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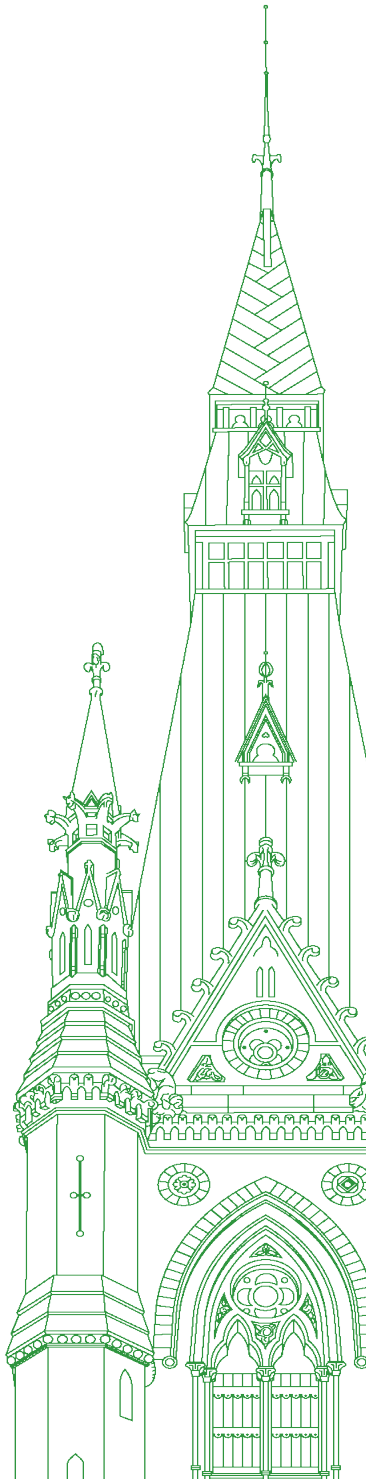

Chair: Mr. Sean Casey

Standing Committee on Health

Tuesday, February 7, 2023

● (1100)

[*English*]

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

Welcome to meeting number 52 of the House of Commons Standing Committee on Health. Today we meet for two hours with witnesses 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 have a few comments for the benefit of witnesses. Interpretation is available for those on Zoom. You have the choice, at the bottom of your screen, of either floor, English or French audio.

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

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

Just before introducing our witnesses today.... Colleagues, you will have had circulated to you—just today, I believe—a pretty extensive interim summary of evidence for this children's health study, as was requested at an earlier meeting. It's outstanding and timely work done by our analysts that I'm sure you're going to find quite helpful.

With that, I now welcome the witnesses who are with us this afternoon.

[*Translation*]

We have Catherine Haeck, a professor in the economics department at the Université du Québec à Montréal, who is appearing by videoconference.

[*English*]

We also have Dr. Bukola Salami, professor in the faculty of nursing at the University of Alberta; Ms. Leila Sarangi, national director, Campaign 2000, who is joining us by video conference; and Susan Bisaillon, chief executive officer, Safehaven Project for Community Living.

Thank you for taking the time to be with us today. Each of our witnesses has up to five minutes for an opening statement.

[*Translation*]

We will start with you, Ms. Haeck.

The floor is yours.

Ms. Catherine Haeck (Full Professor, Department of Economics, Université du Québec à Montréal, As an Individual): Good morning.

I am a full professor in the department of economics at the Université du Québec à Montréal. I specialize in the economics of education and work.

I am happy to be with you today.

My research over the last 15 years has focused exclusively on children and families and on inequality and how it is transmitted from generation to generation. In all my studies, I pay particular attention to large-scale programs and interventions that have an influence on the development of children and families. To do this, I use high quality microdata and causal inference techniques to establish a causal connection between those interventions and children's development or families' welfare.

I have done several studies on numerous subjects, including Quebec's prenatal nutrition program and reduced-contribution childcare programs. I have also looked at the federal reform of parental leave, class size, and the effect of repeating a school year on children's development and academic success. Many subjects have therefore been studied, and when the pandemic happened, I was contacted to do studies that dealt more with children's development in the context of the pandemic.

At the beginning of the pandemic, I set about reading everything that was written about the repercussions of school closings on children and youth. In this regard, I observed that we had a huge amount of information about what was going to happen. We were not working in a total void. There had been events in the past from which lessons could be learned. We had seen that when schools were closed, learning disparities grew. In general, those for whom it is easy will continue to find it easy and get good results, and those for whom it is harder will fall behind; the longer the schools are closed, the farther behind they will be.

We had estimated that the gap between the strongest and weakest would grow by 30% as a result of the closings that took place in the spring of 2020, at the start of the pandemic. That article was published in the summer of 2020, during the pandemic, in “Canadian Public Policy/Analyse de politiques”, which is a serious journal in Canada. Studies then multiplied all over, and confirmed that performance gaps were growing.

In the middle of it all, I became the co-director of the Observatoire pour l'éducation et la santé des enfants, which is based at the Hôpital Sainte-Justine here in Montreal. That observatory was created to monitor children's development during the pandemic and to evaluate various strategies or interventions that could be used to mitigate the effects of the pandemic, and especially of lockdowns, on children.

One of the studies we conducted was done in collaboration with Quebec's ministère de l'Éducation. We had 10,000 Quebec children take a standardized test to learn their level of knowledge of French, and specifically in reading. The test we used in June 2021 was exactly the same as the one that had been used by the Government of Quebec in June 2019. We were therefore able to do a real apples to apples comparison. Approximately 10,000 children took the test in June 2021, and we observed that the strongest 20%, the ones for whom things were very easy, were still just as successful on the test, while the weakest children had fallen well behind. Those results were confirmed by the recent results we have seen in Quebec, in the departmental examinations that took place in June 2022. So that is no surprise. We were expecting it. I did a number of media appearances in April 2020 to try to alert people to the importance of thinking carefully about closing schools and making sure it was a good practice.

Other studies have been done by people at the Observatoire that relate more to mental health, but we have really observed repercussions on mental health everywhere in the world. The hospital data we have here, from Sainte-Justine and elsewhere in Quebec, indicates a rise in visits associated with suicide attempts or suicidal ideation. In fact, that data was updated yesterday in Quebec, and we see that this trend is continuing. We therefore see a deterioration in our young people's mental health. We also see a decline in physical activity and a rise in time spent in front of screens and eating junk food.

I think my five minutes' speaking time is up, but I could continue talking about this subject for a long time. Overall, the effects on children of the pandemic and the measures that we chose to implement in Canada are not negligible.

● (1105)

The Chair: Thank you.

[*English*]

Next we're going to hear from Dr. Salami, a professor in the faculty of nursing at the University of Alberta. Welcome to the committee, Dr. Salami. You have the floor for the next five minutes.

Dr. Bukola Salami (Professor, Faculty of Nursing, University of Alberta, As an Individual): Thank you so much, Mr. Chair, for the opportunity to speak to you today on children's health and the COVID-19 recovery.

Just as a reminder, we are situated on the unceded territory of the Anishinabe Algonquin nation. I pay respect to the first nation, Inuit and Métis peoples of Canada, whose presence continues to enrich our vibrant community.

I am a professor at the faculty of nursing, University of Alberta. I'm also the director of the intersections of gender signature area, which is one of five main signature areas of research excellence at the University of Alberta in the vice-president's research office.

My area of research is on racialized Black people and immigrant health in Canada. I've been involved in around 8,500 research studies on this topic.

According to the UNICEF report on child health globally—and it's been discussed in previous sessions—we know Canada has poorer health outcomes for children than other high-income countries, ranking 30th out of 38 countries in 2021.

Canada has one of the highest rates of adolescent suicide due to health inequities. I know Mr. Don Davies and some others have asked why we rank so poorly.

If we want to make a significant cut to that, it will be for us to consider the inequities that indigenous children face in Canada. For instance, Inuit people have a 6.5% higher suicide rate than non-indigenous people in Canada. If you could half that, you'd be able to make tangible and sustainable gains. Addressing health disparities faced by indigenous populations will yield many gains in improved child health outcomes in Canada.

We have seen the consequences of these inequities in the case of the COVID-19 pandemic. Prior to the pandemic, authors widely said that income was the strongest social determinant of health, while COVID-19 told us that it may not be the most accurate.

COVID-19 indicated that racism can reproduce as well as intersect with income to contribute to poor population health outcomes. Data from Montreal, Toronto, Ottawa and other cities indicate that neighbourhoods with the highest numbers of Black people have a higher rate of COVID-19 than neighbourhoods with lower concentrations of them. In 2020, being Black was associated with increased risk of death from COVID-19.

The influence of the concentration of Black people in the neighbourhood was much stronger than the influence of income inequality in the neighbourhood. The central reason for these disparities is not biological or genetic. Rather, it's because of systemic and structural racism and the inequities that this racism reproduces, including income inequalities and spatial inequalities.

Over the last year we have interviewed Black youth in Canada. We've also surveyed, or are in the process of surveying, around 2,000 Black youth in Canada to shed light on the impact of the COVID-19 pandemic on their mental health.

What we know from the interviews is that from 2020 to now, Black youth have been dealing with two pandemics: the COVID-19 pandemic and the pandemic of the Black Lives Matter movement. Black youth have experienced both oversurveillance and retraumatization from constantly watching news about the Black Lives Matter movement.

For many Black youth, also, sport is their outlet to de-stress and to overcome many societal inequities. The closure of recreational facilities and lack of access to sports had an impact on the mental health of Black youth.

Financial and food insecurity was a challenge for youth. Youth, especially those with disabilities, informed us of their experience of begging for food and going to churches just for the purpose of finding food available.

Some youth experienced separation from their families and challenges reuniting with them due to border closure and immigration restrictions.

Youth also experienced barriers in accessing mental health services. While virtual delivery of mental health services provided some solutions, it also caused some challenges. Youth indicated that the virtual delivery of services contributed to a lack of empathy from service providers, and that it was often a challenge to maintain confidentiality. Sometimes a service provider would call them and their parents would be right there—they wouldn't really want to verbalize.

