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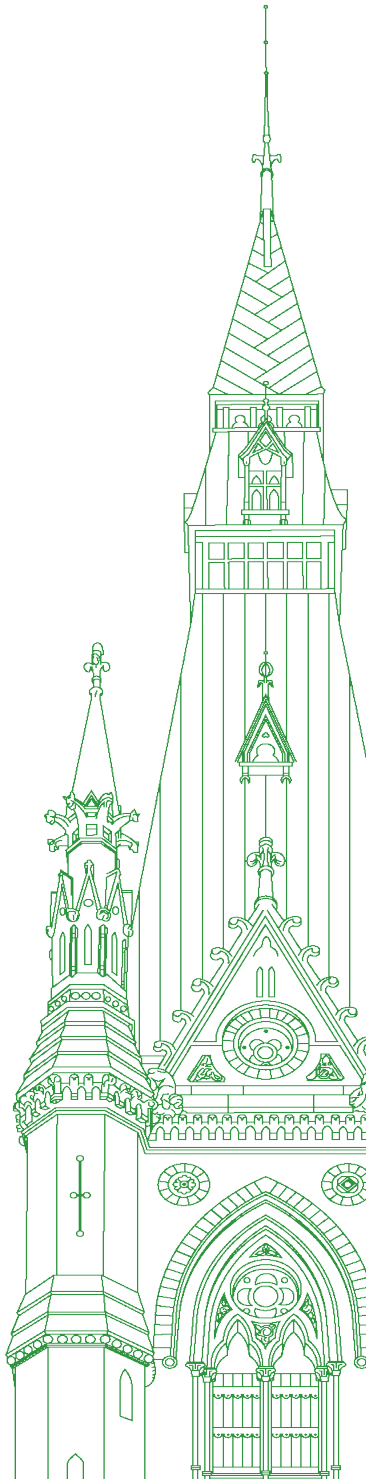

Chair: Mr. Sean Casey

Standing Committee on Health

Monday, April 4, 2022

● (1545)

[*English*]

The Chair (Mr. Sean Casey (Charlottetown, Lib.)): I call this meeting to order. Welcome to meeting number 15 of the House of Commons Standing Committee on Health.

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

Before I introduce today's witnesses, I have a few regular reminders for hybrid meetings. Today's meeting is taking place in a hybrid format, pursuant to the House order of November 25, 2021. Per the directive of the Board of Internal Economy on March 10, 2022, all those attending the meeting in person must wear a mask, except for members who are at their place during proceedings.

I have a few comments for the benefit of witnesses and members. Please wait until I recognize you by name before speaking. For those participating by video conference, click on the microphone icon to activate your mike. Please mute yourself when you are not speaking. For interpretation for those on Zoom, you have the choice at the bottom of your screen of the floor, English or French. For those in the room, you can use the earpiece to select the desired channel. Please don't take any screenshots or photos. That isn't permitted. The proceedings today will be made available via 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.

We are very pleased to welcome our witnesses here today. Thank you for your patience while we fulfilled our democratic duty. That did cause a bit of a delay to our meeting, so thank you for sticking with us. We'll still have the full two hours with you.

We have with us today, as an individual, Dr. Hugh Maguire, head of psychiatry, Nova Scotia northern zone, and assistant professor at Dalhousie University.

[*Translation*]

We are also hearing from the representative for the Association des chirurgiens cardiovasculaires et thoraciques du Québec, Dr. Louis P. Perrault, president and cardiac surgeon.

[*English*]

From the Canadian Pharmacists Association, we have Dr. Danielle Paes, chief pharmacist officer; from the College of Family Physicians of Canada, Dr. Brady Bouchard, president, and Dr. Francine Lemire, executive director and chief executive officer; from the Royal College of Physicians and Surgeons of Canada, Dr. Guylaine Lefebvre, executive director, membership engagement and programs; and from Speech-Language and Audiology Canada, we have Dawn Wilson, chief executive officer, and Susan Rvachew, full professor.

Thank you all for taking the time to appear today.

We're going to begin with opening remarks in the order that our guests appear on the notice of meeting. We're going to start with Dr. Maguire for his opening remarks.

You have five minutes, Dr. Maguire. Welcome to the committee. You have the floor.

Dr. Hugh Maguire (Head of Psychiatry, Nova Scotia Northern Zone, Assistant Professor, Dalhousie University, As an Individual): Thanks very much for inviting me to speak today.

I was nervous enough, and then I saw that with Speech-Language and Audiology in the room, I need to speak as clearly as I can.

First of all, I want to say I'm grateful to be presenting here today and to contribute to this very important work as we look at Canada's health care resources. It has never been as clear that health care is important as it has been the last two years as we dealt with a worldwide pandemic.

In Nova Scotia we did our best to deal with the pandemic, and we saw an upsurge in our use of telehealth, so we were able to use Zoom technology to see patients in rural and remote areas. We're fortunate in that psychiatry and mental health are particularly well suited to this technology, and it did help us see patients in remote areas on an urgent basis who would not otherwise have been seen.

This brought to light the need for improved access to broadband Internet in rural areas, and if the federal government were to support that, it would be helpful. Also, if we were to support rural hospitals in communities to have improved technology to access those services, that would be very helpful.

Even though telehealth is a burgeoning field, it's not the same as in-person sessions, so we still need boots on the ground.

Today I would like to mention the importance of the recruitment and retention of health care workers to Canada, especially rural areas. My experience is with physicians, but I believe my comments would apply to other health care workers as well.

Essentially we're trying to get doctors to come to a rural areas, to stay, and then to be happy that they stayed. Part of the process of getting doctors to come to rural areas is training doctors at home, and we're doing good work in our medical schools across the country to try to find doctors well suited to rural practice and help them tailor their studies to best allow them to do that. We also bring in doctors from overseas, and I wish to speak today to the importance of streamlined immigration.

We have had a number of doctors agree to come to rural Nova Scotia whose arrival here was delayed considerably by challenges with the immigration process. One of the things that came up during the pandemic especially was that we had an inability to effectively communicate with Immigration Canada to troubleshoot some of these problems, resulting in one physician arriving in Canada three weeks before his family, who had to pay for a hotel in London, England for three weeks while waiting for things to get sorted out.

If we were able to have a streamlined process for immigration and then improve communication between the federal department of immigration and our provincial health authorities, that would be helpful.

The federal government has been doing work to promote national licensure for physicians. This is also helpful with portability in helping rural areas reach out to locums when in need. Aligned with that would be a federal locum program where we can, again, access help for doctors in rural areas.

There are doctors who are challenged by the idea of coming to a rural area because they are, frankly, afraid that they won't be able to leave and that they won't be able to get a break, so a federal locum program would assist those doctors in knowing they would get time off when they so much need it.

When doctors come to a rural area, we need to do everything we can to support them in their careers, which means giving them fulfilling work, offering them the opportunity to have a good work-life balance as well as the opportunity to continue to have their continuing education, whether it be by Zoom in their local clinics or getting away to attend a conference. Support we can give in this area would also be quite helpful.

Another thing that would be helpful is also recognizing the importance of having health care workers who decide to come to a community and stay for the long term, so coming up with incentives for longer-term service, I think, is very important.

One idea that I have pitched locally is the idea of a five-year bursary bonus, where any doctor or health care worker who comes to a rural area and stays five years after buying a house in the community would get a bursary paid out gradually over the following five years to encourage them to stay a longer time.

Finally, I would like to speak to the importance of fostering nationwide positive workplace cultures. If we can create positive, healthy workplaces that are culturally safe, welcoming and inclusive, that would be one of the best ways to encourage our health care workers to choose to live in rural areas and also stay.

I know I'm on a timeline here. I know the committee's time is precious, so I will conclude my comments there and thank you for your time.

● (1550)

The Chair: Thank you very much, Dr. Maguire.

You will no doubt have a chance to expand on your comments once we start asking questions.

[*Translation*]

We will now hear from Dr. Louis Perrault, president of the Association des chirurgiens cardiovasculaires et thoraciques du Québec.

The floor is yours.

[*English*]

Dr. Louis Perrault (President and Cardiac Surgeon, Association des chirurgiens cardiovasculaires et thoraciques du Québec): Thank you so much for having me this afternoon to speak on a very important subject for the health care system in Canada.

As mentioned before, I'm the president of Quebec's association of cardiac surgeons. I'm professor of surgery at the University of Montreal. I've been a cardiac surgeon for 25 years, so I've been exposed pretty much to the system day in day out.

My colleague Dr. Maguire raised a lot of very important points. One of the things I wanted to speak to is the fact that our system showed during COVID that it was not on the brink of disaster, but had already collapsed. COVID simply made things evident not only in Quebec but all over Canada. This, in my opinion, is related to chronic underfunding of the health system in Canada.

We saw that we did not have enough beds and not enough personnel. The lessons that we should have learned from the SARS crisis and the Campbell report way back were not either learned or remembered, because all of the necessary tools were mentioned in that very extensive report. I encourage you to read it.

I think that, sadly, a lot of decisions that were made health-wise were with a short-term vision. We do need to look at the way we entice people to become health professionals, doctors, etc. It's all well and good to say we will have immigration, but I think we should have a long-term plan to entice, train and have a sufficient number of health care professionals. That's all across the board. Physicians are part of it, but definitely, they are part of a team. If there's a deficiency in one of the team members in terms of volume, we cannot function properly.

I think to have a proper culture, as Dr. Maguire said, you need to have sufficient team sizes. If you don't have a sufficient size, then people will not stay. They will not come. It's all interrelated, the culture, the workplace environment, etc. That is very important.

I think that the short-term vision should be put aside. There should be some kind of an independent body that would make decisions to look a generation ahead, 20 years ahead, and make sure that we have a health resource plan, also in terms of infrastructure, to be able to take care of the needs of Canadians. We all know that the population is aging, and this is associated with a lot of our health care needs.

The bed levels in Canada are amongst the lowest in, I would say, the occidental part of the world. Beds aren't necessarily always the solution, but definitely they could have been part of the solution during the pandemic. This should be looked at, because there is going to be another pandemic down the road, the same way COVID followed SARS.

I think it's important to have a body that will be accountable, that doesn't just look four years ahead, that makes sure we will get the bang for our buck as Canadians and taxpayers.

I think this is the time when we need to look way ahead. We cannot put aside or put on hold investment in the health care system. Because of COVID, the number of patients that we will have to treat because they were undertreated during the COVID pandemic is going to be enormous. The funding should start now or else we will never get over it.

