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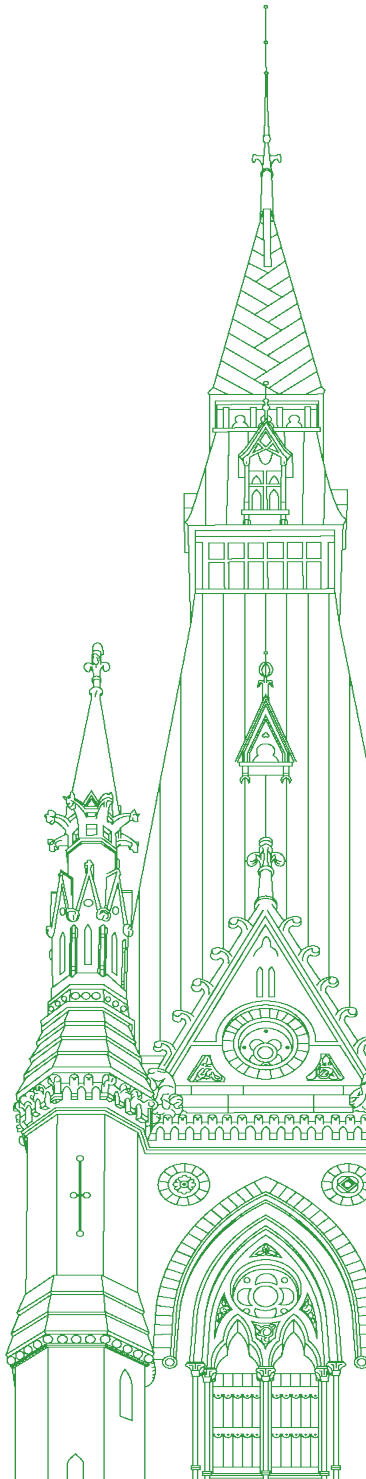

Chair: Mr. Sean Casey

Standing Committee on Health

Thursday, September 29, 2022

● (1100)

[*English*]

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

Welcome to meeting number 32 of the House of Commons Standing Committee on Health. Today, we're meeting for two hours on our study of children's health.

Today's meeting is taking place in a hybrid format, pursuant to the House order of June 23, 2022.

I would like to make 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, and please mute it when you're not speaking.

There is interpretation—

Go ahead, Monsieur Garon.

[*Translation*]

Mr. Jean-Denis Garon (Mirabel, BQ): Thank you, Mr. Chair.

I would like to know if the regulation sound tests were done for all witnesses appearing by videoconference. Could you please tell which of those tests were conclusive?

The Chair: I can confirm that the tests were conclusive for all the witnesses. Everything is in order.

Mr. Jean-Denis Garon: Thank you, Mr. Chair.

The Chair: You're welcome.

Let us continue.

[*English*]

There is interpretation. For those on Zoom, you have the choice at the bottom of your screen of floor, English or French. For those in the room, you can use the earpiece and select the desired channel.

Screenshots or taking photos of your screen are not permitted. The proceedings will be made available via the House of Commons website.

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

I would now like to welcome our witnesses who are with us this afternoon.

Appearing as an individual is Dr. Quynh Doan, a clinician scientist at the department of pediatrics at the University of British Columbia. From the Children's Hospital of Eastern Ontario, we have Alex Munter, president and CEO. From the Hospital for Sick Children in Toronto, we have Dr. James Drake, chief of surgery and chair of the Pediatric Surgical Chiefs of Canada. We also have Bruce Squires, president of McMaster Children’s Hospital and chair of the board of directors of Children's Healthcare Canada.

Thank you to all of you for taking the time to appear today.

Each witness has five minutes for an opening statement.

I'd like to invite Dr. Doan to begin.

Welcome to the committee, Dr. Doan. You now have the floor.

Dr. Quynh Doan (Clinician Scientist, Department of Pediatrics, University of British Columbia, As an Individual): Good afternoon.

I'm a pediatric emergency physician at BC Children's Hospital, and a health services researcher at UBC. My research has a focus on children and youth mental health care access and utilization.

We have been observing a consistent 6% to 8% rise in the number of pediatric emergency department visits for a mental health-related problem since at least 2002. This trend was maintained during the pandemic. It is most likely, however, that social isolation and psychological stress related to the pandemic significantly impacted children and youth mental health and wellness that is not entirely captured through emergency department visits. Simply looking at emergency department visits and hospitalization for psychiatric conditions may underestimate the psychological impact of the pandemic on our children and their resource needs.

To estimate the psychosocial hidden burden of the pandemic on children and youth in B.C., my team used MyHEARTSMAP, a validated digital psychosocial screening instrument that triggers customized health services recommendations based on the assessment data filled out by youth or their parents.

MyHEARTSMAP covers 10 psychosocial areas that maps to four domains of a youth's mental health, including psychiatric, social, functional status, and youth health. We also examined the association between demographic variables as well as families' pandemic experiences, such as schooling and employment status, among other variables, and their severity of psychosocial difficulties as reported on MyHEARTSMAP.

Between August 2020 and July 2021, we reached a diverse and representative sample of children and youth in B.C. using social media, family-oriented organizations, and Angus Reid, a private recruitment company. Our analysis included 424 assessments from children and their guardians at entry and three months later with 60% retention. At the three-month follow-up, we also asked if they had accessed any of the recommended mental health support services that were triggered at the initial screening, and explored which factors were associated with accessing care.

The majority of participating youth reported some degree of difficulties across the psychiatric, social and functional domains. Adjusting for all other variables, we found that older youth were statistically more likely to report severe difficulties in the psychiatric domain. Gender also played an important role. Compared to boys, youth who identified as non-binary or questioning genders were four times more likely to report more severe concerns in the psychiatry domains, and girls were twice as more likely to report greater social issues.

In B.C. during the study period, there was no universal school closure policies; however, youth who were not attending any formal educational programs either at home or in person at a time when school would normally be in session were twice as more likely to report greater severity in the psychiatry and youth health domains compared to youth who were in full-time, in-person school.

Based on their assessment information, consideration for accessing community mental health services was recommended to 74% of participants. While having the assessment done initiated a family discussion about youth mental health support, having a family doctor was the single greatest predictor of accessing community mental health services with an odds of 11 to 1.

In conclusion, psychosocial difficulties were reported by the majority of participating youth during the pandemic. Fortunately, most were mild, thus adequately accessible community mental health supports in the community are essential to curb escalation needs for more intensive, scarce and costly resources. We also note that specific resources to support youth who may be gender questioning or have non-binary gender identities should be considered.

Overall, I'm advocating for nationwide networks of integrated health services through the expansion of multidisciplinary youth health programs, like the Foundry BC model, where primary health care and specialized mental health care providers work collaboratively and cohesively to provide one stop shop health care to youth age 12 and up. This would also address the findings that family doctors and access to primary care are a key resource for youth accessing mental health resources when the needs are identified.

Thank you.

● (1105)

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

Next we're going to hear from Alex Munter on behalf of the Children's Hospital of Eastern Ontario.

Welcome to the committee. You have the floor.

[*Translation*]

Mr. Alex Munter (President and Chief Executive Officer, Children's Hospital of Eastern Ontario): Thank you, Mr. Chair.

I would like to thank the committee for inviting me.

● (1110)

[*English*]

It's a pleasure to be here. CHEO is the national capital's pediatric health and research centre. We have eight sites across Ottawa and the valley. Our main campus is about three miles from here. In fact, you can see the Peace Tower from the top floors of CHEO.

I would invite each and every one of you to come and visit. I'm happy to give you a tour some time.

If you came today, this is what you would see. You would see an emergency department that was rebuilt 10 years ago for 150 kids, which yesterday saw 213 and regularly sees nearly 300.

The longest length of stay in our emergency department yesterday was 32 hours. That is because we are running at an occupancy today of 105%, which means there are no beds, and so children wait in the emergency department with their parents until a bed is available.

September is on track to be the busiest September in the history of CHEO. CHEO is a 48-year-old organization. May, June and July of this year were the busiest May, June and July in the history of CHEO.

If you came today you would see kids transferred from far, far away because there are no beds in their community.

You would also see amazing people. You would see amazing, committed, passionate staff, physicians, volunteers, parents, caregivers showing grit, determination, compassion, delivering skilled expert care and battling through fatigue and frustration.

This is what you won't see today if you come to CHEO. You won't see the children whose surgery has been cancelled because we have no beds. We need to reallocate surgical beds for kids being admitted for respiratory viruses, including COVID.

You won't see the 1,000 to 1,500 kids who are referred this month and will be referred for diagnostic imaging, medical or surgical clinics, mental health care or rehabilitation care, the 1,000 to 1,500 per month who are above our capacity to see and who are being added to our wait-list. That's 12,000 to 18,000 being added to the wait-list this year.

You won't see the approximately 250 staff and physicians whose positions are vacant because of the mission critical health human resources challenges we face in Canada.

I recognize you could tell this story in almost any health care organization, hospital and other organizations across the country. Why should you care about it happening at CHEO? You should care because it's kids, because it's the future.

When a child has to wait for diagnosis for care or for therapy, they suffer. They suffer today and tomorrow, this year and next year. That's bad enough, but on top of that, it could affect and it will affect for many the entire trajectory of their lives.

As you would well understand, when a child is sick, when a child has a disability and is not getting the therapy they need, it's not just the child, but it is the whole family that is affected and often their parent's ability to engage in the workforce, or in broader society.

