HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

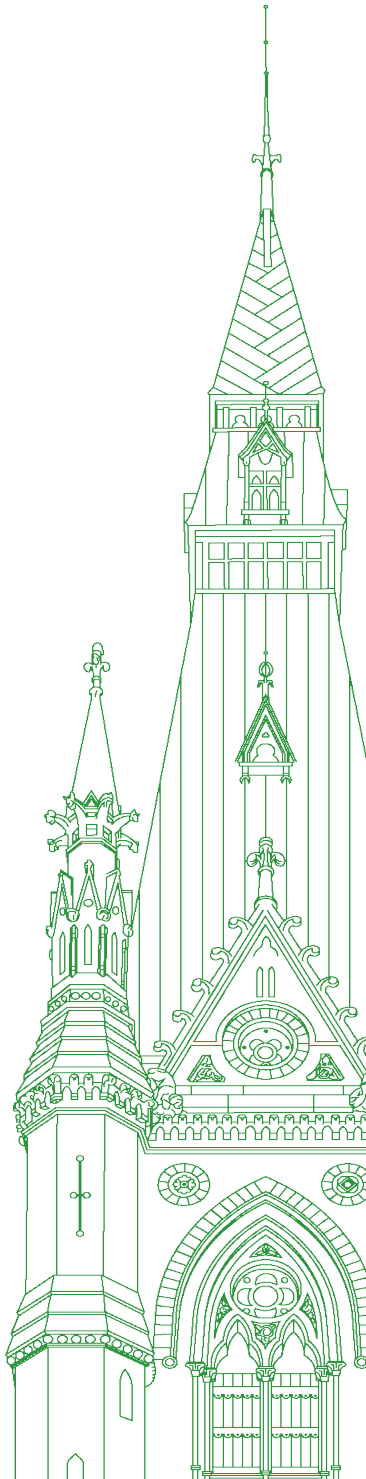
44th PARLIAMENT, 1st SESSION

Standing Committee on Health

EVIDENCE

NUMBER 010

Wednesday, March 2, 2022



Chair: Mr. Sean Casey

Standing Committee on Health

Wednesday, March 2, 2022

● (1620)

[*English*]

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

Welcome to meeting number 10 of the House of Commons Standing Committee on Health. Today, we will be meeting until about 6 p.m. eastern to hear from witnesses on our study of Canada's health workforce. I understand that Dr. Tomblin Murphy has to leave at 5:40, so I would encourage those who have questions for Dr. Tomblin Murphy to pose those questions before then.

Today's meeting is taking place in a hybrid format, pursuant to the House order of November 25, 2021. All members of the committee are present in the room, but the witnesses are on the Zoom application. For those of you who are using the Zoom application, please do not take any photos of your screen or screenshots.

We will be respecting all of the health care directives from the Board of Internal Economy and the public health authorities.

I can inform the members of the committee that all of our witnesses today have completed the required connection tests in advance of the meeting.

To our witnesses, first let me say, welcome. Each organization will be given five minutes to make its opening statement before the rounds of questions.

Colleagues, we have with us today Geraldine Vance, chief executive officer of the British Columbia Pharmacy Association. From the Canadian Nurses Association, we have Michael Villeneuve, chief executive officer, and Dr. Gail Tomblin Murphy, who is the vice-president of research, innovation and discovery, and is also the chief nurse executive for Nova Scotia Health. From the Kingston Health Sciences Centre, we have Dr. David Pichora, president and CEO. From the Ontario Medical Association, we have Dr. Adam Kassam, president, and Dr. James Wright, chief of economics, policy and research.

Mr. Michael Barrett (Leeds—Grenville—Thousand Islands and Rideau Lakes, CPC): Mr. Chair, it looks like there's going to be another vote. Instead of interrupting the witnesses, see if you can seek unanimous consent now to proceed through the bells, once those bells start. Members can vote electronically, with a brief pause until we get the result.

The Chair: Thank you for that, Mr. Barrett.

Do we have consensus to proceed through the bells and to suspend briefly to allow people to vote using the app?

Some hon. members: Agreed.

Chair: That's great. Thank you, Mr. Barrett.

[*Translation*]

Mr. Luc Thériault (Montcalm, BQ): Mr. Chair, I'd like to speak about this issue.

For today, that's fine, because we've already started the meeting. That said, my whip asked me to tell you that the right to vote in the House is a privilege. If someone wants to do so, they should be allowed.

Today, I have permission to vote using the app. However, in the future, I'll need to go to the House.

The Chair: Okay, that's clear.

Thank you.

[*English*]

Now, we'll go to our witnesses. First of all, thank you for your patience. The delay, as you know, was caused by a vote in the House. Through unanimous consent, we've agreed that there won't be another delay, but because there is going to be another vote, there will be a brief interruption. Thank you for your patience and for being here with us.

We're going to start off with opening statements, beginning with Ms. Vance.

You have the floor for five minutes.

Ms. Geraldine Vance (Chief Executive Officer, British Columbia Pharmacy Association): I want to acknowledge that today I'm speaking to you from the traditional territories of the Squamish, Tsleil-Waututh and Musqueam first nations.

The COVID pandemic has shown both the weaknesses in our health care system and the resilience of our health care providers, who have worked for the last two years to meet the unprecedented demands the pandemic has placed on them. It is clear that the federal and provincial governments must renew their commitment to providing the support needed to ensure that Canada has the physicians, nurses and other health care providers ready to face another health crisis of similar magnitude should it come.

The B.C. Pharmacy Association applauds the work of this committee in pursuing much-needed opportunities to recruit and retain a diverse team of health care professionals across Canada.

Today, I want to share the perspective from my province of British Columbia on the resilience that community pharmacists have demonstrated.

As committee members will well know, B.C. has been particularly hard hit since the COVID-19 pandemic was declared. This health emergency was layered on top of B.C.'s other public health emergency—the opioid crisis. Added to that, our province faced a once-in-a-lifetime set of wildfires, heat domes and catastrophic flooding. All of that has added to the stress on the province's health care system. It is a testament to every health care worker in our province that despite the cascade of obstacles, people in communities big and small received the care they needed.

We all know that health care workers have paid the price. They are spent, and they need to know that their governments will put plans in place to make them better able to meet the next crisis. A key part of that preparation is the work of this committee—recruitment and retention of health care professionals.

When B.C. went into a public health state of emergency in March 2020, which included a lockdown on all but essential services, pharmacies were the only community care settings that patients were able to access in person. Pharmacists quickly pivoted to ensure that they met the needs of their patients.

B.C. has more than 1,400 community pharmacies in 158 communities across the province, and nearly every community has a pharmacy within a 30-minute drive. Pharmacies have long served as an important point of first contact for patients seeking medical care. A 2018 review showed that community pharmacists see their patients anywhere between 1.5 and 10 times more frequently than their primary care physicians, and we know that this number has skyrocketed over the last two years. This has meant that more and more patients are calling on their pharmacist to answer questions and to fill in the gaps of in-person care.

In a 2021 national survey, 90% of Canadians said that pharmacy professionals and pharmacies were essential during the COVID-19 pandemic. Three in four Canadians said that pharmacists played a larger role in providing health care services than before the pandemic. In that same survey, 93% of Canadians would trust pharmacists to be the first point of contact in the health care system.

While community pharmacists fill a number of critical roles, there is much more that pharmacists can and should be doing, but unfortunately pharmacists' scope of practice varies greatly from province to province, leaving a patchwork of coverage and patients in different jurisdictions unable to receive the same access to care.

In six provinces and one territory, pharmacists have the ability to prescribe for self-limiting conditions like cold sores and acne. These self-limiting ailments are easy to treat and self-identifiable by the patient. In our view, a national scope of practice for pharmacists should be adopted that ensures all pharmacists are able to deliver the same care at their maximum level of expertise, and this would include prescribing rights. This is particularly important in rural and remote communities that continue to have difficulties in attracting physicians and other health care providers. Allowing pharmacists to practise at their full scope will help patients and those providers already struggling under the pressure of providing care.

Governments have long struggled to harness the expertise of community pharmacists and to leverage the expansive network of community pharmacies. The pandemic has provided opportunities for pharmacists to show that the potential exists. In B.C., pharmacists have been critical in delivering COVID-19 vaccines.

We believe that the federal government should target funding to the provinces that would be used to improve and harmonize a standard scope of practice across the country. We recommend that this committee create a forum of engagement with the Canadian Pharmacists Association and other provincial pharmacy associations to develop a strategy to fully employ the expertise of community pharmacists.

● (1625)

The Chair: Thank you, Ms. Vance.

Next, we're going to hear from the Canadian Nurses Association, with Mr. Villeneuve.

Mr. Michael Villeneuve (Chief Executive Officer, Canadian Nurses Association): Yes, thanks very much, Mr. Chair.

The Chair: You have the floor for five minutes. Go ahead.

