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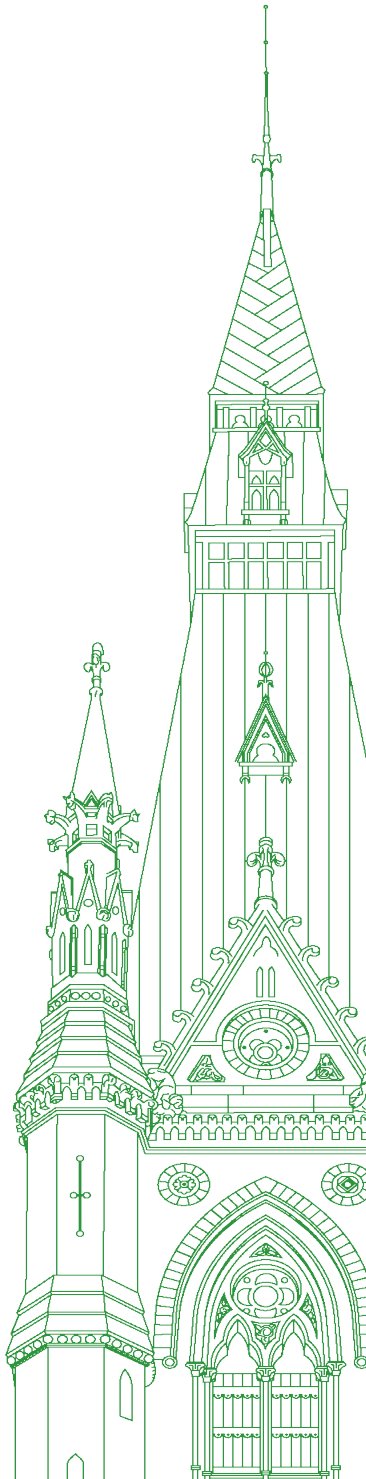

Chair: Mr. Sean Casey

Standing Committee on Health

Monday, March 28, 2022

● (1535)

[*English*]

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

Welcome to meeting number 13 of the House of Commons Standing Committee on Health.

Today we will meet for two hours to hear from witnesses on our study of Canada's health workforce.

Before I introduce today's witnesses, I have a few regular reminders on hybrid meetings.

Today's meeting is taking place in a hybrid format, pursuant to the House order of November 25, 2021. Members are attending in person in the room, and some are attending remotely using the Zoom application. Our witnesses are, of course, using the Zoom application.

I would like to take this opportunity to remind all participants to the meeting that screenshots or taking photos of your screen is not permitted. The proceedings will be made available on the House of Commons website.

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

With us this afternoon for two hours are the following witnesses. As individuals, we have Sylas Coletto, registered nurse; and Brenda Payne, experienced nurse, educator, senior executive, and rural and urban consultant. We have Dr. Martin Champagne, hemato-oncologist and president of the Association des médecins hématologues et oncologues du Québec. From the Canadian Association of Occupational Therapists, we have Giovanna Boniface, president and registered occupational therapist; and Hélène Sabourin, chief executive officer. We also have Cynthia Baker, executive director of the Canadian Association of Schools of Nursing; and Bradley Campbell, president of Corpus Sanchez International Consultancy Inc.

Thank you to all of our witnesses for taking the time to be with us today.

We're going to begin with opening remarks from each witness in the order they appear in the notice of meeting. This means we're going to start with Mr. Coletto.

For the next five minutes, the floor is all yours. Welcome to the committee.

Mr. Sylas Coletto (Registered Nurse, As an Individual): Thank you very much, honourable members, for having me.

I am a settler, cisgendered, white heterosexual male. I am a critical care registered nurse with an honours bachelor's degree in kinesiology and a Bachelor of Science in nursing. I am currently working full time on a Master of Science in nursing.

I have been working as a nurse since January 2018. [*Technical difficulty—Editor*] in cardiac ICU, emergency and, during the main waves of the COVID-19 pandemic, general ICU work in both Saskatchewan and Ontario.

There is a saying among my colleagues: “Health care: destroying my life to save yours.”

I have elected to discuss three themes. These are abuse, balance and value.

First, on the theme of abuse—it happened to me within the last week—I have been sexually, physically and verbally assaulted. I've had various parts of my body groped and fondled. I've been punched and kicked. I've had verbal profanity and threats that I would be followed home and my family hurt. I've had blood splashed in my mouth. I've been spat on and had feces thrown at me. The list goes on. I have been repeatedly assaulted.

This is not an infrequent thing. These patients are completely aware of what they are doing, many times, and it's often much worse for my female colleagues. Like many nurses, I have stopped reporting these incidents. Nothing happens to the assailants. People continue to take advantage. Additionally, I do not have a permanent position. I do not have the benefit of taking paid sick days or personally seeking counselling. However, being constantly assaulted affects my mental health and my family life.

In terms of my mental health, I frequently witness death. That was exacerbated during the COVID waves. I have put many deceased people into body bags to be transported to the morgue. During COVID waves, there was not enough time to mentally process all of the death. I have had limited access to supports, and my mental health has suffered.

For example, I had two patients who were dying at the same time. This was the last time the family members would see their loved ones alive. I was holding up a FaceTime camera to one of them, and I had to tell the family to end the call—again, this was the last time they would see their family member alive—because I had to go and do it with another patient simultaneously. I wanted them to be able to say goodbye one last time. That was one of my very tough days.

In terms of balance, shift work is a very difficult thing to become accustomed to, with rotating days and nights and working 12 hours or more in a shift. I have little time to spend with my family. I have to rest so that I can be at top performance when I next go to work. I am accustomed to top performance. I have represented Canada for rowing internationally. But in this case, if I don't perform every day at work, people die, as we are currently seeing demonstrated in Tennessee, U.S.A. During COVID, I'm working in rooms with the sickest patients 12 to 16 hours continuously, hoping my mask stays sealed and I don't lose that seal, and scared that I will unknowingly contract COVID and bring it home to my family.

I have two degrees. I am working on a third. I have considerable on-the-job training. You would be lucky to be around me if something were to happen and you needed my help. But I do not have access to much assistance, be it financial or scheduling, to pursue my further education. I've had to put pause on many aspects of my career and compromise my work, not really being able to amalgamate the two. It's give up my income to support my family or go to school to try to elevate health care delivery, myself, and the profession to better people's lives. It's very difficult to accommodate both.

On the theme of value as a profession, with regard to representation on decision-making panels or boards, I have not seen very much of it throughout the COVID-19 pandemic. I was being told what to do by people who have never done my job. For example, on the COVID-19 advisory table in Ontario, there are 33 members. There are three leaders and only one RN on the panel, but 22 physicians. Nurses are the ones who are implementing what these advisory boards put forward. I am very confident that there are a lot of smart, well-educated nurses who could have contributed. This tells me that nurses do not matter and we cannot contribute. We have no value in decision-making.

On the theme of fiscal value, I have 13 years of post-secondary education and training. In Ontario, I make $36.53 an hour. In Saskatchewan, I make $6.20 more per hour, and that will go up at the beginning of April. It helps, but I am still underpaid. In Ontario, there's Bill 124, the 1% wage increase. I have been working harder and harder to save people's lives, especially during COVID. I believe I am worth far more than 1%.

As an example, during the COVID waves, we were so short of nurses in the ICU that we had residents, doctors in training, to work underneath us, assisting. They had no prescription rights and could not give medications unless I was right there with them. We were still making our same wage, but the residents were being paid $100 an hour. I felt undervalued.

The same thing was going on in the COVID vaccine clinics. Physicians were making $170 an hour during the day and $215 during the afternoon. We were doing the same job, but I was still making my same wage. I felt undervalued.

● (1540)

This job is taking my family time, deteriorating my mental health through abuse—physical, emotional and financial—and making me feel devalued. I am constantly wondering why I choose to continue to do this work, even though I believe I do good work.

That is what I have to say. Thank you.

The Chair: Thank you, Mr. Coletto.

Next, we have Brenda Payne. You have the floor for five minutes.

Ms. Brenda Payne (Experienced Nurse, Educator, Senior Executive and Consultant (Rural and Urban), As an Individual): Thank you.

I'd like to first thank the standing health committee for the opportunity to provide my perspective on this really important question surrounding what the federal government can do to address, as we've just heard, the acute and very critical recruitment and retention issues and workplace issues for many health care providers throughout our country, particularly with an emphasis on urban and rural communities.

I'm not representing a particular perspective but a whole perspective, in that my perspective has been influenced by my clinical knowledge, training and background—being a nurse. I have both knowledge and extensive experience in many aspects of our health system, which has enabled me to see truly a whole perspective, one that is inclusive of being a provincial public health servant as well as being a patient.

What I'm hoping to contribute to the discussion is an understanding of experiences related to this issue. Throughout this country we're hearing—not as eloquently as from the first witness—from all providers, the public, patients, clients, residents and their families that we are in a critical condition as it relates to recruitment and retention.

I wish I could say that this is the first time we have heard, or I have heard in my career, that there are issues with both the recruitment and the retention of providers, but I am here to say that in fact this is not a new issue. This is an issue that we have been wrestling with for many years and, as a result of the work that was done previously.... The federal government did some extraordinary work leading both the provinces and the territories in 2000 and onwards towards dealing with this same issue.

The issue for us today, however, is further compounded by the fact that we knew this was coming. We predicted—it was a known factor—that our retiring baby boomers would leave a big gap in the system, and a study that was done in 2009 actually predicted that there would be a shortage of 60,000 registered nurses. That is without the consideration of a pandemic, which truly has had a deleterious effect on our health care providers.

