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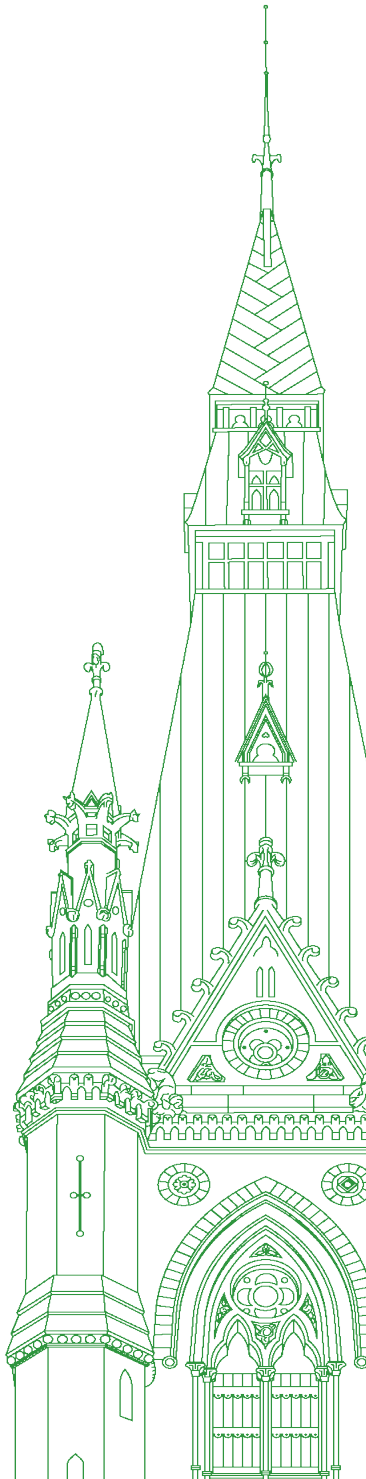

Chair: Mr. Ron McKinnon

Standing Committee on Health

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● (1105)

[*English*]

The Chair (Mr. Ron McKinnon (Coquitlam—Port Coquitlam, Lib.)): I call this meeting to order.

Welcome, everyone, to meeting number 30 of the House of Commons Standing Committee on Health. The committee is meeting today to study the emergency situation facing Canadians in light of the COVID-19 pandemic.

I would like to welcome our witnesses. On this panel, as an individual, we have Ms. Winny Shen, associate professor, organization studies, Schulich School of Business, York University. From the Association des gastro-entérologue du Québec, we have Dr. Mélanie Bélanger, president. From Coalition Canada Basic Income, we have Dr. Cordell Neudorf, professor and medical health officer, and from Moms Stop the Harm, Ms. Leslie McBain, co-founder and director.

With that, we will invite the witnesses to present their statements, starting with Ms. Shen for six minutes.

Dr. Winny Shen (Associate Professor, Organization Studies, Schulich School of Business, York University, As an Individual): Thank you, Mr. Chair, and honourable members of the committee, for the opportunity to speak with you today.

My name is Winny Shen. I am an associate professor of organization studies at the Shulich School of Business at York University and the current chair of the Canadian Society for Industrial and Organizational Psychology.

As an organizational psychologist who conducts research on issues of gender and diversity in the workplace, I have been asked to address the disproportionate impact of the COVID-19 pandemic on women's workforce participation and the importance of addressing these unequal impacts on the road to equitable economic recovery.

There are two interwoven strands that have contributed to more women than men leaving the workforce as a result of the pandemic.

First, in contrast to prior recessions, such as the great recession of 2008, the industries most harmed by the pandemic through job loss are those in which women tend to be more strongly represented, such as those involving people and having significant interpersonal components. This includes the hospitality and retail sectors, which contributes to the greater impacts on young women and women of colour.

Additionally, the pandemic has put more strain on small and medium-sized businesses relative to large organizations. Female-led businesses tend to be smaller on average than male-led businesses, and may be more financially precarious due to greater difficulty in accessing capital. Further, women dominate many segments of the health care workforce on the front lines of the pandemic. Significant burnout and the ensuing turnover have resulted from our protracted battle with this virus.

Second, the pandemic has increased care responsibilities, which have mostly fallen to women. The unavailability or unreliability of child care and school during the pandemic tends to be borne mostly by women, leading to reduced work hours and decisions to leave the workforce. The impacts on single parents, most of whom are single mothers, are particularly stark. Similarly, we know that elder care responsibilities also tend to disproportionately fall upon women. Those have been heightened during the pandemic as well, given the vulnerability of the older population to the virus.

As we look ahead to recovery, we need to ensure that women are not left behind and to carefully consider whether policies could have unintended consequences for women. We cannot simply assume that the jobs lost in female-dominated industries during the pandemic will come back quickly or at all. Companies that are managing costs by understaffing during the pandemic may choose to continue to do so, given ongoing uncertainties.

Additionally, to build a more resilient and fair economy, we should consider how to make gender representation across industries more balanced so that future economic downturns are experienced more equally across different segments of the population. We should also consider how to better protect the most vulnerable, for example by increasing the pay associated with people-oriented work so that more men consider these jobs. Another example would be to incentivize women to pursue opportunities in traditionally male-dominated industries where there is great need for entrance, such as in the skilled trades.

The pandemic has also highlighted the precarity of our progress towards gender parity in the workforce and the related financial security it provides to women and families. Without intervention, the pandemic could have a significant impact on women's careers for decades. We know that employment gaps are often viewed unfavourably by employers, which can make future job-seeking more difficult and can have long-term impacts on future earnings. This may particularly be the case if employers interpret these gaps as a signal that women are not committed to their careers and invest less in their career development over the long term as a consequence.

Finally, the pandemic reinforces the fact that people's—particularly women's—ability to participate in the workforce is dependent on the resources available to support their non-work responsibilities, such as caring for family members.

Thank you for this chance to share my views.

[*Translation*]

The Chair: We now move to the Quebec Association of Gastro-Enterologists.

Dr. Mélanie Bélanger, the floor is yours for six minutes.

Dr. Mélanie Bélanger (President, Association des gastro-entérologues du Québec): Good morning.

I am the President of the Quebec Association of Gastro-Enterologists. I represent 273 members. As medical specialists, we investigate and treat digestive diseases. We are the only doctors fully trained in digestive endoscopies, specifically those needed in the prevention of colon cancer.

Endoscopy is a way of exploring the interior of cavities in the human body. Our practice includes colonoscopies to study the colon and gastroscopies to study the stomach. Thanks to recent technological advances in endoscopy, we are able to use the patients' natural passages to conduct procedures, to take samples, to remove lesions and thereby to avoid classic surgery. These are short procedures, often taking less than an hour, needing no general anaesthesia, no hospitalization and no recovery time. The estimated cost of a colonoscopy in Quebec is less than $1,000.

Colonoscopy plays a crucial role in preventing colon cancer. This cancer is the third most frequent and the second most deadly in Canada. According to the Canadian Cancer Society, each year, 27,000 Canadians are diagnosed with it and 9,700 die.

Colon cancer is unusual in that it can be prevented. This distinguishes it from the early detection approach used in the case of breast and prostate cancers. Colon cancer screening, using colonoscopy with some of the patients, allows lesions that are still precancerous to be removed. Patients therefore develop no cancer at all, preventing surgery, chemotherapy and mortality. The science proves that colon cancer prevention programs reduce the incidence, the severity and the lethality of this very frequent cancer that affects men and women almost equally, starting in the 50s, and sometimes earlier.

Quebec is the only province yet to have an official program of colorectal cancer screening. Patients therefore must take action themselves and ask for a referral for an iFOBT test, also known as a FIT Test. This test is recommended for all Canadians 50 and older. It requires a stool sample and looks for the presence of microscopic traces of blood, blood that is invisible to the naked eye. If blood is detected, the patient is then referred for a colonoscopy. Five per cent of all iFOBT tests are positive, meaning that the same number of colonoscopies are necessary. They are recommended within eight weeks at the most, in order to prevent the lesions progressing during the waiting period.

Of the patients with a positive iFOBT test, 35% will have polyps, or precancerous lesions that can be removed to prevent cancer, and from 6 to 8% will already have cancer, but with no symptoms.

Before the pandemic, about 22,000 colonoscopies per month were performed in Quebec. Since March 2020, access to colonoscopies has been significantly reduced, which has had a major, negative effect on the number of polyps and cancers detected. Because of the marked reduction in endoscopies during the first wave, followed by a recovery that is still incomplete today, only 73% of the number of colonoscopies performed in Quebec in 2019 were done in 2020. So more than 63,000 fewer colonoscopies were performed during the pandemic, meaning that we currently have a backlog of more than 110,000 colonoscopies in Quebec, 63% of which are late.

A lot of catching-up will be required to slow the increase in the number of cancers, and of deaths from colon cancer.

At the moment, gastroenterologists do not have the human resources or the access to the equipment they need to start catching up.

We propose three solutions. First, we believe that new, fully functional endoscopy rooms must be quickly established. Second, specific budgets should be provided exclusively for endoscopy units, as they already are for emergency rooms and operating theatres. This will prevent hospital budgets being cannibalized by other more sensitive areas. It will also allow the specialized nursing staff to become more stable, thereby increasing productivity. Third, we must have reasonable investments in patient follow-up and in quality control.

● (1110)

In conclusion, I hope I have shown you that thousands of silent and asymptomatic Canadians are our patients of tomorrow. We should not let urgency outweigh importance.