[*Translation*]

Mr. Luc Thériault: Mr. Chair, I have a point of order.

It's about speed. I know that the witnesses don't have much time to speak. However, their pace is so fast that it makes the interpreters' job difficult. It would be helpful if the witnesses slowed down so that we could better understand their comments and ask questions about the things that they want to emphasize.

● (1630)

The Chair: Thank you, Mr. Thériault.

[*English*]

Mr. Villeneuve, you have the floor for five minutes. If you go a little over five minutes, because we're going to ask you to slow down a little bit just to make sure the interpretation picks it up, I'll cut you some slack.

Go ahead. You have the floor.

Mr. Michael Villeneuve: Thank you, Mr. Chair and members of the committee, for inviting the Canadian Nurses Association to appear here today.

We applaud the committee's decision to conduct this important and timely study on Canada's health workforce, and we hope the work of members of this committee can help lead to meaningful and much-needed action.

My name is Michael Villeneuve. I'm the chief executive officer of CNA, and I am speaking to you today from the traditional lands of the Algonquin and Anishinabe people in eastern Ontario.

I'm pleased to be joined by Dr. Gail Tomblin Murphy, from Nova Scotia Health. Gail is an expert in the science of health human resources and is chair of the Royal Society of Canada's working group on the impact of COVID-19 on the nursing workforce.

Mr. Chair, I first stepped into health care as an orderly in 1978. During my 44-year career, I have never seen anything like what the nursing profession is going through now. Canada's nearly 450,000 nurses are the backbone of our health systems, but they're completely exhausted and demoralized, and we're seeing many of them leaving their jobs and even leaving the profession. Ninety-four per cent of nurses say they're experiencing symptoms of burnout. Severe burnout among all health care workers has nearly doubled. There are close to 120,000 vacancies in the health care and social assistance sectors, and we've seen alarming rates of nursing vacancies in hospitals across Canada.

These issues are not new, but they've been exacerbated by the pandemic. Nurses have been sounding the alarm for decades on these very same problems, long before COVID-19. There have been studies, reports and literally millions and millions of dollars in research all pointing to some of the very same core problems and many of the same solutions. In modelling work done by Dr. Tomblin Murphy in 2009, CNA predicted Canada would be short 60,000 nurses by 2022, and here we are with the crisis we're living in now.

We know many of the solutions needed to stabilize the workforce. Canada needs a strong, modern, pan-Canadian health human resources strategy. Additional targeted federal funding is needed to help health care systems retain, recruit and provide for adequate levels of staffing.

The federal government has an important leadership role to play in ensuring Canada's health system is sustainable. It needs to work collaboratively with the provinces and territories on both short- and long-term strategies.

In the short term, we need retention incentives for nurses and health care workers to stay on their jobs. This could include retention bonuses, loan forgiveness, tax incentives. Additional funding to the provinces and territories should also be provided to help optimize workloads for health care workers. This could include increasing admin staff, for example, in nursing settings to unlock more time for care.

In the longer term, CNA endorses calls for a national health workforce body that would be responsible for collecting high-quality [*Technical difficulty—Editor*] to support workforce planning at regional levels. CNA also recommends increasing training and education for health care workers by enhancing the number of seats in schools of nursing and increasing capacity for clinical placements for nurses. Finally, we strongly recommend the development of a national mental health strategy for health care workers, which would include funding for mental health supports.

I'll conclude, Mr. Chair, by saying that in an emergency room one of the first things you do is stop the bleeding, and that's what Canada's health workforce needs right now. We need emergency and definitive interventions with immediate action, and then a multifaceted strategy to address the complex problems of Canada's health workforce.

Thank you, Mr. Chair. Dr. Tomblin Murphy and I will try to answer any questions.

The Chair: Thank you, Mr. Villeneuve.

Now we'll hear from the Kingston Health Sciences Centre.

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

Dr. David Pichora (President and Chief Executive Officer, Kingston Health Sciences Centre): Good afternoon.

Mr. Chair and committee members, thank you for this opportunity. I'm speaking to you today from my perspective as a tertiary hospital CEO, an orthopaedic surgeon and a professor at Queen's University.

Like our peer hospitals, Kingston Health Sciences Centre has many complex and integrated roles. KHSC is both a community hospital and a large regional academic centre providing specialized tertiary services to urban, rural and remote communities across a wide area of eastern and northern Ontario. During the pandemic, we doubled our ICU capacity and stepped up to be a critical care partner in the life-saving “team Ontario” critical care network. We accepted approximately 150 critically ill patients from the GTA, northern indigenous communities and Saskatchewan.

In addition, with Queen's University and St. Lawrence College, we train large numbers of physicians, nurses, therapists and technologists. We have developed innovative partnerships, like our federally and provincially funded Weeneebayko Area Health Authority, Queen's and KHSC program that provides access to the full range of health care services and training of frontline workers for the James Bay region. Like other tertiary hospitals, we have a research institute that partners in health care research with Queen's and with other universities across Canada and globally. All KHSC attending physicians have a Queen's faculty appointment.

Beyond our direct roles in health care delivery, leadership and innovation, hospitals have a substantial economic impact. We are major employers in our communities. We support a host of affiliated supply chain, pharmaceutical and medical device industries, and we drive research and development.

Previous speakers at this committee have illustrated how the pandemic has exposed and exacerbated long-standing health care human resource deficits and burnout. Canada is not alone in this crisis. The U.S.A., for example, is experiencing high levels of burnout, with projected deficits of 122,000 physicians and 1.2 million nurses. Other countries will be aggressively competing for our top clinical and research talent. We need to stop training regulated health care workers for export, and ensure that this precious resource is enabled and incented to live and work in Canada.

Those of us working at the front line in hospitals have witnessed two decades of disinvestment, with continuing pressure to reduce expenses, reduce beds and divert scarce resources to community and independent health facilities. As health human resources consume 70% of hospital budgets, inevitably funding cuts lead to staffing reductions.

The ongoing pandemic has highlighted the critical role that hospitals play in health system performance and delivering value for money. During the pandemic, hospitals have been the backbone of our health care system. We rescued long-term care homes, anchored IPAC hubs, provided PPE to community partners, created assessment and vaccine clinics, created and adopted digital and virtual platforms, developed and implemented extender roles to mitigate HHR shortages, and pivoted to build new critical care and in-patient capacity. Any future interventions to address HHR challenges and pandemic recovery must acknowledge, respect and support the contributions that hospitals make.

Mr. Chair, at our Kingston General Hospital site, some of our staff still work in the same building that held the very first meeting of the Parliament of Canada in 1841. For us to attract and retain the best and brightest, we must address the mounting infrastructure deficits and modernize our aging facilities and equipment. To mitigate burnout, health care workers must be able to see purpose and achieve fulfillment in their roles while having adequate workspace and work-life balance.

These objectives require modern hospitals with modern equipment. The Government of Ontario is taking steps to invest in hospitals and long-term care facilities, but much, much more will be needed to ensure safe and high-quality care. A human resource and infrastructure challenge of this magnitude requires strategic commitment and action by the federal government.

Thank you.

● (1635)

The Chair: Thank you, Dr. Pichora.

We will now hear from the Ontario Medical Association.

Dr. Kassam, will you be speaking?

Dr. Adam Kassam (President, Ontario Medical Association): I will.

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

Dr. Adam Kassam: Good afternoon. My name is Dr. Adam Kassam. I'm president of the Ontario Medical Association. I am joined by Dr. James Wright, chief of the OMA's economics, policy and research department.

On behalf of Ontario's 43,000 physicians, residents and medical students, thank you for this opportunity to provide the physician perspective on arguably the greatest immediate risk to the viability of health care in Canada, which is the burnout of health care professionals.

Physician burnout is primarily caused by stressors in the workplace including inefficient work processes and environments, and clerical burden. In other words, the inefficiencies and obstacles in the health care system, not caring for patients, are the major contributors to burnout. In fact, the OMA established a burnout task force in 2019. Its objectives were to survey Ontario physicians, residents and medical students to understand the extent of burnout and then to identify specific solutions.

In March 2020, prior to the pandemic, a shocking 29% of Ontario physicians reported high levels of burnout, while another two-thirds reported some level of burnout. By March 2021, one year into the pandemic, that number was even higher, with 35% reporting high levels of burnout and almost three-quarters reporting some level of burnout.

Ontario physicians face years of working above capacity just to clear the pandemic backlog of more than 21 million delayed medical services, let alone reducing the wait times that have plagued the system for decades. Attempting to achieve this within the existing system will only lead to more burnout. Physicians are incredibly dedicated to their patients. However, at some point the stress is untenable, leading some to reduce their workloads, retire prematurely or even leave medicine entirely. This loss of experienced and dedicated physicians will further exacerbate the situation for remaining doctors.

