HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

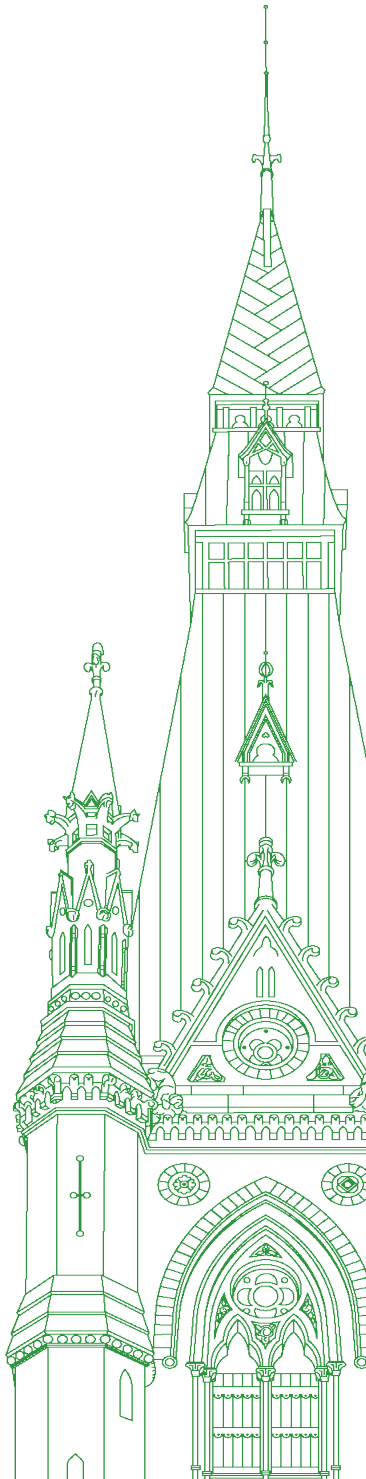
43rd PARLIAMENT, 2nd SESSION

Standing Committee on Health

EVIDENCE

NUMBER 031

Friday, April 23, 2021



Chair: Mr. Ron McKinnon

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● (1300)

[*English*]

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

Welcome, everyone, to meeting number 31 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, more specifically today, examining the collateral effects of the pandemic.

I'd like to welcome the witnesses. From the Canadian Mental Health Association, we have Rebecca Shields, chief executive officer for York and South Central Branch; from the Down Syndrome Resource Foundation, Wayne Leslie, chief executive officer; and from Focus Education Consulting, Kirby Mitchell. Moreover, from the Canadian Cancer Society, we have Kelly Masotti, vice-president, advocacy; David Raynaud, analyst, advocacy; and Stuart Edmonds, executive vice-president, mission research and advocacy.

With that, we will invite the witnesses to give a statement, starting with the Canadian Mental Health Association.

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

Ms. Rebecca Shields (Chief Executive Officer, York and South Simcoe Branch, Canadian Mental Health Association): Thank you so much. It's an honour to be here with the honourable members of Parliament and my colleagues.

I'm going to get to the point and speak very honestly about what I believe are the top recommendations you know from the news, that mental health is an emerging crisis, but I really want to talk about what you need to think about.

In the proposed federal budget, you've looked at investing critical money into mental health services, particularly looking at vulnerable populations and our essential workers. I want to really emphasize two things. You have to invest today in the hot spots; you can't go across Canada. You have to look where it's proportionate, invest directly, and think about those communities. If COVID has taught us anything, it's that, if we aren't looking at the communities that are already impacted, then it's going to explode. The fourth wave will be a mental health wave, and we know from the data from past pandemics that those essential and frontline care workers are facing PTSD, and, for those people who are impacted by PTSD, they're 40% more likely to experience major depression and at more risk of suicide. These are the people who are saving lives today, and we need to be planning for the future.

My second recommendation is around how we plan for the future. It's great that you're using well-known, renowned hospitals and research centres, but the investments have to be in local community organizations that are trusted and have built comprehensive relationships with those communities where there are vulnerable people. When you look at the disproportionate effect of the COVID pandemic on marginalized individuals and BIPOC people, we need to look at those community agencies. Why? It's because those community agencies are the ones that provide the wraparound supports where people are vulnerable. Although you might want to do large Canadian institutions, you need to get the money on the ground so that it can be realized quickly for those individuals, because otherwise their vulnerabilities are only going to increase, which is what we have seen currently in the response to the pandemic in some communities.

My last point is that we have an emerging issue around substance abuse, particularly alcohol and cannabis. We know from the data that, for people who are using cannabis, over 50% report they are using more, and there is more binge drinking in other populations, particularly populations who have children at home, so binge drinking is going up.

My third recommendation, therefore, is that you need to have a public health approach to reducing the use of alcohol and cannabis. Look, I'm in mental health and addiction, and I'm telling you people are using more, and the long-term consequences of using more are that it's going to be harder to treat people as this pandemic continues to go on. We need to use the Public Health Agency of Canada to begin talking about that message to help people reduce the amount that they are consuming.

The Canadian Mental Health Association has done a lot of research through Pollara on the mental health impacts. It is disproportionate, as you know, for women and for women with children. Rates of anxiety are going up, and rates of loneliness are increasing for women. Now one in four women are reporting great anxiety compared with one in five men. It's still not great, but particularly for women with children, we're also seeing increasing rates of loneliness, particularly in the young people 18 to 39 years old. We're seeing also the impacts of social isolation and loneliness on our seniors. More and more, these impacts of loneliness, depression and anxiety are increasing, and people are feeling worse off. People are feeling less hopeful than they ever have; in fact, 80% of Canadians report that they no longer feel that their health is improving.

I will say that there are some good news points in here. People are feeling like they know how to access care, although they are very concerned about wait-lists and whether or not, if they access care, they're going to receive it. We need to make sure that those targeted investments are made so that there is easy access to quick supports.

One support we have in Ontario is the BounceBack program that's funded through the Ministry of Health. This is telephone-based cognitive behaviour therapy specifically designed to ease stress, worry, depression and anxiety. We're trying to promote programs like that to go across Canada. These types of services to help people manage and cope are going to be essential for the broad population.

● (1305)

I want to go back in my six minutes, which is getting less now, to what I really want to emphasize again. I want to talk about post-traumatic stress disorder, particularly in our health care workers and our frontline workers. It has a disproportionate effect on our nurses and hospital staff, our paramedics, our police, our long-term care homes, our home and community health nurses, and all of the staff that are working in congregate care settings. If this is a strain on the population now, it's going to have an impact on our other health services for Canadians. What we're seeing is that those people are beginning to suffer, and burnout is on the rise. If this happens, we are going to have a strain on our health care system. Again I want to urge you to look at those investments and at how we can invest properly.

Further to my recommendations, in my last few minutes I want to talk about trusted community relationships again.

I'm sorry, but I don't know what the yellow card means. Is that one minute left?

The Chair: Yes, but you're actually at six minutes, but take another minute to wrap up if you wouldn't mind.

Ms. Rebecca Shields: I'll wrap up with a final point about about improving access to virtual care through technology. We know that virtual mental health services are making a difference, but there's an equity-of-access issue. If we can't provide equity of access to those vulnerable, BIPOC, and multi-generational populations, we're not going to be able to provide timely care, and the crisis will grow.

Thank you very much.

The Chair: Thank you.

I should have mentioned the cards. I try to put up the yellow card when there's about a minute left, although sometimes I get enraptured by someone's statement and I forget. The red card indicates that someone is at six minutes. When they see that, they should try to wrap up.

Thank you very much.

We'll go now to the Down Syndrome Resource Foundation with Mr. Leslie.

Please go ahead, sir, for six minutes.

Mr. Wayne Leslie (Chief Executive Officer, Down Syndrome Resource Foundation): Thank you very much for the opportunity to be here today.

The Down Syndrome Resource Foundation provides health and education services for children, youth and adults with Down syndrome. Based in Burnaby, DSRF is British Columbia's leading own Down syndrome provider. We're also recognized for our work supporting families of people with Down syndrome across the country.

Classified as a developmental disability, Down syndrome is a genetic condition. It results in a third, “extra” copy of the 21st chromosome, which leads to health problems, developmental delays and learning disabilities.

In Canada, 45,000 to 50,000 people have Down syndrome, so even within the country's smaller disability population it is a small group that, because of their limited numbers, is often overlooked and marginalized.

These factors combine to make them especially vulnerable and disproportionately impacted by this pandemic.

For adults with Down syndrome, COVID-19 hospitalization rates are four times that of the typical population, and death rates are 10 times higher. Their developmental disabilities also make them more likely to contract the disease, because they struggle with or can't comply with safety practices such as masking and physical distancing. In a society where safety protocols are designed to protect the general public, not our most vulnerable, the only safe solution for these individuals is extreme isolation.

DSRF believes the main reason we have not seen higher COVID-19 hospitalization or death rates in our Down syndrome community is because they've been cut off from society.

One example is the education system. Due to the risk of more severe consequences if someone, even a young person, contracts COVID-19, many students have had to stay away from school completely. Attending in person, which is essential when you have a developmental disability, is too risky because school safety protocols are just not designed to protect the most vulnerable students.

It's a very similar situation for adults with Down syndrome or other developmental disabilities in the workforce. In many cases, they have had to stop working completely. Going to work is too risky. They often perform work that simply cannot be done remotely, so they end up completely cut off from employment.

DSRF recommends that efforts to combat this pandemic and other similar health crises should be based on protecting Canada's most vulnerable first. This includes individuals or persons with disabilities, and especially those with disabilities like Down syndrome that often carry significant co-morbidities. When schools, workplaces and communities are safer for individuals with disabilities, they're safer for everyone.

The pandemic has also disproportionately impacted families who care for individuals with developmental disabilities, like Down syndrome. Now more than ever, grassroots and on-the-ground organizations such as DSRF who work directly with these families see the holes, the inequities and the fragility of Canada's social safety net that put our families more at risk.

Children with developmental disabilities, and disabilities in general, are more reliant on their families regardless of their age. Adjusting to lockdowns is far more difficult when you have children with developmental disabilities whose support systems are either disrupted or lost completely. In normal circumstances, families of individuals with disabilities also face financial inequities due to the added cost for things like critical therapies.

