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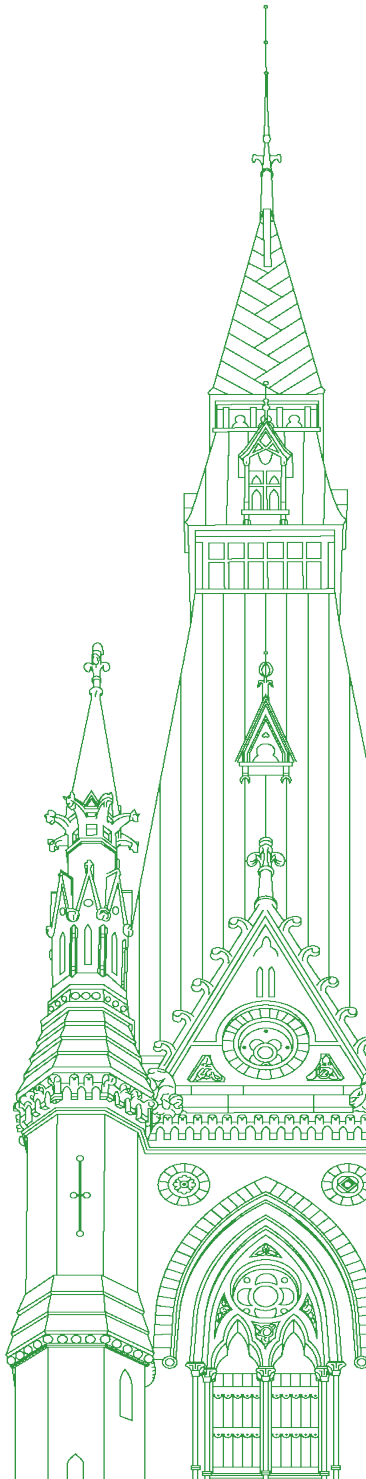

Chair: Mrs. Karen McCrimmon

Standing Committee on National Defence

Friday, November 27, 2020

● (1300)

[*English*]

The Chair (Mrs. Karen McCrimmon (Kanata—Carleton, Lib.)): Good afternoon, everyone.

I call this meeting to order.

Welcome to meeting number seven of the House of Commons Standing Committee on National Defence. Today's meeting is taking place in the hybrid format, pursuant to the House order of September 23, 2020. Proceedings will be made available via the House of Commons website. As you are aware, the webcast will always show the person speaking, rather than the entirety of the committee.

I wish to bring it to your attention that we have a total of six witnesses on the docket for today. I will prewarn you that I will be particularly strict when it comes to time issues and your allocation of time for questions. I think it's really important. All of these witnesses have something to contribute to our study, and I want to say thank you to them for joining us today.

I'll welcome our visitors with short bios. We have Carole Estabrooks, adjunct professor at the school of public health at the University of Alberta. She was chair of the Royal Society of Canada's working group on long-term care. Its members include other esteemed members we have heard from. The working group issued a policy briefing in June of 2020 that outlined the deficiencies in our long-term care sector and recommendations for action.

[*Translation*]

Mr. Alexis Brunelle-Duceppe (Lac-Saint-Jean, BQ): Madam Chair, I have a point of order.

I am really sorry to start off the meeting this way and I know we don't have much time, but unfortunately I am not hearing the French interpretation. However, I did select the channel reserved for that purpose.

Am I the only one having this issue?

The Chair: Okay.

Thank you very much.

The Clerk of the Committee (Mr. Michel Marcotte): Can you speak now?

Mr. Alexis Brunelle-Duceppe: Yes, but I hear nothing.

The Clerk: It works that way.

Mr. Alexis Brunelle-Duceppe: Yes, I hear you now. Perfect.

Thank you.

The Chair: Thank you very much, Mr. Brunelle-Duceppe.

[*English*]

We'll continue.

Réjean Hébert is a professor in the school of public health at the Université de Montréal. He was a member of the chief science adviser's task force on long-term care, again, talking about recommendations for how we address the challenges of combatting COVID-19 in long-term care homes.

Then we have Mr. Richard Shimooka. He is a senior fellow with the Macdonald-Laurier Institute, and he writes extensively on the Canadian Armed Forces.

We have Madam Michelle van Beusekom, who is a co-founder of Protect People in Long-Term Care. It's an ad hoc citizen's group formed in April of 2020 to encourage decisive action to address COVID-19 in long-term care facilities.

Then we have two officials from the Department of National Defence, namely, Colonel Scott Malcolm, deputy surgeon general, and Major Karoline Martin. She was the commanding officer for the Canadian Armed Forces personnel deployed into long-term care homes.

Considering the number of witnesses before us today, I have asked them to try to limit their introductory remarks to five minutes. However, considering that some had already prepared 10-minute speaking notes or background documents, I would like to seek the members' agreement that the longer documents, once translated, will be provided by the witnesses to be appended to the evidence of this meeting.

Some hon. members: Agreed.

[*See appendix*—Remarks by Carole Estabrooks]

[*See appendix*—Remarks by Réjean Hébert]

[*See appendix*—Remarks by Richard Shimooka]

[*See appendix*—Remarks by Michelle van Beusekom]

[*See appendix*—Remarks by Col Scott Malcolm]

The Chair: Thank you, everyone. I appreciate that very much.

With the administrative part of the meeting complete, we will begin with the opening remarks of Professor Estabrooks, please.

Dr. Carole Estabrooks (Professor, University of Alberta, As an Individual): Thank you very much.

In Canada, we are fortunate we have the capacity to call upon the Canadian Forces in crisis.

I'm thankful they stepped up to provide care in nursing homes during the first wave of the pandemic, going into unfamiliar and besieged care settings with little time to prepare. I'm grateful they stabilized parts of the long-term care system that had moved into deep crisis, preventing further suffering and unnecessary death. I am grateful they fulfilled their duty to report, and that those stark reports riveted the attention of Canadians and our leaders on the unfolding catastrophe.

In Canada, over 80% of total COVID deaths have been in long-term care, far outpacing any other country in the world. How could this happen? It could happen only by valuing older adults, and in particular older adults with dementia, less, and only by valuing nursing home care less than the care in hospitals and ICUs.

We knew early in the pandemic that things in care homes were not good and could quickly become catastrophically worse, that attention and action favoured the young and the hospitals, and that decades of inattention, of managing on the thinnest of razor edges, had created these conditions. Still, when the military reports of COVID conditions in nursing homes came out, we gasped, we wept, and for some, a smouldering rage began. I regret that our men and women of the armed services had to step in, but I'm glad they did.

Our governments and our society have known, or should have known, what was happening. For example, the Royal Society of Canada report on COVID-19 and the future of long-term care identified over 150 media reports in the last 10 years about the state of nursing homes in this country. For over 50 years, reports of abuse, insufficient resources, neglect and so on in long-term care have been produced by governments, organizations, unions and the media. In the last three decades alone, over 80 Canadian reports have been produced at considerable cost and common themes have emerged, but little has been done. Every event was seen as an independent and siloed occurrence, and not part of systemic and long-standing problems.

At the heart of the long-term care and workforce challenges, in addition to ageism, is also undisguised sexism. Caring for the elderly in long-term care is considered “just women's work” that anybody can do. This is, of course, patently false. This is complex, demanding and skilled work. It is delivered by personal support workers of whom over 90% are older women and over 50% are immigrants. They are paid the poorest of any worker in the health system, often without benefits or the security of a full-time position, with poor preparation and little to no ongoing education. It's our modern-day workforce of the 17th-century Elizabethan poorhouse.

Before I end, I want to speak briefly to mental health among the military and civilian workers under COVID conditions. We know they are facing and will continue to face mental health challenges. In Italy, early estimates of moderate to severe anxiety and PTSD among long-term care workers approaches 50%. Mild symptoms approach 90%. These effects will linger for years and decades, but they will be less devastating if we act now to support the front-line workers and the older adults in care homes who have survived.

I am pleased to see support for the mental health and well-being of military personnel who were on a temporary assignment. We must turn now to the mental health and well-being of long-term care staff on permanent assignment, who have no such support.

In conclusion, I want to thank the standing committee for inviting me. The long-term care system into which we place our cherished loved ones has endured long-standing neglect because of undisguised discrimination toward the old and toward the women who do the honourable work of caregiving.

COVID-19 conditions in nursing homes have brought forth the deepest existential fear of many Canadians—the fear of dying alone. Just as Passchendaele has come to symbolize the senseless slaughter and unimaginable suffering of Canadians who served, COVID-19 in nursing homes has come to symbolize unnecessary death and senseless suffering among those who built Canadian society and who worked to make this one of the most desirable countries in the world in which to live.

We do not need more commissions, inquiries or reports. What we need is a modern-day equivalent of a bold Marshall plan and its resources to accomplish a root and branch overhaul of the long-term care system. If we do nothing, then once the vaccines are administered, once COVID-19 has passed, once memories fade, once new priorities take centre stage, nursing homes will return to pre-COVID conditions until the next virus. It doesn't have to be this way.

● (1305)

Our oldest citizens can live serenely, enjoying the last stage of life in nursing homes where their carers have time to contribute to the quality of their lives and to provide high-quality care. We can choose which it will be.

Thank you.

The Chair: Thank you very much, Professor Estabrooks.

[*Translation*]

I now give the floor to Professor Hébert.

Dr. Réjean Hébert (As an Individual): Thank you, Madam Chair.

Good afternoon, ladies and gentlemen.

First, I'd like to thank the Standing Committee on National Defence for inviting me here. This is probably the only time it will happen in my career, given that this issue is pretty far removed from my usual concerns.

I'd like to begin by voicing my support for the comments my colleague Carole Estabrooks just made.

● (1310)

The Clerk: Pardon me, Mr. Hébert, could you hold the microphone while you speak? It would greatly facilitate interpretation.

Thank you.

Dr. Réjean Hébert: As I was saying, I support the comments that Ms. Estabrooks has just made. I completely agree with her analysis.

Since we have less time to address you, I'm going to focus instead on a number of facts that should outrage all Canadians.

In this first crisis, Quebec experienced true “age-icide”. I use that word deliberately, because that is really what it is all about, in my opinion. In Quebec, 10% of people living in a CHSLD died during the first wave. In Ontario it was 2.3% and in British Columbia it was 0.6%. Of all the European countries, only Spain has figures somewhat similar to ours. In that country, 5.3% of people living in long-term care facilities died from COVID-19. The death toll was twice that in Quebec.

Why did Quebec experience such a massacre? Several reasons can be cited. I will list some of them, so that what Quebec went through never happens again, in this province or elsewhere.

It became clear that in Quebec, living conditions in facilities like CHSLDs had been neglected over the past three decades. First, CHSLD management and governance have been completely “swallowed up” by much larger health care facilities. As early as 2003, the boards of directors and executive management of CHSLDs were eliminated, and CHSLDs were merged with hospitals and local community service centres in all Quebec communities. This first major reform in 2003 caused the CHSLDs to lose their own administrative entity.

New structural reforms came in 2015. This is when the integrated health and social services centres, or CISSS, were created. Rehabilitation centres and youth centres were integrated and establishments across an entire region were merged. In Quebec, we therefore ended up with very large groups with several missions: the hospital mission, of course which is still predominant; the frontline services mission; the CHSLD mission; the rehabilitation mission, and that of youth centres.

New Brunswick and Alberta also experienced a major merger of this kind that places the hospital at the centre of institutions and marginalizes the other missions of these huge complexes. We are therefore left with CHSLDs that no longer have their own management. Investigator Yves Benoit, who produced a report on the situation at CHSLD Sainte-Dorothée, says the following:

> More than five reporting lines stand between the CEO of the Laval CISSS and the managing first responder (coordinator) of CHSLD Ste-Dorothée.

If you count the ministry, that makes six reporting lines. For example, it could take several days or even weeks to submit a problem to hospital management and get a response. A significant loss of agility was having an impact on how these facilities were managed.

Staffing shortages, especially of personal support workers, are the second major problem. Over the past few years, the work of PSWs has been devalued, not only due to inadequate pay, but also, I would argue, because the human element has been removed from what they do. Putting a time limit on each of their tasks has obscured the PSW's role, which is to provide residents with emotional support. The PSW's value lies therein. The quality of the work environment has deteriorated over the last five years, in the wake of the major reforms in 2015. Over half a billion dollars in excess wage insurance, overtime hours and the use of freelance labour show that things have deteriorated.

The third major issue is the deterioration of medical and nursing care. Physicians have been steered towards clinical practice. They have therefore abandoned CHSLD practice. Similarly, nurses have been steered towards hospitals, where greater needs arose. As a result, medical and nursing care in CHSLDs no longer made it possible to monitor patients properly and, above all, to treat them in the event of acute deterioration.

● (1315)

The fourth major reason is facilities are obsolete. Some facilities have multi-bed rooms, shared bathrooms, or ventilation and air conditioning problems, and some do not have a spare room to provide end-of-life care or isolation rooms for treating infections.

The pandemic has been mismanaged due to the focus on preparing hospitals to receive patients with the virus and massive transfers to CHSLDs of patients at the end of acute care. Priority was also given to hospitals in terms of infection prevention and control, resulting in a lack of both these in CHSLDs. Staff have been moving freely, and they still are, unfortunately. This has contributed to outbreaks and spreading the virus. Problems arose with availability of equipment, and priority was again given to hospitals. Visits by family caregivers, who provide residents not only with emotional support, but also with necessary, even essential, day-to-day care, were not permitted.

Designation of hot spots came late once outbreaks were under way, and staff could not get tested in those facilities. These oversights led to a major crisis. Imagine if it were 10% of children in schools, 10% of children in daycare centres, 10% of an indigenous community. People would be horrified, everyone would stage un rebellion. However, we had no “Old Age...” or “Old Lives Matter” movement for seniors in the first wave. I fully agree with Ms. Estabrooks that this pandemic brought thinly veiled ageism to the fore.

I'd like to thank the Canadian Armed Forces for coming to help limit the damage of this pandemic in our residential facilities.

Thank you, Madam Chair.

The Chair: Thank you very much, Professor Hébert.

[*English*]

Now we go to Mr. Richard Shimooka, please.

Mr. Richard Shimooka (Senior Fellow, Macdonald-Laurier Institute, As an Individual): Thank you for having me at this committee meeting. I really appreciate the opportunity.

My testimony and remarks today are heavily based on my recent report on the post-COVID defence and security environment. I'm a senior fellow at the Macdonald-Laurier Institute—

Mr. James Bezan (Selkirk—Interlake—Eastman, CPC): On a point of order, Madam Chair, we have French coming in over the English channel.

[*Translation*]

Mr. Alexis Brunelle-Duceppe: Plus, we have no French interpretation.

It's all right now. It's been fixed.

[*English*]

Mr. Richard Shimooka: Thank you.

I'm a senior fellow at the Macdonald-Laurier Institute where my focus is international security and strategic and military studies.

In the past year, the COVID-19 pandemic has caused significant dislocations in the Canadian economy, politics and society. If you look into the international sphere, the pandemic has accelerated a number of long-standing trends and introduced several new challenges. Over the past decade, we have witnessed the fragmentation of political, economic and military arrangements that underpin a rules-based international order. The post-Cold War consensus has broken down and, driven in part by the growing conservativeness of national actors in international relations, Russia, China and Iran have rejected or worked to usurp this western-led order.

The fraying of the post-Cold War consensus has occurred among our close allies where populism and nationalism have emerged as powerful and disruptive forces. Their growth is variously blamed on historical lows in public trust of governing institutions, declining economic prospects and rapidly changing societies.

Manifestations include populist leaders such as Viktor Orbán in Hungary or Jair Bolsonaro in Brazil. One of the clearest indications of this emerging era of global power competition is evident in the military sphere. Over the past decade, a dramatic modernization effort has been undertaken by major military powers encompassing increases in funding, reorientations of force structures and the fielding of new capabilities. The breadth of these technological advances arguably sets the period apart from earlier eras, which will affect the fundamental nature of warfare, like with artificial intelligence.

● (1320)

[*Translation*]

Mr. Alexis Brunelle-Duceppe: Madam Chair, I have a point of order. I am sorry.

The interpreter is doing what she can, but sadly it is too hard to interpret what the witness is saying. Perhaps if he spoke more slowly, it might help our interpreter. She just told me that the sound is choppy and she is doing what she can, but if you want to help her do her job, maybe we could find a way.

