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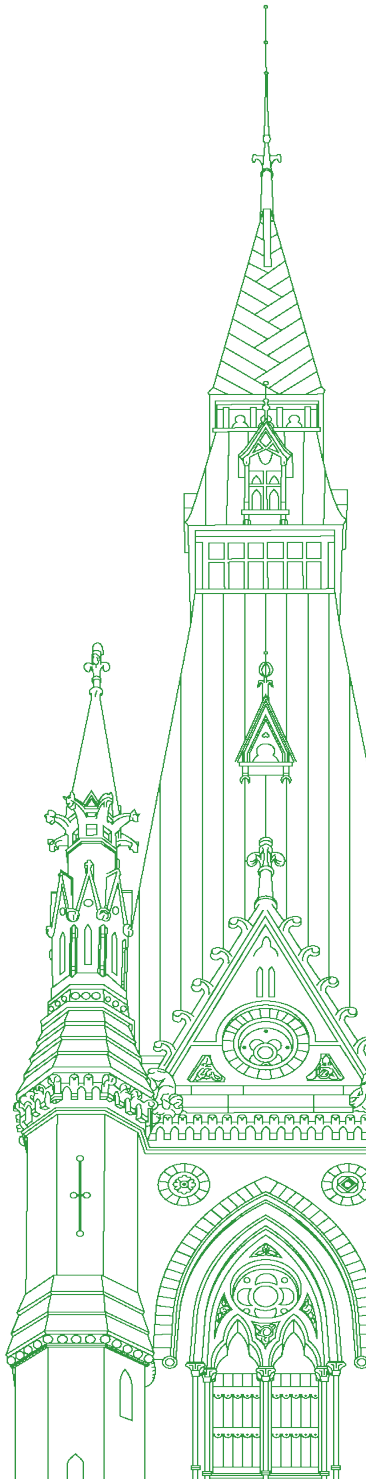

Chair: Mr. Sean Casey

Standing Committee on Health

Thursday, September 22, 2022

● (1105)

[*English*]

The Chair (Mr. Sean Casey (Charlottetown, Lib.)): I call this meeting to order.

Welcome to meeting number 30 of the House of Commons Standing Committee on Health. Today we're going to meet for two hours with witnesses on our study of children's health.

Today's meeting is taking place in a hybrid format, pursuant to the House order of June 23, 2022.

I'd like to make a few comments for the benefit of witnesses and members.

Please wait until I recognize you before speaking. For those participating by video conference, click on the microphone icon to activate your mike, and please mute yourself when you're not speaking. For interpretation for those on Zoom, you have the choice, at the bottom of your screen, of floor, English or French. For those of you in the room, you can use the earpiece and select the desired channel.

Screenshots or taking photos of your screen is not permitted. The proceedings will be made available via the House of Commons website.

In accordance with our routine motion, I am informing the committee that all witnesses have completed their required connection tests in advance of the meeting.

[*Translation*]

We are welcoming a new committee member, Mr. Perron, whom I welcome.

[*English*]

I see Ms. Vien is filling in. Welcome. It's nice to have you here.

I would like to welcome the witnesses who are with us this afternoon. It's an absolute pleasure, after so long, to see witnesses physically present, so a warm welcome to you.

Appearing as an individual is Dr. Michael Ungar, Canada research chair in child, family and community resilience, resilience research centre, Dalhousie University—my alma mater. We have the Canadian Cancer Society, represented by Kelly Masotti, vice-president of advocacy, and Helena Sonea, director of advocacy. From the Canadian Dental Association, we have Dr. Lynn Tomkins, president, and Dr. Aaron Burry, chief executive officer. From Pharmascience, we have Sarah Douglas, senior manager of government affairs. From Speech-Language & Audiology Canada, we have Dawn Wilson, chief executive officer, and Anne Carey, director of speech-language pathology and communication health assistants.

Thank you all for taking the time to appear today. As I believe you were informed, each organization has up to five minutes for an opening statement. I'm going to invite Dr. Ungar to begin.

Dr. Ungar, welcome to the committee. You now have the floor.

Dr. Michael Ungar (Canada Research Chair in Child, Family and Community Resilience, Resilience Research Centre, Dalhousie University, As an Individual): I'd like to say a huge thank you, Mr. Chair, for this opportunity.

I would like to bring you a little bit into my world, which is the study of the resilience of children. I know that we're going to be experiencing a huge amount of delayed pathology because of COVID. I also want to bring you the message that there are potentially a lot of resources in our communities.

When I think about the work that I do, I'm also thinking about a young fellow, 11 years old, who is in elementary school and is exposed to a great deal of stigma. He lives in poverty in social housing, and his parents have incredibly few resources to cope with him. However, this fellow, who has bad teeth and is teased in his community, found inside his school community a custodian, a janitor of the school, who took him under his wing and who provides an element of protection and a sense of belonging.

We don't normally think of custodians at our children's schools as part of a mental health strategy. My research on resilience globally is showing that we need to begin to think about resilience and the health of our children in a more multi-systemic way. We need to get beyond simplistic solutions like offering a child a self-esteem workshop or a mindfulness-based stress-reduction workshop or simply a better educational experience. From the research that is emerging, we understand that when children's lives are thought about in their complexity—and this is what I so appreciate about a panel like today's, where you're seeing many aspects of a child's life represented—we tend to get better social policies. That means how the courts sentence children or indeed how schools respond to children.

My work is about looking at this cascade of positive effects. If we can jump-start one system, whether it's an educational system or better support for families.... The real trick with policy that seems to have an impact on long-term resilience for children is understanding that it is almost like dominoes hitting one another to create the kinds of changes that we're looking for.

In my research and my work, I'm now involved in looking at the impact of boom-and-bust economies on children and families in those communities that, as we green our economy, we're going to be displacing. Literally hundreds of families and communities are dependent on the oil and gas industries in places like Alberta, here on the east coast in Saint John, and indeed Newfoundland.

When we begin to think about resilience, and when we think about children's well-being and mental health, which is my concern, I'm thinking about the impact of even macroeconomic factors as they change family patterns, recreational services and opportunities for children to do the kinds of things they need to do.

A concept I might introduce to policy-makers is the idea of differential impact. What you offer as a policy might have a different impact on the child, depending on three things. First, what are the actual risks they experience? Second, what are the protective factors that are most likely to impact that risk and be helpful? And of course, what is the outcome you are trying to achieve?

All of that leads me to think about St. Mary's, a school outside Saskatoon. When they renovated the school—even though they serve a large population of indigenous children, refugee children and children who are visible minorities—they were having trouble getting those children to the local children's hospital for the appointments they needed. What the school board did, when they renovated St. Mary's, a K-to-9 school, was to build a purpose-built pediatric clinic in the school, so then it was easier for families to get access to those services close to their homes.

That is the kind of multi-systemic thinking, reaching beyond single, simplistic solutions to very complex problems, where systems are working together, that is likely create a cascade of positive impacts that will make our children more resilient, especially as we come out of this period of COVID, when there have been so many delays in their psychological and social development.

I'll leave it at that.

● (1110)

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

Next we're going to hear from Dr. Tomkins of the Canadian Dental Association.

You have the floor for the next five minutes. Welcome.

Dr. Lynn Tomkins (President, Canadian Dental Association): Thank you, Mr. Chair.

[*Translation*]

Good morning, committee members.

[*English*]

Before I begin my remarks, I would like to take a moment to recognize that I am joining you here today on the unceded territory of the Algonquin Anishinabe people.

I'd also like to thank you for taking the time to study this important topic of children's health, and I sincerely appreciate your inviting the Canadian Dental Association to participate in this morning's meeting.

At the Canadian Dental Association, we know that oral health is an essential component of overall health, and we believe that Canadians have a right to good oral health. That is why we fully support efforts by all levels of government to improve Canadians' oral health and enhance their access to dental care.

Poor oral health strains other parts of the health care system, whether through hospital visits for emergencies or through managing the long-term impacts of poor oral health on systemic disease. This is particularly the case with children, as good oral health in childhood serves as a foundation for the rest of a person's life.

Unfortunately, in spite of significant progress over past decades, tooth decay remains the most common yet preventible chronic childhood disease in Canada. It is the most common reason for Canadian children to undergo day surgery, and it is the leading cause of children missing school. Beyond the risk of pain and infection, tooth decay, particularly in young children, can impact eating, sleep, proper growth, speech, tooth loss and malocclusion, and it increases the need for dental treatment later in life.

On a personal level, having been in practice for over 35 years, I can tell you that it is heart-wrenching to see a young child with severe dental decay. This often requires treatment under general anaesthesia in a surgical facility, which can also involve lengthy wait times. In addition to the impact on a child's health, the experience can lead to long-term dental fear and anxiety. Therefore, it is important to ensure that Canadian parents can access dental care for their children within months of the eruption of the first tooth.

Early exposure to good oral hygiene habits and preventive care can make a lifetime of difference for a person's mouth, and while Canada compares favourably to many other countries, too many people, including children, still do not receive the dental care they need. More than six million Canadians each year avoid visiting the dentist, primarily because of cost. This is especially true for low-income families.

While every province and territory in this country has publicly funded dental programs for children, these vary from jurisdiction to jurisdiction, leaving significant gaps. This is why the CDA welcomed the federal government's commitment earlier this year to a multi-billion dollar ongoing investment in enhancing access to dental care for Canadians. It comes after years of encouraging federal investments in dental care by the CDA, and all those who have advocated on this issue, whether on behalf of CDA, provincial and territorial dental associations or on behalf of other health organizations, should be proud that their hard work has led to this once-in-a-generation opportunity.

In particular, CDA appreciates the phased approach being taken by the federal government, illustrated by last week's announcement of a proposed Canada dental benefit and this week's introduction of legislation to implement that proposal. This will allow time to consult and collaborate with all relevant stakeholders on a long-term solution that is well informed, targeted, comprehensive and effective. We appreciate that this interim measure balances supporting the oral health needs of Canadians with several key priorities for Canada's dentists.

We've also appreciated the close collaboration demonstrated so far by Minister Duclos and his team at Health Canada, and we look forward to working with him in the months ahead. We would also like to thank Mr. Don Davies for his advocacy on oral health over the past number of years, which has culminated in this historic federal investment in enhancing dental care for Canadians.

Finally, beyond reducing financial barriers to accessing dental care, there are several other items that CDA has focused on in its written brief to the committee. These include recommendations that the federal government implement the remaining measures of Canada's healthy eating strategy, with a focus on food and beverage marketing to children under age 13; review its programs providing funding for drinking water systems and look for ways to support enhanced access to community water fluoridation; and examine the administration of the NIHB program for first nations and Inuit to ensure timely access to surgical facilities for children requiring dental treatment under general anaesthesia.

