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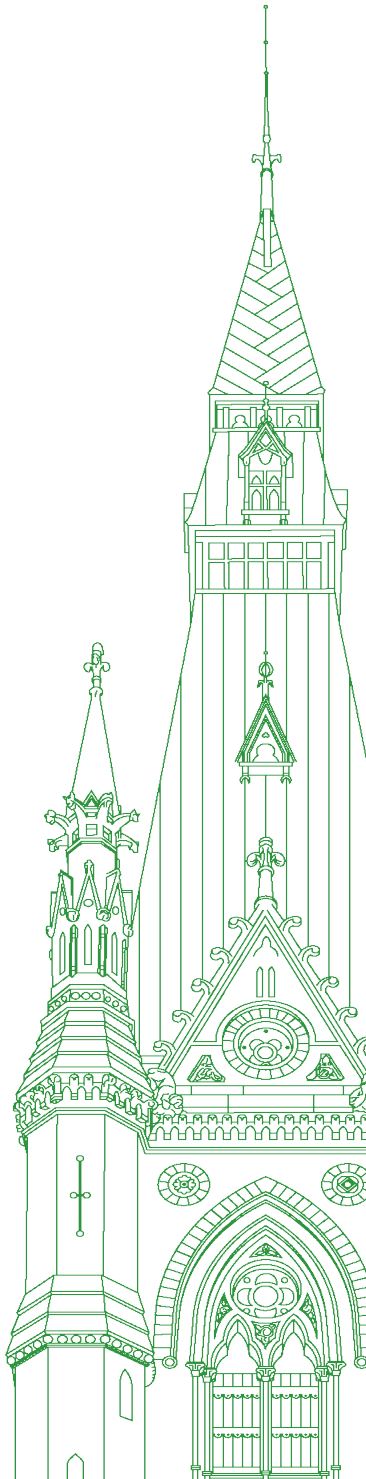

Chair: The Honourable John McKay

Standing Committee on National Defence

Friday, May 12, 2023

● (0845)

[*English*]

The Chair (Hon. John McKay (Scarborough—Guildwood, Lib.)): I call this meeting to order. We have completed all the sound checks and all the weather reports, so we now know that it's a nice day here in Ottawa and elsewhere.

In our first hour we have, representing the Office of the National Defence and Canadian Armed Forces Ombudsman, Gregory Lick—a familiar face before this committee—and Robyn Hynes, director general of operations. Appearing virtually are retired Colonel Nishika Jardine and Duane Schippers, deputy veterans ombudsman.

Welcome, everyone.

With that, you have five minutes to make your opening statements.

Mr. Lick, I'll let you proceed for the next five minutes. Go ahead, please. Thank you.

Mr. Gregory Lick (Ombudsman, National Defence and Canadian Armed Forces): Thank you.

Good morning, committee members. Thank you very much for inviting me to discuss this important topic. There have been many studies on individual or collective aspects of the military-to-civilian transition, access to health care and barriers to accessing benefits and services in DND on the CAF and Veterans Affairs Canada sides.

Parliamentary committees and both of our offices have made many recommendations that either have yet to be implemented or will not be implemented. Simply put, it can be hard to hold the government to account in this regard.

We must get this issue right for members transitioning from military to civilian life. This process represents more than a change of jobs or retirement. For many members, the Canadian Armed Forces forms a critical part of their identity. Leaving the CAF, they lose that connection while facing physical, mental or moral injuries. If you do military transition well, you will have a good civilian.

[*Translation*]

My office issues follow-ups to recommendations contained in our systemic investigation reports. We have clear criteria by which we determine whether our recommendations are fully implemented, partially implemented, or not implemented at all. We posted these reports on our public website.

Since 2016, the results have not been promising regarding the topic you are currently studying.

[*English*]

In 2016 we released reports on three investigations: one on operational stress injuries in the primary reserves and two focusing on the process of transition from military to civilian life. We made eight recommendations, seven of which the minister accepted. None of the accepted recommendations have been fully implemented.

Let me be clear. Our office has a great relationship with the department and the CAF at the working level. Since 2018 the CAF has accepted and implemented all of our recommendations, which resulted from individual investigations. Ms. Hynes, who is the head of our operations group, and I are incredibly proud of that track record, but it's the recommendations stemming from our systemic investigations that often experience slow progress.

[*Translation*]

Take one important example: In 2016, our office recommended that no member of the Canadian Armed Forces should be medically released without all benefits and services, from all sources, including Veterans Affairs Canada, in place.

[*English*]

This committee made a nearly verbatim recommendation in 2018. So did the Senate subcommittee on veterans affairs. So too, in fact, did SSE initiative 28, in which the government set out its goal to “ensure that all benefits will be in place before a member transitions to post-military life”.

The government claims to have checked this initiative off its list, but according to our analysis, it has not.

How do we know this? Our office still receives cases. People are still falling through the cracks. Other organizations exist to provide emergency services to current and former CAF members, including those in the transition process, who are still called to help out. Perhaps worse, potentially many more veterans are not coming forward to indicate that they are unprepared for release, that their benefits and services are not in place and that a timely VAC adjudication is not on the horizon.

Whatever the reasons, we know that the principal problem is slow VAC adjudications. The backlogs have been well documented publicly, and the OVO can best address these issues. I can say with great certainty that this is not a people problem. You have people within VAC who want to do the right thing. It is a process problem. All the new hires and all the money spent to this point would have resolved the issues, were those were the root causes.

● (0850)

[*Translation*]

Solutions have been put forward. We know that improving processes related to service attribution and faster benefits and adjudication decisions would go a long way to improving the transition process.

[*English*]

We must act and be accountable for our actions. We must ensure that the closer we bring the adjudication of an illness or injury to the onset of the illness or injury itself with well-articulated causes and diagnoses by CAF medical personnel, the speedier the outcome will be in adjudication.

For example, the CAF expanded access to the Canadian Forces health information system, which houses medical information required by VAC staff to analyze files and render decisions on VAC benefits and services. However, VAC then put barriers in place, which cause delay and prevent staff from completing their work properly.

Committee members, I am not all doom and gloom. I have seen the good promise that the CAF transition group could make. I hear this from members assigned to the transition units. It's going better. I am very much hoping they can reach full operating capability by 2024.

[*Translation*]

In 2025, we plan on launching an investigation to review how these initiatives will shake out. But I can almost guarantee that some of our recommendations will be the same as they have been for the last decade or more.

[*English*]

Additionally—

The Chair: Mr. Lick, the five minutes have passed.

Mr. Gregory Lick: I have one more paragraph.

Additionally—this is me personally—I have made it my mission before the end of my term to try to bring resolution to the many issues and challenges facing military families. The proper treatment of families weighs significantly on our ability to recruit and retain CAF members. We have seen through numerous statistics that family issues can contribute significantly to members' release. Therefore, the treatment of families is an issue of national security.

Thank you. I now turn it over to Colonel Jardine.

The Chair: Thank you.

Actually you don't. I turn it over to Colonel Jardine, but that's just a technical thing.

Colonel Jardine, we are all awaiting what you have to say for the next five minutes.

Colonel (Retired) Nishika Jardine (Veterans Ombud, Office of the Veterans Ombudsman): Good morning, Mr. Chair and members of the committee.

Thank you for inviting me to contribute to your study on challenges associated with medical release and transition to civilian life.

As the veterans ombud, my mandate is to receive and review complaints from clients of Veterans Affairs Canada, or VAC, who feel they have been treated unfairly. I can also review systemic gaps in or barriers to equitable access to VAC programs and benefits.

[*Translation*]

Understanding the impact of transition on veterans and their families has been a focus of the Veterans Ombuds for the past several years. In 2017, we published a qualitative study to better understand the factors that contribute to a successful transition from military to civilian life. Participants reported that their main challenges included finding a new sense of purpose, maintaining financial security, equating military experience with civilian work experience, and coping with the stigma around mental health.

[*English*]

Most new veterans will seek employment post service, both for financial reasons and to meet the need for a new sense of purpose. There are workplaces that understand what veterans bring to the table, but there are many more that do not.

VAC offers a career transition service to assist serving members and veterans in their journey to civilian employment. However, we have heard from veterans that there is still a gap in translating military competencies to civilian competencies, particularly in the officer occupations. Finding a job and finding purpose are for many veterans the same thing. When their service experience is unrecognizable to hiring managers, it can become a barrier to successful transition.

Veterans with a medical release have access to significant support, both on their way out of the CAF and then onwards from VAC. I am far more concerned about veterans who release voluntarily or for other reasons, particularly those with insufficient years of service to be immediately eligible to receive their CAF pension, which is the determining factor for access to the public service health care plan or the pensioners' dental services plan.

These non-medically released veterans with fewer than 20 or 25 years of service who may nevertheless have service-related illness or injuries are the ones I am most concerned about. Delays by VAC in adjudicating disability claims can have tangible impacts on their well-being.

VAC recently implemented a new program whereby some veterans who submit disability claims for mental health will have immediate access to treatment benefits. I believe this immediate access to treatment benefits should be extended to all disability claimants, or, as we recommended in 2018, VAC should triage claims according to unmet health needs.

● (0855)

[*Translation*]

In 2021, we recommended that VAC provide mental health support for family members in their own right, for conditions related to their veteran's service. Over the past months, I have heard heartbreaking stories of veterans' spouses and family members who are left to struggle on their own.

We say that when a member serves, their family serves with them. We say that families are the strength behind the uniform. And yet, it takes very little for these important people to be disconnected from help they need in their own right. I am more convinced than ever that we cannot continue to rely on spouses and families for their immeasurable, irreplaceable and invaluable support to the CAF's operational capacity and then not meet their mental health needs as a result of supporting a veteran during their service.

[*English*]

In the past, on release, new veterans were pretty much on their own to figure out how to thrive as they returned to civilian life. There was and continues to be great support for those who are released for medical reasons, but that was not and is not necessarily the case for everyone else.

Over the past few years, there has been a growing recognition that the transition from military to veteran is not just a simple matter of handing back your uniform and your ID card. Just as entering the CAF is a bit of a shock—basic training is designed, after all, to instill discipline, leadership, teamwork, service before self, putting yourself in harm's way and, yes, using weapons—leaving the CAF can be just as significant. I firmly believe that once you've successfully completed basic training, you are forever changed. You are never truly civilian again. When we leave the CAF, we are veterans.