Thank you for your attention.

The Chair: Thank you, Dr. Bélanger.

[*English*]

We'll go now to the Coalition Canada Basic Income with Dr. Cordell Neudorf.

Please go ahead for six minutes.

Dr. Cordell Neudorf (Professor and Medical Health Officer, Coalition Canada Basic Income): Thank you. Mr. Chair, and committee members.

I am both a public health physician and an academic who does research into the causes of health inequities and the impact that programs and services have on reducing these inequities and improving health and well-being.

I am speaking to you today in my capacity as a member of Coalition Canada Basic Income, which is a coalition of basic income and anti-poverty groups from across Canada that formed near the beginning of the COVID-19 pandemic in response to the early signs and predictions of the inequitable impacts this event would have on the Canadians who are living in poverty.

Our members have worked for many years with community service organizations, non-government organizations, concerned citizens, people with lived experience, as well as academics and other experts to advance the case for an evidence-informed approach to improving income support programs in this country. As has been well-documented by our chief public health officer, Dr. Theresa Tam, in her October 2020 report called “From Risk to Resilience: an Equity Approach to COVID-19”, there has been a disproportionate impact on subpopulations, those who face racism, stigma, or discrimination in many forms due to both the disease itself, as well as the interventions that we've had to use to bring it under control.

This report outlines several high-impact areas of action as a way forward as we move out of the pandemic, learning from what it has exposed. The first and foundational area mentioned is that of economic security and employment conditions. In the first few months of 2020, groups that worked with populations living in poverty were faced with impossible choices. They were being asked to close or adapt services to keep clients safe from COVID knowing that this then risked disrupting the precarious balance of supports these clients depend on. They have also joined our coalition as they have seen the limitations of our current systems of supports and services first hand.

Income supports that were put in place to help Canadians who found themselves out of work during the pandemic response helped a lot of individuals and families who were one paycheque away from homelessness and poverty, and showed that government can be nimble in mobilizing resources to help those in need. However, some people who did not qualify and were already living in poverty may have received bad advice, or applied for this funding only to find that they were then subsequently cut off from their existing income supports, or were being asked to pay this money back. In other cases, the amounts they had been receiving through existing programs were substantially less than the cost of living, and it made the CERB an attractive option for survival. Others faced eviction once temporary bans on evicting people during the crisis were lifted, or saw their lives thrown back into crisis as precarious supports and services were cut back due to COVID safety concerns. The pandemic and our responses in controlling it, essentially, have exposed gaps in our complex system of the programs and services that we have for those living in poverty.

Multiple studies in Canada and elsewhere have also shown that those living in poverty have had more cases of COVID at a higher rate, higher hospitalization rates, and higher deaths than other Canadians. Fortunately, many studies have already been done that show this doesn't have to be the case. Previous experiments with guaranteed annual income in Canada and elsewhere have shown that participants experienced better health, both physical and mental health, and utilized fewer health and social services. The vast majority have used this more secure base of income to stabilize their current circumstances and better plan for their future. Our existing old age security and guaranteed income supplement programs have moved Canada from having one of the highest rates of poverty for older adults among OECD countries to one of the lowest, while the rate of food insecurity among this age group has dropped 50%. Similarly, the child benefit has raised over 334,000 Canadian children above the poverty line, and UNICEF views it as a model of an effective basic income program for that subgroup.

● (1115)

As we make progress in decreasing poverty in this country through these types of programs, we need to address the other subpopulations who are still living in poverty.

Our current programs and services often have complex eligibility criteria and regressive qualification requirements, such as the need to liquidate current assets or claw back any income earned while on assistance, that collectively serve to keep many families in poverty. This has drastic consequences for their health and well-being, leading to yet more costs to deal with the after-effects of the health and social costs of poverty through downstream funding and even more services.

This pandemic has shown us that we need a stronger base to rebuild on to make us more resilient to face future crises. By adopting a guaranteed annual income, families impacted by job loss during a future pandemic or a major change in the economy would know they were secure while they waited for their jobs to return, or they would have the flexibility to retrain for whatever jobs emerged in the new economy. In addition, we'd have a simplified system with less administrative costs with more of the investment going directly to those in need, simultaneously reducing the indirect costs of poverty and reducing the complexity and inefficiency of our current system.

In closing, the costs of a guaranteed annual income are not insignificant, but the costs of dealing with the after-effects and downstream impacts as well as our complex current system are almost as large, and perhaps even larger, with less impact. Many studies have shown that for the most complex cases, the costs of the health, social service and justice systems' current responses to the effects of poverty and homelessness are enormous. They often leave people in the same or worse condition in the end, with little hope for the future.

We can learn from the successes and limitations of our pandemic response and build back better. Basic income has the potential to enable all Canadians to live healthier lives by reducing the negative health impacts associated with living in poverty. It is for this reason that many health and social service organizations, including public health, endorse developing a basic income for Canadians.

Thank you.

● (1120)

The Chair: Thank you, Dr. Neudorf.

We'll go now to Moms Stop the Harm, with Ms. Leslie McBain, co-founder and director.

Please go ahead, Ms. McBain. You have six minutes.

Ms. Leslie McBain (Co-Founder and Director, Moms Stop the Harm): I am the co-founder of a non-profit national organization called Moms Stop the Harm. Two other moms, Lorna Thomas and Petra Schulz, and I lost our beautiful sons to drug harms in 2013-14. The next year we decided to act. By early 2016, we had an organization of 18 people. Today our members number well over 2,000 families across Canada.

Our aim was, and still is, to advocate for evidence-based drug policies that support rather than punish people who use drugs. We do not want any other family to experience the deep and lifelong pain of losing a child, especially to a preventable cause. We continue to advocate for humane drug policies, and we now have a network of trained peer-led support groups that support families in grief and support families struggling to keep their loved ones with addiction alive.

With the help of provincial and federal grants, we have expanded the groups across Canada. In the past 12 months, our membership has soared. It has expanded to dads, friends, siblings, religious leaders and first nations people. This is a result of the exponential rise in the number of toxic drug deaths and survived overdoses in Canada during the pandemic and the attendant rise in drug use.

How has COVID impacted these families and their communities? The impact has been and remains profound. Given the conditions that the pandemic has imposed on all of us, and the community of drug users and their families in particular, we find that families have increasing levels of stress, fear and anxiety if their loved ones with problematic drug use are still alive. More often now, families receive desperate phone calls as services disappear through COVID restrictions, or the one phone call that no parent ever wants to receive.

Treatment and recovery services are as ridiculously expensive now as they have ever been. There are longer wait-lists and people are dying while they wait. Many families who are fighting for the lives of their loved ones have already faced COVID-related economic hardship. This turns into desperation. Mental health services are inundated and unable to cope with the rise in need.

One of our members, a single mom with two teenagers at home and a son with mental health issues and addiction, has lost her job as a retail manager because of COVID cutbacks. When she had a dependable wage, rent was affordable, child care was within reach and she was able to connect with her addicted son, who chooses to live on the street. She often gave him money or another phone, or bought him clothes or another backpack. Given the reduction of services to help him, she is now his sole protector. Now she does not have enough money to help him much, and she now has a serious gastrointestinal disease caused by the stress. Her doctor says, “Reduce your stress and take these pills.”

The grief within families and communities that have lost loved ones to toxic drug death is a tear in the fabric of Canadian society. Since COVID appeared, the grief felt by families who lose a child to drug death is exacerbated by not being able to gather for funerals, wakes or other traditions. People do not visit or bring casseroles. The surge of the psychological impact of solitary grief rages side by side with COVID fears.

People who have a substance use disorder, which in normal times is challenging, stigmatized and a dangerous disorder to have in this country, have been cautioned to isolate during COVID just like the rest of us. What this means to people who are addicted is extreme vulnerability.

The previous message given for many years, which was “never use alone; always have a buddy nearby”, is almost null. People who use drugs take COVID warnings just as seriously as the rest of us. Using alone is more dangerous now, during COVID, than it has ever been, because of the increased toxicity of drug supply. If a person overdoses, they will likely die alone or suffer permanent brain injury in the absence of help.

COVID has interrupted the normal flow of illicit drugs into Canada. Drugs that traditionally come into Canada across borders, although toxic, were somewhat comprehensible. People who are addicted had some idea of the strength and the inherent dangers. They were still dying and they were still ending up in the ERs, but not in the numbers that we see today.

● (1125)

Local illicit drug manufacturers, not willing to ignore a very lucrative market that suddenly appeared, have hastily started producing powerful substances, throwing in highly toxic drugs in amounts that kill. Toxic drug deaths have increased 120% since 2019.

During COVID, like the rest of us, people with substance use disorder are disconnected from their communities, their families and their living situations. Shelters have closed. Services have closed or become very limited. Safe consumption services have closed or have severely cut their hours. These things often cause increased drug use as connections have disappeared, and connection means everything to people who use drugs, as well as to the rest of us.

I am not an academic. I am not a scientist. I am a bereaved mother who has heard 2,000 stories. I know the wash of grief over this country and I have seen the physical and psychological toll on our members before and now especially during COVID.

If the federal government, in partnership with provinces, could act on the evidence and implement a safe supply of drugs to people who need them, decriminalize possession of personal amounts of illicit substances, and make investments in a system of care that makes rapid access to treatment and recovery and mental health services accessible to everyone, the effects of COVID, the effects of the current drug scene, and the deaths and the desperation of families would definitely be mitigated.