As one parent said to me recently, the average Canadian lives in the green, generally good zone most of the time, periodically moving to yellow or caution, or even red, critical, when they deal with a crisis. Families of individuals with disabilities in Canada live in the yellow zone pretty much all the time, so when the pandemic hit, they went to red, and that's where they've remained. This takes an immense toll.

Not surprisingly, demand for DSRF services has increased, but requests for our mental health services have skyrocketed because families now are harshly reminded of just how fragile their situation is both emotionally and financially.

The reality is that the way Canada has approached its support of persons with disabilities for years has led to the current state where these families are disproportionately vulnerable both emotionally and financially, so they're less able to withstand the extended periods of hardship like those that are being created by the current pandemic.

DSRF recommends establishing things like a federal disability benefit to start changing this. With the added pressure that families of individuals with disabilities face, it's clear why current supports and benefits are falling short.

I will finish by saying that while our disability communities have faced significant challenges during COVID-19, you can use this crisis as a catalyst to make positive and very meaningful changes to how they are treated and protected going forward.

● (1310)

I believe the well-known quote from Mahatma Gandhi perhaps sums it up best: “The true measure of any society can be found in how it treats its most vulnerable members.”

Thank you.

The Chair: Thank you, Mr. Leslie.

We go now to Focus Education Consulting.

Mr. Mitchell, please go ahead for six minutes.

Dr. Kirby Mitchell (Focus Education Consulting): Good afternoon, everyone.

Thanks for having me.

I'm representing Focus Education Consulting today. It's what I do. I'm an education consultant as well as a teacher. I'm also volunteering with the Worldwide Commission to Educate All Kids (Post-Pandemic), where I represent Canada. We currently have 50 countries involved in this commission. In our conversations when we refer to the kids who are living through this pandemic, we look at them using three buckets of schooling.

The first bucket is the physical classroom. That's the traditional classroom where kids usually spend most of their time. Then the virtual, online hybrid version is bucket two. Then there's bucket three: no longer in school.

The commission right now is focusing on bucket three, students living in that bucket where they are no longer in school. Right now the commission estimates that the number of students living in the third bucket is up to 500 million worldwide. More specifically, there are 10 million to 20 million in the U.S.; 60 million to 70 million in India; 24 million in Pakistan; three million to four million in Colombia; and here in Canada, the Institute for 21st Century Questions, the think tank connected to the commission, estimates there are 200,000 kids living in the third bucket between grades 1 and 2, which is about five million in total.

How did we come to this?

When I talk about this I try to paint the picture of a school experience pre-COVID. All of us take ourselves back, and I try to go there as well in this discussion, walking to school in the morning, taking the bus, showing up, standing in front of your school and then the bell rings. There are students who enter their classrooms for first period. Some people go to the study hall; some people go to the gym to work out and some people walk right through to the back of the school and exit. What's common, what's shared with [*Technical difficulty—Editor*] different experiences is a school space.

What we've moved away from because of COVID and the mandated restrictions is that space, the schools. Schools provide beyond just the sports and the relationships and the learning. These are commonly understood as to why kids come to school, but kids also come to school to avoid school. A huge bunch of kids come to that space and spend most of their time in avoidance and disruption and trying to find their place within a space that doesn't really welcome them.

What that allows for, however, is teachers, admin staff, anyone working in the school, friends, peers, an opportunity re-engage them because they're in a space and there are some barriers to leaving. We must understand students leave school mentally, spiritually, way before they leave physically. Online learning has made that speed of exit grow exponentially.

[*Technical difficulty—Editor*] classroom and they're in Mr. Mitchell's class. There's a tab with Mr. Mitchell's class and there's a tab a student will have for whatever former freedom they had. It could be gaming, it could be chatting, it could be exploring a new career. Now all they have to do when they're in Mr. Mitchell's class—and they don't have a relationship with me—is build walls first. For example, a student may be having a test in my class. The Internet goes down and they can't continue the test. They log back in, and because they don't have a relationship with me they feel they can't ask me for more time. Because of that they say that anxiety builds up. They say either they ask the teacher or they escape through this tab.

They close the Mr. Mitchell tab. They can't deal with that stress. They're not going to catch up. They'll never have a chance. They close it and they open that tab and they escape. That's the frictionless exit they experience nowadays because of the online space and the way the system has revisited online learning repeatedly over the last year and a half.

● (1315)

Pre-COVID, there were lots of advantages in coming to school. We had students who were engaged and who are still engaged. We had students who were “attenders”. They attended school, they showed up for class, but they really weren't really engaged. We also have the avoiders.

The third bucket is a combination of students who were avoiding and students who were on the margins, labelled as “behavioural”. Those students are often racialized—Black, indigenous, people of colour—and on the margins. They are excluded from school for behavioural reasons. Their behaviours don't follow the norm in terms of how they behave in class or how they behave in the halls. There's a slow-streaming push-out mechanism that doesn't allow them to be part of the classroom or maybe the school. They may be sent to a special school. Then there's an early exit.

That has been fast-tracked because of the easy exit due to online learning. We are seeing that grow at exponential rates. We now have 200,000 kids, and growing, in that population. Because of the recent closure, my concern is for the students that I usually work with and see walking around in school. That energy of avoidance and resistance is no longer there. It's an online space now, and you either fit in or you don't. There's no resistance. There's no place for them to sit. I don't see them in the halls and I don't see them online. I feel that even more kids, beyond those kids, are being excluded, and for various reasons.

The Chair: Could you please wrap up, sir?

Dr. Kirby Mitchell: Yes.

There are students who have ELDs or are learning English. There are students who have anxieties built up. There are students who are struggling with the new learning model, which is online learning. We're losing those students. There's also the “rich kid” paradox, where kids who are traditionally doing well and have all the resources are leaving school as well.

My concern is that with this last closure, it has been devastating. We're seeing it not only locally across Canada but also globally with ongoing closures and limitations due to the pandemic restrictions.

Thank you.

● (1320)

The Chair: Thank you.

We'll go now to the Canadian Cancer Society.

Will Ms. Masotti be reading the statement?

Dr. Stuart Edmonds (Executive Vice-President, Mission, Research and Advocacy, Canadian Cancer Society): I will start, and then I will hand it off to Kelly halfway through.

The Chair: Absolutely. Go ahead.

Dr. Stuart Edmonds: Good afternoon. Thank you for the opportunity to present today, especially given that right now it's daffodil month, or cancer awareness month.

Unfortunately, cancer does not stop being a life-changing and life-threatening disease in the middle of a global pandemic. More than a million Canadians are living with and beyond cancer. While the impacts of COVID-19 will be felt for months and years to come, so too will the needs of people with cancer and their caregivers change as the impacts of the pandemic evolve.

While most provinces postponed elective surgeries in some form or another during the first wave of the pandemic, some have fared better in addressing this backlog. In certain areas, the surgical backlog continues to grow. According to data from the Canadian Institute for Health Information, during March to June 2020 most people with conditions requiring life-saving and urgent surgery received care. That said, nationwide, cancer surgeries were 20% lower compared with the same time period in 2019.

In Ontario nearly 36,000 fewer cancer surgeries were performed in the spring of 2020 as compared with the year before. Going into the third wave of the pandemic, Ontario had an accumulated a total backlog of over 200,000 surgeries across all categories, with some cancer surgeries again being postponed. In Quebec there were 6% less surgical procedures in oncology performed compared with last year. That represents around 2,200 surgeries.

Through trends in inquiries to our information and support programs and ongoing national surveys of people facing cancer, and their caregivers, we have a sightline into the continued impact that disruptions to care are having on people affected by cancer. A July 2020 CCS patient survey found that almost half reported having their cancer care appointments postponed or disrupted during the first wave of the pandemic. We are concerned that the third wave in parts of Canada will result in more disruptions to cancer care.

The severity of surgical backlogs must not be underestimated. Results of a study involving Canadian cancer patients published in the British Medical Journal suggest that people whose treatment for cancer is delayed by even one month have about a 10% higher risk of dying. Risk also increases the longer it takes for treatment to start.

I will now turn it over to Kelly Masotti.

Ms. Kelly Masotti (Vice-President, Advocacy, Canadian Cancer Society): Along with the immediate impact that COVID is having on cancer surgeries and treatments, we're concerned about a tsunami of cancers yet to be diagnosed. Since the start of the pandemic, global cancer diagnosis has seen a dramatic decline. It's estimated to be at about 40%.

In Ontario, from March to December of 2020, nearly one million fewer cancer screening tests were performed compared with the same period in 2019. In Alberta, more than 170,000 tests, including an estimated 40,000 mammograms, were suspended for two months starting at the end of March.

[*Translation*]

In Quebec, recent estimates predict that more than 5,000 Quebeckers may have cancer without having been diagnosed.

[*English*]

Screening programs help find cancer earlier, when it is easier to treat and outcomes are better. We are concerned that the disruption in screening programs will lead to cancer cases being diagnosed or treated too late. We must continue to encourage people to get screened and cancer systems must plan for the disruptions caused by COVID-19.

COVID-19 has also interrupted oncologic care across the spectrum of cancer care. A survey from the Institute of Cancer Research found that cancer researchers fear that advances for patients could be delayed by almost a year and a half because of the effects of the COVID-19 pandemic.

In Canada, clinical trials were affected to various degrees across the country. These trials can provide access to promising therapies for people with cancer. In many cases, patient recruitment was paused provincially due to assessment of available staff, health care resources and patient safety.

COVID-19 has also undermined public health efforts at disease prevention and health promotion. For example, local public health units have shifted staff and resources to work on COVID. A good example here is tobacco, with large numbers of public health staff who work on tobacco enforcement and smoking cessation redeployed to the COVID-19 response.

Through all of this, governments must lead the response with a comprehensive and coordinated plan of action to address the future burden of cancer in Canada. The response must include all levels of government, the public, charitable and private sectors, academics, policy-makers, politicians and citizens.

The impacts of COVID-19 on cancer control, as well as the increase in the number of cancer cases due to an growing aging population, highlight an increased need for health care services and providers, infrastructure, caregivers, family support and other types of programs and services.

