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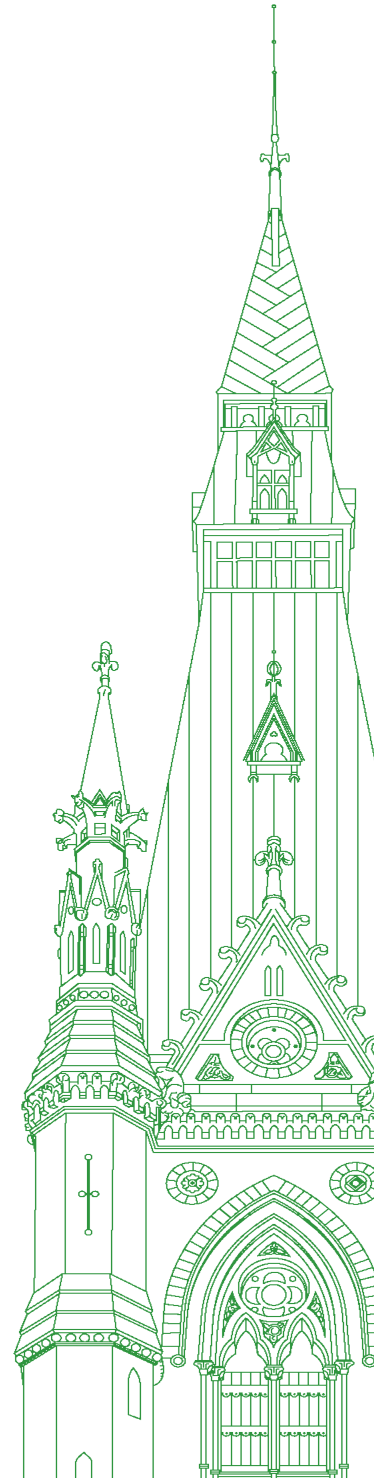

Chair: Mr. Sean Casey

Standing Committee on Health

Monday, April 25, 2022

● (1535)

[*English*]

The Chair (Mr. Sean Casey (Charlottetown, Lib.)): Good afternoon, everyone.

I call this meeting to order. Welcome to meeting number 17 of the House of Commons Standing Committee on Health. Today we will meet for two hours to hear from witnesses on our study of the Canada's health workforce.

Before I introduce today's witnesses, I have a few regular reminders for hybrid meetings. Today's meeting is taking place in a hybrid format, pursuant to the House order of November 25, 2021. Per the directive of the Board of Internal Economy on March 10, 2022, all those attending the meeting in person must wear a mask, except for members who are at their place during proceedings.

I have a few comments for the benefits of the witnesses. Please wait until I recognize you by name before speaking. For those participating by video conference—which I believe is all of the witnesses—click on the microphone icon to activate your mike and please mute yourself when you are not speaking. Interpretation is available on the bottom of your screen. You can choose floor, English or French.

I'll remind you that comments are to be addressed through the chair. Please refrain from taking screenshots or photos of your screen. The proceedings today will be made available via the House of Commons website.

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

Today we have with us, as individuals, Dr. David Gratzer, physician and attending psychiatrist, and Dr. Arjun Sahgal, professor of radiation oncology.

From the Canadian Federation of Medical Students, we have Santanna Hernandez, president, and Montana Hackett, director of government affairs.

[*Translation*]

We also have with us Dr. Anne-Louise Boucher, director of planning and regionalization, and Mr. Pierre Belzile, director of legal affairs, both with the Fédération des médecins omnipraticiens du Québec

[*English*]

From Health Intelligence Inc., we have Dr. David Peachey, principal, and from Sheridan College, we have Dr. Janet Morrison, president and vice chancellor.

Thank you to all of our esteemed witnesses and panellists for being with us here today and for taking the time to impart upon us some wisdom and advice as we endeavour to make recommendations to the Government of Canada with respect to Canada's health workforce. We're going to begin with opening remarks from each witness in the order they appear on the notice of meeting.

Please limit your remarks to five minutes.

With we're going to start with you, Dr. Gratzer. You have the floor for the next five minutes. Welcome to the committee.

Dr. David Gratzer (Physician and Attending Psychiatrist, As an Individual): Thank you, members of the committee, for the invitation to speak today.

"I started watching the clock during the day and thinking more about how many more patients there are and how much time is left in the day. I knew I'd get through it, but I didn't know how I'd feel at the end of the day. Then it just started getting earlier and earlier, and one day, five minutes into the meeting, I was thinking, "Oh boy, it feels like I've been here for a while. I have a long day to go.""

These are comments that a physician colleague recently made to me. When we speak about the recruitment and retention of health care workers, we need to think about several things, and they include the psychological needs of our workers.

My name is Dr. David Gratzer. I'm a medical doctor and attending psychiatrist. I'd like to speak for a few moments this afternoon about burnout and about mental disorders. By way of background, I work at CAMH here in Toronto where I serve in clinical, administrative and educational roles. That said, the views I express today are not necessarily those of the hospital.

Let me take a few moments to talk about burnout, and I'll confess my bias. My roles involve physicians, so I see things through the prism of physician burnout and physician needs, but I think they're applicable across all health care domains.

As you know, physician burnout is a syndrome that is characterized by three things: emotional exhaustion, depersonalization and a reduced sense of personal accomplishment. To be a little bit more specific, emotional exhaustion is feeling used up at the end of the day, that there is nothing more to be offered to patients. Depersonalization is when clinicians no longer view patients as being people but more like objects, and a reduced sense of personal accomplishment, well, that one is clear, but I would add that it is often combined with feelings of ineffectiveness despite years of training and goodwill.

Though burnout has been problematic for years, as you know, everything with regard to physician issues has grown worse with the pandemic. The Canadian Medical Association's national physician health survey, which polls thousands of physicians from sea to sea to sea, suggested that about one in three physicians had been experiencing burnout. That was before the pandemic. As you know, since the pandemic has begun, those numbers have jumped up. The most recent survey suggests that about one in every two physicians, half of our physician workforce, is experiencing some element of burnout. Similar surveys for nursing, occupational therapy and other disciplines of health care have shown something similar. In other words, a bad situation, perhaps not surprisingly, has grown worse.

Let me pivot and talk about the pandemic and mental health disorders. As you know, there's been much attention in recent months to survey results showing that people are more anxious and that their mood is lower. As a psychiatrist, I find this interesting but not necessarily worrisome for most people. Again, I chose my words carefully. Most people have resilience and, as a result, while the pandemic might be stressful, while they might be worried about making rent or about their employment prospects, they will walk away from this relatively emotionally and psychologically unscathed.

But there are groups at risk. I can think of three. First are people who have had a history of mental health problems. Second are those with direct exposure to the virus and illness and third are those who have survived the illness. Many of our health care workers—too many of these health care workers—fall into all three categories and are thus at risk for or experiencing major depressive disorder, post-traumatic stress disorder and anxiety disorders.

The literature suggests that, long after the physical manifestations of SARS ended, there were the psychological manifestations. I think we're going to see something similar with COVID-19. The point is that our problems with COVID-19 will continue after the last patient is discharged from an ICU.

In my closing few seconds, I wish to sound a note of hope. I would suggest that there are thoughtful and practical things that can be done and that are being done. Regarding burnout, a rich literature has developed over the last decade or two, suggesting steps that can be taken.

● (1540)

I think about some of the excellence at my own hospital and some of the work done by people like Drs. Wilkie and Tajirian, who are setting up a peer support group that's been highly effective for doctors. Of course, the treatment of mental health disorders, my goodness, that's my life's work. Never have we been able to do more for people who have mental health disorders. The key, of course, is to recognize these problems and then to take the appropriate actions.