As well, we believe it is essential for the federal government to include oral health as a component in any studies on the long-term impact of the COVID-19 pandemic on children.

Thank you once again for the opportunity to participate in today's meeting. I would be happy, along with the CDA CEO, Dr. Aaron Burry, to answer any questions that you might have.

Thank you.

● (1115)

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

Next, from Pharmascience, we have Sarah Douglas.

Ms. Douglas, you have the floor.

Ms. Sarah Douglas (Senior Manager, Government Affairs, Pharmascience): Thank you.

Good morning, Mr. Chair and members of the committee.

Thank you for inviting Pharmascience to appear before the House of Commons Standing Committee on Health. I'm here today to share our perspective as a manufacturer of medicines on the crucial issue of access to pediatric drug formulations and the challenges we face in bringing these child-friendly formulations to market in Canada.

For some context about who we are, Pharmascience is the second-largest Canadian-owned pharmaceutical company, founded nearly 40 years ago by pharmacists Morris Goodman and Ted Wise. We're a proudly Canadian company, with our global headquarters, manufacturing facilities and R and D labs all located across the greater Montreal area, where we employ almost 1,500 people. Importantly, we invest about $40 million to $50 million annually in R and D in Canada, consistently appearing among the top 100 companies investing in R and D.

[*Translation*]

In 2019, Pharmascience representatives appeared before the House of Commons Standing Committee on Industry, Science and Technology to express their concerns regarding the issue being studied.

Compared to other similar countries, Canada lags behind in the availability of drug formulations specifically for the pediatric population. This is not a matter of demand; pediatricians, nurses, pharmacists, and parents of sick children have always asked for specific pediatric formulations.

Pediatric formulations are drugs that have a dosing regimen tailored to children and have certain characteristics that differ from those of adult products, such as specific formulation ingredients, formulation form—liquid or solid—concentration of active ingredients, indications for product approval, or packaging.

[*English*]

Pediatric formulations are not necessarily simple to develop, but they are essential to have. There are numerous new approaches that allow us to tackle the challenges, but market conditions have made it difficult for manufacturers to launch these formulations in a commercially viable manner.

That being said, I do want to recognize that there has been progress since 2019, including Health Canada's pediatric drug action plan in development and a recent decision from the pan-Canadian Pharmaceutical Alliance that will allow Pharmascience to market levetiracetam, one of the most needed pediatric formulations for epileptic children. This decision marks a possible breakthrough in the reimbursement of pediatric drugs, but it's still early and there's much more work to do.

As a manufacturer, I'd like to highlight our main general concerns that make it difficult to manufacture pediatric formulations in Canada. First, the pediatric market is completely different from the adult one; it is much smaller. The market size difference alone challenges the viability to market these formulations. On top of this, pediatric drugs have been treated the same way as their adult equivalents in pricing. Given the extra effort it takes to market pediatric formulations, this makes prices so low that no one can successfully market the drug. A different pricing grid for public reimbursement of pediatric drugs is needed. Third, nearly all of the drugs identified by pediatricians needing a pediatric formulation are off-patent. This makes the R and D investments by manufacturers extremely risky for pediatric formulations as we may not be able to recoup the investment.

● (1120)

[*Translation*]

Thankfully, Health Canada has heard the call and is developing a pediatric drug action plan with the goal of improving the availability of pediatric formulations in Canada. We are working closely with Health Canada to develop this plan.

As part of the pediatric drug action plan, measures that would help us get more pediatric formulations to market include the waiving of submission fees, as well as a period of market exclusivity for non-patented or generic pediatric formulations. These are measures that exist in the European Union and the United States. Those regions have recognized the need to encourage the creation and availability of these drugs.

[*English*]

It will be absolutely crucial for Health Canada to implement regulatory changes to support the development of new pediatric formulations. This isn't just a call from us. Many other stakeholders in the pediatric space put out a call for change earlier this year. It will also be critical to change the public reimbursement environment and to recognize that pediatric drug prices need a different pricing standard from adult dosage forms. We need to keep up the momentum to get this done, and the steps that are made today will create a better future for children.

Pharmascience is one of the few Canadian manufacturers that have taken the risk to invest in pediatric drug formulations to meet this important unmet need in spite of the unfavourable market conditions. At stake is the health and safety of children. If the policy changes that we are endeavouring are implemented, simple, affordable and significant innovation can be brought to the practice of pediatrics.

Once again, thank you for the invitation to appear, and I'd be pleased to answer any questions that you may have.

The Chair: Thank you very much, Ms. Douglas.

Next, from Speech-Language and Audiology Canada, I believe Dawn Wilson will be speaking for the group.

You have the floor for the next five minutes. Welcome to the committee.

Ms. Dawn Wilson (Chief Executive Officer, Speech-Language and Audiology Canada): Thank you, Mr. Chair and members of the health committee.

I would like to thank you on behalf of Speech-Language and Audiology Canada and our 7,500 members. I appreciate the opportunity to speak to you today about timely diagnosis and access to speech-language pathology and audiology services for children.

We know that effective communication is foundational to a child's social, emotional and educational development. Research has shown that the first three years are a critical period for normal speech, language and hearing development. Early identification of difficulties is therefore key to ensuring timely access to appropriate interventions for long-term success. Learning is cumulative. Difficulties not addressed early are compounded in later years. Thus, addressing communication health needs early has a decisive influence on later academic accomplishments, health, well-being and quality of life. Our members are vital in terms of being part of a primary health care team to support this process.

Across Canada, our services are offered through a combination of public, private and school-based providers. However, insufficient positions and inconsistencies in service delivery result in inadequate access to care. The situation is worse in many rural and remote areas. Parents report lengthy wait-lists in both public and private settings during this critical developmental window, which can be exacerbated for specialized groups such as children with autism. The demand for our services exceeds the capacity of available professionals.

Detection of hearing health issues is critical in the very early stages of life. Access across Canada is inconsistent. Almost half of the provinces and territories received a failing grade on a 2019 early hearing detection and intervention report card. Related, most provinces and territories do not offer universal newborn screening for congenital cytomegalovirus, despite its being the most common infection transmitted from mother to baby during pregnancy. The prevalence rate of CMV is approximately one in 200 newborns and is the leading non-genetic cause of neurologic disabilities and permanent hearing loss worldwide.

In the preschool population, acute otitis media—or middle ear—infections are extremely common, affecting approximately 75% of children at least once before starting school. Chronic suppurative otitis media in early childhood can lead to increased risk of auditory processing disorders later in life.

When speaking to their child's health care providers, parents often report speech and language delays as a primary concern. Prevalence data suggest these difficulties are common. Speech sound disorders in preschool children range from 2% to 19%. Developmental language disorder is one of the most common childhood disorders, affecting 7% of children. Speech sound disorders range from 2.3% to 24%.

Communication difficulties follow a child later into their school years. A recent report indicated that there are insufficient speech-language pathologists working in Canadian schools to meet the needs of students who require their services. These staffing shortages are long-standing. However, closure of day cares and schools during COVID-19 further exacerbated the issue with increased levels of burnout and heavier caseloads. Prior to the pandemic, many indigenous children were already missing literacy benchmarks for their age groups.

Long-standing communication difficulties and their far-reaching effects cannot be easily remediated, though an early investment can have a multiplier effect. A dollar invested in addressing problems today will mean many more saved in the long term. In other words, inaction now carries very high long-term costs. Delayed intervention costs 10 times more than if intervention were accessed early. Children who do not achieve optimal early language learning are not prepared or equipped for compulsory formal education by age five.

● (1125)

We recommend that the federal government work with provinces and territories through recent day care deals to train early childhood educators on speech and hearing delays; that we integrate speech language pathology and audiology services into licensed day care settings, in collaboration with provinces and territories; and that the federal government establish a primary health care transition fund to assist provinces and territories in their work to expand access to speech-language pathologists and audiologists through primary health care teams. Of course, we desperately need initiatives to recruit and retain speech-language pathologists and audiologists in any federal efforts to improve health human resources.

Again, thank you for the opportunity to be here today. We are happy to answer questions.

The Chair: Thank you very much, Ms. Wilson.

Next, we're going to hear from the Canadian Cancer Society.

Ms. Masotti, I know you had some trouble getting online, but I see you there now. I know you're no stranger to parliamentary committees. You know the drill. You have the floor for the next five minutes. Thanks for your patience, and welcome.

Ms. Kelly Masotti (Vice-President, Advocacy, Canadian Cancer Society): Thank you, Chair. Thank you for your patience. I also really appreciate the support from House of Commons IT staff.

Good morning. Thank you, Chair and committee members, for having me here today. My name is Kelly Masotti. I'm vice-president of advocacy. Here with me today is Helena Sonea, director of advocacy.

Before I begin my remarks, first I'd like to acknowledge that we are both speaking to you today from the traditional unceded territory of the Anishinabe Algonquin people.

I'm pleased, on behalf of the Canadian Cancer Society, to participate in today's committee discussion regarding children's health. Cancer is the leading cause of disease-related death in children under the age of 15 years. This is why the Canadian Cancer Society has invested $16.4 million in childhood cancer research projects across the country in the past five years alone.

In trusted partnership with donors and volunteers, we work relentlessly to improve the lives of those affected by cancer, through world-class research, transformative advocacy and compassionate support. We also work to provide real-time support to people with cancer and caregivers. Last year alone, we provided trusted information to over 125,000 users of cancer.ca looking for information specific to childhood cancer.

It's auspicious that we're gathered here today to discuss this topic, given that September is both nationally and internationally recognized as childhood cancer awareness month. We know that an estimated 1,100 children under the age of 14 were expected to have faced a cancer diagnosis in 2021. However, it's suspected that diagnosis for many cancers has fallen since the onset of the COVID-19 pandemic in Canada.

We have had success diagnosing and treating cancer impacting children over the past number of decades thanks to world-class research and innovative treatments. The five-year survival rate for childhood cancer is about 84%. This means that about 84% of children with cancer survive at least five years past their diagnosis.

Although childhood cancers account for less than 1% of all cancer cases diagnosed in Canada, they have a significant and lasting impact on both the individuals and their caregivers. An estimated two-thirds of childhood cancer survivors have at least one chronic or late side effect from their cancer therapy, including a high risk of physical and mental health problems or secondary cancers.

I'll now turn my remarks over to Helena.

● (1130)

Ms. Helena Sonea (Director, Advocacy, Canadian Cancer Society): Good morning.

I will use our remaining time to highlight several areas that require further investigation and resolution to support children's health. It's important to note that the causes of most childhood cancers are largely unknown, and modifiable risk factors usually have little to no effect on most of them, but it is important to recognize that teaching healthy lifestyle choices and preventing certain environmental exposures in childhood may reduce cancer risk much later in life.

