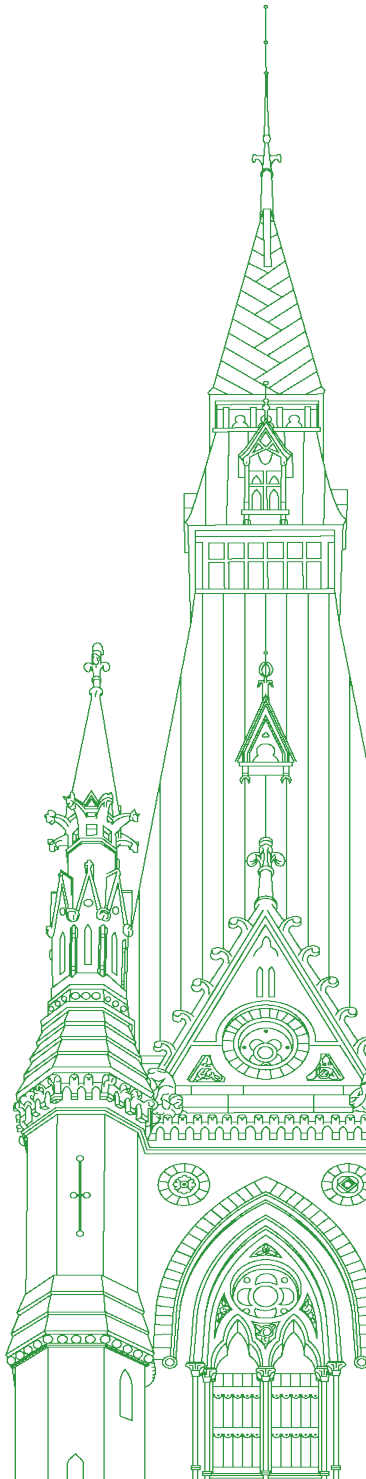

Chair: Mr. Sean Casey

Standing Committee on Health

Wednesday, February 16, 2022

● (1615)

[*English*]

The Chair (Mr. Sean Casey (Charlottetown, Lib.)): Good afternoon, everyone. I call this meeting to order. Welcome to meeting number eight of the House of Commons Standing Committee on Health.

Today we will meet for two hours. Because of the late start, that will take us to 6:14 eastern to hear from witnesses on our study of Canada's health workforce.

Before I introduce today's witnesses, I have a few regular reminders for hybrid meetings. We are meeting in a hybrid format, pursuant to the House order of November 25, 2021, with members attending in person in the room and remotely using the Zoom application.

I would like to remind those who are participating virtually not to take screenshots of your screen. The proceedings will be made available via the House of Commons website.

All public health advisories as well as the directive of the Board of Internal Economy of October 19, 2021, are in force and will be observed.

To begin, each organization has five minutes to make their opening statements before rounds of questions for the remainder of the two hours.

We are very pleased to have with us this afternoon the following witnesses: As an individual, we have Bacchus Barua, the director of health policy studies at Fraser Institute; from the Canadian Association of Radiologists, Dr. Gilles Soulez, president; from the Canadian Federation of Nurses Unions, Linda Silas, president; from the Canadian Medical Association, Dr. Katharine Smart, president; from HealthCareCAN, Paul-Émil Cloutier, president and CEO; and Elaine Watson, chief human resources officer, Covenant Health.

Thank you all for taking the time to be with us and to testify today.

We will proceed in the order listed on the notice of meeting.

Mr. Barua, you have the floor for five minutes. Welcome to the committee.

Mr. Bacchus Barua (Director, Health Policy Studies, Fraser Institute, As an Individual): Thank you very much.

Good afternoon and thank you for the invitation to contribute to the committee's study on Canada's health workforce. It is an honour to be here, and I hope what I have to say is of some value to the esteemed members.

I should state up front that, although I am the director of health policy studies at the Fraser Institute, a non-partisan Canadian think tank, the organization does not hold any positions. Therefore, my testimony is based on my own views and published research.

My understanding is that my job today is to try to set the stage by providing information that may be pertinent to the committee's subsequent discussion on the matter. As such, I would like to focus on three areas: first, highlighting Canada's relative scarcity of key medical resources; second, decoupling the impact of COVID from structural issues; and third, looking through the lens of supply and demand to identify potential solutions.

First, let's take stock. Canada has a relative scarcity of key medical resources, including human and capital resources. Our most recent report on health care performance found that in 2019, out of 28 high-income countries with universal health care coverage, Canada ranked 26th for physicians, 18th for nurses and 25th out of 26 for curative care or hospital beds. Canada also ranked 22nd out of 24 for MRI units and 24th out of 26 for CT scanners per million population.

This relative scarcity existed despite the fact that Canada ranked sixth highest for health care expenditure as a percentage of GDP and the 10th highest for health care expenditure per capita in the same year.

Second, it's important to acknowledge the pressures of COVID in the current context, but to not conflate them with larger structural issues. I provide three quick examples.

The data I mentioned are from 2019. That's a year before the pandemic. Canada's relative scarcity of physicians spans decades. Physician density began to diverge in the mid-1970s and deepened following the Barer-Stoddart report of 1991. While there has been an uptick since the turn of the millennium, projections from a 2018 report I co-authored suggest Canada will still have fewer physicians per 1,000 population in 2030 than the OECD average way back in 2018. It is worth noting here that Canada's relative scarcity is more prominent for specialists than it is for family doctors.

Wait times have certainly gone up during COVID, but have been increasing for decades. The Fraser Institute's survey reports an estimated 25.6 week wait between referral from a family doctor to getting medically necessary elective treatment in 2021. However, in 2019, a year before the pandemic, the wait time was still 20.9 weeks. Similar observations can be made with other international surveys, such as those by the Commonwealth Fund in 2020 and 2016.

The takeaway is that context is important. COVID has exacerbated but is not the cause of the current challenges with the health care workforce. Moreover, the combination of backlogs due to surgical ramp-downs, potential long-term effects of COVID and an aging population will ensure these challenges persist long after the pandemic has passed. The obvious question is, what can be done?

We need to start by understanding that the imbalance between demand and supply of medical services manifests in a number of ways that includes things like: overflowing hospitals, which we also had before the pandemic; overburdened staff, which we're currently grappling with; and rationed care for patients, which Canada has struggled with for decades. Any solution, therefore, lies in reconciling this imbalance between supply and demand through increasing supply, tempering demand and better aligning incentives.

Many successful universal health care countries, including Switzerland, the Netherlands, Germany and Australia, do this in three ways. They embrace the private sector as a partner or pressure valve on the supply side. They employ patient cost-sharing on the demand side to temper demand, with supports for vulnerable populations and exemptions. They encourage competition and incentivize treatment through activity-based hospital funding, which contrasts with Canada's global budgeting approach.

In the absence of these types of reforms [*Technical difficulty—Editor*] improving efficiencies at the margin. However, these will cost the government money and be limited in scope.

Supply can be expanded in a number of ways, including: increasing domestic enrolment and residencies, which are also very important for physicians, as an example; promoting immigration of foreign trained physicians or other important health care staff, such as nurses; and increasing the adoption of new technologies, such as telemedicine, otherwise known as virtual care.

Each of these face unique challenges, but they're not insurmountable. For example, it takes a while to train doctors domestically, and virtual care may eventually face challenges from the Canada Health Act. There's no point having more doctors if their services are not funded, or if they can't find employment, both of which are documented problems under Canada's global budgeting approach for hospital remuneration.

● (1620)

In summary, there is a documented relative scarcity of key medical resources. This scarcity is structural and will persist in the post-pandemic world. Solutions do exist within the current framework, but in the absence of potentially significant reform, they will likely be expensive, limited in scope and only temporarily successful in nature.

I hope these comments have been of some value to the members of the committee.

The Chair: Thank you very much, Mr. Barua.

Next we're going to hear from the Canadian Association of Radiologists.

Dr. Soulez, you have the floor for five minutes.

Dr. Gilles Soulez (President, Canadian Association of Radiologists): Thank you.

[*Translation*]

Mr. Chair, members of the committee, fellow panellists, good afternoon.

My name is Gilles Soulez, and I am the president of the Canadian Association of Radiologists, associate professor in the Université de Montréal's department of radiology and interventional radiologist at the Centre hospitalier de l'Université de Montréal, or CHUM, in Montreal. It is an honour to be here with you today, unfortunately under dire circumstances for Canadians who need care.

Our workforce is burned out and insufficient in number. We need short, medium and long–term investments today to remedy the situation.

As you know, medical imaging is our health care system's gateway for diagnosing diseases, but it is also needed to assess the effectiveness of treatments and to guide minimally invasive treatments in interventional radiology. Whether you have a stroke, cancer, trauma or back pain, medical imagery will often be necessary a number of times in your care pathway.

In the time I have allotted, I will speak to three issues: excessive and growing wait times; the need for health human resources investment; and the need for the latest equipment and information technology to allow for these human resources to be optimized.

Let's first talk about wait times. Canadians are waiting too long for diagnostic imaging procedures, and the pandemic has made this worse. Originally from France, I came to Canada in 1991. At the time, Canada was among the top countries in terms of wait times for medical imaging. After 20 years of underinvestment in health care infrastructure, wait times are again exceeding the P3, priority 3, 30-day wait time across the country.

Prior to the pandemic, patients were waiting on average 50 days for CT scan diagnostics and from 69 to 89 days for magnetic resonance imaging, or MRI, diagnostics, which is already much too long. These numbers have continued to grow owing to a drop in test productivity during the pandemic. At the height of the crisis, we noted a 50% to 70% decrease in radiology services across the country.

At this time, the activities have unfortunately not returned to normal. Our health care system is not currently equipped to handle these volumes. If this situation persists, we are at risk of leaving many patients undiagnosed and untreated.

In 2019, the Conference Board of Canada estimated that the cost of these excessive wait times resulted in a loss of $3.7 billion in gross domestic product, or GDP, and $400 million in lost tax revenues in 2017. The costs will certainly be much worse in 2022.

The second issue has to do with health human resources. Excessive wait times have led to a situation where medical radiation technologists and sonographers are working overtime to try to keep up with the demand. Many of these front–line workers are burned out, getting sick—including from COVID-19—and exacerbating an already dire situation for patients. But the human cost of nearly 24 months of overtime has had a pervasive impact on these front–line health care workers. It is our responsibility to put forward a plan to improve their lives and to take better care of Canadians.