I thank you for your attention. I look forward to answering questions.

● (1555)

The Chair: Thank you, Dr. Perrault.

Next, on behalf of the College of Family Physicians of Canada, we have Dr. Brady Bouchard and Dr. Francine Lemire.

Who is going to lead off?

Dr. Francine Lemire (Executive Director and Chief Executive Officer, College of Family Physicians of Canada): I will be leading off.

The Chair: Okay.

Dr. Lemire, please go ahead.

Dr. Francine Lemire: Thank you for inviting us to speak on behalf of the College of Family Physicians of Canada and our more than 42,000 members. I'll be presenting in English. We will be pleased to respond to questions in both official languages.

My name is Francine Lemire. I'm a family physician and executive director and CEO of the CFPC. I am joined today by our president, Dr. Brady Bouchard, a family physician practising in North Battleford, Saskatchewan.

A thriving health workforce is critical in ensuring that Canadians have timely and convenient access to primary care. We'd like to describe the changes that are necessary to ensure that our health workforce can meet the evolving needs of Canadian communities.

There are 4.6 million people in Canada who do not have a regular family physician, and many cannot access the care they need when they need it. COVID-19 has accentuated and exposed existing gaps in care, particularly for vulnerable populations, such as seniors, indigenous populations and those suffering from addictions and mental health issues. Providing care during the pandemic has been challenging. Family doctors quickly pivoted to using virtual care while providing excellent in-person care when required.

The unique foundational value of family physicians is in providing comprehensive care to patients and families across the ages, including preventative care over time in a variety of settings. The evidence is solid: Countries with robust primary care featuring family doctor leadership have better population outcomes. However, in COVID's wake we're concerned about reports of family physicians and other providers feeling burnt out, retiring early, significantly reducing their clinical commitments or leaving the profession altogether.

Every Canadian should have access to quality care close to home in a family practice. Better access is possible if family doctors and their teams spend less time on the things that aren't direct patient care, such as general paperwork and clinic administration; if more family doctors are available, particularly as Canada consistently lags behind other OECD countries in physician numbers; and if family doctors working in teams are more available to their patients and a wider array of services are available through the team. Addressing each of those areas will retain the workforce, maintain well-being and ultimately improve access.

What can we do? The government's commitment to increase the family physician supply is commendable, but doing so will take time. In the short term, we must ease the burden on the frontline family physicians.

First, establish a time-limited fund to incentivize the retention of family physicians and other primary health care providers who are considering leaving the workforce postpandemic or are already on their way out. Second, provide administrative support to primary health care teams through dedicated funding and streamlined administrative processes, creating more time and capacity for direct patient care. A recent survey of our members ranked administrative support as the top requirement to enhance access.

Looking further ahead, we need to consider several systemic issues to make our workforce supply and distribution more resilient, equitable and adaptable. We welcome recent announcements to increase family medicine capacity in some medical schools. There must be consistent, deliberate action to increase supply and enhance capacity with a focus on under-serviced settings and populations.

Now more than ever, we need a robust provincial and national data strategy. Numbers are not enough. We must understand and take into account what providers do—their scope of practice and their career trajectories. We must sustain and expand practice environments that are good for patients and providers. The CFPC promotes the concept of the “patient medical home”, a vision of care that is collaborative, team-based, patient-centred, and strongly connected to the community and health care system as a whole. Further progress on expanding this type of care must be supported through a dedicated primary care transition fund that we've been advocating for in partnership with the Canadian Medical Association and the Canadian Nurses Association.

There's a general sense of lack of appreciation and support among family physicians, who are feeling burnt out and overburdened. Our members continue to serve as a foundation of Canada's health care system and trusted partners to their patients.

● (1600)

It is critical that family doctors and other health professionals get the support they need, both in acknowledging their contributions and through dedicated support from all levels of government.

Thank you.

The Chair: Thank you, Dr. Lemire.

Next, on behalf of the Canadian Pharmacists Association, we have Dr. Danielle Paes.

Welcome to the committee, Dr. Paes. You have the floor.

Dr. Danielle Paes (Chief Pharmacist Officer, Canadian Pharmacists Association): Good afternoon and thank you for the opportunity to be part of this important and timely study.

My name is Danielle Paes and I am the chief pharmacist officer for the Canadian Pharmacists Association. Today, I am joining you from the traditional and unceded territory of the Confederacy of the Three Fires of first nations: the Odawa, Ojibway and the Potawatomi.

The CPhA represents Canada's 47,000 pharmacists who, along with their teams of pharmacy technicians and assistants, have worked tirelessly throughout the pandemic to support us all.

I want to spend a few moments highlighting the role of pharmacists during the pandemic.

When the pandemic started, pharmacies were one of the only community health care providers to remain open to the public, when most others closed or transitioned to virtual care. They did so amidst great uncertainty, not knowing how to protect themselves or their staff, while also trying to manage drug shortages and disruptions. The pandemic has truly highlighted the essential role that pharmacists and pharmacies play in health care.

Pharmacists have been an important source of COVID-19 information for the public, and have had to navigate a consistently changing environment, in some cases, with little or no advance notice. In many parts of the country, pharmacists distribute and administer COVID-19 tests, and they are the leading providers of COVID-19 vaccines, with over 17 million administered in pharmacies today.

Although COVID has dominated the last two years, the opioid crisis hasn't gone away. Through an exemption provided by the federal government during the pandemic, pharmacists were able to extend care to patients using opioids and other controlled substances. This was especially important, because they helped those individuals struggling with addiction to maintain their treatments.

The pandemic, however, has come with a toll, due to the relentless demands placed on all health care workers within a system that was already stretched. Over the past few weeks, you've heard many common themes from witnesses who have appeared. Our own experience, supported by a national survey that we recently conducted, reinforces the point that the mental health of our pharmacy workforce has been significantly impacted by burnout, labour shortages and patient harassment. It saddens me to share that during the pandemic, almost half of respondents experienced abuse or harassment from patients at least once a week, and some even daily.

Like our physician and nursing colleagues, the pandemic has had a major impact on the supply of pharmacists and their support staff. We're seeing an alarmingly high number contemplating leaving the profession. It's been heartbreaking to listen to the stories of my frontline colleagues, who are exhausted. For most, the stress and pressures they're under at work, coupled with the challenges they face personally, have put them at a breaking point.

We believe urgent action is needed to address this impending catastrophe. The federal government can play an important role in providing direct support to health providers, as well as indirect support through the provinces and territories. This includes targeted mental health resources to help pharmacy teams cope with the struggles they've faced over the past two years, as well as strategies and funding to ensure that we have the appropriate supply of pharmacy professionals, particularly in rural and remote areas.

Financial incentives, loan forgiveness for health care workers and subsidies for employers providing practical experience to students and internationally trained health-care workers are just a few of the recommendations that we believe could help avert a future health care workforce shortage and emergency.

As the committee considers strategies to improve the recruitment and retention of health care providers, I would be remiss if I did not talk about the lack of consistency with our scope of practice in Canada. Many committee members here today are able to get a flu shot at their local pharmacy, but there are still some territories that haven't enabled pharmacists to provide this service. Similarly, in some parts of the country, pharmacists can prescribe for common ailments, like UTIs and skin rashes, but others cannot. This demonstrates clear inequities to care within our existing system.

When it comes to recruiting and retaining pharmacy professionals, the ability for us to work to our full scope, regardless of where we live, is so important to our personal and professional fulfillment. The lack of scope can also disincentivize pharmacists from practising in rural and remote locations. While health and the scope of practice remain mostly provincial jurisdiction, we believe the federal government should provide targeted funding to the provinces to further extend scopes of practice for pharmacy professionals, so that they can deliver better care to patients.

I'd like to acknowledge again the incredible work and sacrifice of all health care workers over the past two years. We owe so much to them.

Thank you to the committee for allowing me to share how pharmacists and their teams across Canada have contributed to and been impacted by the pandemic. We look forward to seeing the positive outcomes from your dedicated efforts.

● (1605)

The Chair: Thank you very much, Dr. Paes.

Next we have the Royal College of Physicians and Surgeons of Canada represented by Dr. Guylaine Lefebvre.

You have the floor.

Dr. Guylaine Lefebvre (Executive Director, Membership Engagement and Programs, Royal College of Physicians and Surgeons of Canada): Thank you, Mr. Chair.

Honourable committee members, I thank you for the opportunity to appear today before this committee to discuss the critically important topic of health workforce recruitment and retention.

My name is Guylaine Lefebvre. I am the executive director of the Office of Membership, Engagement and Programs at the Royal College of Physicians and Surgeons of Canada.

I join this meeting today from Ottawa and the traditional, unceded, unsurrendered territory of the Anishinabe Algonquin nation.

I have been a specialist physician for 30 years. My specialty is obstetrics-gynecology. I have participated as an educator and a leader at many levels of our health care system.

The Royal College, its governing council, our president Dr. Richard Reznick and our CEO Dr. Susan Moffatt-Bruce remain committed to physician burnout and wellness issues. I offer regrets from our CEO who cannot join today. Dr. Moffatt-Bruce is committed to this important work in her capacity as a clinician-researcher as well as her position of CEO at the college.

We represent more than 50,000 physicians and surgeons across the country.

[*Translation*]

Health care, at its core, is about people. Healthy, supported health workers will result in healthier patients and healthier communities across Canada.

[*English*]

I am grateful to this committee for its commitment to addressing issues relating to recruitment and retention in the health workforce. I'd like to share with you what we've heard and what we know from our fellows, our residents and their colleagues in the health workforce, and what we're doing to support them.

[*Translation*]

I am also grateful to the government for the passage of Bill C-3, which protects health care workers from intimidation that they increasingly face in the course of trying to provide care for patients.

[*English*]

While the Royal College represents 50,000 specialist physicians and surgeons across Canada, we're not working alone on this issue. We're working in collaboration with other key stakeholders in health care including the membership of the Canadian Medical Forum with its physician resource planning working group and HEAL—Organizations for Health Action—which represents health care workers from over 40 organizations and disciplines.

We cannot work independently from a system that relies on a team of health care workers, from nurses in the operating room and in recovery to environmental teams that maintain the hospital rooms and clerical staff that look after the entire patient journey. Our physicians are only one piece of the care puzzle, which should always have the patient at the centre of the team.

One in two physicians shows signs of advanced burnout. In late stages of burnout, physicians often lose a sense of professional accomplishment and can contemplate leaving the profession. That's a red flag for all of us.