Thank you.

The Chair: Thank you, Dr. Gratzer.

Next we have Dr. Sahgal, who is appearing as an individual.

Welcome to the committee. You have the floor for five minutes.

Dr. Arjun Sahgal (Professor of Radiation Oncology, As an Individual): Thank you very much, Mr. Chairman. It is an honour to speak to you today.

I am Dr. Arjun Sahgal. I work at the Sunnybrook Odette Cancer Centre of the University of Toronto. Today I am representing myself, as a Canadian physician and professor of radiation oncology, subspecialized in the treatment of brain and spinal tumours.

To provide context, those of us in this field deal predominantly with incurable cancers like glioblastoma. Cancerous brain tumours are the most difficult to treat, and I have been privileged to treat these patients and to try to extend their lives. I have treated patients from those with absolutely no resources to Canadian icons like Gord Downie. It is always humbling that, no matter where they are in the world or whatever their background, the disease indiscriminately takes the patient’s life.

The nature of this work is highly stressful and it presents a major emotional burden. Resources were already limited as we all faced challenges of practising in a constrained and publicly funded health care system, but the past two years of practising during the pandemic have only exacerbated the potential for burnout—and system-wide burnout. From the early days of having shortages of PPE while seeing patients; dealing with the potential of exposing ourselves, our families and other patients to COVID; and triaging patient care based on COVID risk to the current reality of working in an overextended health system and trying to catch up while still managing the increased number of patients with COVID needing care, burnout is being fuelled at all levels of the medical profession.

Moreover, patients and caregivers themselves are burning out, and therefore the realities of limited resources that we face extend to not only the medical practitioners but also the patients themselves. Every facet of care is challenged by the lack of human health resources.

We are short nurses, allied health professionals, personal support workers and doctors. Many have simply retired, quit or looked for another profession as the environment is just overwhelming and under-resourced.

In addition, the system really hasn’t provided additional supports to care for the workers who are at the front line. The system is trying new strategies on the fly, but the question is what can make that difference to help health care workers now? It is not simply recognition.

I often reflect on a system that would improve the efficiency in which we practise through better modernized electronic health record systems, seamless access to imaging tests like MRI and CAT scans, better approval processes for new life-saving drugs and tests, and specialist care and staff to help the administration of health care. More and more, these tasks are being put on doctors, and that is stressing the system and increasing the burnout. In other words, we need to let the doctors be doctors and ensure that clerical staffing is provided by the system so that doctors can look after patients instead of cutting down on patient care to allow time to enter orders and transcribe notes. This would be a major boon for staff retention, especially in northern and rural settings, and would combat what seems to be an increasing proportion of young doctors who are burning out.

I am not an expert, nor do I practise in a rural or underserviced community, but as a specialist I do care for patients from all over Ontario who have rare tumours. I can say, from my northern colleagues, that this problem is much more difficult to deal with in remote centres since there is a much smaller pool of workers and some core services have had to be restricted.

The acceleration of virtual care is helpful in managing the current crisis as we can do more virtually, but we need a fair system and access to resources that span not only hospitals but all care settings, including remote care offices.

Immediate attention needs to be given to new health care models to manage the limited resources that are becoming even more scarce due to the workforce answering with burnout from the constant pressures of understaffing and over-administration.

I do believe that increasing the staffing levels will make a major difference, but this will take time. Accelerated programs for recruitment of nurses and long-term care workers from other countries may be a solution, but we need to train more young Canadians and make it attractive again to go into the field of caring for the sick and needy.

It would go a long way for rural centres to have modernized resources so that the staff could work proudly in that setting, be retained and be able to recruit new staff by offering the latest medical care resources—as they would in downtown Toronto—so that they could do their jobs the way they were trained to do. This could have a positive impact on the burnout rate in patient care.

To summarize, I would say that every health care worker—from the support staff maintaining clean surroundings and security personnel who protected us when protests were happening to technicians, nurses and doctors—strives selflessly to provide only the best care for our patients.

● (1545)

That I believe in and I do believe it's time to protect us from burnout. I thank this committee for this opportunity.

The Chair: Thank you, Dr. Sahgal.

What a perfect segue to our next group, the Canadian Federation of Medical Students.

Welcome.

Ms. Santanna Hernandez (President, Canadian Federation of Medical Students): *Mahsi cho* .

Thank you to the Standing Committee on Health for taking the time to hear from the Canadian Federation of Medical Students. We are an organization that represents over 8,000 students from 15 medical schools across the country and the future of the health care system.

My name is Santanna Hernandez. I am the president of the CFMS and here on the traditional territories of the Treaty 7 peoples of southern Alberta and home to Métis Nation of Alberta Region 3. I'm joined by Montana Hackett, our director of government affairs, and our president-elect, who is joining from the Township, Treaty 6 territory in London, Ontario, as well as Treaty 2 territory.

As medical learners, we bring a unique perspective to this conversation and are strong advocates for learners and the broader medical educational community. We are aware that our partners at the Canadian Medical Association had the opportunity to speak to you previously and we hope that our information and asks will build on the information they shared as we echo the incredibly important issues on the health and human resource crisis, the need for investments on a national health and human resource strategy, and national licensure.

Mr. Montana Hackett (Director of Government Affairs, Canadian Federation of Medical Students): Perhaps there can be confusion on how those issues impact students and what components are missing that impact us as learners, so I want to take a few minutes to break this down for the members of the committee.

One thing that is top of mind for all medical learners is the residency matching process. Each year we see trained medical doctors going unmatched to a post-graduate program. Government plays a key role in deciding residency seats at the varying provinces since those seats are often determined by educational funding and resources to build programs across the country. Only a few weeks ago we concluded the first round of the 2022 residency match and it was a landmark year for all of the wrong reasons. This showcases the urgent need for action from the federal and provincial governments, both from the standpoint of medical student burnout, prevention and retention, but also resource allocation in a health care system that is bleeding workers.

There is a significant need to align the current residency system with the needs of the patient population and the desired career prospects of its future physicians to prevent burnout. This includes government investments in human resource projections and adequate program funding.

● (1550)

Ms. Santanna Hernandez: Secondly, there is an urgent need for national licensure. Currently, the application process for medical licensure requires physicians to submit separate applications to each of the 13 provinces' and territories' medical regulatory authorities that license physicians. This limits physicians from providing services in multiple jurisdictions without going through a separate licensure process for each province and territory. This poses a challenge to residents and staff physicians, who strive to deliver care to patients easily and flexibly. This includes significant patient safety risks and delays in care as administrative burden takes physicians away from their primary focus of patient-centred care.

Practising outside of their own province and territory would allow residents to expand their practice to include underserved rural and remote communities. As future physicians, the burden of these applications in the context of all of our other duties and responsibilities is significant. National licensure would alleviate this issue, while also making patient-centred care more flexible and directed to those who need it most.

We released a joint statement with the Resident Doctors of Canada, the College of Family Physicians of Canada, the Royal College, the Canadian Medical Association, and the Society of Rural Physicians of Canada, advocating for exactly this several years ago and there is an increased urgency for this change now more than ever.

Mr. Montana Hackett: Finally, both preventative and reactive mental health supports need urgent funding. In our 2017 CFMS member survey, it was reported that around 37% of Canadian medical students meet the criteria for burnout. This is a staggering figure, and even more frightening is that it is a prepandemic one.

Wesley Verbeek, who was a medical student in 2017, said it best. Another problem is that students training to care for the mental and physical health of others don't have time to tend to their own health. Wesley Verbeek said, “You have to learn and do so much in a short period of time. There is a lot of pressure to keep going, keep going, keep going, because the more you can continue the status quo, the more likely you are to get matched to the residency you want.”