We would be pleased to discuss each of these recommendations further during our question and answer period or provide further information in writing should committee members wish.

First, the overwhelming majority of people who smoke begin as underage youth. Far more needs to be done to reduce youth tobacco use to help achieve the goal of under 5% prevalence of tobacco use by 2035. Canada is currently faced with a dramatic increase in youth vaping, leading to overall increase in youth nicotine addiction. Among high school students in Canada in grades 10 to 12, youth vaping increased from 9% in the 2014-15 school year to 16% in 2016-17, to 29% in 2018-19, tripling over a four-year period. It is essential that the government take further action to reduce youth vaping, in particular to finalize regulations restricting flavours on e-cigarettes.

Research shows that as much as 90% of food and beverages marketed to children for processed foods are high in sugar, salt and/or saturated fats. Food and beverage marketing has an impact on the foods that children eat, from their food preferences and beliefs and the food they beg their caregivers to buy, to rising rates of childhood obesity and increased risk factors for chronic disease such as diabetes, heart disease, stroke and cancer. There's a clear need for the government to fulfill its commitment to restrict the commercial marketing of all food and beverages to children and youth.

Everyone in Canada needs better palliative care options, regardless of age, gender, income, race or sexuality. Significant work is required to give families who need palliative care, particularly for a child, the support they deserve, including improving education and training for health care workers, addressing equity, supporting children struggling with grief, establishing standards, and improving the quality of care through better research and data collection. There's considerable space for the federal government to lead here, in addition to the necessary improvements to care delivery by the provinces and territories.

Canadians, and especially our children, should also have equitable access to life-saving drugs that play an essential role in treatment and can greatly improve health outcomes and quality of life for people living with cancer. As the government provides further detail on its pharmacare commitment, we would encourage the government to improve access to drugs, accommodate and accelerate approval and funding for innovative cancer treatments and clinical trials, and remove unnecessary administrative barriers to ensure children with cancer have equitable access to the cancer drugs they require without financial hardship on their caregivers, regardless of where they live and where the drugs are taken.

Finally, we know that federal, provincial and territorial governments are due to discuss the state of health funding transfers. From our perspective, ensuring that governments are properly funded to address the critical issues facing Canadians is paramount. While governments may debate the funding amount needed and the funding conditions, what we want to see is taxpayer dollars focused on improving health outcomes, measuring those outcomes, and supporting vital inputs like health research that give children a better chance to live and have a healthier and higher-quality life. Because of investments in world-leading research and clinical trials, we now have a better understanding of childhood disease and treatments that are helping children live longer. We will continue to invest our focus and our dollars to support this work, and we encourage the government to do so as well.

I want to thank the committee again for having us here today. We look forward to your questions.

Thank you.

● (1135)

The Chair: Thanks to you both.

We're now going to proceed directly to questions, beginning with Mr. Barrett for six minutes.

Mr. Michael Barrett (Leeds—Grenville—Thousand Islands and Rideau Lakes, CPC): Thanks very much, Chair.

Thanks to all the witnesses for joining us in person and virtually today. It's great that we're all gathered to talk about children's health.

My question is for our witnesses from the Canadian Cancer Society. It deals specifically with an issue that's been flagged for us as a result of the restrictions and measures that were put in place because of COVID-19 and that have caused delays in the care and screening appointments for cancers. What I'm looking to find out is whether the backlog of care and screening appointments for children is at the same rate, less than, or worse than it is for adults.

Ms. Helena Sonea: Thank you very much for the question. It's nice to see you.

We absolutely know that there is an overall delay for Canadians living anywhere in the country, whether it's access to diagnostics or the treatment and the surgery. Unfortunately, the information is not available at this time, but we can certainly have an additional poke-around for you following this committee appearance here today to ascertain whether or not the delay is more significant for the childhood population.

I think we certainly know that, generally speaking, there is a delay to all different types of cancer diagnoses throughout all age groups, so we will get back to you with the specific number. I would certainly say that my hunch is that it is applicable to this age group as well.

Mr. Michael Barrett: Thanks very much, and I look forward to the information you're able to track down.

In practical terms, can you share with us what the effect is of those delayed diagnostics, care and screening for children who would have had a cancer diagnosis potentially earlier, but it ends up being missed or significantly delayed? What's the impact on them and their families and on the ability for them to be treated?

Ms. Helena Sonea: That's a fantastic question. Since the start of the pandemic, the Canadian Cancer Society has done our very best to conduct patient and caregiver surveys and share these results with government to really demonstrate the increased levels of anxiety and stress that we see with people living with cancer, especially those little ones.

For example, at the start of the pandemic—and I would say that the shift has happened over the past couple of years—caregivers were not able to attend appointments with their children, so that would absolutely cause increased levels of anxiety and stress for all different family members.

Something that I would also add is around grief and bereavement and not necessarily having the access to those types of supports in a comprehensive manner, just because the system was rather inundated with additional mental health requests at that time.

We also know that the psychosocial impacts and requests that come from the cancer community have always been a concern. For example, the Canadian Partnership Against Cancer released a report a couple of years ago, and one of the top recommendations that came from this report was the need for long-term psychosocial support for the cancer community. As Kelly mentioned as part of our witness testimony, the Canadian Cancer Society is proud to provide information and support services to people living with cancer, and their loved ones, in over 200 different types of languages.

Kelly, is there anything you want to add?

● (1140)

Ms. Kelly Masotti: Thanks, Helena, that was great.

Yes, I just have two points as it relates to later-stage diagnoses. If we miss that, then that can be harder to treat, as well as costing the system more.

Mr. Michael Barrett: Thank you very much.

I have a series of additional questions, and I'm probably not going to get through them all.

Perhaps this is something you could provide to the committee later, additional information if you have it, but what would you say are the immediate steps that could be taken to rectify these backlogs, specifically as this deals with children? Would it be addressing the number of pediatric oncologists? Would it be other specialties, haematology? Is it equipment, better research? Where is the most acute pain point right now? How do you think we can address that?

Ms. Helena Sonea: That's a great question that I think requires a multipronged response.

We were thrilled to see in the most recent budget the commitment of $2 billion to help unclog the backlogs. I would say that this type of investment, and then the continued discussions that are ongoing between provinces and territories and the federal government, need to prioritize cancer. We know that approximately two in five Canadians will be diagnosed with cancer, and this absolutely applies across all different age groups.

You're actually going to enjoy this fact. I am nine months pregnant, so pregnancy brings us back to—

Mr. Michael Barrett: Congratulations. That's incredible.

Ms. Helena Sonea: So I have an extra reason to provide you with strong testimony today.

We know that health care providers, both at the front line of service delivery and in supportive roles, play a key role in providing accessible, quality cancer care to Canadians. The Canadian Cancer Society supports recommendations from other health care provider stakeholders to implement a comprehensive and integrated pan-Canadian health human resources strategy, as well as continued investments in health research and, as I mentioned before in my testimony as well, increased access to palliative care, as well as those live-saving treatments.

The Chair: Thank you, Ms. Sonea.

Thank you, Mr. Barrett.

Mr. Michael Barrett: If I can, Mr. Chair, I'd like to say thanks very much to Ms. Sonea for joining us at nine months. I wish very good health to her, her child and her family.

Ms. Helena Sonea: That's very kind.

The Chair: Thank you, Mr. Barrett.

Next we have Ms. Sidhu, please, for six minutes.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you, Mr. Chair.

Thank you to all the witnesses for joining us today.

I also want to recognize that it's cancer awareness month.

My first question is for the Cancer Society. Cancer is one of the leading causes of disease-related deaths in Canadian children over the age of one month. Also, almost 84% of Canadians survive a cancer diagnosis after five years. This survival rate can be improved with new and better treatment.

Last year, the government launched the biomanufacturing and life sciences strategy with a commitment of $2.2 billion over seven years. I'm wondering if the Canadian Cancer Society can comment on how innovation in health care can improve patient outcomes.

● (1145)

Ms. Kelly Masotti: I can start with that.

We want cancer patients to have access to the best treatment in the location of their choice, so any additional funding from the federal government to support innovation, to support drugs and technology that will eventually help cancer patients in the location of their choice, is something that the Canadian Cancer Society is supportive of and thanks the government for.

Helena, I don't know if you want to add anything.

Ms. Helena Sonea: Not at this time, but thank you for the question.

Ms. Sonia Sidhu: The next question is for the Dental Association.

I know we have a broad topic today, primary care, which includes acute and chronic disease. Dr. Tomkins, we had a meeting in my office in Brampton, and I thank you for the work you are doing for all kids, the dental thing. The government is proposing a new Canada dental benefit for eligible families.

Do you see unique barriers for children seeking to access dental care in rural and remote communities? What should be done to improve equitable access so diverse populations can get access to dental care?

Dr. Lynn Tomkins: Thank you for that question.

Cost alone is not the only barrier for Canadians to access dental care, including children. We do appreciate this new program that's coming out. We feel that is a good start and look forward to continuing to work with the minister as we see things roll out.

Certainly, in remote and rural communities, there are challenges in terms of access, particularly with indigenous children, who sometimes live great distances from any centres that provide care.

We support all efforts to encourage dentists and dental staff to locate into remote and rural communities. As well, we are looking at building or creating surgical centres that are close to sites where the communities can access them, especially indigenous-led surgical sites, so children there don't have to be transported from Sachs Harbour down to Edmonton or Calgary to get their dentistry done.

We do appreciate any efforts, which could include things like loan forgiveness for dental graduates who are heavily indebted after leaving dental school, to encourage them to go to these areas.

Ms. Sonia Sidhu: Thank you.

We also heard that unhealthy diet and negative health effects are not always evenly distributed across different populations in Canada. The Cancer Society also talked about a healthy diet and about saturated fat. We know we are already working on the front label packaging.

How can the federal government be more impactful so children can have a healthy diet and adopt that lifestyle? Would any witnesses want to comment on that?

Dr. Lynn Tomkins: Thank you for—

Ms. Kelly Masotti: I'm happy to jump in here to start. Thank you for the question.

Oh, go ahead. I'm sorry about that.

Dr. Lynn Tomkins: We're on the same page. I think we would like to see the healthy eating strategy complete the recommendations there.

In terms of dentistry and getting children to the dentist early, the Canadian Dental Association does advocate and recommend that children be brought to the dentist within six months of the eruption of the first tooth. That gives the dentist the opportunity to assess the child's risk of dental cavities and also to talk to the parents about healthy eating, healthy diet, brushing, flossing and so on.

I think early intervention and early meeting with the child and the family, because it is a family issue, would go a long way toward getting the child started on the right path.

Ms. Sonia Sidhu: Does the Cancer Society want to comment, please?

