HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

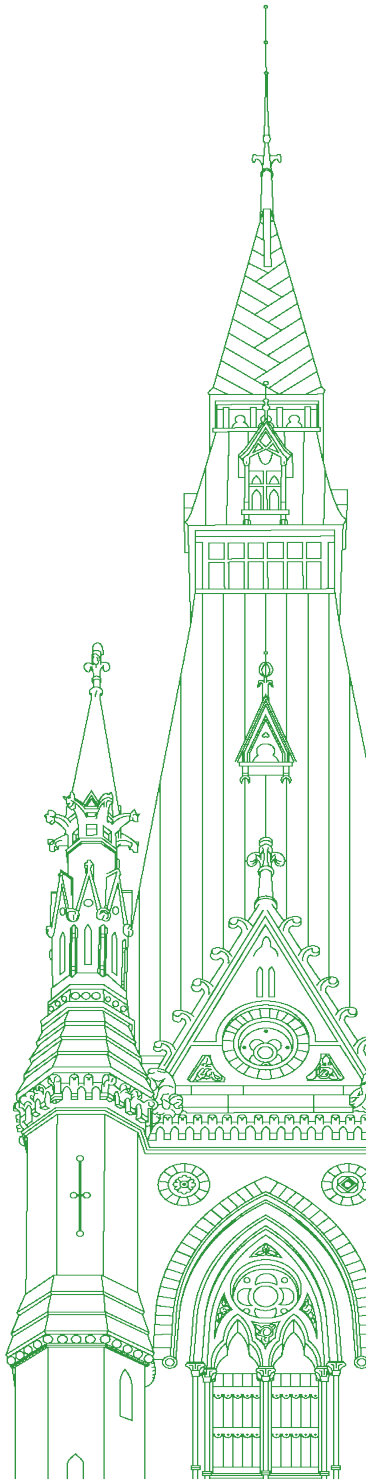
44th PARLIAMENT, 1st SESSION

Standing Committee on Human Resources, Skills and Social Development and the Status of Persons with Disabilities

EVIDENCE

NUMBER 015

Monday, March 28, 2022



Chair: Mr. Robert Morrissey

Standing Committee on Human Resources, Skills and Social Development and the Status of Persons with Disabilities

Monday, March 28, 2022

● (1105)

[*English*]

The Chair (Mr. Robert Morrissey (Egmont, Lib.)): I call the meeting to order.

Welcome to meeting number 15 of the House of Commons Standing Committee on Human Resources, Skills and Social Development and the Status of Persons with Disabilities.

Today's meeting is again taking place in a hybrid format pursuant to the House order of November 25, with members appearing either in person in the room, or remotely using the Zoom application. The proceedings will be made available via the House of Commons website. The webcast will always show the person speaking, rather than the entirety of the committee.

Given the ongoing pandemic situation, and in light of the recommendations from health authorities, as well as the directive of the Board of Internal Economy on October 19, 2021, to remain healthy and safe, all those attending in person shall follow the outlined protocols. As chair, I will be enforcing these measures for the duration of the meeting, and I thank members in advance for their co-operation.

To ensure an orderly meeting, I would like to outline a few rules to follow. Members and witnesses may speak in the official language of their choice. Interpretation services are available for this meeting. You have the choice at the bottom of your screen of either the floor, English or French. If interpretation is lost, please inform me immediately and we will ensure interpretation is properly restored before resuming the proceedings. The “raise hand” feature at the bottom of the screen can be used at any time if you wish to speak or alert the chair. For members participating in person, proceed as you usually would when the whole committee is meeting in person in a committee room. Keep in mind the Board of Internal Economy's guidelines for mask use and health protocols.

Before speaking, please wait until I recognize you by name. If you are on the video conference, please click on the microphone icon to unmute yourself. Those in the room, your microphone will be controlled by the proceedings and verification officer. When speaking, please speak slowly and clearly. When you are not speaking, your mike should be on mute. This assists the interpreters to properly translate. I remind you that all comments should be addressed through the chair. With regard to a speaking list, the clerk and I will endeavour to maintain a proper speaking list.

We are meeting today, pursuant to Standing Order 108(2), on the motion adopted by the committee on Thursday, February 3, 2022, that the committee resume its study of labour shortages, working conditions and the care economy.

I would like to welcome our witnesses to begin our discussion with five minutes of opening remarks followed by questions. As an individual, we have Naomi Lightman, assistant professor of sociology, University of Calgary. From Polytechnics Canada, we have Sarah Watts-Rynard, chief executive officer, and Matthew Henderson, director of policy. From Statistics Canada, we have Josée Bégin, director general, labour market, education and socio-economic well-being; and Vincent Dale, director, centre for labour market information.

I would ask the witnesses to keep their remarks within the five minutes or less timeline.

Dr. Lightman, you have the floor.

Ms. Naomi Lightman (Assistant Professor of Sociology, University of Calgary, As an Individual): Thank you for the invitation to testify for this important study.

My area of research expertise is in care work and its intersections with gender, race and immigration status.

The focus of my testimony will be on how we can best improve working conditions in the care economy to better meet the needs of the often exploited women who provide care for our vulnerable seniors, children and people with disabilities.

To begin, I'll note that a large body of research conclusively demonstrates that the care economy is distinctive. My research finds that across wealthy nations, care work is devalued both socially and economically. People working in care, such as personal support workers, health care aids and child care workers, are doing jobs that we consider “3D”: dirty, difficult and dangerous. These are jobs that most Canadians have no interest in doing, yet these workers are paid significantly less than others doing comparable work. This low pay is in part because the jobs are often associated with “women's work” and because care work is often thought to be unimportant, low skill or marginal.

We know that Canada's care economy overwhelmingly comprises women of colour. By most estimates, in Canada, over 90% of these workers are women. It is specifically racialized immigrant women who are doing these jobs—in particular, Filipina and Black women. Care workers are especially vulnerable due to the frontline nature of their employment as well as their gender, citizenship status, race and/or class.

My recent report, conducted in conjunction with the Calgary Immigrant Women's Association and the Parkland Institute, focused on the impacts of the pandemic on health care aids working in long-term care. We interviewed 25 immigrant women health care aids who detailed how the pandemic had exacerbated their financial insecurity and increased their physical and mental distress at work. They also spoke about their systematic exclusion from institutional decision-making processes.

I will now provide six recommendations for how to best improve working conditions in the care economy.

I do not wish to get involved in the discussion of federalism in Canada and I'm certainly not an expert in federalism, but these recommendations focus on how the government, in collaboration with the provinces and territories, could better fill Canada's labour market needs and protect these essential care workers.

First, given the overrepresentation of immigrant workers within caring occupations, there is a need to streamline processes of credential recognition for care workers and reduce the associated costs so they can work in the jobs for which they were trained in their home countries. As it stands, care workers are overwhelmingly trained as licenced practical nurses or nurse practitioners, but they end up working in jobs as personal support workers because of the practical difficulty of transferring their credentials.

Second, given widespread and growing shortages in health care occupations in Canada, there is a need to further prioritize caring jobs in Canada's immigration point selection system.

Third, there is a need to ensure higher wages and pay equity within care occupations. The pandemic has highlighted how essential these jobs are, yet they remain low wage and precarious. This means raising hourly wages and ensuring proper employment equity standards.

Fourth, there is a need to increase physical and mental health benefits and supports for care workers and their families. These families experience high levels of burnout and distress, which was only exacerbated by the pandemic. At the provincial level, this means implementing guaranteed paid sick days. At the federal level, it means supporting access to affordable child care, mental health supports and affordable dental and pharmacare.

Fifth, in collaboration with provinces, there is a need to ensure that privately operated long-term care and other health care operators do not pay care workers lower wages with fewer benefits than public operators. As well, there is a need to legislate higher staff-to-resident ratios in health care settings and a need to reduce or eliminate the use of casual employees and temp agencies in favour of full-time, permanent work in the care economy.

Sixth, and finally, there is a need to ensure that the voices of care workers are included in all decision-making processes within the care economy going forward, moving away from top-down decision-making processes.

I'm happy to speak to any of this further, either in the rounds of questioning that follow or in follow-up with any members of the committee.

Thank you.

● (1110)

The Chair: Thank you, Dr. Lightman.

Next we will hear from Polytechnics Canada.

Madam Watts-Rynard, you have the floor for five minutes.

● (1115)

Ms. Sarah Watts-Rynard (Chief Executive Officer, Polytechnics Canada): Thank you.

Good morning, Mr. Chair and honourable members. I appreciate the opportunity to address you as part of this important study on labour shortages, particularly as they impact Canada's caring economy.

I come to this topic as the CEO at Polytechnics Canada, a not-for-profit association representing 13 research-intensive, publicly funded polytechnics and institutes of technology. Collectively, our members provide education and training to more than 375,000 learners each year.

Polytechnics provide industry-aligned programming that builds in real-world experience to ensure that graduates enter the labour market ready to hit the ground running. Our members offer a breadth of credentials across sectors in high demand, including four-year bachelor's degrees, diplomas and graduate certificates.

Frankly, Canada's polytechnics train the vast majority of workers in the caring economy. This includes practical nurses, respiratory therapists, veterinary technicians, personal support workers, early learning professionals, dental hygienists and many others. Their close relationships with employers in these sectors also mean that polytechnics are leaders in the delivery of upskilling and re-skilling opportunities, including professional development and micro-credentials.

During the pandemic, this has included training to administer COVID-19 vaccines and short courses for nurses to enhance their urgent-care skills. The training offered by polytechnics is responsive and relevant, flexing as new requirements emerge. Because skill shortages tend to be urgent by the time anyone is talking about them, this ability to develop and deliver training quickly, whether to students or to existing employees, is absolutely critical.

As I reflect on the ways in which Canada's polytechnics can mitigate skills and talent shortages in the caring economy, two overarching policy recommendations come to mind. The first is to increase access, navigation and support for lifelong learning. There is long-standing recognition of the need for reliable, timely labour market information. While there are many groups developing LMI, from a general sense of skills in demand to data that is more industry- and occupation-specific, they rarely use comparable language or methodologies, making it difficult to integrate or navigate. Even if Canadians knew where to find this information, LMI is rarely linked to specific jobs or training opportunities.