There will be a need for more support for the increasing numbers of cancer survivors. Focus is required on the planning of cancer control programs for prevention, screening, early detection, treatment and palliative and other medical care. Research is needed to help plan for this increase in cancer cases and to identify more solutions for effective treatment and supportive care for those with cancer.

● (1325)

[*Translation*]

I'd like to thank you for the time you've given us today. We will be happy to answer any questions you may have. Thank you.

Thank you.

[*English*]

The Chair: Thank you.

We will start our questioning now.

Mr. Barlow, please go ahead for six minutes.

Mr. John Barlow (Foothills, CPC): Thank you very much, Mr. Chair. Thank you for everyone's testimony today.

I want to start with you, Ms. Shields. It's good to see you again.

I had a phone conversation a couple of days ago with a constituent who called. It was a 19-year-old girl who was very upset. Her 20-year-old brother had committed suicide a few weeks ago. He was an apprenticing electrician who was laid off as a result of lockdowns. He had found a job in a restaurant, but lost that when lockdowns were extended. The isolation got the best of him. He couldn't handle the depression and he took his life.

I know that many of us in this Zoom meeting, as members, have had similar conversations with constituents. This is becoming an all-too-common occurrence with many of us—having these types of calls to our offices from people who are completely distraught. This suicide has certainly devastated this family.

I had a virtual town hall with a lot of business owners and community leaders with similar stories of depression, anxiety and suicides.

We spoke late last year. You were mentioning a recent study in December that showed that 40% of Canadians had said their mental health had deteriorated. We saw the numbers of the substance abuse and suicides up. That was in December.

You've talked about a mental health third and fourth wave. I've never heard it put that way, but that's very disconcerting. As these lockdowns and restrictions go on, what do you anticipate the impact is going to be on Canadians' mental health?

Ms. Rebecca Shields: We know from previous pandemics that it is going to increase. Let me explain the why of that. You're right in the sense that uncertainty and vulnerability are disproportionately impacting people. For example, communities that have precarious employment just like that.... I'm so sorry about that young individual. That economic stress and uncertainty can obviously lead to depression, anxiety and, of course, the risk of suicide. That's going to happen. We know that from past pandemics. We saw that from SARS. We saw that there are populations that are at a higher risk than others.

That's what I was trying to get at, the people who are at high risk. They are essential care workers, whether it's our hospital staff or the people who have been on the front lines. They are the people who have been impacted by COVID, and are absolutely at high risk. There are communities that have been highly impacted by COVID. I mentioned BIPOC people, so people who are precariously employed or have lost employment, or on the front lines, or who have suffered from COVID are at risk.

There is a general increase in anxiety and depression. Women, women with children, families with children, they are all tending to have higher levels of anxiety. We also have youth, and people have been touching on that. My colleague, Mr. Mitchell, was touching on the impact to young people, and the increase in anxiety.

What is that looking like in terms of impacts of social isolation? When social isolation becomes loneliness, that turns into chronic loneliness. When we get into chronic loneliness, that's where we have outcomes that are the equivalent of smoking 15 cigarettes a day, and my cancer colleagues will understand how serious that is.

So, you're right. This is what we are preparing for, which is the fourth wave. What are we trying to do? We're trying to increase immediate access to care, but we have to do it in two formats. First and foremost, we need to be planning and training early. I need people on the ground today, so that they're there tomorrow. I can't wait. We can't wait to have trained workers in language or culturally-specific communities available for people, because if they have to wait, the risk of suicide increases.

What we know, and it's really important to understand, is that somebody could go into a hospital and be discharged. The most at-risk period for suicide is that 30-day period following discharge from a hospital. We must have programs that are available right away to transition people, and that's where you need to bolster the communities. You need trusted community partners that can begin to wrap around supports for these individuals.

Organizations like ours provide counselling, employment, housing and food security. When you look at what we can do in terms of supporting navigation and community supports, we have to work with our hospitals and our acute care centres to stabilize people, but then we have to provide that ongoing care in transition. I know I'm talking to people who know and understand this.

You've got the national suicide prevention strategy starting. It's going to take a while, but my recommendation is that the $50 million investment has to come in immediately, and you've got to put it into the communities that are hardest hit.

● (1330)

Mr. John Barlow: I want to build on what you said about having people on the ground immediately. I'm sure you're talking about the PTSD within frontline health care workers. How frustrating is it for them not having...? What I've heard is the concern about stops and starts: We're going to have vaccines; we're not going to have vaccines; we're going to have rapid tests; we're not going to have rapid tests.

How much of an impact has that had on the mental health of health care workers, of not having more of a clear path to accessing vaccines and rapid tests?

Ms. Rebecca Shields: Uncertainty is a trigger for all of us. Uncertainty leads to higher stress. We're dealing with people who are in acute stages of stress and chronic stress. What that means is that they're at a higher risk of trauma, which means they're at a higher risk of depression. Trauma and depression may lead to suicide. We're really trying to build out trauma-informed and trauma-specific services for our communities.

The Chair: Thank you.

Mr. Van Bynen, go ahead, for six minutes.

Mr. Tony Van Bynen (Newmarket—Aurora, Lib.): Thank you, Mr. Chair.

Thank you to all of our witnesses for joining us today and sharing their experiences with and concerns about the pandemic.

It's a great honour to be able to welcome a constituent to the committee and have their voice reflected in the work we do here, so I will be directing my questions to Rebecca Shields from CMHA York Region and South Simcoe and acknowledge that she serves a population of over 1.2 million people across more than 10 different municipalities.

Firstly, Rebecca, I want to thank you for the many projects that you have undertaken in conjunction with community partners like York Regional Police or Southlake Regional Health Centre. You have put together teams to respond to situations that are urgent and often call for a police presence, but also will have the presence of your team so that you can respond effectively to these.

Last fall I moved a motion in this committee to study the impacts of COVID-19 on mental health and the well-being of Canadians. That was well more than four to five months ago. I referred to mental health as being the third pandemic, and it has become the fourth pandemic now, and I very much understand what your concerns are.

You supported the call for the study and said that to achieve full economic and social recovery, we must understand the true impacts of the pandemic on the mental health of Canadians. I completely agree with you, and I thank you for that support.

I know it's critical to invest in comprehensive community-based research to understand the impact and to identify the most promising strategies. You made some references to hot spots. While the scope and the scale of this committee is more broadly countrywide, how would you suggest we go about trying to identify the community-based strategies?

Ms. Rebecca Shields: It is really true that each province and territory addresses health care differently. Mental health affects us all, but we do have unique community needs. This is what we're seeing.

At the very basic level, we understand that COVID, which is a health care issue, has impacted different communities differently in disease with completely different impacts and outcomes. What we're learning from the research on COVID is that we have to translate that into local neighbourhood-based research. We can pull data from our hospitals around, and we do, and share that information, but what does it mean to have population-based research?

There are many components of that, and there are some great leading practices coming out of, for example, the Slaight Family Centre for Youth in Transition at CAMH, where they are looking at youth-specific research. One of the things they are sharing in co-design and co-participatory research is how COVID is impacting youth differently. Not all cohorts of youth are the same. Some might be thriving at home, and, as my colleague, Mr. Mitchell, said, some are not, and how do we understand and address that so we can be designing and delivering services that are effective so that we can take a health equity approach.

In community-based research what we want to have is the lens of health equity across that research, and then to be able to co-design and deliver services that are effective for those communities.

The research must be embedded in community, it must be co-designed, it must take into account a population ethnocultural lens so we can have a health equity approach, as well as addressing other cultural-specific groups like my colleague, Mr. Leslie, said: those with developmental disabilities, the 2SLGTBQ, and our indigenous communities and our Black communities.

All those communities have their own needs, so as we design and break down research, we need to not just stay at a global level, but to really take the investment to dig a little bit deeper because we know that responses must be designed to meet specific needs. The pandemic has shown us this. If we do not take in the specific populations, they get left behind, and without that health equity lens, they are disproportionately impacted.

We can do better, and that's what I would like to see us do.

Thank you again for your question. I hope I responded.

● (1335)

Mr. Tony Van Bynen: Thank you.

The access to mental health resources and supports has been key during this pandemic for many Canadians. Our government has stepped up with the Wellness Together Canada and the Kids Help Phone. I know that CMHA had its own telephone-based supportive counselling.

Was this service in place pre-pandemic? If so, can you elaborate on the changes, or the differences between before and during the pandemic, that your staff have noticed?

Ms. Rebecca Shields: First and foremost, obviously as did all mental health agencies, we switched to, as much as possible, virtual care. That allowed access to people. I mentioned that we need to ensure equity of access. We offered specific counselling for front-line health care workers and we offered a variety of walk-ins. We really tried to take away any sort of wait-list, so we offered a lot of walk-in or call-in services in order to address immediate needs. We expanded the access to the BounceBack program through an investment so that we would not have anybody waiting for that over-the-phone cognitive behavioural therapy that addresses—it's an evidence-based form—worry, low mood, stress and anxiety.

Those are the types of investments that we made to quickly address population health, and then we did deeper dives into specific vulnerable populations like our homeless population.

I see the red card, so thank you very much.

Mr. Tony Van Bynen: Thank you for all of the good things you do for our community.

The Chair: Thank you, Mr. Van Bynen.

[*Translation*]

Now it's Mr. Thériault's turn.

Mr. Thériault, you have six minutes.

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

First of all, I'd like to thank all the witnesses for helping us understand the collateral effects of the pandemic.

I'll begin by addressing the Canadian Cancer Society representatives.

When we began our study on the pandemic, at the very start of the first wave, many witnesses told us that chronic underfunding of health care systems had weakened our systems and that it would have catastrophic effects in the future. At the time, we had two hopes: to find a vaccine quickly and to ensure there was only one wave. We're now in the third wave.

Your comments echo those of Dr. Mélanie Bélanger of the Association des gastro-entérologues du Québec and Dr. Martin Champagne of the Association des médecins hématologues et oncologues du Québec. These specialists have told us that the COVID-19 pandemic has claimed and will claim other victims, namely patients who don't have COVID-19.

We know that the fight against cancer is a fight for early intervention. If you can no longer detect cancer early enough, you're going to have an explosion in costs and increased risk of mortality. Experts have even gone so far as to tell us that the collateral effects of the pandemic would be felt, particularly in the area of cancer control, for 10 years, which would increase the mortality rate by 10% more than the annual rate.