Finally, investments in health human resources must be made now. We need to implement a strategy for increasing health human resources in medical imaging by hiring more staff, implementing new training programs and expanding on existing programs.

A survey of our members indicates that 70% of radiologists see the staff shortage as the most significant barrier to addressing wait times. For example, in the Gatineau region, close to you in Parliament, 25% of technologist positions are vacant. Health human resources are also hindered by aging and often insufficient equipment and by a glaring lag in the integration of information technologies. Those technologies help optimize the organizational process and the work flow with fewer repetitive human actions. They also help ensure the relevance of examinations in a prescription and decrease the number of unnecessary examinations.

We need to work smarter to improve our performance while protecting our staff.

Investment in medical imaging equipment is necessary. In 2019, the Conference Board of Canada estimated that approximately 30% of our diagnostic medical imaging equipment is 10 years old or older. Investment in diagnostic imaging equipment across the country is at a 20-year low. Newer imaging equipment—specifically for MRIs, but also CTs—helps reduce examination times by providing better diagnostic performance and less radiation exposure for patients.

For example, the use of artificial intelligence in recent units and new rapid frequencies make it possible to reduce the time of an MRI examination by 30%.

● (1625)

Our aging equipment also exposes us to more frequent breakdowns than before, which unfortunately makes the problem worse.

In 2003, the federal government, under Paul Martin's leadership, injected $1.5 billion in medical imaging equipment. This really helped Canada ensure equitable access to medical imaging for all Canadians.

The time has come to once again invest in efficient medical imaging equipment and to develop a health human resources strategy for radiology to avoid crippling our health care system and to ensure patients are receiving the right test at the right time, ultimately saving lives.

To summarize, excessive and growing wait times in medical imagery are reducing efficiency across our health care system, as our action is critical in the patient care process. Investments must be made quickly to foster the recruitment and retention of human resources in medical imaging. We need more efficient imaging equipment and information technologies to once again optimize the operational process while preserving our human resources.

A $6-billion investment was included in the 2021 Liberal election platform to reduce wait times, and MRI was specifically referenced, as that is really the area with the most delays.

Investing $1.5 billion in human resources and equipment will not only benefit our front-line and second-line staff, but more importantly—

The Chair: Dr. Soulez, I'm sorry, but your time is up. Could you wrap up your presentation please?

Dr. Gilles Soulez: Okay.

That investment will ensure reasonable access to the care our patients need over the long term.

I would be happy to answer your questions.

Thank you very much.

The Chair: Thank you.

As you know, Dr. Soulez, you will have an opportunity to speak further to those topics. I am sure questions will be asked about this.

[*English*]

From the Canadian Federation of Nurses Unions, Linda Silas, you have the floor for five minutes. Welcome.

Ms. Linda Silas (President, Canadian Federation of Nurses Unions): Good afternoon, everyone.

I'm calling from Ottawa, the beautiful land of the Algonquin and Anishinabe people.

Mr. Chair and committee members, thank you for inviting me to present to this committee on behalf of the Canadian Federation of Nurses Unions. As stated, my name is Linda Silas. I'm the national president.

I want to congratulate the health committee for undertaking this important study. In my world, we would call it retention and recruitment, because if you can't retain your nurses, you will never be able to recruit any.

Prior to the pandemic, nurses were exhausted and burnt out. A University of Regina report on nurses' mental health, which surveyed over 7,000 nurses, found that nurses screened positive for symptoms of PTSD, anxiety and major depression at similar or higher rates than public safety officers. In 2019, 29% had symptoms of severe burnout. Today, it's 45%.

The health workforce accounts for more than 10% of all employed Canadians, over two-thirds of all health care spending and nearly 8% of Canada's total GDP. Nurses are the largest group of regulated professionals in Canada. We have over 450,000 nurses who are responsible for much of the direct, hands-on care provided in Canada's health system. CFNU proudly represents most of these workers, who are at their patient's side 24-7, either in ICUs or in long-term care.

The Conference Board of Canada recently reported that by 2026, Canada could lose 20% of its health care workers due to retirement. Let's remember that over 50% of the health workforce is made up of nurses. In fact, Stats Canada reports that over a two-year period, the number of vacancies for nurses more than doubled. CFNU surveyed nurses across Canada just prior to the omicron wave, and 80% of nurses said there was not enough staff scheduled to meet the demands of patients or residents in long-term care.

Nurses also routinely report 16- to 24-hour shifts in some jurisdictions. This isn't safe. What does it mean to start your shift at 7 a.m. and think you're done by 3 p.m. or 7 p.m., just to be told you are mandated to stay because they are short-staffed? This happens to nurses like Pauline, who's a single mom with two kids. Who does she call at 7 p.m. to come and take care of her kids? What about Yvette, who needs to wear full PPE that looks like a haz-mat suit for her whole shift? Yvette can't even get a glass of water because all the break rooms are too small or simply closed. She is then asked to please stay a little bit longer.

One in two nurses says they are considering leaving their current job in the next year, and I'm pretty sure you're not wondering why. The reality is we can expect that even more nurses will head to the doors unless immediate actions are taken.

Before I finish today, I will share with you two more comments from nurses who are working today while I'm on Zoom speaking to you on their behalf. One said, “Nursing is my life and I have loved being one for 20-plus years. I hate feeling like it’s the worse job ever now and that no one even cares what we are going through.” Another one shared with me, “I am making an exit strategy.”

Please hear their voices now and commit to immediate funding for innovation projects to retain both our experienced nurses and the new nurse graduates who will not survive in their job unless things are radically changed. Please, let's not play the political football of whose responsibility it is. You represent Canadians in every part of this country. That includes Canada's nurses and Canada's patients.

Now it's time for us to discuss solutions such as funding for students, bridging programs, initiatives for late-career nurses and new grads, safe nurse-to-patient ratios, safe working conditions free from violence and mandatory overtime, permanent full-time jobs with respectful salaries and benefits, and a national body or agency to provide the best data and strategies to the provinces and territories.

This is a critical moment for nurses and the people whom we care for. Today's crisis has been years in the making. If we don't act now, we risk suffering a system-wide failure of our treasured universal public health care system.

● (1630)

Once again, thank you to the members of the committee.

I'll answer your questions later.

The Chair: Thank you, Ms. Silas.

Next is Dr. Katharine Smart, president of the Canadian Medical Association.

The next five minutes are all yours.

Dr. Katharine Smart (President, Canadian Medical Association): Thank you, Chair and committee members, for the opportunity to appear before you today.

I'm Dr. Katharine Smart. I'm speaking to you from the traditional territory of the Kwanlin Dün First Nation and the Ta'an Kwäch'än Council. I'm a pediatrician based in the Yukon.

As president of the Canadian Medical Association, it's an honour to represent physicians and medical learners from all jurisdictions. Every one of us has felt the impacts of a health care system stretched beyond its capacity.

For health workers, the pandemic has been unrelenting. We're burnt out, exhausted and demoralized. In caring for patients in an already broken system, we've been pushed to breaking and beyond. Each wave submerges us under deeper layers of backlogs and with even greater workforce and systems impacts. Our health workforce is in the biggest crisis we've ever seen.

Last fall, the CMA and the Canadian Nurses Association co-hosted an emergency summit to learn from nearly 40 health organizations representing nurses, physicians, respiratory therapists, personal support workers, psychologists and educational institutions. They all agree: It's an unprecedented crisis.

There's no question that the CMA is grateful for the federal government's integral part in the pandemic response, but it's not over, and even when it is, health care will feel the repercussions for many years. Health care workers are relying on the leadership of the federal government to support a way forward. By aiding medical professionals, you are helping every Canadian now and in the future.

Chair, having this committee study Canada's health workforce is welcome. There is more to learn of the crisis, but let me tell you what's happening now. Physician burnout is at an all-time high. More than half of physicians report high levels of burnout—nearly double prepandemic levels—and nearly half told us that they are likely or very likely to reduce clinical hours in the next 24 months.

The repercussions of this could be devastating. Already more than five million Canadians don't have a regular health care provider. Only 40% of them can get an appointment within 48 hours. Rural and remote communities and marginalized and at-risk populations are even more disadvantaged.

Over time, we've also created barriers for doctors and nurses practising in a new province or territory. It is why the current regulatory licensing frameworks need to move to a pan-Canadian licensure model. This would allow health professionals to work where they would like to and where the needs are the greatest. It's time to remove these unnecessary regulatory obstacles.

Prior to this pandemic, our health care system was ailing. Today, it finds itself with more cracks than ever. Worse, those who work and care for Canadians are exhausted, burnt out and leaving. The result will affect every single Canadian and put at risk their health and ability to access their health system. This crisis has ballooned past what any jurisdiction can manage alone.

We know that the premiers are focused on an increase in unconditional federal dollars. We believe that more strategic federal investments are required now to support rebuilding health care delivery in Canada.

First, we need federal leadership for pan-Canadian integrated health human resources planning. An intergovernmental approach led by the federal government is now required.

Second, it's time to deliver on the promise to increase patient access to family doctors and primary care teams by delivering on the $3.2-billion commitment. As part of this commitment, the CMA recommends that $1.2 billion over four years be dedicated to a primary care access fund and $2 million to undertake an assessment of interprofessional training capacity of family physicians and other professionals in the area of primary health care. Scaling up collaborative interprofessional primary care is central to increasing access to care.

Third, we need to eliminate barriers for medical professionals by enabling the adoption of pan-Canadian licensure. Medical professionals need to be able to move from province to province to deliver care where it's needed.

The past decades have witnessed remarkable advances in medical science, but we are still reliant on health workers. Just as they have stood at the front lines, it's critical that the federal government create pathways that will stand for the protection of health and medical professionals. We need the federal government to finish this long shift with us.

Thank you, Chair.

● (1635)

The Chair: Thank you very much, Dr. Smart.

Last but not least is HealthCareCAN.

Paul-Émile Cloutier, will you be speaking for the delegation?

● (1640)

Mr. Paul-Émile Cloutier (President and Chief Executive Officer, HealthCareCAN): Yes, I will.

The Chair: Very good. The floor is yours for five minutes. Welcome.

Mr. Paul-Émile Cloutier: Mr. Chair, members of the committee, my fellow presenters, thank you very much for the opportunity to speak to you today.

I am joined by my colleague Elaine Watson, who is the chief human resources officer at Covenant Health in Alberta, one of Canada's largest Catholic health care providers. Ms. Watson is also the co-chair of HealthCareCAN's health human resources advisory committee, and will be available to answer many of the questions that you will have.