Today's technology is capable of something much better. Every Canadian should have access to a dashboard that highlights specific areas of skill shortage in their occupation or region and a directory of where those skills can be acquired—in short, a Netflix for training opportunities.

At last count, Canada's polytechnics had more than 17,000 short-term upskilling and re-skilling programs on the books, many related to the caring economy. We would like to see more deliberate navigation to these opportunities, allowing users to understand where training is available and at what cost, duration and delivery method. Better navigation stands to amplify the impact of lifelong learning supports like the Canada training benefit.

Second, the federal government can make ongoing investments in post-secondary learning infrastructure a part of Canada's growth and development plan. To deal with existing and emerging skill shortages, post-secondary infrastructure must keep pace with industry needs, exposing learners to the latest tools, technologies and labs.

In two previous post-secondary infrastructure programs, the last more than six years ago, the case was clear. Institutions enhanced research facilities and built dynamic new spaces for Canada's talent pipeline. The need for a modern learning infrastructure is foundational to addressing talent and skill shortages. This will inevitably include physical and digital infrastructure that matches the pace and expectations of business. It is hard to develop tomorrow's talent with yesterday's spaces, equipment and tools.

I'll offer one last thought for the committee's consideration as part of this study. Canada's post-secondary institutions themselves are not immune to acute skill shortages. This has huge consequences for the talent pipeline. For example, in February British Columbia increased the number of nursing seats at its post-secondary institutions by 600. Manitoba also recently increased theirs by 400. Both were in direct response to urgent and imminent shortages in that occupation.

As I've said, a defining feature and benefit of polytechnic education is a direct connection to industry, including an emphasis on bringing professional practitioners into classrooms and labs as instructors. When demand is on the rise, so too are salary pressures. This is something that publicly funded institutions have really limited means to address.

● (1120)

When it comes to skill shortages in the caring economy, Canada’s polytechnics are well-positioned to respond. There are, however, important ways this capacity can be nurtured and maximized.

Thank you for the opportunity to address you today. I look forward to answering any questions you may have.

The Chair: Thank you, Madam Watts-Rynard.

Now, we'll hear from Madame Bégin for five minutes.

[*Translation*]

Ms. Josée Bégin (Director General, Labour Market, Education and Socio-Economic Well-Being, Statistics Canada): Mr. Chair, committee members, thank you for inviting me to share some insights on the labour shortages and labour market imbalances affecting the Canadian economy since the pandemic, including in the care economy.

Most indicators are pointing to an increasingly tight labour market in Canada, with the demand for workers accelerating to record levels during the second half of 2021. Job vacancies in the fourth quarter rose 80% compared with pre-pandemic levels, reflecting broad based increases across provinces and industrial sectors.

Last month, the unemployment rate fell to a near historic low of 5.5% while the participation rate reached a record high among core-aged workers. These increasingly tight labour market conditions have resulted in lengthier hiring processes, as evidenced by a rise in the proportion of vacancies open for two months or more.

The unprecedented labour demand placed by COVID-19 on the health care system contributed to the growth in vacancies in the health care and social assistance sector. There were almost twice as many job vacancies as two years earlier in the sector, despite a 6% rise in payroll employment.

With businesses struggling to recruit staff, some have been adjusting their hiring strategies. For example, some employers appear to be lowering educational requirements to attract workers. In late 2021, about 10% of workers who had a high school diploma or less had recently started jobs that typically require university education, up from 4% in late 2019.

To help attract and retain staff, businesses are also adjusting their wage plans. In the two years leading up to November 2021, wages among new hires rose by 10%, compared with 6% for established employees. In the fourth quarter of 2021, almost half of businesses reported that they planned to raise wages for existing employees over the coming year. While wages have been on an upward trend since the fall of 2021, their growth has remained below the inflation rate.

The COVID-19 pandemic has underscored the essential nature of the care sector but also contributed to worsen already existing labour shortages. Census data show that in 2016, care workers made up nearly one-fifth of the total employed population in Canada. Perhaps not surprisingly, women represented the majority of paid care workers, accounting for three quarters of all care workers. Overall, workers in care and non-care occupations were as likely to belong to a population group designated as a visible minority. There were however slightly higher proportions of Black and Filipino people among care workers than among non-care workers, particularly in specific occupational groups. For example, Black and Filipino people each represented 10% of workers in assisting occupations in support of health services and were highly overrepresented among nurse aides, orderlies and patient service associates.

Labour Force Survey data suggest that in recent years workers in care occupations were less likely to have a permanent job than those in non-care occupations. They were also more likely to hold more than one job at the same time. Overall, workers in care occupations were slightly less likely to work full time than those in non-care occupations.

The quality of employment in the care economy is uneven, with workers covered by a collective agreement, which is 57%, generally having better working conditions than those who are not.

Statistics Canada will continue to monitor and report on labour demand pressures that are felt in the various sectors of the Canadian labour market, including those of the care economy.

Mr. Chair, this concludes my opening statement.

● (1125)

Thank you.

The Chair: Thank you, Ms. Bégin.

[*English*]

We will now open the floor for questions, beginning with Madam Kusie for six minutes.

[*Translation*]

Mrs. Stephanie Kusie (Calgary Midnapore, CPC): Thank you, Mr. Chair.

I thank the witnesses for being here today.

I will direct my questions to Mr. Dale first.

[*English*]

Mr. Dale, besides the blip caused by omicron, would you say there is an upwards trend in job vacancy rates?

Mr. Vincent Dale (Director, Centre for Labour Market Information, Statistics Canada): Good morning, everyone.

In response to your specific question, we can look at job vacancies since 2015 when the current survey was introduced. Yes, we do see an increase in vacancies between 2015 and 2019, and then a sharp acceleration from 2019 onwards in association with the pandemic. In summary, the increase in vacancies is long-term, at least over the past seven years, and it has accelerated over the COVID period.

Mrs. Stephanie Kusie: Thank you, Mr. Dale.

Based on your gathering of information and evaluation of this information, what in your opinion do you believe is causing the increase in job vacancy rates?

Mr. Vincent Dale: We can point to several factors for the increase in vacancies. It could, for example, be due to a rapid reopening of an industry where there's an adjustment period required for matches to be made between available workers and vacancies. It may be an indication of normal economic activity where there's turnover and transition within an industry. In some cases it may be a shortage, either an absolute shortage, or some type of mismatch between the working conditions associated with the job and the willingness of available workers to take those jobs. As well there are geographic imbalances, so that there may not be a shortage, but there may be an imbalance between where available workers are located and where the vacancies are located.

There are many factors and it's important to interpret vacancies within a specific industry and occupation in the context of a broader set of labour market and economic indicators.

Mrs. Stephanie Kusie: That's a very thorough overview. Thank you very much.

Would you say there's one predominant reason out of all of the ones you've indicated? Certainly you have indicated many different possibilities across many different sectors and regions, but would you say there's anything predominant?

Mr. Vincent Dale: I wouldn't be able to say there's a predominant factor. Again, I'd repeat that it's very important to look at specific industry and regional factors and analyze a particular situation using job vacancy statistics, but also employment trends, unemployment trends and broader economic indicators. I'll just re-emphasize that there's no single explanation for overall job vacancies.

Mrs. Stephanie Kusie: Okay, so there is a multitude of reasons. Thank you.

Mr. Dale, how long would you expect the upward trajectory of job vacancies to continue?

Mr. Vincent Dale: It's a very good question. We don't have the ability to predict the future. What we do is closely monitor the situation month to month and year to year.

We have seen a small decrease in vacancies over the late fall and winter period. Some of that will be associated with seasonality, and we'll have to interpret some of that decline with caution and see how things develop over the spring and summer.

We can monitor vacancies month to month. We can project, and our colleagues at ESDC and in the provinces and territories can project, demand for specific occupations five or 10 years into the future. Unfortunately, I don't have a crystal ball to project job vacancies in the medium term.

● (1130)

Mrs. Stephanie Kusie: Thank you very much, Mr. Dale.

We can't predict the future, but we certainly can look at trends. I appreciate all of that information. Thank you very much.

Ms. Watts-Rynard, in my assessment, to decrease job vacancies we either need to add more people through immigration or develop more automation. What role do you see polytechnic schools playing in increasing automation and innovation?

Ms. Sarah Watts-Rynard: I think one thing I would say is that there is a vast ability for the institutions to be thinking about simulation, hybrid learning and personalized learning. All of that takes equipment and, as I've said, a post-secondary infrastructure that would support increasing the number of students and their opportunities to take on those roles.

Mrs. Stephanie Kusie: One issue we also see with automation is the high cost for small and medium-sized enterprises to enter into these automation initiatives. Would you have any suggestions, based upon the work of your students and faculty—and trends, once again—on how we could possibly lower these costs for business?

Ms. Sarah Watts-Rynard: Maybe I'll pass this over to my colleague Matt. I know that he has put together some specific examples to share.

Mr. Matthew Henderson (Director of Policy, Polytechnics Canada): Thanks, Sarah.

Thank you for having us here today.

The one piece on supporting business is that the polytechnic model of research is really partner-driven and responsive to industry. We have members across the country working with health care providers and health care organizations to ensure that they're automating and basically being an onboard to the business innovation that's required to propel those businesses to move forward.

On the one hand, our member institutions across the country are providing the education and training for the human capital that's required for the caring economy. On the other side of the equation, the research arm of our member institutions, through the applied research office, is really supporting business to onboard new technologies, whether they be digital or simulated learning, as Sarah said, to ensure that these health care organizations from the private sector are also being moved forward along their innovation journey.

From that perspective, there is one federal program, the college and community innovation program, that explicitly funds college and polytechnic applied research. Increasing support for this program, for example, would certainly amplify at scale the amount of research that our members are able to do with the health care and caring economy writ large.

[*Translation*]

Mrs. Stephanie Kusie: Thank you, Mr. Chair.

I thank the witnesses as well.

[*English*]

The Chair: Thank you, Mr. Henderson and Madam Kusie.

We will go to Mr. Van Bynen for six minutes.

Mr. Tony Van Bynen (Newmarket—Aurora, Lib.): Thank you, Mr. Chair. I'll be sharing my time with Mr. Collins.

First of all, thank you very much to all the witnesses for coming to contribute to this important study.