The government didn't include anything in its budget to help health care systems, even though the provinces and Quebec were calling for a catch-up of 35 cents, rather than 22 cents, per dollar. We could have invested $28 billion, either gradually or in full. But there was nothing. No announcement was made. Nothing is planned for the next five years.

That can change, but the political decision not to intervene to help health care systems recover, to allow them to care for patients and to ensure predictability makes no sense from a health perspective.

If you had to convince the Prime Minister to change his mind today, what would you say to convince him to put money back into the health care system on a recurring and predictable basis, particularly in the area you're concerned about, which is cancer control?

● (1340)

[*English*]

Dr. Stuart Edmonds: Obviously, we share the concerns that you expressed about the future state of cancer control over the next few years. Certainly there are things that governments across the country can do right now in maintaining surgery procedures and also in promoting screening programs as safe programs to encourage patients to make the most of the programs and to get checked out when they have concerns.

I'll turn it over to my colleagues Kelly and David to see whether they have any comments about how we'd bring this up to the federal government.

[*Translation*]

Mr. David Raynaud (Analyst, Advocacy, Canadian Cancer Society): Thank you for that question, Mr. Thériault.

Basically, we can look at this issue from two main perspectives.

The first is how to deal with the impact of the pandemic in the short and medium term. The different health care systems across the country will certainly need to operate at higher capacities than they did prior to the pandemic to make up for the backlog in surgery but also in cancer screening. To do this, they will certainly need new resources. Increasing capacity includes hiring staff, upgrading equipment and creating new infrastructure. So new resources are needed for the different cancer departments across the country.

Then we can also look at the issue in the medium and long term, considering the aging population and the increase in the number of cancers. It's often said that nearly one in two Canadians will be affected by cancer. A concerted approach with a long-term vision and predictable funding is needed to address these future challenges so that Canadians can enjoy the best possible quality of life and health care systems can reduce their costs, including through better prevention and screening.

We certainly encourage the federal government to take a concerted approach involving all governments, charitable organizations, the private sector, researchers, and even citizens, in order to find the best possible solutions to develop this long-term vision and predictability.

● (1345)

Mr. Luc Thériault: Dr. Bélanger said that there were 150,000 patients waiting, 63% of whom were out of time, which is about 97,000 patients. She said that a colonoscopy costs $1,000, but if it isn't done in time, the patient is at risk of developing cancer, which can become a chronic disease creating not only diminished quality of life and even risk of death, but also an explosion in health care costs.

So a decision from an allegedly economic perspective not to invest in health care right now is to perpetuate the explosion of costs and reduce the ability to treat patients properly, improve their quality of life and save the health care system money now. Do you agree?

Mr. David Raynaud: Is it okay to give a short answer?

Mr. Luc Thériault: Yes, absolutely.

Do you agree with me?

Mr. David Raynaud: I agree with the general idea, yes.

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

The Chair: Thank you, Mr. Thériault.

[*English*]

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

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you, Mr. Chair, and thank you to all the witnesses for their excellent testimony.

Mr. Leslie, I'd like to direct my questions to you, if I may. I know that you have been a champion for raising the particular vulnerabilities of people with Down syndrome, and particularly the need to make sure they're not forgotten in terms of prioritization for vaccination.

I'm wondering if you could expand on the reasons for your call and, in particular, if you have any comments on the federal guidelines on vaccine prioritization and whether you think they should be amended specifically to recommend priority access to people with Down syndrome or other developmental disabilities.

Mr. Wayne Leslie: DSRF is primarily a service provider, but this issue very quickly became a pressing issue for our community. We took the opportunity to use our leading voice to assist our community, and a population, as I mentioned, that's often overlooked, to raise attention to the fact that it's a uniquely vulnerable population. Even within the general developmental disability community, it's a smaller subset because of the comorbidities that go hand in hand with the genetic condition that is Down syndrome. As I mentioned, they're four times more likely to be hospitalized and 10 times more likely to die if they contract COVID-19, and because of their associated disabilities they're increasingly more likely to contract the disease.

The challenge we identified very early on was that the focus was simply on people who were dying, understandably, and that's who needed to be protected. But we quickly tried to shift the focus to the fact that if we didn't do something to prioritize uniquely vulnerable groups, and if they weren't unusually isolated in a way that many families would say, as it extended, bordered on cruelty, they would eventually be the next victims in a second, third or fourth wave. The only reason, again, we haven't seen that is they've been extremely isolated. We need to shift how we are viewing these priorities.

One of the key issues we've had is that despite Down syndrome being a very well known but smaller disability, there's often this gatekeeping that comes up. Persons with disabilities find this problem a lot, where they have to do an unusual amount of proving that they have a disability. There were unique vulnerabilities that we felt, at the beginning, should have been easily identified by the medical community and national leading organizations that focus on immunization priorities, and a recognition that some of the larger questions were more complicated. I would describe it, frankly, as low-hanging fruit; and Down syndrome would be one of those disabilities that could have easily been identified long before it was. The community should not have had to fight for the vulnerability that was so obvious, not just to people in the communities themselves, but in the broader community as well, generally speaking.

Mr. Don Davies: I'm very familiar with the wonderful work that DSRF does for our community, specifically focused on people living with Down syndrome; but I also happen to know that DSRF activities and supports extend beyond that to the broader developmental disabilities community at large. I'm just wondering if the comments you made specifically about those living with Down syndrome are more broadly applicable to people living with diverse needs typically. What can you tell us about the impact of COVID on the broader developmental disabilities community as well?

● (1350)

Mr. Wayne Leslie: Thank you.

It's a very good question. The simple answer is that the same things we're talking about extend through the broader community. I'll touch on my colleagues from the education, from the cancer, and from mental health sectors. The important thing to remember, whether you're talking about those with a developmental disability like Down syndrome, or other disabilities like cerebral palsy or autism is that along with their disabilities, they have mental health issues, health issues, cancer and education issues. They're the vulnerable of the most vulnerable. This cuts across all of the populations, which underscores one of our key recommendations.

We understand in a priority crisis management, putting-out-a-fire situation, why you need to focus your efforts on people who are literally dying. But in taking the opportunity to think further forward, we need to approach the recommendations from the perspective of: here's an opportunity to make sure we're taking care of the most vulnerable.

Persons with disabilities, as a larger group, are not an insignificant part of our population. We need to start emphasizing the need to take care of them, whether it's federally, provincially or locally. Down syndrome has a unique set of comorbidities that ramp up the vulnerabilities in health. But in in everything we're talking about with Down syndrome, we share a lot of the risks and vulnerabilities across the entire development disability perspective.

Mr. Don Davies: This may be an unfair question, but to help us get a bit of a quantitative scope on this, I'm wondering if you know roughly what percentage of the Canadian population would identify as having a developmental disability, generally speaking.

Mr. Wayne Leslie: I don't have the exact number. Part of that is because, respectfully, the Down Syndrome Resource Foundation works more directly with, obviously, Down syndrome. But it would be a significant part of the population when you consider the simple fact that it includes those who are on the autism spectrum, which now we've recognized, after years of research—and the medical data backs this up—that people we thought had no development disability, do in fact do. I don't have an exact number, but I don't think I would be exaggerating by saying it is significant.

Mr. Don Davies: Thank you.

I see that I'm getting the red card.

Thank you for your answers, Mr. Leslie.

Mr. Wayne Leslie: Thank you.

The Chair: Thank you, all.

That brings our questioning to a close for this panel.

Hon. Michelle Rempel Garner (Calgary Nose Hill, CPC): We actually have eight minutes left, Mr. Chair. Can we have a brief second round?

The Chair: Sure. We'll have to shoehorn that in. Do we want to have a one-minute round for every party?

That being the case, we'll go with Ms. Rempel Garner.

Go ahead for one minute.

Hon. Michelle Rempel Garner: Thank you, Mr. Chair.

I just want to direct an additional question to Mr. Mitchell.

I read a CBC article in which you were quoted talking about the difficulty in reaching students in virtual class.

In the time I have remaining, could you expand on the forecasted impact you think this is going to have on the high school dropout rate across the country?

Dr. Kirby Mitchell: The most recent closure, I believe, is having a cumulative effect on students. With the first closure, there were some students who resisted and stayed in the system, but some left. The second time a few more left the system. At this point, I believe—as with teachers in the system—they're tired. They're tired of the promise of being back in school versus looking forward and seeing an actual end to this.

I see the summer coming and the weather changing, and especially since in high school we have the quadmesters—and there's a quadmester starting next week—I'm concerned that this may be an easy exit, as I was saying, for a lot of students to kind of disengage or leave school in the upcoming weeks.

So every day counts. Every day we're going to lose 100 to 1,000 kids as they feel less engaged and less connected to what they formerly knew as school, family and community.

● (1355)

The Chair: Thank you, Ms. Rempel Garner.

We'll go now to Dr. Powlowski.

Please go ahead for one minute.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): I have a question for Mr. Mitchell as well. I certainly understand what he's talking about. I have two little kids over there online as we speak.

What can we do right now to help kids to make sure they stay in the system?

Dr. Kirby Mitchell: I want to invite everyone to our commission's meeting. We're having one next Friday. It's a Canada-wide summit at which we're going to come up with a plan. Basically it's all hands on deck.

We're going to try to look at the students who are living in the "third bucket" and, over the summer, re-engage them, reconnect with them and revitalize them. By September, all teachers should be vaccinated. We're hoping we can have a transition informed by what they knew from the previous system, what they know from the current system and what they want moving forward.

It's a child-informed process, along with the experts in the building, but we had our chance. Let's see what the kids want now.

In September we hope there will be a place that's welcoming. It could be as easy as having a welcomer at the door to say, "we want you back." We want it to be that granular.

Mr. Marcus Powlowski: Send us the link.

Dr. Kirby Mitchell: I'll send you the link for sure.

The Chair: Thank you, Dr. Powlowski.

[*Translation*]

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

Mr. Luc Thériault: I'd like to thank the Canadian Cancer Society representatives. We talked earlier about waiting lists. So in this case, we're talking about patients who are already known, but there are also invisible victims right now. Cancer prevention involves screening.