The lack of representation of Black people in the provision of health services is a barrier to accessing mental health services. Despite this, Black kids were resilient. Youth also drew on their inner strengths, community and spirituality to improve their mental health.

● (1110)

Based on the findings we have conducted so far we have some recommendations.

Reinvest in sports participation for youth.

Invest in targeted interventions for high-risk, racialized populations, especially indigenous and Black youth in Canada.

Invest in programs that strengthen community belonging and positive identity, such as parenting programs and mentorship programs.

Address racism experienced in the school system.

Diversify the health workforce, improving access to the profession for internationally educated professionals and implementing measures to ensure the upward mobility of indigenous, Black and racialized professionals and mentorship of Black, racialized and indigenous youth.

Include accountability in anti-racism initiatives, including having anti-racism as an evaluation criteria and as a standard of practice for all health care professionals.

Build and capitalize on the resilience of indigenous, Black and racialized youth, and amplify public information about the contributions of Black and indigenous people to Canada.

Build the capacity of informal support networks such as churches and community leaders, while offering the first point of contact in cases of mental health challenges.

I believe these strategies will contribute to positive health outcomes among Black, racialized and indigenous populations in Canada.

Thank you.

● (1115)

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

Next we have Leila Sarangi, national director, Campaign 2000.

Welcome to the committee. You have the floor.

Ms. Leila Sarangi (National Director, Campaign 2000): Hello. Thank you, Chair and members of the health committee, for the opportunity to speak today.

Campaign 2000 is a non-partisan, pan-Canadian coalition of over 120 organizations working to end child and family poverty.

We submitted a brief to you that we co-authored with colleagues at PROOF, a research program based out of the University of Toronto that focuses on policy interventions to address food insecurity. We are recommending several changes to the Canada child benefit as a key tool enabling the federal government to improve children's health. These recommendations would enable the CCB to have a bigger and broader impact on reducing poverty and food insecurity in Canada.

Our recommendations are these.

First, increase the CCB amounts for the lowest-income households so that there is a targeted focus on families living in deep poverty, by creating an “end child poverty” supplement for families living with incomes below the low income measure, as modelled in the 2023 alternative federal budget.

Second, create an additional supplement to provide more money to low-income families in remote and northern communities.

Third, enable families with precarious immigration status to access the CCB. Many are considered residents under the Income Tax Act, but eligibility for the CCB is arbitrarily tied to immigration status. This means that even though these families work and file taxes and may have Canadian-born children, they are ineligible for the benefit.

Fourth, end the ongoing clawbacks of the CCB for moderate-income families who received emergency pandemic benefits.

There is an inextricable link between poverty and ill health. Research shows that poverty is causally related to children's developmental outcomes. Poverty is one of the strongest and best-established predictors of poor health and child development.

In 2019, more than 1.3 million children—nearly one in five children—lived in families with low incomes in Canada. Their average income was 37% below the low income measure. This is a matter of health equity, as we just heard, since child poverty rates are significantly higher for groups facing colonization, systemic racism and marginalization.

In 2020, despite a global pandemic, we saw rates of child poverty being reduced significantly because of large investments in income transfers to families. These benefits have all expired, and Statistics Canada is predicting that poverty will return to prepandemic levels.

Household food insecurity is the inadequate or insecure access to food due to financial constraints. It is a potent social determinant of health, with associated health disadvantages being similar to those of low income. Living in a household struggling to afford food is toxic to children's health and well-being in ways that are not limited to poor nutrition. These children are at greater risk of mental health problems like anxiety, depression and suicidal ideation.

Food insecurity is not just about food, but rather about the household's financial well-being. It is a marker of pervasive material deprivation, and at its core is a problem of income inadequacy.

The persistently high proportion of children living in poverty and in food-insecure households demonstrates that the CCB has not provided enough money to enable families to be secure. In 2021, 1.4 million children lived in households affected by food insecurity across the provinces. In Canada, the mere presence of children in a household increases the probability of food insecurity. The situation is especially dire in Nunavut, where almost 80% of children live in food-insecure households.

As the primary federal policy supporting low-income families with children, the CCB has the potential to have a much larger impact. It is currently failing to live up to this potential, because it is not providing enough money to lift families out of poverty, and there are barriers to accessing it for families from systemically marginalized communities. The exceedingly high proportion of children affected in Nunavut also demands special attention in the form of an additional supplement for northern families that addresses the high costs of living.

Policies that have increased the financial resources for low-income families have repeatedly shown that they lower food insecurity among families. Considering the strong relationship between food insecurity, poverty and health, the Canada child benefit is very much a health policy. CCB enhancements and reform stand to protect children and their families from circumstances that are very toxic to their health.

Thank you for your time today. I look forward to answering any questions.

● (1120)

The Chair: Thank you, Ms. Sarangi.

Finally, we have Susan Bisaillon, chief executive officer of the Safehaven Project for Community Living.

Welcome. You have the floor.

Ms. Susan Bisaillon (Chief Executive Officer, Safehaven Project for Community Living): Thank you for inviting me here today.

Safehaven is an organization that provides community-based care—respite and residential—to children, youth and adults who live with complex medical needs and disability. We've been around for over 35 years. We have six locations in the greater Toronto area.

We believe our clients have the right to belong in all aspects of society. We're continually striving to advance our work towards inclusiveness with our #WeBelong movement.

Today I would like to highlight how investments into community-based care models for children with disabilities can liberate capacity in our struggling hospitals, provide choice and enhance the system of care. As well, I would like to identify the need for providing enhanced funding to support individuals directly, along with the need for creative housing solutions to ensure that individuals with disability are able to transition into adulthood with dignity and respect when they turn 18.

While our organization operates in Ontario, I know I speak for my colleagues across the country, as our funding and systems of support for vulnerable individuals in Canada aren't adequate.

Safehaven is a unique provider in the province and across the country. We care for children with incredibly complex needs and rare conditions. We are a critical part of the care continuum with our children's hospitals, which are continually under siege with capacity limitations and challenges with health human resources. Many of our clients come from SickKids and Holland Bloorview after very lengthy hospital stays.

Our current system is failing our kids, but we have the opportunity to make it right. Safehaven cares for the most vulnerable children, the ones who were never expected to make it. However, thanks to medical advancements, innovations in care and some of the best pediatric hospitals in the world, these children's lives are being saved, and many are now living into adulthood.

The physical, emotional and financial burden on families who care for a child with complex special needs is enormous. If they are able to care for their child at home, almost always one of the parents is required to quit their job and stay at home as a full-time care provider. Some families cannot cope and resort to giving their children over to government care. It's an act of desperation, but they have no other option to access help, support and services because of the long wait-lists. I'm sure many of you here today are parents and see this as being unconscionable, yet this is happening in our country.

Ontario's Financial Accountability Office detailed that the wait-lists for children's services grew from 1,600 in 2012 to 27,600 in 2020.

Safehaven regularly hears first-hand from families in need of services for their children with developmental disabilities. We are met with requests weekly from families across the province for respite care. We were able to accommodate only half of the families who requested care, due to capacity and eligibility restrictions.

There's a particular challenge with transitioning from children's services to adult services, because these children were never supposed to make it to age 18. An integrated system of care was never developed for the duration of their lives. Parents describe going from childhood into adulthood as being like falling off a cliff. Instead of celebrating their 18th birthday, this is a dreaded milestone. As well, individual funding supports are extremely low for these children who age into young adulthood, if they survive, and this forces them to live below the poverty limits.

As Bill C-22, the Canada disability benefit act, progresses towards the Senate, I want to emphasize the importance of supporting programs like Safehaven, which promote inclusionary care for the most vulnerable. Specifically, children and those who transition into adulthood need a stable income and affordable housing.

These individuals deserve a right to life as much as anybody else or any other healthy child. A young adult should not be sent or even considered for long-term care.

Our proposed solutions focus on investments that need to be made now to make available spaces and programs for children, youth and adults and address gaps in our current system, enhance support for families who want to keep their children at home, and provide good respite programs and residential programs for parents as they age and can no longer care for their children.

Also, medically complex individuals need financial support to ensure that they escape poverty. The very complex children I'm speaking about today need a lifetime of care, from infancy to adulthood.

● (1125)

These are considered medical miracles. We need to ensure they are living longer and we have a system in place that can care for them.

They will never outgrow their disease. They will never recover or get better. They have the right to a safe and secure home and a system of care while they are alive. If we do not address the needs, the gap will only continue to get wider. These vulnerable children and their families deserve better.

The mantras of Safehaven and #WeBelong align with the four pillars of Bill C-22, the new legislation being proposed, with financial security, employment, accessibility, inclusive communities and a modern approach to disability.

We should all aspire to achieve a world where our kids belong to and are part of inclusive environments and communities. Thank you.

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

We will now begin rounds of questions, starting with the Conservatives, and Dr. Ellis, for six minutes.

Mr. Stephen Ellis (Cumberland—Colchester, CPC): Thank you, Chair, and thank you very much to the witnesses. Certainly, it's interesting at this panel to hear all of your statements from very different perspectives. Hopefully, we'll be able to have a rich discussion.

I'm a former family physician. One of the things that make me most sad is really understanding the plight of children in this country, and how government is failing them in terms of the financial needs they have at the current time. We know that's been declining.

Dr. Salami, I have a question for you. It's specifically related to the pandemic. You talked about particular difficulties that children from racialized communities may have experienced during the pandemic. At some point, I suspect that this committee, or perhaps Parliament as a whole, will need to address the pandemic response.

What I would like to hear from you, if I could, is this. What do you think we should have done differently during the pandemic?

Dr. Bukola Salami: It's not as much during the pandemic; it's what we should also have done before the pandemic. One of the things we didn't do so well was addressing issues related to systemic racism, which contributes to child inequities.

One of the big things we didn't do well before the pandemic was race-based data collection. Before the pandemic, we didn't really know about the disparities in health outcomes related to children. I did a review of the literature and found many studies that had been done on immigrant child health, but oftentimes we did not disaggregate that data by race. We lumped everyone together, and then we expected to find a solution. We know that if we had disaggregated the data and looked at Black people separately, we would have been able to have a much more targeted response to this.