Before going into what the federal government can do, the next point is the acknowledgement that in our health systems—and we've studied them, whether on a provincial basis or a national basis, on a regular opportunity—our initial reaction is a very reactive one. We have tended to look at issues as if they were single entities that occur outside of the system.

My knowledge and my extensive experience have shown that in order to address this issue, we must work collaboratively and cooperatively to address what is before us, acknowledging that all levels of government in Canada—the provinces, the territories, our indigenous peoples and other under-represented groups, our education system, our employers in health professions and other relevant stakeholders—can actually come together to help solve this problem.

Having looked at what the federal government has done, we have actually had extensive work done with health human resources, and a strategy that was developed can continue to serve as a foundational document from which to jump-start some work.

● (1545)

My significant worry is that, as we speak, provinces and territories are having to address the shortage of critical personnel in order to provide care. As a result, they're coming up with lots of very innovative ideas. We just heard of one in terms of the increase in compensation, although at 1%. My worry is that unless the federal government takes a facilitating role to bring all parties together, we're going to be left with a further fragmented system and provinces functioning very differently from one another. As was done in the past, I would recommend that we bring folks together. We can do a number of things.

The other point I would like to make is that with the health system, if we're singularly focused, we are not going to be successful in addressing the issues that are before providers, patients and families. I'm recommending a pan-Canadian approach. I would offer that there are a number of things that we can do together to address.... Number one is really confirming, on the demand side, what the pan-Canadian vision is for health. We can begin to look at, identify and share what some really good strategies are to not only recruit, but retain our current providers.

In addressing some of the key workplace issues that have already been addressed by our first witness—

The Chair: I'm going to get you to wrap up, Ms. Payne.

Ms. Brenda Payne: I believe that there are greater risks for not using a pan-Canadian approach to the critical issue that we face. Canadians, our providers and every citizen in Canada are counting on all of us to be able to provide the services when they need it.

Thank you very much.

The Chair: Thank you, Ms. Payne. I'm sure you will get lots of opportunities to elaborate during the questions and answers.

[*Translation*]

Dr. Champagne, you now have the floor.

● (1550)

Dr. Martin Champagne (President and Hemato-Oncologist , Association des médecins hématologues et oncologues du Québec): The Association des médecins hématologues et oncologues du Québec represents 350 members aged 47 on average. Recruitment for this specialty is booming, as the need for oncologists is increasing all the time. We have 55 residents and 22 fellows in medical subspecialties because we must deal with the aging of the Canadian population. As you know, it is expected that approximately one in two Canadians will develop cancer in their lifetime.

People studying in the field have clinical responsibility for the diagnosis and treatment of a variety of hematological diseases, both cancerous and non-cancerous, as well as for cancer care. These people practise mainly in hospital settings. Unlike our colleagues in English Canada, in Quebec, we are also responsible for laboratory operations. The people in that environment have to absorb an explosion of knowledge, which has major repercussions.

The pandemic has had an impact on cancer care because, as has been pointed out, the health system has been oversaturated and a lot of activity has been offloaded. In Quebec, for example, 100,000 people were waiting for colonoscopy before the pandemic, the test used to diagnose colon cancer. Now, over 150,000 people are waiting for this test. We therefore estimate that a significant number of cancer cases have not yet been diagnosed including about one in five cases of colon cancer.

To put things in perspective, a colon cancer screening program is expected to reduce mortality by approximately 20%. In Canada, in 2021, an estimated 28,400 Canadians have been diagnosed with colon cancer and 9,400 will die from it. If offloading has had a significant impact, it means that many more people will die. In addition, because of the delay in diagnosis, the diseases are more advanced and require more intensive therapies. This leads to more morbidity, more complications and more mortality in patients.

At present, we hear of waiting lists for orthopaedic surgery that have grown much longer. But unlike patients who undergo orthopaedic surgery, cancer patients are in the health system for years. So it is not a one-off investment that will solve the problem; it will be necessary to make investments over a long period. Staff shortages have already been alluded to. In some key areas such as pathology, it will be essential that staff are well supported so that oncology recovery capacity is not limited.

The pandemic has had other major impacts. Prior to the pandemic, a survey of Quebec hematologists and oncologists was conducted. More than 80% of them said they had the support and recognition of their colleagues. However, there was a high rate of burnout. Of the respondents, 11% reported depersonalization, 40% reported emotional exhaustion and 16.5% reported psychosomatic problems, giving an overall burnout rate of 57%. These statistics are from before the pandemic, and at that time people were still committed to the profession. We felt Mr. Coletto's passion during his speech. People are still passionate and they still find their work fulfilling.

However, we are very concerned that the pandemic has resulted in less physical contact with patients and colleagues, and this will likely have a significant impact on burnout for all health care workers. According to a study of 153 doctors in Quebec, their stress level is unprecedented, at 61% compared to 35% before the pandemic.

What are the solutions?

Diagnostic standards of treatment and supervision already exist in oncology. So we don't need new standards. But we do need resources. This means investing in health care to improve infrastructure, train staff and facilitate automation in laboratories. I think that the federal government will be able to increase its contribution to health care, not only on a one-time basis, but on a recurring basis to meet the needs in hematology and oncology.

● (1555)

The health care system must be focused on value, not just cost reduction, to maximize patient outcomes with the resources available. This means having an organized and integrated continuum of care. We need information systems. Currently, we are in the Stone Age. We still have systems that are difficult to consult and not complementary. We must therefore facilitate the integration of data through artificial intelligence.

This requires incentives, particularly financial incentives, aimed at aligning the objectives of health care institutions with value. This requires investments in artificial intelligence and computer networks.

In addition, we must facilitate access to the medical professions for new immigrants who are properly qualified to facilitate recruitment and integrate them into a process of onboarding and socialization.

Finally, I would like to highlight the distress of people working in the health sector. We must increase support for organizations that help professionals, such as the Québec Physicians' Health Program. I am referring to doctors, but this applies to all health sectors. We feel that this is essential to combat the psychological distress observed among health professionals.

The Chair: Thank you, Dr. Champagne.

[*English*]

Next, we're going to hear from the Canadian Association of Occupational Therapists. Ms. Boniface or Ms. Sabourin will speak for the organization.

Ms. Giovanna Boniface (President and Registered Occupational Therapist, Canadian Association of Occupational Therapists): I will make the remarks for today. Thank you.

The Chair: Welcome.

Ms. Giovanna Boniface: Thank you.

Good afternoon, everyone, and thanks for the opportunity to present to you today.

I'm Giovanna Boniface, president of CAOT and an occupational therapist who has been practising for 25 years.

I'm joining you today from North Vancouver, which is situated on the lands of the Coast Salish people.

[*Translation*]

Ms. Hélène Sabourin (Chief Executive Officer, Canadian Association of Occupational Therapists): Good afternoon.

My name is Hélène Sabourin.

[*English*]

I'm a registered nurse. I'm currently CEO of the Canadian Association of Occupational Therapists.

I'm speaking to you from Ottawa, on the traditional lands of the Algonquin Anishinabe peoples.

Thank you for the opportunity to meet with you. I have had the privilege of meeting some of you.

Ms. Giovanna Boniface: We would like to talk about two things today: OT workforce issues and challenges, and making the case for universal access to OT.

The OT workforce in Canada has grown from some 7,500 therapists in 1997 to over 20,000 in 2021. Although we have seen good growth, this is absolutely not enough. OTs are an essential part of the primary care team, supporting seniors to age in place, providing vital mental health services, supporting kids with autism, helping to tackle the opioid crisis, supporting indigenous communities and providing long COVID rehab services, to name a few.

Only 3.7% of our workforce is in rural settings, which is very misaligned compared to the 20% of Canadians who live rurally. Eighty-five per cent of our workforce is frontline professionals, delivering vital care in hospitals, community health and long-term care settings.

Demand continues to grow exponentially, and supply simply has not kept pace. The 2013 national survey of 60,000 Canadian physicians found that over 70% expressed difficulties in referring patients to publicly funded OTs. In addition, the Government of Canada's Canadian occupational projection system validates that OT is one of the professional categories where demand will exceed supply until at least 2028. During this time, OT job openings are expected to outpace the workforce by at least 20%. Further validation comes from our provincial and territorial OT associations, who consistently report difficulty in securing therapists for vital positions. For example, earlier this year in Edmonton alone there were over 70 OT positions that were posted and couldn't be filled.

In a 2021 report, Canada's chief public health officer said that COVID provides an opportunity to address long-standing gaps in the health care system, and we could not agree more. OTs, because of their education, competencies and scope of practice, can make an invaluable contribution to transforming the current expensive hospital-centric medical and sickness care model to a less expensive patient community-centric health and wellness model of care. The latter, emphasizing health promotion, disease and injury prevention and management, is well within the scope of function and occupation-focused OT practice. COVID has also demonstrated the critical need for interprofessional, team-based primary care models that include OTs.

So what's the problem? OT services are not widely covered as part of public and private extended health benefits plans, with only five major insurance companies having OT coverage listed as a flex option, meaning that it's not automatically included in plans. Many employers, including the Government of Canada, do not cover OT services in their health benefits plans. With so little coverage, we are seeing Canadians incur out-of-pocket expenses to access services for their autistic child, their teenager who may be struggling with suicidal thoughts, or their parents who want to age in place and need home modifications, to name only a few scenarios.