As our former president, Dr. Franco Rizzuti, explained, “Medical students tend to be high-functioning and highly resilient, but the accumulation of many stressors leads to anxiety, depression and burnout".

Time-crunch pressure, lack of sleep, 70-hour weeks during clinical rotations, witnessing patient death for the first time and personal issues add up, and “even the best coping mechanisms can start to fail,” said Rizzuti. With burnout among residents and staff physicians estimated at 50% or above, the emotional struggles of medical students represent “the beginning of the pipeline,” said Rizzuti. “How are we going to improve overall health and wellness in the general physician population if our trainees—without the stress of running a business, without some of the on-call requirements—have high levels of burnout and depression?”

So the combination of the long wait times and inaccessible mental health supports with trainees, who due to the demands of their learning have limited opportunity to access them, creates a crisis.

Ms. Santanna Hernandez: We have three key recommendations.

A national integrated health and human resource plan, that has an intergovernmental approach spearheaded by the federal government, is urgently required.

We need to eliminate barriers for medical professionals, by enabling the adoption of a national licensure system. Medical professionals need to be able to move from province to province to territory to help deliver care where it's needed.

Finally, we need to increase accessibility for mental health supports, given that medical trainees are facing a mental health crisis.

We are at the beginning of a lifetime of service to our communities, so implementing these measures now translates into better patient care for all. Working with Blackfoot elders here in Mohkinstsis, the Blackfoot name for the city of Calgary, I have been privileged to have many teachings about the importance of walking a parallel path. That is what we must do now. We need to work together to create a health care system that fosters wellness and sustainability, and takes a proactive approach to ensuring patient safety.

We urge you to take action now before it's too late. Our educators need you, and we need you. This is a non-partisan issue. Canadians need you on their team.

Mahsi cho. Thank you to the Chair and the committee for hearing our witness statement.

The Chair: Thanks to you both. I'm sure there will be questions, when we get to that part of the program.

[*Translation*]

We'll now go to Dr. Boucher of the Fédération des médecins omnipraticiens du Québec.

Dr. Anne-Louise Boucher (Director, Planning and Regionalization, Fédération des médecins omnipraticiens du Québec): Good afternoon.

I'm a family doctor, and I represent the Fédération des médecins omnipraticiens du Québec, or FMOQ.

First of all, I'd like to thank the House of Commons Standing Committee on Health, and in particular Mr. Luc Thériault, member of Parliament for Montcalm, for allowing us to make a few comments on the state of the physician workforce in family medicine in Quebec.

The FMOQ is a professional union representing some 10,000 family doctors practising in the Quebec health care system. It is a representative body recognized by the Quebec government to negotiate the conditions of practice with the minister of health and social services. However, it isn't only a union, but also an important player in the planning and organization of general medical care in Quebec, as well as the largest continuing medical education enterprise in family medicine in Quebec.

The FMOQ and its members play a central role in the smooth operation of Quebec's health care system. We saw this during the health crisis related to the coronavirus pandemic. We demonstrated that our organization is an indispensable and necessary partner for policy-makers and network managers.

The pandemic revealed that FMOQ and its members responded to all levels of intervention. They were able to proactively and with great initiative reorganize front-line services quickly, while actively supporting second-line care for patients and the various services offered in institutions. Whether in front line medical clinics, emergency rooms, hospital units, intensive care units, long-term care facilities, local community service centres, home care, palliative care, whether in home or in institutions, or in work related to medical assistance in dying, whatever the practice setting, Quebec family doctors have risen to the occasion. They continue to be so today and will do so tomorrow. They stand in solidarity with the needs of the people.

In Quebec, family doctors cover both primary and secondary care. Across Canada, they are more likely to practise secondary care. The additional effort required by the state of health emergency for family doctors has certainly had an impact on them. This effort has resulted in an increase in the number of days worked and, consequently, in palpable exhaustion in the field. It has been physically, psychologically and professionally stressful to deal with a steady pace of work and to be constantly adapting, both in terms of the coverage of care, where the demand was constantly changing with the pandemic, and within the medical teams, where the unexpected absence of staff due to isolation because of COVID-19 put all professionals in rapid adaptation mode on a constant basis.

The practice of medicine during the pandemic was in some respects disrupted. To give just one example, the rapid introduction of telemedicine into everyday practice has brought about lasting and rapid changes. Unfortunately, to support all these efforts with the public and to coordinate all these changes professionally, our workforce is not at an optimal level. On the contrary, many are missing. As we have said many times in recent months, there is currently a shortage of more than 1,000 family doctors in Quebec to meet all the needs.

There are many reasons for this shortage. In addition to the upheaval and fatigue that the pandemic has caused in the workforce in recent years, there has been a significant increase in the burden of medical-administrative tasks. This has led to a decline in the attractiveness of the profession for new aspiring doctors.

For your information, the Canadian resident matching service promotes a system for applying for, selecting and matching postgraduate medical training positions across Canada. Again this year, graduates are turning away from family medicine in favour of other medical specialties, and this is very important in Quebec. Just over 90 family medicine positions in Quebec remained vacant after the first round of matching. We must never forget that an unfilled position in family medicine can have a negative impact on access to primary care for more than 30 years. For us, this situation is as sad as it is alarming. Family medicine in Quebec urgently needs to be valued by medical students. Too many people, including some at the highest levels, have unfortunately denigrated this profession over the years, which has produced the results we know.

● (1555)

In terms of workforce, there is a shortage of at least 1,000 family doctors in Quebec. That's a significant shortage. Over the past seven years, including the last two years in particular, several positions have remained vacant.

In addition, there is less primary care activity in Quebec than in the rest of Canada. Family doctors in Quebec are more versatile than family doctors elsewhere in Canada. About 50% of them work in at least two practice settings. The number of family doctors per 100,000 inhabitants is lower in Quebec than in the rest of the country.

According to the latest available data for 2020-2021, there are approximately 9,800 family doctors in the Quebec public system, and more than 7,500 of them offer primary care services. In addition, 3,737 caregivers take care of patients in hospitals, 2,453 work in emergency rooms, 2,303 work in nursing homes and long-term care facilities, or CHSLDs, and more than 117 work in obstetrics, where there were at least 34,000 deliveries in 2020-2021. Others work in various sectors, such as palliative care, rehabilitation, and so on.

It's important to consider the versatility of Quebec family doctors, whose contribution to the caseload of family doctors in institutions is between 35% and 40% compared to about 20% in Ontario, if we want to get an accurate picture of the family doctors in Quebec who are available on the front lines. We also want to emphasize that difficulties in accessing specialized investigations and wait times for consultations and surgeries result in over-consultation. For example, patients may consult with their family doctor several times to adjust the dosage of an analgesic or while waiting for surgery or assessment. This, in turn, increases the workload of family doctors.

Furthermore, particularly in remote areas of Quebec, the state of family medicine doctors, while far from optimal, has been relatively stable in recent years. However, some regions such as Abitibi-Témiscamingue, Chibougamau and the Magdalen Islands, stand out. In fact, these geographic areas have a harder time recruiting doctors than others.

There are also rural areas, which are currently the worst geographic areas in this regard. Family doctors who practise in rural areas are often late career doctors who have devoted most of their practice to their communities. There is very little medical succession in these rural communities, which are not always so far from an urban centre. Many young doctors are reluctant to start their careers in such isolated settings. Many sub-territories have significant recruitment issues. With respect to indigenous communities, in recent years—

● (1600)

The Chair: Dr. Boucher, I would ask you to wrap up your opening remarks. You will be able to add details during the question period.