Thank you very much.

The Chair: Thank you, Ms. McBain.

We'll start our questioning now with Mr. Barlow.

Mr. Barlow, please go ahead for six minutes.

Mr. John Barlow (Foothills, CPC): Thank you very much, Mr. Chair.

Thanks to our witnesses for being here today.

Ms. McBain, I'll start with you if that's okay. I certainly appreciate your sharing your personal story. Sometimes it's beneficial when we don't have academics but people who have lived experience, and I know, unfortunately, that too many of us have lost friends or relatives as a result of the opioid crisis, which has been exacerbated by the COVID-19 pandemic.

Certainly we've seen the numbers, as a result of lockdowns and restrictions, and the use of substances and opioid deaths and suicides increase dramatically over the last year. In my province of Alberta we had the second-highest number of suicides in the country ever over the last six months.

Would it help to have a one-stop, single 988 suicide hotline manned by mental health experts? It's something we don't have in Canada right now. Currently we have a different system in every province. Many times when people call they get an answering machine or a recorded message. What kind of a difference would it make? It could be a quick and easy step, a 988 suicide hotline manned by mental health experts. What kind of a difference would that make?

Ms. Leslie McBain: I think anything helps. Everything helps.

If it were a hotline that could address suicide as well as other mental health issues—and I should say including even drug use and addiction—yes, that would be a great idea. It couldn't hurt, but at the same time we need, across the board, connections through a phone line or through a phone app whereby people who are using drugs are able to connect with somebody who is listening.

I don't know if you've heard of the app, but it's like the Lifeguard app, where they have to respond within certain key number of seconds or emergency services are called.

Anything that helps keep people alive during this pandemic is invaluable. Suicides are up, and we need whatever supports are available, so the answer is yes, of course.

● (1130)

Mr. John Barlow: Thanks, Ms. McBain.

My province of Alberta, I know, is piloting that app and program as, I am sure, are other provinces, so that's a good first step.

You talked about the inability to gather and how the isolation has become even more difficult. I think your comment was “extreme vulnerability”.

Is the lack of vaccines and getting the vaccines out and getting people vaccinated and life back to normal—I know that's not an issue regarding opioid use—a huge component of this, just trying to get some sort of pathway back to normal so that people are able to gather again?

Ms. Leslie McBain: Absolutely. I think we're all waiting for things to become safer. When people lose a loved one to any cause, we have traditions. As I said, we have rituals and things that are really important to our mental health in losing someone we love.

Families who lose a loved one to drug harms are already dealing with the stigma and the isolation due to just that, the problematic drug use. We still have that. Without the supports in place that we would normally have, their lives become very dark and desperate a lot of the time, especially if they can't have people coming over to hug them or just to sit with them.

Vaccinations are incredibly important and I think we all know this is the only way we're ever going to get back to any semblance of normal, and especially for the people who are so vulnerable, to grieve that. This will make a big difference.

Mr. John Barlow: Thanks, Ms. McBain. I'm sorry. I don't mean to cut you off, but I just have a limited amount of time.

Ms. Shen, I want to move to you if I could. You touched on some issues that I know many of us are hearing about. Certainly in some Zoom calls and webinars we're having with our chambers of commerce in trying to see the impact on small businesses, one of the biggest messages I'm hearing now is from women who are small business owners, who are now having to take on the stress and anxiety of worrying about their business, worrying about their employees, worrying about their families and also the families of their employees. They're taking on all of that responsibility.

I can't imagine the stress they're going through trying to run their business, working from home and also trying to balance their children's education, which is many times at home.

What would be some recommendations on some programs or steps we could implement or recommendations we could put forward to try to address this? I'm assuming the ramifications of this will be long term.

Dr. Winny Shen: I think that is very true in when managing multiple competing demands all at once. As one recommendation, I know the federal government put in place a lot of attempts to help small businesses, but a lot of that is just going towards keeping businesses afloat. It's not really enough to make any....

It's also very limited in time. It's hard to plan ahead. Even if today is taken care of, tomorrow might not be, and you're worried about not only yourself and your family, but also, as you mentioned, the health and well-being of all the people you are employing.

More consistent, longer-term planning is needed to deal with the pandemic for people who are running businesses, especially given the ongoing uncertainty. We need to find ways to ensure continuity of care for people. I'm in Ontario, where we're in our third lockdown. We know that trying to manage the sudden need to school and care for children at home makes managing work and family responsibilities very difficult at the same time, so we need to find new ways to make sure that we can find care opportunities for people.

I know these are difficult issues, but that's the reality we're faced with. If we don't deal with these issues, we will start to see people who can no longer sustain their business or who are forced to opt out of the workforce entirely.

● (1135)

Mr. John Barlow: Thanks, Ms. Shen, and Mr. Chair as well.

The Chair: Thank you, Mr. Barlow.

We'll go now to Mr. Kelloway for six minutes.

Mr. Mike Kelloway (Cape Breton—Canso, Lib.): Thank you, Mr. Chair. Hello to my colleagues.

I really thank the witnesses for their testimony today.

I'm going to focus on Dr. Neudorf. As you know, I've been an advocate for basic income in my riding and in the Atlantic region. Our government implemented a number of support measures for Canadians throughout the pandemic, most notably the CERB. I think at one time there were about 7.5 million people on CERB.

For me, in essence, the CERB acted as a kind of basic income for those who needed it the most. I'm interested in a couple of things: One, what do you think we can learn from CERB; and two, can we use that model to begin to create a national framework for a basic income?

Dr. Cordell Neudorf: Certainly one of the main things CERB showed us was that it is possible to orchestrate broad-based income support quickly and nimbly from the federal level. It's something that has been debated for some time. Even without pre-planning, we could get that funding very quickly into the hands of Canadians who needed it.

I think what worked well for those who were targeted specifically by CERB could work at least as well for those who perhaps did not qualify. We know that many others found themselves impacted by the pandemic, but not directly because of job loss. There are many people and many types of circumstances into the future that we maybe can't predict, where the economy or people's lives can be thrown into disruption and they find themselves living on the streets or living in poverty.

Taking that kind of approach but asking how we can make it more inclusive and potentially simplify or even replace some of the more complex systems that have been put in place is something to do, I think, in consultation with provinces and territories to see how we can harmonize this.

The reality is that over time we've been seeing the tremendous role of government in being able to provide those kinds of supports for citizens. Over time we've cobbled together improvements to social services and programs. At some point, it becomes so overly complex that it becomes difficult for individuals sometimes to even know they qualify for an existing program or service or have the means to get at it and they don't quite qualify. It costs a lot to administer that kind of system and it ends up not actually meeting the needs of many.

In short, yes, we've learned that a simplified program that can meet the needs of families and individuals who are affected by all kinds of crises is possible and can work.

Mr. Mike Kelloway: I have a follow-up question to that, Doctor, for my colleagues, myself and for Canadians watching.

Are there best practices out there from other countries or other regions of the world where we can extrapolate success? I know that's a broad definition. Are there best practices out there that are happening right now or that have happened that we can learn from?

Dr. Cordell Neudorf: Yes, there have been multiple experiments at national or subnational levels that have tried a basic income approach of one kind or another for a time. It's difficult to just take examples from another jurisdiction and apply them directly to Canada. You have to look at what context we are putting it in. Many of these experiments have shown—similar to what we just talked about with CERB—that they do work.

We've shown that even in the Canadian experiments that have gone on in the past, like in Manitoba in the 1970s and even more recently in Ontario.... That program was unfortunately cut short prematurely, but even in that short time, we found that the direct impacts on improvements in the health of the individuals, their children and families were substantial. There was actually a decrease in utilization of health and social services by families as their lives were more stabilized.

It's also been shown that, overall, the proportion of people using those funds in very productive ways to obviously just stabilize their initial crisis then find ways to build back, do re-education and invest in their families.... It has been substantial and transformative for many of these families.

The research has been done. There isn't a need for another pilot project. It's been shown to work. What's needed is to now implement it in the context of our Canadian system.

● (1140)

Mr. Mike Kelloway: Thank you.

Mr. Chair, how much time do I have?

The Chair: You have 30 seconds.

Mr. Mike Kelloway: I have very quick question, Doctor.

From the research that I've been able to extrapolate from different sources—and we've talked about it here in terms of entrepreneurship—I'm wondering if you could talk a little bit about youth entrepreneurship and how a basic income can assist young people in establishing their own businesses.

Dr. Cordell Neudorf: There's a strong case to be made from multiple sectors for basic income. Certainly, from the entrepreneurial sector, there's some good research that's been done there as well.

The ability to know that during that critical development time where there isn't a short income coming in, but a need to develop that base and start a new business is important. As we've seen during the pandemic now, for those who unfortunately just launched a new business and were facing these kinds of crises, the ability to float over is important. Those are two sides of the same coin.

There's a real ability to stimulate that kind of creativity and entrepreneurship, because of that understanding that you're starting from a stable base.

The Chair: Thank you, Mr. Kelloway.

[*Translation*]

We now move to Mr. Thériault.

The floor is yours for six minutes.

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

I would like to thank all the witnesses for joining us. I will turn to Dr. Bélanger first.

We have gone through the first and second waves, and we are starting the third. The pandemic has forced our networks to organize care into two categories of patients: those who have COVID-19 and those who do not.