The other thing we didn't do too well, which we started doing much better during the pandemic, is capitalizing and mobilizing opportunities related to health care professionals and health service providers, namely Black and racialized health service providers. That's one thing that has changed during the pandemic.

We now have many more Black organizations that have emerged. It's probably also from the influence of the Black Lives Matter movement. We have, for example, Black Physicians of Canada, the Black Physicians' Association of Alberta, and a Black nurses group.

We need to continue to capitalize on some of the strengths of some of those organizations in order to move some of our approaches and interventions along and positively influence the needs of communities.

Mr. Stephen Ellis: Thank you for that, Dr. Salami, I appreciate it.

My next question is for Ms. Bisaillon.

You talked a lot about children with rare diseases. Certainly, we see children with disabilities and rare diseases transition into adulthood, and often the transition is from a children's hospital to an adult hospital. We often have that difficulty. I think Canada is the only G7 country without a rare disease strategy.

Do you have any comments on that, on the difficulty it presents for children with rare diseases, and perhaps disabilities in general?

● (1130)

Ms. Susan Bisaillon: Thank you so much.

You're absolutely right. We do not have a rare disease strategy. For many of these kids who we have, their conditions have been diagnosed. I speak for individuals with medical complexity and rare disease.

Many of these kids were never expected to become adults. That's what I'm grappling with every day. Like I said, these kids were given a home for life in Safehaven when we started, 35 years ago.

You can see medical technology.... We have kids on ventilators. We have kids who are on G-tubes. We're really able to sustain life with a lot of medical technology. These kids are set up to actually live into adulthood.

The issue is that they require a life of care. The transition from childhood to adulthood is incredibly difficult. There is no well-established system. When you talk about rare disease and medical complexity, we need to have a very well-thought-out transition program and a safety net.

That's one thing I'm proud of. We just introduced a new program to enable 14 adults to successfully transition from childhood into adulthood. That was supported, actually, by the Ontario government. I would say it is not very usual across the country.

I think it's really important that we think, when these children are born, that they can potentially go into adulthood. What does that look like? How can we support them? We also need to make sure they have a home. You cannot think of good health in the absence of a home for these children.

I hope I've answered your question. For sure, we definitely need a very comprehensive, well-developed strategy from childhood to adulthood to support children with medical complexity and rare disease. I'd love to be a part of that and see it happen.

Mr. Stephen Ellis: Thank you very much.

I know I have limited time, Mr. Chair.

I'm wondering, Ms. Bisaillon, if you could table with the committee your actual approach to that transition for children from childhood into adulthood. I think it would be interesting for us to see.

Ms. Susan Bisaillon: Yes.

To give you a sense, I joined Safehaven just over five years ago. I spent most of my career in a large academic health sciences centre. I've certainly been very well exposed to the notion of medical complexity.

We developed a program and we felt it was important that it be seamless. When I first said we were going to create a seamless program from childhood to adulthood, people kind of looked at me and said, “Okay, that's very ambitious.” We just successfully transitioned those 14 individuals on the first of this month. We created spaces. We partnered with an organization so that we could have housing for them. They have secure housing. They have 24-7 care provided. They are now in what's considered an adult location. They have a home. It's really exciting for us. I think we're doing something that was never thought possible.

I think this is a model that can be packaged, scoped and spread across the country. I'm in touch with my colleagues in British Columbia and on the east coast. I know it is possible. It requires a commitment and partnership with governments at all levels to really look at housing, to look at how we actually transition the funding models that go with it. They need to have funding for the housing, and they also need to have funding for the care. It's really looking at that comprehensive approach to a system for housing and care.

Like I said, we just did the first 14. These are very complex kids. These are kids who lived in a hospital for a decade—

The Chair: Thank you, Ms. Bisaillon.

We want to try to allocate the time fairly, so that everyone gets a chance.

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

Mr. Brendan Hanley (Yukon, Lib.): Thank you very much to all the witnesses for coming. These are really interesting topics.

If there's one common theme emerging, it's about increasing...what we see in disparity in health outcomes when there's a stressor. Whether that stressor is the pandemic, economic difficulties or racism, the disparities are accentuated.

I want to go first to Madam Haeck.

● (1135)

My question is about whether there are some ways we can help to build resiliency to enable children at higher risk for worse outcomes to do better under stressful circumstances, whether that is the pandemic or the next stressor. How can we do that?

I would ask you to be fairly brief, as well, because I have some other questions.

[*Translation*]

Ms. Catherine Haeck: It is my pleasure to answer your question.

Ultimately, we have to take into account all dimensions of children's lives. The biggest ecosystem in most children's lives is the childcare centre when they are very young—in some provinces they are still at home—or the school when they are older. Clearly i, is extremely important to maintain the systems in which they develop in order to facilitate their success and reduce their vulnerability.

In our data, we observed a striking phenomenon. When a school is closed, the most vulnerable children are the most affected, because there is an entire ecosystem built around the school to help them. So we see that we could help these children more within the school structure, among other places. It would be desirable to do that.

It is therefore very important to maintain these systems and ensure that they stay open. We also have to preserve the services. When there are shocks, all of this becomes very important for these families, for all sorts of reasons. I could talk about this at length, because closing a school also has repercussions for parents and, by a ricochet effect, for children. When we are developing programs and policies, we have to make sure that the most vulnerable are protected.

Things always go well for the less vulnerable children. They come through it. They have all sorts of mechanisms around them that mean it will keep going and they will get through it.

However, when there are changes made, the situation can become quite serious for vulnerable children. The school closings, which lasted a very long time, were quite disastrous.

To be honest with you, I will add that it was really not possible to mitigate that. There was no way to replace daily human contact using Zoom, for example, particularly when we are talking about young children. It doesn't work at all. It is completely utopian to have thought we could replace the school.

Mr. Brendan Hanley: Thank you.

I am reluctant to cut you off, but I have other very important questions to ask.

Ms. Catherine Haeck: No problem.

Mr. Brendan Hanley: Thanks again. It is very important that we hear what you have to say.

[*English*]

Ms. Sarangi, I wanted to thank you for highlighting income disparities as a determinant to child health, for highlighting that gap. You talk about additional support for northern families, particularly in Nunavut.

I wanted to just focus on what you suggested about CCB, if we were to look at how we were to improve CCB, especially targeting children more at risk.

Could you elaborate a little on how you would see that working and how you might suggest that be structured?

Ms. Leila Sarangi: The 2023 alternative federal budget that gets released annually through the Canadian Centre for Policy Alternatives has put forward a model that is income tested. It's a supplement to the Canada child benefit that is income tested using tax-filer data.

The poverty measure that is calculated with tax-filer data is the census family low income measure, which is after tax and adjusted for family size. It's a relative measure of poverty that is based on median income. Anybody who's falling below that 50% median income is considered to be poor, according to that measure.

This supplement would target families below the low income measure. It would give them additional income based on—

[*Translation*]

Mr. Jean-Denis Garon (Mirabel, BQ): I would like to raise a point of order, Mr. Chair.

[*English*]

The Chair: Monsieur Garon.

[*Translation*]

Mr. Jean-Denis Garon: Mr. Chair, there is construction going on near our room. I don't know whether it is a torture chamber or something else. Unfortunately, it is preventing the interpreters from doing their job.

● (1140)

The Chair: Thank you, Mr. Garon.

I am informed that there has been an attempt to contact the workers to ask them to stop working.

We can suspend the meeting while we wait for the problem to be fixed.

It seems that someone is there to try to fix the situation.

[*English*]

Dr. Hanley, you have about another 90 seconds.

Mr. Brendan Hanley: Thank you.

Maybe I'll take this opportunity to move to another question. I think you pointed out a useful reference there.

I want to move to Dr. Salami and then save a few seconds at the end.

Dr. Salami, we heard a story in the media today about the lack of research on Black Canadians and cancer outcomes. It led to that theme of the research environment enabling adequate research on racialized or marginalized Canadians.

Can you comment generally on how you see the adequacy of funding and whether there are ways we should be improving that?

Dr. Bukola Salami: As I said earlier, we have a lack of data—disaggregated race-based data. There is a strong need for disaggregated race-based data.

When you talk about cancer, I just did an analysis of the Canadian community health survey and found that 18% of the Black population have never had a pap smear in their lifetimes. For white Canadians, it was 7%. That has consequences for health outcomes.

As you said, there are disparities in terms of data in cancer outcomes, so I think we need to do more, even in terms of children, to be able to address some of the disparities children face. We need the data out there. We need investment in research to be able to uncover what those disparities are and what the best approaches are to addressing some of those disparities.

Mr. Brendan Hanley: Thank you.

Do I have any remaining time?

The Chair: You do not.

Thank you. I'm sorry for the interruption, Dr. Hanley.

[*Translation*]

Mr. Garon, you have six minutes.

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

First, I would like to confirm that there is no torture in Canada. I therefore retract what I said earlier.

I would also like to take the opportunity to thank all of the witnesses for being with us today.

Ms. Haeck, last fall, an official appeared before the committee and said, in answer to one of my questions, that there were no studies about the effects of the lockdowns and school closings on children's health, socialization or mental health. I am a bit confused, because in your opening remarks, you suggested that those studies existed.

Can you confirm that that is actually the case?

Ms. Catherine Haeck: Yes.

Those studies exist and date from before last fall.

A lot of things were done during the pandemic. As I said, in the summer of 2020, we were already publishing things that gave an idea, based on what we knew from the earlier literature, about the consequences of the impact of school closings. We now have real studies, that were published before last fall.

Mr. Jean-Denis Garon: Thank you.

We are talking about children's health, but it is important to talk about healthcare funding. In fact, an important meeting is taking place today between the provincial premiers and the federal government.

I have the feeling that our healthcare systems have been underfunded for a long time, that the provinces had been experiencing shortfalls in federal transfers for a long time, and that, to a certain extent, children paid for adults during the pandemic. That is, to protect adults, who had more serious symptoms of COVID-19, we closed the schools because the hospitals did not have sufficient capacity.