Ms. Kelly Masotti: Yes. Thanks for that question.

We are entirely supportive of the front-of-package labelling, and we thank the government for implementing this and moving it along. We would also echo the comments of the previous witness to encourage the government to implement all factors of the healthy living strategy.

The Canadian Cancer Society is part of the Stop Marketing to Kids Coalition. Both as part of that coalition and on our own, we wholeheartedly support the introduction of a ban on marketing to kids in any form. We're supportive of the new bill that's been introduced, Bill C-252. This bill is proceeding through the House, but on Health Canada's forward regulatory plan, it should not delay launching Canada Gazette, part I, on marketing to kids in the fall of 2023.

● (1150)

The Chair: Thank you, Ms. Sidhu and Ms. Masotti.

[*Translation*]

Mr. Perron, go ahead for six minutes.

Mr. Yves Perron (Berthier—Maskinongé, BQ): Thank you, Mr. Chair.

I thank the witnesses for joining us.

I want to greet those I did not have an opportunity to greet in the beginning.

Ms. Wilson, in your remarks, you talked about child care and the importance of having speech language pathology or audiology services early on for screening purposes, among other things. You clearly mentioned that a transition fund was necessary to enable the provinces and territories to do their work.

Could you quickly explain your views on this, please?

[*English*]

Ms. Dawn Wilson: Thank you very much for the question.

What's really important is that there be awareness building about the need for early intervention. We know that the early intervention into speech and language problems is essential to child development services, and without that early intervention, the speech and language problems are further delayed.

[*Translation*]

Mr. Yves Perron: Would you say it's urgent that the federal government increase health transfers to the provinces and that decisions be made locally to guarantee those health services? You mentioned daycare. This also affects education.

[*English*]

Ms. Dawn Wilson: Yes, and we applaud the federal government for its investment in the day care deals. We absolutely believe that the deployment of those day care deals is imperative, because we can work directly in day care settings with early childhood educators.

[*Translation*]

Mr. Yves Perron: Thank you very much. I'm sorry to rush you, but my time is limited.

I, too, commend the government for investing in that and, more importantly, for respecting Quebec's jurisdiction by giving it the right to opt out with compensation.

Dr. Ungar, in your opening remarks, you mentioned that various factors are interrelated, like education and family. You also spoke of a domino effect and social repercussions.

In a few words, do you believe that health care needs are the same across the country or do you believe that it's important to consider regional specificities?

[*English*]

Dr. Michael Ungar: Definitely. In fact, that's what we look at when we look at patterns of coping or resilience in populations. We look at very specific cultural and contextual needs due to geography, language, cultural heritage and, of course, histories of trauma, whether it's refugees coming into the country or otherwise.

It is always a question, in a sense, of getting out of this pattern of thinking that we can solve individually focused problems. As a simple example of that, polio is going up, not because we don't have vaccines but because we don't have sociologists addressing the problems.

In other words, we need to get out of this idea that.... For instance, our Social Sciences and Humanities Research Council, which funds humanities and social science research, is separate from our Canadian Institutes of Health Research, which funds all the health research. If anything, we have learned that we need to be thinking more about individual populations and their particular needs in more systemic ways.

[*Translation*]

Mr. Yves Perron: Okay, thank you. So, you're saying that we need to focus specifically on communities and their own unique needs.

I'm sorry to interrupt you, but I see that my time is running out fast. I'd like you to answer yes or no: It's important that decision-making be decentralized to provide services tailored to communities—is that accurate?

[*English*]

Dr. Michael Ungar: It's more yes than no—yes.

[*Translation*]

Mr. Yves Perron: Thank you very much.

Dr. Tomkins, you said that it was important that the money be used for oral health and that public funds be allocated to it. You are undoubtedly aware of the issues around health care falling under provincial jurisdiction and the federal government holding the purse strings. I will also point out that the request is unanimous, it's not only coming from Quebec: All 10 provinces are asking for a 35% increase in health transfers so they can invest the funds in this area. I'd like to know if you support that request.

Furthermore, as I understand the current version of Bill C-31, an individual will be able to submit a dental care receipt for any amount, and automatically get $650. So, if a parent submits a $100 receipt for a cleaning, there won't be any control, any way to know if the remaining $550 is used for oral health. Are you concerned?

I'd like you to answer my two questions quickly, please.

● (1155)

[*English*]

Dr. Lynn Tomkins: In terms of the funding for and access to dental care, we look to see much more dialogue going on between the provinces and the federal government. In terms of how the money is going to be used, I think Mr. Boissonnault said that it's going to be on the honour system. We hope that Canadians are going to use the money so that children can get in to see the dentist for their care.

This is one reason why we're pleased that it's coming. This is being rolled out in stages, so there is the opportunity for intergovernmental dialogue so that the patients who are seeking to receive the care are not caught in the middle. This is going to be an ongoing discussion between the federal and provincial governments.

As I've said before, I'll talk about dentistry, but I'll leave politics to the politicians.

[*Translation*]

Mr. Yves Perron: Thank you very much.

It's therefore important that decision-making be decentralized—

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

[*English*]

Next is Mr. Davies, please, for six minutes.

Dr. Lynn Tomkins: I'd say it's important to continue the dialogue so that we reach the ultimate goal of making sure that kids get to the dentist.

[*Translation*]

The Chair: Thank you.

[*English*]

Mr. Davies, go ahead, please.

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you, Mr. Chair, and thank you to all of the witnesses for being here.

Ms. Wilson, I'd like to begin with you. You painted an extremely clear picture of the extensive needs of children and the critical importance of early intervention in terms of speech and communication development for kids, particularly under the age of three.

Can you give us a sense of the scope of the lack of access to effective therapy? Is this a small problem? Is this a medium problem, or is this a problem across the country in terms of kids getting the access to therapy that they need?

Ms. Dawn Wilson: I can definitely speak to that.

I think the scope of this is nationwide. This is something that is in all elements of our society. In schools, there's a lack of awareness. There's a lack of services in primary care. The scope is large. There is a lack of practitioners. There is a lack of training. There is a lack of data, in order to understand the scope of the problem for our professions. We know there isn't reliable health workforce data. As well, the capacity of our current practitioners is stretched. They have high caseloads, and that impacts their ability to deliver service, as does the nature of Canada and the fact that there are rural populations that are even harder to reach. I would say the scope is far-reaching.

My colleague Anne may have something to add.

Mr. Don Davies: You are a speech pathologist.

Ms. Anne Carey (Director, Speech-Language Pathology and Communication Health Assistants, Speech-Language and Audiology Canada): Yes, I am a speech-language pathologist.

One of the big challenges, especially when we're talking about that zero-to-three age, is that we currently don't have speech-language pathologists embedded in day cares. They're not there. A lot of times, the primary point of care—family physicians or early childhood educators—don't necessarily feel comfortable in recognizing and identifying speech, language or communication delays.

We can think about it like an invisible crisis. If it's physical, you might see it, but for speech-language delays, it's something that is harder and nuanced. It's not invisible to us as speech-language pathologists. We see it, but we're not in the places where we can get the child to access the services that they need.

Mr. Don Davies: Even if a child were attached to a speech-language pathologist and you could identify, say, a child at two who is not just quiet but is actually exhibiting a speech or communication delay, is our system responsive enough that the child would get the therapy they need, to actually make a difference?

Ms. Dawn Wilson: I would say that even if the child is identified, there is still a lack of access to care because there are not enough speech-language pathologists, and they're not working in the areas where they're needed the most. Even if we do progress in the early identification, we still don't have enough. We still need a better approach, and we still need a broader integration into primary health care teams as well.

● (1200)

Mr. Don Davies: Are children from disadvantaged backgrounds at higher risk of developing speech and language disorders than their peers?

Second, we pride ourselves in this country on having universal access to care. Do kids from poor backgrounds get the same kind of access to treatment as kids from families, for instance, that are able to pay out of pocket for SLP services?

Ms. Dawn Wilson: I think there's a lack of public awareness and education around the identification of speech and language disorders. Maybe we could be working with the Public Health Agency of Canada to educate the public around the factors that place infants and toddlers at risk for speech and language disorders. I think what we need is to understand the conditions that ensure the optimum development of speech and language abilities, and we desperately need the appropriate referral pathways to our practitioners to support the care.

Mr. Don Davies: I want to turn to hearing, because it's Speech-Language and Audiology Canada. Are hearing services consistently covered under provincial and territorial public health care programs across Canada today?

Ms. Dawn Wilson: No, there's an inconsistent approach across provinces. I think five provinces are doing relatively well on their early hearing detection and intervention programs. There's also not a universal approach to hearing screening, and we need to do better.

Mr. Don Davies: We've just been through COVID. A lot of health care professionals have tried to shift care to virtual models, with some success.

To what degree have speech-language pathologists and audiologists been able to replace in-person visits with virtual care over the course of the COVID-19 pandemic? Do you see any prospect for improved access to care using technology in the future?

Ms. Dawn Wilson: Speech-language pathologists and audiologists have by and large transitioned to virtual care as a means of supporting access to speech-language pathology and audiology services. The federal government's funding of $240 million in 2020 certainly helped. However, we still need to expand and launch virtual care and mental health tools just to Canadians in general.

Access to additional funding for our practitioners will help them expand the technology that they need in order to properly deliver the care. That includes digital platforms. A lot of our members have moved away from the public system into private practice because of funding cuts, and those practitioners need additional technology to support the delivery of virtual care.

While we have adapted and support the use of virtual care, more can be done to support the practitioners who need to deliver it and who also have to align with the requirements of the Accessible Canada Act.

The Chair: Thank you, Ms. Wilson.

Thank you, Mr. Davies.

Next, we'll have Dr. Ellis, please, for five minutes.

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

Thank you, everyone, for coming.

I will underscore, if I might, the childhood crisis that we have at the current time, despite having a government that's added more to the federal debt than all the other governments combined. I think it germane to really underscore this issue. This is from September 2020:

> Canadian childhoods are in crisis according to a new report released today by UNICEF Canada. UNICEF Report Card 16, which measures the state of children and youth under age 18 in wealthy countries, ranks Canada 30th out of 38 nations on the most recently available data from just before the pandemic.

My understanding is that previously we were 10th out of these 38 countries. Clearly, our children are being left, and they're falling behind. This is obviously a significant and weighty issue.

For my colleagues, I think it behooves all of us here to understand that perhaps these six meetings we're having with respect to child health are really going to be a door-opener for all of us to understand that creating a childhood health strategy for Canada, which I think we're all interested in, is going to take much longer than six meetings, but perhaps this will help us focus better on what we really need to be doing here.

Thank you to the witness for hearing that.

