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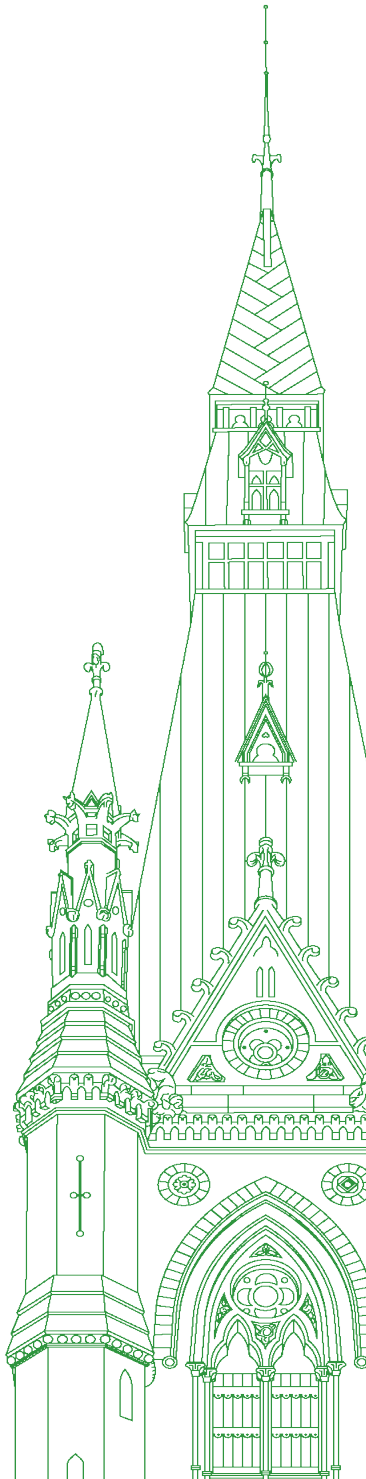

Chair: Mr. Sean Casey

Standing Committee on Health

Tuesday, March 21, 2023

● (1105)

[*English*]

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

Welcome to meeting number 57 of the House of Commons Standing Committee on Health. Today we meet with witnesses for the final panel in relation to the study of children's health. I have also saved some time at the end of the meeting for committee business, so that we can consider study budgets and the amendment deadlines for upcoming meetings.

Today's meeting is taking place in a hybrid format, pursuant to the House order of June 23, 2022. I have just a couple of comments, primarily for the benefit of witnesses, all of whom are online today. Interpretation for you is at the bottom of your screen. You have the choice of floor, English or French. Screenshots or photos of your screens are not permitted. The proceedings today will be made available via the House of Commons website.

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

I would now like to welcome our witnesses, who are with us this afternoon by video conference.

With have with us Professor Nathalie Grandvaux, Université de Montréal; Professor Alain Lamarre, Institut national de la recherche scientifique; Dr. Erik Skarsgard, member of the Pediatric Surgical Chiefs of Canada; and Patsy McKinney, executive director of the Under One Sky Friendship Centre.

Thanks to all of you for taking the time to be with us today.

Each of you has up to five minutes for your opening statement.

[*Translation*]

We will begin with Professor Grandvaux.

Welcome, Professor.

Dr. Nathalie Grandvaux (Professor, As an Individual): Thank you, Mr. Chair.

Mr. Chair, committee members and witnesses, thank you for this opportunity to appear as a full professor from the Université de Montréal and director of the host-virus interaction laboratory at the CRCHUM, Montreal.

I am the co-founder of Quebec's COVID pandemic network, the RQCP, which I co-managed until 2022. I am also a member of the Coronavirus Variants Rapid Response Network, or CoVaRR-Net, which is funded by the Canadian Institutes of Health Research.

I have no conflicts of interest to declare today.

[*English*]

During the initial outbreak of COVID-19, it was evident that children were much less affected by severe acute respiratory symptoms than adults, and particularly the elderly. These observations guided initial public health policies. Children were included in population health measures to limit the general impact of COVID-19 on vulnerable people and to protect the capacity of our health system, rather than to specifically protect their health.

Across Canada, different measures have been taken to limit the transmission of the virus, including at different times the closure of schools, the use of remote education, mask mandates, vaccination or the use of air purifiers. It is reasonable to note that these measures have certainly had negative impacts as described by social science experts.

The optimistic assessment at the start of the pandemic regarding the impact of COVID-19 on children has led to many questions about the relevance of the sanitary measures imposed on children. However, considering that knowledge of COVID-19 has only been made as the pandemic has progressed, several scientists, including me, have supported the application of the precautionary principle in the management of COVID-19 for children.

What is the state of knowledge after three years of the pandemic?

First, the airborne transmission of SARS-CoV-2 is now recognized by the World Health Organization and other public health bodies, and has achieved consensus among the scientific community. It is now clearly established that COVID-19 is transmitted in schools and spreads from schools to homes. Not all children are equal when it comes to complications from COVID-19, and some of the children are also living with relatives who have vulnerabilities to complications related to COVID-19.

The first serious complication observed in children was the multisystem inflammatory syndrome, which has had an incidence of up to six to 10% depending on the age group according to certain studies before 2022. The omicron variant, however, led to a significant increase in transmission among children, accompanied by a major increase in hospitalizations.

It is now clearly established also that COVID-19 is not a disease of the respiratory system only. The acute phase presentation was only the tip of the iceberg. There is now ample evidence of the short- and long-term effects of infection and reinfections. Several studies have now described neurological, cardiovascular and other multisystem impacts of COVID-19 in adults and children independent of the initial presentation of their disease. We can easily imagine that long-term illness will have a major impact on the social well-being and learning ability of children.

The immunity established by vaccines and past infections does not confer complete and infinite protection against reinfections. Immunity to SARS-CoV-2 infection remains relatively short, leaving the children vulnerable to reinfections leading to lost learning days.

We have made a lot of progress in the face of COVID-19, it must be recognized, however, we must draw lessons from our current knowledge. The risk of SARS-CoV-2 infections on children cannot be ignored. Therefore, what is the avenue that we should take in this context to ensure, in the least restrictive way possible, the health but also the learning of children?

Were we right to use methods of limiting transmission in schools given what we know today? My answer is most definitely yes. The precautionary principle and the measures put in place have made it possible to limit infections that have potential for long-term effects. Relying on hybrid immunity established by vaccination and repetitive infections involves the risk of developing long-term complications, the post-vaccination rate of which remains to be determined with accuracy. This risk is not acceptable.

There is an urgent need to consider airborne transmission of SARS-CoV-2 in infection prevention and control. Ignoring it is no longer an option for the long-term management of COVID-19. One of the key measures that must become a priority in our schools, but also in busy public and private environments, is the improvement of indoor air quality through sustainable measures that do not depend on individual human behaviour. Some countries have already committed to implementing such measures, and we must follow in their footsteps to enable a passive reduction of airborne transmission, and thus reduce the need for the use of restrictive personal protective measures. Good indoor air quality has the advantage of protecting against COVID-19 infection, independent of circulating variants, but it also protects against a wide range of other respiratory infections.

Improving indoor air quality is a new frontier in public health, requiring commitment from our leaders at both local and political levels. Just as access to clean water has eliminated the transmission of certain infections in the past, improving air quality will reduce the impact of airborne viral infections.

Thank you.

The Chair: Thank you, Dr. Grandvaux.

Next we're going hear from Dr. Alain Lamarre from the Institut national de la recherche scientifique.

[*Translation*]

Welcome to the committee. Please go ahead.

● (1110)

Dr. Alain Lamarre (Full Professor, Institut national de la recherche scientifique, As an Individual): Thank you, Mr. Chair.

I wish to thank the committee for inviting me to this meeting. I am a research professor at the Centre Armand-Frappier Santé Biotechnolgie of the INRS, or National Institute of Scientific Research, Laval. I also hold the Jeanne and J.-Louis Lévesque chair in immunology. For more than 30 years, I have researched immune antiviral responses and the development of vaccines and immunotherapy to fight cancer and infections. I would like to speak to you today about the importance of adequate funding for health research, particularly for the development of new vaccines, and for maintaining children's immunization status.

Various stakeholders who have appeared at previous committee meetings have highlighted the negative impact that the COVID-19 pandemic has had and continues to have on a number of health determinants and on the education of children in Canada, particularly among indigenous peoples, racialized populations and those living in poverty. Among the negative effects of the pandemic, we expect children's immunization status to suffer in the future. That decline could have serious effects on public health and expose certain children to serious infectious diseases that can be prevented by immunization.