● (1610)

[*Translation*]

Throughout the COVID-19 pandemic, health care workers have stepped up. They have come out of retirement, delayed retirement, worked extra hours, all to keep our families, friends and neighbours healthy.

[*English*]

In a recent story published by CTV, an internal medicine and COVID-19 unit physician explained, “We're going to get to a point where we have skeleton crews everywhere, which is not the way a health-care system can survive.... I would argue that we're not surviving now. We're just barely getting by.”

The reality is that we haven't paid the full price of the COVID pandemic and that day is coming.

[*Translation*]

Burnout, exhaustion, delayed retirements and harassment of health care workers will all result in people leaving these professions and leaving us short of health care workers at a time when there is a tremendous backlog of procedures and care to be provided.

[*English*]

The demands on the health workforce will only increase and we may not have enough people left to provide the care.

We must also recognize that those who remain in the health care sector are stressed, exhausted and have experienced moral distress and moral injury. During the pandemic, health care professionals have been forced into challenging conditions and have had to make impossible decisions. The pandemic has brought to light many issues that already existed in our health care system and have been exacerbated in the last two years.

This means they're worn so thin that it becomes challenging to offer the type of compassionate care that we all want for ourselves and our families. Health workers who are exhausted and burnt out also don't find the same joy and gratification in seeing their patients do well.

As a surgeon, I am intimately familiar with the hardship of knowing that a patient is suffering and needs surgery, but there is no availability of OR time to proceed. The empathy we carry for the patient's pain, the workload of exploring options for care and the challenges of keeping waiting lists all contribute to the moral distress we see with our physicians. Access to care and waiting lists through COVID have gotten even more difficult to manage, but they have been troublesome for years.

In March 2020, Dr. Mamta Gautam, a psychiatrist, offered to hold daily Zoom calls to offer peer support to colleagues across the country. She had approximately 2,000 physicians contact her to join the group. In the first few weeks, between 30 and 50 physicians on average would tune in to the Zoom call each day. That number sometimes reached 80. In addition, according to a recently released survey by the Canadian Medical Association, nearly half of physicians are presently contemplating reducing their workload.

The good news is that together we can effect change. Studies have shown that to reduce the incidence of burnout, improve resilience and ultimately improve patient outcomes, a health system must identify and prioritize a commitment and dedication of resources to support health care professionals. Our colleagues at the Canadian Medical Association have created a physician wellness hub, which is one such resource to support physicians in prioritizing their own health.

Data is a resource that governments can use to understand the current composition of its health workforce to move our system forward from the pandemic. There are existing health workforce datasets, but these are typically limited to a single jurisdiction, based on self-reporting or for-profit databases that were not designed for health workforce planning.

There are also critical data gaps in existing workforce datasets, such as a lack of information related to equity, diversity and inclusion. Cultivating a health care workforce that is representative of the population it serves is critical to ensure the best health care for all Canadians.

The Chair: Dr. Lefebvre, I'm sorry to interrupt. Can I get you to try to wrap up, please?

Dr. Guylaine Lefebvre: The timing is perfect; I'm right there.

The Royal College represents specialist physicians, but our fellows and residents work in teams. To that end, we offer the following recommendations.

Collect and analyze data at a national level, ensuring that we have robust data for all jurisdictions and all professions within the health care workforce and continued, sustainable investments in programs, policies and supports for the entire health workforce.

The Government of Canada has stepped up during the pandemic to support health care workers, but we must recognize that the challenges faced during this pandemic will continue. Let's continue investing in it.

I thank you for your time, and am happy to answer questions when we get a chance.

● (1615)

The Chair: Thank you, Dr. Lefebvre.

Next is Speech-Language and Audiology Canada, Dawn Wilson and Dr. Susan Rvachew.

Who is going to speak first?

Ms. Dawn Wilson (Chief Executive Officer, Speech-Language and Audiology Canada): Mr. Chair, I am going to speak first.

The Chair: Go ahead, Ms. Wilson. You have the floor.

Ms. Dawn Wilson: Thank you so much, Mr. Chair and members of the health committee. I am joined here by my colleague, Dr. Susan Rvachew, and we just want to thank you on behalf of Speech-Language and Audiology Canada for the opportunity to speak to you today about our professions.

Our members focus on prevention, assessment and management of communications, swallowing, hearing and balance disorders across the lifespan. We represent over 7,000 members, who are often assisted by communication health assistants and work in a wide range of settings, including schools, hospitals, early years centres, long-term care facilities and in private practice.

In particular, early intervention from our members set up success for children in the critical ages of zero to six through detection of hearing loss and therapies for speech and/or language delay. Our services are integral to the care, dignity and quality of life for people living in long-term care facilities due to the high prevalence of communications, swallowing, hearing and balance disorders in seniors. These difficulties affect personal and caregiving relationships and are also associated with loss of autonomy, isolation and caregiver stress—and I know, as we can all attest, the ability of residents and facility staff to effectively communicate is paramount for everyone's health and safety.

During the peak of the COVID-19 pandemic, many of our members working in health care settings were redeployed to assist with pandemic response, further contributing to burnout. Moreover, our members play an important part of COVID recovery as many SLPs help patients with speech or swallowing issues post-ventilation.

As a result of the pandemic closures, many infants missed their newborn screen test. According to the Ontario Ministry of Health, two out of every one thousand babies have hearing loss at birth and two more develop it by age five. As a result of hearing impairment, children have difficulty with their speech and language, which can lead to academic, behavioural and emotional issues. Closing schools and day cares impacts the language and literacy of children and has added to the burnout and heavy caseload of school-based SLPs. Already, we know that 45% of indigenous children are missing their literacy benchmarks and that Canada lags behind other developed countries.

Currently, the number of SLPs and audiologists within Canada is not meeting the needs of the population, in particular the growing aging population. Although Canada's population totals around 12% of the U.S. population, the number of Canadian SLPs is around 3% of the number of U.S. SLPs. This poses an issue because the number of SLPs is too small to provide quality treatment to the large and growing number of people with communication and swallowing problems in Canada.

Recently, Northwest Territories Health Minister Julie Green said that adults must wait 19 months to see an audiologist in the Beaufort Delta and 26 months in Yellowknife. There are currently only two audiologists in the Northwest Territories. According to the Health Sciences Association of B.C., early intervention therapies, including SLP therapies, have the longest wait times of any child development centre program. Currently, it is not unusual for children never to end up having access to an SLP before entering kindergarten or to wait months or years before accessing service.

This lack of service for pre-school age children is particularly acute for indigenous children, with devastating consequences for their literacy levels, hearing health, school success, social and emotional health and their vocational outcomes.

As well, according to the Canadian occupational projection system, over the period or 2019 to 2028, the number of job openings arising from the expansion of demand and replacement demand for audiologists and speech-language pathologists is expected to total 3,800 while the number of job seekers is expected to only total 2,800.

As with many of our health care professions, rural and remote areas across the country face issues with recruitment and retention of their workforce. Therefore, we implore the government to recommend and endorse the following initiatives.

● (1620)

We must ensure that speech-language pathologists and audiologists are eligible for the Canada student loan forgiveness program, in particular those who set up practice in rural and remote communities.

We implore the government to provide funding for provinces that will work with partners to create, implement and manage innovative short and long-term strategies and programs that support the recruitment and retention of SLPs and audiologists.

We would ask the that government provide incentives or support to universities to expand or create SLP or audiology programs.

We must invest in telehealth infrastructure as a means of improving access to SLP and audiology services, particularly in rural and remote communities, including our indigenous communities.

We would also like to mention that we support the recommendations provided to HESA by the Canadian Health Workforce Network, who are doing such important work in this area.

We thank you for your time today and we encourage any questions you may have.

The Chair: Thank you, Ms. Wilson.

We're going to move right to questions now, beginning with Dr. Ellis for six minutes.

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

I want to thank all of the witnesses for their statements and being with us today for this exceedingly important study we're doing that affects all Canadians and, probably most acutely, Canadians who live rurally.

Just for full disclosure, I have been a family doctor for 26 years and recently am one of those defectors who have come here to work instead, perhaps for a multitude of reasons. Who knows?

As my colleagues here know, my wife is a pharmacist. I'll give them a shout-out especially because my wife is awesome, but all pharmacists are.

Voices: Oh, oh!

Mr. Stephen Ellis: Thank you. No answer is required

Dr. Maguire, thanks for coming. There are a couple of things that you specifically mentioned, in particular broadband Internet and immigration, that have affected your ability to deliver care and to look at solutions for our very acute problem of the lack of psychiatrists.

Maybe you could give us a bit of a story around the immigration issues that you talked a bit about with the family of a psychiatrist being left in a London hotel for three weeks.

Dr. Hugh Maguire: The doctor in question showed up at the London airport to start his new life in Canada, and when they checked in at Heathrow, he was informed that he was allowed to get on the plane but not his family. His wife and teenage daughter, with their pet dog, had to find a hotel at a moment's notice in London, England.

At the time, I was aware of the problem. We were desperately trying to troubleshoot this so that the family could make it onto the plane and board. We just hit one dead end after another in terms of trying to speak with Immigration or to speak to somebody who could allow the family to board the plane.

The family ended up going to the hotel, as I mentioned. Again, we were trying to reach out through appropriate channels, which would have been through health care in Nova Scotia, through the Department of Health, and then we tried to reach out to Immigration to try to make sure that this family could join their father and husband as quickly as possible. In fact, we just found one delay after the other, and the family was just so frustrated.

They ended up having to spend three weeks in that hotel in London before they got to come to Canada. Meanwhile, the physician had to do his quarantine period in Canada for two weeks alone, without any access to his family. Of course, when they arrived in Canada, they had to do the two-week quarantine as well.

It was a pretty tough start to their life in Canada. We're lucky that this is a resilient family they have settled into this country and made Nova Scotia their new home, but it sure was a rocky start and a fairly emotional one at times.

If we had a way to improve our ability to troubleshoot when those issues arise, that would be incredibly helpful to avoid any future problems like that happening.

● (1625)

Mr. Stephen Ellis: Dr. Maguire, through you, Mr. Chair, do you think it's important that, as part of our short-term solution—especially in rural health care and, perhaps more importantly, in rural psychiatry—we make immigration and attracting physicians from abroad a significant part of that strategy?

Dr. Hugh Maguire: I think so. I think that applies to physicians and any kinds of skilled workers. If there's a way to streamline the immigration process, so that those important workers could be in Canada and providing care while they're finished being vetted, for example, that would be super helpful.