Dr. Ungar, I understand that your expertise is in resilience. That being said, obviously this is a huge topic as it perhaps relates to COVID and the ongoing pandemic and the uncertainty that exists. I guess my question for you, Dr. Ungar, is to understand better what you think about how this is affecting children with the ongoing threat of lockdown and the return of those mandates and sanctions, without any realization of the science that goes along with it, and to understand better what might be helpful from the perspective of the government if they were to release this elusive science that they refuse to share.

● (1205)

Dr. Michael Ungar: Thank you very much for the question.

I won't necessarily get into the politics of what's being released or not, but what I can say is that we do know that children have taken on a disproportionate negative effect. If we look at depression scores or anxiety from Statistics Canada or Public Health Agency of Canada statistics, we know that children disproportionally showed increased or elevated levels of these particular mental health disorders throughout the pandemic. Basically, the older you were, the less you were affected, at least from a mental health point of view. We very much downloaded the crisis. While the physical health crisis was on the elderly, the mental health crisis was largely visited upon our children, because their lives were the ones that were so disrupted. Anyone who has a teenager would know that. All those sporting activities and the rights of passage into adulthood were disrupted, and that has taken a toll.

I am very cautious. When I look at any imposition of new regulations, I am very cautious that most of those regulations are being imposed in zones like children's activities. The consequences are being felt most by kids, even though the impact or the benefit is being accrued in terms of health consequences for the adults: the care providers, the teachers and that type of thing.

There's a fine line to walk here between disadvantaging our children and trying to keep adults healthy. If you look at, say, the work of Sara Austin at Children First Canada, you would certainly see that what we're trying to do is advocate more, so that we can actually think about the needs of children before we put these policies in place. Indeed, let's be really clear that there are long-term consequences as we disrupt children's lives: depression, suicidality, long-term developmental challenges and, as my colleagues here on all the medical sides of this are showing, that whole sort of delayed diagnosis of pathology that is occurring in children's lives and that has lifetime consequences in delayed educational gains, delays entering post-secondary and delayed productivity.

I am definitely on the cautious side in terms of imposing new regulations. I was very much for them, previously, of course—we were in a pandemic—but I am very cautious about carrying these on too long-term in terms of children's mental health.

Mr. Stephen Ellis: That underscores very urgently the need to make sure that the Canada mental health transfer so promised by this government is delivered upon. I also think that it behooves this government to ensure that the science and the mandates are well supported and well broadcast out there among those who perhaps care for children and who have children, like many of us here do.

Thank you, Mr. Chair. I appreciate that.

The Chair: Thank you, Dr. Ellis.

Next, we have Mr. van Koeverden, please, for five minutes.

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

Thanks to all of the witnesses for being here today and for all of their testimony.

I have three questions for three witnesses. I just ask that your answers be as brief as possible.

First, Dr. Tomkins, you stressed the importance of oral health for children, and its being the most preventable and most prevalent health concern for children in Canada, as well as the leading cause for missing school. In your work and experience, do kids in lower-income Canadian households typically have access to the same oral health care as their middle-class and wealthier neighbours do?

Dr. Lynn Tomkins: No, and it's for all the reasons we've just talked about. Cost is a barrier. Sometimes language is a barrier, and sometimes the education and awareness of the parents is a barrier. With this new program that's coming out right now, that would be one of the things we would like to see—that people who are eligible would be made aware of this Canada dental benefit so that they could bring their kids to the dentist.

Mr. Adam van Koeverden: Do you have any recommendations for spreading awareness and ensuring that Canadians are as cognizant as they can be of the need to visit the dentist?

● (1210)

Dr. Lynn Tomkins: Certainly as the Canadian Dental Association that represents 20,000 dentists from coast to coast to coast, we would be happy to partner with the government to make everybody aware of it.

Mr. Adam van Koeverden: That would be great. Thank you very much.

You also highlighted the need for better dental services for people living in indigenous and remote communities across Canada. This summer I was lucky enough to visit the beautiful Cape Breton University to discuss recruiting to those schools people who are actually from and who live in some of these remote and indigenous communities across the country, in order to ensure a longer-term solution rather than recruiting people to go for just six months or a year.

Does the Canadian Dental Association have a position on being able to use some of the newly minted virtual technology that we all avail ourselves of to train potential dentists in rural areas so that they can practise at home for the duration of their career?

Dr. Lynn Tomkins: We don't have a formal position on that, but it raises a very interesting idea. Dalhousie would be the closest dental school. There are 10 dental schools across the country: three in Quebec—two French-language—and one in almost every province, and then one in the Atlantic region.

I do know that the University of Toronto, where I am on staff, is looking at satellite clinics and actually going out into communities where there are going to be students who are interested. A dental school in and of itself is an extremely expensive proposition to build. It's like building a hospital that is almost entirely privately funded, so I think utilizing any kind of....

Dentistry, to a large extent, is still very hands-on. There's not a lot of dentistry we can do virtually, so I think to the extent that we can use technology to recruit prospective students and students from all income levels and from all groups of Canadians, that is something that all the universities are interested in doing.

Mr. Adam van Koeverden: I've visited a foreign credentials qualification school in Mississauga, specifically for dentistry, so that we can maximize the number of dentists in Canada. Very briefly, if you can, do you see a practical application for more schools like that to ensure that people who are qualified get to work in Canada?

Dr. Lynn Tomkins: I think the system we have right now, which is the National Dental Examining Board system, is very equitable. It's very skills-based. It evaluates people on their actual ability to do dentistry.

We have one of the highest standards of dental care in the world, and our dental schools are among the top in the world, so I think we want to make sure that we maintain a balance of providing enough dentists—and currently there are enough dentists in the country, although we have a bit of a maldistribution issue—while we maintain the high standard and have an equitable process for bringing foreign-trained dentists into the country.

Mr. Adam van Koeverden: Thank you, Dr. Tomkins.

My next question is for Ms. Wilson.

Ms. Wilson, the former Secretary-General of the UN, Kofi Annan, famously stated, “Literacy is a bridge from misery to hope.” He talked a lot about its ability to fight poverty and to be “a building block for development”. I'll make a full disclosure: My partner is a researcher and a speech-language pathologist who is studying literacy.

I'll ask the same question of you: Do kids in lower-income families have the same outcomes as their middle-class and wealthier neighbours when it comes to literacy and the determinants of health related to reading and hearing?

Ms. Dawn Wilson: I would have to say no.

Mr. Adam van Koeverden: That's what I was looking to hear. It's important to recognize where the system leaves people out.

My third and final question is for you, Dr. Ungar. You mentioned a really troubling statistic, that the world is seeing a rise in preventable diseases like polio—something that was all but eliminated by vaccination, yet we have politicians questioning the usefulness and practicality of compulsory vaccination programs in Canada to fight diseases like mumps, rubella, polio and many others.

Do you find it troubling when politicians question these types of programs in Canada?

Dr. Michael Ungar: I find it extremely troubling when politicians step beyond their expertise and enter what is the domain of simple science. Where we could actually get really good decisions on scientific merit, I would also encourage those same politicians to take a trip to other countries and other parts of the globe where these diseases are still debilitating the lives of millions of children and then see if they'd be so flip about what we decide here.

I travel the globe on a routine basis, and that is a completely naive position. It's just mind-boggling that anybody would take these positions. We have seen the impact of that, of course, when it comes to COVID as well. There was vaccine hesitancy. In a sense, we had the drugs but we didn't have the sociology to help us understand what was about to happen, and the hesitancy resulted in deaths—and continues to result in deaths.

The Chair: Thank you, Dr. Ungar and Mr. van Koeverden.

[*Translation*]

Mr. Perron, you have two and a half minutes.

Mr. Yves Perron: Thank you, Mr. Chair.

I'm going back to you, Mrs. Wilson.

In response to an earlier question, you said that due to the lack of funding, many professionals who belong to your organization have left the public system to go work in the private sector.

How would you explain that? Why isn't there enough funding?

In your opinion, are government budgets too low for front-line services? I'll repeat what I said earlier, but do you feel that first and foremost it would be a good idea to increase federal health transfers?

● (1215)

[*English*]

Ms. Dawn Wilson: I think it is a good idea to increase federal transfers for health, but the concept of strings attached to those transfers needs to be embedded in whatever transfers are there. How provinces and territories spend their money is not always where we would want it to be. I do support the concept of the health transfer, but there need to be strings attached.

[*Translation*]

Mr. Yves Perron: We're talking about money intended specifically for health care. Thank you.

Dr. Ungar, in response to an earlier question, you just stated that you're always cautious about any imposition of new regulations. I'd like you to elaborate on that.

I'd also like you to tell me if you feel local government should receive more funding. This ties into our first series of questions earlier, when you said it was extremely important that decision-making be decentralized.

Lastly, you'll have about 30 seconds to answer my final question: Are you concerned that the $650 benefit might not be spent entirely on health care? An individual who submits a split receipt would automatically receive $650, and there would be no follow-up.

I'd like to know what you have to say about this.

[*English*]

Dr. Michael Ungar: I actually don't have a lot of familiarity with the last piece of that. I think that's really a political decision. Hopefully, families are encouraged and the funds do go to what they do, but I will say that in terms of the actual money flowing, what I'm perceiving from my perspective is that this is not always a case of more funding. I know this is not politically astute to say—I'm not a politician.

What I will say is that often it's about the service delivery models being dislocated. So much of what my colleagues here have said today is about whether we could be better at co-locating services, as some initiatives nationally have done. I can certainly give you some details on those later.

The largest problem is that we have lots of money floating around, but it is incredibly wasted in many cases. It is not coordinated, and children and parents have to get to multiple domains to get services—rather than us thinking from the point of view of the families and putting those services together so that indeed this would be more cost-effective and we'd be catching more of these pathologies earlier.

It's a systems problem, in part, and not just basically throwing more and more money at these problems.

The Chair: Thank you, Dr. Ungar.

[*Translation*]

Thank you, Mr. Perron.

[*English*]

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

Mr. Don Davies: Thank you.

Dr. Tomkins, I wanted to first of all express our thanks to the Canadian Dental Association and, frankly, to all of your members for their contributions to public health in this country. I know that dentists across this country have long been bothered by their inability to provide necessary dental care. As you've pointed out, oral health is primary health care. I'm really looking forward to allowing dentists to be able to treat more people for this essential health need.

Can you give us an idea, Dr. Tomkins, of approximately how many children across Canada currently lack sufficient coverage to access the full suite of recommended oral health services?

Dr. Lynn Tomkins: Well, one of the numbers is actually in the government's backgrounder for this program: an estimate that approximately half a million children could be eligible to access this program. I think that's probably a good starting point.

Mr. Don Davies: The CDA's written submission to this committee noted that remuneration rates for dentists vary significantly under existing provincial and territorial dental care programs for children. I'll say it bluntly: Dentists have been underpaid generally by the provinces' programs, to the point where often they're subsidizing the care that they have to give.