There are various possible explanations for the decline in immunization, but one merits closer attention, in my opinion. I am referring to the increase in disinformation related to the COVID-19 vaccination campaign which has caused some fear in parents when it comes to having their children vaccinated. It is therefore essential to better understand the key sources of vaccine hesitancy among the public in order to better equip parents through reliable information about immunization so they can make informed decisions about vaccinating their children.

I would now like to take a few minutes to discuss the importance of significantly increasing research funding in Canada, including research on pediatric diseases. There are still a number of gaps in our ability to prevent and treat various childhood infectious diseases. Those include respiratory syncytial virus, which caused serious respiratory distress among children last fall and for which there is still no vaccine.

I have been a professor at the INRS for more than 20 years and have observed a significant drop in research grants in Canada in that time. Funding for biomedical research in Canada comes primarily from the Canadian Institutes of Health Research, or CIHR.

According to a recent analysis by the Canadian Association for Neuroscience based on CIHR data, the success rate of funding applications in CIHR open competitions has dropped steadily since 2005, falling from 31% to below 15% in 2018. Moreover, the budget for approved funding applications has dropped by more than 25% overall, further highlighting the glaring lack of funding.

In addition to the lack of funding for research labs in Canada, there has been no significant increase in the amounts awarded to graduate students by the three federal councils, in most cases, for more than 20 years. As a result, some graduate students are now below the poverty line and are in precarious financial situations. This discourages a number of such students from pursuing a research career.

According to data from the OECD, the Organization for Co-operation and Economic Development, Canada is the only G7 country where whole gross domestic expenditures on research and development have been in decline since 2001. It is now second from the bottom among G7 countries in this regard, with only Italy spending less. The United States, for instance, invests three times more per capita in research than Canada does. This clearly illustrates the considerable effort that Canada will have to make to become one of the world leaders in this regard.

To contribute to the examination of these strategic issues, I would like to suggest three measures that the Government of Canada could consider to maximize the benefits of its investments in biomedical research.

First, Canada's federal investments in research must be increased by 25% immediately, and by 10% per year for the next 10 years so Canada can catch up to other G7 countries in this regard.

Secondly, federal investments in cutting-edge research facilities and in their long-term operating and maintenance costs must be maintained and increased, through the Canadian Foundation for Innovation.

● (1115)

Third, the amounts of student research grants have to be reviewed and indexed to inflation so that young people do not lose buying power and therefore also lose interest in a career in research.

In conclusion, the COVID-19 pandemic highlighted the need for a rich and diverse research ecosystem in order to be better prepared for future health crises.

If Canada wants to once again be a world leader in research and development, over the next decade it will have to make a significantly greater effort and make massive investments in research grants, particularly for children's health.

Thank you for your attention. I am available to answer your questions.

The Chair: Thank you, Professor Lamarre.

[*English*]

Next, we have a member of the Pediatric Surgical Chiefs of Canada, Dr. Erik Skarsgard.

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

Dr. Erik Skarsgard (Member, Pediatric Surgical Chiefs of Canada): Good morning, Mr. Chair.

I'd like to begin by thanking this committee for the privilege of attending today. My name is Erik Skarsgard. I am a pediatric surgeon in Vancouver and surgeon-in-chief at the British Columbia Children's Hospital. I am also a member of the Pediatric Surgical Chiefs of Canada. I have no conflicts of interest to declare.

I've been practising pediatric surgery in Canada for 22 years. For much of that time I've been able to deliver timely, high-quality surgical care to children and their families. That has changed. Increasingly, my surgical colleagues and I are unable to look in the eyes of parents of children who need surgery and tell them with confidence that their child will be all right. This causes anxiety for families and moral distress for our surgical teams, who feel helpless in their ability to ensure optimized health outcomes for the children they treat.

The root cause is reduced access to scheduled surgery for children due to a severe contraction of capacity. This is not a new problem. It was first revealed by the 2007 federally funded Canadian pediatric surgical wait-times project, which resulted in nationally endorsed, diagnosis-specific wait-time targets across the spectrum of children's surgery.

Delivery of surgical care within a benchmarked wait time is critical to optimizing developmental and functional outcomes, with significant delays threatening a child's vision, hearing, speech development, mobility and learning potential, with risks of avoidable pain and long-term disability.

As late as 2018, national data confirmed that only 65% of scheduled surgery in Canadian children's hospitals was performed within the window. With the arrival of the COVID-19 pandemic and the more recent respiratory viral “tridemic”, things have only gotten worse. Surgical wait-lists have essentially doubled, and the percentage of children waiting longer than their wait-time target is as high as 70% in some provinces.

What factors have caused this?

As you are aware, we are in the midst of a human health resource crisis, with a reduced pipeline of specialty-trained nurses to care for hospitalized children with increasingly complex care needs. These include nurses who work in surgical areas like the operating and recovery rooms, but also nurses who work in the emergency departments, wards, and in mental health and critical care areas. It cannot be overstated that this crisis is affecting the care of all children, not just those in need of surgery. The workforce shortage extends beyond nursing to allied health, anaesthesia and subspecialty pediatricians and surgeons, including some hard-to-recruit specialty areas such as pediatric ophthalmology and cardiac surgery.

Many children's hospitals face space shortages, particularly in terms of operating rooms, minor procedure rooms and outpatient clinic space. When surgeons are not in the operating room, they are usually seeing patients in an ambulatory clinic setting. Some specialties have very long wait-lists for new referrals, and despite innovation in referral management, including centralization and the increasing use of telehealth, there are children who are languishing on referral wait-lists with time-sensitive diagnoses. These children represent an unmeasured demand for surgery.

Fewer than a half of all operations in children 18 and younger are performed by trained pediatric surgeons in children's hospitals. Across the provinces there is poor integration between specialty services uniquely available in children's hospitals and community-based services with the capacity to deliver surgical care to some children. In our geographically vast provinces this disconnect means that families often travel to a children's hospital to receive surgical care that could be safely and effectively delivered much closer to home. The lack of coordinated funding of hub-and-spoke models of children's surgical care causes disorganized utilization of existing surgical capacity, and uniquely disadvantages families who live outside the urban areas where children's hospitals are located. It also means there is no line of sight on children waiting for surgery in adult hospitals, where they represent a tiny piece of the pie and risk being overlooked in favour of adult surgical priorities like joint replacements and cataract surgery.

What can be done?

First, our children need targeted and sustained federal and provincial funding for children's surgical services.

Second, our children need pediatric-specific HHR recruitment that will address gaps in all service areas.

● (1120)

Third, our provinces need coordinated, integrated health services planning that “right sizes” child health services to population need so that children have the right operation at the right time by the right surgeon as close to home as possible.

Fourth, our children need governments to encourage and fund innovation that specifically benefits child health. This should span the spectrum of discovery research, implementation science, AI, health technology assessment and regulatory approval so that we are continually improving care and health outcomes for children while introducing efficiency that will drive value in health care.

More than ever before our children need advocacy within a public health system for their unique care needs, including prioritization for surgery. Children are not small adults and are not less deserving.

Thank you for your attention.

The Chair: Thank you, Dr. Skarsgard.

Finally, we have Patsy McKinney, executive director of the Under One Sky Friendship Centre.

Welcome to the committee, Ms. McKinney. You have the floor.

Ms. Patsy McKinney (Executive Director, Under One Sky Friendship Centre): Good afternoon, committee.

My name is Patsy McKinney. I am the executive director of Under One Sky Friendship Centre in Fredericton.

I want to recognize that I am joining you today from the unsurrendered, unceded traditional lands of the Wolastoqiyik in Fredericton.

I want to thank you for the invitation to appear before the House of Commons Standing Committee on Health today.

The indigenous population in Canada is young, rapidly growing and largely urban-based. Nationally, approximately 65% to 80% of Canada's two million indigenous people live in urban settings. The urban indigenous population continues to expand at a rate four times faster than that of the non-indigenous urban population.

Despite being one of the largest and fastest-growing segments of the Canadian population, urban indigenous children face a range of complex health challenges across a variety of social determinants. Our children continue to be denied their inherent rights and equitable access to culturally grounded, quality services due to unstable and insufficient funding, lack of continuity in a patchwork of programs and services, jurisdictional ambiguity and a lack of indigenous control over the planning, design and delivery of programs.

I want to talk briefly about the friendship centre movement and its work.

With a vast majority of Canada's indigenous population living in urban environments, friendship centres fill an essential gap in service provisions as one of the few organizations directly catering to urban indigenous needs in a status-inclusive model. For more than 50 years, friendship centres have aided first nations, Inuit and Métis living in urban environments. Collectively, we refer to our network of over 100 local friendship centres as the friendship centre movement. We deliver over 1,300 programs and serve over one million people per year. The friendship centre movement is Canada's most significant and comprehensive urban indigenous service delivery network.