The Clerk: Yes, Mr. Brunelle. We're looking into it.

[*English*]

Mr. Shimooka, if you could put your microphone a little bit closer to you, speak more directly into it and little bit more slowly, it might help.

Mr. Richard Shimooka: Okay. Thank you.

Collectively, these new technologies have increased the lethality and potential of ways to apply force. Many are vast improvements over existing systems or have no preceding analogue. The technological developments are not strictly limited to military kinetic issues. They also affect our political, economic and social systems such as with cyber-capability. Perhaps one of the most problematic aspects of this emerging military reality is the lack of norms around these new technologies, which may result in greater instability.

The COVID-19 pandemic has further undermined public trust in the governance structures of western states, a fact that is exacerbated by the disinformation campaigns conducted by foreign powers. This is evident in major protests and civil unrest surrounding public health measures and participation in the violent far-right and militias rising in several countries.

Moreover, states' emergency and economic responses to the pandemic have saddled many of them with large debt loads that will require decades of austerity measures to eliminate, thereby limiting their ability to address domestic and foreign challenges. These challenges are particularly key for developing states, which are less well equipped to handle economic and political consequences of the pandemic. They face a weakened global trade system and a growing risk of political fragmentation due to the same forces that are affecting developed states.

In the pandemic's aftermath, many states will adopt a strong domestic focus to rehabilitate their economies and societies. This is evident in Canada's southern neighbour. The incoming Biden administration has already highlighted the immediate need to focus on domestic issues upon entering office. In foreign affairs, the president-elect was clear. He believes that diplomacy is a primary foreign policy tool of the United States, and tends to work through alliances and international institutions. While his administration will likely provide greater leadership than his predecessor's, this means that Canada and other allies will need to shoulder an increasing burden for international security, despite facing the same economic and political challenges as the United States. At the same time, we will be less able to rely on multilateral institutions that have suffered significant legitimacy and credibility issues as a result of the pandemic.

The Canadian Armed Forces are likely to experience greater foreign demands in the coming years, as weak states succumb to centrifugal pressures created by the difficult economic and political environment, and fewer developed states wish to assist in stabilization efforts. The nature of these conflicts poses significant risks for the Canadian Armed Forces. The proliferation of new technologies and capabilities will greatly complicate Canada's ability to intervene as well. The conflict in Nagorno-Karabakh shows how relatively modest unmanned aerial vehicles can have decisive consequences on the battlefield. Particularly concerning is their low cost. Armenia and Azerbaijan are relatively modest economies that could easily afford these novel capabilities.

It is not just low-end conflicts that the Canadian Armed Forces must prepare for. We can observe that China has thus far weathered the pandemic in better condition than most other developed economies, posting a positive growth rate for the rest of this year. Meanwhile, the Russian Federation has continued to play a spoiler role internationally, despite suffering the pandemic's effects. Thus, the challenges of a great power conflict will likely become increasingly acute as the decade wears on.

To respond to these challenges, the Canadian Armed Forces must become increasingly nimble, and nowhere more so than in how it acquires and incorporates these new technologies. The 2017 defence policy white paper, “Strong, Secure, Engaged”, is far too rigid in this age of rapid technological development. Many of these systems require quick, iterative upgrades to maintain their fighting edge, which our government is not well organized to deliver.

The procurement system itself is severely hampered by an overly regulated oversight system that ensures project delays and cost overruns. These issues are exacerbated by the reality that successive governments have seen defence procurement as a vehicle to direct government money into domestic constituencies. This only causes further delays to procurements and eats into the defence budget. The temptation to further exploit defence procurement to these ends will be particularly acute given the clear economic challenges facing the country.

None of this suggests that Canada should act like a global policeman at the outbreak of violence; however, the trajectory of recent international relations, particularly after the pandemic, suggests that the world is becoming increasingly unstable, and that military force may be required to ensure this country's security and prosperity. Canadians must be clear-eyed to the challenges they face, and the country must possess the appropriate tools to address them.

Thank you.

● (1325)

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

Now we'll have Madam van Beusekom speak.

Ms. Michelle van Beusekom (Co-Founder, Protect People in Long-Term Care, As an Individual): Thank you, Madam Chair and committee members, for the invitation to speak here today.

I'm a co-founder of Protect People in Long-Term Care, an ad hoc citizens' group that launched a petition on April 7 asking for emergency funding for LTCs, a national coordinated strategy and the implementation of shared standards. To date, our petition has garnered over 98,000 signatures from every province and territory in Canada.

I'm also speaking to you today as someone with a unique lived experience and perspective. Both of my parents live in Grace Manor, one of the five LTCs in Ontario that received military assistance in May.

I'd like to underscore that many of us with loved ones in LTCs saw this tragedy coming. We are intimately familiar with the systemic gaps and failures in this sector. When we saw what was unfolding in Spain and Italy in February, we quickly realized what was coming our way. Chronic understaffing is endemic in this sector. When families and volunteers were locked out on March 13 in many parts of the country, we knew that staff who were already overstretched would quickly become overwhelmed. Our anxiety rose as we learned that LTC staff were having to fight to get access to PPE. We watched in horror as outbreak after outbreak was announced, yet LTCs in many jurisdictions were not being prioritized by their public health authorities for access to testing to ensure the rapid assessment and cohorting of residents.

My parents' LTC in Brampton, Ontario, reported its first case of COVID on April 7. Each day the numbers rose, but they had to wait an agonizing eight days after that first positive case until their public health authority, which was following Ontario Ministry of Health directives, would finally give them access to testing for all residents.

By then it was far too late. In their LTC, with a population of 120 residents and 36 staff, there were 65 resident cases, including both of my parents, and 21 staff cases, which ultimately resulted in 12 deaths, including two staff.

With staff levels so depleted, those remaining were working up to 16 hours a day. The senior administration at Holland Christian Homes, the not-for-profit that runs Grace Manor, reached out to the Province of Ontario and the local health authority for help. They hoped to partner with the two local hospitals in Brampton and to receive redeployed medical staff from those hospitals. When that didn't happen, they asked—as a last resort in an increasingly desperate situation—to be considered for military assistance. On April 24, the Ontario government formally made the request for military assistance on behalf of five homes.

For Grace Manor, that assistance was vital. Half of its staff was gone. The military presence gave remaining core staff the breathing room to recruit, bring in and train new staff and ensure that proper infection control protocols were firmly in place. Military personnel also provided much needed human contact for residents—many of them frail, vulnerable and confused—who, by this point, had been completely cut off from any in-person visits with their families for over a month. My father so appreciated his conversations with the military personnel from places like Nova Scotia and Petawawa. He told me yesterday that it was a good thing they came.

Why did this happen in the first place? Why was military assistance needed? How did it get so bad?

As we've heard today, it got this way after decades of political leaders ignoring dozens of reports that flagged a host of critical systemic issues, such as underfunding, chronic understaffing, poor labour practices, the lack of shared standards of care and training standards, deregulation, privatization and absence of accountability. We had plenty of warning. This catastrophic failure to protect our most vulnerable should not have happened.

Here we are today in the second wave. Over 12,000 people in Canada have lost their lives to COVID. Eighty per cent of all deaths in the first wave were of people living in long-term care—the worst record in all OECD countries. Dozens of long-term care facilities across Canada are once again in outbreak, yet the same struggles with access to testing and rapid cohorting that we saw in the spring continue.

● (1330)

Kat Cizek is one of my co-founders. Her dad lives in Toronto's Lakeside, an LTC currently in outbreak where COVID-positive residents have been left on the same floor as those who have not contracted the virus. Another co-founder—we're only four—is Kitra Cahana. She is seeing staff and resident infections skyrocket at the Maimonides facility in Montreal, where her father lives. Despite this alarming outbreak, the public health authority has not made testing mandatory for staff and visitors.

I don't have words to describe how excruciating it is to watch this again. Despite all we know, all we learned in the first wave and all the studies and policy recommendations, so little has been done to address the root problems that have caused this crisis. We should not be relying on the military for last-resort crisis management in a sector where the problems and the solutions are this well known. This is not a good use of military resources and training. I am sure it has compromised military operations and budgets in many ways to come to the aid of a sector where private operators have continued to reap handsome profits for their shareholders throughout this crisis.

We've begun to see reports of how Operation Laser has impacted the mental health of military personnel who were thrown into an acute-crisis situation in a unique environment that they didn't necessarily understand. Military medical staff are not long-term care specialists. Caring for high-needs elderly, over 80% of whom suffer some form of dementia, is a skilled activity, even if our society does not recognize it as such.

In the throne speech on September 23, the federal government made a commitment to national standards, yet almost 10 weeks later the details and a timeline have not been shared. It is so disheartening to see the jurisdictional bickering that is blocking the groundswell of grassroots support right across this country for national standards. It is imperative that all levels of government come together to fix this broken system.

I am so thankful that the military was there for my parents and for Grace Manor. I never want to see this happen again. This sector needs to be properly supported. The long-standing problems need to be addressed. We need concrete action on those national standards. The military has other work they should be doing. Speaking on behalf of the 98,000 who signed our petition, I hope we can count on you to help make that happen.

Thank you.

The Chair: Thank you very much, Madam van Beusekom.

Colonel Malcolm, I believe you are presenting the opening statement.

Colonel Scott Malcolm (Deputy Surgeon General, Canadian Forces Health Services Group Headquarters, Department of National Defence): Yes, Madam Chair. Thank you.

Madam Chair and members of the Standing Committee on National Defence, it is a great honour and privilege to be here today, along with Major Karoline Martin. I thank you for the invitation to discuss elements of the Canadian Forces health services deployment into Ontario's long-term care facilities, supporting Canada's most vulnerable in the midst of the COVID-19 crisis.

As you heard in previous testimony, Operation Laser saw the deployment of hundreds of health services personnel. Nurses, medical technicians, medical assistants, physician assistants and dental personnel all came together to form composite teams known as augmented civilian care teams. As the director of health services operations, I was the architect behind the medical aspects of the plan that saw the augmented civilian care teams deploy into long-term care facilities in Ontario. Major Martin had the distinct pleasure to deploy as the officer commanding the augmented civilian care teams within Ontario.

From April to August, we deployed into seven long-term care facilities with the primary mission and goal of saving Canadian lives. Upon our arrival, we witnessed a sector in crisis. Our clinicians and Canadian Armed Forces personnel immediately mobilized and began to work tirelessly alongside our civilian health partners to stabilize the situation and support not only residents but also the organizations and clinicians we were deployed to support.

Although CAF personnel are not experts within the long-term care sector, we responded to the call during a critical moment in Canadian history. Clinical excellence, compassion and patient advocacy are the cornerstone ethical principles that all Canadian Armed Forces clinicians live by. As such, when concerns regarding the conditions and the standards of practice arose, we as Canadians, as clinicians and as soldiers had a clear duty to report our observations. I'd like to stress that our observations were only a snapshot in time that reflected the realities within the long-term care facilities in which we worked during the early stages of the COVID-19 crisis.

The CAF health services personnel who deployed on Operation Laser are a passionate and dedicated group of clinicians who will always advocate for patient and resident well-being and the provision of high-quality health care to Canadians. It is with this lens of systemic improvement that we graciously accept your questions and queries.

We thank you once again for this opportunity and look forward to your questions.

Thank you, Madam Chair.

● (1335)

The Chair: Thank you, Colonel Malcolm.

Thank you to all the witnesses for keeping your remarks brief. That leaves more time for questions.

We'll start the questioning round.

[*Translation*]

Mr. Benzen, you have the floor.

[*English*]

Mr. Bob Benzen (Calgary Heritage, CPC): Thank you, Chair.

Thank you to all the witnesses for appearing today. It's really appreciated.

Mr. Shimooka, you mentioned in your opening remarks that we have a new global era of competition, marked by increased modernization of the military and lots of new technical advances.

Can you give us some sense of what other militaries are doing in terms of this modernization and advancement and tell us if the Canadian military is keeping pace with that, and also how COVID-19 may be affecting our ability to do that?

Mr. Richard Shimooka: As I stated in my remarks, the nature of the technological development is quite broad. It's not just one or two areas like in previous eras. It's not just, let's say, ICBMs, intercontinental ballistic missiles, or it's not just greater communications. Basically in almost every area of military capability we are seeing some advancement.

That is, in part, driven by something that is generally called the broader technologies, such as AI, which are affecting how all capabilities are starting to operate together with greater connectivity between different military capabilities. You see a much greater focus on network capabilities as well as some very specific and unique capabilities that are narrow in focus, such as hypersonics, which is a significant area of growth in the last decade or so among the United States, China and Russia as well. Russia has recently just deployed several new types of hypersonic weapons on large missiles or carried by airplanes.

In that sense, there are quite a few areas that the Canadian Armed Forces must be aware of. As I said in my remarks, if we look at the Azerbaijan and Armenia conflict just recently, we see that UCAVs were a significant part of that conflict and that really did change what occurred and the outcome. Those capabilities range from very low-cost items that cost several hundred dollars, to extremely expensive, unique capabilities that have very wide effects.

The Canadian Forces are trying to adapt to this capability. I would argue that in many cases the priorities that were laid out, let's say in 2017, may not be as relevant as they are today. One of the best examples, referring back to Nagorno-Karabakh, is the development of new types of air defence systems. I'll give an example in the United States. I believe there are now six or seven ongoing air defence system projects that the U.S. Army is undertaking and implementing into service.

Canada has one program in the defence capability guide. It is the GBAD program, and it is identified for delivery, I believe, in 2026 or 2027. That means, for the next six or seven years, the Canadian Armed Forces will not have a dedicated air defence system to defend against threats that, as we just witnessed, have decisive effects in a conflict and are easily and cheaply available to many different countries.

Does that answer your question? Does that give you a perspective of where this squares up?

● (1340)

Mr. Bob Benzen: You gave me some sense of what we need to do to modernize. I think you're saying we can't do everything, but we need to pick some niches, some areas.

You mentioned something about waiting until 2026 to get this air defence, and you talked a lot about technological advances and technological products that we're buying now but that aren't being delivered for six, seven, eight or 10 years. By the time we get them, they will already be out of date.

With COVID-19 we've learned that we have to be quick and nimble, and we have to change on the fly. Is there something from COVID-19 that we can take as a lesson to shorten the procurement time to get our products to us quicker?

Mr. Richard Shimooka: Absolutely. If we look at the development and the rollout of vaccines internationally, as somebody who watches innovation and development of very high-end military capabilities, I'm utterly astounded. We are literally watching, in front of our eyes, a modern scientific miracle, where we have developed a vaccine from almost scratch in the space of a year and will have it basically rolled out and hopefully put into Canadians' hands or arms, or whatever, in just over a year. That's impressive.

One of the things in observing how government operates, especially during times of crisis, is that a lot of the rules, a lot of the straitjackets that are placed on policy implementation, are quickly removed in order to identify ways that we can be more efficient and quicker to do what's required. In terms of the military capability, I believe there has been quite a bit of process put into the system that has actually prevented the Canadian Armed Forces from getting the equipment they need.

If we're talking about GBAS specifically, I look at other countries that identified the problem of UAVs that provide great threat to their countries. They immediately purchased a system, put an interim system into operation and then looked at the long-term solution. However, in Canada, in a lot of cases, and we can look back to Afghanistan or other operations, I feel that we tend not to actually acquire the capabilities that we need until there's a crisis. At that time, it's the worst time. I'd probably ask some of the military members of this panel right now, if they did not have the capabilities needed, how quickly did they have to scramble to get some of them?

I think that's the case.

The Chair: Thank you very much.

Mr. Baker, please.

Mr. Yvan Baker (Etobicoke Centre, Lib.): Thank you very much, Chair.

I'll start by thanking all the witnesses for being here. We have so many wonderful witnesses and I hope we have the time to really have a conversation with each of you and hear from all of you. Rest assured that we'll do our best to ask questions to all of you throughout today's meeting.

First off, in my community of Etobicoke Centre, we lost 42 residents to COVID-19 at the Eatonville Care Centre. This is one of the homes in which the Canadian Armed Forces initially served in Ontario. Therefore, Colonel Malcolm and Major Martin, on behalf of my community, I thank you for your work, for your service and for the service of the men and women who served under your command, for all the work you did and for caring for, and frankly, saving the lives of constituents in my community.