Can you outline the impact that this variation has on dentists' participation in these programs?

Dr. Lynn Tomkins: Thank you for that question.

There is considerable variation across the country. If you go to provinces like Newfoundland or P.E.I., which do have programs, they are funded well enough so that dentists are reimbursed for the cost of providing care and the ability to make a living while they're doing that. In other provinces, programs have been chronically underfunded. Ontario is probably the worst example of that. You are right that dentists who do participate in these programs are actually paying out of pocket to provide the care.

Every dentist will do what they can to provide care. Frequently these kids are part of larger families we treat in our practices, but it's not a sustainable situation. We hope to gain a remedy for that.

● (1220)

Mr. Don Davies: I want to say on the record right now that in any dental plan we create, in my view, dentists have to be paid 100% of the fee schedules in the provinces. They deserve to be treated as the professionals they are. This should not be a program for poor people. It should be a normative program so that people get access to the care they need.

I want to conclude—

The Chair: Thank you, Mr. Davies.

Mr. Don Davies: —by asking about fluoridation. You noted that only 39% of Canadians have access to water fluoridation. Americans have double that.

The Chair: Mr. Davies, that's your time.

Mr. Don Davies: Oh, I'm sorry.

The Chair: Thank you.

You're more than welcome to follow up with a written brief. We're going to move on.

Mrs. Goodridge, please go ahead for five minutes.

Mrs. Laila Goodridge (Fort McMurray—Cold Lake, CPC): Thank you, Mr. Chair—

Mr. Don Davies: Mr. Chair, on a point of order, with Mr. Perron the answer to the question went significantly past the two and a half minutes. I wonder if we could just have a 20-second answer from Dr. Tomkins.

Mrs. Laila Goodridge: Your question started after he told you to stop.

Mr. Don Davies: Oh, I'm sorry. I didn't hear.

The Chair: The question was posed after your time was up. You will get another turn, Mr. Davies.

Mrs. Goodridge, go ahead for five minutes, please.

Mrs. Laila Goodridge: Thank you, Mr. Chair.

Thank you to all the witnesses for being present.

Dr. Ungar, you really tweaked a piece in me with some of what you were talking about, and I really felt as though you were talking about my hometown of Fort McMurray, where there have been multiple traumas placed on many of these kids, from the fire to the flood and then the pandemic.

I'm wondering if you can elaborate a little bit on what communities can do and what individuals can do to help build resilience in kids who have experienced multiple traumas.

Dr. Michael Ungar: That's a great question. Thank you very much for the question.

What we're seeing in other communities is the need for a more coordinated approach. My own work is largely in Drayton Valley, an Albertan community, one of the Canadian communities heavily reliant on oil and gas. What we're learning from those communities, as well as from indigenous communities, is that we need to be thinking about children's lives in a more total way, including recreational spaces, access to green spaces, access to safe water, access to the health care professionals we're hearing about on this particular panel, better coordination and access to child care for families, etc.

I think sometimes what happens is that when we have a mass dislocation or problem, we tend to focus in very quickly on a particular solution, like education, speech-language, teeth or whatever. What we're actually seeing in our research is that the more we are able to co-locate and think about a child's life in its totality....

For instance, I'll give you a very small example. It's not really a child example, but in Fort McMurray there was a big effort to get insurance adjusters to respond to the families who were dislocated after the large fire that occurred. The insurance adjuster became part of a mental health team, in a sense, because when you get people's insurance claims settled very quickly, families can relocate back to the community and people can get back to work. Indeed, family cohesion and children's mental health are better protected when their parents are back at work, houses are re-established, homes are re-established and communities are re-established. Sometimes we tend to partialize this. We tend to think, “Oh, let's just get a psychologist to visit the family.”

I'm a mental health professional, but we miss the fact that without these other coordinated services, trauma tends to persist. Sometimes it's these other allied services. For instance, we know that a child who is better diagnosed as having speech language issues is better ready earlier, is better ready for school, and will have a higher school achievement throughout their life.

We need to get out of this idea that we keep funding single solutions in isolation from others. I think what happened in Fort McMurray is simply another example of how we will get better long-term outcomes when we think more holistically.

Mrs. Laila Goodridge: That's wonderful. Thank you for that answer.

I'm going to switch gears a little bit and go to the Canadian Cancer Society.

You guys raised some really interesting points regarding some of the challenges and issues faced when it came to COVID and getting delayed diagnoses and not being able to have the same level of support when patients were going through cancer diagnoses.

I'm wondering if you can give us any potential solutions you have so we can not just catch up but prevent something like this from ever happening again.

● (1225)

Ms. Kelly Masotti: I'll start this, Helena, and then you can add.

I think what's most important is to continue to place an emphasis on the importance of screening and diagnoses. We have seen a shift to virtual care in some instances, so it would be to continue to encourage parents to take their children to see their family doctor if something arises at a time when they feel they're comfortable to go into a hospital or into the physician's office.

Continue to ask your doctor questions when you have concerns about your child. As well, encourage the government at all levels to make sure there is a continuation of those screening programs. We don't want to see an end to screening programs—provided it is safe to do so—but to continue those school-based screening programs when it's safe to do so and when we can.

That's a short answer. Helena, I'll turn to you.

Mrs. Laila Goodridge: I appreciate that. I have about 30 seconds left and there's just one piece I'd like to say.

There was a little boy in Lac La Biche, Ezra Marfo, who had a very rare form of blood cancer and who passed away, unfortunately, on September 16, just last week. One really amazing thing that his parents were spearheading in trying to save his life was getting more people to swab and get on a stem cell registry. While it's already too late to save Ezra's life, I would encourage everyone to visit blood.ca so they can swab and get on the stem cell registry. They could potentially save the life of a little boy or a little girl.

Thank you.

The Chair: Thank you, Mrs. Goodridge.

Next is Dr. Hanley, please, for five minutes.

Mr. Brendan Hanley (Yukon, Lib.): Thank you to all of the witnesses for the varied and interesting testimony.

I think I'm going to start with you, Dr. Tomkins. Coming from Yukon territory, I'm certainly concerned about dental care, as you are, in rural and underserved areas.

One area I'm quite interested in is the role of dental therapists. I know that you've addressed getting dentists more connected to remote areas and some of the barriers there—surgical centres—but what about dental therapists? We know that Saskatchewan has been a leader in that area. I'm just wondering what your thoughts are on this particular cadre and how we might scale them up as practitioners as well.

Dr. Lynn Tomkins: You may recall that I said earlier that there really isn't a shortage in terms of number of dentists in the country. We see lots of new entrants into dentistry every year, both from our dental schools and from graduates coming from countries outside of Canada.

I think the emphasis has to be on encouraging young people. I teach in a dental clinic. I talk to dental students about going to places like Whitehorse, Atlin, Hay River and so on, and also further north—I mean, that's the southern Arctic—and the wonderful opportunities that are available and the great need there. First, I think, we need to focus on getting new graduates to come to practise in those areas, because the infrastructure, whether it's a dentist or a dental therapist, is going to be the same.

In terms of dental therapists, there have been successes in provinces like Saskatchewan. In my understanding, many of them don't actually end up going out to remote and rural areas. They end up in the larger cities and working in dental offices alongside dentists, because they can provide quite a variety of services. Not to dodge the question, but I'm going to ask Dr. Burry to talk specifically about what's happening right now with dental therapy in Canada.

Mr. Brendan Hanley: If you wouldn't mind, answer very quickly, please, because I have a few more questions.

Dr. Aaron Burry (Chief Executive Officer, Canadian Dental Association): The government has started a new program, which is largely looking for therapists or to educate therapists for the north. It's certainly a step in terms of replenishing what is a very significant number of retirements in that particular discipline, particularly those who are focused on school-based programs, which is something we would certainly support, and in indigenous communities.

Mr. Brendan Hanley: Thank you very much.

Ms. Wilson, I think you mentioned in your remarks the idea of training early child educators to detect and be familiar with speech-language pathology. I'm wondering if you could briefly elaborate on that particular area. Given the real shortage of practitioners, I think we need to expand the knowledge and the ability to screen and detect.

● (1230)

Ms. Dawn Wilson: Yes, I think it's paramount that we work in the early learning and child care centres to improve outcomes for early diagnosis. Working with those ECEs directly in their centres is really important, as well as potentially working through the provinces to incorporate our services through the deals that have been provided to day cares.

I think it's also really important to stress what happens later on and what the impact is if the disorders are not treated. The ability for us to work in those day care centres is critical.

Mr. Brendan Hanley: Thank you. If time permits, I may come back to you.

I want to ask Ms. Masotti or Ms. Sonea this: The vaping stats you related are certainly alarming, in terms of the increasing trends, although I think the data you quoted stopped in 2019. I wonder if you have information on more recent effects—particularly pandemic-related effects—and also evidence about vaping and tobacco use, not just nicotine addiction, and therefore the link to cancer and what legislative aspects may be needed—all in the remaining 30 seconds I have.

Thanks.

Ms. Kelly Masotti: I will do my best to answer quickly.

We're very concerned by the dramatic increase in youth vaping, and there needs to be comprehensive government response.

For example, the draft regulation on flavours and e-cigarettes should be adopted as soon as possible and, indeed, the proposed regulation can be strengthened by removing the exemption of mint and menthol. Among provinces and territories, New Brunswick, Nova Scotia, P.E.I. and the Northwest Territories have implemented legislation banning flavours. It is the same with various states in the U.S. as well as in Europe, where a growing number of countries are doing likewise, including Finland, Lithuania and the Netherlands. If they can do this in all of these places, so can we in Canada.

We have made such great progress in reducing youth smoking. We do not need a new generation addicted to nicotine, but that's what's happening. We do support a tax on e-cigarettes, and it's essential that flavours in e-cigarettes be restricted.

We are concerned. Health Canada has said that e-cigarettes are less harmful than conventional cigarettes. However, the problem is that a large proportion of vapers are still smoking, and we're seeing a rise in dual use. This is also evidence that dual use can inhibit cessation, so we are concerned, and we are seeing a rise.

The Chair: Thank you, Ms. Masotti and Dr. Hanley.

Next, we have Dr. Ellis, please, for five minutes.

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

It's a great pleasure to continue on with this.

Just before I get started, I want to editorialize a bit, perhaps, in terms of admonishing my colleague for his factional line of accusations with respect to vaccines. Once again, we need to understand that those who are vaccine-hesitant need not be divided and conquered and admonished for their choices. They need to be encouraged. They also need to be educated. To continue with this, as I said, factional line of accusation is not helpful.