[*Translation*]

As a national organization representing hospitals, health research institutes and health care organizations, what we repeatedly hear from health leaders is that human resources are the number one challenge facing us and that it must be addressed as quickly as possible.

[*English*]

There is a serious issue because health care is a people business, and health care workers are the foundation of our health system. I commend the committee for taking the time to study this important issue that has been neglected for far too long.

Health workers are more than nurses, physicians and personal support workers. They also include support, custodial and administrative staff. They also include researchers, lab techs and leadership teams. All of these people are needed for the health system to function and deliver quality care to Canadians.

When we look to develop health workforce solutions, we must consider all of these people rather than take a siloed approach by profession. It has to be a multi-professional approach. The exhaustion and burnout felt by too many health care workers due to the pandemic has made a previously tenuous situation far more critical today. There are job vacancies throughout the entire system and likely more to come once the pandemic subsides. Many health care workers are choosing to retire earlier, move to less demanding roles in the health system or leave the system entirely.

While the waves of the pandemic increase demand on the system, health care needs remain even as the worst of COVID-19 recedes. There is still heightened demand on the system as health care workers deal with medical procedure backlogs, caring for people who have delayed treatment and who come in sicker, and treating a population that is living much longer, often with more complex and chronic conditions.

We must rethink our entire health system. Addressing health human resources challenges must be central to this to ensure a more resilient system that can respond to people's care needs.

[*Translation*]

We need innovative short–term and long–term solutions to address health care professionals' concerns. Having the right mix and number of health care workers, in the right place at the right time, to meet the needs of people across Canada is paramount.

HealthCareCAN would like to make certain recommendations to the federal government through your committee.

[*English*]

The first recommendation is to improve the immigration process to better leverage the skills of newcomers to help meet existing health system needs over the short and medium terms.

The second is to collaborate with other levels of government, regulators and educational institutions to increase the number of Canadian-trained health care professionals in the right roles to meet long-term needs.

The third one is to collaborate with provincial and territorial governments and health care organizations across the country to support the health, wellness, safety and resiliency of the health care workforce. This could include increased federal investments in mental health and wellness research, and programs and resources specific to health care workers.

● (1645)

The last recommendation is to establish a pan-Canadian health workforce agency responsible for strategic and standardized health workforce data gathering, research and planning, to help us better understand the current workforce and its future needs. This agency could work with provincial and territorial governments, regulators and health care stakeholders and use the information it collects to develop and implement strategies to address systemic health workforce concerns.

[*Translation*]

Canadians expect the federal government to show leadership and to address these issues in collaboration with provinces, territories and all health care stakeholders.

[*English*]

The status quo is clearly no longer an option. Failing to act now will lead to lower quality care, longer wait times and worse health outcomes.

Thank you.

The Chair: Thank you, Mr. Cloutier.

Before we begin with the rounds of questions, I want to make sure that I haven't improperly spoken for the committee. I indicated at the outset that we would be sitting until 7:14. What I should have said is we have the support of the fine folks at the House of Commons for the full two hours, if it is the will of the committee to sit for the full two hours.

Oh, I'm back on Atlantic time, and I'm in Ottawa.

Do we have the support of the committee to sit until 6:15?

There is consent in the room and on the screen. Excellent.

We will now begin with rounds of questions, starting with the Conservatives.

We have Dr. Ellis for six minutes.

Mr. Stephen Ellis (Cumberland—Colchester, CPC): Thank you, Mr. Chair.

Thank you to all the witnesses for appearing. It's a daunting task and certainly one that I have experienced first-hand as a family doctor who provided all aspects of care. Thank you for coming and attempting at some point to ameliorate this situation.

This question is for our first witness. Thinking about the current funding model and the 7,500 health care workers promised by the Prime Minister during the election and repeatedly during question period, can you tell me how many of those health care workers have been provided to our current system?

The Chair: The question's for you, Mr. Barua.

Mr. Bacchus Barua: Thank you for the question.

I don't think I commented on that, and I won't be able to answer that question.

Mr. Stephen Ellis: Thank you very much.

Dr. Smart from the CMA, I would ask you that same question, if you don't mind answering.

Dr. Katharine Smart: Thank you for the question.

I think at this point we don't have the data to know how many additional primary care providers have been added to the system. What we know is that there are major barriers right now for people providing a longitudinal family practice type of care, as well as many barriers to providing integrated team-based care. This partly is what underlies our desire to see integrated health workforce planning. We feel we need to understand the direction we're headed in terms of providing integrated team-based care, why some people are choosing not to provide that type of care, and the number and types of providers needed to make sure every Canadian has access to primary care. That work has not yet been done, and we feel that is critical as we move forward.

Mr. Stephen Ellis: Thank you.

From the CFNU, Ms. Silas, do you know if any nurses have been recruited from these 7,500 promised by the federal government?

Ms. Linda Silas: Good afternoon, Dr. Ellis. Hello from another Maritimer.

No, we don't know. Dr. Smart was very clear that this is one of our asks, that the federal government take the lead on getting the proper data. Where we know there's been an increase is in the personal care worker workforce. You've seen that in Quebec, Ontario, a little bit in Alberta. That's about it where we have concrete actions for increasing staff.

If you read the last Stats Canada report, you find that there are over 118 vacant positions in the regulated health care workforce, and that does not include personal care workers.

Mr. Stephen Ellis: Thank you.

Mr. Barua, I'll go back to you. Do you have any idea of the number of health care workers Canada may need to help fill any of these vacancies?

● (1650)

Mr. Bacchus Barua: I'll narrow the question down to physicians, because that's really what we've looked at quite a bit.

What I can say is that in 2019, as I mentioned, Canada ranked 26 out of 28 for the number of physicians per 1,000 population. I don't have the data right in front of me, but I believe that equated to about 2.8 physicians per 1,000 population compared to the OECD average of about 3.8. I may have my decimals a bit mixed up. The calculations would be based on that.

Of course, it's really, really important to narrow down exactly what the questions are. For example, as I mentioned, Canada actually does about the same, or relatively a little better, when it comes to family doctors per 1,000 population and is significantly worse when it comes to specialists. Even though that's the case, the demand for a family doctor seems to be a significant issue right now. In my opinion, that really represents a bottleneck, such that people are trying to get into hospital, trying to get treatment, but have to be treated by family doctors in the meantime.

With those ratios, as I said, I don't know what they translated into numbers, but that gives you a rough idea of how far away we are from the OECD average. That's not counting the [*Technical difficulty—Editor*].

Mr. Stephen Ellis: That's great. Thank you.

By my math, that means we're short about 38,000 doctors compared to the OECD average, and 7,500 would be a drop in the bucket.

It's interesting. I wonder, Ms. Silas, if you have any idea of how many nurses we're short. I understand we have 450,000 nurses in Canada. We're talking about losing perhaps 26% of the 50% of health care workers that nurses make up. Do you have any idea of the number?

Ms. Linda Silas: Well, in your beautiful province, Doctor, it's 1,300. That is a very clear number. It's easy to go from facility to facility and count the vacant positions. In the province of Ontario, there are over 20,000 vacant positions. Again, it's a very large number. We're not even trying to reach the OECD average. We're trying to retain the workforce we have.

If we did what Nova Scotia did...honestly. Your premier promised jobs for the next five years for every nursing graduate in their region, and those are permanent jobs. We need actions like that from all levels of government.

Mr. Stephen Ellis: If we might continue—

The Chair: Thank you, Dr. Ellis.

Mr. Stephen Ellis: Thank you, Chair.

The Chair: Next we're going to go to the Yukon.

Dr. Hanley, go ahead, please, for six minutes.

Mr. Brendan Hanley (Yukon, Lib.): Thank you very much.

I want to add my thanks to all of the witnesses. Clearly describing the state of health care human resources in five minutes is challenging for each of you, but I really appreciate the different angles.

I want to note that it's only about every 100 years that a physician is a member of Parliament for the Yukon, and it's only about every 23 years that a Yukoner is the president of the CMA. To honour that occasion, I'm going to direct my first question to my colleague and friend, Dr. Smart.

I want to hear a bit more about how, in your view, burnout has affected not just numbers but the productivity of the physician community in general.

I beg you to keep it reasonably short and concise so I can get all my other questions in.

Dr. Katharine Smart: Thank you, Chair.

Thank you, Dr. Hanley. It's such an important question.

Burnout underscores so many challenges we're having in the system. Our understanding of the impact of burnout has really evolved over the last 10 or 15 years. We know that levels of burnout in physicians have doubled, as I stated. We know that burnout is mostly related to working in systems that are not functional. That is the root cause of burnout for physicians and other health care professionals.

We also know that burnout directly links to things like productivity, as well as quality of care and medical error. Addressing burnout and creating a system in which health care workers can thrive and be healthy is critical to delivering quality care to Canadians.

Mr. Brendan Hanley: Thank you, Dr. Smart.

Ms. Silas, I'd like to ask you to answer the same question, keeping in mind the scope and optimizing the scope of care of nurses within such a broad profession as nursing.

Ms. Linda Silas: The numbers are very similar to what Dr. Smart said. We're talking about a 50% increase, but there's a difference. There's a difference between feeling burnt out, as in just wanting to hide underneath a desk or in a corner, and the over 30% who need clinical mental help. That's where we're seeing a big lack, because there's a lack of services everywhere. That's not only impacting the productivity, because when we survey nurses, they do say the care they're trying to give is good, but there's not enough of them. What it does say is that they want to get out. Again, that's why we need to look at retention.

Out west, from Manitoba up, we have registered psychiatric nurses, again in a different role on the Prairies, to do with mental health. We need to be innovative everywhere across Canada in terms of how we're going to deal with mental health, both for those giving the services in health care and for those other Canadians who need it.

● (1655)

Mr. Brendan Hanley: Thank you.

I'll move to Dr. Soulez.

[*Translation*]

Good afternoon, Dr. Soulez.

Thank you for your presentation.

[*English*]

We know that technology is one of the largest drivers of health care costs. How do you see the balance between evolving technology, adopting a technology and managing the cost driver that newer technology presents?

Dr. Gilles Soulez: That's a very good question.

Definitely when you look at imaging, it's true that the capital investment is quite significant, but the cost of not having a timely diagnosis is really expensive. We need to take into consideration that balance of the money we put in, the investment, and the cost efficiency of the benefit we will have on the patient workflow and patient care. In that regard, it's clear there is more and more investment now in information technologies, on new technologies that will facilitate that workflow and that will really put us in a position to treat more patients more efficiently in a shorter duration of time. If we target our investment, we can really have a good return on investment.