CHEO supports the work of Children's Healthcare Canada. We are a member of Children's Healthcare Canada. Children's Healthcare Canada, as you know, has called for a national child and youth health strategy backed up by meaningful federal investment, as words are not enough. I see Bruce Squires, the chair of the board of Children's Healthcare Canada, is here, and I am sure he will speak to it.

At CHEO we call this pedianomics. I know there is at least one economist on the committee. Pedianomics is the economics of investing in child health, the obvious return on investment of putting children on the path to lifelong health when they are tomorrow's innovators, taxpayers, caregivers and parents. Obviously, investing in children's health produces significant returns to our society. It also helps relieve pressure on the health care system.

In the broader health care system—what in the pediatric world we call the adult health care system—two dollars of every three dollars is on the management of chronic disease. Our health care system is a chronic disease system, and so the degree to which we can put children on the path to lifelong health and address from mental health to physical health, development, address their health issues and their developmental issues early, we will relieve pressure on the health care system later.

Our current circumstances are not caused by COVID. They are not caused by the pandemic. They have been accelerated and amplified by the pandemic. As you've heard from Dr. Doan, and as I'm sure you'll hear from the other presenters, the pandemic has had an outsized impact on the development, physical and mental health of children and youth. We owe them and we owe our country a singular focus on addressing those needs and putting them on the path to lifelong health.

Thank you for doing this study. Thank you for this opportunity. I look forward to the opportunity over the next two hours to have further engagement with you about it.

The Chair: Thank you, Mr. Munter.

Next, from the Hospital for Sick Children in Toronto, we have Dr. James Drake.

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

Dr. James Drake (Chief of Surgery, Hospital for Sick Children): Thank you very much.

Good morning ladies and gentleman. Thank you very much for the opportunity to speak here today.

I am a pediatric neurosurgeon at the Hospital for Sick Children. I am surgeon in chief there and also chair of the Pediatric Surgical Chiefs of Canada.

I'm extremely proud of the fact that the Hospital for Sick Children was last year ranked number one and this year ranked number two in the world by Newsweek magazine, but to be honest, SickKids is struggling.

I'm here to talk to you today about the issues about children accessing scheduled surgical care, which I think is in a crisis across Canada.

As you know, children have time-sensitive developments, which are adversely affected by delay. I've including in the briefing four common conditions, which are strabismus, undescended testicles, orthopaedic deformity and hearing impairment. These lead to lifelong issues of blindness, infertility, chronic pain and disability, and impaired speech development, as a few examples.

We are using every possible resource we can to try to address this issue, but for many hospitals such as SickKids, our wait-list actually continues to grow. The barriers we face are pediatric human health resources, underfunding, lack of operating room space and a regional approach to pediatric surgical care.

Like the other speakers who have been here, we see some of the solutions to be national support for pediatric health care, including surgery, and making it an absolute top priority; national specialized human health resource recruitment and training for nursing, allied health professionals and physicians; and adequate funding models that reflect the complexity of pediatric surgical, anaesthetic and hospital care.

You can imagine the difference between wheeling a 30-year-old patient in for hernia repair and a two-year-old when faced with a large room full of surgical equipment, masked individuals and large needles. Caring for children is very different from caring for adults. As you'll see, the wait-list for children is at or greater than that for adults.

In the brief, I provided some appendices, which I will refer to now.

The first one shows the surgical wait-list for SickKids over the last three years. Because of the pandemic and the current resources we're facing, we have a 150% increase in our surgical wait-list over the last five years. At the moment, 60% of our patients are scheduled beyond the ideal date for their surgery. This has increased dramatically since the beginning of the pandemic.

In appendix 2, the distribution of cases by surgical speciality is listed. You will see, for example, that urology has 2,000 patients on the wait-list at SickKids who are beyond their ideal treatment time.

Like in the adult sectors, our biggest waits are in orthopaedic surgery, plastic surgery, and ear, nose and throat surgery.

We are part of a region. I've shown here in appendix 3 the data around the surgical wait-list in the greater Toronto area. You'll see that the Toronto region has over 4,000 patients who are out-of-window, awaiting surgery. It equals that of the other largest groups of adults, including orthopaedic surgery and ophthalmology. This is not a minor problem for pediatric patients.

In appendix 4, I've listed the self-reported wait-lists by pediatric hospitals across Canada. This does not represent all of the hospitals. This is self-reported information. Nevertheless, as I have shown, there are 21,000 children within these eight hospitals who are on surgical wait-lists. Half of them are beyond the ideal treatment time.

Finally, just to illustrate the impact of the pandemic on children, I have shown CIHI data up to December 2021 in appendix 5. The delay in surgery for children is greater than that for those who are either middle-aged or older adults.

I cannot emphasize to you enough the impact that the delay in access to surgical care is having on children across Canada.

Thank you.

● (1115)

The Chair: Thank you, Dr. Drake.

Next is Bruce Squires, president and chair of the board of directors of Children's Healthcare Canada.

Welcome to the committee, Mr. Squires. You have the floor.

Mr. Bruce Squires (President, McMaster Children's Hospital, and Chair of the Board of Directors, Children's Healthcare Canada): Thank you very much and good morning. I really appreciate this opportunity to speak to you about this vitally important topic.

As noted, I'm joining you today as president of McMaster Children's Hospital and as chair of the board of directors of Children's Healthcare Canada. I'll note that I'm joining from Hamilton, which is located on the traditional territories of Mississauga and Haudenosaunee nations within the lands protected by A Dish with One Spoon Wampum agreement.

The McMaster Children's Hospital is one of the 16 dedicated children's hospitals across Canada. We serve a catchment area of two and a half million people, including half a million children, youth and their families, and provide comprehensive specialized health care to newborn, children and youth and their families from across this region.

Like all of the others you've heard from today, I am here because our teams and the families they serve believe we need to sound the alarm on the health and well-being of Canada's children and youth, and we need to make their health a top priority going forward.

Our teams and the families are worried that what they see and experience directly is not recognized by the public or by our leaders. They believe we need a clear commitment to refocus on the health of our kids. In my view, that's the greatest opportunity for this study by your standing committee.

Why do we need to sound that alarm? You've already heard from my colleagues. You've heard about the 2020 UNICEF report card. Canada ranks 30th and 31st for children's physical and mental health, respectively, out of 38 OECD countries. We're in the bottom third of the report for such key indicators as child mortality, obesity, teen suicide and immunizations. In a country as rich and as developed as Canada, it's inconceivable to most of us that we're performing so poorly. Those working directly with children, youth and families in schools and community agencies and hospitals are not surprised by those figures. That's because they see the impacts on a day-to-day basis.

Our mental health teams see the children who have been waiting as long as two and a half years to access specialized mental health services.

Our child development rehab teams struggle to support parents of children needing school-based rehab as they wait three years for that. And our in-patient teams struggle to provide care to critically ill children and youth following suicide attempts, overdose and substance use and severe eating disorders.

That data was collected before the pandemic. As you've heard, Canada's children and youth have borne the brunt. Their development—physical, emotional, social and spiritual—has been impacted severely by learning loss, reductions in access to physical activity, social isolation, and delays in access to care. Again the data are striking.

You've heard from Dr. Doan about the mental health of Canada's children. At McMaster Children's Hospital, we're seeing a doubling of admissions to our in-patient wards for treatment for substance-use disorders, and a 90% increase in admissions to our eating disorders and patient treatment unit.

Delays in care and increasing demand aren't limited to those related to mental health. You've heard from Dr. Drake. Think about that. Here at MCH, nearly two-thirds of parents of children waiting for surgery have already seen their kids miss the recommended window. Across Canada, hospitals are experiencing unprecedented volumes, occupancy and waits.

This morning at MCH, our emergency department had 10 children who had been admitted to the hospital but who were waiting because we didn't have an in-patient bed. That's because we were operating at 119% occupancy of those beds as of yesterday. What those numbers really mean is kids waiting up to more than 24 hours and critically ill children and their families being transferred across the province, for example, from Hamilton to Ottawa, because we don't have an ICU bed.

I could go on and on. The data clearly paint a picture of how the health of Canada's children and youth is not where it should be.

That leads to what I think really is the overriding ask for this committee, that you recommend that Canada prioritize improving the health and well-being of our children and youth.

There is great impact from the federal government making a public commitment to work with others to prioritize improving the lives of kids. That will of course need to be followed by tangible actions, and you've heard excellent recommendations from experts over the past few days.

I would add first that the “Inspiring Healthy Futures” report can form the basis for the development of a pan-Canadian child and youth health strategy. That is the key first step.

● (1120)

Second, I'd call out some additional key developments. Canada requires a sustained and focused effort to understand and report on the health care of our children and youth. We need to collect extensive data on a longitudinal basis to inform best policy and action. That will link directly to the need for a targeted child and youth health research agenda targeted towards new knowledge on maternal, newborn, child and youth health that, in turn, points towards better support and coordination for the sharing, dissemination, mobilization and adoption of that knowledge across the country.

Third, I'd highlight again a couple of the most pressing areas for focus of a child health strategy. Improving access to specialized services for rural and remote, particularly indigenous, populations remains critical to addressing health disparities and promoting health equity in children's health care and health. Children and youth require timely access to appropriate mental health services close to home. A commitment to earmarking 25% of the Canada mental health transfer for children under 18 would be a crucial first step. There are so many other key areas as you've heard.

As I close, I'd like to thank all of the members of the committee for their decision to undertake the study of child health. As I've said, this is a crucial first step towards beginning to address the crisis that we see in child and youth health across Canada. It's my hope that that first step will lead you to recommend a public commitment and associated action steps to prioritize kids' health and well-being across Canada.

Thank you sincerely for your time and attention.

● (1125)

The Chair: Thank you, Mr. Squires.