We seem to be forgetting that the real effects of the pandemic will really emerge when we have a complete handle on the situation of patients who do not have COVID-19. It would be wrong to think that we will have overcome the pandemic when everyone is immunized because the pandemic will still have collateral effects, perhaps for more than one year, perhaps more than two.

The figures are horrifying. You told us just now that 110,000 people are waiting for a colonoscopy and that 63% of the colonoscopies are late. You also told us that colon cancer is the third most frequent and the second most deadly.

So what are the consequences of those delays? What are your fears?

Dr. Mélanie Bélanger: The biggest impact is not seeing asymptomatic patients for colon cancer screening now and only seeing them later. This will inevitably result in a demonstrable increase in the number of colon cancer cases in the coming months and years.

As a clear illustration, with no pandemic, a monthly average of about 55,000 fecal blood tests in Quebec are positive. An average positivity rate of 5% means that we get 2,750 positive tests. As it is said that 35% of the patients testing positive are in the latency period, we can conclude that, each month, in Quebec, about 1,000 patients are seen endoscopically and therefore avoid developing colon cancer.

Consequently, for every month when those patients are not seen, their lesions progress. The science proves that, for a patient in that trajectory, when you push back a colonoscopy for eight months, you double the risk of cancer and of cancer at an advanced stage.

Not seeing those asymptomatic patients now, through no fault of their own, involves much more than one problem. At the outset, we are dealing with an illness, a cancer, that is completely preventable under normal circumstances. Months later, we end up with confirmed cancer, advanced cancer, and terminal cancer.

● (1145)

Mr. Luc Thériault: According to the Quebec Association of Gastro-Enterologists, with patients receiving a cancer diagnosis, the real effects will only be known in a number of years and could lead to death. We are not going to see those effects in a month, but often only in several years.

We know that, before the first wave, the network was already fragile. Chronic underfunding was already a problem. Everyone came to tell us that.

You told us just now that, in your practice, there was a delay after the first wave. If we continue the current trend, do you feel that will clear the backlog? If so, how long will that take?

Dr. Mélanie Bélanger: In Quebec, as of today, there has been no single month when we have been able to perform the same number of colonoscopies as in the corresponding month last year. The current resources do not even let us stop the backlog from increasing. Let me give you an example to give you an idea of the situation. During the pandemic, we performed 63,323 fewer colonoscopies than by the same date last year. The monthly average of colonoscopies done in endoscopy units in Quebec was 22,000. Compared to last year, the accumulated backlog represents three months of full-time work in all those units in Quebec. That is what we need just to handle the backlog and it excludes any additional patient load.

Our current resources will certainly not allow us to respond to the influx of patients that we know we are going to face. Because of factors like physical distancing and the fact that, in some cases, patients cannot present for their appointments because they have to be in isolation, our current resources will not allow us to conduct the same number of colonoscopies per month. Continuing along these lines will only increase the backlog. Eventually, therefore, we are going to be dealing with patients who are more seriously ill.

Just talk to doctors working on the front lines. We see tragedies every day. In some cases, illnesses are diagnosed too late. I exclude colon cancer here. We see more advanced illnesses, surgical procedures, hospitalizations and deaths that could have been avoided. Avoidable deaths are an everyday occurrence for front-line doctors.

Mr. Luc Thériault: Dr. Soulez, from the Canadian Association of radiologists, told us that these delays are going to increase mortality rates. So you have the same fears. Does it make sense to you to say that, after the pandemic, investments must be sustainable and federal health transfers must be increased?

Dr. Mélanie Bélanger: For colon cancer, we need funding specifically for endoscopy. For things to work, we will have to have more rooms and more staff. Yes, more investment is needed. Because of the size of the backlog that we are currently experiencing, the situation cannot be resolved by reorganizing work or services. We really need financial support. Gastroenterologists are available as needed to work more. We can do the work. What we need is access to secure and well organized facilities and additional payments for our specialized staff, whom we wish to keep.

Mr. Luc Thériault: Thank you.

The Chair: Thank you, Mr. Thériault.

[*English*]

Mr. Davies, please go ahead, for six minutes.

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

On this committee we all agree that the opioid death crisis in this country is sobering. Since 2016, we have had over 20,000 Canadians die from overdose deaths. Last year, in B.C. alone, we had 1,700. That's the deadliest year on record. The last quarter of opioid deaths is the highest that Canada has ever recorded since we started surveilling numbers.

Ms. McBain, what if any is the connection between the federal policy of criminalization of drug use and the harms that come from drug use, including deaths?

● (1150)

Ms. Leslie McBain: Criminalization of people who use drugs tends to push them into the corners. It is incredibly stigmatizing. What is more stigmatizing than being arrested, and thrown into the criminal justice system, when, in fact, you have a substance use disorder, and you need to have drugs you can only find on the street in a dangerous and illicit way?

If possession of illicit substances was decriminalized and people were able to feel safe, in normal times there would be more congregating in communities, and so on, but during COVID times, it just exacerbates the idea of using alone.

Decriminalization is essential for people to actually come out of the closet as it were, to seek services if they are available and to start on a path of possible recovery. We find that as a very big step in solving this tragic problem.

Mr. Don Davies: Thank you.

Moms Stop the Harm has called on all levels of government to work together to change current drug policy to an evidence-based approach that, according to your website, “respects and supports the human rights of people who use substances”, and that specifically ensures “access to a safe supply of pharmaceutical-grade substances”, in addition to decriminalization.

Why is it important to address the supply side of the equation in addition to decriminalizing the possession?

Ms. Leslie McBain: Using the substances that are available to people, which are the illicit toxic substances on the market today, is the reason, the one single reason, that people are dying or suffering permanent brain injury. It just follows that if a safe supply of pharmaceutical alternatives were available to people, and they were able to access those in a low-barrier way, they wouldn't die. That's the hope. We know that it won't completely end the problem, but if the federal government and the provinces could work together to remove the barriers to actually implementing a safe supply of opioids—in particular, a safe supply of fentanyl and heroin, which sounds crazy—and they were safely distributed and used, people would not die.

Really, our primary goal here is to keep people alive. Once people are stabilized on a safe supply, the evidence shows that their lives stabilize. They are more inclined to seek treatment. They can even get jobs and hold good jobs if they don't have that everyday search and everyday danger of accessing illicit drugs.

Mr. Don Davies: You touched on treatment. I think all of us in this committee are aware of the pressing need for people to get just-in-time treatment when they want to seek help and the fact that we just don't have the public capacity. I think we're aware that the delivery of treatment services in this country is essentially privatized.

I'm just wondering if you have any suggestions for what the federal government could or should do to ensure that Canadians can get access to treatment on demand through our public health care system. As I think you pointed out, that clearly isn't the case right now.

Ms. Leslie McBain: I think it's a matter of funding recovery and treatment facilities. As well, having good surveillance, good oversight and good policies in place for those facilities is critical. Substance use disorder is the only health issue in this country wherein people have to go to the street to get their medicine. The treatment for them is inaccessible, mostly for their families, because of the cost, or there are way too few subsidized beds in the facilities.

There are a lot of problems that could be solved, that we know how to solve, but it seems to be a matter of political will, for one thing. It's definitely about funding. We don't send people with heart disease or diabetes to unsupervised facilities that are without oversight. We need to treat substance use disorder like any other disorder, any other health issue.

Mr. Don Davies: I have a few seconds left. Prime Minister Trudeau has explicitly ruled out the decriminalization of drugs. He says it isn't a silver bullet. Do you accept that logic? If not, why not?

● (1155)

Ms. Leslie McBain: I absolutely do not accept that logic. I would say that we need about six silver bullets. It is not a silver bullet; it is one step towards treating people with substance use disorder as human beings, with everything that we all have. To shut it off like that is to me unconscionable. I wish very much that he would reconsider that statement.

Mr. Don Davies: Thank you.

The Chair: Thank you, Mr. Davies.

That brings our rounds of questions to a close. We will thank the witnesses at this point so that we can bring in our next panel.

Thank you, all, for your time today. Thank you for your preparation and for sharing with us your knowledge and experience.

With that, we are now suspended.

● (1155)

(Pause)

● (1155)

The Chair: We are resuming meeting number 30 of the House of Commons Standing Committee on Health. The committee is meeting today to study the emergency situation facing Canadians in light of the COVID-19 pandemic.

I'd like to welcome the witnesses for this panel. As an individual we have Amedeo D'Angiulli, professor, Carleton University; from the Association des médecins hématologues et oncologues du Québec, Dr. Martin Champagne, president and hemato-oncologist; from CHATS, Community & Home Assistance to Seniors, Christina Bisanz, chief executive officer; and from Don't Forget Students, Brandon Rhéal Amyot, co-organizer.

Thank you to all for being here.

We will start by inviting witnesses to make statements.

Mr. D'Angiulli, please go ahead for six minutes.

Mr. Amedeo D'Angiulli (Professor, Carleton University, As an Individual): Thank you for inviting me, Mr. Chair.

I want to contribute to the committee some of the results from a development study on the effects of COVID on children and families. It's an ongoing study of research syntheses, in which we have basically collected all of the available peer reviewed, high-quality research. Today, I want to give you a snapshot, a summary of some of the progress we have been making on the results.

The impact of COVID can be categorized in three broad categories: family dynamics and stress on parents; children's mental health; nutrition, physical activity and media, simply to give you an idea. These categories are a little artificial. They overlap sometimes, but the important thing is that they capture the essential ingredients of the impact.