What's the solution? Occupational therapy must be part of the basket of publicly administered, universally provided health care services. The status quo is absolutely not acceptable and inaction is no longer an option. Canada needs a comprehensive and integrated primary care strategy that includes OTs on all primary care teams across Canada. This will positively impact the health care system by improving the patient experience: the right quality of care, the right time, by the right regulated health professional in communities where Canadians live, study, work and play. This also delivers positive health outcomes, all while reducing per capita health care costs.

At no other time has the impact of disruption on daily lives and function been more apparent. Everyone has been affected by COVID. OTs are function- and occupation-focused regulated professionals. This is in our DNA. Ensuring that Canadians have access to this necessary service is critical to their health.

The time is now. OTs should no longer be considered a nice-to-have option in health care. OTs are must-have health care professionals who can help transform the health care system to better meet the needs of Canadians.

Thank you very much for the opportunity to present to the standing committee today.

● (1600)

The Chair: Thank you, Ms. Boniface.

Next we're going to the Canadian Association of Schools of Nursing.

Cynthia Baker, executive director, you have the floor for the next five minutes.

Dr. Cynthia Baker (Executive Director, Canadian Association of Schools of Nursing): Thank you.

My name is Cynthia Baker. I'm the executive director of the Canadian Association of Schools of Nursing.

I'd like to respectfully acknowledge that the CASN national office is located on unceded Algonquin territory.

Thank you for providing me with this opportunity to speak on behalf of our 95 member schools of nursing in Canada offering baccalaureate and/or graduate programs in nursing.

[*Translation*]

The CASN is the national voice for nursing education. We work to promote high-quality nursing education in every territory and province of Canada, in both official languages.

[*English*]

Personal care workers, practical nurses, psychiatric registered nurses, registered nurses and nurse practitioners are all important members of the nursing health care team.

As registered nurses form the largest group of health professionals in Canada, and as vacancy rates for this category of nurses are soaring across the country, I will focus my presentation on them.

COVID-19 has been filling hospital beds. The number of older adults requiring care is increasing, and experienced nurses are leaving the profession in large numbers. Schools of nursing in all provincial and territorial jurisdictions are responding to government demands to increase seats, open new sites and/or offer additional programs of nursing.

This follows a two-year period of repeated curricular disruptions with the pandemic shutting down—

The Chair: Ms. Baker, I'm sorry to interrupt. Can you drop your mike down maybe about a quarter of an inch? Let's try that and see if that works. We're getting a little bit of static. Go ahead and see if that's okay.

Don't worry; we'll add to your time.

Dr. Cynthia Baker: Okay.

As I said, there have been repeated curricular disruptions—

The Chair: Just a second, Ms. Baker. I took you the wrong way. Can you put the mike between your nose and your top lip?

Dr. Cynthia Baker: Okay.

The pandemic shut down students' access to clinical placements and their access to in-person classroom and laboratory learning. The demands on nursing educators and on nursing students have been heavy.

CASN conducts an annual nursing student and faculty survey. The number of new RNs—

● (1605)

The Chair: I'm sorry, Ms. Baker. My advice is making it worse. Move it up a little higher, please.

Dr. Cynthia Baker: How's that?

The Chair: I think we're in good shape now.

I'm sorry for all the interruptions. Go ahead.

Dr. Cynthia Baker: Okay.

CASN conducts an annual nursing student and faculty survey. The number of new registered nurses entering the health care workforce has climbed steadily from a low of 4,816 in 2000. In the last five years, schools of nursing have been graduating more than 12,000 RNs annually, a higher number than has ever been the case.

This requires qualified faculty, experienced clinical instructors, well-equipped simulation labs, good library resources and appropriate clinical placement sites. Nursing faculty have been stretched to the limit, and clinical placement sites, which are essential to nursing education, are saturated. Additional nursing seats and nursing programs require more faculty, more resources and more clinical placement sites, which currently do not exist.

[*Translation*]

Canada's nursing schools are facing significant pressures and numerous challenges.

[*English*]

The quality of nursing education, however, is critical to the health and well-being of Canadians. Nursing is a complex and emotionally demanding profession. It requires an in-depth theoretical and scientific foundation, strong clinical reasoning skills, solid clinical judgment, honed technical skills, compassion, caring and emotional resilience. Nursing incompetence or a nursing error can put a patient's life in jeopardy.

The quality of nursing education is also critical to nursing retention. Studies demonstrate that nursing graduates lacking the appropriate academic preparation and lacking appropriate transition support when they enter practice are liable to leave the workforce within a year or two. Cutting corners to increase the number of nursing graduates does not produce a safe or sustainable nursing workforce.

There's an urgent need to increase the number of clinically competent, retainable registered nurses in the nursing workforce in all Canadian jurisdictions. There is also an urgent need to overcome significant obstacles if this is to be achieved.

[*Translation*]

Given the complexities of nursing education, nursing school administrators need to have a seat at the table.

[*English*]

Investment in nursing education and the inclusion of nurse educators in developing strategies to address the current health care workforce crisis are critical.

The areas of nursing education that offer potential solutions to a sustainable nursing workforce will be outlined.

Number one is to increase the number of new registered nurses without sacrificing quality through advanced-standing baccalaureate nursing programs for individuals who already have a degree in another discipline. These programs run throughout the full year with four terms instead of two and are therefore completed in two years without any reduction in the curriculum. There was a high demand for admission to these programs. Their graduates typically excel as nurses.

Number two is to increase the number of internationally educated nurses entering the nursing workforce through an increase in collaborative and more standardized bridging programs offered by post-secondary institutions.

Number three is to increase the clinical competence and the retention of registered nursing graduates by supporting their transition to practice through six- to 12-month residency programs. Multiple studies in the United States and Australia have shown that such programs increase safety and the clinical competence and the job satisfaction of new graduates, while reducing employers' turnover costs.

In conclusion, with investment in nursing education, collaboration among nursing education, governments and health care services, and a national commitment to conserve the high quality of nursing education that Canada is known for internationally, the nursing crisis can be resolved. The Canadian Association of Schools of Nursing is strongly committed to contributing to solutions.

On a positive final note, despite increasingly complex health care conditions, applications for admissions to baccalaureate programs in nursing across the country are very high. It's a testament to the potential tenacity of our future nurses.

● (1610)

[*Translation*]

Thank you for the opportunity to shed light on some of the issues related to nursing education and the nursing shortage, and to recommend solutions.

[*English*]

Thank you for your attention.

The Chair: Thank you, Ms. Baker.

Next, from Corpus Sanchez International Consultancy Inc., we have Bradley Campbell.

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

Mr. Bradley Campbell (President, Corpus Sanchez International Consultancy Inc.): Thank you.

Good afternoon, Mr. Chairperson, committee members and distinguished guests.

It is my distinct pleasure to be here today to present on this critical issue of health human resources and the specific work that this committee is undertaking relative to Standing Order 108(2), which asked the committee to undertake a study on how the federal government can facilitate the recruitment and retention of physicians, nurses, nurse practitioners and other health care providers to the public health care system, including a focus on northern and rural communities.

This is an incredibly important docket. It's also not a new topic. The call for comprehensive strategies to address the need for sustainable supply of health human resources has been the subject of numerous commission and expert panels at the federal level for decades, including the Lalonde report in 1974, continuing with the Romanow and Kirby reports in 2002, and additional work launched with Health Canada in 2005 to pursue strategies in four key areas: one, the supply of health care providers; two, effective use of skills; three, creating healthy, supportive and learning workplaces; and four, more effective planning and forecasting.

I believe all of our witnesses have touched on some of these points here today.

Pursuing these goals creates an ideal intersection of federal, provincial and territorial mandates in a number of ways.

First, past federal governments, regardless of the party in power, have sought to address barriers to recruitment of internationally trained professionals, often with initiatives aimed at supporting streamlined immigration and/or work visas.

I've had the privilege of being involved in planning tables, both here and abroad, and have often heard concerns raised about the ethics of recruiting internationally. The primary concern here is that we as Canadians should not be aggressively pursuing strategies in other countries simply to meet our own needs for health professionals at the expense of system sustainability in other countries. It is clear that we need to be conscious of that concern.

At the same time, there are several countries that deliberately train more people than they need as a way to help their citizens pursue careers internationally so that they in turn can send money home to support members of extended families. In these circumstances, global recruitment can help all parties achieve their goals.

Second, many provinces have already led work at the provincial level to retain health care professionals in the workforce by developing integrated solutions to enable truly inter-professional care teams.

I've personally had the opportunity to work with the governments of Nova Scotia and Prince Edward Island in those pursuits and can attest to the fact that provincial-enabled solutions help to get past barriers grounded in individual organizational silos and cultures.

The federal government can help coordinate these efforts on a national level, partnering with provinces and territories to understand local needs while driving toward a comprehensive pan-Canadian health human resources strategy. This does not mean that all solutions will be applicable in all areas, but consistency of purpose can enable local solutions to be created within an overarching context.

Earlier today, when we heard from the witness from CAOT, we heard about how different solutions exist in different settings, including those in the community, which are very different from those that happen in hospitals.

In the end, all solutions must enable the unique needs of the population being served to be met. This will be particularly true in designing solutions for northern or remote communities, which don't always have the same access to services that are routinely available in more urban settings.

Third, I believe the federal government has a unique opportunity to partner with indigenous communities to develop solutions that work for them.

In my career, I've had the privilege to work with some indigenous communities to assist with the creation of indigenous-led pathways and models that enable access to education and care when, where, and how they want to receive it. This includes supporting the training of indigenous people in a variety of health care professions but also assisting non-indigenous providers to better connect with and partner with indigenous communities generally, and indigenous patients and their families specifically, to support solutions, once again, that are defined by them, for them. What is learned through this essential work will help to define solutions for all people who live in northern and remote communities.