In fact, we had one psychiatrist who agreed to come to join us in early 2020. That doctor has still not arrived and has, therefore, given up on his wish to come to Canada.

Mr. Stephen Ellis: We have about a minute and a half left.

Dr. Maguire, could you speak to the necessity of creating a welcoming environment for families of physicians coming to Canada as well, please?

Dr. Hugh Maguire: The goal is to get doctors to come and then to get them to stay. For the family in question, typically when a doctor arrives, we'll make sure that we've made connections for their families, such as activities and plans. For example, the daughter of one family who came is involved in horseback riding. We arranged for that to happen when she arrived.

Also, we make sure that we have lots of professional support in the workplace when introducing the doctor to the new environment and how the system works, and engaging them in social activities. Providing that welcoming environment is key, in fact.

Mr. Stephen Ellis: Finally, Dr. Maguire, if I might, I know that you're a practising psychiatrist who is working in an emergency room as well. How essential would it be to have a pan-Canadian electronic medical record that you could access in the emergency room?

Dr. Hugh Maguire: That would be helpful. It would be terrific. I think we're a long way away, but if we could start the process of getting there, that would be really helpful.

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

Thank you, Chair.

The Chair: Thank you, Dr. Ellis.

Next is Dr. Hanley, please, for six minutes.

Mr. Brendan Hanley (Yukon, Lib.): Thank you very much.

I'm thinking about that dream of a pan-Canadian electronic medical record.

Mrs. Laila Goodridge (Fort McMurray—Cold Lake, CPC): You can do it.

Mr. Brendan Hanley: Let's do it.

Thank you very much to all of the witnesses. Like my colleague opposite, I have also recently joined the dark side from the medical profession.

Mr. Michael Barrett (Leeds—Grenville—Thousand Islands and Rideau Lakes, CPC): The Liberals aren't that bad.

Voices: Oh, oh!

Mr. Brendan Hanley: Both of those are on the record.

On that note, I'm going to go first to Dr. Lemire. She may or may not remember that my first ever work experience as a family physician was, in fact, in Corner Brook, Newfoundland. My first white-water canoeing experience was with Dr. Lemire and her family. It's good to see you again.

Dr. Lemire, my question is about the team-based approach. I'm wondering if you could expand on it. I was really interested in your talking about the administrative support that family physicians are asking for as part of the team.

How does that work? Are there some good examples? Who else is on the team? Who are the important players on the team?

Thanks.

Dr. Francine Lemire: Thank you, Mr. Hanley.

I do remember that canoeing experience quite well, actually.

The team-based model of care is one that we're trying to promote at the moment, and it is already in place in some provinces. Family health teams in Ontario, *groupes de médecine de famille* in Quebec and PCNs in Alberta are some examples of models of care where there is access to a family physician for every person in the practice but where the family doctor also has the opportunity to work with other providers.

We have pharmacists in this virtual room today, and a pharmacist is an important member of the clinical team. We also have social workers, nurse practitioners, clinical nurses, dietitians and physiotherapists. The decision as to which providers we privilege as members of a team depends in part on the population that is served. For these models I've described, there is generally an analysis of who it is that a practice is serving, and then, based on some demographic information, there's a decision made as to which types of providers might be best suited to offer support in providing the best care for that patient population.

For myself, I worked for several years in such a model in Toronto when I was in clinical practice, and that was an example of this, so I had fairly close interaction with the clinical pharmacist in that team, particularly for the frail and elderly patients I was looking after those who were on more than six medications. Every year, the pharmacist would review those patients, and we'd have a conversation about whether all of the drugs were appropriate, whether we could trim one or two or whether there were drug interactions to be mindful of.

Of course, in that practice, we provided immunizations, and clinical nurses were important providers to help us with administering immunizations and identifying people who were due their immunizations who had not had them, so working closely with nurses is very important.

We often don't talk about the receptionists. Certainly, every practice has a receptionist, and having enhanced roles for the receptionists also helped to streamline that care.

I could go on, but these are some examples. In the team I was on, we had a social worker, and the social worker was really quite critical for patients who were dependent on funding from social services, in terms of identifying some potential sources of funding and working with those patients on some of these applications and forms to fill out.

● (1630)

Mr. Brendan Hanley: Thank you very much.

Dr. Lemire, I have one minute left, and I'm going to take as much advantage possible of my time, but that was great, thank you so much.

To the speech and language expert who spoke, I really appreciate that you highlighted the difficulties of recruitment for northern and rural areas. Is there any role for a locum service, a rotating service, virtual care or some of the other potential ideas for servicing northern and remote areas?

Ms. Dawn Wilson: Susan, I'll let you speak to this.

Ms. Susan Rvachew (Full Professor, Speech-Language and Audiology Canada): Thank you, Dawn.

Certainly, there is some room for that. I think we have to consider that there is a massive shortage of speech-language pathologists in Canada, with the number of speech-language pathologists per capita half of what it is in the United States, for example. We could have locums, and we could have virtual care, but there are just not very many speech-language pathologists, so that's an issue.

We are using virtual care quite a bit, and one particular way in which we're using it is to send students into northern communities and supervise those students from the city using Zoom and other technologies. So there is an opportunity for that.

The other thing is to have communication disorders assistants in those communities that communicate with speech pathologists who are spread further apart and are thinner on the ground.

The Chair: Thank you, Dr. Rvachew and Dr. Hanley.

[*Translation*]

Mr. Thériault, go ahead for six minutes.

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

I thank all the witnesses for their valuable testimony.

I will put my questions to Dr. Perrault.

Denial is a refusal to take into account part of reality. Yet the federal government is stubbornly waiting for the pandemic to end to provide structural, recurring and substantial funding to address the part of reality it does not seem to be taking into account: patients who have not contracted COVID-19. So it has adopted a piecemeal approach and provided one-off investments to address a part of reality.

Can you talk to us about the consequences of such stubbornness in a living environment as critical as cardiology? Can you remind us of the consequences of waiting like this?

We are in the sixth wave of the COVID-19 pandemic, but from the first wave, we have been seeing this same reality, that the system was too fragile and that there would be very long–term repercussions on patients.

● (1635)

Dr. Louis Perrault: Thank you for your question.

Your analysis of the situation is good. As my colleague from the Royal College of Physicians and Surgeons of Canada mentioned, all the pandemic did was expose pre-existing problems, such as waiting lists.

At the beginning of the pandemic, we saw that cardiology and cardiac surgery patients tended not to access the health care system out of fear of ending up in hospitals. That not only led to all sorts of new complications, but it also revealed that some problems that may have been detected earlier and treated with due care remained unaddressed, on the one hand, owing to limited access to hospital resources and, on the other hand, owing to patients' completely normal concern over being examined in contaminated environments. Those complications have had a number of consequences. One of them is that patients came to hospitals in a worsened condition, a potentially unstable one.

Imagine the situation. We are in the 21st century; we have the treatments, the diagnostics, the doctors and the team, but we do not have the means to receive patients. This clearly adversely impacts their recovery.

Another thing that is really unfortunate is that, if we wait too long, the accumulated backlog will really have undesirable consequences on all patient cohorts. I am preaching for my own parish, but that backlog has not been noted only in the cardiovascular community. It is also in oncology, where patients have received subdiagnoses, their diagnosis was delayed or they received a diagnosis of more advanced diseases.

The situation was urgent before the pandemic, but it is now critically important to adjust the level of funding, potentially in the form of transfers, and to assure us that the rebuilding and resumption of activities start now. We will not be able to cope with this kind of a situation for many more years.

If I may, I will make a comment to echo the comments of some of my colleagues and other witnesses. Planning is crucial for all health teams right now. One of the things we are seeing is that, in some provinces, like mine, the number of surgery residents has dropped by half over the past 10 years. So if someone needs surgery, it will be difficult for them to get treatment.

Like my colleague from the Royal College said, independent, long-term workforce planning, using evidence-based data, is extremely important for the future, not only for doctors, surgeons, and so on, but for all health care professionals.

I will give you an example. We have had a critical shortage of perfusionists for 20 years, and nothing has been done so far. So we are dealing with issues that have been known for two decades without any solutions being adopted.

Mr. Luc Thériault: So what we have to understand is that the provinces and Quebec need predictability to be able to increase the robustness of their networks, including critical living environments like yours.

Dr. Louis Perrault: That's true for our environment, yes, but if I compare speech pathologist rates in Canada with those in the United States, the difference is ridiculous. So if there was planning and an identification of needs, standards and benchmarks to determine that we need a certain number of speech pathologists per 1,000 inhabitants, and so on, if we had forecasts, we could at least try to reduce the gap between the current number and the desirable number of speech pathologists for all Canadians.

● (1640)

Mr. Luc Thériault: The Fédération des médecins omnipraticiens du Québec and the Fédération des médecins spécialistes du Québec have joined us in calling for a summit to be held to discuss health care funding transparently.

I assume that you are joining your voice to those of your colleagues and that you want to participate in that kind of an exercise, so as to optimize financial resources and set priorities. After all, you know what your priorities are, since you are on the ground.

Dr. Louis Perrault: Yes, I would be interested in that.

That is a key exercise we must all carry out. I don't want to disparage anyone, and we ourselves have used short-term solutions in our cardiac surgery work, including by bringing in doctors from abroad. But those are reactive and temporary solutions, and we need substantive ones.

We need to engage in long-term planning. We should not plan for the next four or five years, but rather for the next 20 years.

For example, we know that it takes 10 years to train a surgeon. So, if a decision was made in five years, shortages for that type of specialist would be very severe. A massive effort must really be made to review the funding and completely overhaul workforce planning.

The Chair: Thank you Dr. Perrault and Mr. Thériault.

[*English*]

Next is Mr. Davies, please, for six minutes.

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

Thank you to all of the witnesses for being here.

To Ms. Wilson, please, from Speech-Language and Audiology Canada, what percentage of speech-language pathologists are women?

Ms. Dawn Wilson: It's very, very high. It's probably 85%.

Mr. Don Davies: What about audiologists? Is it similar?

Ms. Dawn Wilson: No, it's a little bit less. It's more male-dominated in the audiology sector. It's probably half-and-half.

Mr. Don Davies: Okay.

The federal government's Canadian occupational projection system has estimated that over the period of 2019 to 2028, the number of job openings for audiologists and speech-language pathologists is expected to total 3,800, while the number of job seekers is expected to total 2,800.