Also, thank you for preparing the report about what you discovered, the horrific conditions in long-term care homes in Ontario and in Quebec. As a result of your report, certainly in Ontario, the five MPs who represented the homes in which you served ended up, in late May, writing to Prime Minister Trudeau and to Premier Ford asking for a number of things, including national standards to be put in place for long-term care. Of course, as was mentioned by Ms. van Beusekom, in the throne speech the government announced that it would be working with the provinces to establish national standards for long-term care.

Your report enabled awareness and transparency, which has led to advocacy, which has led to the government committing to national standards. When we get to those national standards and they are implemented, that will make a difference for seniors for generations to come, so for that, I'm deeply thankful to you and all the men and women who served under your command. Thank you.

My first few questions are for Ms. van Beusekom. Thank you for being here and for your testimony.

What do you believe needs to be done to address the horrific conditions, frankly, and the practices that were identified by the Canadian Armed Forces in long-term care?

I'm really focusing on the long term. I know there's a response that's needed immediately in the context of COVID-19, and I'm not trying to deprioritize that, but I'm curious about what you think needs to be done over the long term.

● (1345)

Ms. Michelle van Beusekom: I think Carole Estabrooks has done a ton of work on this. I'm so thankful to all the people who have been working on these issues for decades.

The first one is staffing. As I said in my testimony, this sector has been chronically understaffed for decades. Family and volunteers were the glue that held it together. When they were forced to leave it fell apart. As I also said, it was not a surprise to us. In Ontario, the Registered Nurses' Association of Ontario and others have been advocating for a four-hour minimum of direct patient care per day. That's a really good beginning. We need the staffing levels to be increased. We need proper funding for this sector. We need proper training for PSWs. I was talking to the doctor at Grace Manor yesterday and he asked why Sheridan College and others don't have programs for PSWs in long-term care? It's specialized.

As we've heard in today's testimony, it is a specialized skill to care for older adults with complex needs. We need standards of care, and they need to be the same across the country. B.C. did great. Early in April they increased salaries for people who are chronically underpaid, which made it possible for them to work in just one home. They did really well in testing, but it's so uneven across the country. We really need those national standards. Start with adequate funding and with the staffing ratios. Other things can come in the medium and the longer term, but for now we need to support those core staff. The military came in and that was fantastic, but they don't have the relationships. The most important thing is the relationships with the residents. That's what the core staff have. We need to support those core staff who know the residents, who know what they need so they're not run off their feet.

This has been known for decades. We knew this before COVID. There's no excuse for why this isn't happening now.

Mr. Yvan Baker: I appreciate that very much.

I think I have a little less than a minute and a half remaining in this segment.

Ms. van Beusekom, I'll ask you this question but ask you to answer within about a minute or so, if you can. First of all I should say that MP Sonia Sidhu was the one who recommended that we reach out to you. Thank you for coming today. I wanted to let you know that.

Ms. Sidhu advocated, and you have advocated tremendously, as have others in our caucus and elsewhere outside government, for national standards for long-term care. You alluded to that a moment ago. Can you speak to why those standards need to be established?

Ms. Michelle van Beusekom: Yes.

I'm so grateful to Ms. Sidhu. When we launched our petition, we wrote to all kinds of federal and provincial ministers. We got a lot of responses. Member Sidhu was the one person who really engaged with me as a human, and I really appreciate that.

The national standards are so important. Long-term care should come under the Canada Health Act. The needs are complex. People are living to be a lot older. It's not just taking care of people; it's delivering complex medical needs. Canadians should have that same guarantee, that whether you live in Iqaluit, Igloolik, Dawson City, Vancouver, Winnipeg or Whitehorse, you get access to the same standards of care. That should be a principle of our country. Right now as we've heard, it's broken, it's uneven and it's untenable, but we do know how to fix it, thanks to the work of so many people.

● (1350)

Mr. Yvan Baker: Thank you very much.

The Chair: All right. Thank you very much for that.

[*Translation*]

Mr. Brunelle-Duceppe, you have the floor.

Mr. Alexis Brunelle-Duceppe: Thank you, Madam Chair.

I'd also thank the witnesses who are with us. We're addressing issues that are quite significant. I'd like to extend special thanks to the two members of the Canadian Armed Forces.

I thank you for the help you provided in Quebec.

My first question is for Mr. Hébert.

Good afternoon, Mr. Hébert. Thank you for attending the meeting today.

I'm going to cut to the chase. For decades, federal health transfers to Quebec have been shrinking. It goes without saying that you're aware of this, given that you are a former health minister for that province.

Can you describe the impact of the federal government's backlog in administering health care in Quebec and the provinces as the result of declining health transfers? We must remember that when the legislation first came into force, transfers were at about 50%. Today, they are at about 22% or 23%.

Dr. Réjean Hébert: Thank you very much, Mr. Brunelle-Duceppe.

Federal transfers have indeed gone down. What I found most worrisome is that, under the Conservative government, federal transfers were not always evenly distributed. Not only were transfers capped at a certain percentage of gross domestic product, but they were distributed on a per capita basis, regardless of age. Provinces with aging populations, such as Quebec and the Atlantic provinces, found themselves at a disadvantage. It was an equity issue that caused a lot of trouble in those provinces, which had to cope with a more significantly aging population.

What I find more disturbing is how negligently the provinces, particularly Quebec, use the funds. More of this money has gone to hospital services and physicians' salaries than institutional care, and the COVID crisis has made that abundantly clear. Home care has been particularly neglected.

Our Canadian system is really based on hospital care. The system was developed in the 1960s and 1970s when we had a young population, based on medically required hospital care. Now, with an aging population, we really need to look at long-term care, and it's much better to provide long-term care at home. In Quebec and Canada, home care has been neglected over the past 50 years. Compared to other OECD countries, we invest only 14% of public funding in long-term home care, unlike other countries like Denmark, which invests 73% of its budget in long-term home care. We have the lowest marks in the OECD class.

If we had further developed the home care component, we could have avoided some of the massacre we experienced in facilities. If they had had the choice, many people would have stayed at home rather than opting for the institutional solution. I believe things really need to change in Quebec and Canada in this regard.

Mr. Alexis Brunelle-Duceppe: I want to clarify a few things with you. You agree with me that, with inflation, costs in the health sector have increased enormously and that, on the other side, federal transfers have declined dramatically.

I understand that choices had to be made in managing these funds, but the funding rate is around 22%. The premiers of every province and territory and the premier of Quebec are asking to raise this figure to 35%.

Once the provinces have access to these funds, if the federal government decides to transfer them as it should, do you think it will then be easier for the provinces to do their job?

Dr. Réjean Hébert: To me, this issue is that, even with more funding, there would not be more money for institutional and home-based care.

If the past is any guide, the provinces will need to reach an agreement with the federal government in order to set priorities other than hospitals and physician pay and to address the real issues that have been exposed by the COVID crisis, namely, providing high-quality care in institutions, with quality standards, and especially home care. Funding for home care cannot be given to institutions as is currently the case with hospitals. Users must be the focus of public funding decisions.

I believe we need to move toward what several other countries have done, which is long-term care insurance. When I was in the Quebec government, I proposed a form of this insurance. Unfortunately, I ran out of time to implement it. But I think it's essential if we want to provide high-quality care to people.

● (1355)

Mr. Alexis Brunelle-Duceppe: Yes, you did run out of time.

If you were Quebec's minister of health, which is clearly a provincial jurisdiction, and Ottawa was giving you funding on the condition that you use it in a specific way, I imagine you would say to keep the conditions and provide funding instead, which is what is needed to implement this kind of policy.

I assume we agree on this point?

Dr. Réjean Hébert: If, within the past few years, Ottawa had announced billions of dollars in funding for home care, the problem I see is that this money wouldn't necessarily go toward home care, but—

Mr. Alexis Brunelle-Duceppe: Yes, I understand that.

Dr. Réjean Hébert: —instead to the provinces' priorities, and it would perpetuate a hospital-centric model that results in failing to take care of seniors who are losing their independence, and their numbers are increasing. Quebec will be one of the oldest provinces in barely a decade and one of the oldest societies in the world and that the health care system we have now is not at all suited to that reality, because it addresses people's health care needs using a hospital-based approach that is totally inappropriate.

Mr. Alexis Brunelle-Duceppe: I understand. So, you disagree with the provinces about asking for larger health transfers—

The Chair: Thank you very much.

[*English*]

Ms. Rachel Blaney (North Island—Powell River, NDP): Thank you, Madam Chair.

I want to thank all of our witnesses for being here today and for the importance of their testimony.

I just want to start off by saying that I agree that this is an issue of ageism. It is absolutely appalling to me that we don't have a meaningful national seniors strategy in Canada. I think of all of the work that has happened in terms of workforce development and a plan to replace our aging population in the workforce, but there has not been a plan put together about how we're going to support seniors as they age in our country. I want to thank everybody for this important testimony.

I will go to you first, Ms. Estabrooks. You talked about the fact that we're not seeing the very important skilled workers in this sector being respected, especially with the appropriate pay. One of the things that I saw in my province of British Columbia as well as across Canada was that a lot of those care workers were working two or three jobs at two, three or four different long-term care facilities, and as soon as the pandemic happened, some of them lost their employment at other places and were trying to manage their everyday life just doing one part-time job. I'm wondering if you could talk about how that has an impact on the services to our seniors.

Dr. Carole Estabrooks: Thank you.

As many as 30% of PSWs and care aides were working more than one job pre-pandemic. About 70% of that group were working for financial reasons, and many of them couldn't make a decent wage. Wages in Canada pre-pandemic ranged from $12 an hour to about $22 or $24. You can't raise a family on $12 an hour. That condition was there although we didn't know it. Some of us knew it because we had samples from certain provinces that told us that, but we as a country really had no idea that this was going on.

The impact was that they were working multiple jobs and, specifically with regard to the pandemic, the more places you work and the more you travel, the more likely you are to spread the disease. It's not through any fault of your own; it's just the more traffic and the more exposure you have, the more it happens. We have put these “one work site” policies in place in many jurisdictions and they have helped, but they are fraught with unintended consequences.

For chains with perhaps 14 homes that are used to moving their staff around to cover shortages, which all of a sudden can't do that, we have seen some really catastrophic shortages and some loosening of the conditions around that policy to accommodate for that. However, the core issue is that if you don't pay a workforce that delivers 90% of the direct care a living wage and you don't make it possible for them to have full-time employment with sick benefits and vacation benefits, then you're going to have both a dispersion through different homes and issues with respect to workers' commitment to the organization they work for. There is a whole trickle-down effect.

I'm not suggesting that on a permanent basis we might want to put a one work site policy in place. The reason people are working more than one job shouldn't be that they can't make a living wage or get sick benefits.

● (1400)

Ms. Rachel Blaney: Thank you. I really appreciate that.

Colonel Malcolm, first of all, I'd like to thank you and of course Major Martin for your service. I'm the lucky MP who represents the 19 Wing Comox. It's amazing. I know how hard you work and how dedicated you are, not only to our work internationally but here in Canada obviously.

I'm just curious as to whether you could answer two questions for me. One of them has to do with the process once the military is called in. How does that roll out? How do you make an assessment of what's happening and respond to it? Of course, you know the military did provide a report. I'm just wondering if you could give us a few recommendations with respect to how we could prevent this from happening again in the future.

Col Scott Malcolm: Madam Chair, thanks for the opportunity to answer these questions. I'll cover the first one, and then we'll turn the floor to Major Martin, who will be able to speak to the lessons learned, bearing in mind that what we saw there was a snapshot in time, so she will share some of her observations from that moment.

With respect to how the provinces make a request, I will clarify that, as a health services member, it's outside my lane on how that specifically occurs. The process, very generally, occurs through the regional joint task forces, and I know that you've had some of the regional joint task force commanders speak in the past.

In very broad terms, the requests are coordinated from a request from the province itself based on the assessments done by the provincial emergency operations centres in discussions with the regional joint task force commanders. Then a request is sent up through the Minister of Public Safety that comes across to the Minister of National Defence. Based on the requests of the chief of the defence staff, we'll have a look at the availability of forces. Speaking specifically to health services, they would come to the surgeon general to reply as to whether we have forces available to meet those requirements. We would provide the response back to the chief of the defence staff, and then the planning staff would look at our overall ability to respond to that need.

Turning to your second question, I'll turn the floor to Major Martin to speak to the lessons observed in her time working in the long-term care facilities in Ontario.

Major Karoline Martin (Officer Commanding Standards Coy, Chief Standards Officer, Canadian Forces Health Services Training Centre, Department of National Defence): Thank you for the question.

A few themes arose out of the report on our observations, certainly echoing what has been said by other witnesses. Staffing was a huge concern. When we arrived, many of the facilities had as little as 20% staffing, irrespective of what their nursing ratios were pre-pandemic. That made a huge impact on the outcomes of patients.

Second was infection prevention and control and really having that situational awareness of who was positive and who was negative. There were delays with having the results. Sometimes there was a lag of a week or up to 10 days, so by the time you got your results, you no longer had a good situational awareness of where the outbreak was. Also, the IPAC stream has centralized and/or standardized IPAC protocols. We within the CAF had a central IPAC member who provided us that advice, but IPAC was very different among each of the facilities in terms of donning, doffing, what the standard was for PPE, etc.

Finally, there's training. I think when you are looking at a degradation within the health status of a large population, having individuals who are trained in that acute care is paramount.

The Chair: Thank you very much for that.

Go ahead, Madam Gallant, please.

Mrs. Cheryl Gallant (Renfrew—Nipissing—Pembroke, CPC): Thank you, Madam Chair.

My questions are for Colonel Malcolm.

First of all, what vaccine safeguard protocols are in place for soldiers who receive an experimental vaccine?

Col Scott Malcolm: Madam Chair, to date there have been no experimental vaccines, to my knowledge, that have been used on Canadian Armed Forces personnel, nor is there any intent to use any experimental vaccines on our Canadian Armed Forces personnel.

● (1405)

Mrs. Cheryl Gallant: Who is responsible for providing financial compensation for soldiers who suffer adverse reactions to a vaccine or this vaccine?

Col Scott Malcolm: Madam Chair, I'm unaware of any claims by serving or former serving CAF members against the use of an experimental vaccine. As I mentioned, to my knowledge there has never been an experimental vaccine used on our force. Therefore, I couldn't comment as to what the compensatory mechanism would be for that.

Mrs. Cheryl Gallant: We did see, with an anti-malarial drug, that our soldiers were among the first in Canada to be dispensed that. It has been quite an uphill battle ensuring that this required inoculation has been adequately compensated for in the instances where they had bad reactions.

Will the government confirm that no military insurance policy will be voided for soldiers who take this COVID vaccine administered by the military?

Col Scott Malcolm: Madam Chair, it would be outside my authorities to make a determination on that, regrettably. It's not a decision that would rest within health services.

Mrs. Cheryl Gallant: Through you, again, Madam Chair, on whose shoulders would that responsibility lie?

Col Scott Malcolm: Madam Chair, regrettably, within my current position as deputy surgeon general, I wouldn't have the answer to that question. I'm not responsible for the insurance plans of our members. I honestly couldn't suggest right now who within the department would be in a position to answer that question.

Mrs. Cheryl Gallant: Thank you.

Once the vaccine is available, it doesn't make a whole lot of sense to vaccinate soldiers but not their families. When can military families expect to receive a safe vaccine?

Col Scott Malcolm: Madam Chair, with respect to the prioritization of the impending COVID-19 vaccines, those prioritizations will first be made at the cabinet level based on expert advice, including from the national advisory committee on immunization. It will be based on those priorities, at which time it will be determined when our Canadian Armed Forces members will be vaccinated. Also prioritized among those, along with all other Canadians, will be the families of our military members.

Thank you.

Mrs. Cheryl Gallant: For the next roto to Latvia, what are the current COVID precautions being taken for soldiers who are headed there?

Col Scott Malcolm: For our troops deploying to Latvia, and for all of our troops deploying, measures are being taken to ensure that our members are not bringing disease into the country nor impacting those being deployed. Those folks are being quarantined in advance of their departure.

We have also been conducting operational testing on our members being deployed overseas to ensure that they are not, as we've termed it, “asymptomatic”, which means being infected with COVID-19 but not demonstrating any symptoms.

Then, of course, the Canadian Armed Forces has led the way in implementing very robust public health measures, including physical distancing, the use of masks, diligent handwashing and also strong recommendations for folks to have the influenza vaccine prior to their deployment, just to eliminate one other type of infection that could impact operations.

The Chair: Thank you very much.

[*Translation*]

Mr. Robillard, you have the floor.