Retention and recruitment of physicians are paramount, given that one million Ontarians currently don't have access to a family doctor. The lack of physicians is even more dire in Canada's north. Today, northern Ontario is experiencing an acute shortage of at least 325 physicians, including family doctors, psychiatrists, anaesthetists and several sub-specialists. Some communities are critically under-serviced.

The OMA's burnout task force has identified the top five system-level actions required to reduce burnout and drive retention and recruitment: first, streamline and reduce required documentation and administrative work; second, ensure fair and equitable compensation for all work done; third, increase work-life balance by making organizational policy changes; fourth, promote the seamless integration of digital health tools into physicians' workflows; finally, provide institutional supports for physician wellness.

These are all system issues. We need to collectively and collaboratively rethink our health care system so that it doesn't contribute to burnout in the first place.

In fact, in Ontario we have developed a plan for solving our system challenges. OMA's “Prescription for Ontario: Doctors' 5-Point Plan for Better Health Care” was released not long ago, in October 2021. It is available at betterhealthcare.ca and it provides a road map of 87 recommendations under five key themes to achieve meaningful and sustainable improvements for the entire health care system in terms of access, equity, efficiency and integration.

As contained in our “Prescription”, the OMA strongly supports the call by Canada's premiers to immediately increase the Canada health transfer from the current 22% to 35% of provincial and territorial health care spending. This will provide the provinces and territories with the resources necessary to make health system improvements within their respective jurisdictions.

Ontario's doctors also recommend other immediate actions by the federal government to reduce burnout and increase retention and recruitment, including, but not limited to, the following. First, incent physicians to practice in the north by offering a federal tax relief of 15%.

Second, fund Canada Health Infoway to develop application programming interfaces, or APIs, to link the electronic medical records systems used within each province. Linking them would allow information to be exchanged among physicians. The lack of interoperability now is one of the most common digital health factors associated with burnout.

Finally, support the development of virtual care appropriateness guidance by the national level specialty societies that would work together to review all procedures within their profession and determine which can appropriately be done virtually and which in person. Supporting the development of such guidelines would reduce decision fatigue for physicians and support equitable, appropriate and high-quality care across the country.

A publicly funded and universally accessible health care system is a cornerstone of Canadian values. On behalf of all Ontario health care professionals, the OMA implores the federal government to provide the tools and resources required by the province to effect sustainable and meaningful change. If we don't fix the health care system, we will never fix burnout. Physicians and other health care professionals are depending on you. Certainly Canadians don't have time to wait.

Thank you. We're happy to answer your questions.

● (1640)

The Chair: Thank you, Dr. Kassam.

We're now going to begin rounds of questions with Mrs. Kramp-Neuman of the Conservatives for six minutes, please.

Mrs. Shelby Kramp-Neuman (Hastings—Lennox and Addington, CPC): Thank you, Chair.

I'd like to thank all the witnesses who have agreed, and so willingly volunteered their time and expertise, to contribute to today's discussions and the democracy of Canada.

I'd like to start by directing questions towards our witness Dr. Pichora, from Kingston. However, before I get into specific questions, allow me a few minutes to highlight that under his leadership, Kingston Health Sciences Centre has successfully brought together two of Canada's oldest operating hospitals. Dr. Pichora serves, as he mentioned, as president and CEO of Kingston Health Sciences Centre, an academic tertiary care centre serving people all across Ontario. He's a respected orthopaedic surgeon, CEO and professor, and a true pioneer in his field.

Congratulations and thank you for all the work you have done, Dr. Pichora.

As to my first question today, could you perhaps speak to the complexity and the costs of hospital services? The physicians shortage is most acutely appreciated in rural areas of our country, like my home riding of Hastings—Lennox and Addington. The need for highly specialized individuals has never been higher.

Furthermore, could you possibly elaborate on and speak to the interconnectedness of our health care system, along with the mutual dependencies of hospitals and those of community services?

● (1645)

Dr. David Pichora: Thank you. I'll try to address your questions.

Hospitals are very complex and highly integrated organisms, I would say. It's amazing the extent of the just-in-time work we do with teams pulling together. Some of our surgical procedures are just one example of what it takes to deliver this, with highly specialized physicians, nurses, technicians who support various life support systems, etc.

We're the most expensive part of the health care system. It's such a valuable resource that we can't afford to waste any of it. We try to be very good stewards of the resources we receive. People are at the centre of all this. Everything we do requires people. Having a robust and appropriately skilled health care workforce is critical. This is essential to our role in the system.

We don't just look inward. You talked about rural and remote neighbourhoods. Although we're also the community hospital for the Kingston region, like many hospitals would be, we provide a wide range of extended services, including dialysis services in your community. We have satellite dialysis centres in Moose Factory at the Weeneebayko General Hospital, in James Bay. That's just one example of the complex networks. Cancer care is another one. It's a very distributed system. Although we may be the hub for a lot of these activities and the place where the most complex required care comes, we support services throughout the region.

One really good example of this is the Ontario Stroke Network, which has become a highly effective and life-changing network for patients who in the past had a very dismal prognosis in many cases. Now, because of rapid diagnosis, rapid transportation and rapid intervention, we're able to reverse the life-changing effects of strokes and really give people a much brighter outlook. That's an example of the complexity and expense of running a health care system and the role of hospitals.

In terms of interconnectedness, most hospitals are experiencing gridlock at the moment. We certainly are. This is because of increased inflow pressures to our emergency department with patients who are highly complex and critically ill, and then outflow pressures related to home and community care and long-term care, as just two examples. We've heard people talk about the HHR challenges of other sectors of the health care system, and that is having a big effect on hospitals too.

We can't just focus on one element in isolation; we have to have a system-wide look at this.

Mrs. Shelby Kramp-Neuman: Excellent. Thank you.

The Chair: You have another minute if you want it, Mrs. Kramp-Neuman.

Mrs. Shelby Kramp-Neuman: Perhaps I'll continue.

We have one minute left, Dr. Pichora.

We have shortages. There is a lot of fatigue. Our health care system was tired before the pandemic, and this has been highlighted now by the pandemic. There's no quick fix; you're not a magician. How do you see a way out of this? Are there one or two key points you could speak to that you see?

● (1650)

Dr. David Pichora: You're right; there is no quick fix. Right now the thing that's impeding our ability to restore care most significantly is our rising ALC rates for the patients who've completed their journey of care in the hospital and are waiting to go to another destination, whether that's home and community care, rehabilitation or long-term care. That would make the biggest difference in the short term to us, to try to implement remedies that will boost capacity in the community so that a hospital can do what it's supposed to do.

Mrs. Shelby Kramp-Neuman: Fantastic. Thank you.

The Chair: Thank you, Dr. Pichora. Thank you, Mrs. Kramp-Neuman.

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

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

Before I start, I'd just like to send a huge thank you out to every witness today. You represent the people, the workers, who have been supporting our communities through the toughest time that all of us have ever lived through. You truly are the frontline infantry of our system, and while it is very challenging work, Canadians are grateful. Canada has fared fairly well compared to many of our peer nations, and that's because of your hard work and the hard work of your members. We can't thank you enough.

I have a couple of questions. I suppose my first question will be directed to either the Ontario Medical Association or the Canadian Nurses Association. I was just looking over some of the data provided to us from the Library of Parliament, and I always like to see where Canada ranks internationally among some of our peer countries. I used to be an athlete, and it was always good to see where you were at compared to your competition—not to suggest health care is a competition, but it is nice to see where we rank. We all know there aren't enough doctors and nurses in Canada, but it's good to know whether they're on the rise or going in the opposite direction. The data indicates it has been on the rise, just not quickly enough. It hasn't kept up to our population, and it probably wasn't even adequate 20 years ago either.

It's clear, and I think we all agree, that we need to increase the workforce. That's an obvious statement, I suppose, but the next question is how.

I spoke with a constituent today who is a neighbour and a good friend. She is a personal support care worker, and she would like to become a nurse. We were discussing how she could go about that. She has two kids, so it's going to be challenging financially for her. From the Canadian Nurses Association's perspective, how can Carley find the support that's necessary to go from the work she's doing now and join the workforce as a nurse?

Also, perhaps you could touch on the impact that immigration and foreign credential qualifications might have in ensuring we have the workforce necessary to continue on.

Mr. Michael Villeneuve: Thank you very much, Mr. Chair, for the question.

Certainly, there has been a move over many years for nurses. There are four regulated categories, and then there's an unregulated group of support workers—and I'll just use the general term—who sometimes want to move from one level or type of nursing to another. One of the areas where we haven't made it easy historically is in how you move, for example, from being a support worker to a licensed practical nurse, to a registered nurse and so on.

There are more bridging programs now, and they are better than they used to be. There is one thing we haven't done as well historically in nursing. You almost had to start over at each level when you went into a program, so it was a bit discouraging for people who might have been at the top of their game at the age of 35 in one category and wanted to go back and move to another. That's been a bit of an issue, but it is being addressed.