You've already spoken to the rather shocking discrepancy between SLPs in Canada and the U.S. I'm wondering if you could explain to us the primary reasons for the shortage of SLPs in Canada.

Ms. Dawn Wilson: I may ask my learned colleague Dr. Rvachew to speak to this, just from her standpoint.

Mr. Don Davies: Of course.

Ms. Dawn Wilson: I can expand, if needed.

Ms. Susan Rvachew: The first issue, I think, is going to be the number of schools and the number of seats in Canada for training speech-language pathologists. The number of audiologists is actually equivalent in the United States and Canada. I'm not going to speak to whether it's enough, but it's equivalent.

For speech-language pathologists, there just aren't enough being trained. There are 12 schools, and we're training 450 students per year. That number has actually doubled in the past six years, approximately, so we've been increasing the number of students being trained, but it's clearly not fast enough to double the number of speech pathologists in the country.

The needs have been increasing because of the aging of the population. Initially, speech pathology was very carefully directed at children. Now, with the aging of the population and an increase in the number of people with swallowing disorders—for example, people in long-term care homes, post-stroke survivors and so on—there are huge needs in the aging population.

So the needs have expanded, and the capacity to train speech-language pathologists has not expanded fast enough.

Mr. Don Davies: Ballpark, how many people apply to get into SLP programs every year? You mentioned that you graduate 400-and-some a year.

Ms. Susan Rvachew: Yes.

Mr. Don Davies: How many apply to get in?

Ms. Susan Rvachew: Well, there's a weird thing with that. The number applying is actually going down because it's so hard to get in, and people are like.... There are all of these other health care professions where there are huge needs. Everyone is competing for the same pie.

However, that being said, I'm at McGill. Every year we have at least 200 applicants, and sometimes 250 or 275 applicants. We accept 30 students. The number of applicants per the number of students accepted is very high—it's many, many, many, and the requirements to get in are very tight. The students in our program have grade point averages that are very close to 4.0. So there is capacity to expand the number of students we take into our programs.

● (1645)

Mr. Don Davies: Now, this is a bit of a no-kidding question, but I wonder if you could expand a little bit on the impact of early intervention for children, particularly on health outcomes, but also just as importantly on downstream costs.

Ms. Susan Rvachew: I should have looked up that number because there is really good data on that. The main thing has to do with literacy. What's often not recognized is that in the prevention of literacy delay in school, the time to prevent that is in the preschool area. The predictors of a child's not learning to read are deficits in language skills, speech perception skills and speech production skills, and what's called “emergent literacy”. All of that is happening between the ages of 3 and 5.

If a child starts school and their speech and language skills are not within normal limits at that point, at age 5 and age 6, there's then a heightened risk of a whole bunch of bad outcomes. These include their being bullied at school, social and emotional problems, conduct disorders, ADHD—anxiety disorders in girls skyrocket—and not learning to read. There's about a 60% probability that the child will have a reading disability in grade 3. Then the chance of school failure increases the probability of boys—not girls, but boys—coming into contact with the justice system and so on.

The early intervention is absolutely essential and we are really falling down on that.

Mr. Don Davies: I have 15—

The Chair: Thank you very much, Dr. Rvachew.

Okay, 15 seconds. Go ahead. If you think you can get a question and answer in 15 seconds, go ahead.

Mr. Don Davies: I will do my best.

We hear a lot from other professionals about burnout and people leaving the profession. Are we experiencing that in the SLP/audiology world?

Ms. Susan Rvachew: There aren't studies on it, but we are women. I think it's actually higher than 85% now. What people are doing is leaving the publicly funded health system and going into private practice, reducing their caseload size, because there's a big need in private practice. Quite frankly, I did that before I became a professor. There's the attitude of, “I just don't need this.” Because of the rationing of care in the public system, you would rather have a job where you feel like you're making a difference to your patients.

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

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

Next we're going to go back to Dr. Ellis, please, for five minutes.

Mr. Stephen Ellis: Thank you, Mr. Chair, and through you, sir, if I might I will preface this.

I don't need the road map, but I have heard that the College of Family Physicians and the Royal College both have a road map. I will call it a “road map to recovery for the health care system”.

I will start with you, Dr. Lemire. Is that true? That's the question. Is it something you would share with this committee?

Dr. Francine Lemire: I suspect the road map you're referring to is the rural road map.

Dr. Bouchard, correct me if I'm wrong. I'm not aware that we have another road map kicking around.

Certainly, the road map does speak to rural recruitment and retention of family physicians in rural and remote areas in Canada. Certainly, if you would like us to share this with you, we will be pleased to do so.

Mr. Stephen Ellis: Yes. Thank you.

Certainly, we know that rural areas are perhaps more particularly affected in Canada for family physicians.

A second question, Dr. Lemire, is do we think we need to pay physicians differently? Certainly, there are a lot of models out there now on how to remunerate physicians. The world I came from was fee for service. Do you think it's time to make more broad strokes with respect to how we pay family doctors?

Dr. Francine Lemire: The college is on the record recommending or suggesting that we need to take another look to broaden our horizons with regard to how we pay physicians.

Many of the patients we look after in family practice are people who have comorbidities, several medical conditions going on at the same time. Many have chronic conditions. The proportion of frail elderly in our practices is rising. Therefore, looking after these people well, we feel, requires a broadening of how we look at this.

Some of the models, which I described earlier, have a model of payment that is what we refer to as a “blended funding model”, where a physician gets a fee or the practice gets a fee per patient per year to look after them, and then there are some services within this that are provided where there's a fee-for-service component.

This is a model that we would suggest is the preferred model, and certainly might facilitate a more comprehensive and proactive caring for patients.

● (1650)

Mr. Stephen Ellis: Thank you, doctor.

I only have a couple of minutes left.

Dr. Lefebvre, is it fair to say that similar things would apply to specialists?

Dr. Guylaine Lefebvre: Thank you.

Yes. My husband is a family doctor and I can tell you that there are a lot more similarities than differences between specialists and family physicians when it comes to these issues.

I really do think that the solution, as you've heard from many of my colleagues, is to work together. Better data means better planning. We really need to plan and support in an integrated way that reflects the way we deliver the care.

We are already collaborating closely, through the Canadian Medical Forum, with Dr. Lemire and the College of Family Physicians of Canada. We're looking at, for example, the rural and remote realities. The integration of primary care specialists with other specialists will be key, and with other providers as well.

We hear from our fellows right now about how they would love the resources to better support the system as a whole. We've referred to the administrative staff, the nursing, the patient at the centre and the team that we need to support it, and we really don't have that data.

Mr. Stephen Ellis: We have about 30 seconds left, Dr. Lefebvre.

Is it fair to say that my pie-in-the-sky idea of a pan-Canadian electronic medical record would really be essential to...? It would speed up care, in my mind, and make care better and more comprehensive. Is that fair?

Dr. Guylaine Lefebvre: Having a system with the patient at the centre and where we can all talk to the same reality definitely does seem to be an advantage.

The implementation of this, making sure that the physicians and other health care workers who deliver the care have access to that, and the implications relating to privacy and so forth are some of the challenges that stand in the way.

The Chair: Thank you, Dr. Lefebvre.

Thank you, Dr. Ellis.

Next we have Mr. Van Koeverden, please, for five minutes.

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

I believe I should start, as many of my colleagues have, by declaring a bias or a conflict. My girlfriend is a speech-language pathologist, so my questions will probably focus mostly there today.

Dr. Rvachew, Emily Wood says hi. She's my girlfriend and you taught her at McGill. She said you'd probably remember her.

Ms. Susan Rvachew: I do indeed.

Mr. Adam van Koeverden: She's doing a Ph.D. now at the University of Toronto. She'll probably reach out to you at some point and discuss her research.

Over the last couple of years, and actually because of the onset of the pandemic, she started a study on telehealth, so I was hoping to focus a little bit on speech-language pathology specifically, but it could expand to other modalities as well.

Telehealth provides us with an opportunity to look at how some of the challenges with respect to availability of SLPs and audiologists in remote northern communities could be applied. Obviously there are other challenges around connectivity there.

Could you speak briefly about some of the potential outcomes for SLPs who could reach people who otherwise wouldn't have access to one?

Ms. Susan Rvachew: Yes. Speech-language pathologists switched over to telehealth extremely fast. Through the professional association nationally, the SAC, and the organization in Quebec, and at the provincial level all across Canada, many different types of supports were offered to speech-language pathologists to help them do that, learn how to do it, find out what kind of equipment they needed and so on. It's been two years and we actually have quite a lot of experience with it. We're teaching our students how to use that model, and they're getting more and more of their clinical practice hours in telehealth. We're quite excited about it.

There are many issues, which Dr. Maguire spoke to. The first one is the integrity of the Wi-Fi you have and connectivity issues, because for speech-language pathology, it's especially important that you have good-quality sound. Sound delays can be devastating when you're doing speech therapy, so you need to have good-quality connectivity.

The other thing that makes a difference for the equity of the service is that the patient or client has to have equipment as well. Not everybody has the equipment or they might not have good enough equipment, so we have to provide those people with the equipment.

The third thing is that the speech pathologist has to have skills, and not everybody is equally skilled. Then this has to work for the very many different kinds of things that speech-language pathologists do, because we're treating different disorders in different ways. Right now, it's not clear that this works for everything. In our school, we have speech pathologists and students providing that service for different kinds of disorders, and it seems to be working quite well for certain kinds of things. However, we did a study in my lab, for example, on a very severe kind of speech disorder called apraxia of speech and it didn't work. It wasn't good, so it works well for some kinds of things, but not well for other kinds of things.

I'm a bit worried about what will happen. People may decide to provide interventions that are suited to the modality, rather than providing treatments that are suited to the problem the patient has—

● (1655)

Mr. Adam van Koeverden: Thank you, Doctor. I'm sorry, but I have a limited amount of time and I have another question.

One of the things I've learned from Emily is that undiagnosed hearing impairments often lead to really negative future health and societal outcomes for people, particularly young people. That was touched on earlier. I represent one of the largest deaf populations. It's in Milton because Milton has the largest deaf school.

Could you speak briefly about the opportunity that exists in applying some of these assessments earlier in life, potentially through a new national universal early learning and child care program? We might be able to assess some of these challenges earlier in children, providing better outcomes later in life.

Ms. Susan Rvachew: I'm very excited about the national child care program. There are so many opportunities associated with national child care programs.