In your experience with the prevalence and development of cancers, how many invisible patients—the ones who aren't talked about, but who are nevertheless victims of this disease—do you currently estimate are affected each year?

[*English*]

Dr. Stuart Edmonds: David, would you like to take this?

[*Translation*]

Mr. David Raynaud: Thank you again for your question.

It's difficult to put a number on it because every health care system is different and the activities that have been offloaded aren't the same everywhere. That said, we're probably talking about thousands of people with undiagnosed cancer. In Quebec alone, the ministry estimates that about 5,000 people are in this situation.

One study has shown that this could lead to 8,000 to 10,000 deaths over the next five years in Quebec alone. This is in addition to the ones we already have.

Mr. Luc Thériault: Thank you.

The Chair: Thank you, Mr. Thériault.

[*English*]

Mr. Davies, please go ahead, for one minute.

Mr. Don Davies: Mr. Leslie, if you could give your best recommendations to the federal government on how it could best promote the inclusion of people with Down's syndrome in society, what advice would you give?

Mr. Wayne Leslie: In simple form, pay more attention to them. I'll again use the Down syndrome community as an example. We recognize that federally there might be challenges with making attention to this granular enough, but this is a good example of how vulnerable groups, because of their size.... Proportionately speaking, even the larger disability community population is still smaller relative to the size of the overall population, so you need to pay more attention.

To be frank, this needs to be more than lip service. It needs to be more than just political solutions. We need to be thinking about how to bridge the gaps. Even though DSRF and I recognize that a lot of the issues we're talking about are under provincial jurisdiction, there's a role to play federally. There are opportunities to create partnerships and leverage.

A good example of that is some of the funding rolled out as part of the emergency response, which DSRF was able to leverage through United Way. It helped us support the development of mental health programs. While those are great, the risk we have now is that they're short term. They're emergency. They will go by the wayside, we expect, at some point, and then you have those gaps. Some of my colleagues spoke to them.

There are opportunities and roles to play, but this is the catalyst we're talking about. You can use what you're learning through this particular crisis to really draft a better way of supporting persons with disabilities in Canada, in general and in the future.

● (1400)

The Chair: Thank you, Mr. Davies.

Thanks to the witnesses for sharing your time and expertise with us here today. It's most helpful to our study.

With that, we will suspend and bring in the next panel.

We are suspended.

● (1400)

_____(Pause)_____

● (1400)

The Chair: The meeting has now resumed.

Welcome back to meeting number 31 of the House of Commons Standing Committee on Health. The committee is meeting to study the emergency situation facing Canadians in light of the COVID-19 pandemic. More specifically, today we are examining the collateral effects of the pandemic.

I'd like to welcome our witnesses. As an individual we have Dr. Gary Bloch, family physician at St. Michael's Hospital and Inner City Health Associates, and professor at the University of Toronto. With the Canadian Medical Association we have Dr. Ann Collins, president, and Dr. Abdo Shabah, Quebec board member and French spokesperson. With the Canadian Federation of Nurses Unions we have Pauline Worsfold, secretary-treasurer. Finally, with The Mustard Seed we have Mr. Stephen Wile, chief executive officer.

Thank you all for attending today and for sharing your time with us.

We will now start witness statements, with Dr. Bloch.

Doctor, please go ahead, for six minutes.

Dr. Gary Bloch (Unity Health Toronto and Inner City Health Associates, As an Individual): Thank you so much.

Good afternoon. I'm a family doctor, a professor at the University of Toronto and a senior fellow with the Wellesley Institute. I have experience in social policy development as a member of Ontario's income security reform working group.

Over the past year, I have spent most of my working hours on the medical frontlines of the pandemic in my clinics at St. Michael's Hospital and the Good Shepherd homeless shelter, in a COVID-19 homeless recovery site and recently at a COVID-19 vaccination centre for indigenous people in Toronto.

This infectious disease pandemic has been challenging, but every day I battle social pandemics. I work with communities that are disproportionately affected by adverse social conditions, including poverty, homelessness and systemic injustices caused by racist and colonial social structures and policies. The scientific evidence is powerful. These social pressures have a massive impact on health, including higher rates of chronic and acute illness, adverse childhood outcomes and death.

In COVID-19, the communities I work with have faced greater hardship than most. This infectious disease pandemic, placed on top of the long-standing social pandemic, has created what is termed a “syndemic”, a synergistic pandemic in which the spark of COVID-19 has ignited the tinderbox of social inequity built into the structures, policies and institutions of our society.

We have known since the first months of the COVID-19 crisis that the people getting sick and dying live in poverty and without adequate housing, work in high-risk frontline jobs without adequate employment protections and are racialized, disabled, women, indigenous, and, more often than not, impacted by intersections of multiple identities.

I ask you to urgently call for health, public health, and social resources to be redirected to neighbourhoods and communities with the highest burden of illness and with the fewest protections. This includes extending emergency income benefits, guaranteeing employment supports like paid sick days and facilitating access to health supports such as a safe supply of opioids.

Deeper structural changes to our health and social systems will be required to prevent this situation from recurring, and I have three recommendations for this committee.

First, strengthen social support programs to provide a foundation for health. This week's promise of a national child care program is an important step. I suggest that this committee examine income support programs to ensure that all Canadians have access to an adequate income to attain and maintain good health. This could include extending basic income programs beyond those currently in place for seniors and children, with particular attention to the needs of people living with disabilities, indigenous people and others who face historical and structural barriers to living above the poverty line. I also suggest that this committee call for a commitment to end homelessness through increased funding for affordable and supportive housing and housing first programs.

Second, collect data to make social pandemics visible. We must improve social disease surveillance systems. To properly understand health and social outcomes, we require access to disaggregated data on race, ethnicity, income, disability, housing status and other key determinants of social inequity. Public institutions and community agencies should be directed and supported to gather, analyze and report on social data on a community and individual level. I suggest that this committee demand specific health and social outcomes targets for those who have been socially marginalized, with regular reporting and accountability to those targets.

Third, empower those who have been most impacted by adverse social conditions to lead these changes. I have been giving vaccinations at the Auduzhe Mino Nesewinong clinic, a program created and governed by indigenous people. Using their knowledge and community connections, they have provided extensive services to an urban indigenous community that has long been hidden from view.

● (1405)

I suggest that this committee advocate for this approach, which is often called “nothing about us without us”, to be replicated for other projects and other communities, putting those who are most impacted by inequitable social policies in the driver's seat of efforts to redress those inequities. These changes will set the foundation for a recovery that aims to address the disastrous inequities that have characterized the COVID syndemic.

Thank you.

The Chair: Thank you, Doctor.

We'll go now to the Canadian Medical Association. I believe Dr. Collins will start.

Go ahead, please, for six minutes.

● (1410)

Dr. Ann Collins (President, Canadian Medical Association): Thank you, Mr. Chair.

It's my honour to appear before you today. My name is Dr. Ann Collins. I am a retired family physician. I taught family medicine. I ran a full-time practice. I've served with the Canadian Armed Forces, and I've worked in nursing home care. Just yesterday, I was called back into service to administer much needed vaccines to people in my rural home community.

Mr. Chair, I am honoured to appear before you at this time in the pandemic representing the physicians of Canada and the people they care for. I am joined today by my colleague, Dr. Abdo Shabah, CMA board member and emergency physician serving on the front line during the pandemic in Quebec.

As president of the Canadian Medical Association, I am gravely concerned about the state of the pandemic in Canada today. In particular, in hotspot regions where we are facing extreme circumstances, I applaud the federal government for its unrelenting leadership and unprecedented action in leading our national response.

The pandemic has been unrelenting in challenging the physicians and health providers on the front lines, and the third wave is hitting hard. The CMA is deeply concerned about the toll COVID-19 has taken on the people who will steer us out of this health crisis. Emergency doctors are working 12-hour shifts and then being required to work another four hours, day after day. Fatigue and anxiety are high, threatening burnout, yet there is no relief in sight.

Medical professionals are being trained on critical care triage protocols, which may be enacted to respond to the lack of resources. If enacted, physicians will be in the untenable position of making the difficult life-and-death decisions about who gets care and when. The moment we have dreaded and feared, when the pandemic's grip is surpassing resource capacities in some regions, is here.

The CMA implores provinces and territories to continue to act in the spirit of collaboration to ensure that our resources are deployed where they are needed. We must work together for the common good to prevent loss of life wherever possible. Some areas of risk have already benefited from the aid of resources shared by the premiers—most important today is critical care staff. To call these actions laudable is an understatement. The CMA commends the federal government for its leadership in encouraging and facilitating this deployment of national resources.

Canada's recovery is contingent on the recovery of our health system. We vigorously applaud the recent commitment of $4 billion to resolve the backlogs of the first and second waves. I cannot stress too profoundly the incredible urgency for Parliament to pass Bill C-25 without delay.

Still, more is needed. Today, five million Canadians do not have access to a family doctor or a family care team. That's 13% of the country. If our health care systems are a house, primary care is the front door. The drafts are increasing. There's no security when the front door is off its hinges.

Primary care is affordable, it fosters equity and it will be the cornerstone of health care supporting the people of Canada through and out of the pandemic. Expanding primary care will help ensure every single Canadian has access to a family doctor. The right to access health care must not be subject to our status or postal code. Every marginalized and susceptible person in Canada deserves the attention of a primary care team.

Our nation has never been in more dire need of health security. The CMA appeals to Parliament to deliver this critical health care resource. There's still time. The pandemic has exposed the weaknesses, the shortages and the lack of capacity of Canada's public health care systems. We must begin to chart the course in reimagining public health and health care. The long-term mental health impact of COVID-19 on frontline health care workers is coming. We must prepare for it.

● (1415)

All of this will require a commitment to increased and sustained funding from the federal government. The CMA welcomes the Prime Minister's pledge to engage the provinces and territories in a continued and collaborative plan to address the future of our health systems.

The financial commitments the federal government has made to support Canada's pandemic response are exemplary. Investments to date will improve lives. They will save lives. But there are still some missing steps that lie before us. Completing them will allow all Canadians an equitable opportunity at health security. Completing them will sustain our frontline health care workers in the fight they face today and in the care they must provide in the future.