I wonder whether the chronic underfunding of our healthcare system ultimately caused indirect harm to children's health. This is important, because it is a federal responsibility. Children's health itself is not, but healthcare funding is.

Do you agree with my interpretation?

● (1145)

Ms. Catherine Haeck: I agree entirely.

The Belgian schools were closed for much less time. I did my doctorate in Belgium, so I can tell you that the healthcare system in that country has much greater capacity. The system is able to absorb the cost. The schools reopened before the end of 2020, and they were able to measure the impact of the seven-week closing on their children. There were super data, which we do not have.

So it is certain that our system's weak capacity harmed our children. They paid the price, and they are still paying it today. I would really like people to bear this in mind: it is far from over. Adults have moved on to other things, but children are still suffering.

Mr. Jean-Denis Garon: Thank you.

Here in Ottawa, people want there to be conditions attached to health transfers, but what's funny is that there are so many needs all over, that the groups all come, one after another, asking for health transfers that are unique to their own fields. My conclusion is that there is a funding shortfall in general.

Because distinctive features would be needed everywhere, they would not be needed anywhere, in fact. This is particularly true for mental health, which is obviously not under federal jurisdiction, but nonetheless there is a Minister of Health in Ottawa.

If there were better funding for healthcare, stable, predictable, unconditional funding, would we have been able to do more mental health prevention with children in the last few years? What effect would that prevention have today, or what effect would it have had during the pandemic?

Ms. Catherine Haeck: I will give you an example.

I did a study of more than 800,000 children in Quebec using administrative healthcare data from Quebec. I found that we are unable to diagnose attention deficit and hyperactivity disorders properly in Quebec. In fact, that isn't just in Quebec; it's everywhere in Canada.

Because we do not invest enough in healthcare and healthcare services for children, we are unable to diagnose properly. So we find ourselves medicating children for nothing, without knowing the long-term effects of the drugs.

That is one of many examples showing that we are not focusing on prevention. Given that we are under-investing in healthcare, we do things in haste, and that has an impact on the education system. Teachers inherit these children who have not received proper care from the healthcare system.

Mr. Jean-Denis Garon: Obviously, I want to pick your brain about this. Do you feel that the federal government is in a good position to design services, to plan mental health services, to tell the provinces how to orchestrate them, and to assess the needs?

Do you believe that the brains of the thing should be in Ottawa, if we want to provide children with good services and be able to do prevention, particularly in mental health?

Ms. Catherine Haeck: No. Knowing what needs to be done and how to provide the services calls for on the ground expertise. You have to be very close to the ground, and while the federal government does its best, Ottawa is far from the ground. So it is not in a position to make this type of choice.

This really has to be left under the provinces' jurisdiction, particularly knowing that each province's situation is different, in terms of both its cultural community and its health problems, which may vary from one place to another. The provinces really have to be allowed to choose what makes most sense for them.

Services are organized very differently from one province to another already. If the federal government tries to get involved, that risks causing mayhem.

Mr. Jean-Denis Garon: I have 30 seconds left.

I'm going to follow up on what you said earlier. COVID-19, lockdowns, and the fact that the schools had to be closed because the hospitals were overflowing, had consequences for children's socialization, learning, and physical and mental health.

How long are these consequences going to be felt, do you think?

Ms. Catherine Haeck: It's hard to estimate, but certainly they are going to be felt for some time. That will be longer or shorter, depending on the age group. I think some age groups will have been affected much more than others, and I am not expecting that we will see the end of it for at least another five years.

I have no scientific basis to rely on in saying that, but some studies have been done. For example, a study was done in Chile on large-scale school closings, and the effects have been felt even into adulthood among some people who were affected when they were very young.

So it can last a very long time. It depends on the measures put in place: how long it lasts will depend on what we do. Personally, what worries me is that I feel that we are forgetting our children. I feel that we have moved on to other things, we are no longer investing in them, and we are no longer talking about the effects of the pandemic on children.

● (1150)

[*English*]

The Chair: Thank you, 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 for being here.

Dr. Haeck, I'd like to start with you, please. A peer-reviewed journal article co-authored by you discussed the need for a "unified monitoring strategy" to address data gaps on childhood development indicators in the context of the COVID-19 pandemic. You and your co-authors noted a lack of both intersectoral and longitudinal data.

There's going to be a lot of focus on data today, as the provinces gather with the federal government. I think we all acknowledge that the lack of unified longitudinal monitoring systems in most provinces and territories is cited as a barrier to the early implementation of preventative and therapeutic services.

The Manitoba population research data repository is provided as a positive model. Can you outline for us what the elements of Manitoba's data repository are that might make it successful?

[*Translation*]

Ms. Catherine Haeck: In fact, what would have the most success and be the best for us would be for the federal government to put systems in place to collect data about children, and for that data, which would be protected and high quality, to be hosted in data centres dispersed throughout Canada and be made available to all researchers.

Historically, we had access to very good data about children. It wasn't perfect, but it was very good quality. It came from the National Longitudinal Survey of Children and Youth, which was abandoned in 2008, at the time it was last published.

This type of data is extremely important for understanding children's development. We can't just rely on administrative data because, as other witnesses have said, administrative data does not show the child's cultural community or religious affiliation, for example. All sorts of dimensions are missing from administrative data, but they are very important for understanding children's development and welfare.

We need a central initiative that collects data from all over Canada so we can compare results from one province to another; that data set must be large enough to be able to study small groups. I heard other witnesses talk about the fact that we can't study small groups, but it's not because researchers don't want to. I assure you that we want to. However, when we are working with small samples, the data are not valid. When there are not enough people in the sample, we can't say anything about it and Statistics Canada doesn't even let us output the data.

I was a laboratory director at Statistics Canada for several years and I am very familiar with the machine. We need major funding from Statistics Canada in the area of children's health. Children represent almost 20% of our population, but I can assure you that Statistics Canada does not devote 20% of its budget to collecting data on children. The agency can put out the Labour Force Survey every month; it can...

[*English*]

Mr. Don Davies: I'm sorry. I'm going to stop you there, if I may, because I have other questions. Thank you for that.

I will move to Campaign 3000. I'm sorry—2000. It's inflation.

Voices: Oh, oh!

According to Stats Canada, one-parent families with young children are almost five times more likely to experience poverty than couples with children of the same age. You've clearly made a link between poverty and poor health in children.

In your view, what steps should the federal government take to address that disparity?

Ms. Leila Sarangi: I would point out that the majority of those families are led by single mothers, so intersectional, disaggregated data is needed to help us better understand who these families are. The supplement targeted to low-income families that I mentioned would drastically reduce the rate of poverty among lone-mother-led families from an estimated one-third to about 8%, and it would do that very quickly.

Mr. Don Davies: Thank you.

Dr. Salami, I'm a proud graduate of the University of Alberta, so I have to ask you a question.

You clearly linked the intersections of racism, poverty and health among Black youth in Alberta. I know you talked about the need for more research. From the research that has been done, have any solutions emerged that you would recommend we adopt?

Dr. Bukola Salami: One thing that has been repeatedly talked about on this panel is the need for us to focus on the causes of the causes. We've already mentioned some of those causes: income and racial and gender inequality. You talked about single-parent families. For example, I've done research, in the past, on single-parent moms. Black boys living in single-mother households face one of the starkest disparities in Canada, including in outcomes. Providing much more support is important.

When I've done interviews in the past, people also talked about parenting programs. Oftentimes, we think parenting programs are just for kids, but they're also for family health. Kids are situated within the context of families. When families have better health outcomes, it's better.

There's also the talked-about need for community-based mental health service delivery that is focused on not just institutions and acute care but also community. In terms of resilience, there's a need to create community belonging and strengthen positive cultural identity for Black and racialized communities. Spirituality is important, and building the capacity of religious and spiritual leaders. There's also access to sport and subsidizing sport participation, so people are able to capitalize and build on their resilience.

I would say that addressing racism is also of vital importance.

● (1155)

The Chair: Thank you, Mr. Davies.

Next, we have Mrs. Goodridge for five minutes.

Mrs. Laila Goodridge (Fort McMurray—Cold Lake, CPC): Thank you, Mr. Chair, and thank you to all the witnesses for being here today.

I think the variety of different topics covered in today's meeting shows how broad and, perhaps, challenging this subject is. In this committee, we've learned, many times over, that children are not just tiny adults. They are their own entities, with different challenges. As the mom of a small kid, I see that on a very regular basis.

My first question is for Ms. Sarangi.

You touched on a piece very near and dear to my heart: northern and rural communities. After eight years of this government being in place, we're seeing record-high food inflation. In my own community of Fort McMurray Wood Buffalo, we've now seen that a third of the clients of the Wood Buffalo food bank are children, and the demand is rising month over month. We're seeing more and more kids going hungry, and we know that kiddos can't learn if they don't have adequate food.

My question to you is specific to northern, remote and isolated communities: What do you think part of the solution is to this?

Ms. Leila Sarangi: Again, I'll go back to the Canada child benefit: adding an additional supplement for families in northern and remote communities, one that takes into consideration the cost of living. Families in Nunavut have extraordinarily high rates of food insecurity and child poverty. Targeting those families through an additional income supplement is easy to do, because the administrative piece is already there. It just takes a bit more investment in the form of that additional supplement for those families.

That is one very quick and easy way to start to address this. Of course, there are more things that need to happen, but that is one quick and easy low-hanging fruit you can pick off quickly, I think.

Mrs. Laila Goodridge: I appreciate that.

I call Fort McMurray home, and Fort McMurray's groceries are substantially more expensive than what we see here in Ottawa. The further north I go, even in my own constituency, the more expensive groceries get and the more expensive gas gets. As the carbon tax has been added on and is ever increasing, what we're seeing is that it's being passed on to consumers. Milk is now more unaffordable than it was before, because the cost to transport the milk to some of these communities is that much more expensive.

Have you done any studies or is there any research that's been done on how much you would have to increase the CCB in order to combat this record-breaking food inflation?