We're going to proceed with rounds of questions, beginning with Dr. Ellis for six minutes.

Mr. Stephen Ellis (Cumberland—Colchester, CPC): Thank you, Chair, and thank you to all the witnesses for being here today.

It's clear that the difficulties facing children are certainly as great as those for adults, and perhaps even greater. As Mr. Munter said, they are our future; there's no doubt about that.

One thing I spoke about the last time we met was the need for a national strategy on child and youth health, and the sad part is, with the number of meetings that we have at the current time, that's beyond the scope of where we are. I'll appeal to committee members again to give due consideration at the appropriate time that we're going to have to devote some more time to this particular topic if we're going to take leadership and help be a part of creating that strategy.

Mr. Munter, one of the things that we hear about, whether it be adults or children, is the health human resource difficulty we all face. Could you expand a bit on that? Maybe it's outside your area of expertise, but I know you're a well-respected expert in children and youth health.

Do pediatricians need to be funded better? Do we need more residency spots? What exactly does this boil down to?

Mr. Alex Munter: All the above would be the answer.

We have known for some time that we are running short. Before the pandemic, the Canadian Nurses Association projected a gap of 60,000. What happened at the outset of the pandemic was people deferred retirement, and in fact, people "unretired". A lot of the pandemic response was from nurses, physicians and others who came back to work. Now we have a circumstance of people going back to retirement, deferred retirements happening, and we have a retention problem as the environment, the workplace, becomes that much more challenging.

There are two categories of things we need to do. The first is we need to keep the people we have. For sure, there are issues about remuneration, working conditions and so on. The second is we need to increase the pipeline and we need to increase enrolment. We need to make it easier to bring people in. We have eight physicians, mostly Americans, but also from elsewhere in the world, who are ready to start working at CHEO, who will help us with our wait-lists. For example, Jim talked about urology. We have funding for three urologists. We have one on staff now. We have two vacancies. We have a urologist waiting to come to us from California. We need to speed up from an immigration perspective. We need to speed up from a credentialing process perspective, bringing people in. We have people in Canada who could work. We need that to be expedited as well.

Frankly, Canada is one of the only countries in the western world that doesn't actually have a national health human resources strategy, so that's a gap.

Jim and I were talking before the meeting, As with many things, given the specialized nature, there are probably about 30 pediatric neurosurgeons in all of Canada. If two or three retire, that's a significant impact on wait-lists.

We need both a global strategy and a child HHR strategy.

● (1130)

Mr. Stephen Ellis: Thank you.

Through you, Mr. Chair, to you, Mr. Munter again, we're at this significant and terrifying—if I might use that word—crossroads in the sense that we want to improve working conditions, but in order to do that, we need more people. It takes a long time to create a pediatrician, especially a subspecialist, as we all well know, so that's a gigantic issue.

There is another comment that I would make, and I hope you can comment on both of these things in the little time we have left. What do you think about the role of family doctors? Again, it may be beyond your area of expertise, but there's certainly an interplay between how we train family physicians and the need for pediatric care, generalist pediatric care and subspecialists.

Could you comment on that and on where you think we need to go?

Mr. Alex Munter: One of the things we're seeing, of course, one of the reasons for that surge in demand in emergency departments is that we often end up seeing children in pediatric emergency departments who could be seen by family practice and who either don't have a family doctor or are not able to get in to see their family doctor. Bolstering our primary care capacity is absolutely a crucial piece of that.

Here locally we are working. We have something called the Kids Come First health team that works with primary care physicians and community pediatricians. We've set up a couple of urgent care clinics. I think we need a system-wide view of how we support primary care to be able to deliver in team-based models on that first-line response that can help keep children and adults out of hospital.

Mr. Stephen Ellis: Thank you very much.

I think I have about 20 seconds left, Mr. Chair.

Interestingly enough, we've seen this change to team-based care. I was a family doctor for a very, very long time. It's certainly less efficient, but is it better care? What do you think about that, Mr. Munter? I know that's a bit—

Mr. Alex Munter: In 20 seconds?

Mr. Stephen Ellis: In 20 seconds or less, sir, absolutely.

Mr. Alex Munter: That's a longer discussion.

It doesn't need to be less efficient. It depends on what the incentives are that you build in.

Certainly, if I look at some of our most efficient primary care practices locally, when they have psychologists, OTs, social workers and other professionals working with family physicians, they can provide that care in a very timely way to families.

Mr. Stephen Ellis: Thank you. I appreciate it.

The Chair: Thank you very much, Dr. Ellis and Mr. Munter.

Next is Ms. Sidhu, please, for six minutes.

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

Thank you to all the witnesses for being with us.

My first question is for Dr. Drake.

Dr. Drake, we did a study on the human resources shortage. Can you suggest to us what role technology and innovation could play in reducing surgical backlogs? Do you have any advice to reduce the wait-list of patients?

Dr. James Drake: I think that one key way technology can help us is by implementing systems that accurately reflect the number of patients on waiting lists throughout a region, for example, in the greater Toronto area.

We've had several endeavours that have been funded by the province in terms of trying to centralize wait-lists so that children see the first available surgeon who can look after them at a hospital that's very near to where they live rather than coming down to Toronto to receive care there.

The issue we face is that our community partners are also struggling with the impact of the pandemic. That's one big problem, but a second problem, which is just as large, is that children's health care is not always seen as a surgical priority by the hospitals. One of the reasons is that it's not particularly well reimbursed. An anaesthetic for a child is seen as an operation on an otherwise healthy individual, but, as I mentioned in my opening remarks, bringing a child into the operating room is not a simple process. The complexity around providing care for children is higher than for an adult with the same medical problem.

We're working very hard with our regional partners—and I'm talking now about SickKids—in terms of trying to have more children operated on close to where they live, in a community hospital where the majority of the large volume of low-acuity and high-volume cases could be done. I think that's one of the ways of using technology to try to help.

The other thing we're doing is accurate modelling on optimizing the flow of patients through the hospital. We can look at what their underlying problem is, how long their operation is likely to take, where they need to go afterwards and whether they need an intensive care unit bed, and we can adjust the operating room schedules to maximize our throughput.

Finally, the other thing we're doing at SickKids is operating on the weekends. We don't have enough operating space, so we're now operating on weekends to try to address the surgical wait times.

● (1135)

Ms. Sonia Sidhu: Thank you.

The next question is for Dr. Munter.

Dr. Munter, you said you're waiting for the surgeon to come from California. How can we attract doctors so that they will stay here in Canada? Lots of our Canadian-educated medical doctors are working in the States. What incentives can we give to them so they will stay and work here in Canada?

Mr. Alex Munter: First of all, thank you for awarding me a medical degree. You can call me Alex or Mr. Munter, but I haven't quite got the MD yet. You can commiserate with my mother about that disappointment.

Just talking about CHEO, earlier this week, I heard we have been able to recruit two star clinical researchers to our research institute. I was doing interviews last week for a medical leadership position, and most of the candidates were from the United States. Then we have these eight doctors—mostly pediatricians, a surgeon and the urologist is in there too—who are signed up and ready to come.

I think there's an opportunity there. There are a whole bunch of reasons for why people might want to leave the United States, without getting into too much of a conversation about that now. The star researchers, for example, are women, and they're racialized people. They're not feeling comfortable in the United States and they want to leave.

I think there is an opportunity for us, if we make it easy. As an organization that sponsors people to come into the country, from the immigration perspective, in terms of the LMIA that we need to produce and then the licensing perspective, it's labourious and it takes a long time. The degree to which, on the federal side, we could speed up the immigration approvals and, on the provincial side, we could expedite the licensing, I think would make a tremendous difference.

Let me say this. We're talking here about physicians. For example, with CHEO—and I can speak about Ontario—most of the major hospitals share a health record with SickKids, but UHN, the Ottawa Hospital and Hamilton Health Sciences are all on a system called Epic for electronic health records, which is the predominant system in the United States.

A nurse at Cincinnati Children's Hospital who is charting on Epic—a skilled pediatric nurse—could start on Monday at CHEO or SickKids in terms of her technical skill and familiarity with the technology, if she wanted to come and if we were able to bring her here. It's just really hard.

I think there's a conversation to have about how we simplify that. It's not the solution. Nobody should think that importing health care workers is the solution for our system, but we actually need dozens and dozens of solutions, and it's one of them.

Ms. Sonia Sidhu: Thank you, Mr. Munter.

The Chair: Thank you, Ms. Sidhu and Mr. Munter.

[*Translation*]

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

Mr. Jean-Denis Garon: Thank you, Mr. Chair.

Thank you to all the witnesses for being with us today. It is very interesting.

I will begin with you, Mr. Munter. Because of my professional background, I would like to talk a bit about money.

In your opening remarks, you pointed out that the government will at some point have to make significant investments in health care again, one way or the other. I gather that is your position, is that correct?

Mr. Alex Munter: Yes, exactly.

● (1140)

Mr. Jean-Denis Garon: When we look at health care systems to see which are the most effective in certain fields or specialties, we tend to make interprovincial or international comparisons. We look at the various practices in various places and realize that the various systems or governments tend to follow what others are doing, and then try to make improvements.

As to health transfers, the mentality in Ottawa is that, in exchange for those transfers, conditions will henceforth be imposed on each of the provinces. I wonder if that does not prevent each health care system from innovating so that, at a certain point, we will no longer be able to follow what others are doing to make improvements.

What do you think?

Mr. Alex Munter: It would depend on the conditions, wouldn't it?

I understand that there are different views in the federation on the federal government's role in funding the services provided by provincial governments.