That being said, Ms. Wilson, I think that when we originally designed this study, we really knew it was important to begin to understand the effects on speech language acquisition with respect to masking and COVID. That's where we started with this study. I realize that it has morphed into something else. However, I think it's germane that we undertake that line of questioning, especially with something we have never faced before.

Often people want to place a tinfoil hat on my head and say, “Why are you talking about this? This is not an issue,” etc. However, if we do not delve into this deeply, my fear, of course—and hopefully it's shared by a multitude of my colleagues—is to understand.... Are they bad for kids in their language acquisition? We don't know the answer to that. Perhaps you and Ms. Carey could help shed some light on that, or perhaps on what direction we need to take in the future.

Thank you.

Ms. Dawn Wilson: I don't think we have enough research at this point in time to show that there's a long-term impact on the speech and language development in children as a result of masking. We know there's an impact.

Actually, as I was waiting to come into this room, my colleague, Ms. Tomkins, and I were speaking. She was masked, and I couldn't understand what she was saying.

For sure, there's an impact. We don't have enough research at this point in time that I could say with certainty what the long-term impacts are, other than to say that there is most certainly an impact on the ability to understand speech with a mask on and for children to develop those critical skills when masks are being used in schools in particular.

I don't know if you have anything to add because we don't have any research at this point.

● (1235)

Ms. Anne Carey: We don't have the research to give specific data. There are specific at-risk groups. Hard-of-hearing children might be more at risk and things like that.

Mr. Stephen Ellis: Ms. Carey, do I understand correctly that you're a practising speech-language pathologist at the current time?

Ms. Anne Carey: I am a registered speech therapist.

Mr. Stephen Ellis: Have you seen issues related to this, or do you think it's still too early? Do we still not have enough trained professionals like you getting the referrals so that we really don't know where we are?

Ms. Anne Carey: We don't have the data. I think that is the cleanest answer for that one.

Mr. Stephen Ellis: Perhaps between the two of you, do you have any suggestions for how we might proceed with understanding this complicated problem more fully?

Ms. Dawn Wilson: I think we have heard other people here today talk about the need for a reliable source of health human resources data so we can understand the scope of what we're dealing with, because we really don't know. I think we definitely would support any initiatives that the federal government would have to recruit and retain speech-language pathologists and other allied health care professionals to improve the situation in health human resources.

Mr. Stephen Ellis: Thank you very much for that.

Dr. Ungar, resilience is one of those things that are, I think, fascinating to all of us here. It's really about recovery and how we take on tasks in the future. From your perspective on resilience, do you have any suggestions on moving forward on that topic, on what we need to study in the future with respect to how it relates to the pandemic, in particular with respect to children?

Dr. Michael Ungar: Absolutely. I think what we need to do is delve a bit deeper into what the protective factors were or what actually helps a child get through a crisis like this. Lots of funding went out to research studies. Those results will come in over the next year or two, so we don't have a good picture yet, but we do know that children who, for instance, maintained routines in their families and families that had access to technologies for kids seemed to do much better. Children who maintained connections with their extended family members seemed to do much better. Some of those hints are there.

I might also say, because I study resilience, that there's a fascinating emerging conversation—and I say this very cautiously, because the pandemic was horrific for our economy and many people died—about the huge number of lessons learned, things that we should have known were coming. For instance, we saw, especially among adolescents, more accessible counselling services. Adolescents hate coming to counselling generally, but many more would engage and many of them would in fact feel much more comfortable coming to a therapist or seeing a mental health specialist online. This is anecdotal but it's what my colleagues are saying.

Also, in my own home province of Nova Scotia, for instance, we discovered—surprise—that only 93% of our kids had access to technology at home to access the Internet. That was remedied through school programs and government programs to make sure that kids had access to that technology and to Internet connections.

Some of this simply taught us that we had the capacity to create environments that would help children to be much more successful, and that, I think, is really encouraging.

The Chair: Thank you, Dr. Ungar and Dr. Ellis.

Next is Mr. Jowhari.

Go ahead, please, for five minutes.

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

Thank you to all the witnesses for being with us in person today.

I'm going to focus most of my questions on the Canadian Dental Association. First of all, thank you for being here today. Thank you for your submission to the committee and for a number of the recommendations you have made. For full disclosure, I want to disclose that my wife has been a restorative hygienist for 25 years and she is amazing at the work she does. I have access to more than 200 oral health practitioners, whom I proudly advocate for. As well, I fully support my colleague MP Don Davies in ensuring that the level of care provided to those who go to the dentist or who seek oral health care be maintained at the same level regardless of their income and that doctors be entitled to full compensation for providing it.

I want to go back to the recommendations you made, specifically your recommendation number one, regarding consultation and collaboration on dental care. I'm going to quote the summary of the recommendation that you made:

> CDA recommends that the federal government proceed slowly and carefully, taking the time to develop a long-term solution that is well-informed, targeted, comprehensive, and effective. The federal government should consult broadly with dentists and other oral health care stakeholders, as well as collaborate with other levels of government.

I could say that the news around the program that we just rolled out is welcomed broadly by all stakeholders. However, we see that you are cautioning, or you recommend that the federal government take its time and proceed slowly and carefully.

Can you expand on why you are saying that? On what basis are you saying that we should proceed slowly and carefully?

● (1240)

Dr. Lynn Tomkins: Thank you.

Yes, certainly. We have the opportunity to get something going here that's going to have long-lasting effects and, hopefully, is going to be a long-lasting program. It's definitely worth taking the time to consider all the aspects and to consult with stakeholders, dentists, dental associations, the provincial and territorial dental associations, the provincial governments and the patients as well, the people who are receiving the care. It's really important in this first phase—and we appreciate that it's an interim phase—that the input or feedback from the providers is taken into account, because we're the ones with all the questions about the practicality of how this is going to work.

We've had questions here today that highlight that the federal government provides the funding but the provinces decide where the funding goes. I'm not a politician, but there has to be discussion between the levels of government, and if funding does end up being transferred to the provinces for dental programs, which is where they're currently delivered, there have to be significant strings attached.

We would certainly want some sort of national standards of care for a basic program. Also, as I mentioned earlier, we have 10 dental schools across the country with very substantial academic and intellectual depth that can provide information about programs that work and jurisdictions that work well, but right now we have different provinces—10 provinces and three territories—and we have just as many programs, more than one in each province.

All of that has to be taken into account, because we want to avoid unintended consequences. Two-thirds of Canadians have some sort of coverage through employer-sponsored health benefits—all of you would have that—and we don't feel that needs to be disrupted. Seventy-five per cent of Canadians report feeling that they have good access, so it's really about designing something that is going to address the gaps in those groups that are not currently accessing care. It's complex.

Mr. Majid Jowhari: Thank you.

I have a list of questions that my network is asking. I'll gladly share that with the government and the ministry. However, could you share with us the top issue that dentists have regarding the rollout of this program around fees? I would really appreciate that.

Dr. Lynn Tomkins: One thing that's important is that we would not like to see something that adds to the administrative burden. We don't want to be the gatekeepers on determining eligibility and having to chase patients and make them verify. That really comes between the doctor and the patient in the relationship. In terms of the remuneration for the services rendered—I mentioned this earlier—it's not unreasonable to expect that costs be covered and that the person delivering care be able to make a living doing that. We treat as many patients as possible, and we look forward to seeing more.

The other aspect we're hearing about from dentists is something that existed before COVID and certainly has been exacerbated by COVID. There is a shortage of dental staff, and dental staff are highly trained staff. The person who assists the dentist in the office is a highly trained individual with a lot of responsibility, and at any one time in Canada up to a third of dental offices are looking to add at least one person to their staff.

I know that across the health care sector there is a shortage of staff, but it is something that is affecting dentistry. We will do our best to handle the influx of patients, but that is an issue.

● (1245)

Mr. Majid Jowhari: Thank you.

The Chair: Thank you, Dr. Tomkins.

Thank you, Mr. Jowhari.

[*Translation*]

Mr. Perron, you have two and a half minutes.

Mr. Yves Perron: Thank you, Mr. Chair.

I'm going to continue with you, Dr. Tomkins or Dr. Burry.

Do you feel that Bill C-31 provides dental insurance?

[*English*]

Dr. Lynn Tomkins: I'm sorry. I was listening in two places.

[*Translation*]

Mr. Yves Perron: Do you feel that what Bill C-31 provides constitutes dental insurance?

[*English*]

Dr. Lynn Tomkins: No. If you look at it, actually, it's more like a health spending account.

[*Translation*]

Mr. Yves Perron: Are you concerned that not all of the amount would necessarily be spent on dental treatments?

As I explained earlier, based on how it works in the bill, individuals would be required to submit only one receipt to automatically receive $650 per child. For example, they could submit a $100 receipt, then receive $650, and they wouldn't be required to account for the remaining $550.

What's your opinion on this? Are you concerned about it?

[*English*]

Dr. Lynn Tomkins: Well, certainly we would like to see the money being put toward dental care for children. As to whether or not the person actually does it, as I understand it, CRA has various mechanisms for audit and for checking on how the money is used. We wouldn't want to see dentists having to demand that patients justify how they're going to spend the money they've received.

[*Translation*]

Mr. Yves Perron: I hear what you're saying. In an earlier response, you stated that you were concerned about the administrative burden. I feel that it could be an issue too. Of course, you want the money to be spent on dental care, and I understand that. However, don't you feel that decentralizing the handling of the funds to the provinces would make it easier to administer this and prevent excessive red tape by keeping another level of government out of the health care systems?

That's one of my concerns.

[*English*]

Dr. Lynn Tomkins: That's a question I really cannot answer, because it's in the design of the program.

[*Translation*]

Mr. Yves Perron: Does that sound reasonable to you?

You said you're concerned about the administrative burden. I usually sit on the Standing Committee on Agriculture and Agri-Food, and we have the same problem every time we deal with the federal government. It's such a long and complicated process and we always end up with a lot of administrative paperwork.

We already have a level of government looking after health care. Wouldn't it be easier to transfer the funds for those services to that level of government to ensure that it's local services that are making consistent decisions tailored to community realities?

[*English*]

The Chair: Give a brief response if you can, please, Doctor.

Dr. Lynn Tomkins: I refer to what we have now as a health spending account. In a sense, the administration of that is very simple. Going forward, whether we have a federal program or whether we have transfers to provincial programs with the accompanying administrative burden, we would want to be able to see something that utilizes the current system. When you go in to see your dentist, you present, they take your claim and they send it directly to whoever the payer is going to be. That would be the preferred system of doing it. Whether that happens at the federal level or the provincial level is not for us to decide.

[*Translation*]

The Chair: Thank you, Mr. Perron.

[*English*]

Mr. Davies, go ahead for two and a half minutes, please.

Mr. Don Davies: Thank you.