Ms. Leila Sarangi: We have not done that study yet. I think that is a very interesting question, and it's a question I can take back to my colleagues.

We have done a study on the supplement for families in low income and how much it would cost to bring incomes up to the low income measure. In our submission, we have called for an investment of just over $6 billion for that “end child poverty” supplement that would cut rates of child poverty from an estimated 9%, according to the market basket measure, to about 3% in the first year.

● (1200)

Mrs. Laila Goodridge: Wow. That's very shocking. Thank you for that information.

To switch gears a bit, I'll go to Dr. Salami. As a University of Alberta alumna, I'm grateful to see you here. Thank you for the work you've been doing.

You talked a lot about the Black racialized.... Have you done any studies on indigenous people and how that impacts...?

Dr. Bukola Salami: My area of expertise is not.... I'm a strong ally and I know that there is a strong need out there—

Mrs. Laila Goodridge: No worries. I just wanted to see if you had.

It became very evident to me as you were doing your presentation that you are very supportive of community-based supports, like churches. Multiple times over, you talked about that. Again, to draw back on my experience in Fort McMurray, when we had to evacuate, it wasn't the big, bad government that came in and helped and made people feel good; it was churches and different community organizations that came from all over, opened up their doors and made my community feel so welcome in Edmonton and across the province.

One of the things we've been seeing from this government is tightening up on financing. That is preventing some of these church groups from being able to get summer students, and restrictions are being placed on them.

Do you think that's a wise move?

Dr. Bukola Salami: I will tell you, I did that study and analyzed the Canadian health measures survey to look at the mental health of immigrants in Canada. No matter how much we analyzed the data of 12,000 people on the Canadian health measures survey, the two strongest contributors to mental health were community belonging and income. When people feel they belong to a community, they are more likely to rate their mental health as being better.

I also, in the past, interviewed 300 families. When people feel like they belong.... The problem is oftentimes, we expect community agencies to support our racialized communities, but we do not give them the tools and the resources to be able to support or improve mental health.

I would support any activities that provide tools to community organizations to build the capacity of religious leaders and community organizations to address and improve mental health.

Mrs. Laila Goodridge: Thank you.

The Chair: Thank you, Dr. Salami.

We'll have Mr. van Koeverden, please, for five minutes.

Mr. Adam van Koeverden (Milton, Lib.): Thanks very much for all the testimony from all the witnesses. It's been extraordinary. I've been really excited for this study. I'm glad we're focusing exclusively on children for a couple of weeks.

It's been very clear from all witnesses today that the inextricable link between income and health outcomes is critical, and we need to have a greater look at that.

When I look at those UNICEF numbers, I'm troubled as well when I see that Canada ranks so low. Weeks ago I did a little research on child poverty rates in Canada. In 1989 the House of Commons voted unanimously to end child poverty by the year 2000. Despite that, in 2013 it was higher than ever. By 2013 child poverty rates were worse than they were in the 1970s. Since then, thankfully, they've dropped by 71%, but they're still about 4.6% or 4.5%, which is too high for Canada.

I recognize that reducing child poverty doesn't instantly solve the problem, and that health outcomes aren't going to change immediately, even over a couple of years. There are lots of studies that show that if you're poor as a child and not as an adult, then health disparities persist throughout your life. That's something we need to address as well, but through measures like making the Canada child benefit not universal. Not sending $300 cheques to every single family in Canada but rather making it more of a means-tested program has been successful in reducing child poverty rates in Canada, but these numbers are still not satisfactory, particularly when ranked against those of our OECD counterparts.

Dr. Salami, my questions are for you. I loved your testimony. Thank you very much.

I'm particularly interested in subsidies for physical activity for youth. I think physical literacy is one of the best precursors for later health. How can we do a better job of bridging the gap in those OECD numbers, bringing our rank for child health closer to where we would like it to be—in the top 10 ideally, or maybe even better than that?

You have answered the question already, but from the perspective of recognizing that Canada has a low child poverty rate but still really disproportionately poor health outcomes, what can you point to in terms of the cause, and how we can do better?

● (1205)

Dr. Bukola Salami: I must say that poverty and income inequality do not exist in isolation. We also see, for example, race-based inequalities and how those contribute, for example, to income inequality.

Statistics Canada just released a report that found that, contrary to public opinion, African immigrants have one of the highest education rates in Canada. Also, consistent with popular opinion, African immigrants have one of the worst income rates in Canada. Access to professions and addressing those underlying inequalities will support and help in terms of addressing issues related to poverty and also the consequences of that: issues related to health.

Something that has also been talked about in some of the interviews they have done is access to professions for internationally educated health care professionals. We know, for example—and people have said this—that the health care workforce or the general workforce in Canada is like a cappuccino. It's white on top, and it's black underneath.

We need to stir it up, and that has consequences. In the case of the COVID-19 pandemic, it had consequences. We had a higher number of black people affected by COVID-19 because we had more black people on the front lines providing one-on-one care. We had more black people taking the bus. We had more black people with limited spaces, and that increased exposure to COVID-19, so the long-standing inequities that we experienced before COVID-19 had significant impact on the experiences during COVID-19. It is addressing those racialized health inequities that will help us to address some of the health inequities that we experience.

Mr. Adam van Koeverden: Thank you. That's extremely clear. I appreciate that.

You mentioned sport, physical activity and recreation, in your testimony, so I thought maybe I'd provide you with an opportunity to elaborate a little, since that's my policy interest as well.

Dr. Bukola Salami: The youths I have met talked about.... For a lot of Black youth, a way for them to deal with the racism they experience, or the challenges, or just the general everyday stress was to engage in sports. People talked a lot about basketball and being able to engage in that.

Many of the youth discussed.... During the pandemic, in some provinces the bars were open but the sports activities were closed. They felt it was just such an inequity that what could help kids was closed, but the bars were open.

I think increasing access to sports and recreation, including subsidizing recreational facilities for low-income populations, will help in terms of addressing those inequities.

The Chair: Thank you, Dr. Salami.

[*Translation*]

Mr. Garon, the floor is yours for two and a half minutes.

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

I am going to continue with Ms. Haeck.

The provinces are facing much more serious financial constraints than the federal government is. That has been documented by the Parliamentary Budget Officer.

In the long term, we find ourselves in a situation in which healthcare is taking up more and more space in the provinces' public finances. As a result, other government missions suffer.

The second most important mission when it comes to the provinces' budgets is obviously education. Given that you work in both fields, I would like you to tell me whether, in your experience, it is easy for Quebec to come up with new money to work in both prevention and education for young children.

What could the federal government do to facilitate the provinces' funding in those fields?

Ms. Catherine Haeck: Thank you for your question.

In my first economics of education course, I show the extent to which healthcare eats up the budget. The fact that more and more is being invested in these causes funding for more or less everything to decline, particularly in education, but also in the community services that support the most vulnerable people. The result of this underfunding is that very little prevention work gets done.

I sit on the scientific committee on the prevention of obesity at Quebec's Institut national de santé publique, which is its public health expertise and reference centre. The committee has all sorts of lovely ideas about prevention for children and adults, but when it comes time to fund them, there is no money left to do it.

So all the money is often spent on caring for older people, and that is to be expected. However, the result of chronic underfunding of healthcare is that there are no prevention measures. Consequently, obesity among young people in Quebec and everywhere in Canada has risen enormously over the last 30 years. That problem would be fairly easy to solve with properly targeted prevention measures, because doctors and everyone working in the field have a lot of good ideas. However, they have no money to put them into action. So much for healthcare.

The education sector is also underfunded. So we find ourselves with a lot of children who have all sorts of problems and we don't have the resources to help them, because the money is being redirected to other needs that seem more urgent.

It has to be said, however, that children are our future. If we don't spend money on them, we are heading for a wall. We are eventually going to have to wake up. We can't keep investing money elsewhere than in our children, because that is going to catch up with us later on and we are going to find ourselves with a very messed up population when they reach adulthood.

● (1210)

The Chair: Thank you, Ms. Haeck.

[*English*]

Mr. Johns, welcome to the committee. It's so nice to see you.

You have the floor, sir.

Mr. Gord Johns (Courtenay—Alberni, NDP): It's good to see you, Mr. Casey. It's really good to be here.

Thanks so much to the witnesses for your important work. I was listening to you on my way over to replace Mr. Davies, and I really appreciate it.

What I really want to speak about is how, in Ontario, there are 28,000 children on wait-lists for community-based mental health. These waits can range from 67 days to more than two and a half years, depending on the service. That exceeds clinically appropriate wait times.

For children and youth, delays in accessing care—and I'm sure you can speak to it—can have lifelong impacts for them, their families and society. Tragically, it can be a matter of life and death. You talked a bit about UNICEF. According to StatsCan, suicide is the leading cause of death among youth and young adults aged 15 to 34. UNICEF has reported that Canada has one of the highest rates of youth suicide in the world.

We've been waiting for two years for the government's promised $4.5-billion mental health transfer, which clearly is not even enough.

Can you speak about the impact of the delay in that mental health transfer on youth?

Maybe I'll start with you, Ms. Bisaillon, if you want to speak a bit about that.

Ms. Susan Bisaillon: Certainly. The area I'm really focused on is children with medical complexities and more with disabilities, so I can't really comment with much evidence around the mental health.

However, I am in close contact and working with national groups like Children's Healthcare Canada, and with my colleagues in the acute and community systems. They are totally overwhelmed. What I hear is that they're not getting sufficient supports. They're not able to grow their programs to meet the demands.

We've seen the isolation and the mental health issues that have come from COVID rise, even in other focuses like eating disorders, depression and anxiety. The context I'm giving you is really from working with my colleagues.

Mr. Gord Johns: I appreciate that.

Ms. Susan Bisaillon: I certainly can echo that I know it's a significant challenge in Ontario and across the country. Maybe my colleague, Dr. Salami, can also comment on that, as well. It definitely is a challenging area.

Dr. Bukola Salami: I totally agree with the need for community-based mental health service delivery. Right before the pandemic, we did a study in Alberta to look at the mental health of Black youth. We did one before the pandemic, and we did one after the pandemic.