With regard to hearing loss, the universal hearing screening programs across the country are the most important thing because for a lot of hearing loss, babies are born with it. I think that's really important. There are also hearing losses associated with otitis media, which are very common in the indigenous population, for example, so having screening in preschools is very important. Then there's the opportunity to provide early interventions through preschools to children, families and so on. I think it's a very important opportunity that we should take advantage of.

My daughter has autism. She's 33 now, but when she was really young, we were receiving her services in the day care for a while and it was marvellous. They were very good. Then, for some reason, the Government of Alberta decided that wasn't a good thing to do and just withdrew the services. It was quite devastating. I really look forward to the possibilities.

Mr. Adam van Koeverden: Thank you, Doctor. I'll tell Emily you say hi.

The Chair: Thank you, Mr. van Koeverden.

[*Translation*]

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

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

My question is for the Canadian Pharmacists Association representative.

There have been drug shortages throughout the pandemic. That put a burden on patients, but also on health care providers.

Has the situation improved? Is Health Canada more vigilant right now when it comes to drug supply? Are the necessary steps being taken to prevent those shortages?

● (1700)

[*English*]

Dr. Danielle Paes: Thank you for the question.

Drug shortages are a part of the daily life of community pharmacists. The pandemic made it more stressful. It made the pressures more significant.

It ebbs and flows. I think the reality is that pharmacists and the government need to have conversations. We need to be involved in the planning. We need to be ahead of the game as much as possible. We would welcome any opportunities to continue the dialogue to ensure that we set up our pharmacies with the resources, the drugs and the medications they need to help the patients they serve.

[*Translation*]

Mr. Luc Thériault: Does that cause specific anxiety or stress among providers and pharmacists?

[*English*]

Dr. Danielle Paes: Absolutely. Just imagine what it's like to be the face that is delivering that message to your patient: You're not going to be able to continue with the therapy that you've been on because it's just not available.

It requires us to become creative problem-solvers. We need to collaborate with our other health care providers. As you've seen here, there are huge opportunities for us to work interprofessionally to establish the best plan moving forward—whether or not we need to substitute, whether or not we need to modify medication based on availability. I think there's a lot there to discuss and unpack.

The bottom line is, yes, it is a huge source of stress and anxiety for our profession.

The Chair: *Merci*, Monsieur Thériault and Dr. Paes.

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

Mr. Don Davies: Well, while we're outing ourselves, I am married to a speech-language pathologist here in Vancouver.

Voices: Oh, oh!

Mr. Don Davies: Sheryl Palm works at the children's hospital, and I just wanted to give her a shout-out. She's on the cranio-facial team. It's caused me to have a lifelong deep respect for the work that SLPs and audiologists do, and I want to thank you for being here.

I have two quick questions.

First, to the College of Family Physicians of Canada, at present, what's the estimate of how many Canadians lack access to a family doctor?

Dr. Francine Lemire: It's 4.6 million.

Mr. Don Davies: Is that getting better or worse?

Dr. Francine Lemire: I guess the jury is out on that, at the moment. If our concerns about upcoming retirements for family physicians prove to be true, we will have more Canadians without a family doctor.

Mr. Don Davies: Thank you.

Dr. Lefebvre, it's notoriously difficult for foreign-trained doctors to practice in Canada. There are public jokes made about it, such as that the healthiest place to have a heart attack in this country is in a taxicab.

Why is this, and what can be done?

Dr. Guylaine Lefebvre: That's a great question. Thank you.

We of course want to have the best physicians possible to look after the population of Canada. The processes that we require for both Canadians and physicians outside of Canada to join need to be equitable in a way that, when you see a physician anywhere in this country, whatever the province, whether you're in a rural area or in the city, you can trust that the standards are there. There are processes, of course, to ensure that.

There's a complexity when a physician comes from out of country—linked to their background, their culture, the immigration and so forth—that has to be respected. I think at the same time that we as a population are mindful of the fact that it takes a lot of energy for a country to train a physician to become a physician. We shouldn't be seen as people who make it too easy to actually grab from poorer nations to bring them into the country.

It's that fine line of, absolutely, if you're going to be a physician in this country, I'd rather have you as a physician than a taxi driver, but let's do the best we can to train the number of physicians we need in this country right here.

● (1705)

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

Next we have Ms. Goodridge, please, for five minutes.

Mrs. Laila Goodridge: Thank you so much.

Thank you to all of the witnesses for spending some time here with us this afternoon. It's really been remarkable; the more witnesses we hear, the more commonalities we seem to hear all across a variety of different spaces and places.

Dr. Maguire, I'm going to start with you. You really hit something that I think rings true to me. I was wondering if you could expand a little bit further on how you would see a federal locum program working. If you could design it, what would your dream program look like?

Dr. Hugh Maguire: The reason I speak to the importance of locums across the country is so that rural doctors will know they can get a break when they need it. They're already developing national standards around licensure and encouraging the provinces to work together for licensure. I think that's great work and it would be great if that would continue.

I would love to see it happen so that there would be a registry. When we know in advance that a doctor is going to need time away, we could contact that registry, which would put us in touch with interested doctors. It's a great way for doctors to help out colleagues across the country to see how different systems work across the country. I think the more we know about the practice in different parts of the country, the better our health care system gets overall.

That's what I see. I would see it as a standardized licensure process and then having something where there would be a degree of reciprocity. A province would see that a doctor is already licensed in another jurisdiction in Canada that has very similar standards to its own and they could extend temporary licensure quickly to that doctor to allow them to come to help out.

Those are some of the components I would see as being part of that.

Mrs. Laila Goodridge: Fantastic.

Whether it be in Cold Lake, Lac La Biche or Fort McMurray, I regularly hear from people with concerns over lack of care. My understanding is that we *grosso modo* have the right number of doctors; they're just not in the right spaces across the country.

Is that accurate?

Dr. Hugh Maguire: Speaking for psychiatry in Nova Scotia, we certainly could use more distribution of psychiatrists from the city out to the more rural areas. As a general trend, I think there might be some truth to that, actually.

Mrs. Laila Goodridge: Excellent.

Dr. Lefebvre, I'm curious to hear your thoughts on having a federal locum program. I'm wondering if you could expand upon that a little bit?

Dr. Guylaine Lefebvre: Thank you.

I'll be a bit of a broken record on the fact that we don't have data.

Regarding your previous question of whether we have enough doctors, I don't know. Do we have the right kind of doctors? Could we actually use that dataset to inform our medical students to help them choose which profession they go in?

There's been a trend in my own career. When I graduated from my residency, every one of my colleagues wanted to have an office and a position and had in mind that they would have this for life. That's no longer the truth. We now have residents who see themselves graduating with the flexibility to have locums and not have the burden of an administrative office and so forth.

I think it goes both ways in looking at what our graduating physicians are looking for to meet the needs of the populations and starting with what the population needs.

Absolutely, we've heard—

Mrs. Laila Goodridge: I'm sorry. I have about a minute left.

You touched on the next point I was going to get to. Super quickly, I hear that doctors of my generation want work-life balance. They want flexibility.

Are there any studies on that? If so, could you table that with us in the committee?

Dr. Guylaine Lefebvre: There is more data coming out.

I will actually put forward that this generation of physicians is actually teaching us to be wiser about things. They're looking at the rate of burnout we're seeing and saying that they don't want to be in that position. They want help to not be there.

Absolutely, the work-life blending that physicians hope to have is a reality and should be an important question as we look at not only the number of physicians we have, but what those physicians are willing to do. The physician who puts in 150 hours week and the rural person who ends up having to be on call one day in two are unsustainable.

When we look at issues like rural and remote, work-life balance is an important consideration in that equation.

● (1710)

The Chair: Thank you, Dr. Lefebvre and Mrs. Goodridge.

Mrs. Laila Goodridge: Thank you.

The Chair: Next up is Dr. Powlowski, please, for five minutes.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): Thank you.

We're all here trying to address the problem of shortages in the workforce in health care. Certainly, Dr. Maguire has talked about the possibility of using more foreign graduates.

I guess I'm the old man here of the group of doctors. I graduated 36 years ago. Do you know what? Absolutely nothing has changed in 36 years with respect to licensing foreign graduates. They've been around and a number of us have worked in areas.... I've worked most of my life in under-serviced areas and there have always been a lot of foreign doctors in Canada who we could, should we wish to, provide with a pathway to upgrade their skills if necessary, so they can practice in Canada.

Why hasn't it happened in 36 years?

I'm looking across at a couple of other doctors here who are in a similar situation. They, too, have worked in under-serviced areas. I'm frustrated with this. We talked about differences. Dr. Lefebvre, I think, talked about bringing people to the right level, but she's an obstetrician. I've done Caesarean sections myself in developing countries. I know there are a lot of foreign grads who can do better Caesarean sections than Canadian doctors.

If necessary, we can train people, get them up to the required level in order to practice in Canada. What has been the problem?

I would suggest that—and I want to ask a whole bunch of you—there are a number of possible problems.

One is protectionism. Organizations like the CMA and OMA represent all doctors. Yes, doctors in rural areas want to attract more foreign graduates, but I've also done a little bit of work in big centres like Toronto. Do you know what? They don't have enough patients in those places, so they're trying to get people in. If you're a doctor in a big centre, you may not want to license a lot of foreign doctors because that's more competition for you and a possibility you will earn less income. So, I'm suggesting maybe there's some protectionism amongst the medical profession in not making it easier for foreign doctors to get work here.

The second thing is the possibility that the provinces don't want to have more billing numbers because that means higher cost. Third is the problem of colleges and the real kind of problem in that they don't meet the same standards as we do. Fourth is the problem with us and the federal government in immigration.

Dr. Maguire, maybe I can start with you and then I'll pass it on to the College of Family Physicians of Canada and the Royal College. I note that neither of those two bodies mentioned increasing the use of foreign doctors.

Dr. Maguire, maybe we can start with you.

Dr. Hugh Maguire: Doctor, could I just ask you to clarify the specific question?

Mr. Marcus Powlowski: My question is what is the problem?

Do you think there is protectionism in the medical community that is hindering us licensing more doctors or is the problem that the provinces aren't willing to issue more billing numbers? What's the problem in not licensing more foreign doctors?

Dr. Hugh Maguire: That's a good question.

Dr. Lefebvre spoke to some of the differences in where doctors are trained and how they're trained. When we bring a new doctor to Canada, we also need to consider their ability to transfer those skills to a different culture. I think there's probably a fair bit of work that could be done to look at some of those barriers and try to remove them. I think it would be a good idea.