Dr. Anne-Louise Boucher: I'll conclude by saying that, in our opinion, the federal government must significantly increase health transfers to the Quebec government in order to better support family doctors and give them access to better technical platforms for conducting investigative activities.

Valuing the profession of family medicine in Quebec is also a major aspect to consider within our health care system. Family medicine could be promoted and supported through federal funding to Quebec universities, in particular to increase the exposure of students at the undergraduate level to family medicine.

We also want to make an important point. We believe that the federal government and its corporations could be asked to revisit what unnecessarily complicates the practice of family medicine. I'm thinking, for example, of the red tape involved in applying for tax credits and other forms and regulations of all kinds.

With the current shortage of family doctors, we can no longer practise medicine in the same way. We need to be able to delegate more tasks and work with other professionals. We also need to reduce the medical-administrative burden. This reorganization of work requires support and change management that will allow family doctors to do what they were trained to do, which is to practise medicine.

The Chair: Thank you, Dr. Boucher.

[*English*]

Representing Health Intelligence Inc., we have Dr. David Peachey, principal.

You have the floor, Dr. Peachey.

Dr. David Peachey (Principal, Health Intelligence Inc.): Good afternoon and thank you for the opportunity to meet with the committee.

I have prepared a brief opening statement to provide context for the nature of our work and some of the lessons that we have learned.

Health Intelligence has undertaken related work with a team of four, constituted by a project lead, a health statistician, a software engineer and a project manager. Each of us has consulted in health care for 20 years or more, with the major thrust over the past 10 years being resource and clinical services planning. With varying degrees of scope and intensity, we've completed resources and services plans in nine provinces and territories.

I do believe that a fundamental aspect of your mandate in this committee is, in fact, this type of planning, particularly in the domains of recruitment and retention efforts, which inevitably founder in the absence of the ability to recruit to a plan.

Health care systems that are unplanned rarely, if ever, reach full potential. Human resources for health are, intrinsically, the health care system. Without question, technology, beds and pharmaceuticals are vital to its functioning, but the ultimate quality of care received by the people it serves starts and ends with the quality of its human resources for health.

Planning human resources for health addresses the challenge of balancing supply, demand and need in a highly labour-intensive delivery system. Understanding the complexity of the workforce, the contributing roles of supply and demand in generating shortages, demographic trends and working conditions are additive in assessing the current and long-term pressures on the workforce.

Resource planning and related policy initiatives are dysfunctional without coordination across the workforce. In the absence of health workforce planning as the basis of health system planning, policy and implementation, the status quo will prevail. Across Canada, the status quo means a largely demand-based system of growth and change in health workforce needs.

On the other hand, clinical services forecasting is a forward-looking projection based on assumptions regarding key determinants of population need and workforce supply. Resource and services planning is the process of shaping the future forecast according to organizational strategy, policy and objectives. As I'm sure you're well aware, the work of such planning is neither formulaic nor necessarily intuitive. Rather, it is navigational, both seeking information and responding to it.

The methodology that we've used for a little over a decade is an adjusted population needs-based model, or APNM, which utilizes a primary model that is population-needs based, but has specific adjustments and modifications to compensate for known inherent weaknesses. The elements and variables in our model constitute the anchor to underpin the complexity of a rolling 10-year plan with a constant repopulation of the data and the qualitative components as well. The outcoming care is equitable, sustainable and based on population health needs.

This patient-centred care, as was referenced earlier, cannot be achieved in the absence of a collaborative, team-based care, which is characterized particularly by the role optimization of all providers in the system with measured outcomes, mutual respect and a shared responsibility for quality.

The methodology itself, as it's evolved over the past dozen years, follows a sequence. It begins with comprehensive data acquisition, collation and analytics followed by comprehensive qualitative inputs based on significant stakeholder engagement and an updating of our literature database. We assess determinants of need and determinants of supply. All of these come together to evolve into a preliminary data catalogue and from there, into a data compendium. The data compendium evolves into an environmental scan and the environmental scan evolves into the genesis of innovative models of care.

Integrating the final qualitative and quantitative elements of need and supply uses our software and the APNM to generate a forecasting model, including scenarios and simulations that are translated into a base case, a low case and a high case in the construct of a rolling 10-year plan.

With this context and summary of our approach as the backdrop, the following is a non-prioritized list of lessons and key points that, if nothing else, have been constants throughout our work.

First of all, if it's not being done for the patient, then why is it being done? We have survived and are coming out of a provider-centric care system. Hopefully, it'll be a patient-centric system.

● (1605)

Recruitment and retention of health professionals are unquestionably bolstered when there is a resource and services plan in place. Recruitment and retention are, however, best addressed as separate entities, since the drivers differ and are distinct.

Rural and remote care benefits from jurisdictional programs, but requires support with the modern tools of digital health.

Recurrent themes across jurisdictions have been collaborative care, mental health and addictions, palliative care, vulnerable populations, public health, maternal and child health, and care of the older adult. These rise to the top in every jurisdiction where we work.

As referenced—and it's important to stress—to be successful, a resource and services plan needs to be navigational, not prescriptive. Planning must be customized to jurisdictional priorities and a needs assessment. For all providers, it's essential to work by using clinical FTEs, including an academic mandate.

The models of care need to be developed with role optimization of all provider disciplines and a shared responsibility for quality. Failure to achieve advances in models of care perpetuates the status quo and marginalizes non-physician providers.

There also needs to be a much greater focus on generalism. That is one of the keys to health care transformation.

Finally, Mr. Chair, this planning that's been described is absolutely not an end, but a beginning.

Thank you.

● (1610)

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

Finally, we have the president and vice chancellor of Sheridan College, Dr. Janet Morrison.

You have the floor.

Ms. Janet Morrison (President and Vice Chancellor, Sheridan College): Good afternoon.

I am Dr. Janet Morrison, and I'm president and vice chancellor of Sheridan College.

Our campuses are located on the traditional territory of several indigenous nations, including the Anishinabe, the Haudenosaunee Confederacy, the Wendat, the Métis and the Mississaugas of the Credit first nation.

Thank you so much for inviting me to discuss the critical role played by post-secondary institutions like Sheridan in shaping the future of Canada's allied health care workforce.

Before I get started, I want to recognize and thank MP Sonia Sidhu for the role she plays in championing health care both locally and nationally.

Sheridan is one of 24 publicly assisted colleges in Ontario. We have over 55,000 full- and part-time students enrolled in a variety of degree, diploma and certificate programs in the arts and design, technology, business, computing, skilled trades and health. We have three campuses in some of the fastest growing cities in the country: Oakville, Mississauga and Brampton. Our campus in Brampton houses our faculty of applied health and community studies where more than 3,000 learners are currently enrolled in programs such as practical nursing, athletic therapy, kinesiology and personal support workers, among others.

Our graduates play a critical role in frontline care across Ontario in looking after the health and well-being of Canadians, whether they're seniors, youth facing barriers or those living with chronic disease. The applied aspect of learning at Sheridan starts early. Every year we send 1,500 students to field placements in frontline settings, amounting to thousands of hours of service in the community, from hospitals and pharmacies to long-term care homes, shelters, transition homes and sports clinics and, in the private sector, in pharma and health technology.

I want to share a little bit about what we're hearing from our students, alumni, faculty and partners on the ground in the communities on the realities unfolding in their workplaces. Even before the pandemic started, the local municipality of Brampton had declared a health emergency. A lack of qualified and accredited frontline staff to look after the burgeoning and increasingly diverse population of the city was a primary factor. The city, like much of the region around the greater Toronto area, was seeing an influx of new families settling in and an aging population, both of whom needed culturally competent care when a health care workforce was facing a slate of retirements.