In conclusion, I think it's clear that we're in a difficult time. From a health service delivery perspective, it is well known that older citizens tend to have the highest usage of health care services. Given that the first baby boomer turns 76 this year, the need to respond to the needs of the baby boomer generation and the generation that preceded them, my parents' generation, is becoming more and more essential on a daily basis. These generations define the society we live in today, as well as the generations that follow them. They, as well as the generations following them, deserve nothing less than our collective best as we move forward with this critical work to create a sustainable health human resources supply.

When we think of the health care provider workforce, many of them are tired, burned out, frustrated and, as we heard earlier today, suffering on a daily basis—or a regular and consistent basis—abuse at the hands of the patients they are trying to serve.

● (1615)

The pace at which they are leaving the workforce is, simply, rapidly increasing at a level that we cannot sustain. The pandemic served to exacerbate the situation, but it did not create it. The trend has been shifting in this direction for years. We need to engage providers in the creation of new solutions. We also need to understand that as new professionals enter this workforce, both those trained here at home and those recruited from abroad, they need to be supported to thrive in the environments they will be working in.

My final comment is an ask of the people represented at this committee: We need multi-party participation and agreement to move forward in a unified manner. We simply cannot afford for health human resources strategies to become the next political football. We must work together on this.

Thank you very much.

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

Before we go to the rounds of questions, Ms. Baker, we're going to give it one more try.

The problem with the sound from your mike is that it makes it hard for the translators. I think the mike is too close to your mouth. Can you move it up?

Try it now.

Dr. Cynthia Baker: Okay.

Is that better?

The Chair: Okay. We're going to leave it there.

We'll begin rounds of questions, beginning with the Conservatives.

Dr. Ellis, you have six minutes.

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

Thank you to all the witnesses for their thoughtful statements and for appearing here today.

I'll start my questioning with Ms. Payne.

I understand that you have had some experience with studies that we have done in the past. One of the main questions I would ask is this: What do you see as the role of the federal government in the health human resources strategy?

Ms. Brenda Payne: Thank you for the question, Dr. Ellis.

My response would be that it is a facilitating role. The federal government has both the experience and the foundational documents on which to proceed with a pan-Canadian approach very quickly. Their role would be to bring the right people to the table, acknowledging that the work that has been done previously, going up to roughly 2011, would require some updating in terms of both whom we're recruiting and how we make our workplaces appropriate to recruit. They are not the same as the baby boomers or my experience in working in the health system.

I believe the federal government is positioned to move forward quickly on a pan-Canadian approach as they've done with the data piece.

Mr. Stephen Ellis: Following up on that, given that it takes a minimum of four to six years to create a nurse, and longer to create a physician, how are we actually going to get to that appropriate spot? The situation is critical. We have a patient who is bleeding heavily, and we don't even have any—

● (1620)

The Chair: I'm sorry to interrupt, Dr. Ellis. I've just been advised that the bells are ringing in the chamber. In order for us to continue, we need the unanimous consent of the committee.

Is it a 15-minute bell?

Mr. Majid Jowhari: I don't know. I'm trying to figure out where it's coming from.

There are no bells. My apologies.

The Chair: Doctor Ellis, I'm sorry for the interruption. I'll add your time back.

Go ahead.

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

I just wonder if Mr. Jowhari heard the tinkling of glasses, perhaps, but I digress.

You ruined my wonderful metaphor of a bleeding patient who needs surgery but has pressure on a wound. I guess we're in a critical situation.

How can we get this done quickly or expeditiously?

Ms. Brenda Payne: Is the question still directed to me?

Mr. Stephen Ellis: Yes, please.

Ms. Brenda Payne: As we speak, Dr. Ellis, provinces and organizations are dealing with just that issue. They're dealing with it in very creative ways by creating new positions and redistributing roles. My point is that we need to do it in tandem, not as a barrier or adding another bureaucratic level. We need to bring people together to the table very quickly in order to look at some short-term interim strategies, like recruiting internationally.

My experience would say that, not unlike other issues in health care, if we only focus on that, the biggest issue before us is the one that gets our attention. We need to explore what potential solutions there are, but we need to do it in tandem with the provinces and territories.

Thank you.

Mr. Stephen Ellis: Thank you, Ms. Payne. I appreciate that.

Ms. Boniface, with respect to the role of occupational therapists in rural health care, do you see occupational therapists working independently or only in teams?

Ms. Giovanna Boniface: I guess it will depend on the scenario in each of the jurisdictions. In some jurisdictions, occupational therapists are primarily in the public sector, but because of the way the systems are set up and because they're so different across the country, you have services also being provided outside of that system. They're being funded, say, by a Crown corporation. I'll use the example in British Columbia, where you have auto insurance funding or workers' compensation funding, even veterans affairs, which is national. There are some that will be working independently in those regions just by nature of the system being structured that way, because it's not all in one place.

Where you see those interprofessional care teams is in the public system and primarily in community care teams, so there is absolutely a role for them there. We know there are some of those happening in spurts across the country, but it is not consistent. It is absolutely not consistent in that approach, and it really depends on.... What we hear is that it's happening very regionally and it's dependent on what decisions are made in those communities.

There is a role. As I mentioned earlier, we would like to see all Canadians have access to occupational therapy. If you're in a car accident or you're injured at work or whatever the scenario is, you have access when you need it at the right time and you do not have to figure out where on earth it's going to come from. In some scenarios, there isn't any. If you're not in the system in that way, for some people, it's not even an option to have access to therapy.

We really want to see that change and be part of primary...other important professionals, alongside physicians, nurses and other allied health professionals, that they are all part of a team.

Mr. Stephen Ellis: Thank you very much for that, Ms. Boniface.

Ms. Baker, you talked about the critical role of clinical supervision and the lack of current availability. How do you suppose we might fix that?

● (1625)

Dr. Cynthia Baker: The clinical placement situation is a big barrier. One of the ways is, following the graduation, to have residency programs for nurses. I think this is a very important step forward, but during the program itself, there needs to be collaboration between education and service to come up with innovative strategies to offer clinical placements.

The other solution, I think, is to increase the use—and we are increasing it—of simulation in programs: virtual simulation and high-fidelity simulation.

Mr. Stephen Ellis: Ms. Baker, do you believe you have a good handle on how many clinical supervisory positions would be available around the country, or is that something we need to have a closer look at?

Dr. Cynthia Baker: I don't have data on how many are available, but I do have data on how many were employed last year as clinical instructors, and the year before, and the year before that.

Mr. Stephen Ellis: I guess my question would be whether you think that it's good data. For instance, in my neck of the woods in northern Nova Scotia, there would be two hospitals, in Springhill and Amherst, that could accept clinical nurses needing supervision, but they're not really captured because of their geographic location.

The Chair: Give a short answer if you can, please.

Dr. Cynthia Baker: I'm not sure I understand your question. The number of clinical instructors.... The clinical instructors are hired by the schools of nursing. They may be borrowed from a hospital or a health care institution, but they are hired by the education program itself.

Mr. Stephen Ellis: That's fine.

I'll come back to it, Mr. Chair. Thanks.

The Chair: Thank you.

Next is Mr. van Koeverden for six minutes.

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

Thank you to all the witnesses for appearing today. Thank you for your work. Thank you for your resilience, and thank you for supporting so many Canadians throughout the most difficult time that Canadians have experienced. It's certainly the most difficult time that Canadian health care workers have experienced.

I have two questions. The first is for Mr. Coletto. The fact that we both did some boat racing is not why I'm picking on you. You had a really heart-wrenching testimony today and I wanted to come back to ask about meeting the needs of our health care workforce and making sure that young people look to nursing as an occupation that they'd like to choose. It's essential.

It's also essential that that workplace be safe. It's apparent through your testimony today, and through the testimony of others that we've heard, that that's not the case all the time. It provides me with an opportunity to highlight the recent passing of Bill C-3, which does a couple of things. One is that it creates an offence for obstructing or interfering with someone's access to health care services. It also adds as an offence if any person who's providing health care services is being impeded by another person, and that could be in the context of providing care.

You mentioned that it was difficult to take medical leave. Perhaps it was because of the status of your employment at the time, but Bill C-3 also adds 10 days of medical leave in a calendar year.

What are your reflections on the passing of this bill? What needs to be done going forward to ensure that young people choose nursing as an occupation, so that those workplaces are safe and free of the type of harassment that you described to us?

Once again, I thank you for your good work in the face of such challenging circumstances.

Mr. Sylas Coletto: Thank you very much.

This is my first time doing this, so forgive me if I don't answer in the correct way.

With the experiences of abuse, you never know what's going to come in. You never know what's going to happen on a particular day. I've received training on non-violent crisis intervention, but in the real-world application of that in an emergency room, things can change at the blink of an eye.

When I was working in [*Technical difficulty—Editor*], a federal inmate got hold of a gun from one of the guards and bullets were shot. There was no way to see that coming. It was terrifying. To make it appealing to young people.... I haven't seen Bill C-3 work at the hospital level yet. People can start shouting; they get angry and they kind of [*Technical difficulty—Editor*] sudden, and you have to be very attentive to recognize that happening.

A simple answer would be that it would be nice if someone was close by so that when they can hear someone screaming or yelling, they can come in and assist. Sometimes, that's just not the case, because the distance between me and the next nurse, the next doctor or whoever's down the hall is just so far. They're not right there at the time when they need to be—

● (1630)

Mr. Adam van Koeverden: I don't mean to cut you off. I was just hoping to seek further clarification on that point in particular.