In conclusion, Mr. Chair, let me thank the committee for the invitation to share the convictions of Canada's physicians. The CMA and its 80,000 members will be there to fully support the government in addressing the stability of Canada's health systems.

Thank you.

The Chair: Thank you, Doctor.

We will go now to the Canadian Federation of Nurses Unions.

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

Ms. Pauline Worsfold (Secretary-Treasurer, Canadian Federation of Nurses Unions): Thank you.

I want to acknowledge that I'm speaking to you from Treaty 6 land here in Edmonton, Alberta. I give thanks to the fore peoples taking care of the land prior to our arrival.

My name is Pauline Worsforld and I'm a registered nurse. I'm here today to speak on behalf of Canada's nurses.

I serve as secretary-treasurer of the Canadian Federation of Nurses Unions, CFNU, which represents approximately 200,000 nurses and nursing students across the country. This is an elected position, and I've held it since 2001. I also work as a staff nurse in the post-anaesthetic recovery room at the University Hospital in Edmonton. In fact, I got off work this morning at seven o'clock, and I have been requested to work overtime, from 7 p.m. to 11 p.m. tonight, ahead of my next night shift.

As a registered nurse for 40 years, I can speak first-hand of the collateral effects of COVID-19 on our health care system and the people within it. I see my colleagues, fellow nurses and health care workers across the country, struggle to manage psychologically with crushing and unsafe workloads. While health care staffing shortages have existed for far too long in this sector, COVID-19 has brought an already overstretched workforce to its breaking point.

In 2019, the Ontario Nurses Association said that the province would have to hire over 20,000 nurses to reach the country's average staffing ratio. The nursing shortage is so bad in Ontario, and you've all seen the news, that the Ford government is pleading for nursing support from other jurisdictions. It breaks our hearts. We all want to help. The reality is that throughout the country we're all experiencing shortages.

It's time to sound the alarm, and these staffing shortages will have dire consequences for our nursing and broader health workforce beyond COVID-19.

The CFNU conducted a study before the pandemic, and we already knew nurses were suffering mentally, in part because of staffing shortages. One-third screened positive for major depressive disorders and suicidal ideation, and more than one-quarter screened positive for generalized anxiety disorder and clinical levels of burnout. One in two identified having a lack of staff to adequately cover their unit as the number one source of extreme stress in their job.

Burnout has worsened dramatically over the course of the pandemic with nurses being unable to take leaves and working ceaseless hours of overtime on virtually no rest. A StatCan survey of 18,000 health care workers found that 70% reported worsening mental health during the pandemic, and nurses are the hardest hit.

Without urgent and comprehensive action, we risk an exodus of frontline nurses and other health care workers when we emerge from the pandemic.

Our “Outlook on Nursing Survey”, which was nationwide, was conducted just before the pandemic. More than 66% of nurses rated their work environment as fair or poor, and 60% said they intended to leave their job within the next year, with one in four of these same nurses saying they intended to leave nursing altogether. In fact, I work with people who were on the cusp of retiring in one, two, or three years, but they're going in the next six to 12 months for sure. Unfortunately, I'm not one of them.

A recent survey of nurses in Ontario found that 13% of nurses in early career, aged 25 to 35, were considering leaving the profession permanently after the pandemic. According to a report from La Presse, 4,000 nurses have already left their positions in Quebec during the pandemic, which is a 43% increase over previous years.

How will be able to manage with a growing number of nurses leaving the profession when we have an enormous backlog of surgeries and procedures? How will we fill the ballooning vacancies of nurses and other health care workers, with over 100,000 vacancies in the health and social assistance sector at the end of 2020? How?

● (1420)

What is needed now more than ever is federal leadership to address critical nursing shortages across the country, through targeted transfer of funds to the provinces to immediately begin hiring more staff. To ensure a sustainable supply of nurses and other health care workers to meet growing demands, we need the federal government to help us address health workforce information gaps, which would enable adequate health human resources planning.

The federal government could address this through establishing a health workforce agency reflecting international leading practices, and in particular, in Australia. This could fill the data gaps that limit our ability to retain and recruit the workers required, giving us the tools we need to manage the frightening shortages and vacancies we are currently experiencing.

We have the opportunity to ensure nurses and other health care workers have the supports they need going forward, but we have to act, and we have to act fast, for the sake of our nurses and the health and safety of our patients, residents and clients.

The Chair: Thank you, Ms. Worsfold.

We go now to The Mustard Seed, with Mr. Wile.

Mr. Wile, please go ahead. You have six minutes.

Dr. Stephen Wile (Chief Executive Officer, The Mustard Seed): Hello, and warm greetings to all in attendance, including the members of the committee and the chair.

My name is Stephen Wile. I'm chief executive officer of The Mustard Seed. Thank you for having me here today.

The Mustard Seed is a Christian non-profit organization that has been caring for individuals experiencing homelessness and poverty since 1984. Operating in five cities across Alberta and British Columbia, The Mustard Seed is a supportive haven where people can have their physical, mental and spiritual needs met and can grow toward greater health and independence. Our vision is to eliminate homelessness and reduce poverty where we serve.

Currently we serve in Calgary, Edmonton, Red Deer and Medicine Hat, in Alberta; and Kamloops in British Columbia. Our mission is to build hope and well-being for our most vulnerable citizens through Jesus' love.

Through this past year of the pandemic, our vision and mission remained unchanged, but how we do this has required creative adaptation, resilience, flexibility and grace to respond to the ongoing changes while staying focused on serving those in need. This dramatic transformation in our world has provided an opportunity to expand our reach and find creative solutions to help even more of our vulnerable neighbours.

In times of need, when our clients have no one to care for them or a place to call home to provide safety, we are there with open arms and a welcoming spirit. The pandemic has changed many things, but our clients' and staff's well-being, health and safety have always been our main focus.

The trends we have seen this past year are, first, increased numbers of unique individuals experiencing homelessness. In some of our locations, the overall numbers in our shelters were down, and yet we saw the number of unique individuals experiencing homelessness increase. In Edmonton, for example, the number of unique individuals using our shelter services increased by 15%.

Second, those who experience homelessness have increased risk for COVID due to barriers in following public health directives. While we were able to provide a space in Calgary for those experiencing symptoms to isolate, many who experienced homelessness in other cities were unable to easily isolate as a close contact or as being symptomatic. During the beginning of the pandemic, many public spaces were shut down, causing increased challenges for accessing spaces for individuals to remain warm, or bathrooms in which to practise appropriate hygiene.

Third, we have seen significant collaboration between health and social service agencies in the cities we serve, resulting in increased partnership and collaboration to providing wraparound supports, not only in relationship to COVID but to improving the overall health of this population. This has resulted in deep, rich partnerships with other homeless-serving organizations. This has been essential in containing the spread of COVID in the shelter system, but also in creating a coordinated effort to provide vaccinations to our populations.

Fourth, vaccinations have been a challenge, as our overall homeless population in Alberta, for example, has only been eligible for vaccinations since April 19. While many individuals were eligible prior to that due to their complex health concerns, transportation and booking for these vaccinations were significant barriers to their accessing them. The rollout in Alberta, for example, has not been optimal, because of a lack of understanding, in particular by Alberta Health Services, of those experiencing homelessness.

Fifth, we have seen increased numbers of overdoses, substance use disorders and acute mental health concerns. We have seen an increase in maladaptive coping strategies to the social isolation, the lack of comprehensive and available services, and the general anxiety due to the pandemic. For a period of time, we had to close our wellness centre due to public health restrictions.

Moving forward, my recommendations are the following:

First, provide funding for a significant increase in affordable housing. The current and proposed funding for affordable housing barely touches the need, as demonstrated by the rapid housing initiative this past year and the overwhelming response to that initiative.

Second, provide funding for health supports in the shelter system itself. This not only includes primary care, but also allied health professionals, who can target the multi-faceted health needs of this population and the increasing acuity of mental health and substance use disorders, which this pandemic has not only revealed but exacerbated.

● (1425)

Mental health is highlighted in the literature related to this vulnerable population and the pandemic, and for good reason. We have seen the acute effects in our shelters. There is a dire need to provide increased mental health supports, and it is difficult to provide these during the pandemic.

Third, ensure that vaccine supplies are targeted to this population and an effective strategy of care is created to ensure that all who consent to it receive their second dose in a timely and efficient manner.

Finally, after the focus on vaccines and triaging the current public health crisis ebbs, we encourage you to consider a longer-term strategy for approaching and funding the wraparound supports that The Mustard Seed embodies across the sector—all of this in addition to housing.

This pandemic has laid bare the need for increased mental health and substance-use disorder supports in the long term, where individuals are moved out of homelessness not only into permanent housing but also into a system that ensures multi-faceted care to address their social determinants of health and prevent future homelessness.

Thanks again to everyone, the members of the committee and the chair of the committee, for having me here to speak about the work we do at The Mustard Seed. As we say at The Seed, hope grows here. Thank you.

The Chair: Thank you, Mr. Wile.

Thank you to all the witnesses for your statements.

We will start our questioning now with Ms. Rempel Garner.

Please go ahead, Ms. Rempel Garner, for six minutes.

Hon. Michelle Rempel Garner: Thank you, Mr. Chair.

Mr. Wile, thank you for everything you do in our community. What has really struck me throughout the pandemic has been the lack of dialogue on the impact of the pandemic and related restrictions on Canada's homeless populations. I know a lot of us are growing weary of stay-at-home orders and stay-at-home restrictions, but we're very privileged in that we have a home to stay in. I think you've given the committee some very concise recommendations.

I wonder if you could expound a little, perhaps in a bullet-point format, on some of the impacts of COVID on the homeless community in Calgary.

● (1430)

Dr. Stephen Wile: I would be pleased to. One of the really positive things about Calgary, to start with, is that the number of people using the shelter system across Calgary is down significantly. I think the reason for that is that many of our clients have been motivated to move out of the shelter system into homes. For example, in Calgary alone, we have placed almost 450 people this last year into permanent supportive housing.

There have actually been some positive outcomes. The negative outcomes, however, are things like lack of access. Our shelter systems have certainly expanded from overnight shelters to being 24-7. Of course many in the homeless community do not want to spend their entire day in a shelter, so they're wandering around. Especially throughout the winter's difficulties, our Plus 15s were typically havens of warmth for them, and those weren't available to them any longer. It caused them to face more of the difficulties that you have with the elements.