By the way, Doctor, I just want to mention that before I did psychiatry, I did my family medicine north residency training in Thunder Bay.

Mr. Marcus Powlowski: Can I ask the same question, then, of the College of Family Physicians of Canada and also Dr. Lefebvre and the Royal College?

What's the barrier to foreign doctors to be able to practice in Canada? Is medical protectionism involved in not licensing more foreign grads?

● (1715)

Dr. Francine Lemire: Brady, did you want to speak to this?

Dr. Brady Bouchard (President, College of Family Physicians of Canada): If you wouldn't mind, Dr. Lemire, I will.

There are multiple parts to that question, of course. The IMG assessment programs that I'm familiar with are provincial, so there's certainly provincial responsibility there. One obvious structural barrier is that after a certain number of years of not practising in Canada, IMGs are, to my understanding, generally not eligible to enter retraining and assessment programs.

To your second point around protectionism, I'm willing to acknowledge that this may be happening. We are so desperately short of family physicians—where I practice and everywhere that I've heard from colleagues—that I can't see anything but welcoming arms to have additional colleagues, foreign-trained or not, working in our communities.

I would be remiss if I didn't reiterate Dr. Lefebvre's point as well about the ethics of making it perhaps too easy to immigrate and practice in Canada. There are a lot of resources that go into training a physician. Perhaps there are some ethical issues in bringing them from overseas, where the effort has been put into training them.

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

Dr. Lefebvre, we won't get to you, as we're well past time. You are more than welcome and encouraged, if you're so motivated, to drop us a note to augment any of your testimony, including an answer to this question.

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

Mr. Michael Barrett: Thanks very much, Chair.

Thanks to all the witnesses for being here today.

Dr. Lemire, I believe it was you gave the number of Canadians who don't have a family doc. Did you say it was 4.7 million?

Dr. Francine Lemire: Those are the data that we have. Yes.

Mr. Michael Barrett: Okay. How many doctors would it take to fill that gap?

Dr. Francine Lemire: It depends on how you calculate it. We would say that a family physician should be the most responsible provider for about 1,000 to 1,200 people. That is if this person is doing this solely as their scope of work. Many family physicians also will have certain clinical areas where they spend more of their clinical time. If that happens, then obviously the number of people that the family doctor can look after would be less. It would probably be between 500 to 1,000.

Mr. Michael Barrett: Right.

Building on that, I want to ask about the level of care. Based on the calculations that are done on how many doctors we need, in the context of a strained health care system, where we have doctors who specialize in areas that they like or are most proficient at, and they also then lend themselves in areas where they're needed—they do extra rotations in hospitals or, in the context of COVID, they're working at COVID centres—are the doctors providing the level of care that Canadians need and that doctors want to be able to provide to Canadians?

We hear an awful lot about Canadians who are frustrated that they don't get an annual physical or that they can have only one issue per visit. I hear that all the time, that the docs only have time to deal with one issue per visit. There are delayed routine screenings and delayed or cancelled care appointments. This stuff was happening before COVID, and it was exacerbated during COVID.

This list is not a.... It seems that these are all symptoms of doctors who have too many patients and are doing too many things. So is the number of doctors that we need really more than just to serve 4.7 million? Do we have an awful lot of Canadians right now who are on the list at a physician's office, but that doctor can't provide the level of care that they would like to provide or that the individual would like to receive?

● (1720)

Dr. Francine Lemire: We need more family doctors. We need family doctors not only to look after the 4.6 million who do not have one. We need more family doctors in this country.

I think I'll ask Dr. Bouchard to respond to the rest of your question, because he is on the ground. He is providing care in a particular clinical area, mainly because that care is needed in his community.

Dr. Bouchard.

Dr. Brady Bouchard: Thank you, Dr. Lemire.

Certainly, there were significant adaptations throughout the pandemic from physicians stepping into areas where they don't traditionally practice or haven't traditionally practised. They have done their best to provide a high quality of care to Canadians, but that's certainly leading to burnout as well. You mentioned the idea of being overextended.

I mean, this is a complex issue. One issue that was touched on previously was models of remuneration. Particularly in some of our urban areas across the country, with inflation and overhead and staff salaries, the administrative overhead for a practice has astronomically increased, particularly postpandemic. Part of that is just to try to make a living in a fee-for-service practice, for example, where what you can bill and what you can earn into your practice is a set rate that is not changing. Physicians are trained to do their best, and sometimes that may lend itself to limiting to one issue, although we certainly don't endorse that approach.

The other part of that is just the complexity of Canadians. Canadians are aging. They have more medical conditions. They have complex care. There are more therapeutic options available to them. They're waiting longer for specialist consultation. They're waiting longer for surgeries. All of that is certainly contributing to burnout, but it's also contributing to how many patients I can effectively manage in my practice.

I hear from colleagues across the country who have practices. They may have 1,000 or 1,200 patients that they've had for their career, and they're not going to let those patients go. They're not going to fire patients, because there is no other provider, but they do feel overextended for those reasons that I mentioned and many other reasons.

Thank you.

The Chair: Thank you, Dr. Bouchard and Mr. Barrett.

Next is Ms. Sidhu, please, for five minutes

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you, Mr. Chair, and thank you to all of the witnesses for your testimony.

We all heard Dr. Lemire say that 4.6 million people do not have access to a family physician. Dr. Bouchard said we have a shortage of family physicians. You hit the nail, Dr. Bouchard. The aging population needs complex care, and that means we need more doctors.

We heard before that Canadians who attend medical school here have difficulty finding residencies. Sometimes they have to go to the U.S. What can be done to increase the number of opportunities for those students?

Dr. Brady Bouchard: The obvious answer is that we need to increase medical school enrolment and residency places across the country, and we have to make the practice environment enticing to learners. We're only going to entice medical students and residents to train in family practice when they can see that their preceptors or teachers are thriving and enjoying their practice environment.

I trained as what we call a Canadian studying abroad, so I went to Australia for medical school and then came back to practise. I'm from Saskatchewan and I practise in Saskatchewan. For that reason, there are not enough spots in Canada. I was lucky to be able to come back. There were four spots for my residency site and there were 700 applicants, so it is not at all easy.

Ms. Sonia Sidhu: Dr. Lefebvre, do you want to add to that?

Dr. Guylaine Lefebvre: I agree. We have the same reality. When medical students choose to be residents, they have the choice of The College of Family Physicians and a variety of specialties at the Royal College. Increasing access is absolutely part of the solution. Of course, nothing is easy in that, because as you increase access you have to increase the number of teachers, and teachers are somewhat smothered right now in a system that is overburdened. Again, it's about having those multiprofession conversations on how we address the issue.

As much as we need doctors, I think we also need a system that respects that we support doctors to be doctors. One of the problems we see right now is that we have physicians who will tell us that 30% of their day is spent on administrative tasks. If we could lighten up that load, our doctors would have a better quality of practice and we would be able to expand the reach.

● (1725)

Ms. Sonia Sidhu: Dr. Lefebvre, you have spoken several times about the need for better data collection to inform decision-making. As it stands now, which organizations are collecting useful data, and in what areas do we need better data?

You also said that for centralized data, there's some concern about privacy. What specific recommendation do you have on improving data?

Dr. Guylaine Lefebvre: We have limited access to data as a whole for the entire system. There is an opportunity, I think, through the Canadian Medical Association, to look at creating a national dataset that could go beyond only physicians and include our colleagues as well.

The data on physicians that we use often is from CIHI, the Canadian Institute for Health Information. Those datasets are private through the Scott's registry and are really not created to allow us to collect the right data about our physicians. To echo Dr. Lemire, part of the problem in those datasets, which were not created for the right reason, is that we don't really have as part of the data what a person is doing in their practice. A dermatologist working in a cosmetic clinic is very different from a dermatologist who works in an ICU in a hospital, for example, and there are varieties of complexities that way. I do think most of our organizations would be willing and able to contribute to a federally funded dataset.

Ms. Sonia Sidhu: Thank you.

If we're talking about the pan-Canadian side, for which other health care professionals, if any, would a pan-Canadian licence model be useful?

Dr. Lemire, do you want to add on there?

Dr. Francine Lemire: I just want to be sure I understand the question. Are you asking me which professionals or providers besides physicians would benefit from a national licensure enablement?

Ms. Sonia Sidhu: Yes.

Dr. Francine Lemire: I would probably suggest nursing, pharmacy—

Dr. Danielle Paes: Could I interject?

Dr. Francine Lemire: I think the list could actually be quite long of professions that would lend themselves well to national licensure, which would therefore enable and facilitate those who provide care—and that's pharmacists, nurses, physicians—in some rural and remote communities to get a break and be able to take a vacation. I think that goes beyond physicians.

Dr. Danielle Paes: Can I add to that?

The Chair: Very briefly, please.

Dr. Danielle Paes: National licensure would also promote mobility between provinces. We want to have a national approach to making sure we understand the needs, and right now we don't have any data to support the demands. We know what the supply is, but we really need to look at what the demands are and then collectively work at mobilizing our health care workforce to meet those needs and remove any barriers.

The Chair: Thank you, Dr. Paes.

Thank you, Ms. Sidhu.

[*Translation*]

Mr. Thériault, go ahead for two and a half minutes.

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

I will address the Canadian Pharmacists Association representative.

Since recently, in Quebec, pharmacists have been able to prescribe antiviral drug Paxlovid. With all due respect to my doctor colleagues, I have always believed that, following a diagnostic, pharmacists were more qualified to prescribe drugs.

What is your approach concerning that new information, the ability to prescribe this drug?

We will then talk about the issues around Paxlovid.

[*English*]

Dr. Danielle Paes: Absolutely. Paxlovid is a really great example—nd kudos to Quebec for enabling pharmacists to participate in increasing patients' access to it, getting it into the hands of high-risk individuals and keeping them out of hospitals.

I think it's really about optimizing our education as medication experts. It's a collaborative approach. When it comes to the pandemic, we've seen how pharmacists have stepped up.

We've been involved in testing. We've been involved in screening and administering vaccines. If you're already going to a pharmacist to provide you with the pandemic services that we've had throughout the pandemic, prescribing for Paxlovid is a natural fit.

It's also really important because of the short duration for efficacy. We know that there's a short window—five days. Going to different health care settings to navigate this is very complicated for patients, so making sure that we're removing those barriers and giving access is so important. Pharmacists are well versed in drug interactions. They have a full patient history. It would be lovely if they had access to the medical records, but they can work in collaboration with family physicians and other health care providers to make sure that monitoring and follow-up takes place.