Historically, the Government of Canada has failed to uphold the rights of children and care for their well-being. Public policy decisions and budgetary allocations often do not prioritize Canada's youngest citizens, which is evident at all levels of government.

Indigenous children continue to be disproportionately represented in the Canadian child welfare system. This ongoing and growing crisis is the result of the lasting impacts of colonization and the residential school system. Compared with non-indigenous children in Canada, our children are more likely to grow up in families affected by intergenerational trauma and the multiple and interrelated downstream effects of poverty. They are more likely to be removed from their homes, cultures and communities by the contemporary child welfare system.

Urban indigenous children, youth and families face additional barriers to accessing culturally safe programs and services that reflect their needs and best interests, both as indigenous people and as children. The need for culturally safe and accessible urban indigenous-specific and urban indigenous-driven community support is high and continually growing.

There is an urgent and pressing need to ensure that all indigenous children, regardless of residency, can fully appreciate their rights both as indigenous peoples and as children. All indigenous children ought to receive culturally relevant programs and services offered by indigenous-owned and indigenous-operated entities, whether they reside within their respective communities or in an urban setting. Solutions to the health crisis facing indigenous children can be found within our own communities and our organizations.

Friendship centres have a long and demonstrated history of effectively supporting the health and well-being of indigenous children through wraparound services. Friendship centres across Canada will continue to support the holistic well-being and safety of urban indigenous children, youth and families.

The ongoing threats to the health and well-being of children and the violations of children's rights in this country warrant immediate attention, investment and action by all levels of government. With a solid majority of indigenous people living in urban areas and as a young and fast-growing population, effective policy, programs and legislation must adopt an urban lens. Urban indigenous communities and indigenous-led organizations must be part of any solution to meaningfully improve the lives and future of Canada's children.

● (1125)

The friendship centre movement is unique in its ability to uplift and support urban indigenous communities, mobilizing advocacy and collaboration through a national network. All levels of government should be prepared to work with friendship centres, community leaders and indigenous peoples in urban setting to develop collaborative and meaningful solutions that consider the perspectives of all affected individuals and communities.

I want to thank you for your time and consideration. I look forward to answering any questions you may have.

The Chair: Thank you, Ms. McKinney.

We're going to move to questions right away, beginning with the Conservatives.

Ms. Goodridge, please go ahead for six minutes.

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

Thank you to all our witnesses for participating with us today.

I'm going to start by thanking you, Dr. Skarsgard, for providing your notes in advance. It's always very helpful when we have the notes in advance.

One of the questions I have from your notes is about the importance of having a health human resources program and plan that is pediatric-specific. I'm just wondering if you can expand on what that would look like if you were to design something along those lines. What would you want to see in that?

Dr. Erik Skarsgard: Thank you very much for this question and for an opportunity to respond to the greatest challenge, which is that of human health resources. This is a problem writ large in health care. I don't think that's a secret to anyone.

Our challenge is that the needs of our patients in hospital and out of hospital are unique and developmentally specific. We are seeking human health resources that would largely be represented by specialty-trained nurses who have gone that extra mile to get training that is child-specific. This involves post-graduate training programs. They're usually hospital-based. They often require a commitment of time and often are not financially supported. We really need this pipeline of nurses to have a significant number of them directed into or incentivized into being child-specific in their focus of care.

Nurses often travel great distances to come to work in a children's hospital. There are community hospitals that are much closer. The unions would pay equivalently for them to work in a nearby community hospital. It's only their dedication to children that makes them drive farther, commute at greater expense and, really, live out their passion, which is to care for children. That's something that's shared by all of us who work in child health care.

The answer to your question is, really, that we need to enhance the pipeline and then we need to direct part of that pipeline and entice them and retain them in a pediatric career.

● (1130)

Mrs. Laila Goodridge: That's fantastic. That leads really well into my next question.

You talked about how there's a disorganized system that disadvantages families who live outside of urban centres. As an MP who represents a large northern isolated region in northeastern Alberta, I know that there are no children's hospitals throughout my entire riding. That means families in my riding who need those kinds of services often have to go into larger centres like Edmonton or Calgary, which are five or nine hours away, in order to get services.

There has been movement in the last little while to have more services delivered at community hospitals. I'm just wondering if you think situations like that would help not only with the health human resources, to allow some of these nurses who have specialized to stay in their communities, but also to provide solutions to families that are outside of those urban centres.

Dr. Erik Skarsgard: Thank you for this question.

What you described really highlights what I think is the next challenge in children's services planning by the provinces. That is to really make sure we are using existing capacity in the most effective and efficient way, so that we limit children travelling to an urban tertiary or quaternary children's hospital. It goes without saying that some children will have to, if they have a condition that really mandates the type of specialization that's uniquely available in children's hospitals, and then we have to have systems to get them there. However, a lot of the care that's provided in children's hospitals is care that could be safely and effectively delivered in community settings.

What's required for that to happen?

First, we need strengthened partnerships with the regional health authorities. Second, we need to have codesign of pediatric health services planning so there is consideration for having a certain number of pediatric beds and a certain skill set among nurses and pediatricians and allied health within those community centres to provide the type of care, such as surgery, that a child in those centres might need to access.

Mrs. Laila Goodridge: Thank you. I appreciate that. I do have a very limited amount of time, and I want to switch gears here a little bit.

Ms. McKinney, I have quite a few friendship centres across my entire riding. They do amazing work connecting with the community. I'm wondering if you could touch on how important healthy living is for having healthy kids. I've seen some of the innovative work your friendship centre is doing, and I'm wondering if you could expand a little bit on that. I think there's quite a bit there.

Ms. Patsy McKinney: Sure. Absolutely.

We know that children's health isn't based just on the medical system. I'm sitting here with a group of medical professionals, which is amazing. What we also try to do as a friendship centre is to come in upstream so that we're providing programs and services before these children end up unwell. That means supporting families with some of the programs that we're offering, including food security. I know that many of the friendship centres across the country during COVID offered immunization clinics around all of that.

We're better prepared than most mainstream institutions to do this because we understand our community. We understand the people we're serving. The reality for most friendship centres is that they are struggling to be able to do this with a growing population. Just here in Fredericton, I think the indigenous population off reserve has quadrupled.

Mrs. Laila Goodridge: Thank you so much. I think we all appreciate hearing this, but I will cede my time, because I know that we're now over.

The Chair: Thank you, Ms. Goodridge.

Thank you, Ms. McKinney. Don't worry, because I'm sure you'll get a chance to expand on that.

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

● (1135)

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

I'd like to thank the witnesses for being with us today to share their important perspectives.

My first question is for you, Dr. Skarsgard. Can you discuss the impact of the COVID-19 pandemic on pediatric surgery services? How do you believe that the new federal funding commitment will help clear up any backlogs? You talked about the target funding. Can you expand on that?

Dr. Erik Skarsgard: Certainly. Thank you for the question.

One of the other witnesses very eloquently described the impact of COVID-19 on children. In the children's hospital perspective, it was something where we really didn't know what to expect and what impact it would have on children. We did learn some things about transmission to children, but really, in terms of comparative impact to adult health services, we did not see children dying in children's hospitals, as we did adults in the adult hospitals. In fact, what ended up happening was that we sent many of our critical care nurses to work in the adult health system or, in some instances, to look after adults in children's ICUs. It was a very different impact from what was seen in adult health services with COVID.

I think your question about prioritized funding for children was next. We're all so grateful for these transfer payments, but there's always a risk that children are forgotten because children's services represent such a small proportion. Less than 3% of surgeries done in my province are in children under 18. There's been some talk about earmarking a certain proportion of those transfer payments to the provinces so that they must be used specifically for children's services, and I applaud that. I encourage more of that thinking that targets resources specifically to children and does not rely on others to prioritize children with funding.

Ms. Sonia Sidhu: Thank you, Dr. Skarsgard.

My next question is to Ms. Grandvaux.

I'm wondering how obesity can impact the immune system. Can you expand on the importance of ensuring healthy eating and active living? I've had a chance to visit many research sites, particularly around diabetes, and I know that we've talked about the rare diseases too. How can we ensure that children are involved in the research process and that their voices are heard when it comes to decisions about their health?

To follow up on that, how can we better support parents and caregivers in promoting children's health and preventing the spread of viruses?

Dr. Nathalie Grandvaux: Thank you for the question.

You have said it right. Obesity and diabetes were recognized as factors for vulnerability to COVID-19 very early on, in the beginning of the pandemic. These are definitely comorbidities that are impacting the immune system. That's not in terms of the research but, obviously, it has been described more in adults. Often, it is a negligible factor for illness in children.