Another example is the clinical decision support system. With this kind of information system the first-line physician can really do the imaging requisition, but he is guided when he does that to be sure that the requisition is appropriate or relevant for the patient. Having this kind of system installed across Canada, we can save 10% or 15% of unnecessary examinations, so the return on investment can be very good.

We need to really focus on that balance.

Mr. Brendan Hanley: Thank you very much.

Also, my former colleague Paul-Émile Cloutier, I'd like to ask you, when you talked about resiliency of the health care workforce, the cadre, do we have the right mix of health care professionals, and if not, what's missing; what's too much?

Mr. Paul-Émile Cloutier: I don't think that we have the right mix, and I'm not sure I have the answers to what the right mix should be. I think the message that we're trying to give today to the committee is that we need to review this very carefully, taking into consideration all of the professionals who work in the health system.

You were mentioning just a few seconds ago how many people have actually left because of their burnout, the whole bit. We did a survey with the Ontario Hospital Association in Ontario. In terms of all hospital staff, from 2020 to 2021, 45% of people have actually resigned. Of the nurses and RN specialty, we're looking at 71% of the nurses have resigned from 2020 to 2021. In service, which is the service that provides the service to physicians and nurses, about 40% have resigned from 2020 to 2021.

Clearly, there's a message inside the system that it's not working. A lot of people are leaving because they are burnt out. They see that the system is not changing and it's not getting any better.

My fear with this exercise that we're looking at is that if we don't look at the system as a whole first before starting to say, let's do this for the nurses, let's do this for the radiologists, let's do this.... I know there's a need across the board. I'm not being critical here, but if you address only the physicians and the nurses and you don't fix the system as a whole, you will not have done any good service to Canadians and to patient care. That's my view.

● (1700)

The Chair: Thank you, Mr. Cloutier.

[*Translation*]

The Bloc Québécois is now up.

Mr. Thériault, go ahead for six minutes.

Mr. Luc Thériault (Montcalm, BQ): Thank you very much, Mr. Chair.

I want to thank all the witnesses for helping us understand the problem and look for solutions.

I will mainly address Mr. Soulez and Mr. Cloutier.

Dr. Soulez, last time we met, we were going through the third wave of the pandemic, and we talked about structural issues. Today, when I am told about workforce retention issues in relation to work conditions, I realize that we are not experiencing economic issues, but rather pre-pandemic issues, which the pandemic has exacerbated. So these are structural problems.

In that sense, aren't structural solutions required?

Add to that the issue of chronic underfunding. During the first wave, it was said that chronic underfunding had made us fragile. We are currently going through an apocalyptic situation. There is a time bomb in health care networks that may affect us over the next 10 years.

So shouldn't we be talking about structural funding?

Dr. Soulez, I will let you answer this first question. I will then turn to Mr. Cloutier.

Dr. Gilles Soulez: Your comment is very relevant.

What is happening is that provincial operational budgets enable them to resolve only immediate problems and provide services, but the situation is very difficult for the provinces right now. It feels like there is a strategy for infrastructure and health care reorganization.

There is no question that additional funding is needed to implement those long–term reforms. We are talking about structural investments. In my opinion, excellent collaboration with the provinces is needed to successfully define needs, as they are not the same everywhere. Needs can certainly vary from one province to another. So a flexible strategy that fosters integration is needed that would enable various provinces to invest in priority sectors, but always with the help of the federal government when it comes to structural investments. Therefore, long–term investments are needed.

As I said earlier, a return on investments must be ensured, but without having to pay for the grocery bill, if I may put it that way.

Mr. Luc Thériault: Health transfers are indexed at 3%, and a representative of HealthCareCAN, in a brief submitted to the Standing Committee on Finance in 2021, said that, owing to the pandemic, health care system costs accounted for 8.4% of the budget over the very short term. The indexing is expected to remain at 3% until 2027.

I am not here talking about a minor increase in transfers. It is crystal clear that we cannot be serious if we don't respect budget priorities and we don't make massive and immediate investments in the top priority, which is health.

Mr. Cloutier, don't you think that, if we want to have the means to ensure staff retention, considerable and recurrent structural investments must be made over the long term?

Mr. Paul-Émile Cloutier: That is a very good question.

I agree with what Dr. Soulez said a few minutes ago. There is a clear lack of funding in Canada to adequately help the health care system. I admit that the needs are enormous.

My biggest concern, Mr. Thériault, is that if we were to provide funding without knowing what goal we want to achieve or what changes we want to make in the system, we may end up in the same situation as in the past, when funds would be allocated to sectors with virtually no results.

I think that Canadians and even provincial premiers have a role to play. I have written to all the premiers as part of the Council of the Federation conference to let them know that we felt the federal government had to play a crucial role in the funding of the health care system, a more significant role than it is playing today. It must play that role strategically to meet each of the provinces' priorities.

For example, we have a $4.5-billion budget for mental health, but mental health encompasses a broad range of areas. Some provinces may prioritize certain areas of mental health, while others will not have the same priority. That is where we are asking our politicians to be a bit more flexible, in the sense that the government would be prepared to allocate funding to priority sectors while ensuring some accountability in terms of obtaining results. I think this is what Canadians really want to see today.

To answer your question, there is a considerable lack of federal funding for the provinces. According to the Deloitte study sponsored by the Canadian Medical Association, or CMA, it may cost up to $1.3 billion just to cover the care that has not been provided. The provinces don't currently have that kind of money, and I don't think they could provide hospitals with it.

● (1705)

Mr. Luc Thériault: We agree that, in your brief—

The Chair: Thank you, Mr. Thériault. Your time is up.

[*English*]

Mr. Davies, you have six minutes.

[*Translation*]

Mr. Luc Thériault: Okay.

I will come back to this question later.

[*English*]

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you, Mr. Chair.

Witnesses, thank you for being here and lending us your expertise and great ideas.

Ms. Silas, I'll start with you.

I'm just wondering how reorganizing the way we deliver care may impact burnout and the way we can actually retain the staff we have. I'm thinking of things like team-based care or maybe expanded scope of practice.

Do you see any opportunities for reorganizing the way we deliver the services that might actually get us more efficient in terms of how services are delivered to patients?

Ms. Linda Silas: Well, Mr. Davies, you've been on this committee for a long time. You know that all of us have been promoting and delivering care in a different way. We started back in the 1990s with more community health centres to provide better primary care, and we're still, in 2022, asking for better primary care.

With regard to teams, if I look at team nursing, it all depends on who's going to be on it and what it's for. We have years and years of science in terms of talking about the right nurse for the right patient—the right skills and the right education and the right experience for the patient. It all depends; the sicker your patient, the more skills and the more education, etc., you need. We have to be very careful of what some employers have done during COVID, building these new models of care that are plainly just dangerous. We will work on that.

I totally agree that we need to go more toward home care, community health centres and increases in mental health. It could be a program similar to what the federal government established about a year and a half to two years ago, the Wellness Together Canada program. It is an online mental health resource. It's there. It's available for everyone. Okay, now what do we do next?

Mr. Don Davies: Thank you.

I think you just very diplomatically called me “old”.

Voices: Oh, oh!

Ms. Linda Silas: That's just as old as me, because I've been around as long as Paul-Émile Cloutier.

Mr. Don Davies: Yes, that's right, as long as me.

Dr. Smart, perhaps I can turn to you now. I remember when, as long ago as 2007, Jack Layton, the former leader of our party, was crusading for more family doctors. I think the figure at that time was that five million Canadians didn't have access to a family doctor.

I'm going to fire three quick questions at you, and you can answer all of them.

First, you talked about burnout. I'm just wondering if there's any appetite from your members to move from a fee-for-service type of pay structure to more salaried positions as part of the solution to maybe helping doctors who feel that pressure of seeing a lot of patients. Is that something that's worth exploring?

● (1710)

Dr. Katharine Smart: It's a great question. Again, I think it relates back to what some of the structural issues are that are impacting health care delivery. There's no question that some of the existent payment and structural models for primary care are preventing people from choosing longitudinal family practice. We have many examples of successful team-based primary care in Canada that could be scaled. We have experts who are primary care providers themselves who have done research in this area suggesting that different models of payment and working together in a team can better serve Canadians with better health outcomes.

We definitely think these things need to be explored and linked to this $3.2-billion investment in primary care. Part of the need for the integrated health workforce planning is understanding what the barriers are to our new family doctors choosing to provide longitudinal family practice opportunities for patients.

Mr. Don Davies: Thanks.

I want to give you a chance to expand a bit more on what I think is a very creative and novel solution, which is this idea of national licensure for practitioners. Can you give us the 30-second elevator pitch on why that's something the federal government or governments across the country should do?

Dr. Katharine Smart: There are many reasons why a national licensure could be a huge benefit to Canadians, but I think primarily it relates to access to care. As we're learning more about virtual care and how it can be deployed, a pan-Canadian licence suddenly allows any practitioner in the country to be available to any patient. It also provides opportunities for health workforce mobility to provide support in rural and remote parts of the country.

I think there are many, many benefits for physicians and for patients that will improve access, sustainability and retention.

Mr. Don Davies: Thank you.

Mr. Cloutier, I have a number of questions that I want to ask you, but I don't think I'll have time.

One question is on what the federal role is. I presume that the workforce shortages occur across all provinces and territories and across all professions, as you pointed out. You also mentioned the importance of data.

I'm going to lead you a little bit. Do you see the federal government playing a convening coordinating role for helping all the provinces, who are clearly suffering from the same issues, to gather data and help plan a national vision to deal with this problem? If so, I guess I want you to tell us what you see as the federal role in helping address this issue.

Mr. Paul-Émile Cloutier: Certainly. That's an excellent question to be asked.

Believe me that data across the country is not uniform at all. There's no standard plan as to what you're getting and what you're getting it for. I think the federal government's role would be to be a convenor, a facilitator, in getting that kind of data and working with the provinces, the regulators and the major national health associations that collect certain data. At the end of the day, what you want is a system that is standardized across the country so that you know exactly where there's a gap in nursing, physicians or technicians.

When we talk about burnout—and I need to say this, and I know this has nothing to do with your question, Mr. Davies—I was speaking with some of our CEO members. There's a big scare at this moment that, following COVID, many of our managers, who are leaders within the hospitals, the research hospitals, will all say, "*Hasta la vista*, I want to go home. I've had enough of this."