With respect to the number of nurses on call or on duty at a given time, it seems that what you're saying is that with more nurses, it would be a safer environment.

Mr. Sylas Coletto: I can't see it being less safe.

That would cover a large number of safety things. We have baseline staff in our unit, for example. There are six baseline nurses and we're not supposed to have more than six baseline nurses unless it's necessary, such as when we have an influx of patients. If there were more nurses there at baseline and somebody was there to help if something was happening, yes, that would definitely help. Increasing the baseline for nurses being there would be a beneficial thing.

However, right now, given the current circumstances and the way the policies are implemented, there has to be a very good reason. If there's no justifiable reason to have more nurses, due to the algorithms they have in place, there won't be more nurses coming in.

Mr. Adam van Koeverden: Thank you, Mr. Coletto. I appreciate that. Again, I thank you for your good work.

My second question is for you, Ms. Baker, regarding the nurse workforce. I have the opportunity of highlighting something that I think is relevant to that, which is this morning's news that we signed a child care agreement with Ontario. It means that nurses who would like to can get back to work earlier if they have just had a child, or if they're a new parent who would like to get back to work a little bit earlier. That could contribute in a positive way to our nurse workforce. But I think we can all agree that this won't do it; we need more than just that.

How can we attract more nurses to the profession? How can we ensure that it's an appealing future occupation for young people who are seeking out that opportunity? Potentially, you can touch on nursing as a profession with respect to foreign credentials and qualifications for foreign-trained or internationally trained nurses who immigrate to Canada.

Thank you.

The Chair: Please answer as briefly as possible, Ms. Baker. I know it was a comprehensive question, but we're out of time for this round.

Go ahead and answer.

Dr. Cynthia Baker: Okay. I'll be very quick.

Actually, there is no problem with the application demand. The pool of applicants for nursing is very, very high. As I said, we have been graduating over 12,000 annually for the last five years. That's higher than it's ever been. There is no problem in terms of attracting applications, and they're high-quality applications. The problem is keeping nurses in the workforce. It's the attrition and the retention of nurses that have been an issue. Many leave within months of entering the profession.

In terms of international education, this has a lot to do with the regulatory bodies that license the internationally educated nurses. The process is slow. There is an evaluation process that is time-consuming. I don't have the statistics, but I believe a high number of internationally educated nurses in Canada would like to join the nursing workforce.

From a regulatory point of view, I cannot speak for those processes and what needs to be evaluated there. But from the education perspective, this is one area where we could have a potential solution—that is, speeding up and standardizing the bridging programs that internationally educated nurses often have to be involved in. I believe there have been some initiatives in Ontario around that, with government support of bridging programs for internationally educated nurses. That is an area that I think is well worth pursuing and could support an increase—

● (1635)

The Chair: Thank you, Ms. Baker.

[*Translation*]

Go ahead, Mr. Thériault. You have six minutes.

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

In your opening statement, Dr. Champagne, you referred to an article in the British Medical Journal about a systemic review and meta-analysis of mortality due to cancer treatment delay.

I want to talk about the human resources side of things first. Oncology is a crucial area of care. You said that 57.5% of professionals were experiencing burnout before the pandemic. According to the article you cited, an eight-week delay increases the risk of death by 17%, so the mortality rate is higher.

In the face of these challenges, what is morale like among health care professionals? You said these delays would have repercussions on oncological care for years.

Dr. Martin Champagne: Right now, all practising oncologists are seeing patients who unfortunately need to be referred to palliative care. These are patients who could have been cured had they been seen at the onset of symptoms months beforehand. We are seeing situations like that every day. We are encountering patients whose disease is much more advanced than what we used to see.

Certainly, that affects the morale of health care providers, but I don't have any statistics for you.

That said, we are all professionals, and we are realistic. As oncologists, we don't expect to be able to help everyone, so the idea is to see what we can do. Currently, we are treating people, but the fundamental problem is still access to care.

Before the pandemic, 100,000 people in Quebec were waiting for a colonoscopy, the screening for colon cancer, and now that number has hit 150,000. We need resources to meet that demand. It's a huge challenge, but there are solutions.

Oncology is in a unique position. In orthopaedic surgery, for instance, patients receive treatment on a one-time basis, undergoing a knee or hip replacement surgery. It's unfortunate that they have to wait so long for the surgery because it has a significant impact on their quality of life, but once they have the surgery, it resolves their issue. In oncology, however, studies show that, for every 28 days patients have to wait, the mortality rate for colon cancer goes up by 4%. That illustrates how serious the repercussions are when people have to wait months and months to be seen.

When a cancer is diagnosed early, meaning in stage 1, the patient can have surgery, even an endoscopic procedure. The physician can perform a tumour resection, and the rate of recovery is 80%. If the cancer is in a more advanced stage and has spread to the lymph nodes, it's a stage 3 cancer. Without chemotherapy, the patient has a 30% chance of recovery. If the patient receives chemotherapy and radiation therapy, their chance of recovery goes up to 65%, but at the expense of more demanding treatments. Not only does the patient, the person suffering the most, have to be more involved, but so does the care team. The care trajectory is years long, with economic, social and family repercussions.

It's really a disaster in cancer care. We have to make sure we put measures in place to manage the situation. For patients who can be operated on outside the hospital setting, we have to rely on external medical capacity, in the case of a knee or hip surgery, for instance. We keep patients in hospital who need care in connection with abdominal, thorax, colon and other such surgeries.

What we've seen over the past few months and years is that the situation is less problematic in the case of certain diseases. Patients with breast cancer can undergo surgery in ambulatory care units. Patients with breast cancer face delays that are much less significant than patients with other types of cancer. Older cancer patients tend to be put on hold, but their cancers can be just as devastating as the cancers experienced by younger patients.

We are also behind in treating cancers of the bladder, specifically when it comes to cystoscopies. For patients with prostate cancer who could have been operated on, we are sending them for radiation therapy. We have had to change how we manage patients in response to the pandemic, but there will be a price to pay.

The situation is really dire, and patients are the ones suffering the most. I told you earlier that, in 20% of cases, delays in diagnosis were impacting colorectal cancer surgeries in Quebec. I also told you that 9,400 Canadians with a diagnosed colon cancer were expected to die in 2021. If the mortality rate goes up for such a significant share of the patient population, we are going to see dozens, hundreds, thousands of people dying from various cancer-related illnesses.

● (1640)

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

[*English*]

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

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

I'd like to thank all the witnesses for their excellent testimony today.

Ms. Boniface, I want to start with you.

Given your testimony that occupational therapy services are not widely covered as part of public or private extended health plans in Canada, could you give this committee a sense of the average out-of-pocket costs that Canadians are incurring to access OT services?

Ms. Giovanna Boniface: Yes, of course.

Outside of the public system, private occupational therapy services are billed at anywhere from $125 an hour all the way up to $200 an hour, depending on the type and the nature of the service.

A service visit could be, for example, a pediatric occupational therapist who's visiting a family weekly to provide autism intervention. Intervention sessions are about an hour, so that's a typical health care professional rate, along with incurring some expenses related to driving. On a visit like that, you could expect somewhere between $250 and $300 per visit.

This would be the same across private treatment for mental health services or visiting older adults who are looking for aging in place consultation. There are the same kinds of rates even for work site visits for ergonomic assessments to help people who are trying stay at work take a preventive or proactive approach rather than waiting for an injury to happen and then having that funded through a worker's compensation claim. They may not have had that coverage through their health benefits plans.

Per visit, you're looking at something around $250 to $300.

Mr. Don Davies: Do you have an annual figure? Is there an average for what a Canadian who accesses these services might pay in a year?

Ms. Giovanna Boniface: That's a really great question.

I don't think we collect that data. Again, it really depends on the nature of the services. For someone who is providing treatment on an ongoing basis for a chronic illness that might require weekly or biweekly intervention, that $250 or $300 number is multiplied per visit. For someone who is in a chronic scenario that requires weekly intervention, we're going to take that $250 to $300, multiply it 48 times and subtract holiday and vacation time.

For more short-term intervention, like eight to 12 visits, we're going to take that number and we're looking at maybe $1,500 to $2,000 for a block of intervention.

● (1645)

Mr. Don Davies: I wanted to explore the aging in place and living at home. I think it's pretty common-sense that if we can keep seniors out of hospital and in their homes, it will relieve pressure on our system.

Could you outline briefly for us how OTs can support aging or living in place at home and in communities?

Ms. Giovanna Boniface: Absolutely.

Supporting older adults who are choosing to stay home is an area that I have practised in for the majority of my career. Most older adults I meet want to be there.

You're going into the home. You're meeting with the individual in their space where they want to be. You're conducting an environmental assessment and looking at the risk factors and analyzing what is going on in the home. Not everybody lives in single-floor, accessibly designed or universally designed spaces. In fact, for most spaces, we're looking at some type of retrofit, which may be putting in adaptive equipment, say, in the high-risk areas for falls. That would be in bathrooms, kitchens and bedrooms.

For some, we're looking at even more significant architectural renovations if people want to stay in their homes. A lot of homes have stairs. They might require stair glides or some other type of system of modification to make entry accessible. Again, we're looking at universal design principles. You can do that with equipment. There's a piece around getting equipment. Outside of the assessment itself, you're looking for funding to put into place the equipment and recommendations that might be needed for that individual.

There's also education that can happen. For some of that, staying home in place can be around safety to live well at home.