As my colleague Dr. Lamarre explained, there is a need for improving research in pediatric diseases, especially infection and the impact of these comorbidities. There is definitely more research that needs to be done. I think this should be prioritized in the funding in the next years in Canada and worldwide. We need to have a better understanding of how life and comorbidities impact the capacity of children to combat infections.

This can be done through research, of course, but I also liked the intervention from Professor McKinney, who said we also need to work upstream. I think we need more education on all lifestyles and how what children eat impacts their capacity to fight infections and other diseases.

It's definitely a priority. It needs to be integrated. I think it needs to be part of the research program mission from the institute that funds health, but also the social sciences. All of these need to come together in integrated funding to address this question and educate more. It should also be part of education at school to help children very early in their lives to understand how this can impact their lives.

● (1140)

Ms. Sonia Sidhu: To follow up on that, is there any particular area of research or treatment that you feel is being overlooked in the field of children's health?

Dr. Nathalie Grandvaux: I think there are many aspects. I think the health of children has been overlooked overall, as my colleagues described.

It's a limited impact. I can only take the example of respiratory syncytial virus, on which we heard a lot. I have been working on that for 20 years now. It was widely overcome before, because we said it's a limited number of children who will be impacted. Also, indigenous people are highly impacted by this, compared to the general population.

In my opinion, what is widely overcome is what you just described before, which is the impact of comorbidities on the health of children in general, like the food they get all their life, together.... All of this impacts the capacity to fight the disease that will not impact a child, whilst all the good food and everything will make a good immune system to fight all of that.

It's more the correlation between.... We have a lot of research on specific diseases, but we always ignore that not all children are equal in the face of disease. We need to get a diversity of information about how children will respond in their capacity to fight different diseases, depending on their backgrounds and their lifestyles. That's something we have to put more emphasis on in research.

The Chair: Thank you, Dr. Grandvaux and Ms. Sidhu.

[*Translation*]

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

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

What a great group of witnesses we have today to complete this study. We have people who conduct basic research and people working in the field. The entire health sciences ecosystem is represented.

I will try to ask smart questions.

Let me begin with Mr. Lamarre, because I think what he said is important. I think the pandemic showed us that basic research is the foundation for the biotechnology and technology expertise that enabled us to achieve results. This has been so overlooked in Canada, for decades, that we have lost researchers. We lost them because the research grants are pitiful. You mentioned that earlier. We cannot retain talent without adequate financial support, and those are the most important people during a period as critical as a pandemic.

I would like to hear your thoughts on that, Mr. Lamarre. Do we have a strong health sciences ecosystem right now?

In the last three years, have you seen greater awareness and concrete steps on the part of authorities?

You are making recommendations that I have seen before, Mr. Lamarre, and I think they have gone unanswered.

Dr. Alain Lamarre: Thank you for your question. It is right on the mark.

There is in fact a chronic problem with investment in research in Canada, for the past 20 years or so, I would say, and research budgets have stagnated while costs have risen, meaning that we ultimately have less money to conduct research.

I cannot say that nothing has been done in the past three years. The federal government has in fact made major investments, but they have been in fields that had been completely neglected over the past 20 years. The fabrication of biological products, vaccine development, fabrication and biofabrication had been underdeveloped or underfunded for decades, so we have started to catch up in these areas.

In addition, certain initiatives focused on the pandemic, and rightly so. Significant research and development investments were made in vaccines and biological products to deal with SARS-CoV-2. Nonetheless, it bears repetition that future innovation depends on basic research. We cannot predict future needs in the event of another pandemic. So we must continue to fund basic research in a broad range of areas in order to be better prepared for a pandemic caused by another pathogen, or for a non-infectious health crisis. At least we would have the basic knowledge in order to respond more quickly.

So I think investing in basic research is essential. Canada needs to make a major shift in direction because we are really in free fall. Canada is nearly at the bottom among G7 countries in this regard.

● (1145)

Mr. Luc Thériault: It must also be said that we have some valuable talent and brilliant minds.

Before I give the floor to Ms. Grandvaux, I would like to say something.

There would not have been any mRNA vaccines without all the research—as I learned from a close source—done in the 1980s at the Scripps Research Institute, San Diego. In other words, work on that had already begun. Those 40 years of research got us out of the pandemic. Cutting that research means cutting off our legs and preventing us from dealing with global problems in the future.

Ms. Grandvaux, would you like to add anything?

Dr. Nathalie Grandvaux: Yes, two things.

First, it is true that we would not have been able to fight COVID-19 as we did without all the basic research on viruses, mRNAs, and vaccines that was done in advance. Because of that research, we were able to respond more quickly when the pandemic hit. Basic research is essential and it must be protected.

The second point, which I think is misunderstood, involves the use of basic research funding.

We talked about staff shortages. Yet most of the funding we receive is used to fund lab staff. Apart from us professors and a few professional staff, the people in our labs that we depend on are primarily students and postdoctoral trainees. This is really where we are not competitive. We do not offer the same salaries as other countries and we do not have professionals in our labs, slowing down our research.

When we ask for a bigger budget, we often hear that we can make do as scientists, but the money is for staff. That money goes toward our talent and capability. That is where we are really falling short.

I think we really need to understand that to make our research as effective as possible in Canada.

The Chair: Thank you, Ms. Grandvaux.

[*English*]

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

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

Thank you to all the witnesses for their excellent testimony.

Dr. Lamarre, I'll begin with you, please. At your appearance before this committee on June 18, 2021, you said the following:

> According to data from the Organisation for Economic Co-operation and Development (OECD), Canada is the only G7 country where gross domestic expenditures on research and development have been declining since 2001. It is now the second lowest in the G7 on this measure, ahead of only Italy.

If you know, Dr. Lamarre, what portion of Canada's gross domestic expenditures on research and development are directed towards child- and youth-focused health research?

Dr. Alain Lamarre: I wouldn't guess any number, but as other witnesses have said, it's a minority, for sure. There's a lack of funding, in general, but it's probably even more pronounced for children's research. That goes from fundamental research all the way to clinical trials, which are also difficult to conduct for children. There's probably, also, underfunding for clinical trials in children's diseases or for children's medications that are in development.

I wouldn't want to guess any number, but it's probably even more severe than what we see for adult research.

● (1150)

Mr. Don Davies: Do you have a sense of where Canada might compare with peer jurisdictions in terms of how much we allocate towards research for child- and youth-focused health?

Dr. Alain Lamarre: It's probably even worse than the budget allocated to fundamental research in the G7. Yes, we are second-last in that aspect, and it's probably not better than 20th position in the world for children's research. I think there's a lot of ground to be covered.

Mr. Don Davies: Thank you.

Dr. Skarsgard, if I could turn to you.... Is there national data available on the number of children who are on wait-lists for surgeries?

Dr. Erik Skarsgard: There is if we aggregate provincial data. We used to have an organization through what is now Children's Healthcare Canada that kept track of national data. We rely now on provincially aggregated data, so the data that I provided to you is self-reported from children's hospitals.

Mr. Don Davies: Do you see the need for better national data on this? Would that be helpful?

Dr. Erik Skarsgard: I do think it would be helpful, as would more national co-operation. Child health, still, is a provincial responsibility. With greater integration across provinces—sharing of what's working and what's not, dealing with some health human resource pipeline issues, sharing technology and technology assessments so that we can drive the approval of pediatric-specific devices more effectively in Ottawa—I think there's great opportunity for national collaboration in data sharing and in operational management.

Mr. Don Davies: Thank you.

Dr. Skarsgard, in a December 2022 article from the Vancouver Sun, you noted that B.C. Children's Hospital has found ways to add some additional surgical capacity by prioritizing cases that are developmentally timed for the best outcome, such as those for kids with scoliosis or heart defects, for kids with cancer and for those coming from remote areas.

Can you give us a sense of how much additional capacity that strategy has created? Also, what is the current backlog for surgery at B.C. Children's Hospital?

Dr. Erik Skarsgard: I would say that we didn't actually create a lot more capacity. Rather, we shifted the capacity that we had to those priority areas that you mentioned.

We certainly do have some capacity-building strategies that include consistently opening additional ORs, running ORs later in the day and even trying to run operating rooms on weekends—doing elective surgeries on weekends.

I'm sorry. I've just forgotten the second part of your question. I apologize.

Mr. Don Davies: What is the current backlog for surgery at B.C. Children's Hospital?

Dr. Erik Skarsgard: I did provide some figures that show that our current wait-list is about 3,800 patients. That's double what it was before the pandemic. It's important to realize that a wait-list is just a number. What you're not capturing in that number is the percentage of children who are waiting beyond their wait-time target, which is really important for some of those developmentally timed surgeries, like surgery for scoliosis or for cleft lip and pallet. Those children are on the wait-list, and they're waiting longer than they've ever waited before.