Over the past several months, I have visited a number of the transition centres. I'm encouraged by what I see. Extending strong support to all new veterans in the same way that has been done for medically released veterans will go a long way to easing the transition from military back to civilian life. As the veterans ombud, I am focused on the important and lifelong relationship between veterans and Veterans Affairs Canada. The transition centres have a huge role to play in getting that relationship off on the right foot.

[*Translation*]

Thank you again for the invitation to contribute to your work for the Canadian Armed Forces and our veterans.

I look forward to your recommendations.

Thank you.

[*English*]

The Chair: Thank you, Colonel Jardine.

Ms. Gallant, you have six minutes.

Mrs. Cheryl Gallant (Renfrew—Nipissing—Pembroke, CPC): Thank you, Mr. Chairman.

To the ombudsman, Mr. Lick, would you please outline the steps that are involved in the process of being medically discharged?

Mr. Gregory Lick: I could take probably the whole hour to do that, but what I'll do is hand it to Ms. Hynes to take you through those steps and some very general things.

We can also forward information to you in written format afterwards, to give you some of that detail.

Mrs. Cheryl Gallant: Okay, but can I get the shortest possible answer right now, please?

Mr. Gregory Lick: Absolutely.

Ms. Robyn Hynes (Director General of Operations, National Defence and Canadian Armed Forces Ombudsman): There are three main phases to medical release. The first phase is the period of time between when the injury or the diagnosis of the illness happens and when the director of military careers administration makes the decision on whether or not the member will be medically released. There are times, of course, when a member is injured and is capable of returning back to work.

The second phase is the period of time between a member's receiving the decision that they will be medically released and the actual release date. It's about the planning that goes into the transition of the medical release to ensure continuity of care, for example, before that member is released.

Finally, the last phase is the period between when a member is released and up to two years after, when they may be eligible for a number of benefits and services through the Canadian Armed Forces, SISIP and Veterans Affairs Canada.

● (0900)

Mrs. Cheryl Gallant: We still have a situation in which soldiers are medically released due to injuries they incur on the job, yet when they go through the transition process and are in civilian life, they have to go to a civilian doctor in order to be assessed for which benefits they will receive. They're being released from the military due to their injuries, and they get to the veterans stage and have to prove that they have the injuries.

How can that contradiction be solved so that they don't have to fight after they've just been kicked out of the military because of the injuries and they don't have universality of service?

Mr. Gregory Lick: It's an excellent question. It is one that we've already studied and made a recommendation on, in this case. It makes sense that the people who are treating you, who have knowledge of the military environment in which you work—the same as a company—will examine you and are currently your doctor already. They will make that attribution. When you break your leg parachuting out of a plane, it's kind of obvious that it happened on the job. You don't need a civilian doctor to tell you that.

That's why we made the recommendation that the CAF would be best suited to making that attribution of "injury due to service" type of thing. That would be our solution. There may be elements within the CAF about how to do that, but they're the ones with the best knowledge.

Mrs. Cheryl Gallant: What steps need to be taken to have a seamless transfer between DND and CAF to Veterans Affairs, and a seamless interprovincial transfer of documents during service with the CAF versus immediately after discharge?

Mr. Gregory Lick: On the first element of it, to reiterate what I just said, essentially the earlier that service attribution of an injury is made before they release from the Canadian Armed Forces, the better and the more efficient the adjudication would be in VAC. What we've recommended before and what we continue to recommend is to have that service attribution done before they release, so that the adjudication of whatever benefits they should receive is done much more quickly.

On the second part of your question, on the transfer of documentation, we're actually seeing it better in terms of transfer from CAF to Veterans Affairs. That's happening better now, particularly because there are more electronic documents. The issue that you raised about transferring it to civilian doctors is a particularly difficult one, though. I don't really have a solution for that one per se. Making them electronic.... One of the things that we heard from a number of people is that putting them on a CD nowadays, when most computers don't have CD players.... It's something as simple as that, having it put on a memory stick with appropriate security. Those are the small things that cause a lot of irritation for people. It would make the transition more seamless in terms of that transferred documentation.

Mrs. Cheryl Gallant: Do you find that there's a difference between provinces in the transfer of records and transfer of care, or is it the same level of time and difficulty across the board?

Mr. Gregory Lick: I couldn't really comment on that. I think that question would be better for the surgeon general in terms of how they might find that transfer of documentation. I don't think we have received any complaints in that regard that I know of.

Mrs. Cheryl Gallant: How quickly can an injured soldier see a specialist when still in the forces?

Mr. Gregory Lick: Very quickly.

Mrs. Cheryl Gallant: There was a report recently that said that doctors in the military were told to under-report adverse reactions to one of the shots that they're given.

In your report you mention that one of the potential problems is inaccurate or incomplete reporting. One, has this come to your attention, and have you looked into it? Two, if all the medical aspects of what's happened to the soldier are not recorded, will that have an impact eventually should there be any consequences to that when they are out of the forces?

● (0905)

Mr. Gregory Lick: On the latter part of your question, absolutely. If the medical documentation is not full and complete, it doesn't talk about the reasons for the injury and things like that, then the adjudication becomes slower. They have to find other information. They may have to look through other documents, maybe not medical in nature. Maybe they're deployment documents, where they were deployed to, those types of things.

The issue about complaints that come to our office is certainly not about direction to under-report. That is not what we hear. The issue might be that medical professionals are not putting all the information in that they require. The same thing likely happens in civilian medical systems as well, but in this case, the VAC has to use that information to make adjudication. If it's not complete, then the adjudication process becomes slower. The more complete the documentation, the faster the adjudication.

The Chair: We're going to have to leave it there.

Mr. May, you have six minutes.

Mr. Bryan May (Cambridge, Lib.): Thank you, Mr. Chair, and thanks to both witnesses for being here today and helping us with this study.

I hope I'll get both questions in for both of you, but I'll start with Mr. Lick.

I understand the ombudsman's office is currently conducting a systemic investigation, with a specific focus on mental health. Can you share with us today any of the preliminary insights from that investigation?

Mr. Gregory Lick: Certainly. Since we haven't provided it to the minister just yet, we'll cover a few of the findings but not the recommendations.

In that regard, the systemic investigation, which we have just completed and are just about to provide to the minister, was for the purpose of looking at how our primary reserve is treated in comparison to regular force personnel on domestic operations with regard to their mental health.

There are certainly some issues there, similar to what we just talked about with Ms. Gallant in terms of that continuity of care. If something happens on a domestic operation.... Certainly, you can have mental health issues as a result of many domestic operations, including going into long-term care homes, which we saw over the pandemic.

One of the issues is that there is not enough information, and primary reservists and leadership teams may not be aware of all the benefits, services and supports they can receive as a result of injury—whether it's to mental health or physical health—acquired on a domestic operation.

Communication about that information is really important to make sure that primary reservists, in this case, understand what they could receive. Also, making sure that periodic health assessments are done.... In this case, primary reservists, me being one of them.... During my career as a reservist, I received two PHAs during my 17 years.

It's supposed to happen much more often than that. We've seen that not all primary reservists receive those periodic health assessments. It's very difficult, then, to understand, after a domestic operation, if they have received an injury from that domestic operation or if they have aggravated an injury that they may have already had. In this case, we're talking about mental health.

Those are just a few of the areas of findings that we've found. We will be making recommendations to the minister and to the department in that regard.

Mr. Bryan May: Do you have a sense of the timeline for that report?

Mr. Gregory Lick: The minister will probably receive it within a couple of weeks.

Mr. Bryan May: Colonel Jardine, I want to shift gears a bit. We often hear that the CAF has predominantly been a male institution—this is historic—and, as a result, the services and supports around health and well-being have been designed around men. This would apply, of course, to veteran supports as well.

To you, Colonel, what are some of the gaps that emerge out of this for women and gender-diverse members and veterans?

● (0910)

Col (Ret'd) Nishika Jardine: We did a study, a literature review—last year, I believe it was—in which we found a number of significant differences between how service affects men and how service affects women. There are a number of gaps and impacts. If we have time, I would invite my colleague Mr. Schippers to give you a taste of some of that.

We know that service impacts women differently in many ways. As for Veterans Affairs as well, you're quite right; the support, benefits and services were designed with men in mind. It was the default, the norm.

What we know today is that the table of disabilities is being reviewed through a gender-based analysis lens. We look forward to seeing what those changes are going to be. We haven't seen them yet.

We did a report on sexual dysfunction. For example, one of the questions on the medical questionnaire for men given by VAC when they go to see the doctor with this questionnaire is around erectile dysfunction or sexual dysfunction, but on the women's questionnaire, there is no such question, yet we know that women also experience sexual dysfunction. There are those kinds of gaps.

I'll leave it to you. If you would like to hear more about specific examples, I'll let you make the decision to hear from Mr. Schippers.

Mr. Bryan May: He has about 30 seconds.

Go ahead, Mr. Schippers.

Mr. Duane Schippers (Deputy Veterans Ombud, Office of the Veterans Ombudsman): Women are two to three times more likely to medically release than men veterans, 45% due to mental health and 43% due to musculoskeletal issues. Compared to women in the Canadian general population, they're more likely to have PTSD. They are at an 80% to 90% higher risk of suicide than men. Men veterans have a 40% higher risk of suicide than men in the Canadian general population. Women who release as non-commissioned members, the non-officer category, are three times more likely to die by suicide than women who release as officers.

There are some serious income issues, as well.

The Chair: Unfortunately, we'll have to leave the answer there. Mr. May didn't leave you with a lot of time. It's blindingly obvious to people who can count.

[*Translation*]

Ms. Normandin, you have the floor for six minutes.

Ms. Christine Normandin (Saint-Jean, BQ): Thank you very much.

I thank both witnesses.

I would like to start with you, Mr. Lick. According to one of your recommendations, you said that a member of the Forces should never be medically released without all required resources in place. The government accepted that recommendation. Although it claimed to have implemented it, based on the calls you received, you saw that this was not the case.