That said, if the federal government invests in provincial health care systems, Canadian taxpayers are entitled to expect results. That should be the objective. If the federal government makes its investment conditional on expected outcomes, such as reduced wait times or greater capacity to provide care, and it is possible to report on those results, that it what is important.

The federal government has in the past invested in the children's health care system, for mental health, for instance, but it was not possible to see where that money had been spent or what the results were. That is the issue.

Nonetheless, I do of course understand what you are saying.

Mr. Jean-Denis Garon: The fact remains that we have the same goal of providing better care for people and children.

I am interested in cases where a federal taxpayer is also a provincial taxpayer, in Quebec. For example, a representative of Quebec's association of pediatricians appeared before us who supports the requests from all the provinces and Quebec to increase health transfers, without conditions.

Your remarks were moving. You said there will soon be no beds left. Pediatricians in Quebec were not of the opinion that giving the government more money on the ground would compromise their objective of improving the care they provide. That is why Quebec's association of pediatricians supports the provinces' request.

Why do you not share the view of the pediatricians of Quebec?

Mr. Alex Munter: I would like to speak with the pediatricians of Quebec. I am sure we would agree that the investment in children's health care, whether by the federal or provincial government, should produce results. That is the goal.

Mr. Jean-Denis Garon: I understand.

As to imposing conditions, you seem to think that the federal government, which hardly manages any hospitals, has the skills, the public service, and the necessary administrative apparatus to tell the provinces which objectives they must meet and how to do so. The federal government is good at that. Is that what you are saying?

Mr. Alex Munter: The Ontario government does not manage hospitals either. They are managed by organizations...

Mr. Jean-Denis Garon: It is because the systems are different. That is the point.

Mr. Alex Munter: The systems are different, but the federal government and the provincial governments can certainly expect results that can be reported on.

Mr. Jean-Denis Garon: One of the largest transfers the provinces receive, which are based on population size, is the Canada Health Transfer, which in many respects is unconditional. So you think this historical approach is wrong.

Mr. Alex Munter: We could talk about the history of transfers since...

● (1145)

Mr. Jean-Denis Garon: You are saying this is not the right approach because taxpayers have expectations.

Mr. Alex Munter: It is interesting discussing federalism with you. We could go have a drink and continue the discussion.

The Ontario Hospital Association supports the Ontario government's request to increase...

[*English*]

Mr. Majid Jowhari (Richmond Hill, Lib.): Mr. Chair, on a point of order—

The Chair: Mr. Munter, can I stop you there? Apparently, we've lost translation.

Mr. Munter, we're out of time, but I cut you off in the middle of your answer.

If you can, please answer that last question, and then we're going to move on.

Thank you.

Mr. Alex Munter: Yes. I would say that we would support, and I would support, the Government of Ontario's call for a 35% increase of total health care expenditures to come from the federal government. I would support the federal government to put realistic conditions on those dollars to ensure that they actually get to the front line and make a difference and help us help kids in beds and in our clinics.

The Chair: Thank you, Mr. Munter and Monsieur Garon.

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

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you, Mr. Chair, and thank you to the witnesses.

Dr. Doan, I will begin with you, please.

Preliminary results from the study that you're leading, entitled "Child and Youth Mental Health during a Pandemic", found that two-thirds of children and youth in British Columbia have struggled with mild to moderate mental health challenges during the pandemic. You note that this is up from one-third before the arrival of COVID-19.

In an article recently in the Vancouver Sun, you were quoted as saying, "This information is going to be very useful for what they call the shadow pandemic, or what's going to fall out of the pandemic for years to come."

In your view, Dr. Doan, what steps should government take to address the impending shadow pandemic?

Dr. Quynh Doan: As I've highlighted, I think that access to primary care is key for kids with mild and moderate mental health issues to be able to access community-based care that exists. There are still a lot of navigational difficulties for families to access these cares. There are new models popping up every day and families don't know how to connect with those.

Then, access to a primary doctor is key to be able to access community-based primary care. That's number one.

Number two, we often look to hospitalization data, because that's data that we collect. We don't really look at the baseline mental health issues in the community, so I would recommend that we facilitate screening, whether it's in school or through a primary care physician, so we can detect these conditions early so they can access cheaper, more accessible mental health support before they become a crisis and end up in an emergency department having to be hospitalized.

Mr. Don Davies: Thank you.

You anticipated where I wanted to go next because, Dr. Doan, I know in response to the increasing rates of children presenting at emergency departments with mental health issues, you worked to develop HEARTSMAP, which I understand is a tool designed to support clinicians to conduct an efficient, comprehensive psychosocial evaluation for children and youth presenting with mental health concerns.

Could you briefly outline what HEARTSMAP is and how it differs from other psychosocial assessment tools?

Dr. Quynh Doan: Yes. HEARTSMAP was designed for clinicians, but we also have a self-assessment version for youth and parents now. It essentially addresses 10 different areas of psychosocial wellness, namely the home, education, alcohol/drugs, thoughts/anxiety, etc. The families or the clinicians, depending on which tool we're using, score each section based on the information received through their assessment. It goes from no issues to severe issues. Those scores are mapped to different domains of mental health, as I mentioned earlier.

It's not simply a cumulative score, but it's also a pattern of score and it looks at acuity as well. Something may be severe but chronic, with already access to care, and something could be new, but mild.

The tool uses an algorithm that's been validated against a clinician's assessment—a psychiatrist's assessment—and was shown to be valid at triggering the recommendations that a family could use to access the right level of care.

Not everybody needs to see a psychiatrist in emergency departments right away. Many of them actually have behavioural issues, have social issues that could be worked through with a social worker, or with help from occupational therapy. The instrument does the assessment, but also guides the assessment, either for clinicians to refer or families and youth to explore and access in the community.

The screening version, the MyHEARTSMAP version, is currently publicly available online for families to use and screen and access services before it becomes a problem and they show up in emergency where a clinician would then use the HEARTSMAP tool.

● (1150)

Mr. Don Davies: Thank you.

Dr. Squires, Dr. Drake and Mr. Munter, as people who work in pediatric hospitals, I want to put some information to you.

We've heard at this committee, and according to the Canadian Dental Association, tooth decay remains the most common, yet preventable, childhood chronic disease in Canada. It is the most common reason for Canadian children to undergo day surgery. It is a leading cause of why children miss school.

I want to put to you this proposition I've been told about. The most common surgery performed on preschool children at most pediatric hospitals in Canada is treatment of dental decay. Is that your experience at your hospital? If so, would having a good dental care program focused on prevention at a young age of children help relieve the pressure on your ERs and your pediatric hospitals?

Mr. Alex Munter: Not the emergency department, but, yes, by volume, dental surgery is the number one at CHEO. It's the most frequent day surgery, and typically, children whose....

A large component would be genetic malformation and issues related to, for example, associated cleft lip and cleft palate surgery, but there is a very significant proportion that ends up at CHEO because of preventable tooth decay. Certainly, the Canadian Paediatric Society has been very supportive of a national dental care program that would ensure access for all kids, regardless of income, to dental care.

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

Dr. Drake.

Dr. James Drake: Pediatric dental care is a high volume at SickKids, but we tend to see only the most complicated patients who require specific care. Much more dental surgery is actually done in the community, so I think we see a small subset of those patients.

We couldn't agree with you more that it's a really important issue, and particularly in northern communities, I think it's even more of a problem.

We're very aware of this, and we support what other methods could improve dental care for children because, as you've mentioned, it affects so many things in terms of their overall health.

Mr. Don Davies: Dr. Squires.

Mr. Bruce Squires: Thank you. Like my colleague, I haven't yet obtained that doctorate, but thank you for the faith.

The answer clearly is yes. It's just one example of the interconnectedness of the environment and all of the pieces of the health care system, but also the social community and family system in which children live.

The fact is that we can't focus on any one single piece to address the health of children. We need to really get at their mental health and their physical health, which includes dental health as well as, of course, their orthopaedic development. We need to get at their social and spiritual development, so often influenced by schools but also by their community interactions.

I point back to.... That's why we call for a child health strategy because it needs to look at it *in toto*, holistically, and ensure that we don't just target a single piece. Targeting dental care will make a difference, but that won't be sufficient. We need to look at home care, etc.

The Chair: Thank you, Mr. Squires and Mr. Davies.

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

Hon. Mike Lake (Edmonton—Wetaskiwin, CPC): Thank you to all of the witnesses.

I'm struck, actually. As many of you would know, I have a son with autism. He's 26 now, but he was nine when I was elected. I've had the chance to work with almost all of your organizations pretty significantly. Alex, I've toured many times at CHEO.

I will say that as a parent of someone who's very vulnerable, we spent a lot of time in the emergency room in Edmonton because there was really nowhere else to take Jaden, a non-verbal child who couldn't explain what he was going through at times. As I'm listening to the conversation, I'm struck by how that would be also reflective of the challenges of many kids generally, who are too young or are not at that communication level to be able to explain what's going on. The importance of what we're talking about today really dawns on me even more than usual. Thank you for the work that you do.

I'm going to dive into a specific area of spending. This won't be a surprise to others on the committee. We're a country right now that's spending more money than we've ever spent by far, yet we're talking about these crisis areas of spending right here. I'm going to zero in on children's mental health specifically.

We talked a bit about this at the last committee meeting. On mental health, I believe we're 31st out of 38 countries in the UNICEF report. We have a situation where in the last election campaign one of the few things we agreed on as parties was that we need to invest more in mental health. All parties had significant platform commitments on that.