Mr. Don Davies: I have some data from 2018 that shows that only 65% of elective surgeries in Canadian children's hospitals were completed within window, suggesting insufficient national capacity even before the pandemic, which I think we all realize has been exacerbated.

In your view—and you've touched on this a bit, Dr. Skarsgard—what steps should the federal government take to expand Canada's pediatric surgery capacity?

● (1155)

Dr. Erik Skarsgard: I think we need targeted funding for children's health care with the transfer payments to the provinces. We need co-operation in planning within the provinces between, as I mentioned, the children's hospitals in the community that really target the building and retention of child health care capacity. This can't be something that is just a quality improvement project. This has to be something that is identified as a priority and sustained across annual budgets.

The Chair: Thank you, Dr. Skarsgard.

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

Mr. Matt Jeneroux (Edmonton Riverbend, CPC): Thank you, Mr. Chair.

Thanks to everybody for joining us here today.

I got scooped a bit by my colleague and friend at the end of the table, Mr. Davies, on the question I was going to go into with you, Dr. Skarsgard, but I'll also address it in a bit more detail.

There are two facts that really stood out in your testimony here today: that 65% of scheduled surgeries were performed within the window and that this goes back to 2007. This is a crisis, as you indicated a number of times, but a crisis that absolutely should be addressed by all levels of government across the country, quite frankly.

However, there are some 2018 numbers that were quoted by Mr. Davies. I see by your 2023 numbers here that it's 58% out of window. Is this trending in a negative direction? Perhaps you can fill us in a bit on that.

If I could, I'll just add my second question to that before I turn it over to you. To unpack some of what you said to Mr. Davies, is this a matter of resources? Should the federal funding go to more nurses? Should it go to more infrastructure, to operating rooms and to more hospitals in general? If you can unpack exactly where some of that would make the biggest difference, it would be helpful.

Dr. Erik Skarsgard: Thank you very much for the question.

That figure of 65% out of window requires some interpretation, because in some reports it reflects completed cases. An operation gets done and comes off the wait-list, and we are also interested in how long those children waited to have surgery.

You can also have an out-of-window measure on children who have not yet had surgery, and that's perhaps the group that are at greatest risk, because we don't know when they will have surgery. Maybe they will be 60%, 70% or 80% out of window when they finally get surgery. We've shifted our focus to out of window as being an important measure for children who are waiting for surgery because the wait-lists have grown so greatly over the last three years.

I would say that's still a very important number and one that we need to keep an eye on, but it also needs to be measured in the context of the total corpus of the wait-list in the provinces and across the country.

The other question was with regard to...? I'm so sorry. Would you just remind me?

Mr. Matt Jeneroux: Yes, it's no problem. It's about unpacking what would be most helpful. Is it infrastructure, nurses...?

Dr. Erik Skarsgard: In my hospital and in the discussions we have with the other chiefs of surgery at the other children's hospitals, it's nurses. It's nurses who keep our ORs and our recovery rooms open and nurses who staff hospital beds, particularly in critical care areas.

We can have a child waiting for surgery, we can have a room and we can have a surgeon and an anaesthetist, but without a nurse to staff a bed for that child to go to after surgery, we can't start that case. Obviously you can see the shift in the allocation of resources away from children who need beds after surgery, which means that we use that time in other ways, but it's usually to treat children who don't necessarily need a bed after surgery.

Some of the other issues around space and equipment are important, but I would have to say that in my hospital, and in most of the children's hospitals across Canada, it is the nurse human health resource that is the limiting factor.

Mr. Matt Jeneroux: That's interesting.

From what I understand, in British Columbia everybody has to be in the room. I forget what it's called, but the anesthesiologist, nurse and pediatric surgeon all have to be in the room prior to the start of the surgery and get the patient's sign-off.

I'm going to jump to my second question, but if I'm wrong on that, definitely correct me. It's only because I have about 30 seconds left.

The other fact that jumped out was that less than half of all operations for children are performed by people other than pediatric surgeons.

Are these typically family doctors in rural and remote areas? If someone doesn't have the benefit of living in downtown Vancouver and they're in a remote area in B.C.—if they don't go to your hospital—then are they getting their surgery done by a family physician instead?

● (1200)

Dr. Erik Skarsgard: No, definitely not. These are specialist surgeons who may not focus their practice on children, but certainly can provide care for children.

These would usually be children who are older, like teenagers, who don't have comorbidities that would require the care of children's specialists. These would be children who need hernias fixed, gallbladders removed or some minor orthopaedic surgery. All of these things can be safely and effectively done in the community if the community hospitals are set up to provide care and the providers are incentivized to care for children.

They have long wait-lists of adult patients. Quite frankly, the fee guide for a fee-for-service surgeon will not encourage them to do a minor procedure in a child if they have the option of doing an operation in an adult.

The Chair: Thank you, Dr. Skarsgard and Mr. Jeneroux.

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

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

I also appreciate the excellent testimony we've heard from all of you today. Thank you for that.

I'm going to try to pick up a few themes that haven't been discussed as much.

Dr. Grandvaux, first of all you talked about the need to improve air quality and how we can move towards matching what we have achieved in public health in water quality. I think one difficulty is arriving at standards. I wonder if you could reflect on that a little bit.

We know that there's already a tremendous variety in air quality, depending on the size and age of the building. How do we develop standards so we actually know what we're aiming for, rather than a more general improving air quality kind of question?

Dr. Nathalie Grandvaux: Thank you for the question.

It is true. There have been a lot of committees in place—for example, in the U.S., Europe, Belgium and France—to discuss what the standard should be. We already have standards that exist from different organizations.

Experts in ventilation could definitely explain it better than me, but from what I have read and what I see worldwide in countries that have taken on the task of improving indoor air quality is that they rely on CO2 measurements to give an idea of how efficient the ventilation and air exchange is inside. I think, from what they have done so far, it's a good and easy measurement with the apparatus that is available right now. They can measure how the air is changed in an environment.

I think it's really powerful because it will indicate, in terms of infectious diseases.... It's what we need. We need the air to be exchanged to decrease the number of aerosols inside. There are different associations in the world committed to defining the standard. They are already out there. For example, Belgium or France have decided to go with 800 parts per million as a definition. In Quebec, we are still at 1,500, which is far above the international standards that have been decided.

I think we need to discuss with the international commissions to adopt the same standard.

Mr. Brendan Hanley: Thank you.

That's very helpful. Hopefully we can work on developing some national agreement.

I'm going to jump to Ms. McKinney and change the subject a bit.

You mentioned moving upstream. I'm going to take you a little further upstream.

When we look at some urgency of our children's health, particularly indigenous children's health, given the many challenges both prepandemic and postpandemic, there's been a lot of work in the Yukon territory amongst the self-governing first nations in particular on developing language nests and increasing that connection with culture, mainly through language development.

I wonder if you could comment on the importance of supporting indigenous language knowledge development and, through that, a greater connection to one's culture.

● (1205)

Ms. Patsy McKinney: Absolutely. We know it's part of wellness, especially for indigenous people. The loss of our language has impacted our entire family for generations, so we know this. There's a whole body of research out there on mother tongue languages and how important those are for children developmentally. Many of the friendship centres across the country are trying to focus on restoring and resurrecting our indigenous languages. We have two languages in New Brunswick: Wolastoqiyik and Mi'kmaq. We are working diligently on that, but we have to understand it's a challenge, because many of our speakers are aging. We're losing them, so we have a sense of urgency around that.

For indigenous people, it's all connected. We take a holistic approach toward health and wellness. It's not just about how much you weigh or what your blood pressure is. It's about how well you are within your community, culture and language, and how families are being supported. It's very important, especially for children, to realize that our language is as important as other languages.

New Brunswick is the only officially bilingual province in the country. Our French brothers and sisters have done an amazing job of making sure that happens for their children, because they know it's important. It's not as if we have to look outside the country for that. We have amazing examples in our own country and province. French-speaking children can go to French kindergarten, day care, middle school, high school and all the way up to university, but we don't have that. At a minimum, that's what we're hoping for someday.

I don't know whether I answered your question.

The Chair: Thank you, Ms. McKinney.

[*Translation*]

Mr. Thériault has the floor now for two and a half minutes.

Mr. Luc Thériault: My questions are for Ms. Grandvaux and Mr. Lamarre.

At the last committee meeting, Dr. Quach-Thahn said the next pandemic might involve resistance to antibiotics. Do you share that concern?

In this regard, she noted that the increase in viruses at CHU Sainte-Justine was also accompanied by an increase in serious bacterial infections. In that case, shouldn't it be mandatory to maintain or increase immunization?

Could you both comment on that please?

Dr. Nathalie Grandvaux: I can begin.