My question has two parts. Here's the first:

Do you find it problematic that, in a certain sense, the government is correcting the homework we give it? Do you think someone else outside government should see if the recommendation was actually implemented?

[*English*]

Mr. Gregory Lick: I will answer in English, because of the technical nature of the question.

Yes, our recommendation still stands. It was accepted by the government. All benefits and services should be in place before they are medically released.

They are not there yet. Part of the issue, as we talked about earlier, is the fact that in some cases the service attribution is not being done in an efficient manner. We talked about that already. Adjudications, therefore, are slow. There is a tremendous backlog in that regard.

As I said in my opening remarks, there are many people in VAC who want to do the right thing. It's absolutely true. I actually hear it all the time. At the same time, they're stifled, or shackled, by the process issues. There are many of them. I encourage the committee to explore those more than anything.

With respect to your question around whether it should be an outside agency of some sort, I don't believe so. In that regard, in terms of service attribution and making sure that happens quickly, the best people to do it are the people who are treating you and have knowledge of your environment within CAF health services. That aspect, I think, is probably best done by the CAF, as we've already recommended.

In terms of the services and supports for everybody, VAC is well positioned to do that. I wouldn't want to hand it to another insurance agency. I don't think that's the right thing either. VAC is probably best positioned to do that. It just needs better processes to do that.

● (0915)

[*Translation*]

Ms. Christine Normandin: My question had more to do with assessing the implementation of your recommendations. When you make a recommendation and the government accepts it, but you get the impression it is not being followed, should an external party evaluate the recommendation's implementation?

[*English*]

Mr. Gregory Lick: This becomes then the issue of who is best positioned to have oversight over different departments. In this case, it's the Canadian Armed Forces and the Department of National Defence. I think we are well positioned to provide that oversight.

Are there better means of doing that? I've already talked very publicly about the need for independence in that regard. It's making sure the department responds in a timely manner to our report recommendations, which I'm not seeing right now, even though it has generally accepted them in the end.

As I come near to the end of my term, with another year left, I become more and more frustrated at not seeing action. Even all of you as committee members are facing the same thing. You've made recommendations. The department officials say, “They've been implemented, or we're in the process of implementing them.” Well, people are suffering as a result of that, and that's not right.

[*Translation*]

Ms. Christine Normandin: Regarding what you just said, based on the calls you received, you've seen that the recommendation wasn't really implemented. Do you have access to enough information sources to analyze whether recommendations were actually implemented?

Are there other information sources you should be able to access to better follow up on your own recommendations?

Mr. Gregory Lick: We have access to all the information required to follow up on our recommendations.

[*English*]

That's the reason we have progress reports. One of the differences I always talk about with my audiences is the difference between us and the Auditor General. The Auditor General does the same types of reports for various departments, but what happens to them after that? How does it progress?

We put all of our progress reports on our website. They're accessible to everyone. They show—according to our assessment, not the department's assessment—whether there's progress on the recommendations or not.

That is incredibly powerful. It doesn't always get the action as quickly as we would like. It's a means of getting more action. We also see a tremendous amount of benefit from doing that. It provides you as committee members, and all of the public, with heat, light and transparency on what is being done or not being done.

[*Translation*]

Ms. Christine Normandin: I will immediately say what my next question will be, which will be for both of you.

Has a veteran ever left the armed forces voluntarily and after their departure, it turns out they had an undiagnosed mental health problem? With a diagnosis, they could have been released for medical reasons.

That's the subject I'll raise during the next round of questions.

The Chair: Thank you, Ms. Normandin.

[*English*]

That's a good question. She has another two and a half minutes coming to her, so she can get an answer then.

Before I call on Ms. Blaney, Mr. Schippers, when I interrupted you on Mr. May's question, you were in the middle of some—I thought—very interesting statistics which, as far as I know, have not been made available to the committee. I wonder whether that set of statistics could be tabled with the committee after we're finished.

Is that acceptable?

Mr. Duane Schippers: Certainly, Mr. Chairman.

The Chair: Okay. Thank you.

Madam Blaney, welcome to the committee. We're very nice here, by the way.

Ms. Rachel Blaney (North Island—Powell River, NDP): It's very good to be here, Chair.

I want to thank the witnesses so much for their important testimony today.

I'm going to come to Colonel Jardine first. It's very good to see you.

In 2021, your office published an investigative report entitled “Peer Support for Veterans who have Experienced Military Sexual Trauma”. You found that there is a gap in access to peer support for veterans and MST survivors. You recommended the government provide a funded peer-support program that meets the needs of veterans who have experienced MST, and publish the GBA+ for the establishment of the program.

I'm wondering if you could update the committee on the progress that has been made with regard to this recommendation.

● (0920)

Col (Ret'd) Nishika Jardine: Through the chair, thank you. It's lovely to see you again as well.

First of all, our recommendations were accepted. We understand that a program has been in development and is in the process of being implemented. I don't know exactly where they are with it, but I understand it's in implementation.

With respect to the GBA+, this is something that we ask for in almost every report we do and every recommendation we make. We have yet to see those.

Ms. Rachel Blaney: Thank you for that.

I'm going to come back to Mr. Lick. It's very interesting. You talked about how service attribution being decided through legal mechanisms incentivizes rejection and leads to members falling through the cracks. That really concerns me. When we look at the system, between the CAF and VAC, we're seeing too many people falling through the cracks.

For Canada to ask people to provide service to us in that profound way and to let them fall through the cracks, I think, is a significant failure that we should all be responsible for and all take action on.

In 2016, your predecessor published a report entitled "Determining Service Attribution for Medically Releasing Members". Its recommendations were rejected by the then minister of national defence.

I'm wondering if you can speak to why service attribution needs to be as close to the injury or illness as possible, and the principles behind this recommendation.

Mr. Gregory Lick: That is a recommendation we still strongly believe in, as I've already talked about. For me, it makes common sense that the people who have the best knowledge of the environment in which you're working—and, possibly in this case, getting injured, whether that's a mental injury or whether it's a physical injury—are best able to determine that the mental or physical injury that occurred was as a result of that work environment. This came from a number of people within the department too.

One issue raised as to the reason it was rejected was the ethical issue of the treating doctor doing the service attribution at the same time. That's an issue of process. That can be resolved within the organization. A person or a medical professional who has the knowledge of the work environment is best able, I think. It just makes common sense. I can't say it any other way.

In that regard, though, it in fact then allows the service attribution to be done more quickly. Giving it over, transferring files—there's a lot of documentation back and forth over to VAC—and then making an adjudication slows the process down. What we want to ensure is that the services, benefits and supports those people need are in place as soon as that injury occurs. People who are transitioning need those services and supports as quickly as possible. That service attribution piece, if we can do it more quickly, will be good for the people who are transitioning, so that they don't fall through the cracks.

I will say, though, that one thing we will do if people come to us as they're transitioning is this. When there are medical issues, we will intervene sooner. When we intervene, we get tremendous co-operation from the CAF. A lot of times, those transitions are stopped. We make sure that everything that can be done is done before they are released.

In actual fact, when we intervene on a medical issue, we get tremendous co-operation from CAF in that regard.

Ms. Rachel Blaney: My next question is for both of you.

I know that both of your offices have called for legislation to instate independent ombuds offices that report directly to Parliament and have expanded investigative powers.

When it comes to resolving the deeper issues in health services, transition and benefits, how could this legislation protect CAF members and veterans?

I'll start with you, Mr. Lick.

Mr. Gregory Lick: I've talked about this quite often, and so have my predecessor and every one of the predecessors before that. I always ask a question like, "Okay, why is it going to be greener on the other side of the fence?" In that regard, I have three main issues.

One is that I feel we can serve our constituents better in that regard. It provides more accountability for Parliament to provide oversight of a military institution. I think that's a good thing. That's what Parliament is all about—to provide oversight of, in this case, the military and all the forces.

However, the main one I see as the greatest benefit is compelling the department to respond in a timely manner and holding it accountable for the recommendations we make. That is the one area—as I've said lately and over the last number of years since I started—in which we're seeing the responses get slower and slower. Yes, they may have been accepted in the end, but we're left to see whether they're going to accept them or not, and what they are going to do about them.

In fact, the department works on it very quickly, but we're seeing slower and slower responses, and that's not a good thing for—

● (0925)

The Chair: Unfortunately, we're going to have to leave the answer there.

Colleagues, we have 25 minutes' worth of questions and a little more than 15 minutes. I'm going to have to chop everybody's time by a minute.

With that, Mr. Kelly, you have four minutes.

Mr. Pat Kelly (Calgary Rocky Ridge, CPC): Thank you.

It is extraordinarily frustrating when questions are asked, answers are provided through recommendations, then recommendations are ignored. I feel as if we're asking the questions that have been answered already in reports to Parliament.

You referred to health care for the families of serving members as a matter of “national security”. I think that was well put. We are in a crisis of recruitment, and this is a factor in retaining personnel. One of the recommendations made to Parliament in the Veterans Affairs report of 2017 was this: “That the Canadian Armed Forces further integrate family members into their mental health and suicide prevention programs.”

Has that happened with the Canadian Forces?

Mr. Gregory Lick: In some aspects, yes.

The Canadian Armed Forces are working very hard to ensure that family members.... As they are required to support a member going through a crisis.... That's done through various people and staff within the military family resource centres. Spouses or partners are also encouraged to attend different mental health sessions with the members.

Elements of that particular recommendation are being pursued, absolutely.

Mr. Pat Kelly: Okay.

Mr. Schippers, in 2021 you said that “adolescent military dependants...are far more likely to have admissions for injury, suicide attempts and mental health diagnoses than non-military teens.”

Has there been progress in reducing those numbers through access to supports in mental health in the last two years, since that statement was made?

Mr. Gregory Lick: Yes, and I think, as I referred.... The military family resource centres are the avenues, in many ways, to accessing some of those supports. Many of the MFRCs are putting in place various supports—whether that's a teen counsellor or various activities for teens—to try to help support them through the mental health issues they may experience as a result of being a military family member.

Does more need to be done? Absolutely, and this is where I come back to.... I strongly believe that military family resource centres need greater funding to be able to support military families better.

Mr. Pat Kelly: Okay.