Then came the pandemic. For a few very long weeks, COVID infections ripped through the heart of our neighbourhoods in Brampton. This saw record levels of infections and some of the lowest vaccination rates in our province.

Sheridan College stepped up to live out our commitment as an anchor institution by hosting mass vaccination clinics at our Bill Davis campus in Brampton. While we were happy to provide the space, overcoming vaccine hesitancy among local residents required a united effort of social service organizations from the South Asian, Black, Latin and Filipino communities.

The combined interprofessional effort of so many concerned citizens, Sheridan employees who volunteered their time and organizations helped deliver 35,000 doses into arms and enabled Brampton and Peel region to overcome what had seemed to be an insurmountable challenge. That clinic was a huge success, but it also taught us some really key lessons.

First, the pandemic has taken a toll on the amazing health care professionals who serve on the front lines and the system as a whole—nothing you don't know. Health care needs in the community are rising just as the workforce is finding it hard to attract new talent and retain existing professionals with so many either retiring or switching professions. It's anticipated that Ontario will be short 20,000 nurses and personal support workers by 2024. That was before the pandemic. One local doctor told me that he's lost a quarter of his nursing staff in the emergency room.

Second, we saw first-hand and heard from so many that looking after the well-being of a growing and diverse population is an increasingly complex task that requires more one-on-one outreach, trust-building along cultural or faith lines, and intentional and coordinated interprofessional networks of care. This point was further stressed during a round table discussion hosted by Sheridan in January that brought together leading voices from across Peel region, including hospitals, public health units, long-term care centres, commercial laboratories and health care associations.

● (1615)

Third, many internationally trained professionals continue to find it hard to break into the labour market. Given the lessons I've already shared, this makes no sense. Rather than doing odd jobs to make ends meet in order to support their families, many qualified health care professionals could be working to serve on the front lines, helping to address the crisis.

While I speak from the experience of our place in Peel region, I suspect the situation is similar in other parts of Canada. I don't think these challenges are insurmountable, though, so let me share just a few ideas on what the federal government could do.

First, we know that one of the reasons the pandemic hit certain communities harder than others was the prevalence of chronic illness in those communities. In Peel alone, rates of diabetes, osteoarthritis, cancer and heart disease have been rising for years. We need to focus on future-proofing our communities from the next pandemic by addressing chronic disease. Public post-secondary institutions can play a huge role in that work through our research and our applied approaches to teaching that involve field placements in a diversity of settings, community and industry partnerships, and the use of technology. I know post-secondary education is a provincial jurisdiction, but there are many examples of how the federal government has supported academic institutions in areas like skills development, research and tech innovation.

Second, we already attract a lot of international talent to Canada through the post-secondary educational system and through the skilled workers point system of immigration. In both cases, publicly assisted colleges like Sheridan are often a path to a new career and a new life in Canada. Many of our graduates earn work permits and, eventually, Canadian residency.

Internationally trained immigrants also come to us for upskilling through micro-credentials so that they can meet the requirements of Canadian employers, but far too many fall through the cracks. The key pitfall is the lack of consistent and accurate information being provided to individuals in their country of origin by unregulated and often unscrupulous agents before they arrive in Canada.

I urge this committee to engage public colleges to be part of the solution in strengthening the channels of communication for prospective visa applicants, whether they're students or skilled immigrants.

Another area of great stress for graduates who are preparing to enter the health care workforce is housing. Our campuses are located in cities where housing affordability is a huge concern for most people. Solutions that are being discussed have often ignored the student population. Whether they're an international student or a domestic student, limited supply of on-campus and near-campus housing that's safe and soaring rents in suburban neighbourhoods are causing many to live in crowded, unsafe rental units.

At Sheridan, we want to address housing affordability for students, whether they choose to live on campus or off. While we'd like to be able to afford more options, building and operating new units in the GTA is not financially viable for us without government support. Therefore, we ask that post-secondary institutions be made eligible for capital grants under the housing accelerator fund.

Finally, we need to address the critical supports that students need as they transition to the workforce postgraduation. Whether a student is international or domestic, we need to provide the same level of enriched education in theory and applied practices. Both international and domestic students graduating from our programs are ready to help meet the demand for skills in the workplace, and those workplaces, like the health care sector, urgently need them. The federal government can help here by accelerating their careers, making all international students enrolled at accredited post-secondary institutions eligible for the Canada summer jobs program, for example. Doing that would address gaps and needs in local labour markets, it would provide international students with the critical Canadian work experience they need, it would help them build their path to residency in Canada, and they would be fairly compensated for their work placements.

Let me assure you, from what I've seen from our international student learners, they're precisely the kinds of citizens Canada needs to help strengthen our social fabric and our health workforce. Sheridan is hosting a summit on the international student experience later this summer, open to residents, students, post-secondaries, policy-makers at all levels of government and more. We would be happy to share the recommendations from that summit with the committee.

Thank you so much to the House of Commons Standing Committee on Health for inviting me to provide this deputation today. I applaud you for all of the tremendous work you're doing to improve the lives of all Canadians. I'd be happy to answer any questions.

● (1620)

The Chair: Thank you, Dr. Morrison.

We're going to proceed directly to questions now, starting with the Conservatives.

Mr. Lake, you have six minutes.

Hon. Mike Lake (Edmonton—Wetaskiwin, CPC): Thank you.

Thank you all for taking the time to share your experience with us.

I'm going to start with Santanna and Montana. First of all, there is probably a joke in there about my daughter being a big fan about 12 years ago. As I think about my daughter, who is 22 now and in her first year of law school, I see the pressure that she's under. It's hard when I'm trying to figure out what advice to give her about how much of the pressure is a kind of good pressure and how much of it is too much pressure. At times, it can absolutely be overwhelming, and it's clearly too much pressure.

To what extent is the pressure early on in residency in medical school seen as part of the preparation for the future? Where is that line in that amount of pressure?

Ms. Santanna Hernandez: You raise an incredibly important point that we face as medical learners.

One thing that academia does a really great job of is adding things without ever evaluating whether or not we need to continue to keep some of the things that are still pieces of the puzzle.

What we've seen in medical education over the past many decades is our understanding in science. We continue to make new advancements in health care and in how we can provide that care, and we never look at the scope of practice for what we're trying to achieve.

As Dr. Peachey mentioned, we need to really re-evaluate the amount of time that we're spending on things and the things that we're prioritizing. A key thing we see in the way we've done our evaluations is that some of the details we're trying to look at don't necessarily achieve what we need to do. For instance, they integrate antibiotics or pharmacology into our curriculum, but as we know, pharmacology is always changing. The research is always changing. There are a multitude of apps that give us that information at the drop of a hat.

Is this where we need to be spending our time, or do we need to be developing these skills about how to provide patient-centred care in a good way?

When we're thinking about the pressures being put onto us, it comes down to the evaluations and the level of content that we're trying to deliver, but also the pressures and the experiences of those who are teaching us. They're under their own burdens as health care providers in this system. When something like the pandemic is happening, it is just an added layer on top of their responsibilities to provide the training for future health care providers and to continue to support the health care system that is needed to ensure we are successful and we have healthy Canadians.

Hon. Mike Lake: I'm going to jump in. You mentioned Dr. Peachey and the patient-centred care.

Dr. Peachey, you brought up something that made me write a quick note here, which I want you to explain further.

It seems that you were saying our system has been a provider-based system up until now and it needs to change. Can you elaborate on that a little bit?

Dr. David Peachey: Thank you.