I completely agree with Dr. Quach-Thahn. There was concern about resistance to antibiotics long before the COVID-19 pandemic. This should be a research priority in order to find alternatives to antibiotics.

I believe Canada has already invested in this in the past. We must continue this type of research in order to find alternatives to antibiotics.

Viral infections have a significant impact on bacterial infections. We have seen this and we must address it.

As I said before, a certain number of bacterial infections are also picked up from the air and from contacts. If we work proactively to prevent infections, that will also limit their impact.

I will let my colleague continue.

Dr. Alain Lamarre: I would have said the same thing.

I would add that, unfortunately, the big pharmaceutical companies have little incentive to develop new antibiotics. It is a very complex and very competitive market.

So we have to rely on the research done by universities which, however, depends on government and federal funding. That funding must therefore be sufficient, especially for research and development of new antibiotics.

● (1210)

Mr. Luc Thériault: Could immunization be one proactive approach to fight that potential pandemic?

Dr. Alain Lamarre: Definitely.

People working on fighting infectious diseases all agree that we need the highest immunization rates possible. Unfortunately, there are no vaccines that combat all infectious agents. So there are still many more vaccines to be developed.

I mentioned the respiratory syncytial virus, but there is a whole range of illnesses for which there is still no vaccine. Those include HIV, the hepatitis C virus, and malaria. There is still much work to be done in this regard.

The Chair: Thank you.

[*English*]

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

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

Dr. Skarsgard, help me get a better, clearer picture of the state of operating room capacity. Obviously, you can speak about the capacity at B.C. Children's. I wonder if you know a bit more broadly if our operating rooms are being utilized at full capacity right now.

Dr. Erik Skarsgard: We have operating rooms at B.C. Children's Hospital, and, for example, at Sick Kids and other larger children's hospitals in Ontario. I know less about Alberta, but we have children's operating rooms that are fallow. They are empty. It relates to the fact that we aren't able to staff them. The point was made that you need a full team. You need a surgeon, an anaesthetist, nursing and RTs. There are lots of human resources that go into being able to run an operating room, and you need every critical piece to ensure a safe operative encounter for a child. I would say that we don't really lack in many of our hospitals in physical capacity, but, again, we lack the staffing that's required to safely and efficiently run an operating room.

In terms of our operating room efficiency, what we do notice is that, when we shift the focus from elective care to urgent emergent care.... It's important to realize that throughout this period we have never neglected our obligation to look after children who are in need of urgent surgical care, but if you shift a resource that is intended to be used efficiently electively to support emergency care, instead of running eight elective rooms, you run four, and then you run four urgent rooms. That's where your efficiency really goes down, because you're changing.

In a single day, you may have a heart operation, an orthopaedic operation and an appendectomy, and when you do that, when you're shifting teams in and out of rooms, that's where efficiency really takes a hit. It's a capacity that needs both the guarantee of an elective schedule to run efficiently, but also sufficient capacity so you can get at the patients who are on the wait-list and really dig into those to make reductions in those long wait-lists.

The Chair: Thank you, Dr. Skarsgard.

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

Mr. Robert Kitchen (Souris—Moose Mountain, CPC): Thank you, Mr. Chair.

Thank you to our witnesses for being here. It's greatly appreciated.

Some of my questions have already been sort of touched on, so I'll try to touch a little bit differently on them.

Dr. Skarsgard, thank you for your presentation. You talked a bit in your point number one about dealing with the lack of skilled, specialized nurses.

One of the smartest, hardest-working and most compassionate people I know is my wife, Donna. She started her career as a neonatal intensive care nurse in the ICU at University of Alberta Hospital. Then she went to the ICU at the Hospital for Sick Children. She was there for a number of years, and we got married. She moved from there to Sunnybrook trauma centre. She did all this progressing as she went along.

Your comments about how we improve these nurses' skills and get them to be involved is very commendable, and it is something we need. Has the Pediatric Surgical Chiefs of Canada talked to the regulatory bodies or to the universities to look at providing these programs and how they can move forward on that?

● (1215)

Dr. Erik Skarsgard: I can't say that the surgical chiefs have directly, but through our strong collaboration around advocacy with Children's Healthcare Canada, I know that there have been some conversations at the level of provincial nursing colleges trying to create more seats for nursing and then specifically trying to incentivize a diverting pipeline of nurses who then go on to dedicate their careers, as your wife did, to that of child health.

What we do see is the phenomenon of nurses who drive by many community hospitals to commute to work at a children's hospital at personal expense. It's because of that dedication they do that. We need to create more of those nurses who are dedicated to a professional career in looking after children and families. We do that through advocacy in the provinces, and we do that, as was mentioned, in collaboration with these groups that are across Canada so that we can also bring this voice to you and drive the message that we need to target resources of all kinds, but particularly for recruitment and retention, to the pediatric health workforce.

Mr. Robert Kitchen: Thank you.

One of the challenges we see across Canada now is travelling nurses. They're travelling all over the country and all over the world, and taking their skills to various levels, which is a huge challenge. My wife and I moved to rural Saskatchewan, so, as many of my colleagues do, we deal with rural areas. We're challenged in those areas to ensure that we have appropriate staffing. You mentioned quite clearly about community hospital centres having the ability to try to keep people in those local communities before the parents send them or the doctors end up sending them up to the specialty hospitals, in particular the children's hospitals—for example, Pattison Children's Hospital in Saskatoon, or in Calgary, etc.

Ultimately, these are challenges. The concern that is out there is that today the public tends to turn around and look at Dr. Internet and Dr. Social Media to choose the answers and determine what their problems are. Through that, they then jump on it and say they have to go to these...and clog up a lot of the children's hospitals or even our mainstream hospitals.

How do we go about solving that? What steps can we take to try to get Canadians to understand that their practitioners are where they need to be getting their advice from?

Dr. Erik Skarsgard: It's a really good point. I think it speaks to the need for an increased capacity and strengthened relationship of the public with primary care and family doctors. That really should be the source of advice for families, particularly if they're seeking or need specialty care.

In terms of trying to create capacity and create confidence in communities in community health capacity for children's services, I think part of that is a partnership of children's hospitals with those communities and with the providers in those communities where there is a sense, whether from branding or even just presence.... Many of our specialists go to many parts of the remote areas in B.C. to do outreach. They have cardiology clinics in remote areas. Digital health allows that opportunity as well. We can use telemedicine to meet families in their communities and give them the sense that they are really closely linked to specialty care.

I really think it's that strength of partnership with community, where we create child-specific and child-safe capacity to deliver care in those communities, where families will get confidence that it's safe for their 10-year-old child to have their hernia fixed by a general surgeon in Prince George rather than travel all the way to Vancouver.

The Chair: Thank you, Dr. Skarsgard.

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

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

Thank you to all the witnesses today. It's been a fascinating meeting so far, and I look forward to hearing more.

One thing I've been preoccupied by, in listening to some of the testimony today, is how much more valuable a health intervention is at some point early in a person's life, as early as possible, actually, particularly if they're dealing with adverse health conditions early on, like a rare disease or something like that. My questions are around that, about early intervention for people and how that can have a positive impact on the trajectory of their lives.

Last week, on our break week, I was fortunate enough to go to Canmore, Alberta, to take part in an organized activity with Spirit North, a sport organization. It's a charity that provides sport, physical activity and recreational opportunities to indigenous youth, first nations youth primarily, throughout Alberta, Manitoba and Ontario. It was awesome to see so many smiling faces and to see so many young people loving and enjoying moving and physical activity.

My first question is for you, Ms. McKinney. I'm curious about specific interventions that would address and improve children's health issues from an indigenous perspective and how our government can more thoroughly address and support these types of interventions. Are there any studies, programs or policies that you see that have been making a difference and are things that we should do more of?

● (1220)

Ms. Patsy McKinney: That's a great question.

One of the things we're doing here is land-based learning. We developed a nationally renowned program called “Take It Outside”. It's a way of getting our children back out onto the land. It's not just a matter of taking them out on the playground. We take them to an old-growth forest with very natural environments, and it's also a great way for us to teach them their language in that environment.

One of the challenges we face is that families are living in substandard housing. We have really poor air quality and overcrowding, so all of those things lead to really poor health, especially for our children.

Those are some of the things we're trying to do. We actually had a bit of a kickback from the province here around our “Take It Outside” program during COVID. They called it a field trip. It's not a field trip. It's a part of our curriculum to get our kids back outside on the land. What's more healthy—being stuck in a classroom or being out on the land?

Those are some of the challenges we face, which is why it's really important for us to be delivering some of these programs as opposed to the mainstream programming. I know the mainstream has wonderful intentions, but it doesn't always work out well for indigenous families, so these kinds of programs become really valuable to the community.