The party that won and that is now working with the NDP—the Liberals and the NDP—had a promise for a Canada mental health transfer that was to have delivered $225 million in fiscal year 2020-21 and another $650 million in this fiscal year. That's $875 million that was promised to be delivered by now to the provinces through a Canada mental health transfer. It's a total of $4.5 billion and we're supposed to be heading into year three of that funding, but we haven't seen a single dollar so far.

One of the witnesses the other day mentioned this and there seemed to be a little bit of debate whether 25% dedicated to children's mental health was enough or whether it should be more than 25%. The 25% that would have been delivered by now would be over $200 million spread amongst the provinces.

How much difference would it have made over the last year, heading into two years, if we had an injection of $200 million across the country on children's mental health alone?

I'll throw it out to anyone who wants to take it. Maybe I'll go to Bruce first, then Alex and then anyone else who wants to weigh in.

● (1155)

Mr. Bruce Squires: Thanks, Mr. Lake, for sharing your experience with your son. I know that all of us empathize with the challenges that presents.

Again, not surprisingly, the short answer is it would have made a significant difference. I want to be clear that what we do now, as Alex so eloquently described, will often play out as a difference five, 10, 15, 20 and 30 years into the future because we're talking about the trajectory for kids.

The services and the interventions that become possible when we focus additional resources on child and youth mental health, be they community resources, supports to primary care, school services or what we provide in the specialized children's hospitals for kids who are, in many cases, really at the crisis point where they require intensive treatment.... In all of those cases, additional funding at this point would have allowed more access to diagnosis and to treatment for children and youth now.

Hon. Mike Lake: It's fair to say, as we move to Alex, that a $200-million investment over this last period would have yielded generations of benefit in terms of reduced cost.

Mr. Alex Munter: Yes, it is fair to say that.

Anybody who knows me knows that I can certainly talk to you about how to spend $200 million or more.

One of every four children or youth, more typically youth, who end up in CHEO's emergency department in a mental health crisis has been there in the last six months. They come back. That is an indicator of an inability to access community-based mental health services.

For example, here locally, we've created something called 1Call1Click that brings together all 24 child and youth mental health and addictions organizations, including CHEO. There's one way in. All referrals from schools, starting two weeks ago, come in through 1Call1Click. We have nurses in schools. It's a central intake and it's a case coordination service. We think of it as catch and hold, so that as kids come into the system, they don't get dropped in the transitions between levels of care and different organizations.

That program exists because of the Royal Bank of Canada. It does not exist because of support from government. We have been able to stand that up thanks to philanthropy. We were able to convince RBC to commit to multiple years of funding.

We are not able to expand it to reach it's full potential without support from government. At the risk of generating more questions from Monsieur Garon about this, I would say that notional $200 million, whether the carve-out is 25% or more for child and youth mental health, I would want it to leave the Government of Canada, headed out in our case, Ontario, with some kind of reporting back so that you would be able to see that, in fact, 1Call1Click, if that's one of the places it ended up, was where it did end up. It did actually make a difference in terms of improving access and care for kids who need mental health services.

I'm still thinking about the fact that Jaden is 26, because in my mind he's 11. That's quite something.

● (1200)

The Chair: Thank you, Mr. Munter.

We'll have Mr. Jowhari, please, for five minutes.

Mr. Majid Jowhari: Thank you, Mr. Chair. Thank you to all of our witnesses.

I was going to take a different line of questioning. I'm going to continue on the path of mental health. As the founder of the all-party mental health caucus in Ottawa and someone who has personally dealt with mental health issues, I feel obligated to continue on that path.

Mr. Munter, in your remarks you said that despite some of the significant historical investments that were made by the federal government.... Specifically in 2017, a commitment of $5 billion was made, while a commitment of $600 million per year continues until 2027. About $128 million of that, I believe, is going to Ontario. That's aside from the $4.7-billion commitment that was made.

What measures should have been in place for us to be able to see the impact of that money? As you indicated, the investment was made, and we haven't seen the result. I'm really glad that you're supporting putting measures in place. Naturally, measures come with the ability to measure the right data at the right time and report it.

Perhaps you could shed some light on where you think that money went. How should that have been measured so we could see the result today?

Mr. Alex Munter: To be clear, I would also support the Government of Ontario's call for 35% of health care expenditures to be covered through the federal transfer.

If you think back to 2004-05, for example, the funding agreement that was put in place at that time was really focused on access to surgery, access to diagnostics, and had some very specific measures of access—those can be throughput; those can be wait times.

To Dr. Drake's point, if we get better at outcomes, measures.... Certainly in the child and youth mental health space and developmental space, we do track functional outcomes. Any combination of those I think would be effective ways to show value for money and to show impact—

● (1205)

Mr. Majid Jowhari: Would the concept of a strategic, need-based funding based on measures be something that would resonate with you?

Mr. Alex Munter: I'm not entirely sure what that looks like, but if what it produces at the end—

Mr. Majid Jowhari: What would it look like to you?

Mr. Alex Munter: I'm going to go back to the hospital after this, right? For me, it's all about being able to find staff, hire staff for stand-up programs and cut wait times. For me, very practically, very tangibly, it's about improving my ability to do that. It's about not having to rely on philanthropy for essential programs.

However we measure that and assess that in the context we're talking about, which is mostly access, the way to measure it in a really tangible way is measures of access which, fundamentally, are throughput and wait times.

Mr. Majid Jowhari: Measures of access could be access to doctors, access to beds, access to surgeries and access to a group of proactive services. Is that correct?

Mr. Alex Munter: That's correct.

For mental health services, as we've talked about in Ontario, it's a 30-day guarantee that, if a child or youth needs access to mental health counselling where they shouldn't be in a hospital, ideally, but in a community-based mental health agency, they can access that within 30 days.

Mr. Majid Jowhari: I definitely support the community-based mental health approach. I have been advocating for that for a long time.

I have about 30 seconds left.

Who is collecting that data? I know hospitals, and you are here talking specifically about CHEO and saying we have all these numbers.

How do these numbers get to the federal government to be able to put the measures in? Would it be the hospitals or would it be the provinces that have to collect and collate this data and pass it on? We could put something need-based as well as a very measured focus on the funding that we transfer.

Thank you.

The Chair: Give a brief response, please.

Mr. Alex Munter: Mr. Chair, this is a challenging environment. I get these sweeping questions with 20 seconds to answer.

I think the Canadian Institute for Health Information is a receptor of data certainly around throughput and access from hospitals. There are some data gaps, but there is, substantially at the provincial level, the kind of data to be able to report on these matters.

The Chair: Thank you.

[*Translation*]

Mr. Garon, you have the floor for two and a half minutes.

Mr. Jean-Denis Garon: Let us continue, Mr. Munter.

Mr. Alex Munter: Ha, ha! There are other witnesses with things to say, you know.

Mr. Jean-Denis Garon: Yes, but this is so enjoyable.

Mr. Munter, you are a health care manager. Today we are considering a bill that supposedly pertains to dental care and that will have two effects. First, it will give parents a benefit of a fixed amount, regardless of the amount spent on dental care. Secondly, in exchange for the benefit received, the parents will have to fill out some Canada Revenue Agency forms and be audited. Meanwhile, Quebec has a universal system whereby a parent takes their child to the dentist, the child receives dental care, and the parent leaves the dentist's office with a bill of zero dollars.

Do you think that could be considered as a type of insurance? In terms of effectiveness, is it reasonable to give parents $650 for a cleaning that costs $50, rather than reallocating that money to actual care, and asking parents to fill out Canada Revenue Agency forms, or improving the existing programs in the provinces that are effective?

Mr. Alex Munter: I have not read the bill. I have—

● (1210)

Mr. Jean-Denis Garon: I summarized it for you.

Mr. Alex Munter: Yes, I believe you, but I have not had the chance to review how the program will be implemented. It is an interim program, from what I understand.

You are right, in principle. In Ontario, we have the Healthy Smiles Ontario program, but access is very limited. I do not have the exact figures, but as I recall it is limited to people with a family income of $30,000 or less. One way to expand access to the program would be to increase funding. So that would be an investment in an existing structure.

That said, I do not think that is the real question. The real question is—

Mr. Jean-Denis Garon: Yes, that was the question.

Mr. Alex Munter: All right, let me ask you a question then. That is allowed.

Which is the best option: improving an existing system or doing nothing?

Mr. Jean-Denis Garon: I understand.

Mr. Alex Munter: Giving families something is better than not giving them anything, if those are the only two options.

Mr. Jean-Denis Garon: Yes, definitely.

Mr. Alex Munter: In Ontario, we have a system and we could improve it. That would make things much easier for families and for health care organizations.

[*English*]

The Chair: Thank you, Mr. Munter.

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

Mr. Don Davies: Just for the record, of course the $650 payment to families—and there are two of them—is an interim bridge measure to hold families until the permanent dental program is in place. I think that's important to note for the record.

Let me get this right.

Mr. Squires, Dr. Drake, Mr. Munter, you've painted a terrible picture of delays and backlogs for diagnostics and surgeries, particularly for our children. You've all sort of, in one way or another, stated that these were exacerbated by COVID, which of course indicates that they pre-existed COVID, and you've given figures on that.

I'm just wondering if you could give me a general context. What was the initial cause of these backlogs? Have we always had backlogs in surgeries and diagnostics? If not, when did it really start?

That speaks to me of a structural problem that has been developed over time. I'd like to know if you could give us a bit of a description of when it started and what caused it, so that we could maybe try to get some structural solutions on the board.