Mr. Yves Robillard (Marc-Aurèle-Fortin, Lib.): Thank you, Madam Chair.

Good afternoon to the witnesses.

My first question is for Carole Estabrooks.

Dr. Estabrooks, I'd first of all like to congratulate you on your recent appointment to the Royal Society of Canada.

Because of your expertise in this area, I'd like to hear your views on the role of women and visible minorities in long-term care facilities, particularly as personal support workers or nurses.

● (1410)

[*English*]

Mr. Terry Dowdall (Simcoe—Grey, CPC): I have a point of order, Madam Chair.

I'm hearing both languages at the same time.

The Chair: Thank you. Let's look into that.

Can we try it again, Monsieur Robillard?

Mr. Yves Robillard: Do I start all over?

The Chair: Madam Estabrooks, I think the question was directed to you.

Were you able to hear the question?

Dr. Carole Estabrooks: No. I only heard about half of it.

The Chair: Then yes, please start all over again.

Thank you.

[*Translation*]

Mr. Yves Robillard: Okay.

Good afternoon to the witnesses.

My first question is for Carole Estabrooks.

Is it working properly this time?

[*English*]

Dr. Carole Estabrooks: No.

Mr. Terry Dowdall: It's still twice. He has to press his button.

[*Translation*]

Mr. Alexis Brunelle-Duceppe: If I may, Madam Chair, in the interpretation options, there's the "mute original audio" function below "French" and "English".

[*English*]

Dr. Carole Estabrooks: I have the correct one.

[*Translation*]

Mr. Yves Robillard: Should I do what Mr. Brunelle-Duceppe is suggesting?

The Clerk: Yes. At the bottom centre of the screen, there's the "interpretation" option.

The Clerk: Choose the "French" option. Under this option, you'll have one that lets you mute.

Mr. Yves Robillard: Is it working now?

The Clerk: It's working for us. Let's do a test. Say something brief in French.

Mr. Yves Robillard: I'd like to welcome the witnesses.

I think it's working.

My first question is for Dr. Estabrooks.

First of all, I'd like to congratulate you, Dr. Estabrooks, for your recent appointment to the Royal Society of Canada. Given your expertise in the area, I'd like to hear your opinion about the role of women and visible minorities in long-term care facilities, particularly as personal support workers and nurses.

[*English*]

Dr. Carole Estabrooks: Thank you very much for the question.

Over half of the PSW workforce are immigrants. Over half of the people who are immigrants don't speak English as a first language and sometimes don't speak English well enough to understand it readily in a conversational way. It's a highly racialized workforce. We pay almost no attention to that. We don't collect that data. I have that data because we've been working for over 15 years with a longitudinal group in the west. We asked them what language they speak and where they come from, so we have that data.

When I talk to colleagues in Ontario and Quebec, it's even higher. It's not the same in some regions of B.C., and in the Maritimes it's a little bit different. It depends on the ecosystem that you're in. That is part of the reason they are so poorly compensated. They're women. They're poorly educated. They're not given any continuing education. They're not regulated, which means there aren't even criminal background checks, and we don't count them accurately in the country. What we have done is create this workforce that's largely unregulated, and we've deprofessionalized it.

In Germany, they legislated that 50% of the front-line workforce has to be regulated nursing staff, RNs. In Belgium, it's even higher, almost 65%. That's similar in other jurisdictions. Here, the regulated workforce is less than 15%, and that has been a financial decision, coupled with the belief that you don't need complex, competent skilled care for these individuals.

We can provide that care with a high proportion of unregulated staff, but we have to give them proper education. We have to give them continuing education, and we have to support them. We have to address what kinds of issues it creates if we have a highly racialized workforce in terms of the discrimination they feel. We know that COVID had a disproportionate impact on racialized groups, and we know that in some jurisdictions that was manifest in what happened in the workforce, in the nursing homes that had a particularly high proportion of people from other ethnic groups.

Poverty plays a role. The fact that they're women plays a role. All of these things come together and stack up, until you get a workforce that's quite vulnerable. On top of that, they're pretty much voiceless. They're not unlike the residents who don't have a voice; we don't give them much voice. They're at the bottom of a hierarchy, and they're not included often in a lot of decision-making, but they care. This is the thing that astonishes me through all of that. The average care aide or PSW in this country builds relationships with residents and cares and wants to do good work. We aren't even acknowledging....

That's the first step. Then we have look at what it means if a workforce is predominantly female and you have COVID and they close the schools and there's no child care. That's a problem. If you're a woman and you have children and the schools are closed and you're caring for aging parents, that's a challenge, so we have issues and we don't value caregiving. We don't value it for children, and we don't value it for the elderly. There's a very big convergence of these compounding issues of disparity and inequality in this workforce.

● (1415)

The Chair: Thank you very much.

[*Translation*]

Mr. Brunelle-Duceppe, the floor is yours.

Mr. Yves Robillard: Given the vital role they play in these centres—

The Chair: Excuse me, Mr. Robillard, but it's Mr. Brunelle-Duceppe's turn.

Mr. Alexis Brunelle-Duceppe: I'm sorry, Mr. Robillard.

I'd like to thank the interpreters for their exceptional work. I'll do it quickly, but I want to tell them that they're exceptional.

Thank you very much.

It's not every day that we hear from a former minister of health at the Standing Committee on National Defence. You said it yourself, Dr. Hébert. I'm very happy to have you with us.

Just to be clear, do you agree with the demands of Quebec and the provinces that the federal government increase health transfers from 22% to 35%?

Dr. Réjean Hébert: Can you hear me okay?

I switched headsets.

Mr. Alexis Brunelle-Duceppe: Yes. I can hear you just fine.

Dr. Réjean Hébert: Okay.

I believe that we need more health care funding federally and provincially. However, as I said earlier, continuing to invest in boosting physician pay and concentrating health care in hospitals is the wrong approach.

Mr. Alexis Brunelle-Duceppe: Excuse me, Dr. Hébert, I don't have a lot of time. I understood that.

I was asking if, as a former Quebec minister of health, you agreed with the demands of Quebec and the provinces that the federal government pay its share.

Dr. Réjean Hébert: When I hear in the Speech from the Throne that there is a real focus on home-based care and residential care services, it's music to my ears. There is an important negotiation to be made with the provinces to ensure that this money is really directed to home-based care and institutional care, in Canada, in every province in Canada.

Mr. Alexis Brunelle-Duceppe: So, as a former minister of health, you disagree with this demand.

I have one last question for you.

In 2013, when you were minister of health, you said that the federal government does not provide any services to the public and that this duplication of staff is expensive.

Do you still agree with that statement?

Dr. Réjean Hébert: Yes, there is duplication in certain areas. At the time, it was in mental health and in areas such as health care for indigenous people.

I believe we can succeed in reaching an agreement on eliminating this duplication. We have so little funding for health care that we have to be very careful to avoid needless duplication.

Mr. Alexis Brunelle-Duceppe: Okay.

Thank you very much, Dr. Hébert.

We'll make sure your position is known.

My next question is for Maj Martin.

Good afternoon, Maj Martin.

Several important courses, such as career development courses, have been cancelled or offered with a limited number of candidates. This means that there are fewer trained soldiers, NCOs and officers who, in turn, could have trained other candidates. The COVID-19 pandemic really hurt everyone, especially in this area.

Would you be able to tell us what impact these delays are having on the preparedness of our forces?

● (1420)

[*English*]

Maj Karoline Martin: The preparedness and questions about training are not within my field of expertise, but I will turn the floor over to Colonel Malcolm, who is better positioned to answer.

[*Translation*]

Mr. Alexis Brunelle-Duceppe: Perfect. Thank you.

[*English*]

Col Scott Malcolm: I'll have to speak to that in my current role as deputy surgeon general.

Back in March during the first wave, in an effort to respect the public health measures put in place by each of the provinces, the Canadian Armed Forces took a very disciplined role to cease operations in moving and training candidates from across the country so as to avoid becoming a vector. It certainly did slow down our training operations at that time.

We continue now respecting.... With the new information we have about the virus and adhering to public health measures, we will be restarting the training machine as of this fall. While we do have some catch-up to do, we have a plan in place to move that along.

In terms of our current preparedness for wave two, we stand ready to assist as requested by the Government of Canada.

The Chair: Thank you very much.

Mr. Garrison, go ahead, please.

[*Translation*]

Mr. Alexis Brunelle-Duceppe: It's already over?

Thank you.

[*English*]

Mr. Randall Garrison (Esquimalt—Saanich—Sooke, NDP): Thank you very much, Madam Chair, and thank you to the witnesses for being with us today. I apologize, as I had responsibilities in the House of Commons that prevented me from joining earlier, but I know that MP Rachel Blaney did a good job.

I want to start with a question for Colonel Malcolm and/or Major Martin, and I apologize if it overlaps in any way. I did hear part of your responses earlier.

Given the lessons we've learned and the current spikes in COVID-19 that we're seeing, do you feel there's a danger, especially in Ontario and Quebec, that the Canadian Forces might have to be called upon again to provide assistance in long-term care homes?

Col Scott Malcolm: I will take that.

We are seeing right now that we have members deployed to support the long-term care facility in northern Manitoba, so it certainly remains top of mind for the Canadian Armed Forces. We have our teams prepared and ready to go, much as they were in wave one, should additional asks of that nature come from the provinces.

Mr. Randall Garrison: Are there differences, given the lessons you've learned, in how you'll approach intervening, say, in Manitoba now, or if you had to go back into homes in Ontario and Quebec?

Col Scott Malcolm: Perhaps I'll ask Major Martin, who has that coal face experience, to speak to what we've learned from our experiences there.

Major Martin.

Maj Karoline Martin: Thank you, sir, and Madam Chair.

From our first experience, one of the big pieces we learned was team composition and really looking at what those critical clinical capabilities were. Certainly, nursing was at the forefront of it, so as part of our lessons learned, we submitted observations to Ottawa to bolster that team. Again, that is going to be predicated on staff availability and clinical availability, but certainly on more personnel when you're looking at severe staffing shortages.

Mr. Randall Garrison: Given that we've seen COVID now appearing in large numbers in rural, remote and indigenous communities, which often have very limited health facilities, is there a contingency plan in place for the Canadian military to provide assistance to those rural and remote indigenous communities in coping with the spike in COVID?

Col Scott Malcolm: Thank you for the opportunity to respond.

Dating back to wave one and our work with the whole-of-government response plan for COVID-19, part of our planning was related to the potential to respond to the requirements to support rural and remote northern communities.

The Chair: Thank you very much.

Now we'll go to Mr. Dowdall, please.

● (1425)

Mr. Terry Dowdall: Thank you, Madam Chair, and thank you, James Bezan.

I want to take an opportunity to thank all the witnesses who are here with us today and certainly to thank all the military men and women for what they've done during this crisis.

I want to make one quick point. I know that we're short of time, we're worried and it's Friday. One concern is that I think the study and what I'm on this committee for was originally the pandemic and the Canadian Armed Forces. I know we're getting into other discussions that I know are fantastic, but because we're short of time, maybe we could narrow it down to how it's really truly affecting our forces.

My question is for Mr. Shimooka. I'll begin by saying that we had the opportunity on Monday of having his distinguished colleague here, Dr. Leuprecht. He testified before this committee that in his opinion 25% of our active armed forces were dedicated to "domestic operations", like we saw here in Operation Laser, and that the Canadian Armed Forces response to the COVID pandemic is an ineffective use of military resources and will definitely begin to harm our readiness for international responsibilities.

I wonder if you agree or don't agree with this assessment that Canada perhaps should look at standing up and funding a dedicated section of the Canadian Armed Forces for exclusive domestic operations.

Mr. Richard Shimooka: I would couch my answer by saying that I think that's not precisely a question for me. I think that's a question for, I guess, the body politic in determining what the roles are that the government wants to do for Canadians. If I look at different militaries internationally.... Let's take the Coast Guard or the protection of sovereignty. Canada uses its navy in a fashion that is probably more extensive than countries that have more robust coast guard capabilities—like Japan or something like that.

Relating that back to pandemics and aid to the civil power missions, like in this case, I think it is a reasonable ask, so long as there is planning and resources allocated that are commensurate to the task. Too often, I think, governments will saddle the Canadian military with a task and, as the fine representatives of the Canadian military here will show, they will do it to their utmost capability and ability, but the resources aren't applied and given to that mission. That's not just with the aid to the civil power. That's with a lot of different areas.

I would say my view is that I think that could be a legitimate use of the Canadian military. It just needs to be resourced properly and it must be clear that it is one of the tasks they must fulfill at the time.

Mr. Terry Dowdall: Thank you for that.

Also, COVID-19 and the rise of social isolation and physical distancing have affected how we plan and execute our military operations here at home and definitely abroad. Do you see more future use of cyberwarfare and artificial intelligence? What are some of the issues there in terms of our international norms?

Mr. Richard Shimooka: I would argue that those areas of capability are increasing anyway. They are becoming some of the leading edge of military capability and power that we're seeing internationally. I can point to... just a couple of days ago, the U.K. announced, I believe, a 13-billion pound increase in its defence budget over a couple of years and a significant portion is going to go to cyberwarfare capabilities.

I don't necessarily believe that it might be a result of COVID or the pandemic itself, but certainly those are major areas of capability that are increasing in relevance in the international sphere.

Mr. Terry Dowdall: Thank you very much. I don't know if I have a lot of time left, so I have a quick question for Colonel Malcolm.

How many Canadian Armed Forces members are currently deployed on Operation Laser?

Col Scott Malcolm: Unfortunately, I don't have the exact number right now. I'd have to take that one on notice and get back to you.

Mr. Terry Dowdall: This is just a quick follow-up. I know you don't have the number, but that would be interesting, for sure.

Do you know if those members will be deployed on the operation to coordinate vaccine distribution as well?

Col Scott Malcolm: At this time, the role of the Canadian Armed Forces in the rollout of the vaccine is still being explored. Right now we have members—logistics experts and planners—working with the Public Health Agency to assist with planning, but it's yet to be determined what other roles the Canadian Armed Forces may play in the rollout of the COVID-19 vaccine.

● (1430)

The Chair: Thank you very much.

We go next to Mr. Bagnell, please.

Hon. Larry Bagnell (Yukon, Lib.): Thank you very much.

Thank you to all the witnesses.

I don't have a lot of questions because your testimony and your written input is so comprehensive. Thank you for the passion with which you are protecting people who cannot really protect themselves. Some of you in the military, and others, have put yourselves at risk. I really appreciate the efforts of all the witnesses and those who have done that.

I'd also like to congratulate Major-General Fortin, who is going to head up vaccine logistics and operations for the military, which the Prime Minister announced today.

Just as a reminder, in all the recent previous years, each year there has been an increase in transfers to the provinces and territories for health care. I particularly thank Professor Hébert for mentioning that we made a record contribution for the first time on home care recently. I think everyone here would agree that is very important, especially considering recent events.

My questions are for Major Martin. As you know, a high priority for everyone on the committee is increasing the importance of women in the military. My two questions for Major Martin are along that line.

First of all, I'm delighted you've been given such a senior and important role. That's fantastic. From all reports, you've done a wonderful job.

Have you noticed any special needs—I know Mr. Robillard asked this question as well—for the women in the long-term care homes, either as patients or as workers? Are there special needs they have, recommendations specific to women, or is there any discrimination similar to the ageism that was discussed earlier, but specific to women?

Are there any comments on that from your experience in your management role in this situation, Major Martin?

Maj Karoline Martin: Thank you for the question.

I would say that when we're looking at staffing within long-term care, as described within some of the other testimony, certainly being able to provide child care and being able to provide care to other family members did impact those PSWs and those nurses when things started to shut down. Certainly there was a level of staffing degradation that was related to the role of women.

In terms of discrimination, there was none that I witnessed or that was reported to me. I think the majority of the managers who worked in all seven homes were women, so there was certainly a very prominent leadership role that women played within that sector.

Hon. Larry Bagnell: Thank you.

Yesterday I was on a conference call with an organization, not military at all but a similar type of organization. They asked what they could do to increase the recruitment of women. You're obviously very successful. You were recruited. You've risen to the top. Do you have any suggestions about how we could increase women entering the military or how we could improve our recruitment efforts related to the special needs of women?

Is there anything from your personal experience that might help us or guide us to make improvements?