I'll let Mr. Schippers, since it was his observation, comment on the progress, or where we are since that observation was made.

Mr. Duane Schippers: Those stats are from independent research. I don't have an updated statistic on that.

I would say that VAC has expanded. It has coloured a bit outside the lines in terms of expanding its mental health program to include more family members in terms of the kids, but there are limited sessions for those. I think one of the key things is that military life leads to a lot of separation and divorce, so you have a lot of families that are split.

It's all connected to the veteran right now, so it's about getting those services in the family member's own right. The child of a divorced veteran may have a very difficult time accessing mental health care in their own right, and they're at the most vulnerable level. They don't have the financial means to access these things, unlike someone who's employed.

● (0930)

The Chair: Thank you, Mr. Kelly. You had four seconds left.

Mr. Zuberi, welcome to the committee.

You have four minutes.

Mr. Sameer Zuberi (Pierrefonds—Dollard, Lib.): Thank you, Mr. Chair, and thank you to the witnesses for being here today.

I liked what you said, Colonel Jardine: that once you go through basic you are forever impacted and touched.

To share this with the witnesses, I myself was a reservist for five years, between 1997 and 2002—quite a while ago. The time I spent in the reserves continues to impact me and influence me today. For example, each and every morning, I iron my shirt, and I think of the time I spent ironing shirts in basic and infantry, trying to make sure every wrinkle was removed and starching them, etc. To this day, I'm still jogging from point A to point B, and I did so to get to this meeting this morning.

That being said, on the fact that people are forever impacted by their time in the military, I think the work you're doing is excellent.

I want to pick up on a line of questioning that we had earlier. I think the stats are really interesting. We've all commented on the stats that were coming out in terms of how, when it comes to suicide, for women in the military it's two to three times higher than for their male counterparts who have served, and that when it comes to men, it's 40% higher for men than the average within the population. Other stats like that are really important.

That evidence came out because of an acknowledgement that the military historically and traditionally has been a male-dominated institution. Also, the culture of the military is one in which you are basically working in a really serious job, which is to enter combat, essentially. That's what the military is about. It's a high-pressure environment, and rightly so, but you also need to take care of your employees and ensure that people are well taken care of.

My question on the stats is, how do you close the gap between what was mentioned—what we're hearing—and where we want to go in terms of the differences? We've identified some problems, and we know where we want to go. How do you close that gap? How have you been closing that gap?

Mr. Gregory Lick: Well, to be honest, I think the answer—

Col (Ret'd) Nishika Jardine: In my—

Mr. Gregory Lick: Go ahead, Nishika.

Col (Ret'd) Nishika Jardine: I'm sorry, Mr. Chair.

In my role as the veterans ombud, I can only observe and offer recommendations to the minister. The gap that exists, or the impact on women as opposed to men or other equity-seeking groups with service in the Canadian Forces, is real, and we see it. We see the impacts of that. What my office has been calling for is more research into the "why". We don't know why. Without the why, we can't address the root causes.

It's a joint effort between the Canadian Forces and Veterans Affairs Canada, I believe. I've been calling for research, and I believe that is the key piece that is necessary to do now, so that we understand why these things are happening. Then things can be put in place to correct those, so that when you serve, you don't necessarily come out at the other end with illness or injuries simply because the equipment doesn't fit you or for various other reasons.

The Chair: Madame Normandin, in a minute and a half, please.

[*Translation*]

Ms. Christine Normandin: Thank you very much.

So, I'll come back to my question.

Colonel Jardine, you said that soldiers who leave the Forces for medical reasons have good medical follow-up afterwards, whereas veterans who leave the Forces of their own will have to find resources.

Regarding mental health, I was wondering if there are soldiers who leave of their own free will, but would have received a diagnosis and been released for medical reasons.

Does that happen sometimes?

My question is for both witnesses.

● (0935)

[*English*]

Col (Ret'd) Nishika Jardine: I will answer in English, please. Excuse me, but it is harder through video.

I am not certain that mental health.... VAC has put in place a program whereby now, if you put in a disability claim for a mental health condition—not all mental health but some—you're eligible for treatment right away. When I am out there meeting with veterans, I encourage people to submit disability claims if they feel they need to.

I'm asking the government, actually, to go a step further and provide treatment on receiving a disability claim for all conditions, not just mental health.

Maybe I'll leave it there and allow time for Mr. Lick.

The Chair: Unfortunately, Mr. Lick doesn't have any time.

You have a minute and a half, Madam Blaney.

Ms. Rachel Blaney: I have another question for both of you. I'm just trying to get some clarity.

Yesterday, Minister Anand announced the launch of the independent legal assistance program, offering some legal funding for survivors through the sexual misconduct support and resource centre. If survivors have a dispute around eligibility for the legal assistance fund, do we know which of your offices they would actually turn to?

Mr. Gregory Lick: We generally don't deal directly with legal matters like that, in essence, but I believe both the OVO's and my job is to make sure we refer the people to the right place to get that support in this particular case.

As a result of the announcement, our intake team will have the information necessary, so that if people call us, we will refer them to the right place, as we already do for many of those types of things.

Col (Ret'd) Nishika Jardine: I have exactly the same answer.

Ms. Rachel Blaney: Okay, thank you.

My last question, very quickly, is around the harm to serving military family members. You said that it is a concern for national security. I'm wondering if you could explain what you mean by that.

Mr. Gregory Lick: It's quite simple for me. Military families are, as we've always said, the backbone of the military member. They provide the support. They provide the support during a deployment. They take care of the dependants while the member is serving, maybe deployed overseas.

It's much easier, as you will know, if your family is well taken care of. You can do your work. If the military member is always having to worry about what's happening back home.... Are their children being taken care of? Do they have the child care necessary? Do they have the medication? Do they have a doctor they can access to get the support they need? If they are continually worrying about that, they are not able to concentrate on their job, which is taking care of us around this table.

The Chair: Thank you, Madam Blaney.

Mr. Bezan, you have four minutes.

Mr. James Bezan (Selkirk—Interlake—Eastman, CPC): Thank you, Mr. Chair.

I want to thank both offices for the incredible work they do on behalf of those who are serving and those who have served, holding up their values and standing up for their rights and the sacrifices they made for Canada.

I'm struggling with one thing you said, Mr. Lick. You talked about this being a process problem, not a people problem, yet you said that there's an ethical issue with the defence medical team attributing what benefits they have for injury from service. It's ethical for the defence medical team to determine that injury. It's ethical for the defence medical team to say that you don't meet the universality of services. It's ethical for the defence medical team to say that you're going to be discharged and will be leaving the service and transfer you over to VAC. Then how the hell is it not ethical to also say that injury gets this benefit from Veterans Affairs Canada? Where is the process problem?

Mr. Gregory Lick: That's exactly the question I'm asking.

Mr. James Bezan: Then it comes down to Colonel Jardine, then. What is happening at VAC that they will not accept that, or is it CAF pushing back because they don't want to take on that responsibility?

Mr. Gregory Lick: In the original instance, when we made that recommendation, it definitely was our department, National Defence, and the CAF pushing back on that particular issue. The explanation given to me was that this was an ethical issue of a treating doctor at the same time saying, for insurance reasons or benefit reasons, that your injury is due to service.

I think that's just a poor reason in this regard.

● (0940)

Mr. James Bezan: It's a cop-out.

Mr. Gregory Lick: That's not a bad word for it, actually.

We continue to make that recommendation. In fact, for primary reservists now, the CAF does this. It does service attribution for primary reservists, so why does it not do it for all the regular force? In fact, for certain conditions a bit later on, as a result of some of the changes in SISIP, it will have to occur as well, even for regular force members.

I think we're moving along the path to get to the point of this. It may require a different process within the CAF, so that—

Mr. James Bezan: What is the recommendation we need to make at this committee, in this report, to make that happen?

Mr. Gregory Lick: The same recommendation as we put in our report.

Mr. James Bezan: Is that true also over on the Veterans Affairs side, Colonel Jardine?

Col (Ret'd) Nishika Jardine: I understand that the CAF doctors have offered a reason that they don't make attribution to service.

I would ask the committee to ask Veterans Affairs Canada how many claims are denied because of attribution to service, in other words, when they are unable to draw the link between service and the illness through injury. I would ask the committee to ask Veterans Affairs Canada that question. I think it's an interesting question to ask.

I understand it is currently Veterans Affairs Canada that makes the attribution to service. It's what it has always done. It has access to service health records. That access has been simplified. When I'm out on the road, when I meet with military members and with veterans, I tell them about the importance of making that connection to service with their illness and injury. When they submit their disability claim, they should always get advice on how to do that.

I've said repeatedly that the veterans service officers in the Legion are trained to help people do that—making that connection to service in the disability claim, drawing that connection themselves in their own words and telling their story. Then, when VAC accesses their service health records, they can make that connection as well.

A lot of work has been done by the department to better understand the conditions of service on every single trade and occupation in the Canadian Forces. What Mr. Lick is asking for is—

The Chair: Unfortunately, we're going to have to leave the answer there, Mr. Bezan.

The final four minutes go to Mr. Zuberi.

Mr. Sameer Zuberi: I wanted to touch base on the practices we have in Canada, and to look at allies and other militaries that are similar to the Canadian military, to see the spectrum of treatments they have for prevention and for transition to a post-service life. What are the best practices of these other militaries that are comparable to Canada's? Do you have any positive examples that are out there that we can emulate and implement here, within Canada?

Mr. Gregory Lick: Certainly the United States has a very different approach to how it serves veterans, after their service in this case. They have veterans hospitals. They continue their treatment with experienced military doctors, or doctors who have military experience. I think that, in general, is a good thing. It's a good question, I would say, for medical professionals, rather than for me.

Certainly there are lots of countries out there that do it differently. Are they better? It's hard to say. There's also a resource issue that goes along with that, and there's also a legal issue of jurisdiction over civilians as well. There are legal issues that go along with it.

Are there better examples out there? It's likely. I always go back to the United States, but it is a very different process down there for dealing with veterans medical issues. Is it better? I would probably say yes, but....

Mr. Sameer Zuberi: I'm curious. It's been a long time. I mentioned that it's been 20 years since I was in the military. Back then, back in the day, we used to get something called SHARP training, which was once a year. It was this diversity and harassment sort of refresher. We talked a lot, as you know, about the services that are available to people who are serving and those when they clear out.