By and large, my experience in that population is that there's a combination of education, equipment and some more significant architectural considerations that need to happen and to be thought about for homes that people are living in.

Mr. Don Davies: Trying to think systemically, could you outline how upstream investments in preventative care from OTs could accrue benefits in the long term?

I'm particularly interested in whether there are any studies on this or any global figures that would show that we could save our health system money by investing more up front in OT services.

Ms. Giovanna Boniface: Absolutely.

Hélène, is this something you want to take, or do you want me to continue?

Ms. Hélène Sabourin: You can go ahead. I can add.

Ms. Giovanna Boniface: Thanks.

We know from Government of Canada data that injuries cost the Canadian economy almost $27 billion annually. Seniors' falls, according to the Public Health Agency of Canada, are costing around $2 billion annually. These kinds of upstream interventions—this is about being proactive, going into homes earlier, meeting people ahead of a fall, before they get into the hospital, before we see those problems—would be seeing individuals in the spaces where they live, work, study and play. It's about looking at prevention. Prevention of injuries from falls would be the first line of defence, we would say.

There are lots of studies and literature that show that those upfront investments, which could cost between $300 and $500, can make a significant difference in a person's life. Imagine going in and making changes ahead of time so that the fall doesn't happen. There is also a lot of work on health promotion and lifestyle redesign.

Again, these are proactive investments, looking at providing education early, counselling—

The Chair: Thank you, Ms. Boniface.

Mr. Don Davies: Thank you.

The Chair: Mrs. Goodridge, go ahead for five minutes, please.

Mrs. Laila Goodridge (Fort McMurray—Cold Lake, CPC): Thank you to all the panellists for being here today and providing testimony, and a special thank you to all the medical professionals for the service they have done. It is spectacular.

I am the member of Parliament for the riding of Fort McMurray—Cold Lake. It's a relatively isolated, rural location. We often have struggles attracting health care personnel to come and work in our region, whether that be in Lac La Biche, Cold Lake, Fort McMurray or Fort Chipewyan for that matter.

My first question is directed to Ms. Payne.

You were talking about this not really being a new issue in terms of burnout, and not having enough in many rural locations. Could you expand a little bit on that?

● (1650)

Ms. Brenda Payne: What I'd like to do is address the issue from a recruitment point of view for our rural areas.

We know, coming from the east coast, that we have lots of rural communities and that the community needs to be involved. One of the things we've learned over the last five years is that recruitment, particularly in more remote areas in our country, requires every level of government, including the municipality.

We've discovered that when we recruit people, we're not just recruiting them to our organization. We're recruiting them to our communities. We know, from history, that when we're recruiting a nurse, we have to worry about their husband being able to get employment. From a cultural point of view, we know that our providers need to have a sense of belonging. When we recruit internationally, we need to be culturally sensitive to the kinds of communities that will not only recruit but also retain folks.

One of the experiences I've had, which was extremely instrumental in moving and attracting folks to a rural community, was, with federal government funding, to provide some seed funding to try innovative strategies, for example in service delivery. The specific example I'm referring to is that the federal government provided some seed money to test out a rural palliative care program for our northern region in rural Nova Scotia. It then became a great service delivery model for both Nova Scotia and Prince Edward Island.

In response to your question, it's about having opportunities to test out innovative solutions that are particularly aimed at addressing the unique challenges in our rural communities throughout this country.

Mrs. Laila Goodridge: Wonderful.

I would challenge that this is a unique opportunity. Our northern communities often have really spectacular spaces, because they are exactly that: a community.

Do you have any thoughts on things the federal government could be doing to help establish better health care systems? You mentioned that one pilot project. Are there any ideas you have that the federal government could employ that would make health care better in our rural communities?

Ms. Brenda Payne: As all witnesses have said, because the delivery of health care is under provincial jurisdiction, the federal government should work very closely to address the issue.

We're focusing on recruitment, as well as retention and making sure that the workplace environments that folks are working in, regardless of the sector—inclusive of home care and aging in place—are appropriate and supportive. We give them the resources. We understand, again from a generational point of view, that work-life balance is so important.

What kind of strategies and what kind of opportunities do we have to test out some new solutions that are reflective of the different populations, both from a patient-client-resident perspective and for the providers we're trying to recruit? That covers not just nurses, but all health care providers and even some of the new positions that we've established in some of these teams.

Mrs. Laila Goodridge: That's fantastic. Thank you, Ms. Payne.

Mr. Coletto, if you could perhaps answer that same question, that would be spectacular.

The Chair: Answer briefly, please.

Mr. Sylas Coletto: Absolutely.

I am a registered nurse. My spouse is a physician. We have spoken about moving up north to go and work in the northern communities. Honestly, we struggle. We have to search very hard to find the positions that we're looking for, to find resources to help us move, to find the additional education—

Mrs. Laila Goodridge: Mr. Coletto, you can come to Fort McMurray. I can guarantee you that we have an opening for both a registered nurse and a physician. I will get you those contacts. I would love to have you as a constituent.

Mr. Sylas Coletto: Thank you very much.

Mr. Don Davies: I have a point of order, Mr. Chair. Vancouver would like to make a bid as well.

Mr. Sylas Coletto: Okay, thank you. That's perfect. That's very kind of you.

The Chair: We'll go to Dr. Hanley, please, for five minutes.

Mr. Brendan Hanley (Yukon, Lib.): Thank you very much. I'm going to put my hat in the ring for that bid as well.

I thank my colleague for speaking up for the north and for our rural areas. As a fellow northerner, I appreciate the advocacy.

There are so many questions and so little time. I'm going to maybe continue with Mr. Coletto for now.

Thanks for sharing your time and that really revealing frontline perspective. I wonder if you could just share briefly what keeps you going. What inspires you to stay in nursing as a career, despite all of the challenges that you relate?

● (1655)

Mr. Sylas Coletto: Thank you very much for the question. That is a monumental question.

I would summarize that it's made in hope. I have a great deal of hope that I can make someone's life better, or make their death better. I can facilitate them not coming back to the hospital if I can teach them an extra something. I can advocate for them at the very best level, so that they're getting the services they need. I believe I'm pretty good at my job and I can be the best patient advocate and do everything that I can for them.

It feels pretty darn amazing to have a patient's family say that I've made this passing or this hospital stay something that was very tolerable and the best that it could be. That's what I experience.

Mr. Brendan Hanley: Thank you for that.

I was pleased on Friday to be present at the University of Ottawa school of nursing for the announcement from the three ministers—Minister Duclos, Minister Bennett and Minister Khera—on the $2 billion to clear the backlog.

Mr. Coletto, you now have a big injection of money in your hands for the front line. Where would you put it?

Mr. Sylas Coletto: I would probably put it into public health, so that we can keep people out of the hospitals before they can even come into the hospital. The best form of medicine is preventative medicine, doing all the things to address the socio-economic status of people and the social determinants of health, and keeping them out of the hospital beforehand.

Our colleague Ms. Boniface is doing a wonderful job with occupational health, keeping them out of there completely.

Otherwise, if we had to allocate it toward the hospital system, maybe put it toward running campaigns to suggest that a nurse is not a punching bag. Just because you're having a pretty rough day, that does not mean you can take him or her to the grindstone and give them a really hard time. We have to work together here.

Mr. Brendan Hanley: Thank you. That funding was specifically for addressing the backlog of care, and I probably wasn't precise enough.

To your first point, it almost sounds like a planted question, since I'm a public health physician, so that's music to my ears, and I heartily advocate for that.

I want to move quickly to Ms. Boniface.

It's nice to see you again. I think it would be interesting to hear from you again about some of the lesser-known values of the OT profession and what it can offer, especially in the context of team-based care. Maybe you can talk a little bit about the role of OT in mental health support.

Ms. Giovanna Boniface: Absolutely. I guess all health care professionals have a unique value and approach to working with individuals. A cornerstone of occupational therapy is the person: who they are, what they do and what they want to do. It's this intersection of them, all the activities that matter to them, where they're doing them and their context.

Looking at support in mental health, there are a number of strategies that OTs work with related to the goals of the individual. It's always about what the person wants to do, really staying focused and true to that and working with that individual to look at the barriers to being able to do those things.

OTs are really looking at systematically breaking these tasks and the challenges down and then looking at how to overcome those barriers. The interventions can fall into broader themes related to education, relearning of skills and learning new skills—again, always focused on what matters most to the individual. Tapping into their passion and their desires is critical and key. Depending on where that individual is with respect to that mental health challenge, whether it's an in-patient or a community setting, it's always centred around what matters most to them.

The interventions can be very different. It's always about breaking barriers, overcoming those barriers, and life skills integration. If somebody is looking at going back to work—

● (1700)

The Chair: Thank you, Ms. Boniface.

Ms. Giovanna Boniface: —there is some extremely strong evidence around supported return to work.

The Chair: Thank you.

Thank you, Dr. Hanley.

[*Translation*]

Go ahead, Mr. Thériault. You have two and a half minutes.

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

Dr. Champagne, you gave us the facts of the situation, and they were chilling. You raised important questions. How do we eliminate the delays in diagnosing patients—delays physicians have to deal with—and how do we meet people's needs? You said that standards for diagnosis, treatment and follow-up were already in place for the management of patients, and that what was really needed was a major injection of funding. You went even further, saying that one-off investments were well and good—better than a flick on the ear, as my grandfather used to say—but that the situation called for significant and recurring investments that make a real difference, basically health transfers. However, the government stubbornly refuses to deal with the matter of health transfers.