In terms of internationally educated nurses—and other health professionals, of course—we hear across the country that many find that the rigours of getting through the regulatory process are quite difficult. I'll give you an example. I spoke with a young man from Tunis just last week, who has a Ph.D. from one of our very good universities, and he is really struggling to get through the regulatory process to get registered in this country, to the point where he's saying he's just going to go back rather than go through it.

We believe there should be some moves made to help smooth those processes to get people in faster. I know regulators are trying to do that, but I think there's a way to go.

I'll close by saying that one of the areas is language. Often these nurses come from very good universities in other countries, and they're very well educated, but they have trouble with the language test. Yet when I talk to them, I can understand them quite well.

I think together we need to look at all those sorts of hoops that seem to get in the way of bringing people into the health care system when they're interested in working or in moving up.

I'll end it there. Thank you.

● (1655)

Mr. Adam van Koeverden: Thank you, Mr. Villeneuve.

I would pose the same question to Dr. Kassam, a fellow Adam, at the Ontario Medical Association. Can you provide some insight?

Dr. Adam Kassam: Absolutely, and thank you for the question. It's an important one.

As far as health human resources are concerned, you [*Technical difficulty—Editor*] with what we said earlier. A million people in the province of Ontario don't have access to a family doctor. We expect immigration and population growth in the province. We also expect, and are seeing, an aging population that will invariably require more health care utilization. It's not only a combination of a growing population, but a population that's going to require more health care services down the line.

How do we address this? As you said, we need more doctors. It's very clear that we have a physician shortage. We've had this chronically for quite some time.

How do you do that in an effective way? First, you have to stop the bleeding and make sure that we can shore up what we have right now. That's making sure that physicians don't leave the province, the country or their profession. Second—

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

I'm sorry. I have to cut you off because I have to move a motion, if the committee will indulge me.

I move:

> That, pursuant to Standing Order 108(2), the Committee invites the Minister of Health, the Minister of Mental Health and Addictions and Associate Minister of Health, as well as officials, to appear for two (2) hours regarding the 2021-2022 Supplementary Estimates (C), the 2022-2023 Main Estimates, and the 2022-2023 Departmental Plans for the Department of Health, the Canadian Food Inspection Agency, the Canadian Institutes of Health Research, and the Public Health Agency of Canada and that the meeting take place on Monday, March 21st, 2022.

I'm sorry, Dr. Kassam. That was rude. I apologize. I have to get too much done in six minutes.

Dr. Adam Kassam: That's no problem at all. I totally understand.

The Chair: Colleagues, this is the motion that was put on notice at Monday's meeting. The motion is in order. The debate is on the motion.

Mr. Barrett, go ahead, please.

Mr. Michael Barrett: Thanks very much, Chair.

Through you to Mr. van Koeverden, it would be helpful to know if we're going to have ministers and officials for the combined total amount of time. Sometimes they split an hour and an hour.

Also, having multiple ministers and officials over a two-hour period can be a bit of a tight time frame. Is there any leniency on the amount of time that the ministers are available? Of course, I note that we appreciate that the ministers are making themselves available to be at the committee.

Mr. Adam van Koeverden: Thank you, Mr. Barrett.

If you have a preference or a recommendation.... The benefit of having three weeks is that the ministers, particularly the Minister of Health, will potentially have the time. I believe on that date, the Minister of Mental Health and Addictions will only have minimal lines on the estimates. They're not entirely complete, but the Minister of Health will have complete lines.

You're right that there will be a lot of people at the meeting. If you would prefer to have a different balance of officials and ministers, we have the time to discuss it, and I have the time to go and advocate for it with the ministers.

Mr. Michael Barrett: Having the ministers available for the full two hours.... It's important that we're not hiving off the officials. It's important that we also have the opportunity to ask the officials questions. Having the ministers available for two hours and the officials for an additional hour....

Instinctively, I would like to ask for the ministers to be here for three hours. I have lots of questions for both, but if we could focus on the ministers for two hours, members can use the time as they see fit and also ask the officials questions. I appreciate that their time is also valuable, but it's a little less hard to pin their schedules down than the ministers'.

My suggestion is that it would be three hours for the officials and a total of two hours that ministers would be available to the committee.

Mr. Adam van Koeverden: Just so I'm clear, are you asking that this be covered over two meetings—over two Mondays, as the COVID meetings are on Mondays—or are we asking for a three-hour meeting?

I think we can ask if the officials could come concurrently with the ministers on the first Monday, which is the 21st, and then maybe have just the officials for a subsequent hour on the following Monday, or we could have a three-hour meeting.

● (1700)

Mr. Michael Barrett: Following the completion of the first meeting, the committee could discuss if the officials are required the following Monday. Resources are difficult to come by, so tacking on a third hour, especially if we get jammed with votes or anything like that, might be tough. Potentially there would be—if there's a willingness to extend the questioning of officials on the following Monday, if required—the baseline that the ministers will both be available for the two hours at the meeting that's in the motion you moved.

Mr. Adam van Koeverden: Yes, the ministers will be present for two hours, and I will ask about a third hour for the officials. For clarity, I think I said this would be a COVID meeting, and I think it's separate, although it is occurring on a Monday.

The Chair: Just from a procedural perspective, if I may, Mr. Barrett, the motion does indicate that the ministers would be here for two hours. I would suggest, if at the end of two hours there's a willingness to bring back officials for a subsequent meeting, that a motion could possibly be presented at that time if you think that would be required. Is that okay procedurally?

Mr. Michael Barrett: Based on the assurance that the ministers are available for two hours, and based on your comments, Chair, I have no objection or further questions.

The Chair: Thank you.

Mr. Lake, go ahead.

Hon. Mike Lake (Edmonton—Wetaskiwin, CPC): What is our deadline for reporting this back? When do we have to complete this by?

The Chair: There's a different deadline for supplementary estimates (C) than there is for main estimates. As you know, it depends on when the last allocated day is. We still don't know the deadline for supplementary estimates (C), but we do know it's much longer for the main estimates. Because all of the days have not yet been allocated, the firm date for the deadline at this point is unknown.

Hon. Mike Lake: In the spirit of Mr. Barrett's suggestion, then, regardless of when that deadline is, if we decide we want to have officials come, we would have them anyway.

The Chair: Yes, the committee is at liberty to study the estimates even when the time is up. It just can't vote on them. It would become a subject matter study.

Hon. Mike Lake: While we're on the record right now, I just want to make sure, from Adam, that this would be the spirit of what we're talking about.

Okay.

The Chair: Is there any further debate on the motion?

You have the motion before you. Can we proceed by consensus or is there a requirement for a standing vote? Is it the will of the committee to adopt the motion as presented?

I see consensus in the room.

(Motion agreed to)

The Chair: Thank you.

Next we're going to go back to our questions for the witnesses.

[*Translation*]

The next member who can ask questions is Mr. Thériault.

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

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

I want to thank the witnesses for their insightful presentations. A six-minute question and answer period won't give us enough time to cover everything.

I'll start with you, Mr. Villeneuve. A document that you distributed predicted a shortage of 60,000 nurses in Canada by 2022. That's now. You said that this was predicted 10 years ago.

I have several questions about this topic. What factors were used to make this prediction 10 years ago?

[*English*]

Mr. Michael Villeneuve: Thank you.

Mr. Chair, with permission, I will turn this to Dr. Tomblin Murphy, who led the study.

Dr. Gail Tomblin Murphy (Vice-President, Research, Innovation & Discovery, Canadian Nurses Association and Chief Nurse Executive, Nova Scotia Health): Thank you, Mr. Chair. Thank you for this opportunity.

It was quite clear when that study happened some time ago that there were issues similar to the ones today. If we go to a decade before that, there were similar issues at that time. For the study, we focused on what the health needs were—

[*Translation*]

Mr. Luc Thériault: Could you identify these issues, please?

● (1705)

[*English*]

Dr. Gail Tomblin Murphy: Yes. The issues at the time were that we focused largely in this country on increasing seats—nursing seats, for instance, medical seats—without really thinking about what other strategies could be in place: How do we actually retain the workforce that is already there? Retention at that time, and strategies that are still pertinent today, was in finding ways to value the workers, to have staffing ratios and staffing patterns in place so that services can be delivered to Canadians that match their needs.

Also during that time, it was clear that what we hadn't talked about was how providers work together as teams, wrapping around the needs of Canadians. That looks very different depending on the context—you all understand that—but it also depends on the context in which care is being delivered. How can one say that you need to increase a certain number of training seats, for instance, without thinking about the impact of technology and efficiencies in the system, without thinking about when we work as teams—regulated as well as unregulated workers—to address the needs of Canadians, and that there are other alternatives?