Is that information being shared in the same way as diversity training was done back then?

Are there seminars given on an annual basis in terms of the suite of services that are available to personnel?

● (0945)

Mr. Gregory Lick: That's a very broad question. If we're just focusing on the issues that we learned, and likely Colonel Jardine learned as well, during SHARP training, which was the first seminar approach that was taken after Somalia.... In that regard, I took it too. That has changed dramatically since then, into something that I think is much better.

At the same time, your question is talking about all the services and supports. One of the things we note is that the more informed a military member or military family member is about the services and supports they need and require at different times in their lives, the better.

That would be an area where, if we can focus on one thing that is relatively simple to do, it's to get more information out there and more efficient information out there that gets people knowledge.

Mr. Sameer Zuberi: Certainly.

In the 40 seconds that I have left, the reason I ask is that I was a non-commissioned member. Many who are testifying, who are in the visioning, were officers. Officers get this sort of training continuously, but rank-and-file privates, corporals and others are not as well informed; nor do they necessarily get the information in the same way officers do.

The reason I highlight that type of training is that it was forced and annual.

Do servicepeople get a similar suite of information that's forced and annual as there was for the SHARP training of the past?

Mr. Gregory Lick: In different areas, yes, but your question is quite broad and for all the services and supports, probably not. I think what we're finding, and what you'll see in our report on mental health for primary reservists, is that there's an information or awareness gap there that needs to be addressed as well.

The answer, generally, is no, not all the information is shared in the best way. In certain areas, yes, for instance suicide prevention, those things should be done on an annual basis, absolutely. I would say they are being done better than when you and I or even Colonel Jardine took it years ago.

The Chair: Thank you, Mr. Zuberi.

Unfortunately, I'm going have to draw this meeting to a close. I offer an insincere apology for cutting each and every one of you off.

Voices: Oh, oh!

The Chair: As you can see, the time is our enemy. With that, again, thank you for your informative dialogue with the committee. Hopefully, we'll start to move the yardstick forward a little.

With that, the meeting is suspended while we set up the next panel.

● (0945)

_____(Pause)_____

● (0951)

The Chair: We're back in order.

Again, we've already lost a number of minutes off the clock. I'm not going to go through any formal introduction, but simply ask Senator Rebecca Patterson for her first five minutes. Then we will have Dr. Karen Breeck for her five minutes, and then Mr. Booth, who is online, for his five minutes.

I'm given to understand that, Mr. Booth, you have a hard stop at 10:45, so we'll try to respect that.

Senator Patterson.

Hon. Rebecca Patterson (Senator, As an Individual): Good morning, honourable members and colleagues.

Thank you for your invitation to appear today as part of your study on the military health system and the provision of health and transition services under the Canadian Forces Health Services Group. I didn't add veterans there as I kept serving.

As the chair mentioned, I am a senator but I'm also a veteran, having just recently retired from the Canadian Armed Forces as a rear-admiral. I'm a service spouse. I'm a mother of two. I'm also a military mom, because my son is a reserve force member.

I enrolled in the Canadian Armed Forces in 1989 as a nursing officer. During my 34 years with the military, I've been posted across Canada and deployed overseas to Saudi Arabia, Somalia and Afghanistan. I've served as commander of 1 Health Services Group in Edmonton, covering the west and north of Canada from a health perspective. I was the deputy commanding officer of the Canadian Forces Health Services Group and ultimately the commander—or, in effect, the CEO and COO—of health services within the Canadian Armed Forces.

I continue be a member of the College of Nurses of Ontario, the Canadian College of Health Leaders and the Royal Canadian Medical Service Association. Suffice to say, I have quite a bit of experience in the domain we are about to discuss today.

The military health care system is not like the sort most Canadians are familiar with. Unlike provincial and territorial health care systems, the military system provides a spectrum of occupational health services in Canada. This includes medical, dental, pharma, mental and physical health across Canada and around the world. However, it is also responsible for medical and dental procurement of material and equipment, research and development, logistics and recruitment, retention and the training of military health human resources.

International operational health services support involves a high degree of interoperability with our allies and within multinational alliances like NATO and ABCA. The Canadian Forces Health Services Group is, in essence, Canada's 14th health jurisdiction, because serving members of the Canadian Armed Forces are excluded under the Canada Health Act. Despite paying provincial taxes like any other resident, CAF members are not issued provincial health cards and cannot access health care delivery via their respective provincial health care systems. Instead, CAF members receive health services through military health care facilities and not via a local provider in their community.

Health services that are not provided by the military are sourced through the provincial health care system, or through private medical and dental facilities. The CAF must purchase those health services for its members from providers, often at exaggerated rates, just like non-Canadians.

Despite what you've heard, funding for the health care system, which includes everything I've previously mentioned, is a concern. As recently as 2018, an internal evaluation of military health care found that in the period between 2010-11 and 2016-17, so pre-COVID, health care spending in Canada generally rose at a rate of 3.3% per year. In other words, it was greater than the national inflation rate, whereas within the Canadian Forces, it was only funded at 0.7%. This demonstrates the diminished buying power within the CAF relative to the health care it is expected to provide.

As I've mentioned, the CAF often purchases services for its members at higher rates despite having less to spend on health care. This is where the Minister of National Defence, with her respective colleagues in health and intergovernmental affairs, can emerge as a champion for CAF members by working with provincial governments to negotiate better rates more closely aligned with those charged within the provincial health care systems, if not the same rate.

However, colleagues—and I use the term “colleagues” because we are fellow parliamentarians—funding isn't the only issue. There are structural issues related to service delivery and to the human resource side of health care provisions in the military. Health service personnel in the CAF are fully trained sailors, soldiers and aviators in addition to being health care providers. You can appreciate there is no other career quite like it.

You've talked about retention. Salary and quality of life are often higher outside the military for health care providers. We're posted all over the world on a regular basis, and it's extremely hard to maintain required clinical competencies. There is also a mental and physical toll. While the CAF is not a licensor or regulator of health professionals, there is an opportunity for the CAF to lead on either a federal regulatory approval system or greater interprovincial recognition of licensing, in other words, portability.

● (0955)

As I mentioned, military health care is unlike the provincial medical or dental care systems. Given resource challenges within CFHS, both human and financial, coupled with the urgent need to recruit new and more diverse CAF members in general and policy changes that have led to the retention of members for longer and with more complex health requirements, it is critical that we rethink health care in the Canadian Armed Forces.

Thank you. I welcome your questions.

The Chair: Thank you, Senator Patterson.

Dr. Breeck, you have five minutes, please.

Dr. Karen Breeck (As an Individual): Thank you.

The current approach to military health care and transition is much more person-centred and trauma-informed than when I, as a medical officer, was released in 2009. Despite the significant improvements made over the last decade, there is always room for more improvements, especially for ensuring the health and well-being of military women.

Ideally, women’s health issues will become normalized, expected and fully integrated parts of the future military medical system. We should all be able to talk about and care for menstrual bleeding suppression, perinatal mental health, urinary incontinence and menopause with as much ease as we talk about a sprained ankle. Thanks to the ongoing political will and targeted funding from budget 2022, a military women’s health strategy is now under way. However, one area in particular, military women’s reproductive health, will require a multidepartment collaborative approach.

Many military and veteran women are challenged to get pregnant, stay pregnant, stay healthy during and after their pregnancies and have healthy offspring. I have followed the medical journeys of hundreds if not thousands of military and veteran women. In my opinion, reproductive loss and its complications are often more soul-crushing and life-altering for women than any other form of trauma the military has to offer them. Although reproductive challenges are possible for anyone at any time, the question that tortures those so impacted is the unknown around what role the military workplace played, if any, in their individual cases.

Most military reproductive hazard research is still only available on men, yet men make new sperm every 90 days. Women reproduce with the eggs they were born with. The potential reproductive health impacts from military-specific workplace exposure to chemicals, extreme temperatures, pressures, vibrations, sound, radiation and traumas are simply not the same for men and women. It is critical that the risks and effects of non-traditional workplace exposures are better understood for women.

Military women usually love their work and are happy to continue working for as long as they can while pregnant. However, when there are complications, it is often only then, in retrospect, that these same women and their health care providers start to research deeper and understand just how little is actually known in this area. The outcome for many of the impacted military women is a living purgatory of self-blaming guilt around what-ifs. Society at large aggravates this topic, as reproductive loss and its complications are still largely viewed as a taboo topic to discuss in public settings. The internalized, rarely vocalized emotions often manifest into health-related conditions that can accelerate some of these women's release from the military.

Women sign up to the military prepared to give their lives if so required. What military women are not prepared for is to lose their individual potential to create a healthy life because their employer has not yet seen fit to conduct the needed research for women's full and meaningful inclusion into federal workspaces.

The Minister of National Defence's mandate letter already directs her to ensure that resources are available for military women's health. However, the type of foundational occupational research required here cannot be done by the CAF alone, nor should it. Workplace reproductive hazards are not unique to military women. Women in many of the operational new roles in the federal government, including the RCMP, Coast Guard, Corrections Canada, Canada Border Services Agency, Transport Canada and even the Canadian Space Agency all need more knowledge on how to better enable and support women in non-traditional workspaces.

I challenge the committee members to think "big picture". The Minister of National Defence could, on behalf of military women, help develop a strategic plan for the occupational health needs of all federally employed women. Together, Canada could become the world leader in enabling and supporting the health and well-being of women wishing to work in non-traditional workplaces throughout their life cycle.

If not Canada, who? If not now, when?

Thank you.

● (1000)

The Chair: Finally, Mr. Booth, you have five minutes, please.

Mr. Nick Booth (Chief Executive Officer, True Patriot Love Foundation): Thank you to the committee for the opportunity to contribute to this important piece of work.

True Patriot Love is Canada's national foundation for the military and veteran community, and we work closely as a trusted partner with the Canadian Armed Forces, Veterans Affairs and the federal and provincial governments.