Over the years, without calling it provider-centric care, it has clearly been provider-centric care. That is because of the nature of how health systems evolve through looking for evidence.

I go back to wise words of Steven Lewis from Saskatchewan, many years ago. He asked two questions. He asked how you would know if you're giving patient-centred care and how you would know if you were receiving patient-centred care.

One of the themes that comes out of that—and has certainly been perpetuated through the work we've done—is that, at the end of the day, you have to ask this: If it's not being done for the patient, why is it being done at all?

I think that's the transition that must go forward.

It's interesting because in the sort of work we do, we often come against resistance in the early stages, but as it goes on, people embrace and welcome change and, in fact, carry change forward.

● (1625)

Hon. Mike Lake: Dr. Gratzer, I'm going to come to you next and ask if you want to elaborate on that or anything else that you heard because you went first in the testimony and then all the other witnesses went.

I don't know if there's anything you want to specifically zero in on, or if you want to address the question about the pressure and how much of that is part of the preparation.

Dr. David Gratzer: Maybe I'll do all of the above, briefly.

There has been a certain common theme running through the different testimonies about how the nature of pressure has changed with regard to health care. There's more information to know than ever before. That's a good thing. We're able to help patients in ways that we weren't able to help them five or 10 years ago.

There are higher expectations as the consumer revolution that has transformed other aspects of the economy now transforms the health care sector.

With it then comes the challenge of balancing out what we want of our health care workers and what we can reasonably expect of them. I think when we talk about physicians—and of course physicians aren't the only health care workers—things become even more challenging because we've been taught for so long that we shouldn't get ill, we should simply muddle along and so on, as though physicians were somehow no longer human and above that.

When we think about what we want in a health care workforce, I think we need to balance these things out and also recognize that while COVID will come and go, health care has fundamentally changed. I think for a moment of the way people practised in the 1970s, when *Marcus Welby, M.D.* was the most popular TV show in North America. Roughly one in four households tuned in to this American show. If somebody had a heart attack, Marcus Welby would suggest bed rest because there wasn't really that much else to be done. Certainly, one didn't read a lot of papers in order to prescribe four or six weeks worth of bed rest.

Today, of course, we have clot-busting materials. There is good evidence that antidepressants for people at risk would help in the post-MI era. All these things come together.

What am I driving at? There has been a common theme of recognition of burning out and mental health disorders, but also a common place for us to need to find innovative solutions as well.

The Chair: Thank you very much.

Mr. van Koeverden, you have six minutes, please.

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

Last week ministers Duclos and Khera co-announced $379 million for the safe long-term care fund. Standards have been released and much progress has been made. The challenge that persists is workforce-related, and that's something we need to address. The feedback we've received so far will guide us in those deliberations. I thank everybody who came today to provide us with that insight.

My question will be brief, but I'd like to be able to get to more than one witness. I have only five and a half minutes remaining.

I would ask you, Dr. Morrison, with a shout-out to Halton—I grew up really close to Sheridan College—if you could answer this question first and then provide enough time for others to tune in as well. My question is related to the qualifications for foreign-trained and -educated medical professionals in this country. In looking for solutions to attract more talent in the upstream for students who are currently in high school or are perhaps doing an undergraduate degree, it's good to address this problem years and decades from now, but we have a challenge right now. I know that in my diverse community of Milton, we have a lot of people who are qualified to be physicians' assistants, doctors, nurses and personal support care workers who are doing other jobs. They're far more qualified than that.

How can the Ontario but also cross-Canada post-secondary network assist us in training up foreign-trained medical professionals to ensure that we can address this challenge now?

Ms. Janet Morrison: Thank you for your leadership and community presence. You're certainly well known across our campuses.

You know, access is a complicated puzzle. I would suggest to you that we have to make it financially viable for learners. We have to think about the red tape. We have to think about regulatory processes in particular. Particularly for learners for whom English is not their language of origin, the obstacles in terms of the service they can provide and the multilingual capacity they have to deliver in communities, particularly across the GTA, are huge, but we have to figure out how to reduce obstacles to those learners being trained locally. You need to deliver at night. You need to deliver on weekends. You need to provide English-language supports, particularly in areas of pharmacology, for example. If you still need to study that, think about studying it in a second or a third language.

I think there are lots of opportunities. We need to be purposeful and we need to think in very broad terms about access. This is low-hanging fruit that I think we can better deliver on.

● (1630)

Mr. Adam van Koeverden: Thank you, Dr. Morrison.

President Hernandez, I saw you nodding along quite a lot. Can I ask you if you have some ideas to share?

Ms. Santanna Hernandez: Yes. Absolutely.

Prior to my medical education, I did a lot of work in my undergraduate degree in the province of B.C. through the BC Federation of Students. One of the big surveys and studies we did was around fairness for international students. I met with students on a regular basis who had the exact training that you talked about but were unable to make that next step in bringing those qualifications forward.

I think some key things need to be looked at within immigration policy. Oftentimes, we bring them here and we train them in certain fields, but when it comes to getting the immigration points that they need to be able to transition, they have higher immigration points by being a manager at McDonald's than they would by being a teller at a bank or a health care aide or some of these other components. The way the immigration scale works in order to give them those points to become Canadian citizens is more fruitful in other areas.

The other thing we could do is work with our post-secondary partners to create bridging programs that build in some of that English-language competency but also transitions them to meet the accreditation standards we have within our programs that theirs may be missing. There are some differences in care that we are learning, but there are some really practical solutions. We have leaders across this country in both undergraduate and medical education who want to see this work come forward. Unfortunately, if we do this work, we don't necessarily have the ability to implement it without some changes taken by the federal government to ensure that we can do that in a good way.

Mr. Adam van Koeverden: Thank you, President Hernandez; and thank you for your years of work in this field.

With about one minute and 20 seconds remaining, are there any other witnesses who have strong feelings they could share about foreign credentials qualifications...or if the feelings are not strong? They can be medium feelings as well.

Dr. Arjun Sahgal: I would just say it's very important to bring in the appropriate professionals, but it's not necessarily just about bringing them in and them going into the workforce. We have to have a system that can train them so that no matter where they are, patients and communities are receiving the same level of care as if it was a trained physician as a Canadian, going through the Canadian medical system. There are differences. We do see systems where patients are underserviced because of the lack of training of the professionals.

If you want a system where we bring in more health care professionals, which we need absolutely, it has to balance out with the increased training that's provided to them so that we're all at relatively the same standard of care.

Mr. Adam van Koeverden: Thank you very much.

I'll cede the remaining time to the chair.

The Chair: Thank you, Mr. van Koeverden.

[*Translation*]

Go ahead, Mr. Garon. You have six minutes.

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

I'd like to thank all the witnesses for their very informative testimonies.

Dr. Boucher, what's interesting is that we're in Ottawa, the seat of the federal government, which does not manage hospitals or the health care system. The federal government has no functional jurisdiction over the management of health care services. You talked about increasing the Canada health transfer, or CHT. This is an additional unconditional transfer that would be paid to Quebec and the provinces.

There is a great need for doctors, especially in the remote areas of Quebec. How would a significant increase in the CHT help you to promote the profession of general practitioner?

Dr. Anne-Louise Boucher: Thank you for the question.

Let me mention one important element, and that is transfers within medical schools. In a way that varies from faculty to faculty, the undergraduate curriculum exposes students to family medicine in different areas of practice and in different regions of Quebec, whether they are in remote or intermediate regions. If universities had the funds to systematically include introductory family medicine internships in their curricula, all students could be exposed to family medicine at the undergraduate level.

The broad outlines of the curricula are common to the four faculties of medicine in Quebec, but there are still some differences with respect to certain internships, particularly with respect to exposure to family medicine. This may contribute to the fact that exposure to different models of family medicine is not optimal.