Maj Karoline Martin: I can speak from personal experience. My husband and I are both military and have had an almost 20-year career together. Certainly, having communication about the support to families and the support to women's careers is very important. So is better communication about what the military does. I think from an outside perspective, most civilians look at the military as having that very infanteer, very hard, army-type mentality. Really, there could be communication on how there are wonderful opportunities within this organization.

Hon. Larry Bagnell: Thank you, Madam Chair. That's all I have.

The Chair: Thank you very much.

Mr. Bezan, please.

● (1435)

Mr. James Bezan: Thank you, Madam Chair.

I want to thank our witnesses for appearing. I want to thank Colonel Malcolm and Major Martin, our military members who are with us.

Major Martin, I particularly thank you for your testimony at the Ontario long-term care commission. I think it was brutally honest. It really gave everyone a clear picture of the unfortunate events that unfolded and that you and your team were sent in to clean up.

To start, I have a couple of quick questions for you, Colonel Malcolm. If we were in an operation like Afghanistan and had so many of our medical personnel deployed in managing role 3 hospitals in forward-operating bases, would we have been able to handle the domestic response that was required during the first wave of COVID-19?

Col Scott Malcolm: Obviously, I can respond from only the health system perspective.

Mr. James Bezan: But that's exactly what I mean. It's about the number of medical personnel deployed at our role 3s in forward-operating bases throughout Afghanistan. If we had all those people deployed, how would we manage a pandemic like we're experiencing right now?

Col Scott Malcolm: In order to tackle this very complex problem in the spring, we took a very different approach to it. We looked at it through a very needs-based health workforce planning lens. We looked at managing individuals and individual professions in this regard. We had to make some very deliberate decisions.

Certainly, in the face of a large-scale deployed operation like Afghanistan, more challenging decisions would have been made to manage the needs of a larger deployed force and balance those with domestic requirements.

Mr. James Bezan: Thank you.

Will medical health services be required to participate in the rollout of the COVID-19 vaccine, especially now that General Fortin has been appointed as the leader on the distribution of COVID-19 vaccines?

Col Scott Malcolm: As of right now, the additional roles of the Canadian Armed Forces and specifically Canadian Forces health services remain to be determined, though I will note that in the omnibus RFA that was developed as part of Operation Laser, one of the planning contingencies included in it is a role for the Canadian Armed Forces in mass vaccinations. That's factored into the planning, but it remains yet to be determined whether or not we will be required in that regard.

Mr. James Bezan: In preparation, as part of your training and readiness with the Canadian Armed Forces and through your health services group, are you right now training members of the Canadian Armed Forces to actually administrate vaccines across the country?

Col Scott Malcolm: For a number of our clinicians, the administration of a vaccine is a standard part of their training. The vast majority of those folks, be they medical technicians or nurses or physicians, are currently administering influenza vaccinations to our troops across the country.

Mr. James Bezan: I understand that the Canadian Armed Forces have been discussing their participation in the distribution of COVID-19 vaccines for some time as part of Operation Laser.

Colonel Malcolm, have you any idea how many members of the medical health services group will be required to help in this section of Operation Laser in the distribution of COVID-19 vaccines?

Col Scott Malcolm: As the military continues to gain a greater understanding of the needs the Public Health Agency and perhaps the provinces and territories may have with respect to the rollout, the role that Canadian Forces health services may play remains yet undetermined, noting that we have provided a pharmacist and a health care planner as part of that initial planning team.

Mr. James Bezan: In this planning process, when would the Canadian Armed Forces, under the leadership of General Fortin, have a solid plan in place that could be explained to Canadians from coast to coast to coast, so that they understand how the vaccines are going to be distributed, what role the Canadian Armed Forces would be playing, how we get to vulnerable populations and how we innoculate those who are living in rural, remote and northern communities?

Col Scott Malcolm: Madam Chair, that would be a question better placed to Major-General Fortin and the Public Health Agency of Canada. I'm not privy to the details and where things stand on that plan at this time.

● (1440)

The Chair: Thank you very much.

We go over to Mr. Baker, please.

Mr. Yvan Baker: Thank you, Madam Chair. I would like to ask my first question to Professor Estabrooks.

Professor, it's good to see you again. I have about five minutes, so I'm going to try to split my time between you and Mr. Hébert, if possible. If we could keep it within two minutes, I'd be grateful, just so that I have a chance to ask him a question as well.

Professor, do you believe that it is important, in light of what the Canadian Armed Forces discovered and revealed as far as some of the practices and conditions in our long-term care homes are concerned, that national standards for long-term care be established? If so, why?

Dr. Carole Estabrooks: Yes, I do, for some of the reasons articulated earlier. There is a patchwork of what can be expected across the country. It would raise educational standards. It would probably raise care hours and our understanding of the kinds of mixes provided. At the minimum it would reassure and would help the public understand that there's a national interest and a common understanding of what you could expect when you get old and need long-term care.

Not everybody is going to need long-term care when they get old. Dementia is the main driver of admission to long-term care. Those people whose needs overwhelm the family and the community in home care do need long-term care. For them, it's the right place to be if it's done properly.

Right now I think Canadians are afraid—I know they are—to go into a nursing home. The pandemic has exacerbated it. There's no sense, I believe, in the country that this is a national effort in the same way, even though it's still a bit of a patchwork, that health care is. Long-term care is not health care. It's a combination of social and health care. There's no real sense of cohesiveness that I can see in terms of what you get to expect when you get old and need that kind of care.

Mr. Yvan Baker: Thank you very much. I'll switch to Mr. Hébert now.

[*Translation*]

Dr. Hébert, it's a pleasure to meet you virtually. Thank you for being with us today.

My question is the same one I just asked Dr. Estabrooks regarding national standards for long-term care facilities.

In the Speech from the Throne, the government announced that it will work with the provinces to establish these national standards. Do you agree that this is important and a good way of improving conditions in long-term care facilities?

Dr. Réjean Hébert: Thank you very much for the question.

I agree because, in every other field of medicine, we have standards, either Canadian or international, for treating diabetes, Alzheimer's disease, obesity and heart disease. These standards must be based on the best scientific evidence available and, because Canada's provinces have relatively similar health care systems, it makes sense to bring the provinces together to benefit from their respective experiences and expertise.

It's also worth noting that Quebec's health services are accredited by Accreditation Canada, which also have national standards and has applied these standards in Quebec for decades. So, it's normal to rely on not only Canadian standards, but also international standards, to ensure Quebec and Canada have the highest possible standards in the world when caring for elderly people in institutions.

[*English*]

Mr. Yvan Baker: We have about 45 seconds. Briefly, what were some of the most horrific or difficult conditions you or your personnel observed in your service in long-term care, and what could be done about them?

Maj Karoline Martin: Certainly the report answers much of that, but I think for the clinicians it was actually seeing patients dying alone or not having their family with them. That was very challenging for all of the clinicians involved.

● (1445)

The Chair: Thank you very much.

We will go on to Monsieur Brunelle-Duceppe.

[*Translation*]

Mr. Alexis Brunelle-Duceppe: Thank you, Madam Chair.

Dr. Hébert, you spoke about national standards. Does Quebec's department of health and social services currently implement strategies for mental health and elder care? Has the department always done so?

Dr. Réjean Hébert: Yes. The Quebec government has mental health care and elder care strategies. What I have bemoaned for a very long time is that these elder care strategies have been a low priority and the result has been much more carnage in Quebec than in the other provinces and other industrialized countries. This is due to many years of neglecting this part of the system.

Mr. Alexis Brunelle-Duceppe: So, Quebec has elder care strategies. You said that was music to your ears. In other words, the federal government, which has no hospitals, or maybe one or two, is in a better position to overrule the people on the ground.

Is that correct?

Dr. Réjean Hébert: No, I absolutely did not say that, Mr. Brunelle-Duceppe. What I said—

Mr. Alexis Brunelle-Duceppe: Regarding national standards, that's what that means.

Dr. Réjean Hébert: No, that is not what that means. It means that all of Canada's scientists will be able to work together to set best clinical practices, as they do in other fields.

You know, science doesn't stop at the border between Quebec and Ontario. Science is happening across Canada and around the world. So I think that jingoism isn't really helpful in this area.

Mr. Alexis Brunelle-Duceppe: No, this isn't about jingoism.

So as Quebec's minister of health, you would have accepted national standards coming from Ottawa.

Dr. Réjean Hébert: I always accepted that Quebec needs to conform to the highest standards of practice. Whether it's service quality, treatments or diagnostic methods, Quebec must be at the cutting edge of national, Canadian and international standards.

Mr. Alexis Brunelle-Duceppe: So you believe that Mr. Legault is out to lunch when he says he is against national standards and that, as the Parti Québécois minister, you would have been for such standards.

Dr. Réjean Hébert: You are putting words in my mouth, Mr. Brunelle-Duceppe. I didn't say that.

Mr. Alexis Brunelle-Duceppe: The question is whether you would have accepted that.

[*English*]

The Chair: All right. The time is up.

We will go on to Mr. Garrison, please.

Mr. Randall Garrison: Thank you very much, Madam Chair.

One thing I'm very pleased to see today is the discussion of long-term measures for long-term care that might help prevent the future need for the Canadian Forces to use their resources to provide this assistance.

I was particularly pleased to hear Mr. Hébert talking about the need to move from a hospital focus to a home care focus, and Professor Estabrooks and Ms. van Beusekom talking about the need to recognize and appreciate care as an important service in terms of accreditation of staff, training of staff, living wages and all those kinds of things.

I know we're nearing the end of our time. My last question is about short-term measures. I think I'll ask Ms. van Beusekom first.

Do you believe the measures taken before the Canadian Forces departed from the long-term care homes were adequate to guarantee the health and safety of patients in those homes in Ontario?

Ms. Michelle van Beusekom: Thank you for the question.

No, I don't think the measures were adequate. In my view, the biggest issue was testing, which I spoke about. Long-term care should be given priority for testing. As soon as there is a confirmed case, everyone should be tested so that this population can be appropriately cohorted, negative with negative and positive with positive. If that can't be done, you take the positive people out of the location. That was a problem in the spring, and it's still a problem now.

It's testing and it's the cohorting. Those basic things that allow the teams on site to manage the outbreak are not systematically in place, and they're still not in place in Ontario.

Mr. Randall Garrison: Thank you very much. I'm sorry that's the answer we have to hear, but I think it's important for all of us to hear that.

Professor Estabrooks, I would ask you the same question about short-term measures. Are there important short-term measures that you see could be put in place now to help mitigate the negative circumstances that we're certain to face in the coming months in long-term care homes?

Dr. Carole Estabrooks: Obviously, we have to address the testing issue. We have to address the infection and the adequacy of PPE. That's just fundamental, and it's not addressed everywhere. We have to continue to hammer away at the staffing issues because we're going to be.... We have outbreaks right across this country right now. The death tolls and the toll of suffering are not restricted to Ontario and Quebec right now. They're right across from border to border.

The one thing I think we have failed quite significantly at is that we haven't understood that public health measures affect long-term care. Long-term care doesn't sit in a bubble hidden away in some mountain range. If people aren't complying with public health measures, it will ultimately affect the positivity rate in long-term care, and it will ultimately result in deaths and untold suffering. We have to try to understand and help the public understand that we must enforce public health measures because the people in the long-term care setting have no ability to protect themselves beyond what we do for them. That would be, I think, a key issue that we have to address.

We also have to address loneliness. We talk about people dying alone as if it's just a sad thing that happens. It's a catastrophic event. Loneliness and isolation kill people before they ever get to the very end of life. We have to manage visiting in as a safe a way as we can and not shut it down entirely like we did before.

● (1450)

The Chair: Thank you very much.

Mr. Bezan, please.

Mr. James Bezan: Thank you, Madam Chair.

My questions this round are going to be directed towards Mr. Shimooka.

You have done quite a bit of analysis of military spending in the past, and we know there's been a lot of spending during this pandemic to stimulate...to fill in the gaps in incomes for individuals and businesses.

Once we get this under control, have you put any thought into how future budgets by the government could impact defence spending?

Mr. Richard Shimooka: Yes, absolutely. It's interesting to take an international view right now. I'd like to point out that many countries—I'll point out France and the U.K.—have actually boosted defence spending, specifically in the acquisitions sector, and have accelerated purchases of equipment partly as a way to stimulate the economy. I think in the last year you've actually watched, or during a certain time in the pandemic we've actually watched, three major tactical fighter air programs that are somewhere in the region of 20 billion to 30 billion dollars' worth of spending be announced. We've seen the seed money in those programs in order to.... It's sort of as a stimulus measure, partly because the aerospace industry in particular has been extremely hard hit, as we all know, and not just with regard to travel but also with regard to the actual manufacturing and MRO side.

With that being the case, Canada hasn't really done that. Canada just doesn't have a national defence procurement strategy in the sense that it is well-developed and providing money for the investment of capabilities and the like. I think what's going to happen—

Mr. James Bezan: Should we have that strategy?

Mr. Richard Shimooka: Absolutely. I think that's part of it. We have what are called the key industrial capabilities or KICs, and what we do is we take the ITB—the industrial and technological benefits—funding and use that to support Canadian industry. It's not really an effective strategy. A lot of countries have moved away from such strategies. I think the government is going to look at the KICs and try to use them to fund domestic priorities in a kind of roundabout way. That's just going to cut into the budget of the Canadian Armed Forces for procurement and also increase time and delays for equipment.

I would probably caution the government about looking at that way as a stimulus measure for the economy, and I'm quite worried that this is actually what it is looking to do.

Mr. James Bezan: How then would you balance off the interests of economic drivers with the capabilities required for the armed forces, and trying to procure that in the best interests of the taxpayer?

● (1455)

Mr. Richard Shimooka: I think that there's a balance. I'd probably point to some of the stuff that the United Kingdom and Australia have done in the last decade or so. They've moved away from very rigid formulas requiring 100% domestic offsets for foreign-purchased equipment to more flexible arrangements that actually look at the value of what they're getting and at the development of domestic industries.

They also provide significantly large, direct investments from the government rather than trying to do it completely through the ITB format. I think it's a real danger that we have in Canada and you start to see real problems associated with it, especially now that you can alter the selection of military capabilities based on the value proposition, the number of ITBs, where they're located or the value according to the assessment criteria. So—

Mr. James Bezan: Let's just look from the standpoint of one thing we've learned through COVID-19, through this pandemic. We didn't have sovereignty over the production of PPE. We don't have sovereignty over the production of a COVID-19 vaccine. We're depending upon other nations to provide that.

Is there critical infrastructure within the Canadian Armed Forces that we should have sovereignty or control over? Some of these supply chains are critical and paramount to the protection, safety and defence of Canada.

The Chair: Give a quick answer, please.

Mr. Richard Shimooka: I'd say it's stuff like cyberwarfare, stuff that requires really rapid and quick development and having the IT control over that, especially within Canada. Those are the areas that Canada should look at, towards maintaining a domestic industrial base.

The Chair: Thank you very much for that.

Mr. Hardie.

Mr. Ken Hardie (Fleetwood—Port Kells, Lib.): Thank you, Madam Chair. You run a very tight meeting. That's very good. Of course, it's what we would expect.

Major Martin and Colonel Malcolm, the Canadian Armed Forces must have gained some experience 102 or 103 years ago with the Spanish flu. Was there a playbook? Were there learnings from that that you've been able to carry forward into the situation you're facing now?

Col Scott Malcolm: Thanks for the opportunity to respond to that question.

I would suggest that documentation and maintenance of that documentation over that century, while somewhat challenging.... Certainly we were able to look back to more recent lessons, specifically through the H1N1 experience and to roles there. There were some lessons learned but it was suggested that, again, we were looking at more of a known entity in an influenza, with H1N1. There's much more uncertainty with this pandemic, being the first-ever coronavirus.

Mr. Ken Hardie: Thank you.

Early on in our experience with the pandemic, we watched in shock and horror what was going on in Europe, particularly in Italy. That was certainly where I saw the first involvement of the military, in helping civil authorities deal with the situation.

Have there been discussions, exchanges of intelligence or ongoing liaison with military in Europe as to how they've been dealing with this, and are there learnings for us?

Col Scott Malcolm: Thanks for the question.

Both through our NATO allies and through other partners across the globe, we've been receiving valuable lessons, whether it's from Japan, Korea.... Everyone in the military sphere is quite willing to share lessons and we've been keeping abreast of those throughout this time. Given the fact that the first wave came a couple of months after it struck the other side of the world, we were able to be somewhat better prepared, given the limited knowledge that was available at that time.