One of the things we're doing is this land-based learning, but we're also now bringing it to adults. We have land-based learning for university students. All of that we think is really important. It also connects non-indigenous students with indigenous students, which speaks as well to wellness and some of the issues we have to deal with here. We have families living in poverty and substandard housing, and they're being faced with a multitude of really poor health issues. We care about healthy food, but how do you afford to buy healthy food when you're living on a fixed income?

Those are some of the things we're trying to get a little further upstream on before folks end up in the health care system.

Mr. Adam van Koeverden: Thanks, Ms. McKinney. You kind of took the words out of my mouth for my segue to the second half of my question.

With respect to being able to prevent people from having to access the health care system, it's a little bit of a guess that I'm making and I was hoping that one of the doctors might be able to provide some insight as to whether or not this assumption is at all correct.

When we're talking about lifestyle interventions to prevent people from having to access the health care system, I imagine a lot of those are far more effective for adults because they've lived longer and they probably suffer disproportionately from more lifestyle-related illnesses, like type 2 diabetes and others, but I imagine that those are becoming more and more a priority for children's health as well.

Would any of the pediatric experts or the doctors on the call like to comment on the value or the necessity of preventing children from having to access the health care system?

Ms. Grandvaux, go ahead.

Dr. Nathalie Grandvaux: It's a bit far from my expertise, but what I would say as a citizen maybe and from my reading of the literature on the benefits, not my direct expertise, is that I agree with you that lifestyle impacts the diseases that we see in others, but it's a lifelong story and everything we do when we're young also has an impact on our health when we become adults. I think the sooner we teach our children how to get good food, with all the limitations that Ms. McKinney just described, the better. You need to make that as well as physical activity available.

All of this is something that children, when they become adults, will have. It's baggage that they will have with them and that will help them in the long run. Just because we only see the diseases when we are adults does not mean that the behaviour when we are kids is not having an impact over the long term. I think we need to act as early as possible. I think there is a benefit to introducing that and to keeping children from having to go into the health care system when they are kids or they become adults.

● (1225)

The Chair: Thank you, Dr. Grandvaux.

Next is Ms. Goodridge.

Go ahead, please, for five minutes.

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

I will switch gears a little bit once again, and I'm going to start with Ms. McKinney.

In some of the wraparound supports and services you provide, do you guys do anything to help attract more appropriate and culturally sensitive prenatal care so that kids get the best start from the very beginning?

Ms. Patsy McKinney: We don't here, specifically.

One of the things that we did do was that we partnered with Horizon Health. We now have a nurse practitioner who comes to us and is available to many of our folks who come to the friendship centre. That was a big help for us. We noticed that most of the time it's moms with young children who are going to her.

One of the things we are hoping to build is a birthing centre, right here in our new building that we are hopefully going to have within two and a half years. That way our families can come and be able to do those things traditionally with a really good health care provider, while going back towards midwives and doulas and delivering babies in a more traditional way.

We have many people who are pretty excited about that. I believe that, at the friendship centre in Halifax, they had their first child born there, which was pretty exciting.

What we realized is that many of our families who are struggling with health or mental health issues will hesitate to go to mainstream services. The reason for that is the amount of judgment they face. Sometimes it might start off as a small, insignificant health issue that will grow because it's not getting addressed, since they are not going for help.

They will come here. We are trying to provide medical services here at the friendship centre, so that they don't have to go into mainstream services. There are some things for which they will have to go to specialized services, of course, but it's to get them comfortable to come here, because of what they're facing in some of these institutions they're going to.

One of the things we're working really hard on is cultural sensitivity training for the medical profession here in New Brunswick, because people are hesitant to reach out. It's not always safe for indigenous people, culturally.

Mrs. Laila Goodridge: Thank you. That's spectacular.

I think that if more organizations did things like that to have culturally sensitive approaches to child care and child birth, we'd be in a very good spot.

I used a midwife in my first pregnancy, and I'm intending to use a midwife again with the current pregnancy that I am in. I think it can be a very good option for people who are low-risk. As you pointed out, when the choice is between no prenatal care and prenatal care with a midwife, I think that's a great idea.

To switch gears a little bit, again, Ms. McKinney, what other services would you like to see come into friendship centres like yours and across the country to specifically assist children in getting the care they need?

Ms. Patsy McKinney: After-school programming and anything to do with education. Our kids have to go to mainstream schools. I don't know what it's like across the country in other places, but here, the highest level you can go to in community is grade 6—there may be one or two first nation communities that have grade 8—and then they're going into mainstream school. One of the things we really want to develop is after-school programming so that the kids can come here.

Right now we have a head start program. I'm hoping that everybody's familiar with the aboriginal head start in urban and northern communities. That is a federally funded program that has been around for 27 years now. We have one. I think everybody should have one. The beauty of the head start program is that it embraces the entire family. It's not just about them dropping off the kids and going on their way. We embrace that whole family. That's what's really important around delivering programs and services to vulnerable populations.

The mainstream will take a child, and they are just going to deal with the child. We don't operate that way. That's why it's so significantly important. If you have a child with autism spectrum disorder, you have a family dealing with autism spectrum disorder. It's not just about the child.

These are the programs that we're working really hard to develop, but of course we're under-resourced. We don't have enough capacity to do that. We're working hard around being able to deliver some of these programs. I have a wish list that's 20 miles long of programs that I wish I could deliver.

The need is growing faster than we can provide the services, because the population is growing. We also have two universities here in the city of Fredericton, so we have indigenous people coming from across the country to attend university. They're bringing their families with them. Their first point of contact is often our friendship centre. They may have been familiar with a friendship centre wherever they came from, so the first place they hook up to is a friendship centre.

We're hoping that we can have more head starts. There's one in New Brunswick. I say that because somebody should be embarrassed and ashamed that there's only one head start in New Brunswick. There's only one in Nova Scotia. There's only one in Prince Edward Island. We have three in Newfoundland and Labrador.

These are early intervention programs because we embrace the whole family. That's the model that we try to use. It's not just about dividing people up into whatever they need, whether it's mental health or food security. It's a holistic approach to most of what we do.

● (1230)

The Chair: Thank you, Ms. McKinney.

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

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

Colleagues, my apologies for not joining you in the room. I am recovering from a cold, and I just wanted to make sure that you all stay safe.

Dr. Skarsgard, thank you for your testimony and the same to all the other witnesses.

On your recommendation number four you specifically said:

> ...our children need governments to encourage and fund innovation that specifically benefits child health. This should span the spectrum of discovery research, implementation science, AI, health technology assessment and regulatory approval so that we are continually improving care and health outcomes for children while introducing efficiency that will drive value in health care.

Dr. Skarsgard, can you unpack the recommendation, specifically the whole spectrum that you talked about, within the perspective of one of the leading children health issues that we are dealing with in Canada?

Dr. Erik Skarsgard: Sure. Thank you very much for this question.

I'm fortunate to have, on this panel of witnesses, people who can speak much more scientifically and eloquently about the discovery research, the biomedical research, realizing that Canada has traditionally funded a spectrum of research from biomedical to health services research. I'm just trying to cover the waterfront with that statement.

My expertise would be most appropriately applied to the latter half of those priorities, at the end of that sentence. I think that artificial intelligence has great promise for children's health. I think making that a funding priority should be very clear to everybody on this call.

The last two, health technology assessment and regulatory approval, are things that really hit home for me as a practising surgeon, because much of the technology and many of the surgical devices that we use in children really are off-label—meaning, unregulated uses of technology and devices that were developed for adults. That presents challenges from the perspective of Health Canada in the sense that we are not allowed to get into this country some devices that are the standard of care for children's surgery everywhere else in the world, particularly in the United States.

That problem is not unique to surgical devices but also to pediatric medicines. It relates to the fact that the market for some of these—in my instance, surgical devices—is so tiny, even when you extrapolate it across Canada to 16 children's hospitals. For the companies that make this technology, it's just not worth the expense of getting it approved in Canada.

This was really unveiled in the pandemic when we had supply chain issues, and we simply could not get diagnostic tools into Canada. It forced some of these regulations to be fast-tracked.

I would just highlight that this is a deficit in our care. I think it is within the control of this group and others to allow greater consideration of medicines and devices that are proven safe and effective in other jurisdictions, particularly with the FDA, and to see ways to get them into the hands of care providers, who are uniquely interested in applying that device that is approved for use in children.

● (1235)

Mr. Majid Jowhari: Thank you.

I see a number of other witnesses today are nodding their heads as you're speaking and responding.

The floor is open to all of you, if anyone wants to add any comments.

Go ahead.