We engaged about 129 Black youth in conversation cafés and also interviews on their mental health. On the last day of the conversation cafés, Black youth took us through what an ideal mental health service delivery would look like: culturally appropriate, delivered in spaces that are accessible to Black youth, and also provided by Black mental health practitioners.

Youth took that data, and they used it to create the mental health clinic—the first mental health clinic for the Black population in western Canada—during the pandemic.

One of the challenges, of course, is that a lot of the funding for mental health is put into acute care, which usually is a downstream approach to mental health service delivery. If we're able to address some of the upstream approaches.... Before, I talked about the need, for example, to look at community-based mental health service delivery, to build and capitalize on the strengths of community leaders, religious leaders, while also understanding that not everyone goes to a religious leader. We need community support and community to be able to address some of the mental health issues, and also community-based service delivery.

I've interviewed immigrant service providers before. They've talked about the backlog in terms of the long wait-list for people to be able to see mental health psychologists, counselling psychologists and practitioners. We just need much more investment in that in the community.

● (1215)

The Chair: Thank you, Dr. Salami.

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

Mr. Matt Jeneroux (Edmonton Riverbend, CPC): Thank you, Mr. Chair, and thank you to all the witnesses for taking the time today. I think a lot of the testimony's been quite fascinating.

I want to pick up on a journal article that you wrote, Ms. Salami, in CMAJ. This is from the October 24, 2022, edition. One of the quotes in there says, “Racism was the most frequent factor identified as contributing to the mental health of Black youth,” in Alberta. As an Alberta MP, that jumped out at me and was of interest.

I'm hoping you can elaborate on some of those links between racism and discrimination and mental health and wellness in youth. Obviously, your expertise is in Alberta, but if there are other comments from across the country, too, I would certainly welcome them.

Dr. Bukola Salami: Thank you.

That project that I did was only in Alberta. Now, the survey that we're doing currently—with 2,000 Black youth and 50 interviews—is across Canada. In that project, we interviewed 129 Black youth in that focus group. The most frequently talked about contributor to their mental health was racism.

For example, let's take the case of Black boys. Many of them discussed the perception that toxic masculinity was a Black male thing, which, of course, it's not. They also discussed, for example, having always to prove themselves innocent because the first perception is that you're guilty. For everyone else, you're innocent until proven guilty. For Black people, especially Black males, you're guilty before you're proven innocent.

With regard to racism, I remember a quote that one of the youths said. She said, “God, I grew up with so much internalized anti-Blackness. I hated myself. I wanted to be white so bad. I wanted to have lighter lips.” Then she discussed an experience in which she was crossing the street when someone threw a Slurpee at her and calling her a racist bad word. That continues to shape her perception. She's internalized that racism, and it continues to shape her mental health.

Those are some of the things that Black youth deal with in the province of Alberta and, as we've seen in interviews that we've conducted across Canada, across Canada, too.

Mr. Matt Jeneroux: What are some of the best practices, then, that you can suggest? We're at the federal level, but I would certainly welcome you to take the opportunity to dive into provincial and municipal levels as well. What are some of those best practices, then, that we can put in place?

You said your study is ongoing. Perhaps you'll have some outcomes at the end of that, but initially are there some steps we can look at today?

Dr. Bukola Salami: The consultative part of the study is ongoing, but we've completed the qualitative phase, and there are a few things. Oftentimes we are focused on train, train, train and fundraising initiatives. People get training; they get out of the room; they leave everything in the room, and it's all done.

We need to infuse accountability measures into our training. When people are racist, we can say they are incompetent. Infusing anti-racism, for example, in people's evaluations, in granting programs to ensure.... I am always interested.... A lot of the funding programs will say, for example, “You have to identify gender-based analysis plus.” The only thing is that people hear gender-based analysis and sometimes the plus is thrown away. Sometimes we don't know what the plus means, right?

We need to spell out what the plus means. People need to understand that. We need to make sure we collect data on that. I think race-based data collection is also very important and will help in terms of addressing some of these inequities.

● (1220)

Mr. Matt Jeneroux: You mentioned some of that in your earlier testimony, but thanks for highlighting it again. You also mentioned earlier some of the distrust in the Black community.

What factors influence that level of distrust?

Dr. Bukola Salami: I am a member of the Black Opportunity Fund, which serves to address anti-Black racism in Canada through raising a pool of funds.

In the early days of the COVID-19 pandemic, we organized town halls to address COVID-19 vaccine hesitancy. I remember doing one of those town halls. One of the parents said, “Is this another experiment that the government is doing on us?” We had to debunk that. There are long-standing issues of mistrust. For example, unethical studies have been done within Black communities that Black people still know about, or are acutely aware of. There is also racism that Black people confront within the health care setting.

That's why I say that competency related to anti-racism is important. When you go to many standards of practice for health care professionals, for example—and I know this is largely not in the federal jurisdiction, but I must mention it—many standards of practice do not even mention the word racism in them, right? That means you can be practising as a health care professional, and be racist. You can still be considered competent, because it's not seen as incompetency based on the standards of practice. We need to change that. We need to ensure that anti-racism is infused in all evaluations, and also in all standards of practice for health care professionals.

The Chair: Thank you, Dr. Salami.

Next, we're going to Dr. Powlowski, please, for five minutes.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): Thank you. I have a question for Leila Sarangi from Campaign 2000.

You mentioned in your testimony that there were some immigrants with children who paid tax but didn't get the Canada child benefit. Can you try to narrow this down? Which group of people are you talking about here that are in this category?

I got my overpaid assistant Tyler over there to look this up for me. He came up with this list. He said the people who get the Canada child benefit are the spouse or common law partner who are either citizens, permanent residents, protected persons, i.e. refugees, and temporary residents who have lived in Canada for the previous 18 months, and who are validly in the country.

Can you narrow down the category of people you're talking about who are immigrants and pay taxes but don't get the CCB?

Ms. Leila Sarangi: There are people with precarious immigration status who have filed and are waiting for a claim to come through. Their immigration claim has been denied, but they cannot be deported, because the Government of Canada has deemed their home country too dangerous, so they don't have anywhere to go. There are people who are in limbo because of their precarious status. It is not a large number of people, so it doesn't cost a lot of money. In that category, they are considered residents under the Income Tax Act, so while they are waiting, they are here, they are working, and they may be having more children born in the country, but they are still denied the Canada child benefit.

Repealing that section in the Income Tax Act, which is arbitrarily making that eligibility requirement, would not have a very big cost in the federal budget, but it would have a very deep impact for these families who are dealing with many health-related and other issues.

Mr. Marcus Powlowski: You talked about food insecurity in Nunavut. I would have thought part of the answer to that was the nutrition north subsidy. Does your group have any position on those subsidies and whether those ought to be increased?

Ms. Leila Sarangi: Our partners in Nunavut and the Northwest Territories have talked about how the subsidies go to retailers and are not necessarily passed on to residents. I get photographs of the cost of food in the grocery stores on a regular basis, where it's about $75 for a piece of steak or $60 for diapers. It's outrageous that the nutrition north program funding is going to the retailers and not necessarily being passed on to the local residents there, which is why we're calling for income transfers directly to families and individuals.

● (1225)

Mr. Marcus Powlowski: Do you see that as a better way of addressing food insecurity than improving the nutrition north program?

Ms. Leila Sarangi: From our assessments, yes, that is one of the ways we would prefer to see food insecurity in the north addressed.

Mr. Marcus Powlowski: Now I'll turn my attention to Dr. Salami.

You mentioned the fact—and I agree with you—that obviously the biggest social determinant of health is poverty, but you just fleetingly mentioned that under COVID perhaps that wasn't the case. Do you want to just elaborate on that? What was a greater social determinant of health under COVID?

Dr. Bukola Salami: In 2020, an analysis was done in Montreal, Toronto and Ottawa on neighbourhoods, and when you look at neighbourhoods and COVID-19 distribution, it found that the strongest determinant of whether or not you'd get COVID in the early days of COVID was whether or not you were Black—the concentration of Black people in the neighbourhood.

Before the COVID-19 pandemic, I always told my students that income was the strongest determinant of health. During COVID-19, I started taking caution, but of course there is income.... I mean, racism does not exist in isolation; it intersects, and it reproduces income inequality. It also then intersects with income inequality. Those are some of the lessons we've learned.

I think what would be very important going forward is for us to start collecting race-based disaggregated data, which we did not have before COVID, to really shed light on how to ensure that we can have targeted interventions to address disparities.

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

Next we're going to Dr. Kitchen, please, for five minutes.

Mr. Robert Kitchen (Souris—Moose Mountain, CPC): Thank you, Mr. Chair, and thank you all for being here today. It's greatly appreciated.

I appreciate, particularly Dr. Haeck and Dr. Salami, your comments on dealing with mental health, in particular on the aspects of dealing with how it impacts sports and education and how important that is. It's something very important to me, recognizing that it was a great benefit to me many years ago when I was dealing with aspects along those lines. With that said, I hope I'll be able to ask questions on that.

My main first question, though, is.... Thanks to our analysts, we received some interesting information from CIHI, the Canadian Institute for Health Information. They point out that medical complexities make up about 1% of the pediatric population, and they're heavy users of the health care system at around basically 50% of our total hospital costs, which are quite significant numbers.

With COVID, it unfortunately appears that we're seeing a lack of education in public usage of emergency situations in bringing children to hospitals, which is tying up a lot of hospital areas such as emergency rooms with situations that might be able to be dealt with at home with better education systems and better understanding of the health care system. These are important things, so I guess my question is, how do we get that education to Canadians such that they understand it?

What we saw with COVID and we've seen over the last couple of years is basically uncertainty and misinformation that the public believes is coming from government. We as a federal government are trying to deal with something that is provincial in nature, but how do we as a federal government advance that education so that we can educate parents to understand how to deal with health issues for their children?

Ms. Bisaillon?

Ms. Susan Bisaillon: You're absolutely right. The CIHI study was a really important study. It was done in the last few years, I would say. We're hoping to get the information updated.