Dr. James Drake: You're absolutely right. There have always been backlogs in the health care system for both adults and pediatrics that go back for decades, and in most pediatric centres, around 20% or 30% of the patients were beyond their recommended treatment. The pandemic had a major hit on these backlogs because, as the CIHI data has shown, there are 600,000 procedures that have not been completed compared to how we were doing before. That's an enormous number of surgeries. They accumulated because the hospitals were shut down, and it took a long time to ramp up, and now many hospitals can't get back up to 100% because of the current health human resource issues.

I think every hospital has experienced this differently. We're 150% above where we were prior to the pandemic. There are always going to be patients on waiting lists. That's to be expected, but the idea is to get as many of them as possible treated before this recommended date.

All I can say now is that it seems to everybody that this is out of control. We have teenagers waiting for spine surgery who wait two to three years for their operation while their spinal curvatures increase. We have other patients who are limping around with a dislocated hip who can't have their hip repaired because we can't bring them into hospital.

What seemed to be not ideal but manageable has become, I think, a crisis. To deal with this problem, we have to increase our volumes well beyond what we did before, because of this backlog. That is the struggle. How do we do that when we are limited by the number of personnel, the number of operating rooms we have, and honestly, pushing the health care workers who have been phenomenal during this two and a half year period. They're tired. They're burnt out, and yet we're asking more and more from them. That's our problem.

The Chair: Thank you, Dr. Drake.

Mr. Don Davies: I'll come back to you later.

The Chair: Next, we have Mrs. Goodridge for five minutes.

● (1215)

Mrs. Laila Goodridge (Fort McMurray—Cold Lake, CPC): Thank you, Mr. Chair.

Thanks to all the witnesses.

I'm going to start with Alex Munter.

I was looking at your Twitter feed. You were talking about something yesterday that is very top of mind for me as the mom of a little dude who is teething: the shortage of pain medication for babies and children that we're experiencing across the country. I don't think enough is being done to address this issue, specifically by the Government of Canada.

I'm wondering if you have any suggestions as to what the government could or should do to try to get through this.

Mr. Alex Munter: I hear you on the teething. I have a four-year-old, so it's a recent enough memory. You have my empathy.

It is a concern. It is one of many supply chain problems we're facing, from a supply perspective. I'm told by our pharmacists that the result of ramping up production should be evident in four to six weeks.

We at CHEO and experts from other children's hospitals have worked with the Canadian Pharmacists Association to develop some guidelines, supports and information for families, in particular—some workarounds, in terms of using, for example, adult Tylenol, ibuprofen and infant formulations on older kids.

I think the warning—

Mrs. Laila Goodridge: I've seen—

Mr. Alex Munter: Let me finish, because there's a real warning here: Don't try this at home. Pharmacists are extremely helpful and they will work with you to help you make the calculation and make sure this is done in a safe manner.

Mrs. Laila Goodridge: Thank you.

I saw the recommendations that came out and I think that's great. I tried giving my one-year-old Tylenol instead of the Motrin we normally give him and it all came right out, because he doesn't like the taste of the infant Tylenol. I can't imagine trying to give him a compound of adult Tylenol and having him actually consume it. That's just my experience.

I see Dr. Doan shaking her head quite a bit.

I was wondering if you could possibly add to this. What can the federal government do, in your opinion, to try to get through this issue?

Dr. Quynh Doan: I agree with what's been discussed.

I think one issue is the right dose for the right person in the right formulation. We have been using a lot of the infant formulation for older children for convenience. With my immigration background, I think you just have to conserve and use what you absolutely need to, when you need to. Guidance on when to use infant formulation and when to teach our older children to swallow tablets is one way, as well.

I've had kids in the ER who would drink down the whole infant bottle, because they won't swallow a tablet, and the dosage is such that you will consume the whole bottle in one shot.

Mr. Alex Munter: Mr. Chair, if possible, I would add something in terms of what the federal government could do.

Three-quarters of medication used on Canadian children has never been tested on Canadian children, because we do not, in this country, have a regime of pediatric clinical trials. In a place like CHEO or SickKids where you have specialized pediatric pharmacy, the safety risks are contained, but it is a concern.

One recommendation of Children's Healthcare Canada is, in fact, to establish—as is the case in Europe and the United States—a regime to ensure there is broader research and clinical trialing of a medication before it is used on kids.

Mrs. Laila Goodridge: Thank you.

Mr. Squires, I also see you nodding along. Do you have anything further to add?

Mr. Bruce Squires: Thanks very much.

I was going to go where my colleague Alex went. I'll just extend that to point out that, when we think about a child health strategy and a federal government role, it's about ensuring we apply a child health lens to policy decisions, and not only health care policy decisions, but others.

If you think about examples like some of the pharmaceutical shortages and, of course, around immunization, too often, as those discussions are happening, there is not a lens to think about what the implications are for children and youth in Canada. As Alex just described, regarding pharmaceutical trials and decision-making, we very often don't look at children and youth, but that just multiplies across so many other dimensions.

If you have a child health strategy, hopefully a component of that is the federal government's lead in ensuring we always apply that lens: What are the implications, the circumstances, and the needs of children and youth?

● (1220)

The Chair: Thank you, Mr. Squires.

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

Mr. Brendan Hanley (Yukon, Lib.): Thank you very much, and thank you again to all the witnesses. It's been great testimony today.

I'm participating from my constituency of Yukon.

I have lots of specific questions. To frame this, clearly we're addressing a crisis in child health care. We need to look at the short term and the long term, as well as child and youth health, and as a public health physician, of course, that's an interest of mine. We must also recognize the overlap between health care access as a determinant of child health in terms of the backlogs that have been described today. How do we set ourselves up for addressing backlogs, the capacity of our workforce and access to primary care, but also for the longer term?

On the performance side, when we spend so much as a country, why do we seem to be getting less value for our dollar and how do we get more efficient with our dollars? Thus, I think of that federal role. Should we not be demanding results on how we fund on behalf of Canadian citizens? When we're offering money, what are the outcomes we should be asking for? Even though we don't get into the weeds, we need to be able to, I think, demand outcomes in improvement and performance.

Dr. Doan, I was really interested in your testimony. One thing I am concerned about is the access to the family doctors inhibiting access to mental health services. That's worrying to me.

I love how, with development of the MyHEARTSMAP, you're getting more self-management, which is almost like self-triage in a way. However, given that I think we're going to be facing a shortage of doctors for years to come, how do we get beyond...build primary care and self-management and enhance access to mental services, making that whole referral pathway more efficient?

Dr. Quynh Doan: Family doctors have a short amount of time to spend with each patient. I think that if patients come in already with a sense of where the issues are and they have self-screened, that can facilitate the conversation with the family doctor. They can hone in on what types of resources are available and the referral process can be accelerated.

Before the pandemic, I was hoping to work with primary care physicians and pediatric offices to have the screeners available in the office. Then the pandemic hit, so we had to go online and we reached the families directly in their provinces.

Facilitating screening, where they can actually discuss the result right away with a health care provider, is helpful, because if they do a screening at home and they can't access their primary care physician, what happens? They go to the emergency department, and they may or may not need emergency care. I think that the timing of the screening and access to primary care and navigation support are essential.

We also need to support our family doctors, because they didn't train in psychiatry. Their being able to access advice and counselling on how to manage certain situations without having to refer to a psychiatrist and wait for six months is also useful. A referral system for physicians—

Mr. Brendan Hanley: Thank you very much.

Mr. Squires, money comes from the feds, and somehow it trickles down to you in your centre. You mentioned improving rural and remote care in place. You're a centre of expertise. What are the innovations and areas for improvement so that, as an urban centre of expertise, you can support care in place in the more remote and rural settings, especially if you had more funding at your fingertips?

Mr. Bruce Squires: Thanks very much, Dr. Hanley. It's certainly great to see you again.

There are a number of different initiatives that I think can help there. I point back to some of the things that you, yourself, talked about 20 years ago, 30 years ago, which really take advantage of the improving technologies that allow us to break down the barriers to the sometimes specialized care and expertise. That really helps in dealing with the challenges that children and youth face in their health and health care.

Again, there is a relatively specialized nature to so much of children's health and children's health care. Fortunately, in many cases, the number of children who need that specialized care can be quite small. We're never going to be able to be in the place where we have as many specialized professionals in every single location, but by virtue of communication technologies, we can do a far better job of enabling and supporting those who are in rural and remote communities. That is particularly primary care and family physicians with that additional level of support and expertise.

If we go back to the role of a national child health strategy and the federal government helping to create the infrastructure both, again, from the hardwiring technology and software perspective but also from the support to networks of researchers at the front line of care providers and then, of course, to parents, youth and families to help them.... Much of this is about the information they need. Put all those things together and we can make a really big difference.

I point first to that. It's not rocket science. It is communication technology, but it's something that we have at our disposal right now.

● (1225)

The Chair: Thank you, Mr. Squires.

Next is Mr. Lake, please, for five minutes.

Hon. Mike Lake: Thank you again, Mr. Chair.

I want to dive into a conversation about dental health for a second. In prefacing, I mentioned my son earlier. At 26, he has some teeth-grinding issues and things that really do impact him. The importance of dental care is not lost on me.

It's interesting that we wound up in this conversation where we're putting together a list of things facing kids. We're talking about dental and we're talking about mental health almost like equal things on the list. Certainly, governments can tackle multiple priorities at the same time. I do notice though that in the Liberal platform there was no mention of anything related to dental investment and a promise of $4.5 billion for a mental health transfer.

I do notice that of the witnesses who have come before the committee, almost none of them have talked about the dental crisis we have in Canada, but many have talked about the mental health crisis. Almost everybody has talked about the mental health crisis that we have in Canada.

I have a really straightforward question. In pediatric emergency rooms across the country, where is the most pressing need, if you were to compare the dental crisis in pediatric emergency rooms versus the mental health crisis in pediatric emergency rooms across the country?