I want to spend some of my time on the Statistics Canada witnesses. In my riding of Newmarket—Aurora, there's a specific interest in the impact of disabilities on employment, and on the inability to acquire employment. Could you please tell the committee what the unemployment rate is for those with disabilities? Could you also specify the numbers based on age and gender?

That's for Statistics Canada, whoever wants to run with that.

Go ahead, Ms. Bégin.

Ms. Josée Bégin: Thank you, Mr. Chair, for the question.

What I would like to propose is that we can provide additional information based on the latest results of the labour force survey. We have recently developed and published labour market indicators for disability status. I believe some of that information could be provided by age. However, the information based on gender is not available at this moment. It would be available for release later during the year.

Mr. Tony Van Bynen: All right. Thank you.

Could you explain the factors, based on the information that you do have, that contribute towards the rise of unemployment in people with disabilities?

Ms. Josée Bégin: I will turn to my colleague Vincent to see if he has anything to add.

Mr. Vincent Dale: Maybe I'll take a step back and explain the data that Madame Bégin just referred to as new data that we've developed in the past several months using the labour force survey, but also additional information we had collected that allowed us to identify people with disabilities.

Traditionally in Canada we've relied on the census of population and the Canadian disability survey to measure labour market conditions for people with disabilities. We have enhanced the labour force survey to start to include statistics on people with disabilities. Unfortunately, that data is very fresh, it's very new, and we don't yet have a trend to be able to speak to exactly the medium-term or even the longer-term dynamics.

One thing maybe I'll mention is that the short analysis we did publish recently pointed to the very dynamic nature of disability itself. We saw, for example, an increase in the number of people reporting disabilities in the labour force over the pandemic period, especially people with mental health disabilities.

One of the challenges in responding to your question is that the group of people with disabilities is not a stable group. It in fact changes, so I would invite you to think of a dynamic situation where disabled people are becoming employed or unemployed. However, employed people are also becoming disabled or not disabled. It's quite challenging to separate those factors, especially for very specific periods of time or very specific geographies.

Now, having said all that, we will pull together some analysis for you and do the very best we can to respond to your specific question.

● (1135)

Mr. Tony Van Bynen: Okay. I'd like to shift very quickly from the trailing indicators to leading indicators.

During her appearance before the committee on March 3, Leah Nord of the Canadian Chamber of Commerce called for the federal government to play a leadership role in facilitating, convening and funding efforts to improve labour market information for analysis purposes for demand-side workforce planning for key professions and sectors in the economy.

What kind of labour market information does Statistics Canada currently collect? To what extent have you been able to engage with businesses to look at the labour force demand management?

We'll start with Ms. Bégin.

[*Translation*]

Ms. Josée Bégin: Mr. Chair, I thank the member for his question.

As my colleague Mr. Dale mentioned earlier, Statistics Canada collects a variety of labour market indicators that we need to look at together to fully understand the nature or the dynamics of the labour market at a specific time of the year.

For example, we collect labour market information through the census and the Labour Force Survey. We also collect information on employment insurance benefits, earnings from businesses, and job vacancies. The Job Vacancy and Wage Survey, which my colleague alluded to earlier, covers about 100,000 businesses in Canada every month and every quarter, which means it's a broad survey.

Your question also touched on Statistics Canada's relationship with business. Over the last few years, Statistics Canada has done a lot of work in terms of its outreach activities, namely with the Canadian Chamber of Commerce, to build relationships and to understand the challenges that businesses are facing, whether they are related to the labour market or the pandemic, among other things.

For our part, in terms of labour market indicators, we also participated in these discussions in order to improve our understanding of the required and relevant indicators that would help companies better understand the labour market they are dealing with.

The Chair: Thank you, Ms. Bégin.

[*English*]

Your time is up, Mr. Van Bynen.

Mr. Collins' is up too.

Now we go to Madame Chabot for six minutes.

● (1140)

[*Translation*]

Ms. Louise Chabot (Thérèse-De Blainville, BQ): Thank you, Mr. Chair.

Thank you to all the witnesses for their presence and testimony today.

I have several questions for Statistics Canada officials.

Ms. Bégin and Mr. Dale, thank you for being here. Either one of you can answer me.

First of all, Mr. Dale, I appreciated your comment. It is something we should also think about when we talk about job vacancies. There cannot be a single explanation for the notion of vacancies or for labour shortages, because they can be either structural or organizational for various reasons. Even if there are overall statistics, the means and solutions cannot, in our opinion, be the same for each activity sector. Your research is important.

Ms. Bégin, in the second paragraph of your presentation, it reads: “Job vacancies in the fourth quarter rose 80% compared with pre-pandemic levels, reflecting broad based increases across [...] industrial sectors.”

Do you have disaggregated data to share with us?

You mention an overall increase of 80%, but which industrial sectors are you talking about?

Do you have data broken down by province or territory?

Ms. Josée Bégin: Mr. Chair, I thank the member for her question.

Yes, we do have the data broken down by province, but also by industry sector. I don't have the information with me today, but Statistics Canada will be able to provide detailed information after this meeting that compares the most recent data we've published with pre-pandemic data from the beginning of 2020.

Thank you.

Ms. Louise Chabot: Thank you.

Without going so far to say that it shocked me, one point in your presentation raised questions. You said that by the end of 2021, 10% of workers with a high school diploma or less were in skilled jobs, as they are sometimes called in the jargon of the world of work, meaning university-level jobs.

Can you tell us which specific areas or sectors of activity are affected?

In Quebec, when we look at the overall employment situation, we see that skilled jobs account for the largest number of job openings.

Is what you're saying a response to that?

Ms. Josée Bégin: Mr. Chair, I will turn to my colleague, Mr. Dale, who led this part of the analysis published by Statistics Canada.

Thank you.

[*English*]

The Chair: Is somebody following up on Madame Chabot's question?

Mr. Vincent Dale: I'm sorry; I forgot to unmute, and I hope I'm following the right protocol by responding in English on the right channel.

We will have a look at our ability to break down that observation by province and by industrial sector. Often what we do in our analysis is to look at national level findings as signals or indications of what's happening in the broader labour market. It's not always possible, because of sample sizes, to break those types of observations into smaller groups, but we'll do our best and reply back to the committee with as much detail as we can.

● (1145)

[*Translation*]

Ms. Louise Chabot: If I may, my question was those with a high school education or less who are in jobs that require a university education.

Do you know what particular sector this applies to?

[*English*]

Mr. Vincent Dale: I'm sorry, I don't have that information offhand. We would have to go back and look at it.

[*Translation*]

Ms. Louise Chabot: I understand. You're saying that it's possible to obtain this information, yes?

[*English*]

Mr. Vincent Dale: The only constraint on sharing that information with you is the sample size, the number of observations that we have. Beyond that, we'd be happy to give you as much detail as we can.

[*Translation*]

Ms. Louise Chabot: Very well.

I have one last question, Mr. Chair.

Regarding the higher proportion of Black and Filipino people among care workers, is it possible to get that information broken down?

When you talk about care assistants, we would like to know exactly what you mean, because there are many designations. In Quebec, for example, orderlies have qualified training. Does this mean that there are Black and Filipino workers in those positions without qualified training? Can we have more information in writing for these questions?

[*English*]

The Chair: We would ask the witness to provide that information to the committee in writing. It's a detailed question, so could you follow up with a detailed answer to the committee?

Now, we go to Madame Zarrillo for six minutes.

Ms. Bonita Zarrillo (Port Moody—Coquitlam, NDP): Thank you, Mr. Chair.

Thank you to all the witnesses today. I want to go to Ms. Lightman about her research that really exposes the exploitation of and the discrimination against personal support workers in long-term care. I want to ask a few more questions or hear more about the challenges these workers find themselves in.

You mentioned that many of them have credentials but they are not able to realize work that accepts those credentials, so could I have a little bit more information on the challenges of having credentials recognized and the limitations that keep them in these precarious jobs?

Ms. Naomi Lightman: As stated, we know that there is vast overqualification of immigrant women working as personal support workers in long-term care. Some figures estimate as many as 44% of caregivers worked as nurses prior to migrating to Canada and, according to a Statistics Canada report, 67% of nursing graduates from the Philippines are considered to be overqualified for their current jobs.

Based on the research that I've done in trying to unpack this labour market mismatch, we know that the process of transferring credentials needs to be accelerated. It needs to be faster, it needs to be easier and it needs to be more affordable. Many of these women are sending remittances to their home countries, are working multiple part-time jobs to make ends meet and are supporting families, and the current process does not allow them the time or the financial means to go about upgrading their skills. This leads to quantifiable downward labour market mobility relative to other workers, as well as being stuck in precarious working conditions.

I think there's a lot of work to be done to reduce the barriers these women experience to their working in the jobs for which they were trained in their home countries.

Ms. Bonita Zarrillo: Thank you, Ms. Lightman.

I also want to touch on the points you made about systematic exclusion from decision-making and also the lack of mental health support. I really want to understand if there any types of supports for these women and these workers who have precarious immigration status as well. They're tied to these jobs, but do they have the ability to speak out or are there repercussions? Do they fear repercussions from speaking out based on the precarious nature of their work, and even as it relates to mental health support or family support that isn't available to them, are they concerned about their loss of status or work by speaking out?

● (1150)

Ms. Sarah Watts-Rynard: Absolutely.

I think the intersection of precarious work and precarious immigration status leads to highly vulnerable working conditions for these women. The pandemic has really exacerbated the physical and mental health challenges of these jobs.

The women I spoke to talked about increasing demands on the job due to the pandemic, heightened levels of stress tied to fears of becoming personally infected with the virus or fears of infecting their family and their children, and overwhelming feelings of loss and helplessness as a result of watching long-term care residents die of COVID-19 in large numbers.

Many of the jobs they're working on do not have supplementary health insurance, meaning they're often having to pay out of their own pocket for any physical or mental health supports they need on top of basic services. Especially for these jobs that we know are very much on the front line and that we see as being essential services and sort of valorize in the language we use, there's a need for more structural physical and mental health supports. These are also very physically demanding jobs.

To speak to the second part of your question.... I'm sorry. Can you remind me? You spoke of mental health. What was the other component?

Ms. Bonita Zarrillo: It was just that they couldn't speak out because their immigration status was tied to a job, and if they were to speak out, they'd lose the job and their status.

Ms. Sarah Watts-Rynard: That's certainly true for those who are waiting for permanent residency through the caregiver program, but even for those who do have permanent resident status, there's a very top-down decision-making structure within many health care institutions.