Regarding the stress on parents, one of the things we see reported in the peer reviewed literature is the effect of home schooling and the fact that the parents have to juggle careers and to take cuts or make a financial decision to lessen their income to stay with children. There aren't a lot of external supports to make up for these losses. But at the same time, the surprising thing is that there are protective factors and positive influences on family dynamics due to the fact that the children are closer to their parents.

One of the essential things that has been very much talked about is what is now called the “she-cession”, the fact that women are hard hit by this economic collateral damage of COVID. One of the surprising things is that there is a perception that men have taken up more of families' domestic work. Even so, women continue to be at a disadvantage because they are likely to have jobs that cannot be performed at home. They work 15 more hours at home on unpaid domestic labour, and they are the ones who are suffering more from the economic situation, with an increased risk of gender gap, increased poverty and divorce. You should look at the Stats Canada report that was released in 2020.

For young, middle and adolescent children, we have an array of factors at play. Disability is one major factor, which also plays into stress and the family's hardship. Domestic violence is not necessarily addressed by the fact that there is isolation and home orders. Lack of socialization especially hits young children in periods when socialization is very important for communication and learning.

Virtual learning is also not a positive experience for some of the students, and it is not necessarily leading to very good outcomes. You have poverty in youth. There are also the added effects of media exposure, especially the fact that we are constantly immersed in a media war disaster climate that unconsciously plays on the mental health of young children.

Many of these changes are due to school closures, or the flip-flop of closure and opening and changes. The main outcomes are documented as being increased anxiety and depression.

To conclude, other aspects that are intimately correlated and have an affect on children and youth are their sedentary behaviour and decreased physical activity, which is correlated with a higher use of social media and mobile devices, and a decrease in the quality of nutrition, especially take-home fast food and other things that are not appropriate nutrition for development.

● (1200)

We are working on a general framework to make more sense of this. I have provided the document. Maybe you could look at the framework that we are creating to interpret and organize this data and make it more accessible and contribute to the ongoing study.

Thank you so much.

● (1205)

The Chair: Thank you.

We'll go now to Dr. Champagne, president and hemato-oncologist.

Doctor, please go ahead for six minutes.

[*Translation*]

Dr. Martin Champagne (President and Hemato-Oncologist , Association des médecins hématologues et oncologues du Québec): Good morning, Mr. Chair. I thank you and the members of the committee for your invitation.

I am going to discuss the impact of COVID-19 on cancer, a chronic disease with acute episodes of care over a long period of time. It is very different from single episodes of care such as orthopedic surgery for hip or knee replacement, or cataract surgery.

The postponement of medical activities has caused diagnostic delays that have major consequences. Indeed, a longer diagnostic delay allows cancer to progress, leading to an increased risk of relapse and a decreased chance of cure. For patients, the consequences are important since it will result in increased morbidity. As patients are sicker and are sick longer, the intensity of treatment required will have to be increased because the disease will be more advanced. The more advanced stage of the disease will also result in higher mortality. Because cancers are diagnosed too late, the impact of the pandemic will be felt for many years, both on patients and on the human and financial resources required by health care systems.

Three things need to be tracked: waiting lists, patients on those lists whose care has been delayed, and diagnostic delays, which are very telling of the real impact.

Let's talk about screening programs first. Patients with symptomatic illnesses come to the emergency room, are seen, and for the most part, are managed. That hasn't changed much. Screening programs, on the other hand, diagnose patients at early stages who do not have symptoms. It is estimated that screening programs can reduce mortality from detected asymptomatic cancers by 20% to 40%. This is because diseases discovered at early stages require much less intensive, easier care. They can be limited sometimes to simple surgery rather than requiring a combination of surgery and chemotherapy.

In Quebec, colon and breast cancer screening programs were shut down in the first wave of the epidemic in March 2020. It has not been possible to catch up diagnostically for these patient cohorts. I will provide data in a few moments.

During the previous sessions, Dr. Bélanger explained the strategy for screening for blood in the stool, occult blood, for colon cancer. Patients who test positive for blood in the stool will undergo colonoscopy, which sometimes reveals polyps, a lesion considered precancerous, or even colon cancer.

Presumably, we are seeing a significant reduction of about 28% in tests performed compared with the previous year. The cumulative backlog, despite the lull in the COVID-19 pandemic over the summer and early fall, has not been cleared. What is known is that the less screening that is done, the fewer diagnoses are made. There are not fewer cancers, it's just that they haven't been screened.

In care-delayed patients, there is less occult blood screening and the number of patients who are found to have blood and to whom we want to offer colonoscopy has increased. So the care-delayed patients represent significant numbers, on the order of about 152% if you look at the entire cohort.

In Quebec, about 800 fewer colon cancer surgeries were performed this year than at the same time last year. Dr. Bélanger noted that this cancer is the third leading cause of cancer death in Canada. So this is something that has important consequences. Indeed, as the cancer progresses, surgery may become pointless and one must then turn to chemotherapy or radiation therapy.

These observations are essentially the same for breast cancer, where screening is down 30%, so at 70% of the previous year's level. There are far fewer patients diagnosed with the disease at an early stage. For Quebec as a whole, there is currently a reduction of about 22% in the number of biopsies confirming the diagnosis of cancer, the biopsy being the first step in the confirmation of a cancer. This means that for approximately 60,000 new cancer diagnoses annually in Quebec, there is a cancer diagnosis deficit of approximately 10,000 people.

● (1210)

As a result, there are significant delays and timelines for many oncology surgeries are not being met.

In conclusion, we really need to be concerned about these delays, because patients and society will pay the price. For 13 of the 17 cancers that were studied, a four-week delay in diagnosis increased the risk of mortality by 6% to 8%.

For colon cancer, each four-week delay in diagnosis increases the risk of mortality by about 6%. For breast cancer, the increase is 8%.

British epidemiologists estimate that the mortality rate for cancer patients could be as high as 20% in the next year, but that the price to be paid could extend over 10 years. Indeed, there could be 10% excess mortality per year for the next 10 years.

To solve this problem, we must preserve human resources. As Dr. Belanger mentioned to you, we need significant additional investment to ensure that we have the human and material resources to provide the therapies that patients need.

I have appended several charts that come from the Quebec Ministry of Health and Social Services that give examples of delays in diagnosis and delays related to the various tests that I mentioned.

The Chair: Thank you, Doctor.

[*English*]

We go now to CHATS Community & Home Assistance to Seniors.

Ms. Bisanz, go ahead, please, for six minutes.

Ms. Christina Bisanz (Chief Executive Officer, CHATS Community & Home Assistance to Seniors): Thank you very much, Mr. Chairman and members of the Standing Committee on Health.

My name is Christina Bisanz, CEO of CHATS Community & Home Assistance to Seniors. As an advocate for providing choice for seniors to age at home, CHATS appreciates this opportunity to provide input on the effect of the pandemic on older adults.

CHATS is the largest senior-serving organization in York region in south Simcoe, supporting 8,500 older adults each year through a variety of multicultural programs and services designed to support the health, wellness and independence of seniors and their family caregivers.

Our person-centred programs focus on the social determinants of health in order to enable our clients to live safely and with dignity at home, keeping them out of hospital and long-term care as long as possible. CHATS has been deemed an essential service provider throughout the pandemic, providing support such as transportation to medical appointments, meals on wheels and food security services, caregiver counselling and telephone reassurance calls, just to name a few.

Our personal support workers continue to work on the front line within our assisted living sites, helping seniors with bathing and personal care, meal preparation, medication reminders and other activities of daily living. We've kept our adult day programs open for high needs and dementia clients, which in turn provides their caregivers with greatly needed respite, and when we were no longer able to offer in-person community wellness programs due to public health restrictions, we very quickly designed and delivered virtual wellness and social programs to ensure that our seniors were able to stay connected and engaged with the programs and each other.

In addition, we've worked with our hospital partners to support hospital-to-home transitions for seniors, reducing their risk of readmission.

We're very thankful for the funding that we receive from the seniors new horizons program and other supports, which made it possible for us to be innovative and serve our clients in a virtual world and address emergency needs for food security.

While the ongoing pandemic has illustrated that being in their home and in their community is a safe place for vulnerable seniors to live and receive care, it has also exposed a number of growing risks. I'd like to highlight four of these.

First, the imposed social and physical isolation has led to increased loneliness, depression and a general decline in the physical and mental health of seniors. Many of our clients have not had physical contact with family and friends in a year. Concern with their personal safety by allowing workers into their homes caused a number of our clients to reduce or cancel services, further insulating their social isolation and putting their safety and well-being at risk.

Second has been the impact on family caregivers, who have been experiencing unprecedented and overwhelming levels of stress in keeping their loved ones at home. Frustration and anxiety have led to an increased potential for and incidence of elder and caregiver abuse. The lack of sufficient respite care and support is leading many caregivers to their breaking point.

Third, the pandemic has shown just how dependent we are on the scarce resources of personal support workers in all parts of the health system. The overall shortage of PSWs in Ontario is even more prevalent and more critical in the community sector. Our frontline heroes are also experiencing high levels of stress and anxiety for fear of being exposed to COVID or exposing their clients to risks. Many come from racialized and marginalized communities. With wages generally lower than in the long-term care and hospital settings, the community sector is not in a position to compete for a resource that is crucial to enabling many frail seniors to continue to live at home, where they want to be.