It's a very natural fit for pharmacists, and it makes sense because that relationship is already established with the patients that they serve.

● (1730)

[*Translation*]

Mr. Luc Thériault: If I understood you correctly, that is a Quebec practice you would like to see adopted elsewhere.

[*English*]

Dr. Danielle Paes: Absolutely. This is again about making sure that we are giving Canadians access to the medications and the services that they need, regardless of the postal code they live in. We need to see this type of progressive, creative, “meet the patients where they're at” approach to health care across the country, so kudos to Quebec for demonstrating how this model can work.

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

Next is Mr. Davies, please, for two and a half minutes.

Mr. Don Davies: Thank you.

Dr. Lefebvre, I get my teeth cleaned every six months by this wonderful person who is a Bulgarian-trained pediatrician who came to Canada and actually did all the requirements she had to do for her schooling but couldn't get a residency. I think this was just touched on.

Would I be correct in speculating that Canada has a real bottleneck? We have too few residencies. Is that part of the problem as well for all those who may be seeking to qualify to practice medicine in Canada?

Dr. Guylaine Lefebvre: Obviously I'm not in a position to comment on that individual's circumstance.

Mr. Don Davies: Yes, right, nor on the state of my teeth.

Dr. Guylaine Lefebvre: I'm sure they are great. It's funny how life diverts us sometimes.

We have a lot of specialties in Canada, and at the Royal College we continuously talk to members about what additional competence they need and what subspecialties we build. Again, what's missing is the data capture. Where are we missing individuals and how do we release that? Do we have a little too many here and not enough over there? That has not been the purview of the Royal College. The access to speciality exists, and how it gets managed in the field is something we are definitely keen to collaborate on.

Mr. Don Davies: Thank you.

My last question is for Ms. Wilson. I'll give the last word to you. What would you recommend to the federal government to help address the shortage of speech-language pathologists and audiologists in Canada?

Ms. Dawn Wilson: What we need to do is consider creating more spots for speech-language pathologists in schools. We need to consider more funding for jobs. Speech-language pathologists are subject to funding cuts and have been throughout this pandemic, so the government needs to be accountable for health care transfers that go to the provinces to support the vital funding that we need to support the jobs that are being cut. Lastly, we need to ensure that we have people coming into the profession by providing the right supports. Right now speech-language pathologists in particular are not the most well compensated, so with the move to private practice because there's a loss of jobs in the public sector, the government could look at supporting the right mixture of employment for speech-language pathologists.

We are losing people every day based on caseload, burnout and poor wages. This really is a concern, and once people go into private practice, they are faced with the same types of issues because there's a lack of funding for people in the community for the services they need. That also falls onto the other side of things in terms of how services are funded for the people who need them. For the public like you and me and our children, how do we manage insurance coverage? How do we manage the right supports so that people can manage access to services? There are a number of things.

● (1735)

The Chair: Thank you, Ms. Wilson and Mr. Davies.

Next is Mrs. Goodridge, please, for five minutes.

Mrs. Laila Goodridge: Thank you so much.

This question will be for Dr. Bouchard. You touched briefly on how inflation really impacts doctors in a fee-for-service space. I'm wondering, with the record-breaking inflation that's currently at 5.7%, if you guys are feeling the impact of that on practices in your area.

Dr. Brady Bouchard: Absolutely. As I mentioned, although it's not my personal experience, our urban areas—Vancouver and the greater Toronto area—are certainly feeling it the most, but we're feeling it across the board. I want to emphasize again that in the fee-for-service setting where family physicians are running a business, they need to pay for a medical office administrator, a clinical nurse and salaries within their clinic. They need to pay overhead. They need to pay for medical supplies. They need to pay for utilities. Absolutely, they're feeling the hurt. That's part of the uniqueness as well. Other businesses can increase prices. We're certainly not advocating for that for family physicians. We strongly believe in a publicly funded medicare system, but it does limit how you can make a living.

Mrs. Laila Goodridge: Effectively you're saying that this rising inflation is making it more difficult for doctors to just do their job?

Dr. Brady Bouchard: Absolutely. That's why we see physicians moving out of practice. That trend was there prepandemic as well. They're moving out of comprehensive office practice and moving into areas such as hospice care, obstetric care and emergency medicine—areas where they do not need to carry the burden of overhead and staff salaries. We need to reverse that trend.

Mrs. Laila Goodridge: That's wonderful. I hope my colleagues opposite have heard the fact that continuously printing money has some consequences on public health, as we're currently hearing.

One other question I have for you highlights the fact that you had to study abroad. Do you think there is a space for universities across the country to have more space for students from rural communities to get into med schools?

Dr. Brady Bouchard: Yes, absolutely.

That's part of the rural road map that Dr. Lemire mentioned before, which we've collaborated on with the Society of Rural Physicians of Canada. The key to recruiting rural physicians to practice rurally, whether that's family physicians or specialists, is to recruit medical students from those communities. People who have ties to a community already are much more likely to go back to a community to practice and more likely to stay there. I think it's a clear, smart strategy going forward.

Mrs. Laila Goodridge: Fantastic.

Do you have any other suggestions on how we could recruit and have more rural physicians?

Dr. Brady Bouchard: Certainly, the advent of virtual care has made it easier for patients to access specialist care across geographic barriers. That's certainly a barrier for rural physicians. I practice rurally. An additional contributor to burnout of rural physicians is the moral injury of trying to get patients access to care that they might have been able to access in a more urban setting.

Really, we need rural health equity. Certainly, as mentioned by everybody else here, we need data nationally around the distribution of physicians, where we may be over resourced, whether we are maldistributed or just do not have enough.

We need to know who's doing what practice and where, because a family physician is not a family physician, and a Royal College specialist is not a Royal College specialist.

● (1740)

Mrs. Laila Goodridge: Wonderful.

Dr. Maguire, are there any jurisdictions in Canada that are doing better that we could perhaps look to?

Dr. Hugh Maguire: Yes, there are actually a couple of schools in Canada. Memorial University is doing a lot of work in the area of recruiting rural students, as are areas of Ontario, with some of their more rural and remote training programs. Those are all really worth looking at. There's some good success happening there that could certainly be copied in other parts of the country.

The Chair: Thank you, Ms. Goodridge and Dr. Maguire.

The last round of questions is going to come from Mr. Jowhari, for five minutes.

Mr. Majid Jowhari (Richmond Hill, Lib.): Thank you, Mr. Chair. Thank you to all our witnesses. Specifically, thank you to my colleague, MP Don Davies for opening the opportunity for me to acknowledge all the oral health workers, especially the restorative hygienists. I would like to acknowledge my wife.

Voices: Oh, oh!

Mr. Majid Jowhari: I looked at all of my colleagues, and I didn't want to go home on Thursday night and not have acknowledged my wife. She's amazing. I attest to that as do all the patients for whom she's been working for the past 22 years.

Here you go, Homeira. You're amazing.

I also would like to go to Dr. Paes.

I have a very good friend, Dr. Akil Dhirani, who is a pharmacist. He has a number of pharmacies across the GTA, and one of them is in my riding. We often engage in very deep conversation about various skills that pharmacists can bring to the table when it comes to oral health. He talks about the utilization of other capabilities as they relate to the pharmacists.

We talk about national licensure, which we have also talked about here today; opportunities for actually forming a patient-centric care, where all the health care providers come together and provide an integrated care; and partnerships with various levels of government, as well as prescribing capabilities.

In your opening remarks, you talked about lack of consistency in the scope of services, and fragmented funding.

Can you please expand on this lack of consistency and the implication of us, one day, being able to move into virtual care?

Dr. Danielle Paes: The lack of consistency is a huge area of frustration to the profession because, depending on where you're practising, you're able to do things...and the funding and support to be able to offer the services that we are capable of giving to our patients is limited. There's a huge opportunity for us to rethink what health care looks like.

When you enter the doors of a pharmacy, you're not just entering the doors to see your pharmacist. You're entering the doors to Canada's health care system. I think there needs to be a shift to incorporating pharmacists into the greater health care system, and rethinking how we can utilize our skills and our knowledge in collaboration with the other health care providers and the other systems in place so that we're not only being efficient, but we're also being effective.

Right now, there's no way of showing the impact that pharmacists' interventions have on the prevention of hospital room visits. We want to be able to triage patients and make sure we catch their conditions. We want to make sure their health conditions are managed early on, not later on, when the implications are.... As we heard earlier on, the delay in treatment, or even in identifying therapy, has severe consequences for the patient and for the health care system.

So leveraging pharmacists is a really smart thing to do, and it's what we want to do. We want to provide care. But I will say that the system needs to be supportive of that. That includes funding and that includes a reduced administrative burden. There are so many barriers or system constraints that prevent us from being able to deliver the care that we want to and that we're capable of doing.

● (1745)

Mr. Majid Jowhari: Thank you.

You talked about the barriers as being system-specific. To go back to virtual care, can you highlight some of the opportunities that exist there for us to be able to move even faster, if and when needed, into virtual care?

Dr. Danielle Paes: You know, virtual care is double-edged. It's wonderful, because it gives access to patients in the comfort of their home. That being said, not everybody has access to technology, such as in rural parts of northern Ontario. I spoke to a pharmacist who said he had to set up a kiosk in his pharmacy to help his patients download their QR code to show that they were immunized.

There's a whole group of patients and a demographic that virtual care may not be the right method for, but it's a multimodal system. In some cases, access to virtual care would be a phenomenal asset to individuals, especially if you wanted to do a medication review or to consult on a drug-related question or query. I think there are a lot of opportunities there. Technology can be an enabler, but it is not the solution for everybody. Knowing that 95% of the population lives within five kilometres of a pharmacy, you have access points already in place.

Let's rethink how we leverage and utilize our existing workforce so that we can care for Canadians the way we know how and want to.

The Chair: Thank you very much, Dr. Paes and Mr. Jowhari.

Thank you to all of our witnesses for being with us today. This has been a fascinating and informative discussion. Thank you for the work you do on behalf of patients and on behalf of your colleagues in your respective professions. Thank you for your articulate presentations here today. We are extremely grateful to you. It will aid us greatly as we put together a report for Parliament.

With that, is it the will of the committee to adjourn the meeting?

Some hon. members: Agreed.

The Chair: We're adjourned.