The Chair: Thank you, Mr. Cloutier.

Do you want to finish your thought? We're well past time, but go ahead.

Mr. Paul-Émile Cloutier: My closing point is that the stress is not just at the clinical level; it's across the system, from the front line right up to the leader of any institution.

To answer your question, the government should be a facilitator and bring all of this information together.

The Chair: Thank you, Mr. Cloutier and Mr. Davies.

Next we have Mrs. Kramp-Neuman for five minutes, please.

Mrs. Shelby Kramp-Neuman (Hastings—Lennox and Addington, CPC): I'm Shelby Kramp-Neuman, MP for Hastings—Lennox and Addington.

I'd like to start by thanking all of you for joining us. I'm not a doctor by any means, so I am pleased to be surrounded by your level of expertise. This is my first term in office and my first time on the health committee. I'm thrilled to be here.

I'm going to start by jumping into something that has already been spoken about, , and that is the issue of burnout, workload, stressors and anxiety.

Years ago, becoming a nurse was a very sought-out career. It should still be the case, but when you are a nurse during a pandemic, it's the last place you want to be. We should work to try to regain that and encourage people to get into the workforce. I'll speak a little more specifically.

Excessive workloads due to insufficient human resources in the health workforce were happening before COVID, and if anything, they've been heightened by COVID. The additional stresses and the anxiety that has been brought on by the pandemic have resulted in additional burnout. Mental health is huge, and the consequences we're all seeing in our colleagues, in our neighbours and our friends, especially in the health field, are anxiety and depression.

You've already spoken to some of the levels. There's 50% burnout and 45% want to resign. This has already been spoken about, but do you see a role for any specific supports the federal government could provide health care professionals and providers within their respective organizations? What role do you see for us in providing that level of resolve with regard to mental illness, stressors and anxiety? It's a big question.

● (1715)

Ms. Linda Silas: I'm not sure who you are addressing your question to, but you said "nurse", so I'll jump in.

Welcome to this committee. You'll see it's the best committee on the Hill. It's very productive.

The federal government did it before, and we have to remind ourselves of that. The last crisis in health human resources was in 1997. There were round tables established by the federal government from 1997 to about 2008. Then we hit a recession and everything went down the drain. We had nursing sector studies, medical sector studies and allied health sector studies. We are way too small a country to expect 13 jurisdictions to have all the data, all the best practices and all the experts. That's where the federal government can come in: They can fund these projects.

I think Paul-Emile Cloutier said it well. We have to have accountability. Yes, the federal government needs to increase its share from 22% to 35%, but there has to be a plan, from long-term care to mental health to acute care.

Mrs. Shelby Kramp-Neuman: Perfect. Thank you very much for that.

My second question is a complete curveball. We were talking about mental health and burnout, but I'm going to talk about recruiting new doctors and nurses.

The federal and Quebec governments have jurisdiction over immigration. An option for recruiting health care providers is to accept internationally trained people. Again, this pandemic has highlighted the need for this.

Can any of you speak to what initiatives have been implemented to encourage individuals from other countries or who have studied elsewhere to become part of Canada's workforce or to get on the roster here in Canada? Of those, which professions have been the focus for these initiatives? In your view, have these initiatives been successful?

Dr. Katharine Smart: I can comment on that. Thank you for the question.

We know there are huge barriers right now for international medical graduates to be able to practise in Canada. There are many physicians who were trained in other countries living here and not working in the health care system. There are many barriers that could be addressed with initiatives from the federal government.

On issue is the ability to have people trained and assessed within our system, and the cost and the barriers to that. That area could be supported by the federal government.

The other piece is the assessment and licensing process. I'm referring back to the need for pan-Canadian physician licensure. We have that same process where each province and territory has its own way of assessing credentials, training and licensing international medical graduates. That creates a huge bureaucratic barrier.

We feel there are certainly opportunities for the federal government to support international medical graduates to be able to better access the system, the training, the supervision and the assessment that they need to enter our system. There's also the side of making sure that the licensure process is more transparent and clear and that there aren't barriers there.

There are, of course, ethical concerns with Canada not creating enough human health resources within our own country and taking those resources from other countries. We do believe that in the long term, we need to be self-sufficient in creating enough of the resources here. However, there are many physicians, nurses and other health care professionals who are already here in Canada and are not currently able to practice.

● (1720)

The Chair: Thank you, Dr. Smart.

Thank you, Mrs. Kramp-Neuman.

Mrs. Shelby Kramp-Neuman: Thank you.

The Chair: Mr. Jowhari is next, please, for five minutes.

Mr. Majid Jowhari (Richmond Hill, Lib.): Thank you, Mr. Chair. Thank you to our witnesses.

Before I get into my question, on behalf of myself, my colleagues on this committee, as well as all the 338 members and all Canadians, please accept our gratitude to all your members. We thank you and your members for what you have done over the last two years and for what you continue to do despite all the uncertainty and unknowns. Thank you for keeping us safe.

Some hon members: Hear, hear!

Mr. Majid Jowhari: Once again, thank you for your testimonies.

I was listening to the testimony. It looks like virtual care is emerging as one of the ways that we may be able to address the gap. I talked about the gap.

For my first question, I want to start with Mr. Barua.

You talked about the OECD. You talked about what I perceived to be the gap between the funding and the delivery. It looked like we were number six or seven when it came to the amount of investment that we do in health care. That puts us in the top 20%, yet we rank 25 or 26 out of 38 when it comes to delivery or capacity.

How do you explain that gap? If we want to close that gap based on the current funding, where would we be? How could we benchmark against those who are sixth and seventh and whose delivery is at the top 20%?

Mr. Bacchus Barua: You're absolutely correct. There is a fundamental imbalance between how much Canada spends on health care and what it gets in return. As you mentioned, we rank sixth highest in the OECD in terms of health care spending per GDP. If we stop to adjust that for age, we actually end up ranking second highest.

I'm stressing this point because when the conversation starts to revolve around more money being pumped into the system, we have to understand that we're already one of the highest spenders. We have a federal government that is deeply in debt. We have provincial governments that are not going to be balancing their budgets for a while in many cases. We have to really understand why this money isn't translating elsewhere.

It's not just in terms of resources. We also have the longest wait times in the developed world. We rank mediocre when it comes to utilization. We have a mixed record when it comes to—

Mr. Majid Jowhari: My apologies. How do we address the gap?

Mr. Bacchus Barua: There's a fundamental imbalance between the two.

Mr. Majid Jowhari: I apologize for interrupting you, but how do we address the gap? You've told us we have the money, but you've told us from a capacity point and delivery point of view we are not there. Mr. Cloutier talked about a structural investment and a long-term investment, flexible and collaborative. How can we address that gap?

Mr. Bacchus Barua: I'll reiterate the three points that I made in terms of differences of policy. That's what qualifies a more successful health care system from a less successful health care system.

There are three things that these other successful health care systems do. They partner with the private sector either as a partner or as a pressure valve. These are countries like Australia, Switzerland, the Netherlands, Germany. Importantly, they also temper demand. They expect patients to share in the cost of treatment, which is a vital strategy in almost every other universal health care country. Importantly, they fund their hospitals based on activity, which is very different from how Canada does this. This way of funding hospitals incentivizes hospitals to treat patients and ensure that hospitals get paid whenever a patient comes in. That takes away the entire process of having this sort of budgeting that we have.

The last thing I will just mention is in terms of virtual care. Because you mentioned that, I wanted to talk to that point. It's that I think virtual care will absolutely help, and in many cases it has already been taken up. However, it's important to understand that virtual care so far is only really in the realm of GPs and physician services. It's not going to provide—

● (1725)

Mr. Majid Jowhari: Yes. Thank you for going to virtual care. In the tail end of your opening remarks, you talked about challenges facing virtual care vis-à-vis the Canada Health Act.

Can you briefly make some comment on it and if you run out of time, could you make a submission? It is really important for us to understand what those challenges are. Thank you.

Mr. Bacchus Barua: This is really an unexplored area. I think it will not be a challenge for awhile, but it's very important.

Virtual health care is usually offered by services that are really outside the public health care system and these services are offered also for pay. As you well know, when you have user fees and charges, that creates conflicts with the Canada Health Act in the way it's structured in terms of sections 18 through 21, in terms of user fees and copayments.

If these services, which are considered like virtual services, are considered medically necessary, this may create a conflict in the future with the CHA. This is not explored right now and I hope that it doesn't get to that, but it is a potential problem in the future.

Again, I stress that virtual care right now is only a solution in the area of GPs. It's not going to help with specialists and it's not going to help with [*Technical difficulty—Editor*].

The Chair: Thank you, Mr. Barua.

[*Translation*]

Mr. Thériault, go ahead for two and a half minutes.

Mr. Luc Thériault: Mr. Cloutier, also in your brief, you said, "The Canada health transfer has not kept pace with increasing health care costs caused by inflation, population growth, population aging, population health status and health system improvements." We should add the pandemic to the list.

Based on what you said earlier, you doubt that the provincial governments and the Quebec government, which have not been listened to on issues related to health, are benefiting substantially from hindsight and what they are currently experiencing to properly use the health transfers given to them.

However, for 30 years now, the federal government has never pulled its weight on health care. If it did, we would not be having this conversation today. I find your position a bit strange.

Wouldn't it be preferable for Quebec and the provinces to show a united front to demand substantial, recurring investment that would give them predictability and allow them to fix what can be fixed within the system?

Mr. Paul-Émile Cloutier: You may have misunderstood my response. I think the brief that you mentioned is our pre-budget brief, in which we agree that the federal government must increase transfers to the provinces when the time comes. Everyone is obviously in agreement on that issue.

Mr. Luc Thériault: Don't you feel that the time has come, given that if action is not taken now, the costs assumed by the health care system could continue to skyrocket over the coming weeks and months because of the pandemic? There are people who are not being screened for cancer right now. That will cost us dearly in the future.

Mr. Paul-Émile Cloutier: That's where the collaboration between the provinces and the federal government comes in. In some of our messages at HealthCareCAN, we have invited all the premiers and the prime minister to hold a first ministers' conference on health to try to assess the state of health-related costs in the provinces. The costs of one province are perhaps not the same as another's.

Mr. Luc Thériault: Would you support a health funding summit being held?

Mr. Paul-Émile Cloutier: I would fully support that.