During that study—and, to the question—the strategies that were important.... If we did nothing at all, we would see a shortfall: that is, a shortfall between what Canadians needed in terms of health needs and the supply to deliver the services. It's both components: needs and requirements for care, as well as supply. If we did nothing, we would see a gap of 60,000 predicted in 2022. If we had put strategies in place—things like dealing with attrition rates in universities and supporting students using principles of equity, diversity and inclusiveness, as well as other supports like incenting students, supporting them during employment and looking at other things—that, on its own, would have helped to reduce the actual gap.

However, if we had added to that and looked at strategies to keep nurses working, for instance—that is, physically well and mentally well—that would have helped to reduce the gap. In living through COVID, as an example, we have not necessarily dealt with—but we have seen the light shone on—the mental health problems and issues that continue to be in the way of nurses, as well as deterioration in physical health through exhaustion, heavy lifting and working oftentimes very, very short-staffed.

[*Translation*]

Mr. Luc Thériault: I was more concerned about what happened 10 years ago, long before the pandemic, that led to this difficult situation.

In Quebec, nurses are leaving the public system to work for private agencies because they have more control over their work schedule and better working conditions.

Doesn't this show the issues within the public systems? Given the situation, is there a way to reinstate the working conditions that nurses find in the agencies?

[*English*]

Mr. Michael Villeneuve: Go ahead, Gail.

Dr. Gail Tomblin Murphy: Mr. Chair, what I would like to say is that we know that health care is a federal but also a provincial and territorial issue. If we look across this country, what the Royal Society of Canada paper has demonstrated is that some of the provinces and territories are taking on innovation and investing in innovation differently from others.

If I speak to the question you have asked, overall this is not a phenomenon that just came into play 10 years ago. The work I do globally tells me that the time when we pay attention to shortages and gaps in the health workforce is when there is a crisis of some kind. A crisis can be fiscal in nature; it can be a pandemic, or it can be a surge or a threat. When those critical points are not in place, then governments across this country oftentimes relax and become quite complacent with putting strategies in place to address the workforce.

In the example you have provided, COVID has helped us to appreciate that, indeed, oftentimes we need to think about alternative arrangements and options to ensure that Canadians across this country are receiving care.

During COVID—

● (1710)

The Chair: Thank you, Dr. Tomblin Murphy.

Next we have Mr. Davies, please, for six minutes.

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

Thank you to all the witnesses for being with us.

Ms. Vance, I want to start with you, please. We know we have a problem with access to primary care in Canada. I think we all recognize it. Historically, the family doctor has been considered the first point of contact, and I think that's giving way to a more modern notion of better utilization of a team-based approach to health care.

I think you touched on that in terms of the role of pharmacists and how better use of pharmacists and their expertise as allied health professionals may relieve pressure on the family physician. I think the example you gave was perhaps allowing pharmacists to provide prescriptions for common, easily diagnosed ailments.

Could you expand on that? I'm curious whether that could extend to things like prescription renewals or maybe injections. I know pharmacists have played an important role in COVID. What other things could pharmacists do that might take some of the pressure off the family doctor and provide quicker access to care for patients?

Ms. Geraldine Vance: Thank you very much for the question. I will apologize to the interpreters from earlier for being *trop vite*. That's bad French, but there you go.

If we look across the country, Alberta really has set the stage for demonstrating what pharmacists can and should be doing in terms of primary care. As I noted in my remarks, Canadians are anxious to interact with their pharmacists and get more care from their pharmacists, so they are not the barrier in any way. In Alberta, there are prescribing rights, and in Saskatchewan, Nova Scotia, Manitoba and pretty much across the country, including the Yukon, they were recently given some authority during COVID for what is categorized as minor or self-identifiable ailments, such as shingles.

If I may, I will use a very personal example. I got shingles about six months ago. My primary care physician has not been in their office since March 2020. I had a call with my physician on the phone, and it was me who identified it was shingles. I went to the pharmacist, who looked at the medication that had been prescribed and intervened with my physician to get a different medication. I showed my pharmacist where the shingles were, and thankfully, it was in not too difficult a spot.

Pharmacists deal every day with their patients. I think no one in this country would disagree that we need more support for doctors and nurses, absolutely, but we are missing a huge opportunity by not better employing community pharmacists, who, as the stats from 2018 show, see their patients as much as 10 times more than patients would see their family doctor.

As we look ahead at the solutions, we need to ensure that we are looking at employing the resources we have, in addition to augmenting those that exist.

Mr. Don Davies: I think that's where my mind is going, and I will give my own little personal example.

I have been on medication for a long period of time. I have to get a renewal about every six months. This has happened probably 25 times. I have to go back to my doctor for the renewal on something I know I'm automatically going to get.

Is that something that would be just as easily or maybe even better handled by a pharmacist?

Ms. Geraldine Vance: Yes, absolutely. In British Columbia, we have adaptation and renewal rights, and our college, in fact, is looking at expanding those at this time. Throughout the pandemic, for two years, many patients were getting their prescriptions renewed by their physician over a telephone call.

I think in terms of the notion of saying that patients with stable conditions whose medications do not vary over a period of time should not have those easily renewed at the pharmacy, that case can no longer be made. That frees up family physicians to see patients in person who really need their care. I think, again, it's about better utilizing pharmacists to ensure that family physicians have the time to spend with those patients who need to see them.

● (1715)

Mr. Don Davies: I'm interested in the economics of it too. Is it possible for you to give a comparison between what the cost would be of me going to my doctor for my prescription renewal versus me going to the pharmacist and what the dispensing fee would be?

Ms. Geraldine Vance: If you were to do an adaptation, if a pharmacist were to renew your prescription, we are talking about a $15 fee. In British Columbia, for a patient to go for a basic 0100 family physician visit, that's in the neighbourhood of $40 to $65, so certainly economically the numbers are there that would allow for redeployment of those resources to do other things.

Mr. Don Davies: Ms. Vance, I want to put some data collected by the Canadian Institute for Health Information to you. It says the number of pharmacy graduates in Canada dropped from about 1,300 in 2016 to 1,256 in 2019 and 1,255 in 2020, while the number of pharmacists in Canada increased over that period from 34,000 to 44,000. When I looked a little further, the data also showed that in 2020 international graduates accounted for 34% of the overall supply of pharmacists.

What can you tell this committee about where Canada is getting our pharmacists from? It seems to be a bit of a success story in terms of our ability to attract foreign-trained pharmacists and get them working in this country, which is not necessarily the case for other professions. What can you tell us about that?

Ms. Geraldine Vance: Absolutely. I think we saw 20 or 30 years ago how dependent Canada was on foreign-trained physicians who came from places like England, Scotland and Ireland. We're seeing pharmacists come from around the world. Canada is a good place to practise pharmacy, so we are certainly seeing them easily integrated into the care that they provide in communities and also in hospitals. I think it does serve as a demonstration of what is potentially possible in the other professions.

Mr. Don Davies: Thank you.

The Chair: Thank you, Ms. Vance. Thank you, Mr. Davies.

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

Mr. Michael Barrett: I have a point of order, Chair.

It looks like the vote call will be in just about four minutes, so rather than interrupt Mr. Ellis's time, I'm just wondering if this would be a good spot to suspend until we've completed voting.

The Chair: To the witnesses, there's a vote happening in the House now. We do have a capability of voting on our phones, and we'll need to suspend to ensure that it happens. We'll be back with you in about 10 minutes.

The meeting is suspended.

● (1715)

_____(Pause)_____

● (1725)

The Chair: I call the meeting back to order.

Thanks again for your patience, witnesses.

We're going to resume the rounds of questioning.

I recognize Dr. Ellis, please, for five minutes.

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

Thank you to the witnesses for their patience. I hope they enjoy seeing democracy in action here. That's the best part of it all.

I have a question for Ms. Vance.

You talked about trying to ensure that there was some sort of conformity across Canada with respect to skills that pharmacists might use. Would that also include something like a pan-Canadian licence?

Ms. Geraldine Vance: It's hard for me to speak to regulatory issues. I think it's not dissimilar with positions.... There's a skill set that is applicable regardless of the province in which you practise. You need to meet provincial regulatory requirements, but there's a commonly accepted set of practice expertise. That's what we're looking for.

If you look at prescribing rights across the board, Alberta has the broadest use of pharmacists, in this province. Other provinces, like Nova Scotia, allow for prescribing this and that, and different provinces have different things.

We're thinking that a standard scope of practice would be a good place to start.

Mr. Stephen Ellis: Thank you very much for that. I appreciate it.

Dr. Kassam, we talked a little bit about some of the solutions, and of course the OMA has presented a very comprehensive picture of that.

I'm wondering about the short-term look at recruiting physicians. It would appear that if I did my math right, we're perhaps around 500 short in Ontario. How might we change that in a very short term? What are one, two or three things you might think of?

Dr. Adam Kassam: Thanks for the question, Dr. Ellis. It's a very important question as far as health resources are concerned.

The first thing we need to do is stop the exodus in the profession by shoring up what health care resources we have right now in terms of physicians spread across the province.