Those who are personal support workers or health care aides, certainly from the research I've done, do not feel they're in a place to speak out in terms of their thoughts about what could make the system work better. Certainly those in publicly funded and unionized work environments felt more free to speak up, but the overwhelming trend I saw was of workers who felt that, even as they saw institutional mismanagement, not enough PPE and very low staff-to-resident ratios, they had a limited voice to speak up.

I think that's a space where we need to include their voices in the decision-making processes going forward as we rethink our long-term care institutions in light of the COVID-19 pandemic.

The Chair: A short question and a short answer, Madam Zarrillo.

Ms. Bonita Zarrillo: Thank you for that.

This is a question for Stats Canada.

There's a saying that you can't improve what you don't measure, and I note that Ms. Nord from the Chamber of Commerce said in her testimony:

> I can tell you the age distribution of the construction workforce. I can tell you how many women, indigenous peoples and new Canadians work in the trade. I can even break these numbers down by jurisdiction.

The same can't be said for the care economy. Why don't we capture this over-indexed women's work? Are there plans in place to start measuring the care economy in a greater and more granular way?

The Chair: Thank you, Madam Zarrillo.

If the answer could be provided in writing to the committee, it would be appreciated. The time has gone well over.

Ms. Josée Bégin: We can do that. Thank you.

The Chair: Thank you.

Mr. Ruff, you have five minutes.

Mr. Alex Ruff (Bruce—Grey—Owen Sound, CPC): Thank you, Mr. Chair, and thank you to the witnesses for coming.

As a bit of a preamble, I represent a very rural riding, likely with the second-oldest demographic in Ontario, so try to keep that in mind when responding, please.

My first question is for Polytechnics Canada. It's around the dashboard you suggested. Who are you suggesting is responsible for that at the federal level?

Mr. Matthew Henderson: I think there is a variety of organizations that would be well positioned, Statistics Canada being one of them. I think the point is that there's a lot of awesome work being done in data collection on both the supply and demand sides, whether by the Labour Market Information Council, Statistics Canada, Future Skills Centre, industry associations, sector councils, etc.

I think maybe there just needs to be some alignment to take otherwise fragmented systems and put them together and align the methodology so that we're able to make these comparisons over a longer-time horizon. Certainly one of the national bodies that is overseeing some of this work would be well positioned to lead the effort.

Thank you.

● (1155)

Mr. Alex Ruff: To expand on that a bit, one of the challenges much of rural Canada has is the lack of access to the Internet. As we go more digital, and considering as well the challenges for people to access and go through this, can you expand a bit on the importance of having Internet access right across this country?

Mr. Matthew Henderson: That's an excellent point. That's why, as we make gains in the navigation to lifelong learning, those need to be complemented by an equal commitment to broadband across the country. This is to ensure that as we're developing digital services, we're not exacerbating existing inequalities and that, as we're increasing the navigation to lifelong learning, those living coast-to-coast-to-coast in Canada are able to access it as well.

The point is that it needs to be complemented by gains in making the Internet more widely available across the country, so that folks will be able to access such a platform as we're suggesting.

Mr. Alex Ruff: My next question is a bit of a change in direction. In Ontario this past year—I know we're delving into a bit of provincial jurisdiction—they've reintroduced a nursing education program, which I think will be essential to helping fill some of the labour shortages in long-term care homes with PSWs, and getting more people trained more easily. More importantly, it will help retain them where those college locations are in our home areas.

Could you expand on whether this is the type of program where more provinces and the federal government could take a role in providing some guidance and support?

Mr. Matthew Henderson: Certainly. Without getting into the challenges of federalism and the federalist nature of the country, 100% of them are looking for best practices, and some of the provincial programs that have been set up throughout the pandemic to expedite the transition from to employment would help to mitigate some of the labour gaps.

To the second point that you raise, as our CEO Sara Watts-Rynard indicated in her remarks, post-secondary infrastructure is a big piece to ensure that we're providing education and that training that is very much industry-aligned and that students are learning on the equipment that is used in the workplace. Part of that is increasing the simulation capacity of education training, which would then, in turn, increase access to ensure....

For example, Conestoga College in Kitchener, Ontario, has a centralized location where they are able to lead the training for folks who are working in rural communities through video conferencing and other software. As we are able to make broadband more accessible across the country, the ability to use simulated learning to expand the access to education and training is an important additional step.

Mr. Alex Ruff: I totally agree. It goes back to my earlier point about rural Canada and the importance for the federal government to focus on rural Canada even more. You can't move forward on some of this without it.

My final, quick question will be to Stats Canada. Can you expand a bit on part-time versus full-time unemployment rates? Is there a difference between rural and urban areas?

Thanks.

Mr. Vincent Dale: I can respond to that question.

We'd be happy to provide you with that information. I don't have the details at hand, but we can easily provide that information.

The Chair: Thank you, Mr. Ruff.

We'll go now to Mr. Collins for five minutes, to finish up the first panel.

Mr. Chad Collins (Hamilton East—Stoney Creek, Lib.): Thanks, Mr. Chair.

My questions, to start, will be for Statistics Canada.

As noted in the opening, we continue to see strong economic growth across the country in all provinces and territories. The recent labour force survey noted that we gained approximately 337,000 jobs, dropping our unemployment rate to 5.5%. As I think Ms. Bégin noted in her opening, it's much lower than the prepandemic numbers from 2020, where the rate was 5.7%.

Can you verify the numbers as they relate to the unemployment rate? Can you provide us a snapshot of where we've made gains, and in what sectors? How do our numbers compare to our neighbours south of the border?

Ms. Josée Bégin: Statistics Canada could provide additional information in writing on industries terms of provinces. We also do some analysis from time to time to compare with the United States. We would be happy to provide that information.

Mr. Chad Collins: Okay.

Do you have that information this morning as it relates to sectors and where we have made the strongest gains, and as it relates to employment growth?

● (1200)

Ms. Josée Bégin: I don't have that information with me. I can turn to my colleague, Vincent, to see if he has additional information.

Mr. Vincent Dale: To partially address your point, there are some sectors, for example, professional, scientific and technical services, the industry category that includes the tech sector, that have shown a significant employment increase compared with prepandemic levels. There are a few others, but I would want to verify them. Health care employment is up, compared with the levels before COVID-19. That is not a surprise. In industries like accommodation, food and recreation, which are very affected by public health shutdowns, employment is not yet back to prepandemic levels.

We can go through the data and give you a comprehensive response, but in general it's true to say that some industries have experienced substantial growth compared with prepandemic levels, and others have not yet recovered.

Mr. Chad Collins: Thank you for that, Mr. Dale.

I was pleasantly surprised to see strong gains in the construction area. As you know, Mr. Chair, our government is very anxious to see an increased housing supply and more units constructed to assist with the affordability issue.

I noticed in the report that the construction sector experienced some good gains. Do we traditionally see seasonal bumps in this sector? If so, are these gains comparable to what we would have experienced prior to the pandemic?

Mr. Vincent Dale: I can respond to that.

The data we report in the labour force survey released every month is what we call “seasonally adjusted”. In other words, we've taken steps to remove the impact of seasonality. When we say that employment in that sector is higher than pre-COVID levels, you can take that as being in addition to any seasonal effects.

I will note that construction is interesting in the sense that, while employment has exceeded pre-COVID levels, it's also one of the sectors with quite a large increase in job vacancies. In other words, the total labour demand, both met and unmet, is substantially higher than pre-COVID levels. You can think of investments in infrastructure and other factors driving construction activity as being responsible for that increase in overall labour demand.

Mr. Chad Collins: Okay. Thanks, Mr. Dale.

If I use the 37,000 jobs that were created, you highlighted that you monitor that through building permit activity. I know, coming from the municipal sector, that the value of the permits is an important indicator to look at. In terms of the sheer number of permits, is that tracked as well, and then do you break that down by commercial, residential, industrial and institutional, much like municipalities would?

Mr. Vincent Dale: I don't have those details at hand. There are other colleagues in Stats Canada who are responsible for the building permit data, but we'd be very happy to dig up that information and report back to you.

Mr. Chad Collins: Okay.

Thanks, Mr. Chairman.

The Chair: Thank you, Mr. Collins.

That concludes the first group of witnesses.

I want to thank you for appearing. I would ask all the witnesses, as the questions were quite technical this morning, that if you could follow up with the information the committee requested, that would be great. I know it's tough to cover it in six minutes when you're dealing with that type of detail.

Thank you for appearing, and, please, if you could submit any additional information you feel is relevant to the committee in writing, it would be most appreciated.

With that, we'll suspend for two minutes while we transition to the next group of witnesses.

Thank you.

● (1204)

_____(Pause)_____

● (1208)

● (1205)

The Chair: We'll resume with the second grouping of witnesses.

We have, from the Canadian Centre for Caregiving Excellence, James Janeiro; from the Canadian Medical Association, Katharine Smart; and from the Canadian Nurses Association, Michael Villeneuve, chief executive officer.

We will start with the Canadian Centre for Caregiving Excellence for five minutes.

I would ask the witnesses to please keep your comments within five minutes because committee members have an extensive list of questions.

Mr. Villeneuve, you may begin.

Mr. James Janeiro (Policy Consultant, Canadian Centre for Caregiving Excellence): Wonderful. Thank you for the opportunity to present.

My name is James Janeiro. I'm here on behalf of the Canadian Centre for Caregiving Excellence.

We are a new organization powered by the Azrieli Foundation, and we'll launch in May.

We believe that caregiving is the next frontier of public policy in Canada, and our mission is to support and empower caregivers and care providers, advance the knowledge and capacity of the caregiving field, and advocate for effective and visionary social policy, all with a disability-informed lens.

Like many sectors of the economy, the profession of paid caregiving is plagued by systemic issues that have been laid bare by the pandemic. Low wages, unstable work arrangements, unpredictable hours and insufficient training have all be exposed in many areas of the caregiving economy. The sector is comprised of many racialized and newcomer workers, most of whom are women. We have all heard of the working conditions and staff shortages in long-term care and the impact that has had on seniors across the country.

In the developmental services sector, many staff supporting children and adults with intellectual disabilities work for more than one employer to make ends meet, or rely on gig work to supplement their wages, while both full and part-time employment opportunities go unfulfilled for months.