On the complexities, that top 1% of them—you're absolutely right—takes up a huge component of the dollars. In terms of thinking about how we work with families, there are not well-established programs. There's not a lot of data. As I listen to my colleagues, I see that there's a huge issue with regard to data with our population.

Certainly, those families may be supported in the acute care sector. That's why they go back to a lot of the hospitals: We don't have well-established continuum-of-care supports. Families need to have stronger supports in the community. They need help to understand how to cope in the community so that we're using our health care system—acute care for acute care—and have well-established home- and community-based care, where families then can cope.

Right now, with the way the system is, we don't have that cross-continuum support. That's what I've been advocating for so that we have an established system of care across, outside of hospitals, and so families don't have to go to the hospital and, to your point, so parents can access services in the community as opposed to going to an emergency department.

● (1230)

Mr. Robert Kitchen: Thank you very much. I appreciate that.

Perhaps if any of the other witnesses have anything they'd like to add on that, they can provide it to the chair or the clerk and analysts and we can get that out. I'd appreciate that.

On the issue of sports, which we're looking at and dealing with, Dr. Salami, you talked about that and how one of the recommendations is a possible reinvestment in sports targeting youth, especially for indigenous and Black populations. I agree with you a hundred per cent on that. I see such a benefit from sport. Unfortunately, because of COVID, we lost that ability to get people out.

I'm just wondering if you have any further comments along those lines, because for a lot of it, we start to look into an issue.... You sort of touched on suicidal ideation and that aspect. Participating with groups and being together sort of helps us to communicate among each other.

Dr. Salami, do you have any comments along those lines?

Dr. Bukola Salami: I think one of the things about sports is that it goes through several pathways to influence health, whether it's mental health or physical health. We know that sports also contribute.... As I said, community belonging is one of the strong determinants of mental health, at least based on my analysis. Sports can also help in terms of fostering that belonging and social inclusion of Black and racialized kids.

Especially in light of the recovery from COVID-19 and the separation and social isolation that people have experienced, it's of vital importance to invest in sports activities for all kids, but also to ensure that it's subsidized for those who are much more marginalized within society.

The Chair: Thank you, Dr. Salami.

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

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

My first question is for Dr. Salami.

You talked about racism, but what role do culture and language barriers play in affecting the health outcomes of immigrant children and youth when they don't have any awareness of vaccination or disease prevention? How does that come in?

Dr. Bukola Salami: Someone asked about improving access to emergency services. I think that one of those things is addressing issues related to language barriers and also those related to culture as a social determinant of health.

Years ago, the Public Health Agency of Canada used to have racism subsumed under “culture” as a determinant of health. Now we realize that there are many more differences in terms of racism and culture as the determinants of health, so yes, it's very important in terms of being able to address culture. It's also important to address issues of racism, and also, for a lot of immigrants, to address system navigation: just knowing where to go and how to navigate the system.

Oftentimes, we think of language barriers in terms of, “You speak Arabic and you speak Arabic; just come together and you can interpret for each other, and voila, everything is all done.” Some of the research I have done tells us that there are complexities in terms of interpretation services. You know, one of the participants I interviewed, an immigrant service provider, talked about that. For example, if you have two interpreters, one from the Taliban tribe and one from the Pashtun tribe, and you bring them together and tell them to interpret for each other, there may be clashes in that, because you are bringing together the oppressor and the oppressed.

There also are delicate aspects in terms of gender-based violence. Sometimes you may want to match based on gender.

There are so many complexities in terms of culture and interpretation services, yet, without interpretation, it makes it so much more challenging to address the needs of immigrant populations in Canada.

● (1235)

Ms. Sonia Sidhu: Thank you.

How can health care providers better serve the needs of immigrant populations, particularly in terms of language and culture? You already talked about that.

However, can you also discuss the importance of research and data collection—which are very, very important—and how we can bridge that gap? What data and research are needed to better understand the health needs of children in Canada, and how can the federal government support the collection and analysis of this data?

Dr. Bukola Salami: I think we need to subjugate our data. One of the challenges, and one of my colleagues said this.... For example, I did a study where I looked at the mental health of immigrant and non-immigrant kids in Canada. When you look at all of the data together, everything gets clouded, but then when you start to disaggregate it.... The problem is that when you go, for example, to the Canadian health measures survey, which I try to use, you cannot disaggregate the data. The analysis is just not possible.

When you go to the Canadian community health survey, which has the largest sample size, and in which you may be able to disaggregate the data, they do not collect data on children who are less than 12 years old. Maybe that's one of the places that we need to begin to start collecting data.

My colleague talked about the longitudinal survey of immigrant children and youth, which also provided disaggregated data related to immigrants in Canada, and there was another national study. However, many of those longitudinal studies have been discontinued.

For example, when you look at much of the small-reach longitudinal data across Canada, some of the challenges are that the sample size for the racialized population is so small.

I'm currently doing a study for the Public Health Agency of Canada, looking at how race-based data is collected for black populations in Canada. There are culturally appropriate ways that we must infuse into our race-based data collection to ensure that we have appropriate sample sizes. Right now, at least with the Canadian health measures survey and the Canadian community health survey, the percentage of black, racialized immigrant population interviewed in those surveys is less than the percentage they represent of the Canadian population. That has to change and we need to be able to disaggregate that data.

Ms. Sonia Sidhu: Okay, thank you.

Ms. Bisaillon, are there any final comments you want to express on that?

Ms. Susan Bisaillon: Just listening to the conversation is so interesting. I also think of it from the perspective of vulnerability. I deal with a lot of clients and families who are new immigrants or refugees coming into the country. They are labouring over the fact that they're new to the country and there are issues because of access.

Some of the comments I want to emphasize are about trust in the system. During COVID, I had a lot of experience on the ground with indigenous and other marginalized communities.

There is a lot of work to be done in terms of educating our health care colleagues and frontline staff about culturally sensitive care and working with people of different races. There are a lot of biases there. That goes to your point about the standard of care. If you're working in the health care system, there should be standards around how we interact and work with people of different cultures and backgrounds.

The Chair: Thank you, Ms. Bisaillon.

[*Translation*]

Mr. Garon, the floor is yours for two and a half minutes.

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

I find it very interesting that you are talking to us about data, particularly data that enables us to implement good social policies and compare ourselves to others, for example. It's the flavour of the month.

My question is for you again, Ms. Haeck.

I get the impression that each group of researchers wants its own data and there are a lot of very specific little data collection initiatives.

What would the ideal model be, in Quebec and in Canada, that would enable researchers to get data that is comparable and accessible to everyone, and would put Canada on the world stage?

Do we have that model today?

● (1240)

Ms. Catherine Haeck: No, we don't have it today.

In fact, there are a number of initiatives funded by the federal government. It funds all sorts of projects all over Canada, where people create their own databases. When researchers do that, the data they collect belongs to them and is not disclosed to others. So the researchers are funded out of public money, their data belongs to them, and the data is not accessible to other researchers.

So the best way to work it is to go through Statistics Canada so the study is conducted using recognized methods, so we know how it was done, so the sample is representative of the population and important minority subgroups...

Mr. Jean-Denis Garon: Forgive me for interrupting you.

How is it that this is still not the case? How is it that we are still working in a decentralized manner and we don't have this model? How do you explain that?

I'm surprised at your answer.

Ms. Catherine Haeck: I have no idea.

For example, the data used for doing the UNICEF report that some people have talked about is the HBSC data funded by Health Canada, but it is not accessible to researchers. I have tried to obtain it, I promise. It is impossible to access that data, even though it is collected using public funds and is used to position Canada on the world stage.

This isn't data that comes from Statistics Canada. We can't validate or verify the data. The methodology used is not easy to understand, to make sure the research has been done properly, and we can't be certain that the samples used are representative of Canada.

In my opinion, assigning the data collection to an organization of researchers rather than to Statistics Canada, for ranking Canada in the world, makes no sense. I don't know what logic is behind this arrangement, but this kind of funding, which is allocated here and there around the country, is very common.

The Chair: Thank you, Ms. Haeck.

[*English*]

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

Mr. Gord Johns: Thank you.

Ms. Sarangi, in May 2022, Auditor General Karen Hogan did a report. She stated that with the CCB, the government has not done enough to help hard-to-reach Canadians access the benefits they're eligible for, and it failed to improve the lives of individuals who need the help the most. She cited indigenous peoples, housing-insecure individuals, new immigrants, newcomers to Canada, refugees and people with disabilities as being disproportionately impacted. I can see that in my own riding, certainly with indigenous people who might be behind on their taxes and whatnot. They said it lacks insight.

What changes need to be made? In your recommendations, you talked about the cost of families not getting the CCB as a result of these failures.

Ms. Leila Sarangi: Of the changes that need to be made, automatic tax filing will go a long way. It will help people who have filed taxes in previous years, for whom the CRA has information. They can automatically file taxes, and then individuals can go back in later and make any adjustments. That's something that was in the mandate letter to the minister. We feel that should be moved on.

We need to broaden that income tax system using those kinds of initiatives that are more community-based.

Mr. Gord Johns: There's still no comprehensive action plan.

Can you speak about the cost of that to the children who are impacted?

Ms. Leila Sarangi: There's a deep connection between material deprivation that comes along with not having access to those benefits.... There's a lot of money that is left on the table from families who are not filing taxes and don't have access to that money. That means children are going to school without the right kinds of clothing and without food in their stomachs. Families are missing out on medication. Rents are not being paid.

I think, as we're talking about some of those social determinants of health, we need to look holistically, including at how to keep people housed adequately and how to make sure people have access to medications. Those basic needs are things families have trouble with. They cannot access them if they're not receiving their income benefits. That leads to a lot of stress in families, and it leads to worse mental health and all the outcomes we've been hearing about from all the panellists today.

The Chair: Thank you, Ms. Sarangi.

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

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

As I said at the outset, it's been a very interesting panel to help us understand the plight of children in Canada and, perhaps, some of the way forward.

I have a question for Dr. Salami, if I may, and then I'd like to turn to the other witnesses in a different vein.