Lastly, when the pandemic was first declared, an incredible spotlight of concern shone upon seniors. New funding, community response, offers of support to make phone calls and send letters and other examples of generosity and caring were unprecedented, but as the pandemic continued, the interest started to wane. Funding support ended with the fiscal year, but the needs and challenges for seniors because of COVID haven't stopped. Let's not leave our seniors behind.

I thank you for your time and attention, and I look forward to your questions.

● (1215)

The Chair: Thank you, Ms. Bisanz.

We'll go now to Don't Forget Students, Brandon Amyot, co-organizer.

Mr. Amyot, please go ahead for six minutes.

Mr. Brandon Rhéal Amyot (Co-Organizer, Don't Forget Students): [*Witness spoke in Ojibwe and provided the following text:*]

Aaniin kina wiya.

[*Witness provided the following translation:*]

Hello, everyone.

[*English*]

My name is Brandon Rhéal Amyot. I'm student at Lakehead University in Orillia and a co-organizer with the Don't Forget Students campaign. I am speaking to you from the territory of the Chippewa Tri-Council of Rama, Beausoleil and Georgina. These are lands under the Williams Treaties and the Dish With One Spoon wampum, long stewarded by the Anishinaabeg, the Haudenosaunee and the Wendat. I mention this not just because it's important to recognize the land, but because of the impact that the pandemic has had on indigenous peoples and, in particular, indigenous students and students of diverse communities.

Members, I speak to you today to raise a grave concern about the impact of the pandemic on post-secondary education, students and recent graduates. This pandemic has taken an immeasurable toll on our financial outlook, our job prospects, our quality of education and, most important, our mental health and community health.

In the past year, students and recent graduates have fought hard to get governments to listen and to act. At the beginning of the pandemic, we called for the CERB to be extended to students and recent graduates. After almost two months of advocacy, the Canada emergency student benefit was launched. This provided four months of relative stability and support for students and recent graduates, but hundreds of thousands of international students and recent graduates were not eligible, and recent graduates who are still in search of jobs and who were not eligible for CERB also could not access this program.

The other large program, the Canada student service grant, as you all know, did not end up rolling out and also did not equitably address the impact of the pandemic on students. In the end and to date, of the over $9 billion originally promised for aid to students through the pandemic, $3.2 billion remains unspent. If I'm to be frank, I feel that politics came before students and before responding to the impact this pandemic has had on us, the post-secondary system and our communities.

We're now 13 months into this pandemic, and I probably don't need to tell you that here in Ontario, where I live and attend university, new COVID-19 cases have hit an all-time high. This third wave is particularly impacting me and other young people across the province and across the country.

The toll this has had on my mental health is difficult to measure, and it's difficult to measure the impact it has had on our mental health for all of us post-secondary students, but research just this past November from the Ontario Confederation of University Faculty Associations and others paints a bleak picture—one that I'm living in. The lack of attention to post-secondary from all levels of government during the pandemic and the legacy of systemic underfunding have led to the pandemic being able to wreak havoc not only on our education, but on our lives.

Most recently, one of the casualties was Laurentian University. This is the product of mismanagement, systemic policy failures and underfunding, and it's not only billions of dollars lost in economic activity but a community ripped apart. These systemic issues are not unique to one school. They are present in this system across the country.

Students and recent graduates were barely making ends meet as it was, and we're barely making ends meet now. Despite the picture that is sometimes painted, we are not a homogenous group of recently graduated high-schoolers. Students are parents, caretakers and workers. Some of us, including me, are disabled and are struggling to cope. This is not an environment conducive to learning, and it is not an environment conducive to innovation.

Meanwhile, recent graduates and those about to graduate are facing one of the worst job markets in a generation and will be crushed under the weight of record high student debt and unreasonable payments. What possible justification is there for collecting student debt payments and interest during a pandemic? In the best of times, these payments are difficult to make. We have to find a better way, not just to get us through the COVID-19 pandemic, but to fully realize the potential of post-secondary education in this country as a part of a social, environmental and economic recovery.

In the short term, all funds that were originally allocated to students—and additional funds—need to be invested towards supporting us through the pandemic. This means relaunching the Canada emergency student benefit—or whatever you want to call it—in May and including international students in the eligibility. It means including all soon-to-be-graduating and recently graduated students in direct supports. It also means extending the moratorium on student loan debt and interest payments until at least the end of the pandemic, with commitments to significant student debt relief.

We have to think about the long term, and that means systemic investments in post-secondary students and education. It means expanding the Canada student service grant with a goal of returning to a fifty-fifty cost-sharing model. It means increasing funding to institutions, and it means creating a federal vision for a universal post-secondary system in collaboration with students, workers and academics.

● (1220)

With these measures, the government can begin to address the impact that the pandemic has had on students and our mental health and well-being, and the long-standing inequities and gaps within the post-secondary system.

In closing, I want to thank this committee for reaching out to hear from students, and I urge members to take action.

Meegwetch.

The Chair: Thank you, Mr. Amyot, and thank you to all the witnesses for your statements.

We will start our round of questions at this point with Mr. Maguire for six minutes.

Mr. Larry Maguire (Brandon—Souris, CPC): Thank you, Mr. Chair.

I want to first go to Dr. D'Angiulli, just to look at the best ways....

You talked about the delay in medical screenings and interventions. There are delays in all ages, I believe you said.

Can you give us your impression of how this compares with other countries? I guess that's one of the biggest issues I'd like to know about. With regard to the delay in medical screenings, you say there's help for teachers and that sort of thing in those areas in your presentation that you gave us today.

Can you elaborate on how that compares in Canada with other countries and what context they have for reopening?

Mr. Amedeo D'Angiulli: Canada is doing much better than countries like Italy, and this I can tell you from own experience. One of the things that Canada is doing very well is managing the online environment better than other countries.

However, we are, I would say, better and worse. It's a relative term. To be clear, we are lagging behind some of the Scandinavian countries, for example, and other countries like Australia and New Zealand.

The approach that most of the countries in the EU are taking, for example, is to enhance the online environment to give schools and parents more contact and to change the way that schools operate with the input of the students and parents. What they have done in Scandinavian countries is to reduce class sizes to have more one-to-one time, redefined spaces for physical activity and other things, which is critical right now, because play and socialization in young children, for example, is vital. You cannot replace it online.

My 3-year-old sits at a computer like a zombie. She doesn't really engage with the media. You need some form of engagement that is person to person.

We can do it. As a country, we have the ability and the skills. We have some of the best schools in the world. However, we are still not quite getting it.

Compared with other countries that don't have resources, of course, we are doing much, much better.

● (1225)

Mr. Larry Maguire: Thank you.

You were talking about home-schooling and working from home—the change is a lot for many parents—and disabilities and the domestic violence.

Can you elaborate a bit on that and what needs to be done?

Mr. Amedeo D'Angiulli: Well—

Mr. Larry Maguire: Talk about the disabilities as a specific case.

Mr. Amedeo D'Angiulli: With regard to disabilities, I think we need to have much more one-to-one tutoring and a lot of support for parents. Parents are really struggling.

I think we need to find ways to do that, to create a space for de-stressing for parents, who maybe are stuck in an apartment with children, and one of the children, or more, has challenges and needs to be helped.

Mr. Larry Maguire: Ms. Bisanz, first of all, I just want to say, thank you for all of the work you're doing with your frontline efforts. We just can't say enough about the frontline workers and caregivers who have made the situation so much better than it could have been.

I'd just like to ask you a little bit about what you talked about, the social isolation and that sort of thing. I've heard some really devastating stories in meetings that I've had with seniors' advocates regarding the feeling of social isolation, as we just talked about, which many are experiencing during this pandemic. Being cognizant of the federal and provincial jurisdictions that we have to deal with, is there anything that we, as federal legislators, can push to combat this issue? What can we best help with?

Ms. Christina Bisanz: I appreciate that currently we are funded predominantly by the provincial governments and bound by the rules and regulations of the provinces. I think that looking at the challenges of social isolation is not something that's unique to COVID and the pandemic. This has been going on for a long time. I know that the federal government has had discussions about the development of a federal seniors strategy, as well as potentially looking at national long-term care regulations in a structure.

I think within that context we also need to be very realistic about addressing social isolation and loneliness on a pan-Canadian basis, and some of the ways in which the federal government can support the provinces, and then down to the actual frontline agencies, to address those challenges and concerns. Part of that is looking at ways we can reimagine housing structures and opportunities. Instead of rushing to build more long-term care facilities, for example, of 300 or more beds and towering facilities, can we not look at how we can address the housing strategies and work with Canada Mortgage and Housing to incentivize developers to start building different forms of product that enable seniors to age in place and do so in a way that promotes social engagement among them.

● (1230)

Mr. Larry Maguire: I think that's a good point. A lot of our senior facilities are over 60 years old.

The Chair: Thank you, Mr. Maguire.

We go now to Mr. Van Bynen for six minutes, please.

Mr. Tony Van Bynen (Newmarket—Aurora, Lib.): Thank you, Mr. Chair, and thank you to all the witnesses who have taken the time to share their perspectives and to help inform this committee on the collateral impact of COVID.

My question is for Ms. Bisanz.

Hi, Christina. It's always good to hear from you, and thank you for being here today and for the work you do to support seniors and caregivers in York Region and in Simcoe County.