It would be remiss of me not to take this opportunity to thank the government for its tremendous support of the 2025 Invictus Games, for which True Patriot Love was honoured to be able to coordinate the successful bid on behalf of Canada. We look forward to welcoming the world to Vancouver and Whistler for the first-ever winter edition of this inspiring event. The committee may also like to note that we have made both supporting transition and the mental health of military and veteran families key legacy strands for the games.

As the national foundation, True Patriot Love works across the spectrum of issues facing our service members and veterans. We support our military families and children, especially as they navigate the issues of multiple deployments or location away from their home community, and provide significant support through the military family resource centres and other local partners.

We fund a range of programs to assist the health and well-being of both serving members and veterans, including mental health, homelessness, and employment and transition support. For those who may have become injured or ill, we contribute to their recovery and rehabilitation through sport, expeditions and the creative arts. We help with their reintroduction back into local communities post-uniform, often a challenge after long periods away.

We are pleased that the committee is reviewing this subject. Our service members deserve the best support while in uniform as they transition and post-release. We know that many struggle both through illness and injury, and also with the change in their status, access to support systems and the lack of a sense of purpose once they release.

An estimated 10,000 military families are required to relocate each year, of which approximately 8,000 must move to a new province or territory. Approximately two-thirds of families experience periods of absence from their loved ones due to operational requirements. In a recent survey of Canadian Armed Forces spouses, 24% found child care extremely difficult to re-establish after relocation.

The nature of military life also makes health care more challenging, especially for families. There can be multiple moves and a lack of family doctors in local communities. Military families may experience an unfamiliarity with civilian organizations and have little time to navigate this before moving on again. I recently spoke to a military mother who said she had spent the whole of her child's formative years with her fingers crossed.

This can have a corresponding impact on mental health, which may in turn be a challenge in accessing support but also brings the associated stigma or fear of losing duties or status. Serving members may seek mental health care off base so that their chain of command is not aware and it does not impact their careers.

This situation is not new nor unique to Canada. However, it has been made more challenging through the COVID-19 pandemic, with many programs either being cancelled or switched to digital delivery. While this can have some positive implications, especially as we try to provide services to a geographically dispersed Canadian Armed Forces and veteran community, people suffering from service-related mental health conditions may simply not be able to take advantage of virtual services. We should seek, where we can, to ensure in-person provision is available and that these are reopened where they still remain closed as soon as practicable.

However, technology can also offer opportunities. In 2019, True Patriot Love received funding from the Veterans Affairs Canada well-being fund to explore how innovative technology can benefit veterans' mental health. In particular, we stood up an expert advisory council that has been focused on how to allow better access to a serving member's or veteran's own health records.

Following a two-year study involving veteran focus groups, the technology sector and representatives of Veterans Affairs and Canadian Forces health services, we are developing a proposal for a veteran health record digital safe. As the committee may be aware, traditionally these records have been provided either in paper form, often long and cumbersome, or in a technological format, such as a disc or memory stick, which are outdated and often not usable. This digital repository would be far more portable and user-friendly and would allow veterans to grant permission to access medical records to authorized health care service providers.

Second, we have proposed a feasibility study to test the electronic transfer of medical records for health care clinician use. This also would have the advantage of preventing veterans from having to repeat their story on numerous occasions, something we have heard can be very challenging and potentially triggering.

● (1005)

Third, the system could provide a repository of anonymized information to allow researchers to have a better understanding of the issues and prevalence. We hope that Veterans Affairs will grant permission for a feasibility study shortly.

I would also flag two other matters for the committee, in brief.

Firstly, they will be aware that the government is developing a new national employment strategy for veterans. I would encourage the two studies to align, as mental health challenges for our veterans cannot only be combat-related or service injury-related, but also drawn from the stress, anxiety or depression following release.

The Chair: Could you come to your conclusion, please?

Thank you.

Mr. Nick Booth: Yes.

We're working with the Government of Ontario on a major pilot to strengthen hiring former service members into the health care sector and the private sector, mirroring the U.K.'s "step into health" program.

To conclude, to ensure that military members and their families can remain in service for the optimal time and complete a positive and healthy transition to civilian life, we would hope the government both promotes the comprehensive provision of care to our military community and recognizes the value of community supports that might often provide essential services and offer choice to a service member or veteran from a more formal Canadian Armed Forces or government program, should they wish.

Thank you.

The Chair: Thank you, Mr. Booth.

Colleagues, we have 35 minutes left. We'll get through the first round if I cut it back at least a minute for everybody. Then we'll see where we go for the second round.

You have five minutes, Mr. Bezan.

Mr. James Bezan: Thank you, Mr. Chair.

I want to thank all of our witnesses. I particularly want to thank Dr. Breeck and Senator Patterson for their service to Canada as part of our defence medical teams.

Senator Patterson, you talked about how things are paid for in the Canadian Armed Forces health care. We have universality of service that all of our troops have to meet, yet they don't meet universal health care.

Should part of the Canada health transfer be paid to the Department of National Defence and the Canadian Armed Forces or should the provincial health agencies quit charging our troops when they have to visit a provincial health facility?

● (1010)

Hon. Rebecca Patterson: Thank you, Mr. Chair.

That is actually a really pressing question because taxpayers want to make sure that their money is being used correctly.

I'm going to take this in two steps. The first step I'm going to talk about is how the CAF or the department pays for health services.

We have arrangements right now with each province, which are locally negotiated. Now, as we are excluded from the Canada Health Act there are times.... It comes into three buckets. There is an employer health tax, which is sort of a health transfer that a few provinces expect from the Canadian Armed Forces. We then have services for hospital type fees, which can be even $89 to step inside the door, as well as amplified service fees for using facilities. Then we have individual physicians providing care, which, as we all know, are negotiated with the provinces through their respective provincial organizations' associations.

I think the first thing we need to do, as part of the overall health transfer negotiations that are being opened with the provinces, is to say that the federal government runs a health care system—the deliverers of care. We need to have a seat at the table for those negotiations to deal with those rates.

In terms of a component of the health care transfers, especially potentially the one-time component, I think that is definitely worth consideration. What is going to be quite important is to understand that while health care is funded in the military, it is from a fixed budget within the whole defence department. If there isn't enough, as a baseline funding within health care, it comes from something else within the department.

We know that the Canadian Armed Forces needs more funding to do what they're doing—gas for tanks and health care. That's an oversimplification.

Thank you.

Mr. James Bezan: I appreciate that.

One thing that we haven't dove into yet is that our current defence team, of course, is treating our forces who are on training and on exercises, but not necessarily being exposed to a traumatic injury like we experienced when we were in theatre, like in Afghanistan.

How do we maintain that skill set within our defence team? How do we deal with surge capabilities in the case when we are deployed and in a hot conflict? Where do we find the personnel that are out there?

I know reservists could play a part in that. I just wanted to get both of your experiences on that side of it.

Hon. Rebecca Patterson: If you like, I'll start, and we can go from that point on.

When we're talking about surge capability, one way the health human resource component of the Canadian Armed Forces health services is structured is that you have a military-civilian mix of teams, meaning that the backbone was always intended to be civilian care providers, allowing uniformed personnel to maintain their clinical competencies. That costs money, by the way, that eats into that budget I was just talking about.

That is fine, but the challenges in that space right now are that there have been complaints about contracting within the department. However, if you cannot employ a health care provider through the public service because the salaries themselves are too low, there is no other choice, because to go without care means that you don't have people ready for deployment.

May I add that one of my recommendations to you is going to be that there is an urgent requirement for the public service to go through and review salaries of clinicians within the public service framework. This benefits more departments than the Canadian Armed Forces. The rates have to be competitive. This will then allow more military people to be able to surge forward and go elsewhere.

I might be out of time.

Mr. James Bezan: I have 30 seconds, so Dr. Breeck, I just want to switch over to your specialty in women's reproductive health.

You were saying that we don't have enough research here in Canada. Do any of our other allies have research that we can use as a baseline to start this discussion on how we protect women's reproductive health?

The Chair: Be very brief, please.

Dr. Karen Breeck: It's an extremely complicated area, and newer technology is required to even understand the baselines. Again, I do appreciate, especially for the unusual military environmental exposures, that our best bet is to work with our allies to start gathering the data so that we have higher numbers of women so we can start documenting and moving forward.

People look to Canada as leaders in this area, which is why I have more to do.

The Chair: Thank you, Mr. Bezan.

Mr. Fisher, you have five minutes.

● (1015)

Mr. Darren Fisher (Dartmouth—Cole Harbour, Lib.): Thank you, Mr. Chair.

Thank you to all our witnesses.

I want to go to you first, Senator.

It is the end of Nurses Week. Happy Nurses Week, and thank you for your incredible service. You had the understatement, perhaps, of the day when you said, “I have quite a bit of experience.” I would say that's quite the understatement, based on your resumé, so thank you for your service.

You gave Mr. Bezan one of your recommendations. I am interested in all of your recommendations, and I feel that I want to take away as much of my preamble as possible and give you the floor. Can you speak from your own personal experience and tell us what we should be doing based on your experiences?

Hon. Rebecca Patterson: Thank you, Mr. Chair.

I'm going to approach this from our level as fellow parliamentarians. I'm going to break it down into buckets.

The first bucket is how we fund, because when you fund health care, you fund defence, which is key. That is why it's in my first recommendation. People may say, you know, $10 million here and $10 million there, it doesn't matter.... It matters a lot. My first recommendation is very much the biggest budget chunk. It's how we provide health care and how we purchase from the civilian sector, and I use the term “purchase” very deliberately.

My first recommendation is that, as part of the intergovernmental arrangements with provinces, federal health care very specifically is in there and is negotiated along with the transfer taxes, because the federal government delivers health care as well as pays for it. That is my first recommendation.

The second one that comes out of there—I'll pull up my little sheets here because of my age—is that we're looking at things such as an urgent replacement funding-wise to replace the health records that Mr. Booth very clearly talked about. We have a Frankenstein system that was one of the first medical health records in Canada and needs replacing. There are no more bolt-ons capable.

It is a patient safety issue to not invest about a half a billion dollars in replacing this electronic system. If we do this now—because process takes time—from an information passage you will be able to address everything from patient safety for serving members no matter where they serve to then moving them through to transition so that there is a seamless transfer of records between the civilian sector and the military into Veterans Affairs. That is another recommendation I have.