Could you clear some of this up? I have read Bill C-31. Of course, to get the money, a person has to attest that they will use the money for dental services and has to keep the receipts for the service. When we send Canadians the child benefit payment every month, we have no guarantee they're going to spend it on their children either, but we still send the money to families.

Mr. Perron just made a wonderful argument for why the Canadian health care transfer has to have conditions attached to it—so we can make sure that provinces spend it on the things that it's being transferred for, much like he wants to make sure that the money transferred to families ends up being paid for dental care, I would suppose.

I want to finish the question I asked before. The CDA's written submission to this committee noted that in 2017, only 39% of Canadians had access to community water fluoridation, whereas 73% of Americans had access to it in 2018.

How important is fluoridation to oral health, and what steps should the federal government take to try to encourage fluoridation of our water?

● (1250)

Dr. Lynn Tomkins: It's extremely important to oral health, because if you get community water fluoridation and you get fluoride added to the water in the right amount, it will enable those teeth to be stronger. I have benefited from that myself. You probably have as well.

However, it comes down to the municipalities deciding whether or not to update their infrastructure. Whatever the federal government can do to support the infrastructure that is going to.... First of all, we need to have good water systems. In the beginning, we need to have a good water supply and to make it possible for those municipalities to add the fluoride to the water through their support.

Mr. Don Davies: Thank you.

Ms. Douglas, I have a quick question for you. What is the impact to children of not having access to pediatric formulations in, say, oncology? To be brutally blunt about it, do children die as a result of not having access to formulations specifically for them?

Ms. Sarah Douglas: The challenge with the lack of pediatric formulations for children results from using adult formulations off-label. What this tends to mean for children is compounding of drugs. In some forms it's a pharmacist, either in a hospital setting or in a community pharmacy setting, crushing a tablet. It could sometimes be parents crushing tablets and mixing them with apple sauce or something like that for their children to take the medication.

However, the problem is that sometimes children find it difficult to.... They don't like the taste because sometimes, when the medicines are compounded, they have a taste to them that children don't like. Getting adherence from children to take their medication is difficult at the best of times, so this makes it much more challenging. The advantage of having specific pediatric formulations is that you can make medications for children in forms that are appropriate—like syrups for younger children, or microtablets but with syrup flavours that children like—and children are going to be more compliant with in their therapies.

The Chair: Thank you, Ms. Douglas and Mr. Davies.

Next is Dr. Ellis, please, for five minutes.

Mr. Stephen Ellis: Thank you, Chair.

On that note, Ms. Douglas, just to underscore that, as we all know very clearly, or at least those of us who practise medicine do, children are not just little adults. Certainly, the Tylenol and Advil shortage that currently exists and the certain significant stress and anxiety that causes for parents really is a way to underscore the need for the development of specific pediatric formulations. I appreciate your efforts on that front.

Dr. Tomkins, perhaps you could talk a little bit more about this jurisdictional approach to the proposed dental program. I'm certainly loath to understand why I would believe that the federal government could administer a program in any way, shape or form that would be efficient or effective. That's beside the point, of course. That's political. But if these programs exist in 11 of 13 jurisdictions in Canada already, then why do we need a federal dental program?

Dr. Lynn Tomkins: What we have now is an interim program. The money is going to low-income families and children who need it. What we would say is that as part of the dialogue, we would want to be involved as we develop this program going forward. You are correct; there are programs in existence across the country and they are successful to varying degrees. Some are fairly well funded, work well and reach the populations they're designed to reach. Some of them are not. There really is a tremendous variation from jurisdiction to jurisdiction.

That will be part of the continuing conversation we have. We represent the provincial and territorial dental associations. They have had the opportunity to meet with the minister and make their concerns known. Each province is a little bit different. It's a lot like Confederation. I think if we keep our focus on the big outcome, which is ensuring that Canadians who don't currently have access to dental care.... If we can work together, we will find a system that works. Whether it's slightly different in every province, we don't know, or whether it ends up being a federal program, we don't know, but we are here to provide the information and the feedback on things going forward.

Mr. Stephen Ellis: Thank you, Dr. Tomkins.

Again, Dr. Tomkins, if I may, do you know which programs jurisdictionally are very successful and which are less successful? I guess the question is this: Why do we always have to move to the lowest common denominator? Why can't we help those who are less successful be more successful and model their care after those who are more successful? Again, the follow-on question is, why does the federal government have to get involved in a provincial issue?

● (1255)

Dr. Lynn Tomkins: Well, as I've been told and led to understand, the funding comes from the federal government and then the provinces decide how it will be used. If you look at provinces like Prince Edward Island and Newfoundland, they do have reasonably good programs. No program is perfect. For instance, as I understand it, in Newfoundland they cover certain things, but they don't cover prevention. In other provinces, they cover different things. I think from a public policy point of view, if we want something that will reach all of the populations, we need to have some sort of national agreed-upon standard that will be the basic dental care plan. That will then be part of the discussion.

The other part of your question is really part of the debate that's going on between the provinces and the federal government right now.

Mr. Stephen Ellis: I guess that's the thing; if we're having a policy debate, that's one thing, but if we're creating legislation that's going to create more bureaucratic issues and cost to create an entirely new program, that seems kind of nonsensical to me in something that already exists. I just fail to understand what the need for that is and why we should be supportive of this.

That doesn't mean that dental care is not important. I've been a family doctor for 26 years. I see a plethora of dental problems that could be easily prevented and treated. As you well know, Dr. Tomkins, because I understand you're a practising dentist, you know what I treat them with—antibiotics, inappropriately.

That being said, then, I continue to fail to understand, if we have programs in 11 of 13 jurisdictions, why we don't make them better instead of creating a new program. If we want to have a strategy on this, wouldn't it make more sense to say, hey, let's make a strategy? Why do we need to spend all this money on a program that to me is looking for a home?

I guess I'm wondering what the CDA thinks of that.

Dr. Lynn Tomkins: Those are all very good points. As I understand it, with the current Canada dental benefit, this is something that has a finite lifespan. As I said, this will be part of the ongoing dialogue.

I don't know if Aaron wants to add to that.

Dr. Aaron Burry: No. I think you've outlined some of the things we would like to see, which is better coordination between the benefits and a conversation about improving programs right across the country at this particular point in time.

Mr. Stephen Ellis: Thank you, both of you. I appreciate it.

The Chair: Thank you, Dr. Ellis.

The last round of questions will be posed by Dr. Powlowski.

You have the floor for five minutes, sir.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): Thank you.

I have questions for Dr. Ungar.

I was wondering about the available psychological support services for children who come from war zones. We've obviously had a big influx of such children in recent years, first with Syrians, then with people from Afghanistan and now, most recently, with people from Ukraine.

Certainly, you know and will appreciate that the vast majority of kids are really resilient. I know of kids from Afghanistan who have seen their close relatives die in front of them. I know of Ukrainians who have close family members on the front line. They seem to be doing all right. Obviously, I don't think all of the kids need psychological services.

One, do we have enough services to serve their needs? I guess I'm also thinking of all those people—for example, schoolteachers—who aren't used to this situation and how to identify somebody who maybe needs help, and whether there ought to be any kind of screening to see who among those kids needs help.

Dr. Michael Ungar: Thank you for the question. You raise lots of great issues here.

What I can tell you is that for younger children, I think there is a bit of an assumption, not that you're making it at all.... You seem very clued into this, and I thank you for that, but there is sometimes an assumption that a child will come out of a war zone and in fact somehow that has always resulted in a mental health challenge. That's not actually supported by the evidence.

Actually, what many children do experience, especially adolescents, is a lot of difficulty transitioning or integrating in during this phase of their resettlement, but because they maintain connections with family and a positive identity, they feel that they're not necessarily the cause of their being dislocated—it's not like they did something personally wrong—and a lot of those attributions and patterns of thinking actually are quite protective.

I just want to reassure the panel here that a lot of these children do need care, but many actually come with many of the resources to cope well. Our wonderful settlement organizations that are national in scope, many community groups, our religious organizations that adopt these families in their communities, the service clubs and educators, all of that creates, if you will, an environment rich in that kind of mental health supports. My estimate is that maybe one in 10 of these children, or perhaps two or three in 10, may need some sort of tertiary-level mental health intervention, and then you're right: It is a challenge to find culturally competent, linguistically appropriate interventions that would actually match.

Now, the good news is that across the country there are people, such as social workers, who act as cultural brokers. There are community organizations through faith communities that are reaching out to families and children. There are a lot of grassroots initiatives. I like that, because it takes away the necessity to always focus on a Ph.D. in child psychology who has to treat.... What we're actually understanding is that there's a relatively small number of children who would need that level of care, mostly because we as a Canadian society are incredibly good at wrapping communities and educational facilities around the children who are coming. We're seeing that. We saw that with the Syrians, and we certainly have seen that with the Ukrainians as well.

● (1300)

Mr. Marcus Powlowski: Maybe there's no quick answer to this. Most kids are resilient, but some not so much. Why the difference? Which kids aren't resilient, and how can the system try to encourage whatever it is that makes kids more resilient?

Dr. Michael Ungar: Actually, what we see is that the children who tend to show more of those patterns of coping successfully have internal strengths—sometimes it's just the genetic lottery, if you will—but more often it's about patterns of extended family, opportunities in their communities to use their talents, recreational spaces, access to a cellphone and technology so that they can remain connected to their extended peer group, language skills, and an education system that adapts. There are a lot of factors that you can actually put in place that are well researched and that actually create the optimal conditions for children to survive well.

Of course, as your questions indicate, there are also children whose past risk exposure is so severe or so unique, or they have a constellation of risk problems, that you do need to tailor an intervention specifically for them. This is not related to refugee children, but if you look, for instance, at the Kids Help Phone, which is a national effort, you will see that it's actually overused or used disproportionately by children in rural communities and by indigenous children, largely because it's a protective factor that is very adaptable to people living in more marginalized communities and rural communities. I think that's where we get thinking about protective factors as really tailored to the risks that a child experiences, while not forgetting that most children respond really well simply to all the good things that we tend to give kids through communities that care about the newcomers who arrive.

The Chair: Thank you, Dr. Ungar.

Thank you, Dr. Powlowski.

That concludes our rounds of questions.

To all of the panellists, thank you so much for being here with us today. This is our first witness panel on this study, the first of six we have planned. It's a very broad topic, and I think the diversity of expertise that we had in the room today reflects how broad the topic is.

Thank you very much for sharing your expertise and experience with us. I have no doubt that it will be of great value in framing our thinking as we move through this work. We are, indeed, grateful to you for the time that you've given us and the thoughtful and comprehensive way in which you've addressed all of the questions.

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

Some hon. members: Agreed.

The Chair: We're adjourned.