The same is true for home care staff who provide life saving care to vulnerable people living in their homes.

We must do better to support paid caregivers in their work. In doing so, we can make the profession of caregiving more attractive and help address long-term labour shortages across all areas of the economy. After all, paid caregiving is a job, and workers deserve to be paid an adequate wage. Unfortunately, wages in the caregiving sector are simply insufficient to draw staff into the profession and keep them in the field.

The home and community care sector in Ontario is one example where insufficient investment in wages has created a labour shortage. Frontline staff in this sector are the lowest paid of the entire health care system in Ontario.

Over the past decade, provincial budgets have created new capacity while freezing base budgets. Consequently, many providers are providing services at funding rates that are vastly out of date and do not reflect increases and the real cost of operations. It is becoming increasingly difficult to attract and retain staff, which impacts the quality of life of clients living at home and ultimately puts more even more stress on our health care system.

As the federal government contemplates the twin challenges of labour shortages in caregiving and pressures on our health care system, we submit that federal health care funding tied to increasing both capacity and base wages in the home and community care sector across the country would result in higher wages, improve recruitment and retention, improve quality of care and ultimately put less pressure on emergency rooms.

As we begin to repair our economy, we recommend that your study also consider the bigger picture of caregiving. All caregiving sectors are experiencing labour shortages. Which in turn creates other labour shortages across the entirety of the economy.

In 2018, one quarter of Canadians provided care to someone who needed it. A study published in 2013 projected that over half of all Canadians will provide unpaid care at some point in their lives to a friend or family member in need. This care is disproportionately delivered by women. Out of necessity, many caregivers need to partially or fully withdraw from the labour market to care for their loved ones, which further contributes to labour shortages across the country as these potential workers, turned caregivers, cannot work full-time for want of available paid caregiver support. In effect, this further shrinks the number of working age adults who can fill jobs. This dynamic was estimated to cost upwards of $1.3 billion in lost productivity per year. It drives down incomes and contributes to the gender wage gap.

As you prepare the study on labour shortages in caregiving, we urge you to consider the many negative effects of underfunding and low wages in paid caregiving. Addressing this issue would improve the quality of life for millions of vulnerable people who need care, including seniors able to live at home longer thanks to high quality home and community care services provided by personal support workers.

It would create new automation-proof jobs in the predominantly female, racialized and newcomer caregiving economy, and reactivate many unpaid caregivers who could rejoin the workforce when their loved ones' care needs are met. Caregiving can be a rewarding career and sustain a good quality of life if properly supported and compensated.

Thank you for the opportunity. I look forward to your questions.

● (1210)

The Chair: Thank you, Mr. Janeiro.

Madam Smart, you have the floor for five minutes.

Dr. Katharine Smart (President, Canadian Medical Association): Thank you, Chair and committee members, for the opportunity to appear before you today.

I'm Dr. Katharine Smart, and I'm speaking to you today from Ottawa on the unceded territory of the Algonquin and Anishinabe nations. I'm a pediatrician based in Yukon.

As president of the Canadian Medical Association, I am honoured to represent physicians and medical learners from all jurisdictions. Every one of us has felt the impacts of a health care system stretched beyond its capacity. For health workers, the pandemic has been unrelenting. Two years in, organizations representing health workers across the country are sounding the alarm. Canada's health care system is collapsing.

As the national organization representing physicians, we too are calling for action. Doctors [*Technical difficulty—Editor*] are experiencing.... Over 50% of physicians and medical learners reported high levels of burnout—30% compared with pre-pandemic levels. Moreover, nearly a half of physicians reported that they would likely reduce clinical hours. The shortage of colleagues to cope with current and future demands is nationwide.

As many Canadians are feeling that the loosening of health measures are signalling an emergence from the pandemic, the same cannot be said for health workers. Our health workforce is in the biggest crisis we've ever seen, and because of it Canada's health system is on life support.

[*Technical difficulty—Editor*] grateful for the federal government's integral role in the pandemic response, but it's not over. Health care workers are relying on the leadership of the federal government to support a way forward. By aiding medical professionals, you are helping every Canadian—now and in the future.

Last fall, the CMA and the Canadian Nurses Association co-hosted an emergency summit to learn from nearly 40 health organizations representing nurses, physicians, respiratory therapists, personal support workers, psychologists and educational institutions. We knew then that we were collectively experiencing a human health resources—or HHR—crisis.

We recently met again, with close to 40 organizations representing health workers. What we heard is disheartening. Health workers are depleted and distressed. They're facing harassment, and leaving their careers and professions entirely.

The repercussions of this could be devastating in a country where already more than five million Canadians presently have no regular health care provider. Of those with a doctor, only 40% of patients could get an appointment within 48 hours, and 46% of physicians are considering reducing clinical hours over the next two years.

What we're learning is more than alarming; it's potentially catastrophic. Time is of the essence. More than a quarter of practising physicians claim low rates of overall mental health. Recent figures show that 20% of frontline health care workers have thought about suicide. A crushing 6% had planned an attempt.

To worsen matters, the barriers we've created over time for doctors and nurses practising in a new province or territory aren't helping to fill the 118,000 job vacancies in health care and social assistance across the country. It is why the current regulatory licensing frameworks need to move to a pan-Canadian licensure model. This would allow health professionals to work where they would like and where the needs are greatest. It's time to remove these unnecessary regulatory obstacles.

The result will affect every single Canadian and put their health or ability to access their health system at risk. This crisis has ballooned past what any jurisdiction can manage alone. We know that the premiers are focused on an increase in unconditional federal dollars. We believe that more strategic federal investments are required to support the rebuilding of health care delivery in Canada.

First, we need federal leadership for pan-Canadian integrated health and human resource planning. An intergovernmental approach led by the federal government is required.

Second, it's time to deliver on the promise to increase patient access to family doctors and primary care teams by delivering on the $3.2-billion commitment. As part of this commitment, the CMA recommends that $1.2 billion over four years be dedicated to a primary care access fund, and $2 million to undertake an assessment of interprofessional training capacity of family physicians [*Technical difficulty—Editor*]. Scaling up collaborative, interprofessional primary care is central to increasing access to care.

Third, we need a pan-Canadian licensure model that supports access to care, especially for rural and remote communities; continuity of care, including cross border virtual care; the mobility of patients and providers; and overall creates a more streamlined licensure process.

● (1215)

The past decades have witnessed remarkable advances in medicine, but we're still reliant on health workers.

Just as we have stood on the front lines, it's critical that the federal government create pathways that will stand for the protection of medical professionals. We need the federal government to finish this long shift with us.

Thank you, Chair.

The Chair: Thank you, Dr. Smart.

Now we go to Mr. Villeneuve for five minutes.

Mr. Michael Villeneuve (Chief Executive Officer, Canadian Nurses Association): Good afternoon and thank you, Mr. Chair and members of the committee, for inviting the Canadian Nurses Association, the national and global professional voice of Canadian nursing, to appear today.

My name is Mike Villeneuve and I am speaking to you today from the traditional lands of the Algonquin and Anishinabe people. I'm the chief executive officer of CNA.

Mr. Chair, I have been working in health care for the past 44 years [*Technical difficulty—Editor*]. I have never seen the gravity of the kinds of [*Technical difficulty—Editor*]. CNA predicted Canada would be short about 60,000 nurses by 2022. We're a quarter of the way into that now and [*Technical difficulty—Editor*] shortages are worse than we imagined.

Canada's nearly 450,000 nurses, 91% of whom are women, are the backbone of our health systems. Today, they are completely exhausted and demoralized. We are seeing alarming numbers of them not just leaving their jobs, but even the profession.

Many nurses face working 16-hour shifts, have not been able to take a day off or take a break, or have had their vacations suspended and they face chronic and dangerous understaffing. Rates of severe burnout among health care workers have almost doubled. You heard what Dr. Smart said about the number of people who have planned and attempted suicide. It's 6%. It's alarming.

Vacancies for registered nurses and registered psychiatric nurses have increased by over 85%, which is the largest increase of all occupations. Nurses have been sounding the alarm for decades about these problems—long before COVID-19. The issues are not new, but they have been exacerbated by the pandemic.

The factors influencing nurse retention have been studied intensively for 40 years through myriad studies, reports and millions of dollars in research. Nurses have a clear understanding of the problems and we know the solutions needed to stabilize Canada's health workforce crisis.

The challenge is creating and sustaining political will at all levels to implement these tough changes. Canada needs targeted federal funding to help health care systems train, retain, recruit and improve education and working conditions for health care workers. The federal government has an important convenor and coordinator role to play. It needs to work together with provinces and territories on both short- and long-term strategies. Maintaining the status quo cannot be an option.

In the short term, we need retention incentives for nurses and health care workers to stay in their jobs, such as retention bonuses, student debt forgiveness and tax incentives. Additional funding is also needed to help optimize workloads for health care workers. This could include increasing administrative, cleaning and other support staff in nursing settings to unlock more time for care.

In the longer term, CNA echoes the calls for a national health workforce body to collect high-quality data to support a strong, modern pan-Canadian health human resources strategy that includes planning at the provincial, territorial and national levels. CNA also recommends increasing the number of seats in schools of nursing and greater capacity for clinical placements. We recommend expediting the process for recognizing internationally educated nurses and funding for mental health supports for health care workers.

We need emergency and definitive interventions with immediate action and a multi-faceted strategy to address the complex problems in Canada's health workforce. We have to be bold and creative. Strategies that serve to retain a nurse at 25 are not going to be the same as what will retain a nurse at 65. What attracts people to stay in home care may be very different from critical care or palliative care. We need to be nimble, marshal the evidence and develop a tool box of strategies that can be adapted across care settings and across career stages.

Finally, as the proportion of older adults in Canada rises, we will need a strong care economy and workforce to support our aging population into the future.

In conclusion, we applaud the committee's decision to conduct this important and timely study. I'd be happy to try to answer any questions.

Thank you, Chair.

● (1220)

The Chair: Thank you, Mr. Villeneuve.

We will now open the floor to questions, beginning with Madam Gladu for six minutes.

You have the floor.

Ms. Marilyn Gladu (Sarnia—Lambton, CPC): Thank you, Chair.

Thank you to all of the witnesses for being here today and for all the work you've done.