I'm trying to go faster for you, Mr. Chair.

The other thing we're having a look at is investing in infrastructure. It is a challenge throughout the department. I'm going to look at CMED here, which one of our honourable members who is here can really appreciate. That's the central medical equipment depot in Petawawa. It is an ancient building. The pandemic has shown us that multidepartmental relationships for unique medical procurement storage require a national solution and investment. It's important, but we can't get it across the start line: Invest in infrastructure within health care.

Do I still have time, Mr. Chair? Okay. I can get through these. I promise.

The next area is health human resources. This is a pan-Canadian health care issue, and this is very timely. If I focus very tightly on the Canadian Armed Forces, we are in direct competition with other sectors and the Canadian public, not only to find people who wish to wear uniforms but also to find public servants or even contractors to do that. In order to make it a career of choice—we can deal with the military side in a minute—I strongly recommend that some impetus be put behind the public service to do a review of all the occupations within the public service that deliver direct clinical care to make sure that salaries and benefits are competitive. Please keep in mind that whether I be military, RCMP, CBSA—you name it—I probably don't serve in a major centre but in a small and remote area of Canada. We also need bilingualism.

The next area is to look at federal health capacity.

I'm sorry, Mr. Chair. I can get it all in here. I used to own the official languages portfolio.

For the federal health capacity, when it looks at everything from day care to health care, I think we need to think differently about it—which the Canadian Armed Forces can benefit from—by looking at a federal health system that looks something like the public health care system down in the U.S., where you have licensure and federally regulated care providers at a national level. They become tools of the federal level, beyond the provincial jurisdictions, to very closely target care, whether it be health care for the military and the RCMP, perhaps, or day care—things that have become the barriers we meet all along. We need to be very progressive in looking at federally regulated, certified and transferable.... This is what we need to have a look at to determine if there is a better way of doing business. I do believe there is some work ongoing in other departments.

[*Translation*]

That's all. Thank you.

● (1020)

[*English*]

The Chair: Thank you.

Mr. Fisher, that was a brilliant question.

Madam Normandin, you have five minutes.

[*Translation*]

Ms. Christine Normandin: Thank you very much.

I thank all the witnesses, especially Doctor Breeck and Senator Patterson.

My questions are for you both.

Do the Canadian Forces give enough consideration to women's morphology when acquiring equipment? We know equipment that fails to consider it can cause medical problems.

Furthermore, during deployment, is there any disparity in medical treatment? When they're deployed, do women receive adequate services?

[*English*]

Hon. Rebecca Patterson: Do you want to start and I'll follow?

Dr. Karen Breeck: Thank you for your important question.

I think the Canadian Armed Forces has come a long way with the help of gender-based analysis, with doing the right thing moving forward for new procurements. Of course, a lot of the equipment in the military is old, though, so it has all of the older issues. We're looking at submarine accommodations, different kinds of accommodations on different ships. These things are already taken into account on newer ships, but we still have a lot of older equipment. That's one problem.

I do think we've done amazing work at places like DRDC, Toronto, for looking at different equipment pieces. That's still in evolution. We're still learning how to do it, but a lot of that is moving forward.

For me, the area that is still the most interesting is deployment. For me, there are three totally different types of medicine. There's the primary care where I'm your family doctor—normal medicine. Then there's the occupational medicine where you are employed, and I am the company doctor and ask how I can maximize so that you can work for me for 30 years. Then there's the deployment medicine, where I know you might be hurting yourself and I'm actually sending you out still, knowing you might hurt yourself. It's a very different type of medicine.

When we're deployed, there are many different ways that can be. It isn't just army. I came mostly by way of air force, so every time the wheels are up, we're deployed. There are many different ways deployment can happen, but we're often isolated by ourselves and we have to figure out how to do things.

If we look at something like a UN mission and start thinking with that women, peace and security lens, we are not necessarily with other Canadian resources or assets, but we're hoping for that equivalency. It's often quite hard to have that kind of equivalency for some of our UN missions. We, to my knowledge, don't have minimum medical standards of women's health training for the UN-level health. Often we'll say, “There's a U.S. base nearby, so we're good”, but especially on women's health issues, and especially even more so lately, there are still lots of different treatments and resources that might not be available in a U.S. location that would be in Canada.

We often still don't have basic basics in some of the UN kit, so things like birth control pills or the kinds of medications that would be needed after a sexual assault, vaginal infection information or even just a speculum, instruments to be able to properly examine a woman's vagina. That may not be available at that first stage, so suddenly something that really should be pretty simple to take care of becomes a big to-do. You have to leave the mission. Especially if you're in a conflict zone, even leaving the mission is actually quite dangerous. You're actually taking yourself out, and it could be a two- or three-day thing.

At one stage I was in Germany, and we would have women still having to come up from Afghanistan to Germany to get primary medical care that could have been ideally dealt with already on site if we all had a higher level of awareness of the right products, the right treatments and how to deal with common women's issues.

Hon. Rebecca Patterson: I've also realized I cannot hear simultaneous translation and the French.

[*Translation*]

That's a big problem for me.

[*English*]

I'm going to just build on what Dr. Breeck has said.

On the UN side, it is beyond Canada's control, because the UN provides the health care. However, what is really important is that through groups like the women, peace and security ambassador, we are trying to influence how women are included, whether it be the Elsie initiative that's within nations or also feedback that we're giving to the UN.

However, it behooves us as part of our planning process to ensure that there is a chain of care or evacuation should it need be.

The next thing will go more to preventative care and making sure that women have the right health before they go, so that is dealt with, with the exception of common episodic illnesses that are feminine in nature. It's investing in this women's health program and women's health research. How do we keep women healthy is where we're going.

● (1025)

The Chair: Thank you, Madam Normandin.

Ms. Blaney, you have five minutes.

Ms. Rachel Blaney: Thank you so much, Chair.

I want to thank all the witnesses testifying today, but a special thanks to Dr. Breeck and Senator Patterson for their service. I really profoundly appreciate it.

Dr. Breeck, I'm going to come first to you. We've had CAF officials at this committee, and there was some confusion on whether MST survivors can access OSISS and funded peer-support groups. I'm just wondering if you can speak to the significance of peer-support programs and how you think the programs should be structured.

Dr. Karen Breeck: Thank you for what I think is a really important question. If I can, it's very complicated, so I'll step back a little bit.

What problem are we trying to solve? To me, as a clinician, what you had is an injury in your workplace. I almost don't care what it is. You were injured in your workplace, so how can we help and support you. Whether that injury is from combat, whether that injury is from a sexual misconduct, you have an injury that is an occupational injury.

We now are calling a lot of these issues moral injuries and occupational stress injuries. The terminology, I think, we're still evolving and we're still learning. It's really important that we identify terminologies clearer, because it does cause constant confusion. What is an OSI, an operational stress injury and what is military sexual trauma? If I asked everyone here, I would guess I would get different answers from each of you.

I had an opportunity before COVID, where I had 10 generals in a room and I asked each of those generals the question: Is military sexual trauma an OSI, yes or no? Everyone had an answer, and it was literally straight down the middle. Five said, “Why are you asking me? Of course it is.” Five said, “Why are you asking me? Of course it is not.” That speaks to how we have the problems especially on the MST side, when a number of decision-makers assume that it's always included when we hear the words OSI, yet we have senior decision-makers that assume that it has nothing to do with it.

At the end of the day, my humble opinion here is that 10 years from now we won't be using this terminology at all. We'll be focusing on moral injury. We'll be focusing on where you go and what you need for help right now versus the hyperfocus on how you did the injury. We'll be focusing instead on the human and how we can help.

I think a lot of the issues on that day, in that moment, your genetics, your family history, your childhood, your health that day, your meaning, how that person looked like someone you knew, and you got overwhelmed from your trauma and you had a trauma response.... That's all we're talking about here. You had a trauma response. As we understand more now, I think we're finding very rapidly that if we can give you the right resources up front, you may not need medical care at all. You don't need to be medicalized. You don't need to be pathologized. You don't need to be medicationalized. You don't need a label. You don't need a diagnosis. You just need someone to say, “This is normal. You're having a normal reaction to an abnormal situation. Let me help you. Let me sit with you and tell you it's going to be okay. I will give you tools and resources.”

That's where peer support comes in. It's so important. Then we wouldn't necessarily need to go to VAC, because we can't go to VAC until we're already down the line. When we already have a diagnosis, when we already have major depression, anxiety, post-traumatic stress, that's when VAC picks up, yet the majority of people I know aren't there yet, so where do they go for help and support?

Peer support, if done holistically for everybody.... Right now, it's really a confusing area. Can I go to the operational stress injury clinic if I have military sexual trauma? Of course you can. Okay, so it is an OSI then. Because I'm going to the OSI clinic, it must be an OSI. I can go to the OSI social support program for me and my family. Oh, I can't. Why can I not? Why do we fit in one place but not the other?

There are a number of layers of confusion and hence that was a complaint that formally got brought to the veterans ombud and there is a report on it. We're still very much in the process of trying to find an equivalency for how to help everybody who has an occupational health injury, not preferentially just one group over the other. We need to help everyone, and peer support is a big part of that.

● (1030)

The Chair: Thank you, Ms. Blaney.

We have less than 15 minutes and 25 minutes' worth of questions. This is not going to work. It's three, three, one, one, three, three, and I'm going to be hard on the three.

Mr. Kelly, you have three minutes.

Mr. Pat Kelly: Thank you.

Senator Patterson, we heard from the CAF ombudsman earlier about issues around attribution of injury, and then, once transitioning into Veterans Affairs, having to seek private diagnosis.

If a member has been certified by Canadian Forces medical personnel as unfit and unable to meet universality of service, is there any ethical reason, which has been raised, why that doesn't automatically carry through and enable a veteran to obtain appropriate medical support services?

Hon. Rebecca Patterson: I think that's a fabulous question. Just to let you know, I'm stuck right in the middle of it, personally, because I retired in January. I'm trying to figure the system out, and I come from a health background.

Just so you know, it isn't the medical services that declare you not universally fit. It's the CAF itself, and that is a technicality.