Given what you've observed, do you think the government's wait-and-see approach makes sense from a medical and economic standpoint?

Dr. Martin Champagne: The trajectory of a cancer patient involves chronic care punctuated by periods of acute illness. After being diagnosed, the patient needs adjuvant therapies, after which, the patient goes into remission. Patients who go on to experience a relapse require new and more intensive therapies. That episode is followed by a honeymoon period, when the patient once again goes into remission and so on. When you're talking about cancer care, one-time funding doesn't do the job because patients experience a cycle of acute and less acute episodes for years.

Significant and meaningful investments are needed. Our computer systems are outdated, which ends up costing us a tremendous amount of time. Say Ms. Boniface goes to a patient's home to provide care, I can't get access to that information. The technology exists, but our current system merely returns the same information that the nurses have collected, the patient's family status, telephone numbers and so on. Everyone is constantly duplicating the exact same data that have already been collected.

Significant and meaningful investments on the system side would result in time savings, not only for health care workers, but also in terms of equipment, ensuring a smooth flow of information. That is crucial, but it would clearly require huge investments on a national scale.

Mr. Luc Thériault: You need more robust systems.

It's also important that the funding reflect rising costs. The longer we wait, the more it's going to cost.

Is that right?

Dr. Martin Champagne: That's right.

The Chair: Your time is up, Mr. Thériault.

[*English*]

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

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

Ms. Baker, I appreciate that you mentioned that it's more of a regulatory issue, but I'm curious if you could give us some sense of how easy or hard it is for foreign-trained nurses to acquire the ability to practise in Canada.

Dr. Cynthia Baker: Sure. The process, as I understand it, is that there is a national portal, and they apply to that national assessment centre. All the data goes to this group in the United States that evaluates and assesses their credentials and their knowledge. I think that process takes about a year. Following their assessment, they identify what they consider to be gaps in their education or competencies. Then it goes to the provincial jurisdictions, and they take bridging courses to make up what's missing. Then, I believe, depending on the jurisdiction, they may have some OSCEs, based on the entry-to-practice competencies. It's quite a long, involved process.

There is one area I do see that could speed things up. While that first step in the process of assessing the credentials is happening, there are bridging programs. There have been some initiatives, but I think we need more of those initiatives and perhaps a more standardized, one-year program across the country for internationally educated nurses so that they can be moving along with the process. When they get the results from that initial assessment, they would have completed the bridging programs.

● (1705)

Mr. Don Davies: Ms. Baker, your description presumes there are gaps. Surely there must be people who are trained in U.S., British or European nursing schools where there are no gaps, where they're as well trained as any nurses here. Does our system permit for an expeditious and efficient pathway for those people into practising in Canada?

Dr. Cynthia Baker: Again, you're asking the wrong person, because this is regulatory. Yes, they seem to come out with gaps, but I'm not the best person, really, because I don't know the areas from which they come out with gaps.

Mr. Don Davies: Fair enough. Thank you.

The Chair: Thank you, Ms. Baker, and thank you, Mr. Davies.

Next it's Mr. Lake, please, for five minutes.

Hon. Mike Lake (Edmonton—Wetaskiwin, CPC): I'll start with Mr. Campbell. I don't really have a specific question for you, but you've been listening in and no one has asked you a question. I'm wondering, as you're listening to everyone else speak, if you have any thoughts.

Mr. Bradley Campbell: I do.

The issue of international recruitment is an interesting one, because it used to be a lot smoother. Then we went to the regulatory model and this single agency that we now contract with, which as I understand, and as Dr. Baker said, is in the U.S.

It's always been interesting to me as an observer. I've done work with governments, like the one in Barbados, and The University of the West Indies, and they're very keen to look for partnerships where they can bring foreign-trained professionals, whether those be physicians, nurses or others who are surplus to their needs, and partner with universities in Canada to create these special pathways to get people here without the associated challenges.

Again, to Mr. Davies' point, I think there may be different pathways for nurses trained in the U.S., England and Europe. They also have significant shortages. Our ability to recruit them here is a challenge, whereas there are organizations like The University of the West Indies, the Government of the Philippines and others who train people. They follow what used to be called “test accreditation standards”, which used to be considered acceptable. Then they would come and it would be more of a fast-track process, as Mr. Davies has said, where they would have a bridging program for maybe six months for specific courses.

It's a question of how we speed up that process of identifying what those gaps are, because right now it seems very cumbersome and very bureaucratic.

Hon. Mike Lake: Thanks.

Ms. Boniface, for people who might be watching this or reading it later—not to overstate how many people watch the health committee live online—let's say an occupational therapist were working with someone with autism. What would it look like in terms of what they would do?

Ms. Giovanna Boniface: Thanks for that. For OTs, as I mentioned earlier, the approach will be the same. It's looking at what a person needs, wants and has to do in their daily life and overcoming some of those barriers. When we're looking at working with people with autism, primarily children but also adults with autism, we're looking at development. We're working through developmentally appropriate goals related to the occupations or the activities of that individual.

For children, we're looking at goals related to play, their socialization and social interaction skills. From a cognitive perspective, it's attention, motor skills and self-care. Again, it's considering the personal goals and interests.

Like other health care professionals, we start with assessment and evaluation. Then we provide activity-based interventions through direct treatment and in consultation, especially when it comes to children, with their families. If the kids are in school, we're working with their educators as well as any caregivers. This could be in the areas of physical needs, sensory processing and emotional health in all environments.

With that population, we also work around transitions, when individuals are moving from one developmental milestone to another, such as going from elementary school to high school, or from high school transitioning to living independently, into the workforce or into post-secondary education.

● (1710)

Hon. Mike Lake: I have many more questions but I have limited time.

You talked in your opening statement about "transforming" to less expensive care. I mean, let's be clear; money is always going to be an issue. We have an aging population and more people using health care. How does OT help to transform to, in some sense, better results overall, let's just say, for the money that we're spending?

Ms. Giovanna Boniface: Well, this takes in elements that I and other guests here have mentioned already. One is looking at a proactive, preventative approach, making those upstream investments and preventing individuals with preventable diseases or conditions from entering the system.

I'll use falls as an example. This is a high-cost area. We know what it costs. It's highly studied. We know that it can be prevented and what investment in prevention looks like. There are many studies out of the U.K. and the U.S. that look at some very innovative and interesting models of even providing care in the emergency room, before the person.... They've come to the hospital, but before they get into a bed or into the system, they're able to triage with a nurse and an OT. The individual can get back home quite quickly. You can do these preventative investments, as I mentioned, early on in care.

Another scene would be, in these primary care teams, looking at an interprofessional approach. There's a high demand, as you've heard today, with nurses, colleagues I work with every day, as well as physicians. A gap that has not been well tapped into is the utilization of allied health professionals on these teams, including OTs. There are lots of studies, which I'm happy to send you afterwards, looking at these models that are working.

Again, we see some really interesting stuff coming out of the U.K. When you can't make more money, and you're having these challenges with the workforce, just by virtue of this need these models and these creative things are happening. I'm happy to send you some of those things. They are also looking at the cost-effectiveness and the cost-benefit analysis, and the return on investment on those things.

The Chair: Thank you, Ms. Boniface and Mr. Lake.

Ms. Sidhu, go ahead, please. You have five minutes.

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

I'd like to thank all the witnesses for their testimony.

Thank you to all the health care workers. You are doing great work on the front line. Thank you so much for that.

Ms. Baker, we regularly heard, even before the pandemic, about trained health care workers not being able to work in their field. They come here as skilled workers but are limited by provincial regulatory bodies. Can you tell me what needs to be done to ensure that these individuals are able to have their credentials recognized so that they can work in Canada? You said that the evaluation process is slow, and you talked about standardization and bridging programs. How can the federal government help work on that?

● (1715)

Dr. Cynthia Baker: That's a really good question.

I think the process is very slow, and unnecessarily slow. There is this national assessment portal. It's the national assessment [*Technical difficulty—Editor*]. It would be to work with that national organization, because that incorporates all the provincial and territorial regulatory bodies. I think if there was more national agreement about the process and about speeding up the process [*Technical difficulty—Editor*]. I think that's where we would start.

I would also like to see, as I said in my presentation, more national work being done at the level of bridging programs, making them standardized and flexible. Certainly there will be some people coming from some health care systems where there's so little difference, but I think the notion of identifying gaps and then building specific programs, flexible programs, is very long-term and cumbersome, so there needs to be a simpler standardized bridging program.

There's a lot of experience now in Canada with what the needs are that an internationally educated nurse.... Much of the adaptation is at the level of the culture of different health care systems. There is already a lot of knowledge about what the needs are and how to address these needs.

That's not a very clear answer, but I think it's a very important area.

Ms. Sonia Sidhu: Thank you.

My next question is for Ms. Boniface or Ms. Sabourin.

Earlier today I was able to participate in the child care announcement at my local YMCA in Brampton, which widely served as one of the main day cares for our local hospital workers during the pandemic. Based on the provinces where this has already been rolled out, has this had an impact on the health care workers who are parents?

Ms. Giovanna Boniface: I don't know if we collect data specifically related to measuring that, although I'm going to take note and look at that. Like many other health professions, I think our workforce is 93% or 94% female. As a result, the pressures of child care, culturally and however that is, still largely fall on women.

In the OT workforce, we see a trend where we see some peaks and valleys. We have a higher-than-average rate of part-time employees, which we believe is partially related to not only caregiving for children but also caregiving on the other end, for aging parents. Then we see that same population heading out a little bit early, which could be for a number of reasons.