The Chair: Thank you, Mr. Cloutier.

Thank you, Mr. Thériault.

[*English*]

Next we have Mr. Davies, please, for two and a half minutes.

Mr. Don Davies: Thank you.

I'm not sure which of you, Ms. Silas, Dr. Smart or Mr. Cloutier, can answer these, but I have two questions.

First, what steps can or should the federal government take to improve credential recognition for internationally trained health care workers? This is a perennial issue in this country.

Second, I suspect our immigration system is, at least, part of the solution here as we identify shortages. How can we more effectively use our immigration system to plug some of these holes?

That's for any one of the three of you who has an opinion on it.

● (1730)

Mr. Paul-Émile Cloutier: Mr. Davies, I'd like to ask Elaine Watson to respond to this one, if you don't mind.

Mr. Don Davies: Of course.

Ms. Elaine Watson (Chief Human Resources Officer, Covenant Health, HealthCareCAN): Good afternoon, everyone. I'm happy to provide some thought.

There are some elements of the application system for internationally trained health care workers. It is difficult to navigate. There can be some aspects of the labour market impact assessment that create a barrier. We could work more effectively with the licensing bodies and their counterparts in the countries that people are immigrating from, and we can also make it easier for people once they arrive in Canada.

As an immigrant myself, I can tell you that the application process and getting into the country did not match my experience when I got here. Helping people to settle in the country and be able to access those roles as quickly and effectively as possible, and making sure that those licensing requirements are all dealt with before people get into the country are ways that the federal government can help.

There are some quite straightforward elements to that that can be addressed quite quickly.

Mr. Don Davies: What about nurses, Ms. Silas?

Ms. Linda Silas: I agree with Ms. Watson. We have a system in Canada that is over-regulated by provinces and by territories. Dr. Smart talked about it. It is very difficult for all provinces and territories to go and recruit outside our country, because there's literally no support.

I'll reinforce, like Dr. Smart mentioned, that we need to grow our own. Ours is a large country. Nursing, medicine, radiology, etc., are all beautiful professions. We need to make them great.

The key is, as Ms. Watson said, that those internationally educated health care professionals who come to our country need to be facilitated, and we need to make it welcoming when they establish their roots in our country, especially in rural and remote areas. It is very difficult to go and live in rural and remote areas when you've never lived in Canada at all. The federal government can play a role there to help all the provinces and territories.

It goes back to our main recommendation. We need to bring all of the experts together to determine what the best strategies and the best practices across the world are, so that we can steal them. We can borrow them and implement them in our country.

The Chair: Thank you, Ms. Silas.

Thank you, Mr. Davies.

Next we have Mr. Lake, please, for five minutes.

Hon. Mike Lake (Edmonton—Wetaskiwin, CPC): Thank you, Mr. Chair.

Thank you to all of the witnesses. I'm echoing my colleagues' thanks.

Mr. Barua, I'm going to come back to you. I'm going to make an admission. When I first voted in 1988, I voted for the NDP. There's full disclosure here.

Some hon. members: Oh, oh!

Hon. Mike Lake: The reason I switched politically over the years—I speak to university students a lot and they ask me this question—is not because the things I care about changed, but because how we get there changed.

A big trigger for that for me was the cuts in the 1990s to the transfers, particularly the health transfer. I believe $35 billion over multiple years was cut. I pulled up a chart here, and it's more shocking when looking at the chart than I remembered, seeing those devastating cuts. It was a Liberal government at the time, largely instigated by debt that was run up in the 1970s and interest charges on that debt in the 1980s.

Mr. Barua, what was the impact of those cuts in the 1990s, and have we ever really fully recovered from them?

Mr. Bacchus Barua: I'm not entirely sure I can answer the question directly. I can say two things that may be relevant.

First, the situation with physicians is directly traceable to the Barer-Stoddart report of 1991, which recommended a 10% reduction in medical school enrolment, a 10% reduction in residencies and also less reliance on foreign physicians.

This was reversed somewhat at the end of the 1990s, as Dr. Silas mentioned, with the Canadian medical task force and enrolment started up again. However, and this is the important caveat, enrolment and residencies only make so much of a difference if there are no jobs. The jobs we have in Canada that are offered are restricted heavily by global budgets.

To that point, in 2013, there was a survey by the the Royal College of Physicians and Surgeons of Canada, which showed that 16% of newly graduated physicians could not get a job in Canada. These are things that are tied together. The reason I bring it up is to caution that one cannot simply look at increases in the medical workforce without looking at how those jobs and services are going to be funded.

The second thing I want to highlight, when it comes to things like the Canada health transfer and the federal government's role, it's important to start from the point that health care is technically a provincial responsibility. The federal government uses essentially spending power in order to dictate the characteristics of the provincial health care systems through the Canada Health Act.

It's important, because what works in British Columbia might not work so well in Prince Edward Island. One of the things that happens when you increase the Canada health transfer in excess of GDP growth rate, which is what has been done by the governments of Prime Minister Trudeau and former prime minister Harper, is that you actually have a further reliance of the provinces on the federal government, which means less ability for the provinces to actually tailor their own programs.

I know I didn't answer your question directly, but those are two important pieces of [*Technical difficulty—Editor*].

● (1735)

Hon. Mike Lake: To that end, I think everybody in this committee agrees that we need to increase investment. I know our platform had a $60-billion investment over 10 years, including a significant focus on mental health.

In your opening remarks, you talked about us being very high in spending and very low in terms of some of the other numbers, sort of the outcomes of that spending. If that's the case, what are we spending the money on?

Mr. Bacchus Barua: That's the entire health care spending question.

I cannot answer that question directly. I can say that the policies that differentiate Canada from more successful universal health care systems are clear and stark. It is the attitude toward the private sector versus thinking about universal health care as a government only approach. It is thinking about the importance of copayments for tempering demand, which is something that's practised in pretty much every other universal health care country, even if it's purely within the public sector. It's how these hospitals are funded. Those factors are what dictate what we see in the more successful universal health care countries.

To give you an example, according to the Commonwealth Fund, 62% of Canadians reported less than four months for treatment. In Germany, that number was 99%. In Australia, it was 72%. In the Netherlands, it was 87%. In Switzerland, it was 94%. What puts these countries together? They all do universal health care differently.

I appreciate the discussions we're having right now. They will make an impact at the margin, but you're not going to see significant change unless you actually think about significant reform at some point.

The Chair: Thank you, Mr. Barua.

Thank you, Mr. Lake.

Next we have Ms. Sidhu for five minutes.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you, Mr. Chair, and thank you to all the witnesses for their testimony.

We all know the heavy workload on health care workers. There is burnout, and mental health is impacted. There's now a shortage of health care workers. We are discussing that.

When we met last month, Ms. Silas, and Dr. Smart, you can also answer, the issue we were all hearing about was that even before the pandemic, trained health care workers were not being able to work in their field. They come here as skilled workers, but are limited by provincial regulations. When the pandemic began, some provinces gave them emergency authorization. Now there is no agreement. We don't disagree that we need more health care workers.

What is your organization going to [*Technical difficulty—Editor*] and barriers that skilled workers face? Do you think it's a lack of training resources?

Ms. Linda Silas: On the question of internationally educated health care professionals, yes, it's a college issue and a provincial and territorial issue.

You might remember about seven to eight years ago Canada went to an American-based NCLEX exam to pass for RNs. We approached the premiers of each province and territory saying that they had made a mistake. One, it's going to make it a lot easier to attract nurses to go to the U.S., and, two, too many are failing, and especially in the French language. All the ministers of health said that it was out of their hands because they gave them total accountability and responsibility on that. We have to go back to the health ministers and the regulatory college to fix how they enter and evaluate internationally educated foreign nurses or others. That's the key. What the federal government can do is, again, bring best practices to the provinces and territories. It is crucial to do that.

We'll send you a brief. We'll also be presenting to the FINA committee that we need bridging programs. We were working on bridging programs in the early 2000s. A lot of you went back to the 1990s. I started it. But in 2004 we had a health accord that all the premiers and prime minister agreed on. Paul-Émile will remember it was signed at 1:30 a.m., in September 2004, where we looked at where the money was going to go and how it was going to increase 6% per year.

We can do it. We need bridging programs for personal care workers who want to become licensed practical nurses, and licensed practical nurses who want to become RNs, and so on. That's how we build skills for our current workforce and our future workforce.

● (1740)

Ms. Sonia Sidhu: Thank you.

Dr. Smart, I heard from my constituents about Canadians who attend medical school here but have difficulty finding residencies. Sometimes they have to go to the U.S. to find a position in residency. I heard you say there are bureaucratic or credential barriers. Can you explain how the federal government can play a role in that?

Dr. Katharine Smart: Thank you for the question.

I think there are two aspects to what you're asking.

One is the training opportunities for Canadian-trained medical students to enter the residency training process that's required to become a practising physician in Canada. Again, this is part of the issue with not having a national integrated workforce plan. There isn't necessarily coordination of the number of spots available in medical school relative to the number of post-medical school training opportunities. That mismatch does create...some people who have trained to be physicians, but then aren't able to access that next step of training to allow them to actually practise. That, again, needs to be part of a plan, and we believe a national lens on that would be helpful.

The other piece I think you're talking about is the regulatory structural barriers for international medical trainees who are physicians from other countries, who are entering Canada and unable to work. Again, there are really two issues there. The first is the cost involved in accessing a Canadian licence, the training and apprenticeship process that foreign-trained physicians often need to access to be qualified here. That is very challenging. The second is that it's very cost prohibitive, and there are lots of barriers in terms of allowing people to access that system. there is, again, the fact that because this is regulated by the provinces and territories, the approach to credentialling and what's required to obtain the licence is different in every province and territory. Again, there's no singular structure, and that creates a lot of unnecessary challenges and barriers at the regulatory level.

I think the opportunity for the federal government would be to provide that support, whether it's through bursaries or other monetary supports, to allow foreign-trained physicians that training and the financial support needed to be able to access it. It's upscaling the availability of those opportunities, and it's creating a pan-Canadian approach to credentialing and what those requirements are for Canadian licensure so we're not having these individual provinces and territories creating regulatory barriers for foreign-trained providers.

The Chair: Thank you, Dr. Smart and Ms. Sidhu.

Next we're going to Dr. Ellis, please, for five minutes.

Mr. Stephen Ellis: Thank you, Mr. Chair.

Again, thank you to the witnesses.