As for what we can do immediately, we can fund more medical student spots as well as residency spots. It makes no sense to have an increase in medical enrolment that is not followed by commensurate residency training spots. That just worsens the problem.

Finally, of course, we need to align incentives in a variety of regions. To be very frank, in northern and rural parts of our province, we have trouble retaining and recruiting physicians. Aligning incentives, whether that means financial support of infrastructure or innovation incentives.... These are areas that we believe would actually serve a purpose for retention and recruitment in areas that are under-serviced.

● (1730)

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

I have one other question. Has the topic of pensions for physicians come up? What does the OMA think of that?

Dr. Adam Kassam: This is an important issue because, as most people on this call and in this committee know, physicians have to self-fund their pensions. Unlike other public service workers, there is no pension for physicians. This is a huge problem for our profession broadly. It is also a challenge as we think about the future of the profession, as far as being able to care for themselves and their families into old age is concerned.

The pension issue is a very live one. It's one that the physician community is very strongly in favour of. It requires attention at both a federal and a provincial level to really move that ball down the field.

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

Dr. Tomblin Murphy, we have some numbers here from the OECD: perhaps 8.8 nurses per 1,000 population. In Canada, we're around 10 per 1,000. Can you tell us a bit about why there might be a discrepancy there in the number of nurses we have, which is above the OECD average?

Dr. Gail Tomblin Murphy: Thank you for the question.

When we do comparisons between OECD countries by numbers, I think that looking at a number of something by population only gives us one picture. It doesn't give us what the needs of the population are or the care delivery system in which nurses and others are actually participating.

The OECD comparisons are helpful, but I think the better comparator is for us to look more closely across this country by provinces and territories and better understand that. In terms of OECD, we probably are ranking pretty well, but we need to be thinking about more than numbers per population as we look at any provider group.

Mr. Stephen Ellis: I have one quick question, Dr. Tomblin Murphy.

In Nova Scotia, since it's our home province, how many nurses do you think we're short?

Dr. Gail Tomblin Murphy: Across the province, we are looking at high vacancy rates. In Nova Scotia Health, the provincial health authority, as you're aware, there are about 800 vacancies right now. We are already working short. We do have many good strategies in place that we are feeling very optimistic about, strategies that have to do with hiring students, for instance, during their programs, which gives students a sense of value and of becoming part of the health care system early, as opposed to at the time of graduation.

We are also looking at ways to precept and mentor nurses much differently, such as by using the pool of retired nurses, who have a lot to offer. As you're very well aware, we are also looking at strategies to better prepare to receive internationally educated nurses by taking it very seriously, in terms of preparing in the province as well as across the country. We need to, so we can successfully integrate these workers in a timely way, in a way that recognizes their credentials and moves them into our health care system delivery through bridge programs for CCAs, LPNs, NPs and others.

The Chair: Thank you, Dr. Tomblin Murphy.

Next, we'll go to Dr. Hanley for five minutes.

Go ahead, please.

Mr. Brendan Hanley (Yukon, Lib.): Thanks.

I'd like to add my gratitude to all of you for having appeared and given your time, especially in a somewhat interrupted way, this afternoon.

I have so many questions, and so little time. I'm going to start with Dr. Kassam.

I think you mentioned credentialing in your opening remarks. I wonder if you could give me your views on how we could be more efficient in international credentialing, and also maybe comment on the question about pan-Canadian licensure and whether you would see that as an advantage.

Dr. Adam Kassam: Sure. Thank you so much for the question, Dr. Hanley. Given your expertise in your area, I know this is something that's germane to not only your understanding but also the understanding of the committee.

Obviously, we need to have an international strategy for health human resource recruitment, and that will invariably include a pathway to credentialing. This is obviously a very complex situation, because it requires multiple institutions, including the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada, as well as the provincial colleges of physicians and surgeons. A multilateral approach will have to be undertaken, but invariably this will also have to relate to what we are very deeply committed to here in this country, which is quality of care. It's not necessarily quantity of care, but quality of care. How do you ensure a minimum quality of care and competence from places around the world so that Canadians can continue to receive the best and, frankly, highest-quality care that they deserve and need?

This is also a challenge in that space, and there needs to be a strategy for onboarding, whether that means apprenticeship programs or perhaps even a more streamlined approach to being able to stand for and, frankly, challenge the board examinations, which are, of course, necessary in order to proceed through licensing. These are conversations that need to happen at a federal level, and this is where you and your colleagues have a great role to play.

● (1735)

Mr. Brendan Hanley: Thank you very much.

I have a question for Dr. Pichora.

You gave fascinating opening remarks. Thank you very much for all your work and your vision.

I'm wondering what a postpandemic hospital looks like, or should look like, versus a prepandemic hospital. In other words, what have we learned from our experience with respect to what we can do and what we maybe do not need to be involved in? Where are the efficiencies? Maybe give a quick synopsis on that.

Dr. David Pichora: Well, apart from the fact that everything has changed, it's a little hard to give you one or two examples. We're learning how and where digital and virtual care is most effective. It's not useful everywhere, but it's highly useful in selected places. We have a lot to learn about how to integrate virtual care into our traditional and future planning with regard to how we deliver care.

Just as we've been talking about maximizing the scope of practice for various health care workers—the Americans talk about "practising at the top of your licence"—we need to do the same thing in hospitals. Our main site is a highly intense critical care site. It's a trauma unit with cardiac surgery and neurosurgery. Our Hotel Dieu site is an ambulatory site where we deliver day surgery, short-stay surgery, highly effective hip and knee replacement, cataracts and bariatric surgery.

We need to have those sorts of strategies when it comes to how to build out the ambulatory system. We've learned that we have to partner a lot more effectively across the health care system in every way. For example, we're working with an independent health facility around assisting and delivering our cataract volumes. I can see the potential to do more of that as we get better integrated and more effective and efficient at doing it. With distributed networks, we're spending a lot of time assisting other hospitals, larger and smaller. There needs to be more of that as well.

Those are just a few examples of many things that have changed. Some things we need to restore from the past, some things we need to continue doing that we've learned from COVID, and other opportunities are yet to be developed.

Mr. Brendan Hanley: Mr. Chair, do I have any more time?

The Chair: You have about 20 seconds.

Mr. Brendan Hanley: Okay.

Mr. Villeneuve, rural versus urban in 15 seconds....

Mr. Michael Villeneuve: We need more nurses in rural.

The Chair: Well done, and thank you.

[*Translation*]

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

Mr. Luc Thériault: Dr. Kassam, I appreciated the fact that your association said that it supports the requests made by Quebec and the provinces concerning the chronic underfunding over the past 30 years and that it agrees that health transfers should be increased by 35%. This amounts to $28 billion, including an additional $6 billion for Quebec. I haven't done the calculations for Ontario. I liked the fact that you provided figures for your needs.

What would you do with an extra $6 billion in Ontario?

[*English*]

Dr. Adam Kassam: Well, I wish I had $6 billion in my bank account. It would be a lovely dream to be able to have that.

As for where we think investment is required, we obviously think about the backlog of service that unfortunately expanded during COVID and now exists for a shocking number of 21 million health care services in the province of Ontario. It's probably much larger across the country. Getting through that backlog of care and reducing wait times is the key number one priority.

Number two is investment in mental health and addiction services. We know that over the past two years with COVID, we've seen an escalation, unfortunately, in opioid-related deaths and overdose deaths as a result of the exacerbation of COVID and the pandemic on these populations. Investment in mental health and addiction services would be number two.

The third area of investment would be trying to make community care, home care, and retirement and long-term care more robust.

Finally, it would be pandemic-proofing our future by investing in public health to ensure that we are better prepared for the next one.

● (1740)

[*Translation*]

Mr. Luc Thériault: I appreciate your response. A number of stakeholders argue that targeted investments would be required to pull the system out of the current situation. They claim that the people working in the system wouldn't be able to identify the priorities and take the necessary steps with the increase in health transfers. I really appreciate your response.

What's the main reason for the 11-month wait for an MRI scan and the fact that 502,476 people are waiting?

[*English*]

Dr. Adam Kassam: Unfortunately, we know that smaller problems become larger problems. People have been waiting for a variety of different care. It could be primary mental health and psychiatric services. It could also extend to cancer screenings, of course, such as colonoscopies and mammograms. It also extends to procedures and surgeries that people have been waiting for: hip or knee replacement surgery, cataract surgery or cancer removal surgery. It runs the gamut of our health care system.

What we have found over the past 21 months within this pandemic is that we have seen an escalation, unfortunately, in terms of late presentations of pathology, which means advanced stages of disease and of course perhaps the worst prognoses. When we think about a system-level perspective, this actually costs more to deal with.

We know that the pandemic has had a significant impact on the ability not only to provide service but to provide service in a timely way. It is now our task as a country to think about the future.

The Chair: Thank you, Dr. Kassam and Mr. Thériault.