Mr. Ken Hardie: It seems that you will be called on with respect to the issue of getting the vaccines out. How good are you guys at logistics? This is your commercial.

Col Scott Malcolm: Unfortunately, you're asking a doctor about how good we are with logistics. That's not my area of expertise but I can tell you that, when it comes to medical logistics, we relied very heavily on our medical logisticians to get PPE around the world—when we supported Operation Globe—and also into the long-term care facilities. They did marvellously. No member went into those long-term care facilities without having the top-quality PPE they required to protect themselves and the vulnerable populations they were serving.

Mr. Ken Hardie: I have time for another quick question to Ms. Estabrooks and Ms. van Beusekom.

Isolation has been mentioned. What do we do about it? What are your suggestions?

Dr. Carole Estabrooks: We can't eliminate risk. We have to accept some risk when we allow visitors and family in, but we can mitigate that risk. We can limit the number of people in. We can ask that families comply, and if families don't comply with the infection control practices, they shouldn't be able to visit. However, we must let them in, because individuals who are older with dementia deteriorate not just physically from being alone in bed but very rapidly cognitively when they have no contact, in particular with familiar people.

Remember, people are walking into the room with masks, gowns and hats. They don't have good sensory comprehension as their dementia progresses. They can't hear well and they can't see well, so it's frightening and confusing. We can mitigate the risk. We must accept there'll be some. We can do this quite safely if we're thoughtful about it, and we have to. We can't let people die alone.

● (1500)

Ms. Michelle van Beusekom: There's a great precedent in Ontario with the essential caregiver program, which was introduced thanks to the lobbying of many people. Each resident now has the right to two essential caregivers. I am one for my parents. That makes all the difference. We're tested regularly. We're trained in PPE and infection control protocols, and it makes a world of difference. Going into their home, I see the decline of people who don't have access to family members.

It can be done safely and Ontario is actually a leader in that regard. That should be extended across the country in my opinion.

The Chair: That brings us to the end of our time.

[*Translation*]

Thank you, everyone.

[*English*]

Thank you so much for your brevity, and for treating the time of the fellow witnesses and committee members with such respect. I thank you for being with us today. We know your time is precious.

With that, the meeting is adjourned.

Carole A Estabrooks, CM, PhD, RN, FRSC, FCAHS, FAAN, FCAN is Professor & Tier 1 Canada Research Chair, Faculty of Nursing, University of Alberta.

I am the Scientific Director of the longitudinal *Translating Research in Elder Care* applied research program in LTC. My research focuses on quality of care, quality of life and quality of end of life for older adults living in LTC homes, and on LTC workforce quality of work life. I also focuses on moving research to action to support evidence informed policy decisions.

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Opening remarks

In Canada we are fortunate that we have the capacity to call upon the Canadian Armed Forces in crisis. We are thankful that they stepped up to provide care to frail, vulnerable older Canadians in nursing homes during the first wave of the pandemic – going into unfamiliar and besieged care settings, with unfamiliar charges in their care, with little time to prepare. We are grateful that they stabilized parts of the LTC system that had moved into deep crisis, preventing further suffering and unnecessary deaths not from COVID-19 but from the terrible conditions COVID19 was permitted to establish. We are grateful that they fulfilled their duty to report – that those stark and pointed reports riveted the attention of Canadians and our leaders on the unfolding catastrophe.

In Canada over 80% of country COVID deaths have been in LTC, far outpacing any other country in the world. How could this happen? Only by valuing older adults and in particular, older adults with dementia, less. Only by valuing nursing home care less than care in the hospitals and ICUs. Only by discriminating actively and passively against older adults with dementia who live in care homes

Nursing homes or LTC homes have their origins in 17th century Elizabethan poor law – when poor houses and alms houses were created. Why would that matter in the 21st century? Well Elizabethan poor law created the concept of the deserving poor and the undeserving poor whose needs could be ignored.

In this, our second Elizabethan age, amidst the COVID crisis, we see in full display (1) a mindset of discrimination against older adults and (2) the creation of the undeserving ill and needy who we deemed could live acceptably in conditions most of consider intolerable – in a sector profoundly underfunded, understaffed, unmodernized functioning in a patchwork system of regulation, inspection, oversight and accountability.

Some have argued that care homes and their vulnerable residents were used as a human shield to protect the health care system, government, and society. Dying to protect us.

We all knew early (if we were associated with LTC) that things in care homes were bad and could quickly become catastrophically worse – that attention and action favored the young and the hospitals, that decades of neglect and inattention – of managing on the *thinnest of razor edges* had created these conditions. Still when the military reports of COVID conditions in nursing homes came out, we gasped, we wept and for some a smouldering rage began.

I regret that our men and women of the armed services had to step in but I am grateful that they did. As a Canadian I am proud of their work.

For over half a century, reports of abuse, insufficient resources, neglect and so on in LTC have been produced by governments, organizations, unions, and the media. In the last 30 years alone, 80 Canadian reports have been produced at considerable cost, common themes have emerged (many focusing on the workforce and working conditions) and little was done – even when nearly 2 dozen seniors burned to death in Quebec or when Canada's most prolific serial killer emerged in Ontario nursing homes.

Our governments and our society at large have known or should have known what has been happening – for example, in the Royal Society of Canada report on *Restoring Trust: COVID-19 and the Future of LTC* we identified over 150 media reports in the last 10 years alone, in nursing homes in this country.

Experts, the public and the media have not been able to capture and hold enough attention for action. It took reports from our Military to spur action, and thank god those reports emerged but – we need to ask *why is that*? *and what happens beyond the duty to report?*

These military reports from Quebec and Ontario, while they did galvanize attention and action, are however unlikely create lasting impact on the Canadian LTC system because the root causes of the situation were not addressed.

At the heart of the LTC and workforce challenges (in addition to ageism) is undisguised sexism. Caring for the elderly in LTC is considered "just women's work" after all *how hard can it be to feed and toilet people – pretty much anybody can do it*. **This is of course patently false**. Caring for an increasingly complex population of the frail and vulnerable elderly is complex, demanding and skilled work. **It is honorable work**.

It is delivered by personal support workers of whom over 90% are older women, half of them immigrants. Paid the poorest of any workers in our health system, often without benefits or the security of a FT position, with poor preparation and little to no ongoing education. Treated as if they have little to offer beyond basic care and with insufficient support by a team of professionals. Our modern day workforce of the 17th century Elizabethan poor houses.

Before I end I want to speak briefly to issues of mental health among the military and civilian workers under COID conditions.

I am pleased to see support for the mental health and well-being of military personnel who were on a temporary assignment. We must turn to the mental health and well-being of the LTC staff who have no such support and who are not there temporarily.

Early prevalence estimates of moderate-to-severe symptoms of anxiety and/or PTSD among LTC workers are as high as 43%, with mild symptoms reaching 87% (Italy; Riello et al., 2020)

LTC staff in Spain working with COVID positive residents report high levels of secondary traumatic stress from work presssures, high exposure to suffering, lack of PPE, and minimal supervisor support (Blanco-Donoso, 2020).

In Ontario, health care workers have been disproportionately infected, making up nearly 20%of COVID cases by late July 2020, significantly more than the estimated global rate of 14% for health care workers.

The mental health issues experienced by personnel working on the front lines will not be gone by this Christmas, by Easter, or by next Christmas – many of them will linger for years and decades. But they will be less devastating if we act now to support personnel on the front lines in care homes and elsewhere, if we act to support families who have suffered and if we support the mental health needs of those older adults in care homes who *have* survived.

We do not need more commissions, or inquiries or reports. We do need a modern day equivalent of a **Marshall Plan** to accomplish a root and branch overhaul of the LTC system.

These places where we have placed and forgotten our elders – these are homes, not chronic hospitals or poor houses. Homes charged with delivering quality care – in the service of a good quality of life, a good end of life and a good death. Even with dementia these are achievable ends.

Conclusion

I want to thank the Standing Committee for inviting me to speak. But what now? is there a role for military beyond reporting? We are all, when we are our best selves, accountable for each other, how do we ensure action? I am grateful for the work and care of CAF members in LTC, but the LTC system into which we place our parents, siblings, spouses and long term companions has endured over 50 years of eroding funding and neglect, because of undisguised discrimination toward the old and toward women and the work of caregiving.

COVID-19 conditions in nursing homes have caused excess death, indescribable suffering and operationalized the deepest existential fear that many Canadians have – the fear of dying alone.

Just as Passchendaele has come to symbolize the senseless slaughter and unimaginable suffering of Canadians who served, COVID-19 in nursing homes has come to symbolize unnecessary death and senseless suffering among those who built Canadian society, among those who once served, whether in the armed services or in regular, everyday civilian life to make this one of the most desirable countries in the world in which to live.

If we do nothing, then once the vaccines are administered, once COVID-19 has passed, once our memories fade, once we can forget again about the deserving old in nursing homes, once new priorities take centre stage – nursing homes will return to pre COVID conditions, we will not have learned, and nothing will have changed – not really. Until the next event.

COVID-19 is a global tragedy but if we work together to address both our immediate needs and a truly rot and branch overhaul then the sacrifice (including the sacrifices of the CAF) will mean something. Something good and honorable.

A LTC home (a nursing home) is not a chronic hospital. It is a home and for most of its inhabitants it will be their last home. The older adults in these homes require both health (quality of care) and social (quality of life) care. They are old, half over the age of 85, frail, with many co-existing diseases; about 80% of them have dementia, itself an age related, life limiting disease. Their care has been and is increasingly complex and demanding.

Yet over half of Canadians surveyed say that they would rather die than go to a nursing home. How is it that we have let it come to this in Canada – a high income, high quality of life nation? How have we let 85% of Canada's COVID-19 deaths occur in nursing homes – the highest rate of any country in the world.

We have thus far failed in our duty to care for our most vulnerable citizens. With particular savagery in some places in Canada. We should each of us, stop and recall each day – that we, in the worst of the first pandemic wave in some parts of Canada, left old people to die in their own excrement, without water, without food, without human contact. Old, vulnerable Canadians. Somebody's parent or grandparent, husband or wife, brother or sister, friend or long time companion.

This is everyone's problem. Not just a problem in Ontario and Quebec. Every one of the some 1800 nursing homes in Canada is but one step away from an outbreak of COVID-19. Witness the tragedy unfolding in Campellton, New Brunswick. One physician with COVID-19 who gave it to one patient who then went to work in their nursing home, and gave it to 3 staff and 15 seniors, one of whom has died – so far. One step away, that is all any nursing home, in any province or territory is.

It is complacency and non-malevolent neglect; it is our attitudes toward the old and infirm; it is our attitudes toward the work of caregiving – the purview of women; it is our belief that anyone can care for an old person with dementia – these got us precisely where we are today. It is also our baffling belief that we could manage a system as complex as the LTC sector without decent data. Something more akin to using a Ouija board than an evidence informed approach. *In the 21st century*.

Blaming is not useful. The task now is to solve the immediate problems, and then turn sharply to the medium and longer term problems. Or this will assuredly happen again.

Not because we do not know what to do. I can cite 100 reports (literally) gathering dust on shelves. I can cite thousands of research papers, offering solutions to various of the many challenges. I can personally cite you over 10,000 interviews my own research team has done with direct care staff. They tell us they are under duress, inadequately prepared, that they miss and rush essential care – because there is not enough staff and not enough time.

What needs to happen?

1. We must ensure every LTC home in Canada is ready for the possibility of a second wave
2. We must continue to fix the worst of the workforce conditions: pay, benefits, working in multiple sites
3. We must ensure LTC homes have the equipment and resources to "test and trace" all residents and staff; to screen all workers and visitors; to screen all families; to ensure all have proper PPE and training in infection control
4. We must help women workers whose children are out of school and whose own aging parents may need care – with innovative strategies for child care and for respite
5. We must treat families like families – not visitors
6. We must assess the impact of "one-site work" policies to make sure there are no unintended consequences
7. We must ensure competent management and leadership in all LTC homes
8. We must figure out how to deploy available workers if a LTC home is crippled by staff who are sick themselves
9. We must have data – for heaven's sake – we need to get good data, so that we can manage the LTC sector properly

What does not need to happen?

1. Another commission, inquiry, report, study – I can point you to 80 reports in the last 30 years, done in Canada at an extremely conservative estimate of 24M that all say essentially the same thing we – point to the same solutions time after time
2. We must not favor acute care over LTC
3. We mustn't engage in unrealistic thinking – that this is easy and will not take resources. It is hard work and of course it will take resources, but it won't bankrupt the country
4. We cannot engage in endless acrimonious debates over federal vs. provincial jurisdictions

Do any of us believe that the old person lying in their own excrement, thirsty, in pain, alone and afraid as they died wondered whose *jurisdiction* it was to help?

Thank you.

Operation Laser – Canadian Armed Forces (CAF) in nursing homes

First some facts from the previous testimony (document review from Melissa)

- 729 personnel provided front line support in LTC facilities, 393 were women, you can link into the % of women who live and work in LTC.
- 55 members serving in LTC facilities got COVID, no hospitalizations were necessary.
- The leadership summarized the Report observations as "patient & staff safety considerations:
    - Noted all facilities were different
    - Some had non-adherence to policies related to infection control
    - Some had inadequate staff training and supplies
    - Some had deficiencies in infrastructure
    - Some had concerns over standards of care
- There is a CAF mental health program called "The Road to Mental Readiness" that helps personnel prepare for deployment. Apparently, there were services tailored to the specific needs of troops going into LTC. Social workers and Chaplains were made available during deployment. This program also offered Post Deployment services

Carole's Comments

It will be very important to be positive about the military response. The MP's were all effusive in their praise for their service in LTC, so

- Begin with stating how fortunate we are in Canada to have the CAF willing and able to serve the LTC homes in crisis. Express your gratitude also for them stepping up no only to provide assistant to the most vulnerable population during the pandemic but also in fulfilling their duty to report.
- For over half a century (50 years) reports of abuse, neglect and so on in LTC have been written, seen in media - governments and society have known or should have known what has been happening (here use the list of media articles) in nursing homes in this country.
- Experts and the media have not been able to get enough attention for action. It took reports from the Military to spur action, and thankfully they did but – as a society we need to ask why is that? and what happens beyond the duty to report?

Military Reports

- Described the circumstances they encountered, and did it well. They did have an impact in catalyzing action, however that action in the two provinces Quebec and Ontario may not have the lasting impact on the LTC system as the root causes were not included in such a report. Ageism and sexism discussion can go here. Value in a life lived …….
- Go into the RSC report and stress that more studies are not needed, action is needed, then the recommendations
- **Add in Eric's paper!**
- Come back to the military report summarizing the issues as patient and staff safety, but include Quality of life and work
- Then go into the sexism part and the interesting issues around women, value of women's work
- Say the military reports become much more powerful when they are considered within the health and social system context – they describe the effects of decades of ageism and sexism on those who live and work in LTC

Mental Health

- I think it is worth mentioning that you are pleased to see the support for the mental health and well-being of military personnel who were on a temporary assignment, then consider the mental health and well-being of the LTC staff who have no such support and who are not there temporarily.

    - Early prevalence estimates of moderate-to-severe symptoms of anxiety and/or PTSD among LTC workers are as high as 43%, with mild symptoms reaching 87% (Italy; Riello et al., 2020)
    - LTC staff in Spain working with COVID positive residents report high levels of secondary traumatic stress explained largely by social pressure from work, high exposure to suffer ing, lack of PPE, and minimal supervisor support (Blanco-Donoso, 2020).
    - In Ontario, HCWs have been disproportionately infected, making up nearly 20 percent of cases by late July 2020 which is a significantly higher rate than the estimated global rate for HCW infection at 14 percent.

- Preparing the CAF staff for deployment in LTC is important, and if you can help, offer to assist in the preparation if any future such deployments, this may help prepare the CAF staff for what they will be facing. You can

describe the systemic issues, describe the workforce and the resident population
- Make the point that this is a “home” not a hospital and the significant differences between the two – the link here is the mental health and well-being of residents and families and perhaps the information about the indirect Covid-19 related deaths (Washington Post article)

Conclusion
- In addition to thanking them for the invitation, ask what now? What is the role of CAF beyond reporting? We are all accountable for each other, how do we ensure action happens?
- You are so very grateful for the CAF members work and their support for LTC, but we have endured 50 years of eroding funding and neglect, due to ageism and sexism – how can we as a country move forward? These members have fresh eyes and first-hand experience, is that what it takes?