Dr. Alain Lamarre: Yes, regarding that last point, I would add only that this is good not only for devices and medication but for vaccine development. We've seen that during the pandemic. We're really dependent on the proper evaluation of vaccines by Health Canada. We need to move in a very efficient manner. To rely on other jurisdictions to speed up the process is something that I think was done in that situation, but it needs to be expanded probably to developments of other biomedicals, vaccines or for cancer, so that we don't reinvent the wheel every time.

Of course, there are always going to be some specific needs and country-centric jurisdictions, and things like that. The main scientific problems stay the same. You don't have to redo the whole thing every time, I guess.

Mr. Majid Jowhari: I know I'm out of time, but may I ask for the chair's indulgence? I would like to hear from Dr. Grandvaux. Could you give us 30 seconds of additional time? I would really appreciate it.

The Chair: Answer very briefly, please.

Dr. Nathalie Grandvaux: The transition from research to translation or application in children is also a place where we could make the same comment about weakness. A major improvement could have been made for RSV infections, but it was blocked because we needed a company to make something special that didn't exist for children. The market is too small, so it was blocked. With specific funding, we could solve the transition and have children-specific treatments that are in the research pipeline but that we cannot apply because of these limitations.

The Chair: Thank you, Dr. Grandvaux.

[*Translation*]

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

Mr. Luc Thériault: Dr. Skarsgard, you talked about a crisis in human resources. Can you outline the various reasons for this crisis? We have some idea of the reasons in Quebec. We have a number of problems retaining staff.

Was this situation anticipated and was there proper planning? Did faculties of medicine foresee it? Is the quota system excessive? Moreover, if we decide to limit quotas further, that will require a lot more money because those people will have to be trained.

In short, what are the main reasons that people are leaving certain fields of medicine? The loss of those people will clearly have an impact on certain aspects of medical practice.

I would like you to tell us about some of those causes.

● (1240)

[*English*]

Dr. Erik Skarsgard: Thank you for the question. It's one that has a complex answer, depending on which component of the human health resource team you are talking about. Realize, again, that we're focusing on child health teams.

We've spoken quite a bit about the need for more nurses. I will highlight, in passing, some of the other areas. At Children's Allied Health, there are respiratory therapists, physiotherapists, occupational therapists and child life specialists. All of these people are very specially trained and have skills specific to the care of children.

You brought up faculties of medicine and workforce planning that refers to the physician members of the provider teams at children's hospitals. This is a very significant challenge, because we are often recruiting for very targeted needs.

I'll give you an example. We have a challenge here. We're in need of an ophthalmologist who can treat a very specific and rare type of childhood retinal cancer. Where do you find those people? We don't train them in every province. They are trained internationally. One barrier to bringing them onto our faculty relates to physician licensure at the provincial level. There needs to be greater cooperation among the provincial colleges of physicians and surgeons to see how we can tap into this pipeline of expertise. It isn't created within Canada, but it exists in North America and internationally. We need fast-track ways of identifying a workforce need and then filling it through recruitment.

I hope that answers your question.

The Chair: Thank you, Dr. Skarsgard.

The last question for today's panel will come from Mr. Davies.

You have two and a half minutes.

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

Ms. McKinney, I don't know whether you touched on this, but I'd like to probe a little deeper, if you did.

In January 2022, the New Brunswick Institute for Research, Data and Training and Under One Sky announced a partnership to study the impact the head start program has had on participating families and to examine inequities among the families who applied and the general population of New Brunswick.

Could you provide this committee with an update on that research?

Ms. Patsy McKinney: It's really early on and it took quite a bit of time to get all of the ins and outs of it to the province and to that department at the university.

We've partnered with the university on multiple research projects and we realize that, if we can do this and do it really well, we'll be able to use it across the country because we have 133 head start sites spread out across this country. It took a while for us, because we wanted to make sure that the integrity of our families and their children was protected.

We also kept the information from the children who were on our wait-list. In the beginning here, we were licensed for six children. Think about that for a minute—six children. We're now licensed for nine children. This is a huge population, but anyway.... We realized early on.... We kept our files for the children who didn't enter, so there is a possibility that we could do some comparisons once they get into mainstream schools as well.

As I said, it's still very early on in the process. I'm not a research expert on anything. I've been participating in a lot of research, but I'm not an expert. We have learned over the years through the Urban Aboriginal Knowledge Network that the data can be really useful for us to be able to leverage funding and resources.

We'll keep you posted if you're interested in that. We're very interested in how this could unfold for the head start program across the country, actually.

The Chair: Thank you, Ms. McKinney.

Thank you to all of our witnesses.

As I indicated at the outset, this is the final witness panel for the children's health study. It's been a fascinating and varied course that we've taken through the various panels, so I guess it's appropriate that we end with one that was both fascinating and varied.

Thank you all for being with us. Thank you for being so patient in sharing your expertise. We wish you a good day and many thanks.

Colleagues, we're going to move now to committee business in public, unless the will of the committee is to do otherwise. I don't propose to suspend because, although the original plan was just a couple of housekeeping items, there are a couple of other items that are going to be raised.

I will ask you to deal with the housekeeping items first.

One is the study budgets that have been circulated to you. The other is simply a deadline for the submission of amendments on the private member's business that's coming to us next week. Is it the will of the committee to deal with these study budgets as a group or do we need to talk about...? Okay, I see at least some heads nodding.

Could I have a motion to adopt the project budget for the main estimates, which is Thursday's topic; for Bill C-252, which is coming before us next Tuesday; and for Bill S-203, which might be coming to us next Thursday unless something else happens today?

Is it the will of the committee to adopt these budgets as presented? Because we're in public, I think we actually need a mover.

Mr. Davies, do you care to move the motion?

● (1245)

Mr. Don Davies: Mr. Chair, I so move.

The Chair: Thank you.

Is there any discussion or any opposition?

(Motion agreed to)

The Chair: Thank you.

For Bill C-252, which is Ms. Lattanzio's bill that is coming to us next Tuesday, we are required to set a deadline for the submission of amendments because unrepresented parties also have a chance to propose amendments. I would like to suggest this coming Friday in order to have time to have them circulated.

Do we have the consensus of the room to set a deadline for the submission of proposed amendments as this Friday? I need a motion to set the deadline for Friday at noon.

Mrs. Goodridge, thank you.

Is it the will of the committee to adopt the motion?

(Motion agreed to)

The Chair: Thank you very much. Those are the housekeeping items that I wanted to deal with.

I understand there may be at least one or two other motions. The floor is open.

Mr. Lake.

Hon. Mike Lake (Edmonton—Wetaskiwin, CPC): I believe today that we have unanimous consent for this motion:

> That the Preamble, the long title and all clauses of Bill S-203, be adopted, on division, without amendment, and that the Chair report the bill to the House.

The Chair: We're in committee business, so the motion is in order.

Is there any discussion on the motion?

Go ahead, Monsieur Thériault.

[*Translation*]

Mr. Luc Thériault: We can pass the bill on division.

The Chair: Okay.

Does the committee wish to adopt the motion on division?

[*English*]

(Motion agreed to on division)

[*Translation*]

Mr. Luc Thériault: Mr. Chair, I would just like to add something for the benefit of all members.

I want to salute the efforts of Mr. Lake, who has shown great determination and done an excellent job supporting this bill, and above all with a diplomatic touch that is very much appreciated, by our side, at least, and probably by all parties. It has allowed us to reach a solution like this one today.

He is a good man, and probably the party's best spokesperson for the cause, without prejudice to the other Conservatives in the House.

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

Well said.

● (1250)

[*English*]

Congratulations, Mr. Lake.

Thank you, everyone. I think Monsieur Thériault speaks for us all in that regard.

Go ahead, Mr. Davies, please.

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

I would add my voice to that, as well, and thank Mr. Lake for his championing of this issue. I think he represents Parliament so well on this issue, and I want to thank him for his hard work.

I would like to move a motion on scheduling. At our last meeting, we decided to study the PMPRB issues, but we left it to schedule. I would propose that we set aside two days, on any two of the following: April 25, April 27, May 2, May 4, May 9 or May 11.

The Chair: The motion is in order.

Is there any discussion? Essentially, we have already adopted a motion to conduct a study. The motion before you is that the study be held over two days. There are five dates listed, of which we would take up two.

Is there any discussion?

Go ahead, Mr. Thériault.

[*Translation*]

Mr. Luc Thériault: Mr. Chair, I don't have a problem with that, since we agreed at the end of the last meeting that the next study would be about breast implants, in keeping with our work schedule.

[*English*]

The Chair: Do we have consensus to pass the motion as presented?

(Motion agreed to)

The Chair: Is there further business to come before the meeting?

Is it the will of the committee to adjourn?

Some hon. members: Agreed.

The Chair: I see consensus.

The meeting is adjourned.