● (1635)

Mr. Jean-Denis Garon: What you're telling us is that decentralization and significant regional factors interfere with the type of training of family doctors, and that essentially, it's the people on the ground and the provinces who are best positioned to put in place training that meets the needs.

Is that it?

Dr. Anne-Louise Boucher: Yes, that's exactly it.

Medical schools have the power to develop elements of their curriculum. It's important to understand that before the selection and matching of family medicine or specialty medicine residents, doctors don't make their choice in the last two or three months of their undergraduate training. They do it several months before that.

These programs sometimes require more funding because there must be family doctors and settings available to receive them. Second, you have to get out of the hospitals if you want family doctors to gain experience in primary care and not limit their training to the hospital setting. You need to think outside the box. Of course, there's a certain cost to that, because it takes infrastructure, staff and family doctors. They need to free up or at least adapt their patient care duties to mentor learners.

Mr. Jean-Denis Garon: Thank you, Dr. Boucher.

During the pandemic, the federal government had to make emergency injections of over $30 billion into provincial health systems. The Minister of Health has bragged a lot about this, by the way. Now there is offloading, surgeries have had to be postponed, and a one-time amount of $2 billion is being offered to the provinces and Quebec. From what I understand, the situation in the hospitals is critical. You say that the lack of training in family medicine could have negative consequences for 30 years.

How does this approach of making conditional, one-time and poorly planned transfers without having a long-term vision prevent us from training family doctors to help people on the ground?

Dr. Anne-Louise Boucher: We are still facing this crisis. Even though the pandemic is running out of steam again, there is still some catching up to do not in terms of providing care, but also in terms of making the environment attractive for caregivers and learners.

One-time transfers allow us to catch up, but we need to take a medium- and long-term view. When a family medicine position is left vacant, it represents 30 to 35 years of reduced access to primary care in Quebec. If you multiply that by 1,000, I'll let you do the math on how many people won't have access to care. If they do have access, the delays won't always be acceptable.

Mr. Jean-Denis Garon: Dr. Boucher, the Bloc Québécois and others had suggested holding a national summit on health care, where stakeholders could have discussed these issues on the ground directly with the Prime Minister, directly with Ottawa. I know that Dr. Amyot, your president, has been supportive of this approach.

Why is it important to make Ottawa aware that it is the people working on the ground who are best placed to understand the reality of the environment?

Dr. Anne-Louise Boucher: Canada is a very large country. Each province, each region, has its own reality. When broad pan-Canadian principles are established for the quality or direction of health care, applicability on the ground becomes a major issue, whether it's in the provinces or in the regions. They are in the best position to know the reality on the ground and the local or regional characteristics based on the type of population, ethnicities, urban realities versus the reality of intermediate and remote regions.

Canada certainly has a role to play in establishing principles of equity, basic care and access to free health care, but their applicability needs to be assessed by people on the ground. There are too many different realities from coast to coast. You can't have a one-size-fits-all rule.

● (1640)

The Chair: Thank you, Dr. Boucher and Mr. Garon.

[*English*]

Next is Mr. Davies, please, for six minutes.

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

Ms. Hernandez and Mr. Hackett, I'd like to address some questions to you first.

It's infamous now that Canada has a shortage of family physicians. The last number I saw was some five million Canadians who don't have access to a primary care physician, which is pretty shocking for a country that claims to have public, universal access to medicare.

Can you give us a bit of a snapshot, representing medical students and the next generation of doctors? What is the feeling in medical schools among your colleagues about whether they are going to go into family medicine? If not, what are some of the reasons that your colleagues don't go into family medicine?

Mr. Montana Hackett: I can speak to that. It's a fantastic question.

I am someone who wants to go into family medicine, so maybe I'll be biased towards this. Santanna is as well.

It's a very good question and something that, as we've been talking about, is very specific to the region and to the people who are entering medical school. The conversations around career prospects at medical schools are that you very much need to find the thing that is going to bring you the most joy and the thing that you're going to be the best at. Ultimately, being a physician, and different types of physician, is a very personal thing.

Ultimately, medical schools are about teaching us to be generalists. We graduate having all of the core competencies to be a physician from a generalist perspective, but the way we've seen care change over the last 20 or 30 years is that because of the quality of care and the expansive nature of health care specialists, more and more hyperspecializations are required.

At the same time, you mentioned that family medicine is deeply needed in this country. As someone who is currently on his clinical rotations, this is something that I see quite consistently. It's immeasurable how many people come in the emergency department or the hospital who do not have a family physician. The impact on them—not only from systemic factors, but also preventative medicine in terms of being able to access care—is quite devastating for those individual patients.

From a medical student perspective, it's something that we all have to consider that we need as individuals and that the populations we're trying to serve need as well.

Ms. Santanna Hernandez: Unfortunately, there is this hidden curriculum within our educational agenda that we are taught by subspecialists. A big part of that comes from how compensation of our preceptors is given.

One thing we hear from our folks in Quebec, from the FMEQ, the student organization that represents the Quebec students, is that our family physicians are actually not compensated the same way as the specialty positions are in the province of Quebec, so there's less incentive for them to be part of teaching us. If we're not being taught by family doctors, how are we supposed to get excited? How are we supposed to get students excited about wanting to be family physicians?

As someone who loves family medicine, it's the only thing I've ever wanted to do, and as a military medical student I'm fortunate enough that I get to continue on that pathway. However, we need to support our physicians to be able to teach us, to get us excited about it. That's what we're not seeing, the support of our physicians who are out on the floor who are our educators.

Mr. Don Davies: Thank you.

Switching more to the residency, Mr. Hackett, I think you talked about this.

I'm curious about how many graduates, approximately, from Canadian medical schools do not match a Canadian residency position and are therefore unable to practise as physicians in that area.

Mr. Montana Hackett: If you want to explore that question, you can ask Santanna.

● (1645)

Ms. Santanna Hernandez: Yes. As somebody who sits on those committees, I probably have more numbers at the top of my head.

Mr. Don Davies: Please, Ms. Hernandez. I thought it was Mr. Hackett who raised it.

Ms. Santanna Hernandez: Yes, he definitely raised the point.

On average recently, we've seen about 70 medical students a year go unmatched after the second iteration. Oftentimes we have many family medicine seats that are available, especially in the province of Quebec. They do a better job of making more seats available.

Oftentimes this becomes a political issue. As you might see in the province of Alberta, our physicians don't actually have a contract, so there is a lot of variation in what their compensation can look like. That definitely has an impact on people wanting to match to family medicine here in Alberta. This year, 26% of our family medicine seats went unmatched at the University of Calgary, which is the highest we've seen.

As somebody who wants to match here in the province of Alberta, because my family is here and my ancestry is from the Cold Lake First Nation up in northern Alberta, I would love to be able to stay here and practise here in my province. Unfortunately, there is a political aspect to medicine, as you see here as we're representing to you today, because there are political pieces that support our ongoing success and governments decide residency spots. Therefore, we need to work with them to develop programs that have seats for students, to be able to continue to train them.

Mr. Don Davies: Mr. Chair, do I have any time left?

The Chair: You have about a half minute.

Mr. Don Davies: Just quickly, then, Ms. Hernandez, you mentioned coming from a rural area. We know that Canada already lags behind the other member countries in the OECD in numbers of physicians per thousand, but that's particularly acute in Canada's large rural areas. Despite 19% of Canadians living in rural areas, they're served by only 8% of physicians.

Are there any suggestions you might give us about how we can attract young medical students to practise in underserved or rural areas?