Correcting institutional deficiencies and funding long-term care differently

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While media attention is rightly focused on the plight of seniors who are dying in residential institutions or are confined to seniors' homes, there is a need for post-disaster preparedness. First, we need to investigate the root causes of the disproportionate impact that COVID-19 is having on people in group living environments. How did we get here? What have we done – or rather what have we neglected to do – to create the conditions for such a massive loss of life to take place? But after the investigation, we must act quickly; there are ways to rectify the situation and put in place measures that will prevent a recurrence of this tragedy and enable vulnerable seniors to live a better life in society.

Canada is aging; we say that often, but we don't realize how rapidly. In less than 15 years, people over 65 will make up more than 25% of the population. Japan is already there, and we will now overtake most of the European states that were once called the "old countries." This population aging is not a social, economic or even health disaster. However, we must acknowledge the facts and adapt our institutions and services to this new reality.

Clearly, we refuse to see our collective aging; we refuse to see our old men and women. We even use all sorts of different words to hide the reality: the aged, the elderly, senior citizens, elders. These euphemisms conceal our deep denial of aging and old people. We continue to behave like a young society, starting with our health care system. Reforms in recent decades have made hospitals even more central to the system and institutions, while elder care at home or in institutions has taken a back seat. In every area – budgets, construction and renovations, managerial concerns, medical or nursing resources, or assistance and support staff – hospitals get top priority.

The COVID-19 pandemic and the disaster it has caused in residential institutions demand concrete action to contain the crisis, prevent a recurrence and better organize services for seniors. First, we need to rectify the situation by deploying immediate solutions that will limit the damage and, most importantly, prevent the scenario from recurring during the inevitable second wave. We must also recognize that the institutional solution is still preferred in Canada because of the history of the creation of health insurance systems. Above all, we must come up with lasting solutions to better serve the elderly, especially those who are becoming less independent, whether they are at home or in residential institutions.

1. Containing the crisis

In Quebec, we are still in the midst of a health crisis in CHSLDs (long-term care homes) and other seniors' residences. As of September 10, 2020, there had been 3,676 deaths in CHSLDs, or 9.1% of their residents. The shortage of personal support workers (PSWs) is only the tip of the iceberg; the causes of this "perfect storm" are broader than that. PSWs are the forgotten members of our health care system. In this complex structure, increasingly focused on hospitals and their technology, we have forgotten the human being who needs care and the human being who provides care. Care encompasses much more than executing procedures; it includes listening, being compassionate and patient, smiling, comforting and much more – all tasks that cannot be measured for productivity targets. This is the essence of PSWs' work, what motivates them and what makes their tasks fulfilling and compelling. Of course, remuneration is part of the solution, but working conditions are just as important, if not more so.

CHSLDs must be not only living environments but also care environments, as they accommodate people with multiple medical conditions. Hence, it is important to have a dedicated and competent team of doctors on site. In the blind pursuit of the goal of returning family physicians to offices, the CHSLDs have been stripped of their medical staff. Nursing supervision, which is essential for planning care and performing professional and technical procedures, has also been diluted. As a result, residents have to be taken to the emergency and the hospital for even the slightest decline in their medical condition, which has adverse effects: contamination, mental confusion, unwanted and inopportune interventions, etc. In addition, the expertise to deal with crisis situations and order the necessary measures to prevent the outbreak or spread of infections is often lacking.

In an epidemic, the availability of protective equipment (masks, gowns, visors), designating compartmented areas, and prohibiting staff from working at more than one site or unit are essential conditions for preventing the spread of infection. Moreover, stable staffing in care units is also a prerequisite for high-quality, humane care, even in normal times. A study by Liu et al.[1] comparing mortality in residential institutions in British Columbia and Ontario identified the formal prohibition of staff mobility as a significant factor in the much lower mortality rate in British Columbia. While Ontario was slow to ban mobility, Quebec did not do so in the first wave and still tolerates it today.

The physical facilities in CHSLDs are often outdated: rooms with multiple beds, shared washrooms, inadequate ventilation, and lack of sprinklers and air conditioning. In these conditions, residents lack a minimum quality of life, and staff do not have a healthy, pleasant work environment. There are also no extra rooms for end-of-life care or isolation of residents when they are infectious. The poor quality of the facilities increases the risks during heat waves and outbreaks. An intensive renovation program is needed to correct these deficiencies and create safe, attractive environments.

Lastly, successive reforms of the health and social services system in Quebec have eliminated local management of CHSLDs. CHSLDs are part of regional superstructures that include hospitals, rehabilitation centres, youth centres and local community service centres (CLSCs). Decision-making authority and management are centralized, and there is no local leadership in each facility. It is fundamental that each CHSLD should have a management team responsible for the specific organization of that institution's services and, most importantly, for quick and effective response to crisis situations.

To prevent a new surge in deaths during a second wave of COVID, we need to rebuild medical teams, improve nursing staffing, recognize the work of PSWs, strengthen measures to prevent the spread of disease, renovate facilities and introduce local management in CHSLDs.

[1] Liu, M., Maxwell, C.J., Armstrong, P., Schwandt, M., Moser, A., McGregor, M.J., Bronskill, S.E., and Dhalla, I.A. (2020). COVID-19 in long-term care homes in Ontario and British Columbia. Can Med Assoc J. doi: 10.1503/cmaj.201860; early-released September 30, 2020.

2. Canada's health care system and the institution-centred approach

The Canadian health care system and the *Canada Health Act* have put hospitals at the centre of the health care structure. While this choice was justified in the last century to meet the needs of a younger population, it is much less appropriate for an older population struggling with chronic disease and disability.

Compared with other industrialized countries, more seniors in Canada and Quebec live in group settings that provide care and services. The percentage of the 65-and-over population living in long-term care is 5.7% for Canada and 5.9% for Quebec, while the average for OECD countries is 4.7%.[2] But Quebec has a particularly high number of people in retirement residences, with more than 100,000 seniors (7%) living in such homes. More than half of the places in retirement residences in Canada are in Quebec. Nearly 20% of Quebec's over-75 population has chosen this collective lifestyle, which groups seniors together in a form of independent self-exclusion from other social groups.[3] These seniors of the so-called "silent" generation seek safety and access to services when needed. Their baby-boomer children also saw it as a practical way to provide their parents with support and safety. While those residences were struggling to fulfil their mandates prior to the crisis, it is clearly nothing but an illusion in light of the COVID-19 outbreaks and the general lockdown that the pandemic has created in these settings.

The popularity of group housing stems from the inability of society and the health care system to provide the necessary home care services for people who are losing their independence. In the absence of adequate home care, the pressure on CHSLD accommodation has increased, and a lucrative market of unlicensed private CHSLDs and retirement residences has developed in a haphazard manner, without government control. However, today's and tomorrow's seniors would prefer to continue living at home as long as they have access to sufficient, high-quality services if they become less independent. This requires a change in the way we look at independence support services: instead of moving people to housing solutions that address their needs, we should be adapting and developing the range of available services and let people live where they have chosen to grow old.

Only 14% of public long-term care funding goes to home care in Quebec and Canada. All other OECD countries put more of their public funding into home care, with Denmark ranking highest at 73%.[4] This lack of investment is a funding choice; the Canadian health care system essentially covers medical and hospital care. As a result, long-term care accommodation from continuing-care hospitals is covered by the public health insurance system, while home care is funded at the margin, at the discretion of each province. Hence, it is easy to understand why the institutional solution was preferred.

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[2] OECD. *Health at a Glance 2019*. https://www.oecd-ilibrary.org/social-issues-migration-health/health-at-a-glance_19991312

[3] Hébert R. *Les vieux se cachent pour mourir, 2016*. https://www.ledevoir.com/opinion/idees/464685/les-vieux-se-cachent-pour-mourir

[4] Huber, M., R. Rodrigues, F. Hoffmann, K. Gasior and B. Marin. 2009. *Facts and Figures on Long-Term Care. Europe and North America*. Vienna: European Centre for Social Welfare Policy and Research.

3. Investing more but differently

Investing more in home care will not be enough to effect significant change. In a longitudinal study of all the services used by all Sherbrooke seniors from 2011 to 2015, we observed a significant progressive decline in home care services over the period, from 200,000 visits per year in 2011 to less than 60,000 in 2015. The decrease was particularly significant for those receiving more intensive services. This is especially troubling since the 2013-2014 budget included an additional $110 million for home care, a 20% increase in the base budget. Clearly, that increase did not translate into improved services. Instead, institutions reallocated the funds on the basis of their priorities. At that time, home care provided by CLSCs was funded from the same budget as hospitals and long-term care homes. So the additional funds were used by hospitals. It is easy to imagine that with the 2015 reform, this situation has not improved and that the recently promised investments in home care are unlikely to translate into additional services for home care users. Managers of the current supersystems cannot resist the temptation to reorganize revenue sharing to relieve the rising costs of regular hospital care.

The situation is probably similar for federal transfers for home support. In 2017, the federal government announced an investment of $6 billion over 10 years for home care through health transfers. There is no guarantee that this substantial injection of funding will result in a significant increase in services. The concern is that provinces and institutions have other priorities, with access to hospital care monopolizing their attention.

This means moving away from the current institution-based funding model. Instead, needs-based funding should be put in place for long-term care. This is the principle of public long-term care insurance, which has been introduced in many countries over the last 20 years, including Japan, South Korea and most continental European countries.[5] In those insurance systems, the individual's needs are assessed using a disability assessment tool. A benefit is determined on the basis of the level of need. That benefit is used to fund public or private services chosen by the individual or family members based on the intervention plan developed by a health professional, often a case manager. Some countries even issue a cheque ("cash for care") directly to the individual, who then arranges for the services. The quality of the service providers is assured through an accreditation mechanism, and the quality of the services provided is assessed by the case manager. Those insurance plans are usually funded on a pay-as-you-go basis through employer-employee contributions, a tax on retirement pensions, income tax or other specific forms of revenue (e.g., electricity charges or the abolition of a public holiday).

That is what was offered in Quebec's "autonomy insurance" proposal in 2013, when I was a Cabinet minister in the provincial government. Like most other provinces, Quebec already has a number of resources that would facilitate the rapid implementation of this important reform: an assessment tool that is already widely used for everyone who needs home or residential services (the Multiclientele Assessment Tool [OEMC], part of the Functional Autonomy

[5] Hébert R. "L'assurance autonomie: une innovation essentielle pour répondre aux défis du vieillissement." *Canadian Journal on Aging* (2012), 31(1): 1-11.

Measuring System [SMAF]); a classification system consisting of 14 standard disability profiles (Profils ISO-SMAF) that translate the need into resource requirements and benefits; case managers already deployed as part of the integration of services following the Program of Research to Integrate the Services for the Maintenance of Autonomy (PRISMA) project; computer tools to support the development of the intervention plan and the allocation of services; and an efficient management organization that is already keen on this type of funding, the Régie de l'assurance-maladie du Québec.[6]

Autonomy insurance meets several needs:

- It ensures equitable public funding for people requiring long-term care and services, regardless of their living environment and service providers.
- It offers a solution to interregional and inter-institutional equity issues in the provision of home support services.
- It establishes public management of all independence support services, whether they are provided by public institutions or private companies.
- It gives users back the freedom to choose their living environment and service providers.
- It ensures the quality of the services offered by public and private organizations and encourages service providers to emulate or compete against each other to better meet needs.

There was to be a specific, protected budgetary program to isolate this funding from the institutions' overall budget. At that time, it was estimated that cumulative annual investments of $100 million to $200 million would be required to meet seniors' needs and adjust for expected population aging. The additional investment projection for 2027 was $1.3 billion, $1.5 billion less than the projections based on the status quo institutional solution.

Following the publication of a white paper,[7] which was well received by all stakeholders, a bill was introduced in the National Assembly in December 2013. Because a snap election was called and the Marois government lost, the bill never passed. The bill was not revived by subsequent governments. The bill is dead, but the idea is not, and the components needed to make it a reality are still present. It is now even more relevant because of the COVID-19 crisis.

In the Canadian system, there are two feasible ways of implementing this form of funding. One option would be long-term care services legislation modelled on the *Canada Health Act*. The new law would set out broad principles that would encourage the provinces to introduce specific funding for long-term care with a focus on home care. If the principles and conditions were met, a federal contribution to the system put in place by the provinces would be provided under the new law. The other option would be to establish a Canada Home Care Benefit, under which the federal government would provide direct federal funding to people who meet certain

[6] Hébert R, Gervais P, Labrecque S, Bellefleur R. 2016. L'assurance-autonomie au Québec : une réforme inachevée. *Health Reform Observer*, 4(1): First article. DOI: dx.doi.org/10.13162/hro-ors.v4i1i.2737
[7] Hébert R. 2013. *L'autonomie pour tous : livre blanc sur la création d'une assurance autonomie*. http://www.assnat.qc.ca/fr/travaux-parlementaires/commissions/csss/mandats/Mandat-24161/index.html

disability criteria. The provinces already have standardized needs assessment tools that could be used to determine eligibility and the amount of the benefit. In any event, no matter which option is considered, negotiations with the provinces are essential to define the contours of the legislation or program.

Conclusion

The current crisis in Quebec's long-term care institutions is the result of the health and social services network's neglect of elderly people who are no longer independent. The CHSLDs are in need of a major overhaul in governance, management, funding, service delivery, and the quality and safety of facilities. Medical and nursing supervision must be enhanced, and working conditions – not just pay – must be improved for PSWs. Facilities need to be renovated, and management and governance need to be reformed.

Canada's health care system must adapt to an aging population. Hospitals should no longer be the focus of priorities and decisions. Chronic diseases require a different approach based on quality home care. The funding of services should no longer be based exclusively on institutions but on the changing needs of users. Public long-term care insurance would help achieve this goal.

Our seniors deserve to grow old at home with the services they need. If we tailor our approach to the funding and organization of services to 21st-century reality, Canadians and Quebecers will choose to grow old at home and will resist the siren song of residences and other places of institutionalized social exclusion. This is the kind of society we want for today's seniors and for the seniors of the future, a group we will all inevitably join.

About the author

Dr. Réjean Hébert is a geriatrician, gerontologist and epidemiologist. After a long career at the University of Sherbrooke, he is now a professor in the Department of Health Management, Evaluation and Policy in the University of Montréal School of Public Health (ESPUM). He was Dean of the Faculty of Medicine and Health Sciences at the University of Sherbrooke from 2004 to 2010 and of ESPUM from 2017 to 2019. He was the founding director of the Sherbrooke University Geriatric Institute's Research Centre on Aging, the Quebec Network for Research on Aging, and the Canadian Institutes of Health Research Institute of Aging. His research focuses on the organization of services for seniors losing their independence, front-line services and patient engagement. He designed and validated the Functional Autonomy Measuring System (SMAF) to measure the needs of seniors and persons with disabilities. He led the Program of Research to Integrate the Services for the Maintenance of Autonomy (PRISMA) group, which developed and validated an original model of service coordination that improves the efficiency of the health care system while preventing loss of independence among seniors. From 2012 to 2014, he was Minister of Health and Social Services and Minister responsible for Seniors in Quebec. In 2019, he was awarded the Armand Frappier award, a Prix du Québec recognizing exceptional contribution to the organization of research.

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Prepared Testimony of Richard Shimooka
Given at The Standing Committee on National Defence
November 27th 2020.

Richard Shimooka is a Senior Fellow At the Macdonald-Laurier Institute, where his focus is on international security and strategic and military studies. This testimony is heavily based on a recent MLI report on the post-COVID-19 defence and security environment.

In the past year, the COVID-19 pandemic caused significant dislocations to Canadian economy and society. However, as we look to the international sphere, the pandemic has accelerated a number of long-standing trends, and introduced several new challenges. Over the past decade, we have witnessed the fragmentation of political, economic and military arrangements that underpinned the rules-based international order that emerged in the aftermath of the Second World War. In its final iteration, this order was defined by the promotion of such liberal political values as freedom of expression, poverty reduction and democracy promotion.

That impulse seems to have run its course, however. The post-Cold War consensus has broken down, driven in part by the growing assertiveness of national actors in international relations. Several powers, such as Russia, China and Iran, have rejected or worked to usurp this US-led international order. The fraying of the post-Cold War consensus has also occurred among close allies, where populism and nationalism have emerged as a powerful and disruptive force. Their growth is variously blamed on historic lows in public trust of governing institutions, declining economic prospects, and rapidly changing societies. Manifestations include populist presidents such as Viktor Orbán in Hungary, Jair Bolsonaro in Brazil and the rise of the Five Star Movement in Italy.