I've seen the positive impact of your important work over almost 10 years that we've worked together in the Newmarket council, and I appreciate your hard work in recruiting and engaging so many volunteers and your efforts to raise critical funding that you need to serve your community, like so many of the other non-profits.

You support a broad and diverse community, and firstly I'd appreciate hearing how COVID-19 has impacted the way you serve your clients and how you've adapted to continue your support.

Ms. Christina Bisanz: Thank you very much, MP Van Bynen.

The key change or impact that has occurred in our services has been the need to move to virtual programming, as opposed to in-person programming. Not unlike many other home and community support agencies, we pivoted very quickly to look at ways in which we could deliver social connectivity but using virtual means. By that I'm referring to both telephone and Internet communication and programming.

We also developed a number of activity packages through our adult day programs and dropped them off in a contactless way to many of our clients so that they had activities that would engage them in things such as crossword puzzles or recipes, things that they really could use to make them feel connected even though they were required to be physically isolated and sheltering at home.

The biggest thing is that shift to virtual programming, which we don't anticipate is going to go away any time soon. Even when whatever the date is that the pandemic is declared over, we know that our clients are going to continue to have hesitancy and fear about going out and being in larger groups again. We anticipate the need to continue to provide virtual programs and support our clients to do so through providing them with tablets and Internet connectivity. Providing them with technical support is going to become even more important because that's not something that typically a lot of older adults would have had access to or be comfortable using.

I can report that the response to our virtual programs has been overwhelming. It still doesn't replace the in-person contact, but it has been very well received because it is a lifeline by which people are able to know that they can connect on a daily basis or a couple of times a week. They can access physical activity. We do yoga and other physical activity exercises for them. They know they have that in terms of looking forward and that connection.

Mr. Tony Van Bynen: Thank you.

How many volunteers do you have to deliver the service?

Ms. Christina Bisanz: Before COVID, we had close to 500 volunteers. They truly are the heart and soul of the organization, because we wouldn't be able to deliver near the breadth of services that we do without them. Unfortunately, and particularly in the first wave of COVID, you'll recall that anyone over the age of 70 was advised to shelter at home and not go out. Our clients tend to skew to retired people in that age group, so unfortunately we had to ask a number of our volunteers just to hold off until it was safe for them to become involved again.

● (1235)

Mr. Tony Van Bynen: Thank you.

The Standards Council of Canada, the Health Standards Organization and the CSA group announced the launch of their process to create new national long-term care standards.

The new national standards will take into account lessons learned from COVID-19. We've heard a lot of that from you already, but based on your extensive experience in working with seniors, what would you recommend would be important considerations for this group to explore?

Ms. Christina Bisanz: Let me say this, if I may: As the experience from COVID and the tragic situation that affected so many frail elderly in long-term care homes has really highlighted, certainly for our organization, the time has come for us to stop questioning why people need to go into long-term care and instead focus on how we can help them to stay at home, in their own homes where they want to be.

Without doubt, there is a need for long-term care for very complex needs and conditions, but we also believe with better investment in home and community supports it is quite possible, quite feasible and better for people to be able to age in place and to have the choice to do so. Instead of solely investing in the creation of more institutionalized care, we need to start talking about how we enable people to exercise their choice to stay at home as long as possible.

Mr. Tony Van Bynen: Now if the federal government leads to a process to set out long-term care standards, how might those standards help to strengthen the home and community sectors?

Ms. Christina Bisanz: I think it needs to be seen as an end situation. Long-term care needs to include a consideration of home and community supports as well, so its not an either-or option but an "and".

I think we need to look at those standards and at a way in which there could be better integration between long-term care and home and community supports. By that, I mean not just assuming, when somebody ages and has complex care needs or advanced dementia, that long-term facilities are the default. We need to look at how there could potentially be a way to support through both sectors those individuals who need the enhanced care but can still be involved and connected to their communities.

Mr. Tony Van Bynen: Thank you.

The Chair: Thank you, Mr. Van Bynen.

[*Translation*]

Mr. Thériault, you have the floor for six minutes.

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

I would like to thank all of the witnesses for their insightful testimony. Their contributions will surely help us to make important recommendations.

Dr. Champagne, thank you for your presentation, which was very clear. It was so clear that it is chilling. What you are telling us is that over the next 10 years, there will be a 10% increased risk of mortality.

There is no medical care without diagnoses. Still, when it comes to cancer, the diagnosis must come in time. Screening is therefore crucial in the fight against this disease. Yet, currently, patients who do not have COVID-19 are bearing the brunt of this pandemic, just as patients who do have COVID-19.

However, we weren't talking about it much, we weren't talking about it enough. If we want to find solutions, we still need to have a diagnosis and a clear picture of the reality. What we understand from your testimony is that the pandemic has had two effects in terms of costs. First, it requires additional, one-time costs to address the pandemic, but it will also cause further increases in system costs because of undue delays and postponements.

The underfunding was there before the first wave. We are in the third wave, and there is no guarantee that there will not be a fourth.

Are you concerned? What should be done?

● (1240)

Dr. Martin Champagne: I am very concerned.

Let's take the example of colon cancer—it always comes back to that example. If you have stage 1 disease, which is very localized, surgery will put an end to the episode. You have an 80% chance of cure, and after that, it's over.

However, if the disease has started to spread into the lymph nodes, which are like filters around the tumour, and the disease is now in stage 3, you will need additional chemotherapy for a period of about six months. There are costs associated with that, and there is certainly increased morbidity for patients, as they have to endure the effects of treatment. The chances of recovery will be less: at best, it will be 50% to 65%.

This means that a large number of patients, one-third to one-half of them, will eventually relapse and return to the health care system for other equally costly therapies that will require human resources. The physical resources exist, the hospitals exist. We can always imagine revamping hospitals, but we know that antineoplastic treatments, cancer treatments, cost tens of thousands of dollars per episode of care for a patient.

These are health care system costs that will be recurrent for many years. Relapse does not necessarily occur in the first few months after the initial diagnosis, it can occur, two years, three years, five years, or even 10 years later. This imposes a human burden on the patients, who will suffer more, but also on the entire health care system, which will necessarily have to make major investments in human and material resources.

Mr. Luc Thériault: Dr. Belanger was telling us that a colonoscopy costs $1,000. The patient who does not have timely access to a colonoscopy will end up with a chronic health problem and become dependent on the health care system over many years. You are telling us that it will not only cost a lot more to maintain the quality of life of such a patient, but it will also create other costs for the health care system. So we have to expect an increase in the cost of services in the health care system right now if we are going to treat these people. Yet we do not currently have the resources to care for them.

Dr. Martin Champagne: The already very limited resources are running out. Even during the lull we experienced between the second and third wave of the COVID-19 pandemic, we were never able to exceed the maximum activity level of 100%. As a result, we never erased the diagnostic delays that jeopardize our patients.

Mr. Luc Thériault: Currently, Quebec and the provinces believe that the chronic underfunding in health is, among other things, related to the fact that for the past 30 years, the federal government has not contributed enough to health transfer payments. Quebec and the provinces are asking for an increase, not of $0.22 but of $0.35 per dollar, which is equivalent to a 35% increase. The shortfall is therefore $28 billion. We're also asking for a 6% indexation, because we're at 3% right now. The system costs are at 5%.

During the first wave, the Prime Minister often said he would address the situation after the pandemic. Now we are experiencing a third wave. Do you think it's visionary to say that there is a before and after and that we need to invest in health care now to give the system some breathing room and care for people?

Dr. Martin Champagne: I practise medicine, not politics, but we can certainly imagine right now that without major additional investments, the health care system will not survive the financial burden imposed by the COVID-19 pandemic.

Mr. Luc Thériault: Have you evaluated the costs that will result from the lack of resources? For example, let's compare the cost of a $1,000 colonoscopy to the cost of the surgery and chemotherapy needed to treat colon cancer. How much would the costs be in the latter case?

● (1245)

Dr. Martin Champagne: In more advanced stages of cancer, each episode of care delivered over a trajectory of a few years costs several tens of thousands of dollars per year. For example, immunotherapy for lung cancer currently costs $35,000 to $50,000 per episode of care. Thus, the costs absorbed by the health care system to treat advanced lung cancer are very significant.

Mr. Luc Thériault: Do you feel that the appointment scheduling system is currently a bit antiquated? It often works through fax machines. Do you think we should also invest, as the Canadian Association of Radiologists is calling for, in a much more efficient system using cloud computing, for example, that would allow for patient self-scheduling?

Dr. Martin Champagne: These are things that could definitely make it easier to access care. A lot of hospitals are outdated.

It's also important to understand that the COVID-19 pandemic imposes physical distance. For example, when a common waiting room serves two rooms for ultrasound, two rooms for CT scans, and one room for magnetic resonance imaging, we can't proceed as we used to. We cannot accommodate 15 patients at the same time and send them one after the other to the different rooms. We have to impose a temporal and physical separation.

For example, if Luc Thériault needs a CT scan, Martin Champagne cannot be in the waiting room at the same time as him. He will have to wait. The system's capacity is therefore diminished. We do need modalities that will allow for better communication. Diagnostic means and contact with the patient have changed. Telemedicine is used a lot and many of the means put in place in a disaster situation could also facilitate access to care. Many records are not yet computerized, for example.

Mr. Luc Thériault: Thank you.

The Chair: Thank you, Mr. Thériault.

[*English*]

We'll go now to Mr. Davies for six minutes.

Mr. Don Davies: Thank you, Mr. Chair.