I'm going to start with Mr. Villeneuve.

Talking about nurses, my daughter is a nurse. I'm certainly well aware of many of the issues facing nurses. She's been attacked. She has been forced to work overtime. She has had her vacation suspended. Even though she's only in her twenties, she's one of those considering leaving the profession.

If we look at all of these issues, why have they not been addressed? They've been known for a long time, but nothing seems to have been done.

Is it a lack of money or a lack of political will? What do you think?

Mr. Michael Villeneuve: Thank you, Mr. Chair, for the question.

That's the million-dollar question, isn't it? We've been looking at these issues; I can tell you that I've been involved in this since the year 2000. At that time, the conference of deputy ministers directed the country to develop a nursing strategy for Canada to address the shortages in these ongoing issues.

I can share with the member, Chair, that I looked at it again this morning. It was published in 2000, if you want to look it up. The nursing strategy for Canada had a number of recommendations. Its first recommendation was to create a Canadian nursing advisory committee to talk about all these issues. I happen to have the honour of being the executive lead of that.

Again, I looked at those 51 recommendations. Hand to God, you could just change the date on both of those reports, and literally every single thing we're talking about today is exactly the same. There just has not been the will to make the kind of changes we need across the system. Frustratingly, some places do it very, very well, so one might ask why all the rest don't. Many hospitals in this country don't have any trouble recruiting people and retaining them. I would say don't even invent anything new: Just copy that and do it in other places. We know the solutions.

It's been a tremendous frustration, Chair, that we haven't seemed to be able to move the dial. I won't go into the rabbit hole of gender, but I am very, very concerned that this is not the case in workforces heavily dominated by men. I've watched it play out for almost 45 years.

● (1225)

Ms. Marilyn Gladu: Thank you very much. I fully agree. I'm increasingly concerned when I see that we have an aging demographic and an increase in dementia, which will only exacerbate, I think, the already difficult situation.

Mr. Janerio, do you have any information about the percentage of PSWs who are not full time? We see that people chronically are made to take two and three part-time jobs with no benefits. Is there a quantity that you can put to that?

Mr. James Janeiro: That's an excellent question. I don't have that data off the top of my head, but I can certainly get back to you with it.

I can say that there has been an interesting development over the course of the COVID-19 pandemic. This is speaking specifically about the Ontario experience with COVID, but it was replicated in other provinces. As the realities of COVID became clear, and it became obvious that staff working for more than one employer was a vector for transmission of the disease, a number of agencies in the PSW sector, developmental services and other caregiving sectors started to move people purposely from part-time to full-time employment. They offered them the opportunity to go from being a part-time employee to a full-time employee, certainly with predictable hours but often with benefits and access to pensions and stuff like that.

Speaking in Ontario, at least, there was a lot of interest among those part-time staff to go to full-time employment, given the option. Even as the orders enabling all of that stuff have started to recede in Ontario, the interest in staying on as full-time employees rather than going back to part-time is huge. I would say it's probably the vast majority.

Ms. Marilyn Gladu: Absolutely. That's the direction we need, for sure.

Dr. Smart, we heard testimony the other day from Linda Silas about nurses. About 8% of them lost their jobs because they weren't vaccinated. That just made the situation even worse when there was already a shortage of nurses.

With respect to doctors in this country, did we see something similar? I've heard anecdotally at my office about different things—doctors who decided they were going to shut their offices, doctors who shut their offices because they felt their conscience rights were being threatened, and people who had their licences threatened.

I mean, I hear these things anecdotally, but in terms of a labour shortage, was there an impact from the pandemic on the medical staff?

Dr. Katharine Smart: I don't think we've seen a really significant impact that way amongst physicians. Over 99% of physicians are fully vaccinated against COVID-19 across the country. Certainly, we've heard a case here or there, but I don't think we've seen a substantial impact on the workplace.

I think we have seen other impacts, of course, from the pandemic. Many people in the community who were trying to provide primary care had to pivot to totally virtual health on a very short timeline. They have tried to maintain access for their patients over the past two years with changing public health requirements. That's been very stressful. It was one of the things noted in our national physician health survey as contributing to burnout—just the constant need to adjust to new expectations and ongoing and crushing workloads.

Ms. Marilyn Gladu: What are the biggest barriers to getting more doctors in Canada, which is clearly what we need? Is it credential recognition? Is it financial donations from the federal government? What is the barrier?

Dr. Katharine Smart: I think one of our biggest challenges is that without a human health resource plan, we've never defined clearly how many positions are needed to serve Canadians on different levels of medicine. For example, we know that we need people in primary care. Well, what's that exact number? We know we need specialist care. What's that exact number? Where should the physicians be located?

Without that pan-Canadian human health resource plan, it's then challenging to start back at the beginning. At the medical school level, how many people should we be training? How many should there be at the postgraduate level? How many people should we then be training in these different specialties of medicine, which types and where? Right now I think the issue is that none of this is integrated. That's very challenging, and it means we have these shortages.

The other piece is that we do have internationally trained medical graduates in Canada who have been unable to access the system. They remain uncredentialed and unlicensed, and they haven't been able to participate in the systems that exist to get into actual practice and caring for Canadians. There's also work that could be done there to bring more of those folks on board and into our system.

● (1230)

Ms. Marilyn Gladu: Very good. Thanks so much.

The Chair: Thank you, Ms. Gladu.

We'll go now to Mr. Long for six minutes.

Mr. Wayne Long (Saint John—Rothesay, Lib.): Thank you, Mr. Chair.

Good afternoon to my colleagues.

Thank you to the witnesses for your testimony.

I'm a member of Parliament for the great riding of Saint John—Rothesay. Last week I had an opportunity to sit down with Dr. John Dornan, who's the CEO of Horizon Health Network. We talked about very innovative ideas, but also, obviously, a lot of concern came out of that meeting.

Again, I thank MP Zarrillo for this wonderful study, and we're here today because we certainly are faced with a crisis in the community care economy—doctors, nurses, caregivers—in every sector. From a federal perspective, as an individual and an MP, as a federal politician, as the federal government, I look for answers as to what we can do. We certainly recognize that jurisdiction is a major issue when it comes to our involvement in health care matters.

My first question is for you, Dr. Smart.

You alluded to the $28-billion ask from the provinces for health care, but you also mentioned that it may be better—and I don't want to put words in your mouth—targeted. Can you just elaborate on what you mean by targeted investments?

Dr. Katharine Smart: I think what we see is that there are certain areas right now within the health system that are particularly in crisis. We believe that targeted investments to ensure that funds go to supporting those areas have more opportunity to create accountability in the system and outcomes for Canadians versus large sums of money being absorbed into a general budget. For example, with regard to surgical backlogs in diagnostic imaging, we know there are hundreds of thousands of Canadians waiting for those procedures, so targeted funding for that, earmarked for hospitals to make sure those services are provided, would benefit those Canadians directly.

We know that there are significant issues with mental health, which has worsened for Canadians throughout the pandemic. Again, funds that can be targeted towards that will ensure that Canadians have better access to more holistic and more extensive mental health supports.

We're talking about primary care. Again, this is a huge crisis. Over five million Canadians are without access to a primary care provider. This is the front door to our health care system, so when you have Canadians without access to that type of care, it's very problematic. It increases costs over the long term, as many chronic diseases remain unmanaged and patients bounce between intermittent types of care.

Targeted investments, in terms of increasing integrated, team-based care, we think, again, can go to creating those better outcomes for Canadians. That's why we're recommending that the federal government, in alignment with stakeholders, identify those priorities and ensure that the funds go to meeting those goals.

Mr. Wayne Long: Thanks for that answer.

Also, I had a meeting with Dr. Michael Barry, a past president of the CMA.

How severe do you think the shortages are in infrastructure or issues with infrastructure? Certainly he talked about diagnostic imaging equipment. What level of concern do you have with the age of the infrastructure?

Dr. Katharine Smart: The things that need to be replaced vary across the country and across communities, for sure. We see that with diagnostic imaging equipment, with surgical equipment and, really, hospital equipment. I think you're going to see that different jurisdictions have different challenges.

I think the other big infrastructure issue we have is the infrastructure for providing primary care. In our traditional model of fee for service medicine, that infrastructure is provided and funded largely by physicians. That's becoming more challenging with rising labour and rental costs, and a lot of physicians are challenged to open and maintain primary care clinics because of the cost associated, as well as the ability to staff those particular forms of infrastructure.

I think there are many challenges in that domain, absolutely.

● (1235)

Mr. Wayne Long: Okay. Thank you for that.

Mr. Villeneuve, thanks for your testimony.

Again, recognizing jurisdiction between federal and provincial governments, how do you think that we as a federal government can help provinces and territories when it comes to staffing shortages?

Obviously, sadly, there's not a nurse—MP Gladu's daughter, any nurse that I talk to—that is not severely overworked. The mental health crisis in our nursing sector is of major concern.

What can we do as a federal government, Mr. Villeneuve?

Mr. Michael Villeneuve: Thank you for the question, Chair.

One of the realities across the country.... If we just look at nursing, there are roughly 450,000 nurses. We have a terrible shortage of nursing care. I'm never sure if we have a shortage of nurses. In many places, half of those people are part-time. What are the kinds of things you can do, even if you took a chunk of them and moved them to full-time hours?

Many people who are internationally educated graduates in the country are not getting into the system as quickly as they could.

What do you do to move people in and retain them?

People who are in the system are telling us that the reason they're going is not the money or retention bonuses. It's staffing. If the federal government could make some effort.... We had suggested a $300-million package to support better staffing.

The government could use some incentives, such as tax forgiveness, for example. If I'm 25 and you said to me that if I stayed for five years, you would wipe my student debt clean, that would get my attention, or if I'm 65 and you say to stay for two more years and you'll forgive the first 25% of my income. There are some creative levers that the federal government could do that would be attention getting for people.

The nurses are telling us, for example, late in career that they're making pretty good money. Five thousand dollars doesn't attract someone who is in the $80,000 to $100,000 category to stay in terrible working conditions.

What do you do to keep as many people in the system as possible?

We think the strong funding support of the federal government plus convening some planning—the federal government is good at doing that—would go a long way to shoring up the resources in the nursing sector.

Mr. Wayne Long: Thank you very much.

[*Translation*]

The Chair: Ms. Chabot, you have the floor.