One of the clearest indications of this emerging era of global power competition is evident in the military sphere. Over the past decade, a dramatic modernization effort has been undertaken by major military powers, encompassing increases in funding, reorientations in force postures, and the fielding of new capabilities. The breadth of technological advances arguably sets this period apart from earlier eras, and some, like artificial intelligence, will affect the fundamental nature of warfare itself.

Collectively, these technologies have increased the lethality and potential ways to apply force. Many are vast improvements over existing systems or have no preceding analogue. These technological developments are not strictly limited to military-kinetic issues — they also affect our political, economic and social systems, such as with cyber capabilities. Perhaps one of the more problematic aspects of this emerging military reality is the lack of norms around these new technologies, which may result in greater instability. For example, China's has plans to become a world leader in AI technologies by 2030, and has shown few qualms in harnessing developments to support its national aims.

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The COVID-19 pandemic has further undermined public trust in the governance structures of Western states – a fact exacerbated by disinformation campaigns conducted by foreign powers. This is evident with major protests and civil unrest surrounding public health measures, and the rise of violent far right movements in many countries.

Moreover, a state's emergency economic response to the pandemic has saddled many with large debt loads, which will require decades of austerity measures to eliminate, thereby limiting their ability to address domestic and foreign challenges. The challenges are particularly acute for developing states, which are less well-equipped to handle the economic and political consequences of the pandemic. They face a weakened global trade system, and the growing risk of political fragmentation due to the same forces affecting developed countries.

Thus, in the aftermath, many states will adopt a strong domestic focus to rehabilitate their economies and societies. This is evident in Canada's southern neighbour, where the Incoming Biden administration has already highlighted their immediate need to focus on the domestic issues upon entering office. From his victory speech several weeks ago, the President-elect stated his plan to:

> restore the soul of America, to rebuild the backbone of this nation, the middle class, and to make America respected around the world again. And to unite us here at home.

In foreign affairs, the President-elect was clear: he believes diplomacy is the primary foreign policy tool for the US and intends to work through alliances and international institutions. While his administration will likely provide greater leadership than its predecessor, this also means that Canada and other allies will need to shoulder an increasing burden for international security, despite facing the same economic and social challenges as the US. At the same time, they will be less able to rely on multilateral institutions that have suffered significant legitimacy and credibility issues as a result of the pandemic. Nowhere is this more evident in Europe, with the suspension of the Schengen agreement for borderless travel, though it also extends to the World Health Organization and the UN.

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The Canadian Armed Forces (CAF) are likely to experience greater foreign demands in the coming years, as weak states succumb to the centrifugal pressures created by the difficult economic and political environment, with fewer developed states willing to assist in stabilization efforts. The nature of these conflicts also pose significant risks to the CAF.

The proliferation of new technologies and capabilities will greatly complicate Canada's ability to intervene as well. The conflict in Nagorno-Karabakh showed how relatively modest UAVs can have decisive consequences on the battlefield. Particularly concerning is their low cost – Armenia and Azerbaijan are relatively modest economies and could easily afford to field these novel capabilities.

Moreover, it is not just the low-end conflicts that the CAF must prepare for. As we can observe, China has thus far weathered the pandemic in a better condition than most other developed economies, posting a positive economic growth rate for this year. Meanwhile the Russian Federation has continued to play a spoiler role internationally despite suffering the pandemic's effects. Thus, the challenges great power conflict will likely become increasingly acute as the decade wears on. Considering these new capabilities and the CAF's lack of an effective response to them, Canada's ability to operate in even a moderately threatening environment is questionable.

To respond to these challenges, the CAF must become increasingly nimble in how it responds to them – nowhere more so than in how it acquires and incorporates these new technologies. The 2017 defence policy statement *Strong, Secure, Engaged* is far too rigid in this age of rapid technological development. It set out a 20-year timeline for force structure decisions and budgets, projections that are unlikely to remain valid even in the medium-term. Many systems

also require quick iterative upgrades to maintain their fighting edge, which our government is not well suited to deliver.

The procurement system itself is severely hampered by an overly regulated oversight system that ensures project delays and cost overruns. These issues are exacerbated by the reality that successive governments have seen defence procurement as a vehicle to direct government money into domestic constituencies. This only causes further delays to procurements and diminishes the purchasing power of the defence budget. The temptation to further exploit defence procurement for stimulus spending will be particularly acute given the severe economic challenges facing the country.

None of this suggests that Canada should act like a global policeman in every outbreak of violence. However, the trajectory of recent international trends, particularly after the pandemic, suggests that the world is becoming increasingly unstable, and that military force may be required to ensure this country's security and prosperity. Canadians must be clear-eyed as to the challenges they face, and the country must possess the appropriate tools to address them.

Standing Committee on National Defense
Impacts of the COVID-19 Pandemic on Canadian Armed Forces Operations

Presentation by: Michelle van Beusekom
Co-Founder: Protect People in Long Term Care

November 27, 2020

Speaking Notes:

Thank you Mister Chair and Committee members for the invitation to speak with you today.

I am a co-founder of *Protect People in Long Term Care*, an ad hoc citizens group formed in early April in an effort to propel our political leaders to take decisive action and avert the looming catastrophe in Long Term Care. On April 7, we launched a petition asking for emergency funding, a national coordinated strategy to address the unfolding crisis and the implementation of shared standards. To date our petition has garnered over 98,000 signatures from every province and territory in Canada.

I'm also speaking to you today as someone with a unique lived experience and perspective - both of my parents live in Grace Manor, one of the five Long Term Care facilities in Ontario that received military assistance in May.

I'd like to underscore that many of us with loved ones in LTC saw this tragedy coming. The systemic gaps and failures in Canada's long-term care system are something we are intimately familiar with. We saw what happened in Spain and Italy in February and we knew what was coming our way. Chronic understaffing is endemic in this sector and when families and volunteers were locked out on March 13 in many parts of the country, we knew that staff who were already overstretched would quickly become overwhelmed.

We couldn't understand why LTC staff members were having to fight to get access to PPE. And we watched in anguish and horror as outbreak after outbreak was announced - yet LTCs in many jurisdictions were not being prioritized by their public health authorities for testing to ensure the rapid assessment and cohorting of residents.

My parents LTC in Brampton Ontario reported their first case of COVID on April 7. Each day the numbers rose, but they had to wait an agonizing 8 days after that first positive case until their public health authority – following Ontario Ministry of Health directives for testing – would finally give them access to testing for all residents.

And by then it was far too late. In their LTC with a population of 120 residents and 36 staff, there were 65 resident cases including both of my parents and 21 staff cases which ultimately resulted in 12 deaths including 2 staff.

With staff levels so depleted, the remaining staff were working up to 16 hours a day. Administrative staff with the requisite training left their offices and were working on the floor providing resident care. One amazing nurse I know started sleeping in a separate apartment on site to be closer to work. The doctor donned his PPE and started organizing and running the zoom calls for families with COVID positive residents.

The Senior administration at Holland Christian Homes, the not-for-profit which runs Grace Manor, reached out to the province of Ontario, and the local health authority for help. They hoped to partner with the two local hospitals in Brampton and to receive redeployed medical staff from those hospitals.

When that didn't happen, they asked – as a last resort in an increasingly desperate situation - to be considered for military assistance. On April 24, the Ontario Government formally made the request for military assistance on behalf of five homes.

For Grace Manor, that military assistance was vital. Half of their staff was gone. The military presence gave them the breathing room to bring in and train new staff and ensure proper infection control protocols were firmly in place.

Military personnel also provided much needed human contact for residents – many of them frail, vulnerable and confused - who by this point had been completely cut off from any in-person visits with their families for over a month.

My father so appreciated his conversations with young military personnel from places like Nova Scotia and Petawawa. He also marveled at their cleaning prowess. They clean really well, he told me, they even disinfect my garbage pail every morning.

I am so thankful the military were able to come to Grace Manor. It allowed them to get new staff trained and in place. And it allowed the core staff – those who hold those vital relationships with residents which is essential for quality care in a Long Term Care setting - to get back to a slightly more normal rhythm.

But why did this happen in the first place? Why was military assistance needed? How did it get so bad?

It got this way after a full 30+ years of political leaders ignoring report after report that flagged a host of critical systemic issues: underfunding, chronic understaffing; poor labour practices; the lack of shared standards of care and training standards; deregulation; privatization; and absence of accountability. Family and volunteers

were the glue that kind of held things together before March. COVID, in that fragile context, and the loss of family/volunteer support, collapsed the system. It's a tragedy that should not have happened and a catastrophic failure of our most vulnerable.

And here we are now – in a second wave. Over 12,000 people in Canada have lost their lives to COVID-19. In the first wave, 80% of all deaths were people living in Long Term Care - the worst record in all OECD countries. Today, hundreds of Long Term Care facilities across Canada are once again in outbreak. And despite the devastating loss of life during the first wave, the same struggles with access to testing and rapid cohorting that we saw in the first wave continue.

Kat Cizek is one of my cofounders at Protect People In Long Term Care. She is seeing this nightmare unfold with her own father at Lakeside Long Term Care Centre in Toronto in outbreak where Covid positive residents have been left on the same floor as those who have not contracted the virus. Another co-founder Kitra Cahana, is watching as staff and resident infections skyrocket at the Maimonides facility in Montreal where her father lives. Despite this alarming outbreak, the public health authority is not making testing mandatory for staff and visitors.

I don't have words to describe how excruciating it is to watch this happen - again. Despite all we knew before about the failings in long term care, all we learned during the first wave, the release of new studies, the surfacing of old ones, the swift release of policy recommendations by organizations like the Canadian Society for Policy Alternatives and the Royal Society of Canada and growing public discussion and awareness of key problems already understood by those of us with loved ones living or working in the sector (chronic understaffing, poor labour practices, an absence of shared standards of care, outdated infrastructure, deregulation and lack of accountability) little has been done to address the root problems that have caused this crisis and taken so many of our loved ones from us.

As I've mentioned, the problems have been exceptionally well documented. In Ontario alone, 35 reports were conducted between 1999 to 2020 – reports that consistently called for immediate attention to staffing ratios, staff mix, professional practice and funding support to ensure quality care. To quote Doris Grinspun, the CEO of the Registered Nurses Association of Ontario: " It is disheartening, exhausting and expensive to continue to study problems that are known and understood and where the missing factor is the political will to act decisively rather than, once again, kick the can down the road with more commissions and more reports. Enough of over-studying and under-acting in this sector – we know and the government knows what needs to be done to improve and save the lives of LTC residents."

In the Throne Speech on September 23, the Federal Government made a commitment to National Standards for Long Term Care – yet almost 10 weeks later, details and a timeline have not been shared.

We should not be relying on the military for last-resort crisis management in a sector where the problems and the solutions are this well known. That is not a good use of military resources and military training. And I'm sure it has compromised military operations and budgets in many ways – to come to the aid of a sector where private operators have continued to reap handsome profits for their shareholders throughout this crisis.

We have begun to see reports of how Operation Laser has impacted the mental health of military personnel who were thrown into an acute crisis situation for which they don't have the requisite training. Military medical staff are not Long Term Care specialists. Caring for high-needs elderly, over 80% of whom suffer from some form of dementia, is a highly skilled activity – even if our society does not recognize it as such. Military personnel were thrown with very little training into an environment they didn't necessarily understand that was experiencing catastrophic failure. They like LTC staff, residents and their families will carry this trauma for the rest of their lives.

It is so disheartening to see the jurisdictional bickering and doubling-down that is blocking the groundswell of grassroots support right across this country for national standards. As I mentioned, our little petition started by four anguished citizens with full time jobs and many other responsibilities has garnered over 98,000 signatures.

With the number of cases in LTC on the rise again and dozens of homes in outbreak across the country, it is imperative that all levels of government come together to fix this broken system and that a timeline and action plan are put into place.

The studies have been conducted, the solutions have been documented and the policy recommendations have been prioritized and mapped out by dedicated professionals who have been fighting for decades to ensure dignified lives for our most vulnerable older adults.

What has been missing to date is the political will to do the right thing.

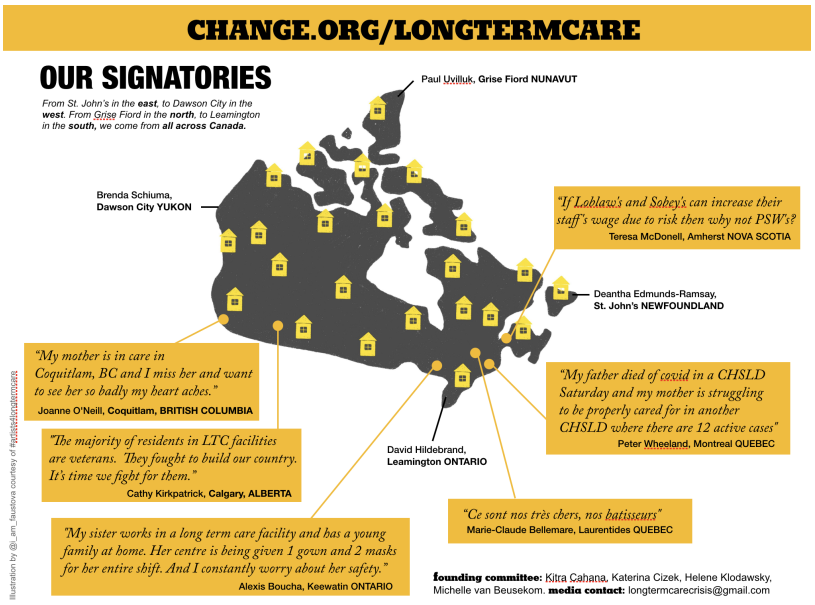
I am so thankful that the military were there for my parents and for Grace Manor. And I never want to see that happen again. This sector needs to be properly supported. The long-standing problems need to be addressed. And we need concrete action on those national standards.

Speaking on behalf of the 98,000 who signed our petition, I hope we can count on you to help make that happen.

Thank you.

Michelle van Beusekom

Protect People in Long Term Care – Our Petition and Updates
Updates include an overview of media coverage
https://www.change.org/p/petition-for-emergency-funds-for-c-19-crisis-in-long-term-care



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Colonel Scott F. Malcolm
Deputy Surgeon General, Canadian Forces Health Services Group

Major Karoline Martin
Chief Standards Officer, Canadian Forces Health Services Training Centre

27 November 2020

Opening Remarks

Madame Chair, and members of the Standing Committee on National Defence, it is with great honour and privilege to be here today along with Major Karoline Martin and I thank you for the invitation to discuss elements of the Canadian Forces Health Services deployment into Ontario's Long Term Care Facilities supporting Canada's most vulnerable, in the midst of the COVID-19 crisis.

As you have heard in previous testimony, Operation LASER saw the deployment of hundreds of Health Services personnel. Nurses, Medical Technicians, Medical Assistants, Physician Assistants and Dental personnel all came together to form ~~a~~ composite teams known as Augmented Civilian Care (ACC) Teams. As the Director of Health Services Operations I was the architect behind the medical aspects of the plan that saw the ACC teams deploy into long-term care facilities in Ontario. Major Martin had the distinct pleasure to deploy as the Officer Commanding the ACC Teams within Ontario.

From April to August, we deployed into seven Long Term Care Facilities with the primary mission and goal of saving Canadian lives. Upon our arrival, we witnessed a sector in crisis. Our clinicians and CAF personnel immediately mobilized and began to work tirelessly alongside our civilian health partners to stabilize the situation and support not only residents but the organizations and clinicians we were deployed to support.

Although CAF personnel are not experts within the Long Term Care sector, we responded to the call during a critical moment in Canadian history. Clinical excellence, compassion and patient advocacy are the cornerstone ethical principles all CAF clinicians live by and as such when concerns regarding the conditions and the standards of practice arose, we as Canadians, clinicians and as soldiers had a clear duty to report our observations. I would like to stress that our observations are only a snapshot in time that reflected the realities within the Long Term Care Facilities in which we worked during the early stages of the COVID-19 crisis.

The CAF Health Services personnel who deployed on Operation LASER are a passionate and dedicated group of clinicians who will always advocate for patient and resident well-being and the provision of high quality healthcare to Canadians. It is with this lens of systemic improvement that we graciously accept your questions and queries.

We thank you once again for this opportunity and look forward to your questions.