I understand that we can certainly invest in both things, but you are folks who live in the real world where you're making decisions based on priority and triage every day.

Maybe, Dr. Drake, I'll go to you first and put you on the spot.

Dr. James Drake: I think what you're asking is actually an extremely complicated question. I don't think there's an easy answer here.

I do think that the health care leaders, such as you have here today, and the health care physicians and nurses are the best ones to try to prioritize what is really important and what is falling behind compared to others.

We get into this discussion all the time. The best one I can give you is you have two patients who are waiting for emergency surgery, and it's up to the surgeons to decide between a neurosurgeon and a cardiac surgeon who's patient needs to go first.

You're talking about very different things. There are universal measures of health care and of well-being. I suppose that's one way of doing this, but to try to compare one group of illnesses to another one is extremely hard to do. The problem is that they are all important. There are ways of looking at what are the impacts to these patients both in the short term and the long term. There are measures out there. I'm not an expert on them. That is one way trying to get at what really is the biggest problem.

● (1230)

Hon. Mike Lake: Maybe I'll phrase it a different way.

Did you or any of your organizations advise the government that while they made a $4.5-billion promise on mental health, they ought to focus on dental care instead? They've clearly changed directions from what they promised in the election a year ago. Did any of your organizations say to the government, “Hey, dental care is a more pressing priority”?

Dr. James Drake: This is above my pay grade. I would defer to our CEO, or Dr. Munter here.

Voices: Oh, oh!

Mr. Alex Munter: If you're going to give me a medical degree in the process, I'm happy to answer the question.

Voices: Oh, oh!

Mr. Alex Munter: Mike, in Ottawa at CHEO—these are the numbers I would be familiar with—only one in eight children whose severe dental pain requires hospital care gets it in the clinically appropriate wait time. We do have a serious issue there. The Canadian Paediatric Society for many, many years has been calling for expanded access to dental care, just as they've called for expanded access to mental health care.

As Jim says, we don't really have the luxury in our organizations of turning away sick children on the basis that their disease, their syndrome or their disability is not a public policy priority. We should be able to do both. That's what I'm getting to.

Hon. Mike Lake: Exactly.

Mr. Alex Munter: Certainly, we've had a historic underfunding of the mental health and addictions system that has collided against a very significant increase in demand, particularly starting in 2009 in the child and youth health world. That needs to be resourced. That needs to be responded to. At the same time, we have kids in pain because they can't get dental surgery, which is the part of it that we would see, with seven-eighths of them not getting that surgery in time.

So it's both. We need to respond to both.

The Chair: Thank you, Mr. Munter.

Dr. Powlowski, you have five minutes, please.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): Let me pivot from comparing apples and oranges to talking about some totally different bananas here—surgical backlogs and long wait times. Certainly, this has adverse effects on children's health. It's also very stressful to both the children and their parents. What can we do about it? How much is the solution more money in the system?

Dr. Drake, you already talked a bit about it. There are only so many surgeons, only so many anaesthetists, only so many OR nurses and only so many ORs. Do you have the capacity to ramp it up to do more surgeries to address this backlog? You talked about already working on weekends. How much more could you or would you want to work in terms of working evenings and weekends in order to address this problem?

Dr. James Drake: It's a really good question. I think the issue with the backlog is that we think this is a temporary problem that we can get beyond, assuming that we can get the health human resources that we need. But how do we hire into something that's going to last two or three years before we clear this? Then what do we do?

We think this issue about access to health care is going to continue well beyond the impact of this pandemic. We are currently hiring as many people as we can for nursing, and for physicians and surgeons, etc. The issue is, how do we keep these people? At SickKids we are over-hiring as much as we can and we are not able to actually keep our heads above water. At the moment, for example, at SickKids we normally would run 16 ORs. Now we can only run 14, because we don't have the nursing support.

The physicians, the nurses, everyone is willing to do this. We are willing to work evenings and to work weekends, but we need the people in place to do that. It's going to last for several years. Then once we get beyond that, we think it's going to require additional resources to keep things under control.

● (1235)

Mr. Marcus Powlowski: I think one of the impediments to ORs is alway OR time and not having enough ORs open. Would more money in the system allow you to open more ORs to be addressing the backlog?

Dr. James Drake: There's been a lot of discussion today about money and outcomes and how we compare to other developed health care systems. I think that it's not the only solution.

The issue of efficiency has been brought up today, and it's obviously extraordinarily important. I can assure you that all the children's hospitals are working on how they can become more efficient in what they do—that's certainly something that we focus on all the time—and that's things that we're trying to improve in terms of improving the health care that we can deliver.

Funding is, obviously, extremely important. It's really important, but I think it has to be taken—

Mr. Brendan Hanley: Mr. Chair, I have a point of order.

I'm not hearing anything. I don't know if it's just me.

The Chair: Can the other participants online hear okay?

Dr. Quynh Doan: Yes.

Mr. Bruce Squires: Yes.

The Chair: I think it's just you, Dr. Hanley.

Mr. Brendan Hanley: It must be just me. I'll try to adjust accordingly then.

Dr. James Drake: I think the most important thing is to see children's health care as a very top priority, and I'm not sure that's universally accepted, so I think that's the first thing.

The second thing, I think, is encouraging investment in regional approaches in terms of how health care is delivered. The physicians are willing, so we are willing to have the first available surgeon and the patient on the longest wait-list—whoever is most appropriate to look after that patient.... However, we need to be integrated across hospitals in order to do that properly.

Mr. Marcus Powlowski: I see Mr. Squires' and Dr. Doan's hands up. Do they want to answer the same question?

Mr. Bruce Squires: Yes, if I could, just really quickly. I absolutely support Dr. Drake's responses but would add that, yes, the answer is that additional investment in an under-resourced children's health system would make a difference.

I just want to highlight for this table how small our current investment is in children's health as a percentage of the overall investment in health care across Canada. Specific to Ontario, the Children's Health Coalition, which includes all the children's hospitals and the organizations representing child development institutions and community mental health agencies, put forward a plan to really address making kids count and improving our children's health system.

The total cost is about $250 million per year, perhaps a little bit more. That's relative to a $75-billion health care budget in Ontario, so if you think about those numbers across the country, it's a relatively small amount that will make a difference.

The Chair: Thank you, Mr. Squires.

Dr. Doan, I know you want in on this. We're past time, so if you could be succinct, it would be greatly appreciated.

Dr. Quynh Doan: Thank you, yes.

I just want to add that you can't look at any one of these problems independent of the others. They're balancing measures. It's not just the OR time. Once they're done the operation, they occupy a bed for some days. That's a bed that we can't admit a sick patient from the emergency department up to. Everything has to be balanced at the same time.

● (1240)

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

[*Translation*]

Mr. Garon, you have the floor for two and a half minutes.

Mr. Jean-Denis Garon: Thank you, Mr. Chair.

I will leave Mr. Munter alone for a few minutes.

Dr. Drake, when we...

The Chair: Just a moment, Mr. Garon.

[*English*]

Mr. Garon and Mr. Munter, the rule of thumb in the committee is that the witness is allowed as much time to answer the question as the person posing the question takes, with some flexibility.

[*Translation*]

You may start over, and I will interrupt the witness if I have to.

Mr. Jean-Denis Garon: I am not sure I understand what you just said, Mr. Chair. Could you repeat it?

The Chair: I said that, according to committee rules, witnesses may give an answer that is long as the question.

Mr. Jean-Denis Garon: Is that a way of saying my questions are too long?

Voices: Ha, ha!

The Chair: Mr. Garon, you have the floor for two and half minutes starting now.

Mr. Jean-Denis Garon: Dr. Drake, looking at rising costs to health care systems in recent years, we see that inflation or real economic growth of 2% or 3% used to cause a cost increase of 5%, 6%, or 7% to health care systems, depending on the province.

Please tell us what role the increasing cost of acquiring new technologies plays in these rising costs for health care systems.

[*English*]

Dr. James Drake: That's a really important question. In fact, the technology that's used in health care has a cost increase that's well above the annual rate of inflation, so the technology costs typically increase on the order of 5% to 10% per year. It's something that we really struggle with in trying to have the most updated technology for our patients as we absolutely can. It's also worth saying that most of the technology that's developed in the health care system is developed for adults, because children represent a smaller proportion of the patients who are receiving care.

We have to adapt adult health care to children, and it's not a simple translation. It's really important that we stay current in terms of our health care technology. For example, we all struggle with having the most up-to-date MRI scanner or the most up-to-date nuclear medicine scanner and so on, and it's the same with operating room equipment.

It's a really important problem, and I don't think there's an easy solution.

[*Translation*]

Mr. Jean-Denis Garon: I would like to go back to something Mr. Munter raised earlier.

At your hospital, Dr. Drake, to what extent do you rely on philanthropy to purchase the most important technology for children's health care?

[*English*]

Dr. James Drake: Yes, we rely quite heavily on philanthropy and, fortunately, Canadians are amazing in the way they step up and see that children's health care is extremely important. They seem very willing to help support us, but we still struggle to stay abreast, particularly for the very expensive pieces of technology such as an MRI scanner.

[*Translation*]

Mr. Jean-Denis Garon: Thank you.

[*English*]

The Chair: Thank you, Dr. Drake.

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

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

To any of the children's hospital administrators, if you know, what is the hospital bed capacity and occupancy of children's hospitals in Canada? Does anybody know?

Mr. Bruce Squires: I'll take that question.