Those are some of the restrictions. The ability to find food has been an issue as well. Many of the people in the shelter system are bottle collectors. Of course people aren't throwing away as many bottles. In Calgary, for example, I don't know what the percentage is, but we're down by at least 50% in the number of people who come downtown during the day or stay around the downtown core. That impacts them as well.

Hon. Michelle Rempel Garner: Just following on that, I'm concerned about ensuring that the homeless population in Canada is adequately thought about in terms of the vaccine rollout. I would imagine that some of the challenges would be access, information getting to people, booking appointments, and then giving your clients tools, like a vaccine card or something.

Are there any challenges that you're identifying right now that you think need to be rectified in short order, in order to ensure equitable access to vaccination for your clients?

Dr. Stephen Wile: Yes. I think one of the obstacles for our clients is that there's often a lack of trust, right? The people they tend to trust are the people who are there to serve them: our shelter workers and our street-level workers.

In terms of one of the difficulties we're facing right now, we have an example in British Columbia. In Kamloops, our shelter service received their vaccinations at least a month earlier than we did in Alberta, and one of the things we discovered in Kamloops is that when we booked our clients for a vaccination, the response rate was about 30% from our shelter clients who wanted to get a vaccination. When we booked our clients in coordination with our staff, with our staff getting their vaccinations at the same time as our clients, the rate moved to 80%.

We've been telling Alberta Health Services that if you want this population to get vaccines, you need to have our support workers get their vaccines at the same time, as an example to them. Unfortunately, that has fallen on deaf ears. In this past week, we have vaccinated 90 of our clients of approximately 250 or so—

Hon. Michelle Rempel Garner: Mr. Wile, I don't want to cut you off, but I have about 30 seconds left and I want to get this on the record. Because I know the federal government is starting to do some education on vaccination, is there anything specifically at the federal level that you would recommend to the committee in terms of that education component—how to target that to your clients and how to partner with you on that information in providing service?

● (1435)

Dr. Stephen Wile: Yes. I think that overall there needs to be a deeper level of communication with the people on the street, the service providers, because this is a unique population. If we treat this population like the rest of the population, we will likely have difficulty in getting the level of vaccination that we feel is necessary to protect this group of people.

Hon. Michelle Rempel Garner: Thank you for everything you do.

Thank you, Chair.

The Chair: Thank you, Ms. Rempel Garner.

We'll go now to Ms. Sidhu for six minutes.

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

We know that our communities and our medical professionals are under increased stress in the third wave. My community is a hot spot of COVID-19. I want to thank all frontline medical workers, nurses and doctors who are saving Canadians every day.

My question is for Dr. Collins. We know that our government announced new supports for Ontario, including sending federal health care staff and equipment to the front lines and more. In your testimony, you referred to an additional $4 billion from the federal government going towards the Canada health transfer to help provinces get through this pandemic. What are some immediate needs that you think the provinces should be targeting?

Dr. Ann Collins: Through you, Mr. Chair, we commend the government for the added $4 billion directed to address the backlog and the million dollars for vaccine delivery. We are not yet fully aware of what the impact of this pandemic will be on backlogs. We know that there have been incredible increases in wait times. We know that people have delayed seeking medical attention. What that will lead to when they arrive, of course, is diagnoses that are much more complex, and the need for diagnostic and treatment services will be that much more complex as well.

We also feel that it's imperative that there be a commitment to a previous promise that every Canadian should and can have a family doctor. We know that primary care is critical in how we deliver care to Canadians, including what is going to be needed post pandemic, and there is also the incredible requirement for what we anticipate is going to be needed to provide mental health care not only to health care providers, but to their patients as well, as we come out of this pandemic.

Ms. Sonia Sidhu: My next question if for Dr. Bloch.

Dr. Bloch, my mother is presently undergoing treatment for cancer. She's fortunate to have family members supporting her. Can you speak to how patients with a serious illness, especially those with COVID-19, are able to cope when they do not have a support network? What issues do you see among low-income and racialized communities, and what solution do you propose?

Dr. Gary Bloch: My mother-in-law is also undergoing treatment for cancer, so I've experienced this personally. What I see among my patients is that what it takes to address health issues is truly being magnified. It's being magnified by the COVID pandemic itself and a lack of access to services, both within hospital and primary care services, although we are certainly doing our best to support people. It's also magnifying the social divides and barriers, and the gaps we see in our society, right?

What were previously, for some, lower levels of barriers are now rising. People who live in high-risk neighbourhoods, especially people who are racialized, people who live in higher-risk buildings, especially people who are low income, are finding it even harder to access supports and medical care than they did before.

There are a number of ways we can approach this. For a start, I would echo what Dr. Collins put forward about the need to put primary care at the forefront of our health system response. It is truly primary care providers who can come from within the health care system and dig most deeply into the realities of people's lives.

This is what I spend my time doing every single day. This is true of people who live in low-income situations who are socially marginalized, and as Mr. Wile pointed out, people who are right on the margins and homeless. We are the ones who are truly accessing people everywhere.

We need to look at a higher systemic level of support. When we talk about the fact that people who are racialized and with low income have more difficulty accessing services, we need to think about why that is. We do not need to look at the individuals, but at the systemic factors behind their difficulty in accessing services.

There is real racism built into our systems that pushes people who are racialized away from accessing care. We need to do a deep dive as a health care system into understanding why that is, first, by collecting and looking at data to allow us to understand what the experiences are of people who are racialized, who face other elements of social marginalization, and then by targeting specific health care and social services toward those communities to correct those inequities.

When it comes to addressing the needs of people who are low income, I don't want to sound pat, but the answer is not all that complicated. Living on low income requires a response of increasing access to income. I certainly see that, and I've always seen that as a health-relevant response to a health-relevant issue. We need to urgently ensure that our income support programs provide an adequate income for anyone to live and survive in Canada

● (1440)

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

[*Translation*]

We'll now go to Mr. Thériault.

Mr. Thériault, you have six minutes.

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

I'd like to thank all the witnesses for their contributions, which help us understand the collateral damage caused by this pandemic. One of our concerns is patients who haven't had COVID-19. Physicians from the Canadian Medical Association have provided an overview that talks a lot about the management of the pandemic. We've heard very little about the collateral damage to patients who haven't had COVID-19.

Dr. Bélanger, from the Association des gastro-entérologues du Québec, recently told us that urgent matters should not cause us to lose sight of what's important. When we talk about the fight against cancer, we agree that this disease doesn't wait for pandemics or their resolution to spread.

Dr. Collins, I get the impression that you have a very clear idea of what the post-pandemic will be like. When will it take place? You said earlier that something had to be done during the pandemic, that you were pleased with the funding to deal with what happens during that time and that we would have to see afterwards, but what do you mean by “after”? When will this happen?

Dr. Ann Collins: Thank you for your question.

I'll ask my colleague, Dr. Abdo Shabah to answer it.

Dr. Abdo Shabah (Quebec Board Member and French Spokesperson, Canadian Medical Association): Thank you, Dr. Collins.

Thank you for your question, Mr. Thériault. It's quite relevant.

It's undeniable that the tragedy of the pandemic today is compounded by collateral effects caused by delays in medical procedures. CMA investigated this issue in October of last year and recently released a report on reducing delays.

I'll mention some of the findings of the report. As COVID-19 cases began to increase in Canada, it became clear that there was additional pressure on the health care system. This is what we're experiencing today, on a daily basis.

You talked about what is urgent and what is important. We're dealing today with what's urgent, but the report also talks about what's important. This includes procedures such as joint replacement, which affects quality of life, cataract surgery, or diagnostic imaging, which has a major impact not only on quality of life but also on survival. When we're trying to diagnose cancers, for example, we're facing significant delays that result in a significant backlog of procedures and a significant increase in wait times. The situation surrounding these interventions, which are essential to survival and have a significant impact on [*Technical difficulties—Editor*], allows us to take a look at the precarious nature of our health care system.

Therefore, we're calling on all levels of government to expand primary health care services and increase support for health care so we can deal with those backlogs that were already starting to build up by the time we realized the situation, during the first wave of the pandemic. There was a second wave and now there is a third wave. It's clear that Canadians will suffer the consequences of that.

● (1445)

Mr. Luc Thériault: Dr. Champagne, from the Association des médecins hématologues et oncologues du Québec, said that the effects would be felt over the next 10 years and would result in a 10% increase in the mortality rate. It was based on a publication of the *British Medical Journal*. Knowing that four weeks' delay implies an increase in mortality of between 6%, 8% and 10%, it's undeniable that resources must be increased at this time.

Earlier, the Canadian Federation of Nurses Unions told us about the labour shortage. Performing surgery that could solve cancer early still requires respiratory therapists and nurses, among others, in the operating room.

From a medical point of view, do you think it makes sense to say that health transfers will be increased substantially and repeatedly, but only after the pandemic?

That's why I was asking the question. When is “after”?

Does this make economic sense? We know that a colonoscopy costs $1,000. If it isn't done in time, the patient becomes a chronic disease patient who ends up in the system. System costs will increase over the next 10 years. Costs will skyrocket.

Is there a logical medical and economic case for a substantial and recurring post-pandemic investment?

Dr. Abdo Shabah: Thank you for your question.

Again, I think it's extremely important to support the provinces and territories during and after the pandemic through federal health transfers. I think your point is well taken: we must act on what is urgent, because the pandemic is now.

What's important is planning ahead. At the Canadian Medical Association, we believe that constructive dialogue on the best funding model would ensure that all patients in Canada receive the same quality of care, today, during the pandemic and after the pandemic. These discussions on increasing health transfers for the post-pandemic period should take place. We look forward to engaging in such conversations in the months ahead.

Mr. Luc Thériault: Can we be content with $4 billion, when the common front of Quebec and the provinces is in the order of $28 billion? That's not to say that when we start negotiating, we can achieve that. The fact remains that the federal government's fair share of health care would allow health care systems to get back on their feet.

It was well known at the beginning of the first wave that the systems were already weakened. They were barely able to properly care for their patients.

Can you imagine them after a third, fourth or possibly fifth wave?

Now is the time to address it and invest. Don't you think so?