I think it's how we write our policies at a departmental level, in terms of what you're going to accept. I will try to give you something useful here. We need to have a policy—seamlessness between service and post-service time—where it isn't the member trying to navigate the system, which is what it is now. The whole burden is put on the member: “Find this. Pull that. Give that. Dig this up.” What we have to look at is not only policy changes that state, “If you have someone who has an expertise in military attribution—they did this while they were deployed in Somalia, for example—it doesn't have to be reproven for at least the initial stages within VAC.” We need to have a look at, through seamlessness, policy and mandate letters between, I'm going to say, departments, because that's always a unique space.

Secondly, how about making that health record seamlessly transferable? While there are some privacy technicalities that go in there, what you shouldn't have to do is an absolute complete review of everything that's ever happened to you. In order to leave the military.... Even if you leave without medical release, it's the same situation. You don't come out of this unscathed, unfortunately. When it has been attributed, why can't that be the first record already in the system in VAC, which starts the assessment before you? It's the same questions being asked again and again.

A seamless health record policy—to do that, as well as a mandate, would make it easier.

The Chair: Thank you, Mr. Kelly.

Ms. O'Connell, you have three minutes.

Ms. Jennifer O'Connell (Pickering—Uxbridge, Lib.): Thank you, Mr. Chair.

Thank you for everyone's testimony. It has been exceptional.

Senator Patterson, thank you. You've done a lot of our work as well, I think. In your testimony, you've given us a lot,

With only three minutes, Dr. Breeck, could one of the problems be that, in dealing with women's health—even in civilian life—the needs of women's health care are still so misunderstood? There's a lack of expertise, again, even in civilian life. The stigma around talking about it—again, even in private life—could be part of the problem.

Then, there's a second piece to that: Are there not other industries that have come along further, in terms of dealing with non-traditional—even that is a ridiculous term—work for a woman who might be in a high-intensity or physical job in the private sector, so we could build upon reproductive health care and policies that could translate into military life? Obviously, travel, the intense schedule and things of that nature may not be completely compatible or comparable, but there could be some lessons learned even in the private sector.

Could you elaborate?

● (1035)

The Chair: There's a minute and a half.

Ms. Jennifer O'Connell: I'm sorry.

Dr. Karen Breeck: I'll speak faster.

Absolutely, we know there's a bias across the board, on the civilian side. If I can.... To me, it's different buckets again. We already know there's a bias in primary health care. That, of course, comes over into military health care, but now we have a bias in occupational medicine as well.

Most of the original occupational hygiene rules and regulations were done in the 1970s, mostly in the U.S., which is why it's almost all male data. We need an entire revisal of all those occupational health hazards, one that now includes women. It just hasn't been done. That is a government...because it's a government-specific issue for employment.

I'll add onto that one more layer, and that's the operational level. For women doing military flying, diving and these kinds of very unique-to-the-military occupations.... Again, it is a government responsibility to do research at that level, because it's not the primary care.

When we talk about industry, there's no question. We can always learn from other areas—mining and non-traditional areas. Again, I'll highlight that all of them, though, when we start talking chemical exposure, vibration, sound and these physical things.... The last major updates were in 1970. We need a country to step forward to do an across-the-board major review—now that women are coming into these environments—of what is and isn't dangerous.

We may find a lot of the issues are not dangerous and that it is safe, but right now we don't know. It's that initial research, by the federal government, hopefully, and across departments.

[*Translation*]

The Chair: Ms. Normandin, you have one minute.

Ms. Christine Normandin: Are services for sexual misconduct survivors located in the right geographic areas? Are they too present in big cities, rather than being close to military bases, where the victims are?

[*English*]

Hon. Rebecca Patterson: I can give you a direction on where to go for that information. It has been part of the overall work on sexual misconduct since 2018. It's about the concentration of serving members. That's where the services are concentrated. It's especially support through family resources centres, which were mentioned previously, as well as within health centres.

I'm going to stop there. More information can come from the Sexual Misconduct.... It has a new name.

Dr. Karen Breeck: It's the Sexual Misconduct Support and Resource Centre. It used to be called SMRC. Yesterday's announcement officially announced the new name of SMSRC.

If I can add to that, again, I find it really important that we define our words. A lot of people interchange sexual misconduct with sexual assault, yet the vast majority of sexual misconduct is not sexual assault. It is not always sexual assault resources that are required. There are often much more complicated and alternative resources for the other things that still come under sexual misconduct as well.

The Chair: We're going to have to leave Madam Normandin's minute behind, here.

Ms. Blaney, you have one minute, please.

Ms. Rachel Blaney: Dr. Breeck, what work needs to be done, and what gaps are there around women's reproductive health and reproductive rights in the military?

Dr. Karen Breeck: In one minute...?

I'm about finding the root cause. Anything that helps is great, but on the root cause, we won't know what we won't know until we do something at a very broad, strategic level that should be helping all of the women.

Again, I think of it as a quiltmaker. We have all of these different departments making quilt pieces, but we don't have a quiltmaker yet to make sure all women benefit from knowledge on, whether we're menopausal, pregnant or breastfeeding, how and when it is safe or not safe in our newer work environments.

Within the CAF specifically one area we often talk about is medical. Medical still looks at the primary care as equivalent, but there's another layer that's government. What are the employer job benefits? Other militaries offer egg and sperm banking. You can choose to delay a pregnancy because you want to go on a deployment, say I'm going to Sudan for two years and I want my eggs already banked now before I get exposed to whatever I get exposed to. Those are employer job benefits.

Obviously, they're not going to be provincial equivalent. That would be an easy, simple thing that would help support women to have choices to be able to have eggs banked.

● (1040)

The Chair: Thank you, Ms. Blaney.

Mrs. Gallant, you have three minutes.

Mrs. Cheryl Gallant: Dr. Breeck, with respect to the army, navy and air force, is there one branch where reproductive loss is higher? If so, which one?

Dr. Karen Breeck: I look forward to when this committee puts forward a recommendation that we study these questions.

In fairness and in follow-up, right now women's health is especially hurt by our electronic patient record. It was, again, ahead of its time in its time, but it does not include easy ways to put down our grava or para. It doesn't have easy ways to incorporate pregnancy-related information. It's not set up in a way for us to capture the data easily to do the research on, whereas a newer electronic patient record would actually help address and capture that. We're over 30 years now for women doing this. We should have data and we don't.

Mrs. Cheryl Gallant: At what point, generally, are pregnant members shifted over to civilian doctors for prenatal care?

Once a member with a young child is posted elsewhere, or a newborn comes along the way, how is that child cared for? In places like Renfrew county, we have tens of thousands of people on wait-lists. Often, military families go their whole posting time without ever being assigned a doctor.

Dr. Karen Breeck: Prenatally, when I joined we were expected to do all of our own prenatal care and work directly with an OB/GYN, who often actually invited us to be part of the actual delivery.

However, as time has progressed, anything to do with women's health issues tended to be outsourced. It's now considered pretty standard that we outsource almost immediately upon pregnancy. It actually causes a number of issues and problems when you are still actively doing unusual work that needs that occupational medicine oversight. That isn't the job and responsibility of the civilian sector. This is where one of our gaps happens. I think we lose a lot of our women unintentionally because we're not always overseeing that occupational level while they're pregnant. When they're pregnant they're over there.

I'll allow my colleague to talk about child care.

Hon. Rebecca Patterson: There are two things. There is a project under way within health services now, which is the women's health strategy. We need support to continue to develop that strategy, which includes bringing OB/GYNs on board. That will help with some of this oversight and trying to reduce that gap. Continued support of the programs already under way is going to be essential, and funding.

Secondly, when it comes to child care, we get stopped every time. I had my children in Petawawa, by the way, and it is a showstopper. It impacts operational readiness of jets and planes and tanks. We need to look at some way of navigating around provincial jurisdictions. It's definitely worth a project at a federal level—controlling our own health care systems and funding them.

The Chair: Thank you, Mrs. Gallant.

Ms. O'Connell, you have the final three minutes.

Ms. Jennifer O'Connell: Thank you.

Senator Patterson, you touched on the health care increases compared with the CAF health care increases. I wrote down 0.7% increase, in comparison to the provincial and territorial health care agreement. Do we have the data? We might assume that the investments would be parallel to the civilian public system, but there may be a higher need in certain parts of the health care spending for CAF.

Do we have the data to break that down, in terms of how much we should be increasing year over year and in what particular priority areas?

Hon. Rebecca Patterson: That is a wonderfully complex question, and not my current work.

There are two things. Health care inflation is a Canada-based thing. Because we purchase civilian products—we train from there—even if we deliver the care, we purchase it. It's based on those inflation rates. That is data that needs to come from elsewhere.

When you look at how much we actually pay, that data base is building within the Canadian Armed Forces. When you ask whether there are going to be specific areas, health care that is delivered to CAF members is always going to be funded.

My reinforcement piece is controlling how much we spend in comparison to a civilian receiving the exact same service. It's what we're being charged for. I have to go back—it's a bucket with water in the bottom. Every time you slosh it one way, there's a space. The Canadian Armed Forces and the Department of National Defence make no money. They spend. That's what they do.

You need to indirectly hit it by looking at what we're being charged and where we're being overcharged. “Overcharged” is my opinion; that doesn't reflect the department. However, the data is a baseline there and building.

● (1045)

Ms. Jennifer O'Connell: If I can quickly get a question in on the day care piece, how would that look? Would we work with provinces and territories to reserve certain spaces, or would it need to be a completely stand-alone system?

Hon. Rebecca Patterson: I'm going to tell you what we have experienced.

Again, doing health and being a champion for women seeking child care, the challenge is that day cares are provincially regulated, as well as child care providers. Because it's not a core service delivered by the federal government, retaining spaces is not possible because it has some provincial funding in there. It is a model, but we haven't been able to overcome it.

What happens with a highly mobile community such as the Canadian Armed Forces is that we tend to be in remote areas where populations don't move. If it has to be open to provinces, as soon as a military member leaves, it's filled by a civilian. That is wonderful, but it means there's no access. We have to think differently.

The Chair: Thank you, Ms. O'Connell.

Unfortunately, I have to bring the gavel down on this meeting.

All three of you have been very helpful in our deliberations. Thank you, again.

With that, the meeting is adjourned.