Ms. Louise Chabot: Thank you, Mr. Chair.

Thank you to all of the witnesses.

I would like to speak to the situation described by representatives of the Canadian Medical Association and the Canadian Nurses Association.

We are seeing labour shortages across the country. The problems vary from province to province and they have different causes, but there is an overall problem with burnout, as well as with recruitment and retention. As you said, it's not about using the same strategy from one industry to another.

My problem is not with what you said, because I think you are painting a general picture of the situation. However, you know very well that the real solutions fall each province's jurisdiction. I will give Quebec as an example. I am a nurse by profession and I was a union representative for nurses for quite some time. As in every province, the major nurses' unions, the Fédération de médecins omnipraticiens du Québec and the Fédération des médecins spécialistes du Québec negotiate the organization of care and the conditions of practice in areas that affect them. The same approach cannot therefore be used to fill full-time vacancies. The federal government cannot use a unilateral approach, as this is not its area of expertise, but that of the provinces.

However, I agree with you that it is absolutely necessary for the federal government to invest significantly in our public health care and social services. Under Canadian law, we must provide universal, free public care and we must have the tools to correct the unfortunate situation you describe. These investments cannot have strings attached.

Quebec and the provinces are making demands to this effect. The federal share of provincial health care spending is currently 22%. If nothing is done, it will be 18% in five years. Restoring the balance between the federal and provincial share of health care spending is imperative, because we see that the federal share is decreasing. The federal share of funding used to be 50%, but now it is 22%. Furthermore, the federal government is not making any commitments. Currently, the federal government commits to giving one-time payments to meet specific needs, but these are not recurring or predictable amounts of money.

Do you agree that the best solution is bring up health care funding to at least 35%, with no strings attached? That would support workers.

● (1240)

[*English*]

Mr. Michael Villeneuve: Excuse me, Chair, is that question for me or Dr. Smart?

[*Translation*]

Ms. Louise Chabot: The question goes to whoever would like to answer.

[*English*]

The Chair: Yes, she did not direct it to anybody in particular.

Mr. Villeneuve, and then Dr. Smart.

Mr. Michael Villeneuve: Chair, yes, I'll just make a very quick comment.

Although the CNA does not have an official position on the federal and provincial split, I think it would be safe to say that we would support a return to a better balance for the provinces and territories, but I think we would also say that that return of a higher per cent being paid federally, in the sense unconditionally, could also be accompanied, as it has been in the past in accords.... And I know FPT health accords chill the blood of some people, but they worked in some places to provide change.

So I don't see that it has to be one or the other, but rather, could you not have both?

Thank you, Chair.

Dr. Katharine Smart: I can also comment.

We certainly support and recognize that there's a need for the Canadian health care transfer dollars to increase as well, and that predictability and sustainability of funding is important. However, we do also support the idea of targeted funding for the reasons I mentioned earlier, which is to improve collaboration at the federal-provincial levels to allow us to scale up things that are working in certain parts of the country into other parts of the country, and to create accountability for where those dollars are going, to make sure that they're actually achieving the outcomes that Canadians want to see in the system.

Mr. James Janeiro: Mr. Chair, if I could also add, certainly the Canadian Centre for Caregiving Excellence hasn't weighed in on this particular issue quite yet, but I will say that, similar to Monsieur Villeneuve's comments about the federal spending power buying change in the system, our submission is that the core issue among paid caregiving is wages. It's difficult to address wages without some conditionality, some strings, or however you'd like to put it, from the federal government as these funds transfer, to make sure that particular problem is addressed, which has knock-on consequences for the overall quality of the system.

Thank you.

The Chair: You have 20 seconds, Madam Chabot.

[*Translation*]

Ms. Louise Chabot: I think that wages are a provincial matter, and they have their own employment policies and their own labour policies and legislation. In Quebec, the Pay Equity Act has been in place for 25 years. I therefore don't think that compensation is a federal matter.

[*English*]

The Chair: We've run out of time.

If somebody wants to respond in writing to that, they can.

We will now move to Madam Zarrillo for six minutes.

Ms. Bonita Zarrillo: Thank you, Mr. Chair.

It's certainly been wonderful to hear from the witnesses today and at the last few meetings. I think what's clear, and one of the reasons I was motivated to see this study happen, is that there is systematic and systemic gender discrimination as well as discrimination towards immigrant women, more so than for others. This is the root of the problem.

We have an opportunity to expose it here in this study and to set conditions for those working in the care economy, and also to elevate the reality that this is part of the economy which underpins every other part of the economy. So I really appreciate the comments today.

My first question is for Dr. Smart about the asking and asking that has happened and the federal government's not necessarily listening. Are there any thoughts or conversations around why your organization might feel the federal government hasn't been listening?

● (1245)

Dr. Katharine Smart: I think right now where we find ourselves is feeling that people are listening and hearing our concerns. We certainly appreciate the opportunity to present to you today and at other parliamentary committees, as well as in other contexts.

I think the concern and the challenge you're hearing from all of us is how we can move from laying these problems out to the actions and solutions to solve them.

I think, as Mr. Villeneuve said, these are not necessarily new issues. We've been talking about the same things now for a long time. The same issues keep coming up. If anything, I think the pandemic has made the issues more acute. It's brought them more to the awareness of the average Canadian at home, who's been hearing about this every day.

I think the challenge our organizations are finding is how to move from having our concerns heard and the opportunity to share what we're finding and learning on the ground, [*Technical difficulty—Editor*] to help us solve these problems. I think where we find ourselves today is really needing to move to action.

And our concern, I believe, is that if we stay with the status quo, we're very close to having Canadians not being able to access care at all in different contexts. I think that's extremely worrisome for the future.

Ms. Bonita Zarrillo: Thank you so much.

I agree. Just on that topic of actions and solutions, my next question is for Mr. Villeneuve on the studies he referenced that were done back in the early 2000s.

Mr. Chair, I wonder if we could have those studies come to the floor and be part of the information for the analysts.

But I did want to ask Mr. Villeneuve how we make these studies, these insights and this information, actionable. What needs to happen?

Mr. Michael Villeneuve: I think we're actually at a strange point of opportunity, Mr. Chair, just because of COVID-19.

We've talked about this, as I said, for 20 years or more. We predicted the shortages of 60,000 this year, and here we are.

But COVID has accelerated what would have been a more protracted period of retirements of older nurses. I can tell you, for example, that in my time serving as a patient care manager at Sunnybrook in Toronto in the areas of neuro-ICU and neuro-surgery and so on, you could often find ways to make conditions a little easier for older nurses by reducing their hours and giving them different jobs and so on to keep them longer. We've had this compressed, and they're now saying they're not going to do that any more.

What I would say to the member is that I feel, for the first time in a long time, that people are hearing us. I think the crisis at points of care.... For example, at a Toronto, 905-area hospital that I won't mention, staffing was all set up for next week. This was a couple of months ago. I came in Monday morning and 25% of the nurses were off—25%. So when you become at material risk of not being able to actually run an organization, it gets people's attention.

I'm not giving a very good answer to the member, but I hope that the emergency nature of it now will propel us forward into some actual action, because the solutions aren't new.

Thank you.

Ms. Bonita Zarrillo: Thank you for that. I agree with you that the critical nature of it is forcing a response. Hopefully we can do a little bit more planning as well as respond to the critical....

I want to go back to Dr. Smart. I've heard over years—I'm talking about a decade, at least—that it's the provincial professional organizations that limit the number of doctors and health care workers that can come through. I'm just wondering if there's any truth to that, that the professional organizations in health care are limiting the number of seats at universities to get people graduated and these foreign credentials recognized.

Dr. Katharine Smart: I think in the past there have been some limitations at the government level in restricting billing numbers for physicians in order to try to direct the health workforce into certain locations. To my knowledge, I don't believe that we see the provincial and territorial medical associations at all limiting numbers of training spots, either at medical school or at the post-graduate level.

What we do have is a lack of coordination between the outputs that we're trying to achieve in terms of practising physicians, in primary care specialities as well as other specialty areas, and post-graduate training opportunities. Again, this also speaks to the issue also with credentialing and licensing. This is another reason that we feel there is a strong opportunity for a pan-Canadian licence.

When you look at IMGs and their ability to be credentialed and then brought into the Canadian system, you see that it looks different in every province and territory, and the cost associated with that is significant. It is a definite barrier to our being able to mobilize those physicians into our workforce.

We believe that when we start talking about things like decreasing those regulatory barriers and looking at things like a national licence, it would allow us to remove some of that administrative burden. It would also give the federal government an opportunity to fund and support those physicians to be credentialed, trained and brought into our system. Those are examples of solutions, I think, where the federal government definitely has levers it could pull that would have a strong outcome.

We also believe that by creating a pan-Canadian human health resource strategy, we're then able to go to the medical school and post-graduate training level and make sure that those things are aligning to create the outputs of both numbers and types of physicians needed in the system.

● (1250)

The Chair: Thank you, Dr. Smart and Madame Zarrillo.

Now, we go to Mr. Liepert for five minutes.

Mr. Ron Liepert (Calgary Signal Hill, CPC): Thank you, Chair.

Thanks to the witnesses for being here today.

Dr. Smart, I appreciated all of your comments throughout the pandemic. Like many other Canadians, I was sitting in my living room watching way too much TV, but your comments were well voiced during the pandemic.

I want to start my comments, and then ask questions ultimately. I'm probably going to ask all three witnesses to comment at the end.

As a bit of background, I had the privilege of serving as health minister in Alberta from 2008 to 2009. One of my first observations was that health care had multiple structural problems. We were already spending 50% of our provincial budget on health care, and what has happened since then, as you have described today, Dr. Smart, similar to being on life support and a crisis. One of the first things I did when I was health minister was to fire 12 regional health boards, three other boards and to create the Alberta Health Services Board, which runs all of the health system in Alberta today very successfully.

For too long, in my view, politicians have simply buried their heads in the sand and said they can't look at making changes to how we do health care in this country. What do we do as politicians? Well, we do another study, like we're doing here today.

I can just about tell you what's going to come out of this study, with all due respect to all of the witnesses who have appeared before us. I know Mr. Long doesn't liked to be called part of a “coalition”, so I'll call it an “NDP-Liberal marriage” that happened last week. I can predict what this report's going to look like when we table it, and there will be another report—

Ms. Bonita Zarrillo: Mr. Chair, I'm going to ask for a point of order.