Perhaps you could provide a quick answer to this, please, Dr. Smart. I'm wondering, with the advocation for a pan-Canadian licence, are you suggesting we get rid of provincial colleges and registrars?

Dr. Katharine Smart: Thank you for the question.

No, I don't think we're suggesting that, but I think what we would like to see is better coordination, with one national standard that every Canadian physician can be umbrellaed under, with ongoing co-operation and coordination at that provincial and territorial level, which will still be important from a regulatory perspective.

We do believe that there are opportunities to have that pan-Canadian licence with the coordination of existing structures and also in being able to break down some of those barriers so that you aren't necessarily having to seek licensure in each individual province independently.

● (1745)

Mr. Stephen Ellis: Unfortunately, as a physician, it sounds like another layer of bureaucracy to me, but that's just me.

Dr. Soulez, we've talked a lot here about virtual care and perhaps the utility thereof. Do you see any difficulties, sir, as it relates to your profession as a radiologist in terms of more virtual care, perhaps, that primary care physicians or teams are using?

Dr. Gilles Soulez: That's actually a very good question. It's clear that the virtual care definitely increased the load of imaging, because the physicians are not examining their patients. We are seeing more ultrasounds and more CTs. This is something we need to take into consideration when we do virtual care.

In terms of this increase in imaging demand, we cannot address that. We are behind schedule and, more than ever, it's very important to improve the guidelines and the reference guidelines in being sure that every examination is relevant.

Mr. Stephen Ellis: Thank you, sir. I appreciate that.

Monsieur Cloutier, you talked a bit in your original statement about immigration. I wonder if we're noting any specific holdups at the federal government level. Certainly, as members of Parliament, we understand the deluge of cases of immigration holdups, and I wonder if you have any comments specifically on how that relates to health care professionals wanting to come to Canada.

Mr. Paul-Émile Cloutier: It's an excellent question. If you don't mind, I'll pass it on to my colleague Elaine Watson to respond.

Mr. Stephen Ellis: Thank you.

Ms. Elaine Watson: Thank you for that.

I think I would give an answer that is similar to the previous one. I think that if there were an ability to expedite health care workers who have been identified to have the skills, knowledge and experience to fill the positions that we have available in Canada, that we could expedite their entry into the country and minimize the bureaucracy related to the licensure, so that we can start that process before—

Mr. Stephen Ellis: Excuse me. If I might just interrupt you there, I apologize.

I know that obviously there are strategies. Do you know specifically that we are encountering delays with respect to immigration as it pertains to health care providers? Do you have any data on that?

Ms. Elaine Watson: Yes.

Mr. Stephen Ellis: We are.

Do we know how long the delays are?

Ms. Elaine Watson: I can't answer that question right here. I can tell you that they are significant.

It obviously has slowed down during COVID because of the barriers that vaccines and entry into the country have created, so I would say that it's not necessarily an issue right now, but it is something that we're going to have to pay attention to with the deluge of exits and retirements, etc., that we're going to see once the pandemic is dealt with.

Mr. Stephen Ellis: Right. Thank you for that.

Ms. Silas, I'm wondering about us accrediting programs abroad. I understand that currently the National Nursing Assessment Service is an accreditation service that is actually outsourced to the United States. I wonder if that is true and what the likelihood is of us sending accreditation teams to, say, nursing programs abroad.

Ms. Linda Silas: Yes, it is true. Some provinces are sending accreditation teams outside and abroad for nursing programs, mostly in the Philippines. That exists. Some provinces believe that's the way they're going to fix the shortage. I can tell you now that it will not. We need to work on a better and broader pan-Canadian health human resource strategy to do it.

Mr. Stephen Ellis: Thank you.

Mr. Barua, I don't think we have too much time. Do you have any ideas, sir, about the cost barriers to educating health care providers in Canada?

Mr. Bacchus Barua: Unfortunately, that's not something I've looked at [*Technical difficulty—Editor*].

Mr. Stephen Ellis: Dr. Smart, do you have any comments on that?

The Chair: Make it a brief answer if you could, please, Dr. Smart.

● (1750)

Dr. Katharine Smart: One of the things we know is that there are huge costs to obtaining training in medicine. That can be a real barrier when you look at diversity in terms of who enters the medical profession right now, and that then, of course, goes on to where people choose to ultimately practice. I do think that those cost barriers do have an impact.

The Chair: Thank you.

Dr. Powlowski, please, for five minutes.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): I'll start by commenting that Mr. Lake said he started voting NDP, and as he got older and presumably a little wiser, he joined the PCs. Maybe with a couple more years and a little more wisdom, eventually he'll become a Liberal.

Following on from that, Mr. Barua, you talked about underfunding of the system. It seems pretty clear that you think that's a large part of the problem. What are we going to do about it? That is the question. How accepting are Canadians going to be of higher taxes in order to pay for higher health care?

Luc talks repeatedly about the need for more money going to Quebec in order to provide adequate health care in Quebec. I think other provinces feel the same way. However, how much are Canadians willing to pay?

You've talked about user fees and the option of private health care, which both seem to be prohibited under the Canada Health Act. Should we allow those things?

There have been a number of surveys where people have asked Canadians what the most important thing is for them in defining what a Canadian is, or what the most important value is as a Canadian. Most Canadians repeatedly say two things: hockey and universal health care. Clearly, of those, the more important one is hockey, but health care comes in a pretty close second.

Would Canadians be willing to countenance user fees and privatization of health care? We're all politicians here. Basically, would this sell in Canada?

Do you think Canadians would be willing to accept that? Is any party going to have the cojones to do that, and is this something that we might need a national referendum on?

Mr. Bacchus Barua: Thank you so much for the question. That's quite a big one.

To start, I just want to clarify. I don't think I explicitly said that underfunding is an issue. We are one of the highest spenders. I think there is an imbalance between how much we spend and what we get in return.

When it comes to the policies that separate us, I want to reiterate that there are actually three. It's not just private health care and user fees, but it's also how hospitals are funded through activity-based funding.

On what you said in terms of the identification of universal health care as a core Canadian value, it's important to stress that universal health care does not in any way mean only a government-mandated health care system the way Canadians have been led to believe. Most other countries with universal health care have really a hybrid system with most of these policies.

Switzerland and the Netherlands, for example, are at one extreme of universal health care, where they simply mandate all their residents to purchase private health care in a market that includes both public and private providers. Most other countries, including Australia and Germany, have both public and private hospitals delivering public services. All these countries have some level of user fees. Some of them are deductible; some of them are a small copayment like 10% of the cost of care. All of them have exemptions. All of them have caps on the total level of out-of-pocket payment. These are all universal health care countries and all of them fund their hospitals in a different way.

To your last question regarding political appetite and also the Canadian appetite, I can't answer anything regarding politics. I'm not a politician or a political pundit. What I can say is that there are a lot of new surveys that do indicate that Canadians are changing their view in terms of how they perceive reform and their willingness to experiment and try different things that have been shown to work in other countries. This is obviously a result, partly, of our overburdened public health care systems, but also as a result of a better understanding of how other countries with universal health care simply do universal health care differently.

Mr. Marcus Powlowski: Can you maybe cite in a little more detail those studies as to the acceptability?

Although other countries that provide universal health care may allow extra billing and some privatization, I think most countries, when they think of universal health care, do not think of those things as being part of it.

Do you have further numbers and evidence? Maybe you don't, and if you don't, that's fine. Again, I'm figuring the Canadian public will not buy this. They will consider this as being an unwarranted compromise to the universal health care system that is so important to all Canadians.

● (1755)

The Chair: Provide a brief response if possible, Mr. Barua.

Mr. Bacchus Barua: [*Technical difficulty—Editor*] don't have the numbers on hand, but I believe that the study that you might find useful was conducted by secondstreet.org in Alberta.

With regard to Canadians' accepting these sorts of reforms, I will say this. I have great faith in Canadians and their ability to understand new information. I think that the pandemic has shone a wonderful light on how other countries do universal health care, how many of them do it differently and how many of them have features that are probably valuable in the Canadian system.

Of course, all of this would be understood to be within a Canadian framework, which would be unique in its own way.

The Chair: Okay, thank you.

[*Translation*]

Mr. Thériault, you have the floor for two and a half minutes.

Mr. Luc Thériault: Thank you, Mr. Chair.

Dr. Soulez, you practise medicine in Quebec. You will know that, since 1992, Quebec has restructured three times to try to do more with less.

Based on your assessment, what should be done over the short and medium term? Over the longer term, I imagine that we will focus on training, which has been deficient because of underinvestment over the past 30 years. We need people to overcome these issues.

In the short term, what are the most important measures to take? At the end of your response, please tell me if you would support a summit on health care funding.

Dr. Gilles Soulez: Your question is a very broad one. I will focus on medical imaging, our field of expertise.

Overall, two urgent needs must be addressed quickly. First of all, the working conditions of our radiology technologists must be improved to ensure their retention. This is a really important piece because there is a shortage of technologists. Therefore, a retention strategy is required immediately. The profession is somewhat undervalued.

The other truly urgent need that can be addressed quickly is the integration of an information technology system. Currently, it makes no sense that a patient is still sending off a fax to book a medical imaging appointment. When you look at the patient treatment process, from the moment the doctor writes the prescription to the moment the patient books an appointment until the moment they undergo the examination, you see that several of the information systems used are not integrated. Serious priority needs to be given to system integration. In my opinion, it would spur huge savings in staffing and lessen the burden on staff.

The next, longer-term priority for investment is equipment. That investment would certainly provide us with more modern equipment than what we currently have. Concerning staffing, the focus needs to be on training. For example, in Saskatchewan, there is no training for technologists. In Quebec, we could do more training. We also have a lot of technologists who are leaving the field. Therefore, there needs to be improved training, greater value placed on technologists and efforts to retain them.

I think that if we focus on those components, we can improve performance, but, once again, I am a big proponent of integrated IT. That can help us a lot.

Mr. Luc Thériault: What about the summit on health care funding?

Dr. Gilles Soulez: I support it.

The Chair: Thank you, Mr. Thériault.

[*English*]

We have Mr. Davies, please, for two and a half minutes.

Mr. Don Davies: I've made it my mission in life that whenever anybody says health care is provincial jurisdiction, I must intercede. The Constitution does not even mention the words “health care” and does not give it to either the provinces or the federal government. In fact, the Supreme Court of Canada has said the following:

> In sum, “health” is not a matter which is subject to specific constitutional assignment but instead is an amorphous topic which can be addressed by valid federal or provincial legislation, depending in the circumstances of each case on the nature or scope of the health problem in question.