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

Mr. Don Davies: Thank you.

Ms. Tomblin Murphy, do you have any general idea, just ballpark, as to how many foreign-trained nurses there are in Canada right now who are unable to practise because their credentials aren't recognized?

Dr. Gail Tomblin Murphy: I actually wouldn't have that number. I would defer to Michael Villeneuve on that number.

The Chair: Sure.

Mr. Villeneuve, go ahead.

Mr. Michael Villeneuve: Thank you.

We don't know the exact number. We hear through anecdotal reports across the country that there are many in the pipeline waiting to get in, but I can look that up for you and would be happy to report it back.

About 9% of the nursing workforce are internationally educated, if that's of any help, but that's been a long-standing pattern of individual migration.

Mr. Don Davies: We know that it's a problem, for instance, with foreign-trained doctors, who I know have a really hard time getting credentialed in Canada. Can you give us a sense of how serious an issue that is, if it is at all, with respect to nurses in the country?

Mr. Michael Villeneuve: Go ahead, Gail.

Dr. Gail Tomblin Murphy: I can answer that, Mr. Chair.

What we have learned is that we haven't done a very good job. There are some provinces and territories that have taken this seriously, definitely the federal government as well, to find innovative ways we can actually spend more time with our workers prior to their coming to Canada: for instance, working at the country level and offering distance learning, English while in country, and moving towards the credentialing opportunity while in country.

We have also found that some of the innovation here is actually preparing communities, whether it's for children in school or the employers, businesses, universities, colleges and—

Mr. Don Davies: Sorry, I'm getting a sign and I want to get one question in, if I can, to Dr. Kassam.

Dr. Kassam, the OECD provides a breakdown of various categories. They say that Canada has the second-highest proportion of generalists in 2019 but was below the OECD average for the proportion of specialists.

I'm interested whether it's your experience that we're having difficulty getting specialists. If so, what categories of specialists are most needed in Canada? Where is the deficiency for retention and recruitment most acute?

Dr. Adam Kassam: I think it's a hard question to answer because it is highly regionalized. You might not need a dermatologist in downtown Toronto, but you might need one in northern Ontario. It really is matching supply and demand, and need, with the appropriate service to be provided.

Generally speaking, we have a very good understanding that there is a broad shortage of both family doctors—primary care—and specialists in northern and rural communities, at least at is pertains to Ontario. This is why we need not only an urban and suburban health human resource strategy, but also a rural and northern strategy as well.

● (1745)

The Chair: Thank you, Dr. Kassam and Mr. Davies.

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

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

If I may, Dr. Pichora, I have an interesting question, perhaps, to start. You talked about doubling your ICU capacity during the pandemic. How were you able to do that?

Dr. David Pichora: In the early phases of the pandemic, as you know, emergency departments really closed down. People stopped coming. There was lots of capacity in regional hospitals, our local post-acute care hospital, rehab and [*Technical difficulty—Editor*] and there was capacity in long-term care. You can argue in the end whether it was a good idea to move so many patients into long-term care in the province because of the consequences, but nevertheless, that happened.

Hospitals had a lot of empty beds. Our occupancy was the lowest it's ever been. Our ALC rate was the lowest it's ever been. We were able to redeploy staff, reconfigure facilities and bring in additional monitoring and ventilator equipment to create additional ICU beds. But for every one of those beds we created, we had to close five acute-care beds. Fortunately, those beds were empty at the time. We had to redeploy the nurses and other health care workers who were staffing those beds. We were able to do that last spring. We could not do that today, because of staffing shortages. The hospital is full. We have the highest number of ALC patients we've had in two years. We have about a hundred nurses off today with COVID-related...either they're infected or their family members or kids are infected.

In terms of the ability to ramp up that level, we're still running more ICU beds than we ever ran before the pandemic, but to get back to that double rate where we were in May and June, we would not be able to do that today.

Mr. Stephen Ellis: Dr. Pichora, is it fair to say that your hospitals generally run at 95%, 100% or 130% capacity, as we do in Nova Scotia?

Dr. David Pichora: Most Ontario hospitals run in those ranges, yes.

Mr. Stephen Ellis: Dr. Pichora, I have a couple of other questions. You talked about maximizing the scope of practitioners. Do you think that will require alternate payment schemes for physicians?

Dr. David Pichora: That's one of the options. We do have an alternate payment plan here at Queen's that has protected physicians from the ebbs and flows of the ability to bill fee for service during the pandemic.

With the nursing shortages and others, we've hired and trained a lot of nurses, as many as we could, but as you've heard, hiring and replacing all of those nursing vacancies in the next few years is a daunting challenge. We've been hiring extenders and trying to train new classes of workers to support our nurses: OR techs to support the OR nurses, for example, or mobility aides who can get patients walking so nurses can practise at the top of their skill. We've done a lot of that to extend the capability of our existing staff while we continue to try to hire regulated staff.

Mr. Stephen Ellis: Dr. Pichora, we've talked a bit about virtual care, and certainly there are issues around virtual care, such as how it's done and which cases you should choose, but that doesn't take into account the Internet and all those types of difficulties, such as difficulties that elderly people may have using the technology.

What kinds of challenges do you see on a regular basis? We heard from Ms. Vance. She talked to her doctor on the phone, which, of course, for diagnosis of shingles is not helpful. I find those examples hard to take as a physician. What do you think we should do about that?

Dr. David Pichora: It's complicated. There are opportunities. In my own domain, doing certain follow-up visits by virtual care or by telephone can be quite effective and save patients from having to travel long distances. On the other hand, doing consultations and providing urgent and emergent care in orthopaedics and many other specialities requires hands-on care. I think we have to find the balance; it's not all or none.

Dr. Kassam could probably speak to this better than me. Because of the nature of family practice and the size of the offices, the size of the waiting rooms, the staff and the availability of PPE, they really had to resort to telephone care and virtual care more than any of them would want. As a consequence, I think that has contributed to building the backlog of patients needing referral. Certainly in our own orthopaedic practice, new referrals to my colleagues fell like a stone during the first few stages of the pandemic, and it's starting to come back now as care is returning to the office setting, so I think that's something we need to learn from.

● (1750)

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

Next is Mr. Jowhari for five minutes, please.

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

Thank you to all our witnesses.

My question is going to go to the CNA: Mr. Villeneuve and Ms. Tomblin Murphy.

Welcome to our committee; it's good to see you both once again.

In your advocacy, in the documents you provided, you've noted that the crisis requires a multipronged solution. Can you elaborate on this and define what factors play into the solution that you're recommending from the short term to the medium and long term?

Mr. Michael Villeneuve: I think I'll start. Thank you very much, Mr. Chair.

There are a couple of dynamics at play. One is that different waves of COVID have impacted different sectors. We know the terrible outcomes that happened in long-term care, for example, in the first wave. We've just heard Dr. Pichora talk about critical care, and in the third wave, critical care was pretty badly hit. Maybe it was the fourth wave; I'm losing track of the waves at this point. It really hit long-term care. We really stressed critical care, and this last one has really pushed all the buttons in medical-surgical units, in general hospital units. There are still some people going into ICUs, but hospitals are full, so we have three major sectors of the health care system that have really impacted nursing.

At the same time, older folks like myself, who might have been lured into staying a bit longer before retiring, are saying they can't do it anymore, so their retirement phase, which might have been five years or something, is being compressed because of the COVID experience, and we're seeing them saying they're going to leave the profession.

A Canadian Federation of Nurses Unions study showed us that, in most recent polling, it was the nurses at the beginning of their career and mid-career who wanted to leave or intended to turn over. You hit three big sectors; you hit new-career, mid-career and late-career nurses, and we're in a pickle.

The things that are going to help retain a nurse, for example, who's 63 are very different from those for a nurse who's 25. That 25-year-old nurse might be delighted to stay for a return of service if the student debt was cleared, for example, but that's not going to make a difference to nurses in their sixties. That's the kind of thing we need when we talk about a need to look at a very multifaceted approach to how we're going to treat the problems, not just the problem.

Mr. Majid Jowhari: Ms. Murphy, do you have any comments before I ask the next question?

Dr. Gail Tomblin Murphy: Thank you.

I would agree 100% with Michael. Clearly the evidence tells us that some of the incentives are pretty simple. It might be helping to reduce the debt from tuition, for instance. It could be incentives that would be, again, looking at working to maximum scope and providing regular hours, which means that we have the appropriate staffing in place.

Also, right across the board, in the sectors that Mike talked about as being hit hard, I think many of our nurses who felt inexperienced were put in situations that were stressful for them. I think what we need to do is have investment in ongoing professional development, so that we can teach on the fly, which was learned in COVID, but in a way that nurses as well as other team members are feeling—

Mr. Majid Jowhari: Thank you. I have one quick question and about a minute and 15 seconds left.