Dr. Abdo Shabah: That is certainly true.

Much more is needed. However, we already applaud the federal government's commitment to provide $4 billion to the provinces and territories to help them resolve these backlogs. All parliamentarians are being urged, in fact—

Mr. Luc Thériault: But this amount isn't recurring. They key is predictability and recurring investments, which will allow us to anticipate what we can do.

Thank you very much.

The Chair: Thank you, Mr. Thériault.

[*English*]

We'll go now to Mr. Davies.

Mr. Davies, go ahead. You have six minutes.

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

Dr. Collins, on April 16, the Canadian Medical Association issued a release that said the following:

> ...we are at a critical juncture where a truly national approach to combatting COVID-19 will make the difference between more or fewer lives saved....
>
> We act as one country when crisis hits with wildfires, floods and other tragedies. This pandemic has reached a new level that requires a national response....
>
> We are one country, and it's time we started acting as one by deploying resources where they are most needed. If we can't achieve this through voluntary co-operation, then more and stronger measures might be needed.

Right now, we are seeing a severe crisis in Ontario. ICUs are overwhelmed. Doctors are being compelled to take people off ventilators if they don't have a 70% chance of survival. This is an emergency.

In your view, should the federal government play a stronger role and use its authority under the Emergencies Act to deploy resources where they are most needed?

● (1450)

Dr. Ann Collins: Through you, Mr. Chair, I'm afraid I'll have to defer to legal experts who would be in a better position to address Mr. Davies' question. I do, however, want to commend the federal and provincial leaders who have signalled their intention to support the crisis in Ontario by encouraging health care professionals within their jurisdiction to answer the call of duty.

I can say that the CMA's members, too, are eagerly seeking ways to help and are ready to volunteer their time and put themselves at risk to help the acute care crisis emerging in certain jurisdictions across the country.

Thank you for the question.

Mr. Don Davies: Thanks, Dr. Collins.

On April 20, you released a statement in response to budget 2021 that said the following:

> We are...disappointed that this budget did nothing to address the problems faced by the nearly five million Canadians who must navigate medical issues without consistent access to a family doctor or a primary care provider. The federal government has committed on numerous occasions to ensuring each Canadian has access to a primary care professional, but we have yet to see any real commitment to this ongoing issue.

What will be the impact of this lack of action?

Dr. Ann Collins: Primary care is clearly the front door to the health care system, and as I've stated earlier, we don't know the full impact the pandemic has had with respect to wait times, and so on, but we know that those Canadians who do not have a family doctor are going to have a much harder time navigating the system to deal with issues such as their mental health care. We know that seniors need strong access to primary care.

We've not mentioned it today, but patients with long COVID are going to need primary care. Thus, we need to see a commitment to delivering on that, to expanding the role of primary care teams. Also, we need to start being more innovative and look at how we deliver health care with respect to the social determinants of health and taking in the many issues beautifully outlined by Dr. Bloch around equity in health care.

Mr. Don Davies: Thank you.

Ms. Worsfold, on April 19, CFNU put out a new release commenting on budget 2021, and it quotes CFNU president Linda Silas saying the following:

> Canada's nurses were counting on the government to honour its previous commitments, including implementing universal public pharmacare, developing national standards for long-term care and meaningfully responding to the growing funding crisis in our health care system. It is disappointing that little progress has been made on these critical issues.

In your view, how will those failures manifest themselves on the ground in the year and years ahead?

Ms. Pauline Worsfold: Since I'm on the front line, I see it on a regular basis, where people now don't have benefits coverage, so stop taking their medication and end up in the emergency room with a bleeding ulcer, let's say, and then have to have emergency surgery, and so on.

There is a financial cost to the system, as well as a human cost, to not having a pharmacare plan for all people living in Canada. I think the savings that implementation of a pharmacare plan would reap would be able to support some of the things we've heard put forward today by the other witnesses. The cost savings of a national public pharmacare plan would be able to support the programs and plans that so need that coverage, up to and including the long-term care situation that we have going on now. We could support them with additional funds for proper care and levels of care delivery.

Mr. Don Davies: Thank you. I'll just stop you there, because I'm going to squeeze one more question in.

On March 30 the CFNU said the following:

> *It took the Public Health Agency of Canada...until January 2021 to acknowledge what unions and many experts have said all along. Health-care workers are at risk of airborne transmission when in close proximity to an infected person. Yet PHAC still does not require health-care workers in COVID-19 units and 'hot zones' to wear protection from airborne transmission, such as N95 respirators.*

Can you tell us what the impact of that lack of guidance from PHAC is on frontline nursing staff?

● (1455)

Ms. Pauline Worsfold: Well, nurses know: Nurses know the truth. We follow science and we make decisions based on scientific evidence. We said right from the get-go that nurses and health care workers in the hot spots and dealing with COVID-positive and COVID-presumptive patients should have access to the PPE that's required, whether it's an N95 or something else. I think the effects will be devastating. We've seen a number of health care workers already die from contracting COVID. It just breaks our hearts, because it's a tragedy that could have been avoided.

The Chair: Thank you, Mr. Davies.

That brings our first round of questions to a close.

I wonder if the committee is interested in a short snapper round of about 30 seconds per party.

Is there any interest in that?

I think there is some interest—

Mr. Don Davies: Chair, I see that we have four minutes. Why don't we go one minute per round?

The Chair: We can take a shot at it. One-minute rounds generally take eight minutes, but go ahead.

We'll start with Mr. d'Entremont for one minute, please.

Mr. Chris d'Entremont (West Nova, CPC): I think Larry was going to pick that up.

The Chair: Okay.

Mr. Maguire, please go ahead for one minute. I'll start your time now.

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

It's good to see all the witnesses. Thank you for your presentations.

Dr. Collins, in previous discussions we looked at a number of the other issues that you dealt with as well. Today you talked about critical care and the recovery that's needed, that front-door approach. One of those areas is in regard to long-term care and seniors.

I wonder if you could expand on some of the things you asked for there. You looked for greater stay-at-home opportunities. I think one of your reports comes out showing that it's $95 to keep a person in the home and $150 in a long-term care facility. Perhaps you could expand on that and on exactly how the vaccine rollout has occurred in our long-term care facilities and whether it has been successful at this point. I know it has reduced the numbers tremendously in there.

I just want to get your response in regard to the plan for long-term care in the future, probably, as much as anything.

Thank you.

Dr. Ann Collins: With respect to vaccine rollout, we have seen a marked reduction in cases in long-term care in this third wave of the pandemic. That is a good thing. We have called for and do support national standards that would improve oversight and accountability in long-term care going forward.

Regarding efforts to support seniors staying in their homes, from a survey, 96% of Canadians who were 65 and older said they would do anything to stay in their home as opposed to going to a long-term care facility. We do encourage collaborative discussions between provinces and the federal government to support senior Canadians in that endeavour.

Thank you for those questions.

The Chair: Thank you, Mr. Maguire.

Ms. O'Connell, please go ahead for one minute, please.

Ms. Jennifer O'Connell (Pickering—Uxbridge, Lib.): Thank you, all. I'm sorry I can't ask you all a question, but I appreciate your all being here today.

Mr. Wile, I want to pick up on what you were discussing. Vaccine distribution obviously is a provincial responsibility, and can vary. I am actually curious with regard to your work and advocacy on things like showing a health card in order to get a vaccine. I could see that it could be problematic if somebody were homeless or experiencing some trauma. I know that in my home province of Ontario, technically there shouldn't be these restrictions. However, different local health agencies are handling it differently.

Could you maybe elaborate on your experience? Are there any best practices we can share with provinces and territories?

Dr. Stephen Wile: With the population we serve, it is a challenge, because, regardless of what ID they have, whether it's their birth certificate or whatever, many of our staff spend a lot of time as advocates going to their home province to get their ID. I think the best thing we can do is a system like a database, which we have in most of our cities, to accurately keep track of all of these individuals who are getting their first dose. Our concerns are about the second dose. Will they be available?

Thank you for the question.

● (1500)

The Chair: Thank you.

[*Translation*]

Mr. Thériault, you have one minute.

Mr. Luc Thériault: Ms. Worsfold, in Quebec, the pandemic accelerated the desertion of nurses, with some even leaving the profession. This is likely due to the fact that we still have a long way to go to ensure the recognition and professionalization of nursing, which plays a vital role.

Do you agree with me that this recognition and professionalization is first achieved through better working conditions? Let's take the example of what we've done for personal support workers, giving them a significant salary increase to go and get that expertise and not lose it.

If we lose this expertise, we'll lose a lot more; it's not enough to simply go out and get what we need with money to get new resources.

[*English*]

Ms. Pauline Worsfold: I couldn't agree more. Working conditions are always our number one concern as working nurses, the frontline nurses. Short-staffing contributes to the working environment and the level of care you can deliver. Working conditions are number one.

Violence in the workplace is something else. It's really had a spike during the pandemic. That's a big contributing factor as well. Nurses don't want to go home at the end of their shift feeling like they haven't done their best and given the highest level of care to their patients, residents and clients.

The Chair: Thank you, Mr. Thériault.

We go now to Mr. Davies for one minute.

Mr. Don Davies: Thank you.

Ms. Worsfold, I want to find out if you can give the committee an accurate snapshot today of whether nurses, particularly those in COVID-19 units and hot zones, are getting access to the proper personal protective equipment they need.

Why is the Public Health Agency of Canada not updating its guidelines with respect to airborne transmission?

Ms. Pauline Worsfold: I can't speak to why the Public Health Agency is not updating its guidelines, because the science is there. Something as recently as this week has come out again in support of the aerosolization of COVID. I don't know why they're not; I can't speak to that.

It depends on where you are as to whether you have access to the proper protective equipment. Your safety really depends on where you live and if your employer is supplying you with the proper equipment for your own safety.

The Chair: Thank you, Mr. Davies.

That really and truly uses up our time for this morning.

I really want to thank all of the witnesses for sharing their time and expertise with us today.

I want to particularly acknowledge Ms. Worsfold. I know that you came off a long shift. You're about to go on another one. I really hope, after spending your morning with us, that you're able to get some sleep.

I appreciate all of the witnesses today.

Thank you to the members.

With that, we are now adjourned.