We don't currently have a system that allows us, on a real-time basis, to track occupancy or even bed capacity across Canada, so again, the short answer is, right now, no. We cannot tell you exactly what that occupancy is, but I can tell you, as I talk to my colleagues across the country, what they are saying—and you heard it earlier from Mr. Munter—is what we're seeing this September is far in excess of what we've ever experienced. We always have a little bit of a bump in emergency department visits and in-patient occupancy at this time of year as we return to school, but this year the pressures are unprecedented.

We speculate that is related to a more significant viral surge, and we have some evidence that's what was experienced in the southern hemisphere, particularly as it relates to influenza and RSV, not actually COVID. Really, the key point is, in the current context, including with the HR challenges you've heard about, children's hospitals across the board are struggling to handle that increased demand.

● (1245)

Mr. Don Davies: Can I assume that your pediatric hospital beds are all full at any given time?

Mr. Alex Munter: We are at 105% today. I checked that.

The stats I know are from Ontario. We have approximately 900 pediatric beds, and the bulk of those are in children's hospitals, and then there are some small pediatric units in larger community hospitals principally in the GTA. We have fewer than 100 pediatric critical care beds in Ontario. The Ottawa Hospital has more critical care beds for adults than the entire pediatric critical care system. It's a small system and, therefore, it's a fragile system. It's historically undersized and certainly undersized relative to the demand that we are now experiencing.

The other thing to say about pediatric care that's important is that so much of it is on an outpatient basis. At CHEO, 80% of all surgeries are day surgeries. We've hundreds of thousands of outpatient clinic visits. Much of our activity is not on the bedded side of our operations but on the outpatient side.

The Chair: Thank you, Mr. Munter.

We now have Dr. Ellis for five minutes.

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

I have two questions for both Dr. Drake and Dr. Doan.

We know there's significant pressure on the health human resource part of our system. The two questions are these: Do we need to change how we primarily pay physicians, meaning, move precipitously away from fee for service? Do we need to pay physicians more?

Just to be clear, I'm not practising at the current time, so it's not a vested interest question.

Dr. James Drake: I think there's a particular issue around pediatric care that perhaps isn't recognized. Particularly with pediatric surgeons, we recruit people from all over the world, because the number of specialists in, for example, pediatric cardiac surgery or pediatric orthopaedic surgery, is small. It's a very small pool of people we can access, and we are competing on the global stage. We compete with organizations in the States and the U.K. You name it and that's where we're competing. We really do need to have competitive salaries.

One example I can give you is that, in the last three years, 35 physicians and surgeons have left SickKids, usually for what we would call a lateral move. We struggle to compete, particularly with the United States, but also with other jurisdictions.

The issues around how physicians are funded are important, but I would say we have an even bigger problem at the moment with nursing. It's very hard for us to compete at the moment with the United States in terms of nursing. One solution proposed is to make the certification process much faster, in order to make immigration much easier, because there are many individuals around the world—that's where we need to recruit from—who would be very interested in coming here. We need to make it as convenient as possible for them.

Mr. Stephen Ellis: Through you, Chair, Dr. Doan, could you give us a comment on that, as well, please?

Dr. Quynh Doan: I agree with what's been said, but I would also add that, at this stage, the working conditions are so difficult and the moral injuries have been so impactful that it's not just about the funding model. It's also about healing the system and making it available for us so we can do the work we come in to do.

Coming into the emergency department and being told, “There are 10 patients waiting for a bed. You have no beds tonight, so do whatever you can in the emergency department” is demoralizing, so people are leaving the practice. A lot of my colleagues are running a pediatric clinic in the community rather than taking shifts in the emergency department because it's so brutal.

It's not just about how much you pay them. It is also about fixing the system so they can actually do what they are meant to do when they come into work.

The second thing is location. In B.C., we're having a hard time recruiting, because the cost of living is so high compared to the salary. It's not one-size-fits-all across the country, essentially.

● (1250)

Mr. Stephen Ellis: Thank you very much, Dr. Doan.

Mr. Munter, I really like the idea of this 1Call1Click program you developed in partnership with RBC, funding-wise. What are the barriers preventing other jurisdictions from adopting that same program? I look at our hospital, the IWK in Halifax. To me, this is an ideal program. How do we get better at sharing innovative ideas like that?

Mr. Alex Munter: It's a great question.

It's the only model of its kind in Canada and we're proud of the innovation. The folks who developed it and who are expanding it are certainly presenting it in many environments. I'm sure they'd be happy to go to Halifax, Nova Scotia—it's a beautiful place to visit—and share the model and information. It's certainly a scalable model.

I would say one advantage we have in Ottawa related to child and youth health, but also other parts of the health care system, is that—Nova Scotia might be similar—we are big enough that we have a series of specialized services: a children's hospital, francophone and anglophone addictions treatment facilities, crisis programs and so on. We're big enough that we have a comprehensive system, and we're small enough that we can all get in a room and figure it out.

Some places are too small. They don't have the organizations, or the scale isn't sufficient. Toronto, for example, is too big. It's much harder to organize a larger number of providers and organizations around systems.

I think, in Ottawa, we're in a bit of a sweet spot, but I would expect, knowing the folks at IWK and the role they play in the province, that Nova Scotia is probably a comparable scale and can pull off some of these kinds of innovations.

I'll send you the information about 1Call1Click.

The Chair: The last round of questions today will be posed by Mr. van Koeverden for the next five minutes.

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

Thanks so much to our witnesses today for their extraordinary contributions to today's meeting.

Mr. Munter, I think our moms would get along very well.

My question today turns to the reality that I think we all agree on, which is that we need a better strategy to address children's health in Canada. Can you talk a little bit about the nuts and bolts of that just with respect to what your priorities would be for a strategy to address children's health in Canada, and your comments or your reflections on the need to address preventative health care?

We did talk a lot about surgeries for spina bifida and childhood cancers and things like that. I'm not suggesting that any of those might be affected by lifestyle, but are there any ways that we can address childhood health from an interventions perspective, a prevention perspective? What would your priorities be in that regard?

Perhaps I would start with Bruce.

It's nice to see you on Zoom. I hope to visit you at McMaster sometime soon. Thank you for the tour a couple of months ago. It was extremely informative.

Mr. Bruce Squires: Thanks very much.

Certainly, I would welcome all members of the committee to join us. I know that our colleagues right across the country would always be very keen to show folks around.

I really appreciate the question; I think it's a great way to finish.

Clearly, your question is premised on that we will have a child and youth health strategy put forward for Canada, so where do we start? With such a long list of opportunities, I point back again at a few things. First of all is a source, the “Inspiring Healthy Futures” report which, by the way, was produced by four of the leading national health organizations, including UNICEF and CIHR. They listened to children, youth, health providers and multiple sectors—education, social services, justice—and all of our communities in developing, really, a comprehensive framework and component. I'd really point the committee back to the “Inspiring Healthy Futures” report.

Then I would highlight again that we need a national health data strategy that relates to children and youth. We actually don't track how we're doing in terms of health. As much as we've talked about performance, we don't know, in a comprehensive and ongoing way, the health of children, youth and their families across Canada. As I said, then we can use that to inform a health research agenda, a health information knowledge transfer agenda and, ultimately then, guiding policies around priorities, which, as you've already heard, certainly rest in mental health but also in addressing inequities in health status outcome and access across the country.

Thank you so much for the question.

● (1255)

Mr. Adam van Koeverden: Thanks, Bruce.

Is anyone else eager to answer?

Mr. Munter.

Mr. Alex Munter: I would agree with that.

I have two quick things.

One is that, in overarching policies related to health, there be a dedicated child and youth component. Jim has spoken about some of the challenges in the recruitment of specialized personnel. Again, Ontario is what I know. Ontario data at the moment would tell you that there's no increase in volume in emergency departments, and it would tell you that primary care has recovered its volumes. That's true for the system as a whole; it's false for children. More children are going to emergency departments, and primary care is not seeing as many kids. So when you look at the whole system, kids get washed out in terms of impact. That's the first thing. Any broader strategy needs to have a carved-out, focused attention to children in health.

The second is to remember that one of the things that makes pediatric care different is that intervention can be prevention. If we talk about mental health, we know that two-thirds of adult mental health conditions and addictions trace their onset to adolescence. If we can intervene effectively in adolescence, that is actually prevention. It's treatment. It's treatment in the moment, but it is prevention of illness, need and cost later on.

Mr. Adam van Koeverden: Thank you.

I'll ask very quickly if Dr. Doan or Dr. Drake have brief comments to finish this off.

Dr. Quynh Doan: Yes, thank you.

I would like to echo the previous witnesses' recommendations.

From a perspective of someone who applies for a research grant, researchers are always asked if they are working with knowledge users and policy-makers to make their research applicable and useful. I would say for accountability for funding, the reverse should also be applied. When funding is distributed, there should also be a commitment to work with clinicians, scientists and researchers to put in place the measures and evaluation to measure the impact of that funding and investment.

Dr. James Drake: I would finish with something you've already heard so far with this group.

It's really important to remember that children are not little adults. They are our future. The decisions that we're making are going to affect them for generations. That's where we are coming from.

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

It's an excellent, thoughtful note on which to finish.

When we hear the challenges that you are facing in your everyday professional lives, I can't say it emphatically enough: Thank you for what you do. It has to be difficult, clearly.

It also underscores how valuable your time is. We very much appreciate that you came here and so patiently answered all of our questions and provided us with a ton of information that's going to be extremely valuable in our work.

Thank you very much on behalf of the committee.

Colleagues, I understand that we're going to have the draft report on health human resources in our hands, hopefully by the end of today so we're well positioned to review it next week.

Is it the will of the committee to adjourn the meeting?

The meeting is adjourned.

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