Thank you to all of the witnesses for being here.

I'm going to direct my questions to Don't Forget Students.

May I call you Brandon?

Mr. Brandon Rhéal Amyot: Yes, absolutely.

Mr. Don Davies: Thank you, Brandon.

I want to zero in on a few things. I want to preface by saying that I know every single Canadian has been terribly affected by the COVID crisis, but I think that seniors and young people have particularly had their lives disrupted in certain ways—I think students in particular in that regard. I want to ask you a couple of specific questions.

What would be your recommendation to the federal government in terms of the appropriate policy to handle student debt and interest payments for student loans at the federal level?

Mr. Brandon Rhéal Amyot: I think that, short term, obviously we need to get through this pandemic. We shouldn't be charging recent graduates interest and student debt payments. We paused it for the first six months of the pandemic, so I believe the federal government should work with the provinces and territories to refreeze payments to the National Student Loans Service Centre for the remainder of the pandemic. Long term, we should be looking at progressively and aggressively writing off student debt federally—the federal portion—and urging the provinces to do the same because, at this point, we have reached a critical junction in post-secondary policy and in terms of student debt. It is not in the economic interest of Canada to continue to burden people with student debt.

Particularly if we're talking about the marginalized communities in Canada—low-income students, indigenous students, women—they have a longer and harder time paying off student debt than their peers. If we're looking at this through an equity lens too, we need to acknowledge that. We should be working towards the progressive elimination of student debt, but in the short term, student-loan interest payments and debt payments.

Mr. Don Davies: Just so that I'm clear, Brandon, right now as we speak, are graduates paying federal interest on their student debts?

Mr. Brandon Rhéal Amyot: It's my understanding that a freeze on interest has been implemented or is about to be implemented. They are still making hundreds of dollars in payments a month; there's just no interest. Frankly, the removal of interest is not sufficient, not during the pandemic and not in the best of times.

● (1250)

Mr. Don Davies: Let me flip to the other side of the equation.

I think many of us who have been to university know how critical that four-month period in the summer is for your making the money that you need for tuition and to pay your living expenses through the year. I also know that there's been a significant expansion by the federal government in terms of funding the Canada summer jobs program.

What is the situation right now with employment for young people? We're in the middle of a serious third wave across this country. Are there plentiful jobs out there for students this summer so that they can go out and earn the money that they need to pay their tuition and living expenses come September?

Mr. Brandon Rhéal Amyot: Jobs for young people are not at the high they were in May 2020. The job market for young people still has not rebounded. While I acknowledge the changes or expansions to the Canada summer jobs program, a summer jobs program is one part of a larger policy that we need to implement. Frankly, I have been responsible for administering a Canada summer job at a non-profit, and I've also been on the receiving end of a Canada summer job. There are inequities that exist within it. International students are not eligible. If you're over the age of 30 and you're a student, you're not eligible. We need to be creating larger programs that capture more students and young people to ensure that people are not slipping through the cracks, especially with the way the job market is, the financial realities of COVID. Those have a significant impact on mental health and well-being. That's part of why I'm calling for the reinstitution of the CESB.

Mr. Don Davies: I don't know if it's possible, but could you give us a bit of a glimpse into the mental health of students right now? They've been particularly dislocated. People can't go to class. They're learning online. They're isolated. Can you give us a general idea of how students are feeling in this country right now and whether there are specific challenges facing them that we should know about to respond to in policy?

Mr. Brandon Rhéal Amyot: Of course. It's difficult to capture in a short answer, but from my own experience, as much as the university and the student union and other organizations and friend groups have tried to maintain a sense of community, it is not the same. That's the case across Canada, not just for students, despite the whole point of being on campus being to build a sense of community student life. That aids in our education, in our coming out of these institutions, in getting jobs and finding community and volunteering. We've lost a lot of that.

In terms of the impact on mental health, some students have been working at grocery stores and if you're a health care student, you've probably been on the front lines in some capacity. From looking at the intersections, we see that students are struggling with mental health across the board, but some students in particular are more challenged by the pandemic.

I don't have access to my cultural ceremonies as much as I did before the pandemic, and that's of course because I want to keep my elders safe, but it's not the same over Zoom. You can't exactly [*Technical difficulty—Editor*].

Mr. Don Davies: That interruption may be particularly ironic.

The Chair: Yes, I think we lost Mr. Amyot.

Mr. Davies, go ahead with one more question if you can. I'll give you a little extra time.

Mr. Don Davies: Thanks. I'll try to be quick.

It's budget day today, Brandon. It's an important day. What would you like the Prime Minister and the Finance Minister of this country to do for students if you could give them any single piece of advice? Improved Internet connections might be something.

The Chair: I think we've lost Brandon.

Is there anyone else?

Mr. Don Davies: Thanks, Mr. Chair.

I think I was pretty much near the end of my question time anyway.

The Chair: Very well. That brings us to the end of our first round of questions. We might be able to shoehorn in a quick snapper round. Would everybody be interested in one minute per party?

Some hon. members: Agreed.

The Chair: Okay, seeing no dissent, I will go ahead with Mr. d'Entremont for one minute.

Mr. Chris d'Entremont (West Nova, CPC): Thank you.

I had a great question for Brandon, but unfortunately he's not here.

Mr. D'Angiulli, my wife is a teacher. She and her colleagues have gone through a lot of instances where classes had to be shut down. Classes were not on today. There were two instances where schools had to be shut down in Halifax region.

When do you think we will see truly negative effects on our children as we start to recover from this pandemic? Will there always be a level of anxiety as we talk about pandemics or the effects of certain sicknesses, as it rolls around?

● (1255)

Mr. Amedeo D'Angiulli: I think it will be different for different age groups. We probably will see the largest impact on the younger kids who started kindergarten and grade 1, and then I would guess, if everything goes well, things will get really hot this fall at the beginning. I think the first three months or so will be hard for everybody.

The Chair: Thank you, Mr. D'Angiulli.

We'll go now to Mr. Van Bynen for one minute.

Mr. Tony Van Bynen: Thank you, Mr. Chair.

Clearly the provinces are the main players here but, Ms. Bisanz, how can the federal government help?

For example, one of the issues facing long-term care is the workforce, and while nurses are a key component, personal support workers make up the largest part of the LTC workforce. How can we address issues like recruitment, retention of staff, low wages, lack of benefits, insufficient training and inadequate infection prevention?

Ms. Christina Bisanz: That would take a whole chapter to answer, but it's a great question.

I think the biggest challenge we have right now is that there are very few people who are even interested in becoming PSWs because the wages are low, particularly so in the community sector, and that's a function of how we are funded.

As I said in my remarks, it's very difficult to compete with hospital and long-term care, and with the emphasis, certainly in Ontario, on increasing staffing and hours of care in long-term care, we can already hear the siphoning of PSWs out of community care and community support. That's very concerning.

I think from a federal perspective, we need to take a health human resource approach that also considers making personal support workers one of the priority groups for immigration, and then providing them with the appropriate support, adequate wages and working conditions that will retain them in those positions.

The Chair: Thank you, Mr. Van Bynen.

[*Translation*]

Mr. Thériault, you have the floor for one minute.

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

Dr. Champagne, thank you for taking the time to come and give us a picture of the situation. It is very enlightening.

I have a quick question. Since the first wave, have you or your colleagues been able to identify any patients who have had less treatable cancers because of treatment delays?

Dr. Martin Champagne: Every week, we see patients coming in with cancers that are more advanced than they would have been if those patients had been diagnosed when their symptoms were starting or if they had been screened.

As a result, this is, unfortunately, a daily occurrence for oncologists. This situation does not occur only in Quebec. Some provinces were less affected than ours in the beginning, in the first wave and in the second wave, but when you read the newspapers today, you see that the same scenario is happening all over Canada.

Mr. Luc Thériault: So the catastrophic situation that Ontario is currently experiencing should also have a fairly catastrophic effect on Ontario patients.

Dr. Martin Champagne: Absolutely.

[*English*]

The Chair: I see that Mr. Amyot is back.

Mr. Davies, I'll give you a bit of extra time, because you lost your witness earlier.

Mr. Don Davies: Thank you, Mr. Chair. That's generous of you.

Brandon, I want to give you a chance to answer my last question. It's budget day today. What advice would you give the Prime Minister and the Minister of Finance regarding the best measures to help students in this country?

● (1300)

Mr. Brandon Rhéal Amyot: Thank you, and I apologize for my cut-off.

I was actually about to touch on the fact that Internet has been an issue for post-secondary education across the country. Even in bigger cities, it's an issue. I have missed many a class because my Internet cuts out, as it just did here, so now I'm on mobile data.

To answer your question regarding the federal budget today, we need to go bold with our post-secondary policy on funding. During the pandemic, we need to reimplement the Canada emergency student benefit. We need to extend it to international students. We need to put a moratorium on student loan debt repayment and interest. In the long term, we need to increase federal transfers to the provinces for post-secondary grants for students to reduce the amount of debt we have to take on.

We need to increase institutional funding, and the federal government should create a federal post-secondary education committee. We are the only G7 nation with no federal oversight of post-secondary education. It is time to get bold, when it comes to post-secondary policy, so that Canada can really stand out on the world stage.

The Chair: Thank you to all the witnesses for your excellent testimony. It is most helpful to our study.

Thank you to all the members for your excellent questions. Those also are most helpful to our study.

That concludes our business for this morning.

The meeting is adjourned.