The Chair: On a point of order, Madam Zarrillo.

Mr. Ron Liepert: This is not going to cut into my time, I hope.

Ms. Bonita Zarrillo: Mr. Chair, I'm concerned about parliamentary language here. We're talking about a very gendered, discriminatory reality for many women over the years, and the member's going to use words like “marriage”.

It really is non-parliamentarian to try to belittle women and the importance of the work they do by using ridiculous terms like “marriage” in regard to government.

This is an important study. It's important to women and people who need care in this country. It's unparliamentary.

The Chair: Thank you, Madame Zarrillo.

We're now moving into debate.

Mr. Liepert, you have the floor.

Mr. Ron Liepert: Well then, why don't we call it a “coalition”—which it really is anyway—if that will make our NDP member a little happier?

We have, in my view, a structural problem in health care. Until we address that, we could commit double the money that we're committing today and it'll simply change nothing. We won't go off life-support and we won't get out of the crisis.

Here are some of the structural problems. Dr. Smart, I'd appreciate your comments on.

We have an outdated model of how we pay doctors. We have doctors doing work that clearly other professions could do, but that's the way they get paid. It's not the doctors' fault. Again, that's the elected people's fault.

Secondly, we have professions within health care that are not prepared to change their scope of practice. A lot of things could be done in health care at different levels, but professions are pretty strident in what they stand for.

Finally, we have public sector unions that wield far too much power in the public health care system.

I'd be interested in comments from all three of our guests today on whether money is the solution or whether we have a structural problem within health care, which, if we don't address at the federal level.... It's not a case of not getting off life-support; it will crash and burn.

● (1255)

The Chair: Okay, he's directed it to all three.

You have a minute and 20 seconds left to respond.

Dr. Katharine Smart: I can start.

Thank you, Chair, for the question.

I certainly agree, and the Canadian Medical Association agrees, that we have both issues at hand. There's no question that there are many structural issues within the health care system, including outdated payment models, outdated structural models and outdated ways of trying to provide primary care in a traditional, siloed, fee-for-service model. These aren't serving Canadians by any means and certainly aren't serving or attracting newer physicians into that style of practice.

That's why you've heard us advocating for integrated, team-based care and the creation of medical homes for patients where they're able to access a variety of health care professionals to address their needs. It's absolutely true that our current systems don't necessary allow for or incentivize that type of care. It often leads to unnecessary visits and unnecessary things in the system that aren't benefiting patients.

It's also why you have heard us speak to the idea of scaling virtual care, as that's another tool that could be used to allow patients better access. It would also allow more collaboration amongst health care professionals to make sure that patients are really seeing the right person at the right time.

We do also agree that just by...more dollars into a system that's not functioning well, we're not going to have the level of accountability and the deliverables that Canadians deserve. However, it is also clear that the dollars going into health care are declining. That's against an aging population with more complex health care needs.

We certainly agree that we need to reimagine the system. We need to look deeply at what these structural barriers are, understand how we can work in a more integrated and team-based environment and how we can have people working within their full scopes of practice to benefit Canadians. At the same time, we need to be increasing those investments so that the health care system is sustainable.

The Chair: Thank you, Dr. Smart, you are just in time.

Mr. Liepert, thank you for your question.

Now we go to to Madame Ferrada for five minutes.

[*Translation*]

Ms. Soraya Martinez Ferrada (Hochelaga, Lib.): Thank you, Mr. Chair.

I would like to inform you that I will be sharing my time with Mr. Coteau.

I have two brief questions. My first question is for Mr. Villeneuve.

Mr. Villeneuve, in January, not so long ago, your association made the following statement in a press release: “Governments must work together as a federation in crisis to immediately negotiate innovative strategies [...]”. This referred to challenges caused by labour shortages in the care economy. The statement was signed by two nursing associations.

Ms. Smart, you spoke earlier of a national strategy to integrate training. I'd like to hear more about this idea, about how we can deal with this on a national level.

What do you think those innovative strategies would be?

You mentioned some of them earlier.

I would like to hear briefly from Mr. Villeneuve and Ms. Smart about these innovative strategies.

[*English*]

Mr. Michael Villeneuve: My feed cut out a bit, but I think I got the gist of the question.

We have tabled a number of suggestions in our pre-budget submission, which I'll be happy to share with the committee. Things that tend to work for nurses are boosting the staffing, tax incentives and loan forgiveness.

The thing that is slightly longer-term, but that we think is very critical and gets somewhat to the other questions asked, is that we have to do some planning. With no disrespect to my great colleague, Katharine Smart, who's a famous pediatrician, you could trip over pediatricians in this country trying to find someone to care for your elderly parents. It's the same for nursing.

We don't operate in 13 silos. We're a fluid country. People are educated in one place and they practise in another. We think that a really deep dive into purposeful planning would make a big difference.

I don't want to use any more of your time.

Thank you.

Dr. Katharine Smart: I'll also comment.

From our perspective, in terms of innovative ideas, we've mentioned some of them today, such as national licensure and opportunities to create more mobility within the health workforce. They also create a lot more opportunities to scale and consider virtual care, and how it can be used to address access issues, particularly with things like rural and remote patients being able access specialist care.

The other piece is scaling integrated, team-based models within the primary care system. We are hearing over and over from our colleagues in family medicine that the old style of the fee-for-service siloed business model in family medicine is not attracting new doctors. They want to work in teams. They want to provide collaborative care to their patients.

Those two ideas, if implemented, would have quite profound impacts on access and sustainability.

Thank you.

● (1300)

The Chair: You have two more minutes.

Mr. Michael Coteau (Don Valley East, Lib.): Could I jump in now?

The Chair: Go ahead, Mr. Coteau. You have two minutes.

Mr. Michael Coteau: Thank you very much, Chair.

I have a question for Mr. James Janeiro, but first I want to thank Mr. Villeneuve for serving the community of Don Valley East. You mentioned Sunnybrook. I want to say thank you for all the work you've done. There's no such thing as retirement, so I'm sure we'll see you around sometime in the near future.

Mr. Janeiro, I have a quick question for you.

We always see posts up for jobs in the developmental sector, and they stay there for a long time. Can you talk a bit more about why it's so hard to find people, specifically in this sector?

Mr. James Janeiro: There are many factors that go into it, but the simple, boiled-down point, unfortunately, has to do with wages. Wages in this sector are simply too low, particularly for the work it entails. If you can imagine, it's supporting children and adults with intellectual disabilities, often in a congregate care setting like a group home, which means it's a lot of attending to daily care needs. There's some feeding, some toileting, lifting and that sort of thing. It's taxing work, it's difficult work and the wages, unfortunately, at the moment do not match up with the difficulty and the nature of the work.

I'll also say, though, that another part of it is the structure of the work. I alluded earlier in my comments to the ratio of part-time versus full-time work, though as time goes on—a lesson from the pandemic—there is a move towards full-time work, rather than part-time opportunities. We've seen, for example, that those full-time opportunities tend to be scooped up a lot more quickly than part-time opportunities, which I think is a reasonable expectation.

The last thing I'll put on the table here is that the developmental services sector, like the personal support worker sector and other parts of caregiving, is often a first job for newcomers to Canada. One of the realities of the pandemic over the last couple of years is that fewer newcomers are coming to Canada and needing that first job. We have felt that pinch across the care network, the care economy, such that we're seeing fewer and fewer new people come up. We're seeing repetition, where somebody was in the sector, left the sector, and is now back again for one reason or another, but we're seeing fewer entrants into the sector, we think in part, because the pipeline of people interested in these jobs coming from abroad has been narrowed by the pandemic.

Hopefully, as we get to a postpandemic stage of COVID, we look forward to newcomers coming back to Canada in large numbers and welcoming them into our sector as a great first job, and maybe a second and third job as they get used to life in Canada.

The Chair: Thank you, Mr. Janeiro.

Mr. Coteau, your time is up.

We started a bit late, so to be fair, I'm going to go to Madame Chabot, and then Madam Zarrillo, for one short question to finish out this round. I see no objections.

Madame Chabot, you have a short question.

[*Translation*]

Ms. Louise Chabot: We know that, in the context of the labour shortage, there is a tendency to recall people who have retired, be they doctors or nurses. This was the case in Quebec, at least, where the right tax conditions were created to avoid penalizing them.

Could the federal government find tax solutions to encourage retired workers to return to work?

[*English*]

Mr. Michael Villeneuve: Mr. Chair, I would be pleased to take a short crack at that.

I think that's a reasonable solution. What we must be careful about is where we have really major shortages. For example, we're very pressed in critical care. The kinds of people coming out of retirement may want to step back in and do.... For example, we saw a lot doing vaccine clinics and so on, but they may not be as easy to move right into critical care, acute care, operating rooms and so on, unless they are very, very current. Yes, it will attract some people, but whether it attracts the calibre—I mean that in the sense of safety—of the kinds of people we want, I'm not so sure.

We'd have to look at that.

● (1305)

The Chair: Thank you, Madam Chabot.

Madam Zarrillo, one final question.

Ms. Bonita Zarrillo: Thank you.

I'll direct this question to Dr. Smart.

This is around ancillary economy-driven aspects of the care economy. We've talked a lot about care work itself. I'm just wondering if Dr. Smart has any comments about what ancillary businesses will also grow and that we need to invest in within Canada. I'm thinking about PPE. I'm thinking about anything, such as infrastructure, lifts and things like that.

I would love to hear some thoughts as to how this will all swing around to other areas of the economy.

Dr. Katharine Smart: There are definitely opportunities for Canada to grow its economy in terms of things like providing PPE. Also, vaccine production, I think, is going to be critical. If we're learning anything from COVID, it's that the playing field keeps changing. There's still lots of innovation coming with vaccines. Our ability to produce and scale those up within the country I think would be quite meaningful.

The other area is pharmaceutical production. There's an increase in global drug shortages. The ability to produce and provide pharmaceuticals within Canada would also be a benefit. I think there are many potential aspects of our economy that would be related to health where we could be producing things that we would need in the health care sector that would also be an economic benefit to Canadians.

Thank you.

The Chair: Thank you, witnesses, for your very valuable input into this study and your testimony today before the committee.

With that, I will adjourn the meeting for today.