Although we don't collect data specifically looking at child care, we can definitely make some inferences around the fact that our profession is primarily female, so we know about those pressures.

In my experience, out in my neck of the woods, I'm not familiar with any programs that are supporting, say, our large health authorities, like Vancouver Coastal Health and other larger authorities in the north and on the island. But we'll look with keen interest to how this impacts that area.

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

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

● (1720)

Mr. Stephen Ellis: Thank you, Mr. Chair. I appreciate that.

Again, I'll thank all the witnesses here today.

For Mr. Campbell, some of the things we've talked about are internationally trained physicians, nurses and other health care providers. In your international experience, does it make more sense to attempt to accredit more international schools at the school itself or to continue, perhaps, as we are in accrediting individuals?

Mr. Bradley Campbell: Both options could work, but there are a number of strategies under way [*Technical difficulty—Editor*].

Mr. Stephen Ellis: We lost him.

That's unfortunate, but maybe Mr. Campbell will come back to us.

[*Translation*]

Dr. Champagne, in light of the pandemic, do you think it will be necessary, if not essential, to avoid service closures and triaging?

Dr. Martin Champagne: Triaging has had very unfortunate repercussions. It's crucial to ensure the continuity of hospital activities. We have to find a way to make sure patients are moved to appropriate settings after their hospital stay. Patients who are recovering from COVID-19 should not remain in hospital. All needs that can be met outside the hospital should be. For instance, colonoscopies and knee and hip surgeries can be performed at specialized medical clinics. Certain activities can be performed in other settings to free up hospital resources for patients who genuinely require hospital care.

Without question, we must avoid triaging. We've learned a lot from the pandemic, in particular when it comes to the importance of having a sufficient supply of masks and gowns. The experts have been warning us for years. They knew an epidemic or pandemic was coming eventually, but we didn't listen.

Acquiring a supply of equipment is expensive, but had we been better equipped, we could have continued to perform hospital activities and avoided the consequences of triaging.

Nevertheless, what's done is done. Now we need to work hard on finding the solutions to fix the problem, and I think they are out there. We need to rely on local solutions. Introducing a one-size-fits-all or top-down approach is always very problematic. Local teams have the capacity to be innovative; they know the care settings and they know the needs. I think it's really important to decentralize care management if we want to maximize hospital performance and avoid having to triage patients.

Mr. Stephen Ellis: Dr. Champagne, you talked about care that could be provided outside the hospital setting.

Did you mean by the private sector?

Dr. Martin Champagne: No. I think the public sector has the capacity to continue providing care, but outside the hospital setting. Those services could be publicly funded. As far as I'm concerned, patients should not have to pay out of pocket. I don't believe in that. I think the system is very fair and ensures universal access.

Earlier, my colleagues in occupational therapy highlighted the undeniable need for better access in some sectors. I have no doubt that's true, but I don't think we need to look to the private sector to deliver that care. Whether the private sector should handle the administration side of things is another discussion, but people should not have to pay out of pocket. That would not make care more accessible.

[*English*]

Mr. Stephen Ellis: Dr. Champagne, you talked about a solution for the 150,000 patients waiting for colonoscopies. What is the solution for that, sir? Is it these “outstanding” clinics or clinics outside the hospital? Is that what you were referring to?

[*Translation*]

Dr. Martin Champagne: Yes, that's right. A colonoscopy is a technical procedure. Colonoscopies to screen for colorectal cancer shouldn't be performed solely by gastroenterologists. In some provinces and U.S. states, nurse practitioners perform colonoscopies, so other health care professionals can be called upon to provide support.

A colonoscopy is ordered further to a positive result from a fecal immunochemical test, which is an analysis to detect occult blood in stool. The individual has to see their doctor for the test to be ordered, and that delays the process. A lot of people don't have a family physician to send the test results to.

The Régie de l'assurance-maladie du Québec sends women 50 and over a letter asking them to undergo a mammogram to screen for breast cancer. The same approach could be used for colon cancer screening tests. Patients could be sent a prescription and asked to go to the pharmacy or a local community services centre, say, to pick up the kit to test for blood in the stool. The test results would then be analyzed, without the family physician having to be involved in the process. There is no reason why only the family physician can ensure that follow-up. All it would take is a test result management system to quickly refer patients to the appropriate health care professional.

● (1725)

[*English*]

The Chair: Thank you, Dr. Ellis.

[*Translation*]

Thank you, Dr. Champagne.

[*English*]

The last round of questions for today will come from Dr. Powlowski, please, for five minutes.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): Is Mr. Campbell still there? I prepared my questions for him.

The Chair: Wouldn't you know it.

Mr. Marcus Powlowski: It's okay. I can ask someone else, but is he not there?

The Chair: He is not.

Mr. Marcus Powlowski: I will pose my questions to Ms. Baker.

You talked about licensing foreign graduates, and that would certainly seem to me to be the easiest way of dealing with the shortage of nurses. You talked about this new national portal, which I'm not familiar with, but I know it varies widely between jurisdictions as to what foreign graduates have to do to get licensed in that jurisdiction. For example, my wife went to nursing school in the Philippines. Some of her fellow students are working in California, working in Alberta; however, they can't get a job in Ontario. It seems kind of haphazard as to who requires what qualifications.

With this national portal, does everyone have to go though it? Even if they go through it, isn't it still up to the provinces as to the actual requirements in order to get a licence?

Dr. Cynthia Baker: Yes, that's the contradiction in the system. There is the National Nursing Assessment Service. The members of the National Nursing Assessment Service are all the regulatory bodies in all jurisdictions. It's supposed to be a sort of one boutique type of thing, but from my understanding of how it works, it's just the first step of the application. It takes about a year's time to go through this national service, and then it's back to each provincial jurisdiction. I know the regulations vary from one provincial jurisdiction and territorial jurisdiction to another, so there are more hoops to go through and more evaluations to go through. It is a very long and involved process.

I think it has improved, but I was at the International Nurse Education Conference about four years ago. There may have been some improvements, but I heard a presentation from one nurse from London, U.K., who had come to Canada, not because she was seeking out Canada, but because she had married a Canadian. She had just, after seven years, been registered to work in Ontario. She had a baccalaureate degree. I think she even had a master's of business administration. She had been managing units in England. It was a very long process.

I think there have been improvements, but the complication is that there's sort of a national assessment service but then it is a provincial and territorial decision. It varies across the country and there seem to be a lot of steps to go through.

Mr. Marcus Powlowski: I think the example of the British nurse who took seven years is an apt example of how this maybe isn't working that well. Does it make sense to you—and I guess there are some other nurses on the panel—that they have this national portal that kind of evaluates the standards of education the nurse has and then says that it's actually up to the provinces, and the provinces have other rules?

How can we make it a better system? There are jurisdiction issues, obviously. Most health care delivery is by the provinces. The regulation of professionals is by the provinces. Would having a pan-Canadian health strategy, or a Canadian workforce planning task force, help to address these inefficiencies and to have a system that makes more sense and doesn't require seven years to circumnavigate?

● (1730)

Dr. Cynthia Baker: Was that question for me?

Mr. Marcus Powlowski: Why don't I give it to you first? I know there are a couple of other nurses on the panel, if they want to comment afterwards.

Dr. Cynthia Baker: I know there are others who may want to respond.

I do think there needs to be collaboration among the regulatory bodies that are part of this national organization, and perhaps agreement across the country about what the steps are. Maybe have a good look at how to reduce the steps and make the process a little bit more efficient. Their role is to protect the safety of the public and it is important, but there are probably ways that the public could be protected but people could be moved along a little more quickly.

I don't know if other nurses would like to speak to this issue.

Mr. Sylas Coletto: I would like to say something to that, please.

It would be wonderful to have a pan-Canadian licensing program. If my licence works in Saskatchewan, B.C., or wherever, then, in each province, I'd pay a governing body, but I wouldn't have to transfer my licence from an Ontario licence to a Saskatchewan licence. Rather, my licence would be accepted within the provinces, and I could pay into each province's college of nurses.

The Chair: Ms. Payne, very briefly, go ahead.

Ms. Brenda Payne: Very quickly, having been registered in a number of provinces in our own country, I can say that even moving from one province to another isn't as easy as one would think. I believe that's another reason—and you've said it all—that a pan-Canadian approach is the only way to go in order for provinces not to deal with this issue in isolation. We need to work together in order to find the solutions to enable nurses to move across the country as well as internationally.

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

Mr. Coletto, I want you to know that your reactions aren't recorded in Hansard, but we got the message.

Mrs. Laila Goodridge: I have a point of order, Mr. Chair.

The Chair: Go ahead, Mrs. Goodridge.

Mrs. Laila Goodridge: Thank you.

Just to Mr. Coletto, if you are serious and you want to come to Fort McMurray, please get in touch with my office, and we will get you hired.

The Chair: That's not a point of order, but she's persistent.

Mr. Sylas Coletto: When my wife is done her residency....

The Chair: Colleagues, we had some technical difficulties and lost Mr. Campbell, so we're going to reach out to him to afford him the opportunity to respond in writing to the question he was in the process of answering when the screen froze.

To all the rest of our witnesses, thank you very much for your patience as we work through the technological challenges of today's meeting. The workforce crisis in Canada is a huge, complicated and multi-faceted problem, and we had a large and diverse panel to discuss it today—it's only fitting with a problem of this nature.

We thank you very much for your input and advice to the committee. It will serve us very well in our work on this study, so thank you for being with us.

Is it the will of the committee to adjourn?

Some hon. members: Agreed.

The Chair: We're adjourned.