Dr. Salami, you specifically referenced the credentialing of internationally trained health care workers. I can well imagine that it sets a great example for children and families. Of course, generally speaking, jobs in the health care sector are better paying than others, which again helps kids.

Can you talk a bit about any ideas you may have about credentialing international health care providers?

● (1245)

Dr. Bukola Salami: I should preface by saying that my doctoral work was actually on the migration of Philippine-educated nurses to Canada to work as domestic workers. That was about nine years ago, but some of the issues still exist now.

I am also on some WhatsApp groups for some internationally educated professionals. In the past I have helped organize information sessions to bring together the National Nursing Assessment Service with internationally educated professionals. There are small things we can do and there are big things we can do. In some of those sessions, internationally educated nurses have talked even about the length of time it takes in terms of credential assessment, or about being able to have a checklist on the website, so that when they're sending their documents back home, those back home know that these are the things they need to provide to be internationally educated.

In terms of provinces, there are so many differences in requirements, in both English language requirements and other requirements. Then there's the three-year entry into practice competence. The requirement is that you must have practised in Ontario within the last three years to become an internationally educated nurse. When you go to Alberta, it's five years. Why are there so many differences across Canada in terms of that?

Opportunities that allow professionals to be able to practise across different provinces may also be beneficial for internationally educated professionals. For example, at the federal level.... A lot of the policies related to internationally educated professionals fall under the provincial level. At the federal level we can do more by supporting the National Nursing Assessment Service to be able to facilitate.

For example, right now a lot of the processes related to credential assessments for internationally educated nurses are actually done in the U.S. That slows down the process. If we want to really hasten it, make it so that it's done in Canada. It will cost us more, but then how many gains will we have in terms of patient outcomes and the supply of human resources? I think in Canada that's one thing we need to explore. Is it possible to actually have things done in Canada so that we are able to move internationally educated nurses faster through the system?

Mr. Stephen Ellis: Thank you very much.

Doing more things and making more things and having Canadians prosper really makes sense to our side of the House, anyway.

That being said, I have a couple of other questions, so I'll change gears a bit.

Professor Haeck, you talked about school closures and certainly a difference in Belgium. Did any Canadian jurisdictions that you know of do a better job than others? That's not to create disparity but to look at lessons learned as we go forward.

Ms. Catherine Haeck: In terms of school closures, it was pretty uniform across Canada, but some provinces reopened schools a bit faster. In Quebec we reopened schools a bit faster than elsewhere. Then again, it wasn't that much faster, so it didn't make a big difference. I know schools in Ontario were closed a bit longer than elsewhere, especially in southern Ontario, where in January 2021 they were closed for a while.

Thinking about it, I love this about Canada. We're able to do different things and learn from each other, and I think we really should try to learn from what we did. The problem is that we don't have data to learn from all of this, because we didn't collect data on kids over the last three years.

Yes, there were some provinces that were marginally better, but there was nothing fantastic.

Mr. Stephen Ellis: Thank you very much.

I think I'm almost out of time, Chair, so I will cede the rest. Thank you.

The Chair: Thank you, Dr. Ellis.

Mr. Jowhari, you have five minutes, please.

Mr. Majid Jowhari (Richmond Hill, Lib.): Thank you, Mr. Chair, and thank you to all the witnesses. This has been very great testimony focusing on many things, whether it be the social determinants of health, the impact of COVID on the most vulnerable, or the data and some of the research done around the intersection of gender, race, class and nationality.

A lot of the questions I had were answered, but I'd like to take a little bit of time and look forward. Specifically, I'd like to look at the policies that exist, the practices that exist, the opportunities there and what we should really focus on to address some of those challenges.

With four minutes remaining, I'm going to go to each one of the panellists here and ask for a one-minute intervention. I want to acknowledge that health is a shared jurisdiction between provinces, territories and the federal government, but if there was one area of policy that we could focus on to help improve or eliminate some of the challenges you highlighted, what would that area be? That would be really helpful for our study.

I'll start with Professor Haeck and continue in the order in which you presented. Could you please give us that one policy that you think we should be advocating for?

● (1250)

[*Translation*]

Ms. Catherine Haeck: I think that when it comes to policies, we are investing massively in childcare all across Canada. I think that is a good initiative; it's a way of providing high quality services for the most vulnerable. For children, everything happens primarily before the age of five.

I think that is where we have to put our efforts in order to do a good job everywhere in Canada. That being said, it is necessary to collect data so we know whether our work is effective. Just throwing money around without knowing what is being done will not help us.

[*English*]

Mr. Majid Jowhari: Thank you.

I'm proud to announce that our government has made sure that the $10 day care is a reality now, so thanks to all the provinces who participated in this.

Next we go to Dr. Salami.

Dr. Bukola Salami: I would say addressing racism as a social determinant of health. As I said, there is segregation in the health care workforce. How do we have interventions that ensure that there is diversity across all levels of the health care workforce, from leadership positions to frontline service delivery?

Mr. Majid Jowhari: Thank you.

That's very informative. The timing is perfect, as we are about to release our findings related to the health care workforce.

Next we go to Madam Sarangi.

Ms. Leila Sarangi: Thank you.

I have talked a lot about the Canada child benefit and what can be done to broaden and enhance that. I think our bottom line is raising incomes for families. That goes a long way. Studies have shown how raising incomes in low-income families leads to better overall health and wellness and better outcomes for children.

Just because the day care model has been mentioned, ensuring that the expansion of that model goes into the public not-for-profit day care systems and that it's accessible to families who are on low incomes.... Campaign 2000 has worked with advocates and researchers to put forward a “zero to $10 a day maximum” sliding scale model to make sure it is accessible to the families we are concerned about who are on very low incomes.

Mr. Majid Jowhari: Thank you, Madam Sarangi.

Last we have Madam Bisaillon.

Ms. Susan Bisaillon: Thank you.

I think a lot of the work you're doing with Bill C-22 is very exciting. I really encourage you to embrace that new legislation and see what we can do with it.

What I really want to emphasize today is that being born with a disability and a complexity should not mean that you are living below the poverty level. It's really addressing the poverty, and also making sure that as these children age out of childhood, when they reach 18 they have a successful transition and affordable place to live.

That would be my request to leave with you today. Thank you.

Mr. Majid Jowhari: Thank you.

I listen to all four of you focusing on day care; on ensuring that our health care workforce is empowered, diverse and inclusive; and on strengthening the CCB and making sure that the most vulnerable and those who are in need are not left behind. This is very much aligned with what our government has been doing over the last seven years. I would like to thank you for your testimony today.

Thank you, Mr. Chair.

● (1255)

The Chair: Thank you, Mr. Jowhari.

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

Mrs. Laila Goodridge: Thank you, Mr. Chair.

In that same vein, Ms. Bisaillon, I think the work you do and the work that your organization does is spectacular. In my community we're relatively northern and isolated, and we don't have lots of those extremely specialized services available, which means that lots of families that need those services end up travelling down to either Edmonton or Calgary and oftentimes end up relocating to those centres just in order to get the specialized care.

You highlighted having more services available in communities and having more respite. Can you expand a bit upon models that have worked in smaller centres to allow for some of those places to exist?

Ms. Susan Bisaillon: It's a great question.

We know that when children are born and have complexities and life-saving needs, the best place for them is in the large academic health science centres. We have those centres across the country. We talked about Calgary and Edmonton, Alberta. We have them in Toronto.

The thing is, once these kids become stabilized, it's the development of really strong programs in these remote communities. You can have good respite programs. They may be small. It could be a small setting. Having those hub and spoke models and having that interconnection between.... If there was a program or organization that was provincial or national, you could have supports for those remote communities. The only time they would need to access the large academic centres in the large centres is when they have an acute episode. Then they would need to go there.

There are mechanisms to develop this and families shouldn't have to relocate. You can do it in small pockets. I think what COVID has made us do—which we've done extremely well—is pivot towards virtual care. There are opportunities to use virtual care technology. We had to switch overnight from going to in-house for all of these visits in academic centres to doing virtual care.

The technology exists. There are capabilities for monitoring children in these remote communities. It also gives you a sense of some precursors for when there is decline and when they should go in.

I don't think we should shy away from this notion of remote supports using technology, virtual care and hub and spoke models to support families close to home.

Mrs. Laila Goodridge: Thank you.

We have one super special little kid in my community of Fort McMurray. Madden is dealing with Batten disease. For the first chunk of time, the family had to go down to Edmonton to get all of his injections.

Through working with the Stollery and the Stollery foundation, he's now able to get his injections in our community, which means the family has a bit more stability and more supports. Frankly, they don't have the same level of support when they're five hours from home.

These kinds of things are spectacular, and I'd love to see more. I think our communities benefit when we have more fulsome support of that.

Are any jurisdictions doing a better job when it comes to some of that innovative work?

Ms. Susan Bisaillon: I'm very well connected nationally. I chair a community of practice for health care professionals across the country, so I have a sense of that.

What I was trying to emphasize today is that we're still very much in our infancy around these programs. There are pockets that do it extremely well. When I look at the east coast, in Newfoundland, I see some really great home care options.

I've been working with my colleagues in British Columbia, who are doing some really neat work and expanding the notion of “medical complexities” into “health complexities”. Rather than just looking at the physical health and the mental health, we're trying to be broader in our thinking. Also, Alberta is doing some excellent work.

Everybody's trying to work together to build on what each province is doing, but we don't have an integrated, sustainable model. I think having those supports is really important.

To your point, families shouldn't have to move to these large cities. They can be successfully cared for. Technology and medical innovation are really exceptional. We need to be much more strategic and innovative. This committee has the ability to help us start to do some of those models.

● (1300)

The Chair: Thank you very much, Mrs. Goodridge and Ms. Bisaillon. That brings us to the top of the hour.

I want to sincerely thank all the witnesses for being with us today. When the committee decided to embark on a study on children's health, we knew that it was a very broad, multi-faceted topic. That is evident in the diversity of the experience, expertise and advocacy that you've brought to this very interesting discussion. We're very grateful to you for that.

Thank you so much, everyone.

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

We're adjourned.