Another one of the recommendations that were made by the association seems to demand the creation of a national health care workforce body that collects data and supports health workforce planning at the regional level. We heard similar recommendations from CMA.

Can you please explain the key benefit of such a data collection tool, both at the provincial level and at the federal level?

● (1755)

Mr. Michael Villeneuve: First I want to give you the fast answer. We collect data across the country. For example, we know there are 349,000 nurses, and the areas where they work. What we don't do is articulate that and make it interoperable with what the physicians are doing, the needs in communities and whether those 349,000 nurses are doing the right thing.

If someone asked me today whether there is a nursing shortage, I'd say, well, there are 350,000 nurses and 95,000 doctors, so I don't know. Tons of them are working part time. What if they were working full time? There are a lot of what-ifs. Our plea for an agency or a structure where we bring data together, planning together, is to talk about what society needs, who can best meet it, and then how many of them you need.

The Chair: Thank you, Mr. Villeneuve and Mr. Jowhari.

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

Hon. Mike Lake: Thank you, Mr. Chair, and thank you to all the witnesses. This has been a great meeting.

We heard a lot about how the funding situation needs to be resolved. If you take a look at the platforms of our respective parties, I think we all recognize that.

I'm pulling up a chart here of funding for the last 30 years. We've been on a solid trajectory, since about 2003-04, with the growth of transfers being faster than the growth of the economy. But with the devastating cuts, if you take a look at the chart from 1993-2001, is it fair to say that we've never caught up from the impact of those cuts?

I'll maybe ask Dr. Kassam to start.

Dr. Adam Kassam: Absolutely. When we think about Canada health transfers and the fact that shared spending is now sitting at close to 22%, at least in the province of Ontario, it simply isn't good enough. That's why we've called for an increase. It's why we stand in solidarity with all of the premiers. I believe at the last council of first ministers, all the premiers were there basically advocating for an increase in Canada health transfers. The reason it's important is that, as this money flows to the provinces, we can address a lot of the issues that we've brought up here in this chamber today.

Absolutely, it has not met the needs of a growing and aging society, which we unfortunately have in this country—and it's a beautiful country—and we need to be able to sustain the level and quality of care by having commensurate investment in these areas.

Hon. Mike Lake: Dr. Kassam, I'm going to stick with you.

In that vein, we're all inundated, especially at this point in time, with asks for massive new amounts of government spending. The government is going to have to say no to significant good asks given our spending situation, which is pretty challenging in Canada, if we're going to say yes to dealing with this crisis in health.

We acknowledge that we're going to need to spend more. Our party's platform projected $60 billion in additional spending over 10 years. As we do that, thinking about technology, thinking about how to get more with the dollars we are spending, can we leverage technology to improve the quantity and quality of care that is delivered?

I'll ask a second question in parcel with that. Can we also use technology to improve the system to avoid the burnout that all of you have spoken about?

Dr. Adam Kassam: Absolutely. Those are very astute questions.

Let me take the first one, which is whether we can use and leverage technology innovation. Can we scale up and level up in this country our ability to deliver service—i.e., health care services—to the people who need it at the time that they need it? Absolutely. We saw what happened during COVID with virtual care.

Yes, we're talking about appropriateness. We, as a profession, need to figure out what is appropriate and what is better served for patients in terms of in-person care. That conversation happens in real time and is being grappled with not only in this country, but, frankly, around the world.

I absolutely believe.... We've seen this take place in a robust way in this province, in Ontario, throughout the past 24 months. One of the things that are important to recognize is that, as we start thinking about a recovery and a rehabilitation in our society post-COVID—and we're still here, still dealing with the aftermath and trying to prevent a next wave—we can't have an economic recovery without a health care recovery. This is where we think that investment is so very important, and using technology to leverage our ability to do so is extremely crucial.

To your second question, which was about using technology to help with system-level change to reduce burnout, I absolutely hope so. We know that technology, in some capacity, is actually a driver of burnout. I'll give you an example. As physicians, we have electronic medical records that are often not connected to one another. Having to click through a bunch of different sites and different areas can actually contribute to burnout if that information is not available to a provider in real time because it's on a different network, for example.

If we can have this integrated, hopefully in a meaningful way, we can reduce burnout and have doctors be doctors, continue seeing patients and see more of them, and also reduce the administrative burden that is a driver of burnout in the sector.

● (1800)

Hon. Mike Lake: Thank you.

How much time do I have left?

The Chair: You have 20 seconds.

Hon. Mike Lake: I'm not going to ask a question. I'm going to make a comment to Ms. Vance.

I come from Alberta. I live in that world where I can go to my pharmacist and get help that, if I were in another part of the country, I would have to go to the doctor for, and it is fantastic. Talking about innovation, some of the innovations aren't necessarily technical, but systemic. That's to reinforce some of what you're saying.

Thank you.

The Chair: Thank you, Mr. Lake.

The last round of questions will come from the Liberals.

Ms. Sidhu, you have five minutes.

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

I would like to share my time with Dr. Powlowski.

Thank you to all the witnesses for your valuable information.

My question is mainly for the OMA. We heard at previous meetings that the one issue contributing to the worker shortage was the provincial regulatory bodies. They make it difficult to move between provinces and to admit foreign-trained professionals, especially IMGs.

We heard from Dr. Murphy about the nurse shortage of 60,000 by 2022. We have our lab technicians. There are only five medical laboratory education programs in Ontario, and they all have waiting lists. We also have a shortage of PSWs.

Dr. Kassam, you said that in creating residency support and recruitment, we need a multilateral approach. What do you think are the best strategies and best practices, so that we can create more residency places for our IMGs? I know some of the Canadian students, the IMGs, even did Kingston General Hospital electives, but they're waiting for residency spots.

What can we do to fill those gaps?

Dr. Adam Kassam: There's no question that there are bottlenecks in being credentialed from an international medical graduate perspective, and this is something that comes up quite commonly in our discourse as we think about a health human resources strategy for the future.

An international approach is very important, where we think about being able to match not only the supply of IMGs, for example, but also the demand for different kinds of physicians and where they are appropriate. For example, it would make absolutely no sense to train more surgeons without a commensurate increase in the ability to have those surgeons operate. Right now, we have a limitation in our ability to have surgeons operate, because of operating room time and the numbers of operating rooms that are available. Simply credentialling more surgeons is not going to make the problem better; it's going to make it worse. You're going to have more unemployed specialists.

It's really a matter of identifying the need and the scope of practice based on the jurisdiction, and then being able to tie that into a minimum threshold of competence. That is the task of a federal body like this, but also perhaps a task force that would be required to better understand [*Technical difficulty—Editor*].

The Chair: Dr. Powlowski, go ahead.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): The problem in my mind is pretty simple: We don't have enough primary care practitioners to work in rural areas. We haven't for the past almost 35 years, since I graduated from medical school. The other problem now is not having enough nurses. It would seem to me the problem could readily be solved by looking at credentialling far more foreign graduates. In my 35 years of being a doctor, I've met so many people, doctors and nurses in Canada, who were trained in other places but were unable, despite all their efforts, to get credentialing in Canada.

It would certainly seem to me that if we want to address the health care shortage quickly, the federal government could give more money to the provinces, and the provinces could then implement more positions to upgrade the skills of foreign-trained graduates so that they come up to the standards required in Canada. That may mean academic upgrading, practical upgrading or more residency programs. Could we do that?

Let me first ask Dr. Pichora. Could you, at Kingston, open up more positions for academic training? I'm thinking for maybe just a year or two, or maybe shorter, depending on where the person has graduated from. Could you provide a tailored, practical upgrading, if necessary, in order to get practitioners out quickly? Presumably they'd still have to write the licensing exams. I'm not thinking of surgeons, because the problem is not OR spots, but I'm thinking of primary care practitioners and nurses.

● (1805)

Dr. David Pichora: Yes, we would try to do this and work with the universities and colleges to support it. Primary care is an interesting one, because we have a very large family medicine program here, but it's a distributed education model, and they have placements all over Ontario and beyond. They don't just train in Kingston. We need to take advantage of models like that. We have lots of hospitals in the province where surgeons could go to receive part of their training. We do some of that already with Lakeridge, for example. There's probably a lot more opportunity to do that than we take right now.

The downstream effects are significant. One of the biggest concerns I hear about is in the physiotherapy and occupational therapy training programs, where they just can't get access to enough clinical placements, which they need to finish their training. It's not just physicians; it's nurses and others.

The Chair: Thank you, Dr. Pichora and Dr. Powlowski.

That completes the round of questions.

I want to offer a sincere thanks to our witnesses. You're all very busy professionals. Your expertise is evident. We will benefit from it greatly in our work on this study. I know that we would like to have you here longer. It's too bad for the interruptions, but we certainly had quality. I appreciate your sticking around and being so generous with your time.

Thank you very much, everyone.

Is it the will of the committee to adjourn the meeting? We have consensus.

The meeting is adjourned.