The only thing given to the provinces is the establishment and maintenance of hospitals. Of course, in 1967 we didn't even have universal health care.

The reason I point that out is I want to drill into something. It sounds to me that, as Ms. Silas said, we have to develop our home-grown talent here. That means more seats. It means more seats in nursing schools, medical schools, for technicians—everything.

Would the witnesses support a federal fund that was targeted to the provinces specifically for the purpose of expanding seats in professions? The province could determine where the scarcity is, but I'm referring to tied funding in that regard. I know that some people refuse any kind of tied aid from the federal government; I don't.

Is that one way to get more seats in these schools to create the bodies we need?

● (1800)

Ms. Linda Silas: I totally agree, Mr. Davies.

We need support from the federal government, and we need support from committees like yours not to throw in the towel on our universal public health care system. There are close to a million health care workers who have worked their hardest and their best over the last two years, and the worst thing they could hear right now is, "We're throwing in the towel, and we're going to privatize the whole thing to make a few very rich."

Help us educate more. Help us improve the working conditions. That will help and reduce all the wait times. We know how to do it; we just need help.

Mr. Don Davies: Mr. Cloutier, is that something that we should consider doing—targeted federal funding conditional upon provinces using that funding to create more positions?

Mr. Paul-Émile Cloutier: I totally agree with the position that Ms. Silas pointed out to you. I think that would be a way to address a component of the problem.

My biggest fear is that you have a number of stakeholders here who all have interests with their stakeholders. I think it would be totally wrong, especially at this juncture, to do something that would only address certain components of the health care system when in fact I think that what we need to do as citizens and as governments is to start to rethink what kind of health care system we want and need for Canadians post-COVID.

COVID has given us a number of lessons. We weren't prepared, and we need to prepare for the next virus that might come over to our place. I think that reflection has to be global. It can't be just about nurses. It can't be just about schools. It can't be just about funding. You have to look at the system as a whole, and that's why I come back to Mr. Thériault's comment.

Yes, I think there needs to be a dialogue at the federal and provincial levels, including some of the stakeholders around this table, to try to explain what's happening and to try to find a solution that will be acceptable for all Canadians.

The Chair: Thank you, Mr. Cloutier and Mr. Davies.

Next is Mr. Lake, please, for five minutes.

Hon. Mike Lake: That's a good segue into my line of questioning.

Mr. Cloutier, that was in our platform. We talked about that in the election campaign, coming together within the first 100 days.

I listened with interest to Mr. Soulez talk about technology and innovation, and come back to it time and time again. I talked about the cost of the health care system and the fact that all of the parties agree that we need more investment in terms of the transfers. I want to see how we can get more efficient with the money that we're spending right now.

I have a very specific question for each of the witnesses, maybe starting with Mr. Cloutier and Dr. Smart.

What innovations in terms of either technology or structure would result in...? I'm not talking about spending more money. It might be a little bit more money, but what innovations would result in more productivity per hour of work for the folks that you represent?

Mr. Paul-Émile Cloutier: Dr. Smart, do you want to go first?

Dr. Katharine Smart: I think there are several aspects that are challenging. We're talking about increasing productivity on a backdrop of people who are incredibly burnt out and already working really extensive hours in conditions that are very challenging to sustain.

You've heard from Ms. Silas about nurses being mandated overtime. It's very common in medicine to work without a break for 24 to 36 hours in acute care settings, which is really shocking in this day and age. We have family physicians providing care throughout the day and then spending hours and hours at home due to the administrative burden now of health care delivery, after hours and in unpaid ways.

When we're talking about efficiencies, we need to recognize that right now our system really puts a lot of burden on individual practitioners to overcome a lot of the system's issues that make the delivery of care challenging, and those things need to be addressed.

Again, it comes back to what Dr. Cloutier was saying about integrated planning. We can't solve any of these issues as individual practitioners or at individual levels of government. We really need integrated care plans to look at what are our health human resources and how we deploy them in a way to meet the needs of Canadians. How do we allow everyone to be at their full scope of practice so that we do get those efficiencies in the system.

I don't think it's a question that any of us can answer in our own silo. We really need to come together, look at what the barriers are, what the challenges are and then come together with actual solutions.

● (1805)

Hon. Mike Lake: Mr. Cloutier, do you want to weigh in? Ms. Silas can answer afterward.

Mr. Paul-Émile Cloutier: I totally support what Dr. Smart said. When we speak about integration, it's integration that includes home care and long-term care. We saw during COVID that long-term care was like the poor cousin of the system, and it was just left there on its own.

The integration has to be primary care, acute care, long-term care and home care. It's starting. People realize that the system is wrong in the way it was structured, and that now is the time to have that reflection and dialogue as to how we integrate all the components of the health care system to make it an excellent system for Canadians.

Ms. Linda Silas: I totally agree with the previous two speakers, but also Dr. Soulez, who talked about integration. For the last two years, I haven't seen my primary health care provider. Everything's been virtual, either on the phone or on Zoom, so we need to expand that and we need to make it safe. That's an area where we'll all have to be at the same table from scope of practice, integration and the virtual world of health care.

Let's think about it as innovation and not degrading the health care services we give to Canadians currently.

Mr. Paul-Émile Cloutier: If I may, I like the innovation, I like the virtual care, but in that equation we also have to examine what the risks are. If we don't examine the risks, we'll never know if what we're putting forward in terms of innovation is actually going to be helpful and that we're going to have positive outcomes. That has to be part of the equation.

The Chair: Thank you, Mr. Lake.

The last round of questions will come from Mr. van Koeverden, please, for five minutes.

Mr. Adam van Koeverden (Milton, Lib.): Thank you very much, Mr. Chair.

I'd like to thank all of our witnesses today for their testimony, their experience and their efforts over the course of these very challenging last two years. This has been a very productive meeting, and I'm really grateful for all of the wonderful testimony.

My first question is for Ms. Silas. It relates to the way the government has demonstrated a practical approach to partnering with provinces and territories. It's relevant to consider how well our child care agreements have gone over the course of the last couple of years. Maybe this presents a model for potential future investment partnerships with provinces to provide targeted support in certain areas.

I'd like to hear your reflections on how we might invest in and partner with provinces and territories in strategic ways that would improve the quality of care and potentially result in the hiring of more nurses, nurse practitioners, physicians' assistants and doctors. What are your reflections on how the federal government can partner with provinces and territories to increase that workforce participation?

Ms. Linda Silas: I mentioned earlier the 2004 health accord. All the premiers, the prime minister and health ministers got together and signed an agreement for 10 years. I've worked with many premiers over the years—almost all of them—and if you show them the money, they will make changes. That's what we're seeing for child care. It's "What kind of money" and then there are standards.

That's what I expect we will see with long-term care. It will be, "Show me the money" and then we'll get the standards. We need to do it with mental health. We need to do it with our acute care sector. In our acute care sector right now, the crisis is the health human resource crisis. If we don't fix that, we won't have anything to worry about, because we won't have a system.

You heard from all the stakeholders here. We're calling for an agency of experts with the proper data and the proper funding for strategies to help us to do our jobs.

The worst thing I hear from nurses almost on a daily basis is, "I go into work every day and I know I'm not able to provide the care I should be providing. The sad thing is, I know I'm going back in tomorrow to do the exact same thing." We need to stop that. We need to give them hope. I have trust in all of you that this is what will happen. You will give them hope with an amazing report from this committee, just like you did in 2019 on violence in health care. It was the best report.

Now we need to work together and fix it.

● (1810)

Mr. Adam van Koeverden: Thank you very much.

I wouldn't mind building off of that a bit and reference that so much of your membership has been targeted in protests and in violent ways. I'm grateful to see that our new law in place to protect health care workers from on-site protests and that violence has had—

Ms. Linda Silas: With all due respect, we have to get the police to enforce it. Dr. Smart and I were there when Minister Lametti introduced it and we were very proud. It was a big success, but look at what has happened in Ottawa and other regions. The police haven't even read the act yet, so we need to enforce it. It can't just be an act written on beautiful paper. It has to be enforced.

I'm sorry to interrupt.

Mr. Adam van Koeverden: No, it's encouraged. I'm really grateful for that, and I couldn't agree more that a law that's not enforced is certainly not helpful, and we've seen only a few examples of it being enforced in Ontario.

I'd like to touch on "strings attached". It's a commonly used term now. This is for anybody who feels strongly about this issue. It's probably our last chance to hear from anybody.

I know that challenges are different across the country. We're a federation, and various jurisdictions experience different challenges.

When considering how to invest and partner up with various jurisdictions, provinces and territories, what types of strings should the federal government consider in those partnerships with provinces and territories?

Dr. Katharine Smart: I could comment on that. Thanks for the question.

From the CMA's perspective, what we would like to see is that the dollars used by the federal government to motivate action at the provincial level are really targeting what we see as the biggest issues facing the health care system. For us those are clearly backlogs and catching up on surgery and diagnostic imaging, as we've heard about; commitments to ensure that all Canadians have access to primary care, which is foundational in our system; and also cost savings in the long term when people have a longitudinal care provider. We know that long-term care needs to be seriously addressed as does mental health.

We would like to see strings attached to targeted funding to make sure that those four priority areas are actually addressed and that we move the dial in terms of quality and access in those domains.

The Chair: Thank you, Dr. Smart.

Thank you, Mr. van Koeverden.

Colleagues, we've reached the appointed hour, so, first of all to our witnesses, thank you so much for being with us. Thanks for sticking it out while we were exercising our democratic duty and delaying the commencement of the meeting.

Thank you so much for the last two years and for what you and your members have done and for the research that has been presented today. This has been an excellent and informative session. We're extremely grateful to you for your leadership in your respective professions and for the patient and insightful way that you handled the questions today. It will be of great value to us in doing our work and making recommendations to the government, so thank you so much.

Colleagues, before we wrap, there are a couple of housekeeping items. We'll see each other again on Monday, February 28 to hear from the Public Health Agency of Canada and the Auditor General on our COVID study before we hear from more witnesses on this particular study on March 2.

I remind everyone that any supplemental witness lists for this study are to be submitted to the clerk by end of day tomorrow.

Supplemental lists for the COVID study are due by five o'clock on March 3.

Is it the will of the committee to adjourn the meeting?

Some hon. members: Agreed.

The Chair: We have consensus.

Thank you again, everyone, and have a good evening.