Ms. Santanna Hernandez: As somebody who had to travel 27 hours to deliver my third child because I lived in Fort Nelson, B.C., at the time, I think a key piece of that is giving rural communities access to the resources they need to provide care. I had to travel to Burnaby to deliver my child because that was the only place I could afford to stay with family.

If we had access to resources there such as anaesthesia, ultrasound and things like that....

I had to travel four hours for my ultrasound.

Doctors don't necessarily want to provide care where they don't have the resources to provide care to their patients. They constantly feel like they're failing those individuals because they can't do things in an adequate timeline and have to depend on urban partners to desperately take some of their patients in a reactive manner instead of a proactive manner.

Mr. Don Davies: Mr. Chair, maybe the record can reflect Mr. Hackett's enthusiastic head nodding.

Mr. Montana Hackett: Yes, very enthusiastic head nodding. Thank you.

The Chair: Actually, I'm glad you got that last question in. That was an extremely good exchange, very valuable to us. Thank you both.

Next will be Dr. Ellis, please. You have five minutes.

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

Certainly as someone who was a family doctor for 26 years and has been intimately involved with this system from a matter of all aspects of family medicine, this is an opportunity that's near and dear to my own heart.

The real premise for me is that I'm not entirely certain the Canadian population understands the precipice at which we all sit as Canadian citizens, with the looming disaster, and that frightens me.

That said, Dr. Gratzer, you talked a lot about physician burnout, perhaps half of physicians being burned out at the current time.

It's a gross generalization, but if physicians are going to recover from burnout, could you maybe, in a brief amount of time, tell us how that might happen, and how long does it take if it happens?

Dr. David Gratzer: Every individual is different and everyone's experience is different, but we do see over the last decade the literature growing much more thoughtful and mature, which is a fancy way of saying other people are looking for answers and I think there are some.

They include, first of all, a culture of wellness making it possible for physicians to get care and get timely care and making it acceptable for physicians to want that. We see as well that empowerment can be useful. While I am very grateful to be a physician, like others have commented today there are incredible frustrations including some very modern frustrations with regard to electronic medical records and the like. Addressing that sometimes with very simple steps can be useful.

Of course, one can also think about ways of physicians supporting each other just like other health care workers. One thinks about peer support and the like.

What I'm driving at is that while burnout is a very common phenomenon, there are very reasonable steps one can take to address it. The key is to do that, and to move away from the thinking of not so long ago across North America and across the west, which is doctors don't get sick and we don't need to worry about doctors getting sick.

We spent an enormous amount of time today talking about how to get more people in the health care workforce, very reasonable conversations, and they impress upon us the importance of retaining those individuals, and making sure that they work in an effective and efficacious manner as well.

● (1650)

Mr. Stephen Ellis: Great. Thank you for that. I appreciate it.

Through you, Mr. Chair, to Dr. Sahgal, you are certainly working in a very subspecialized area of brain and spine radiation treatment. How are we going to catch up with respect to the numbers of physicians we're short?

You talked about electronic medical records and reduction of administrative work, but also we need more people to do the work. How are we going to get them quickly into the Canadian system?

Dr. Arjun Sahgal: I will say one thing we have noted during the pandemic as a result of the delays is that cancers are much more advanced than they ever were before. The things we see are horrendous and we never saw those.

We're all trying to work to catch up. The hours are really quite long and we need more staff. Part of it is not just to hire more staff but actually have the hospitals allow for those staff to work.

This is what happens. A certain number of physicians can do a certain amount of work, but now we don't have the nurses or the clerical support. The hospitals try to reduce their budgets by reducing the amount of help that is given to the physicians and to the allied health force, and that increases our burden. The burden is always on us because we are not employees of the hospital but our own individuals working within the hospital care.

At the end of the day we do need to increase the number of physicians to combat the burden, but the system has to ensure that they give us the levels of support to work because, as was mentioned before, we do everything that we do but we don't have the support now to fulfill our mandate of caring for patients.

Mr. Stephen Ellis: I appreciate it.

We have about 30 seconds left.

Mr. Hackett, you made one comment I thought was interesting. You said it was a landmark year for all the wrong reasons. Notwithstanding COVID, I assume you were talking about something else. Perhaps you could enlighten us on that.

Mr. Montana Hackett: Yes, absolutely.

It was in regard to the point about unmatched graduates in our country. That is a significant piece of burnout for students.

Imagine going through all of the necessary stages to get into medical school, being in the single digits of people who get in, and then going through medical school learning everything you need to know, getting your clinical rotations finished, building an application to apply to the position you want to serve your community within, and then not getting it, not being matched at all to anything.

I cannot even begin to describe to you how traumatic that is for people. Santanna and I have talked to numerous students this year in particular who have gone through this and it is a humongous source of burnout for students in the medical profession. Obviously, it's a waste of resources when it comes to these are people who are trained doctors at that point who are not getting into the system.

The Chair: Thank you, Mr. Hackett, and Dr. Ellis.

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

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

Thank you to all the witnesses for being with us.

My first question is for Dr. Sahgal. Thank you for the hard work you do at Sunnybrook. I just want to echo my colleagues.

Many families have been coping with delays in surgeries and cancer screening. Postpandemic, we are expecting to see an increased rate of cancer. With the recent federal investment of $2 billion to tackle this issue.... Off the top, what recommendation do you have?

You also said that to combat this burden.... What do you think? How fast can we increase the resources? What kinds of resources can we provide?

Dr. Arjun Sahgal: Thank you very much, MP Sidhu.

I think one issue is the ICU beds. We definitely have to increase the ICU capacity and then the surgeries can happen. Alongside the increase in ICU capacity, we need the staffing. That's where we're starting to fail. We don't have the nurses and the staff to manage the patients post-surgery. It's a very delicate balance right now.

I would just impress upon the committee overall that the disparity in various health systems to allow for budgets for clerical and nursing staff to try to manage the pressures that are on the hospital system is not necessarily helping the backlog of COVID cases. That's where cancer patients are suffering. It's harder for us to get tests when we know we need them. It's harder for us to get surgeries. We don't have nursing supports the way we used to. Again, we're being overloaded with the administrative tasks.

Whatever transfer payment comes, if you can ensure that certain amounts are there to allow for those services so that we can do our jobs, that would be very positive for the burnout rate.

● (1655)

Ms. Sonia Sidhu: Thank you.

The next question is for Dr. Morrison.

Dr. Morrison, thank you for your leadership.

We heard a lot in these meetings about foreign-trained health care workers not having their training and credentials recognized. What role would you like to see colleges playing in resolving this issue and ensuring skilled professionals are in the right jobs?

Ms. Janet Morrison: When we hosted the health care summit at Sheridan in late January—that was a convened round table, as I said—I was quite impressed by the discussion and the solutions. They're not particularly mind-blowing. The problem is one of talent. We heard that it is one of scope of practice and ensuring that the full scope of professional practice is duly leveraged. It is about model of care—the right care at the right time and the right place.

A lot of the solutions that came to the table from partners focused on many of the themes we've talked about today, such as collaboration, the use of technology, outreach to underserved communities and the use of data to inform where we're going and what needs to happen.

I'm compelled to just underscore that I've worked in medical education for about half of my post-secondary career. The challenges of ensuring that we have the right talent in ancillary services to position physicians and more specialized talent to do their jobs is critical. An absence of focus on PSWs, practical nurses and administrative medical support staff.... I think that deserves our focused attention right now.

Ms. Sonia Sidhu: Thank you.

You mentioned the idea of future-proofing ourselves against the next pandemic by focusing on chronic disease. As you know, many chronic diseases are a huge concern in many communities across Canada, including Peel region.

How can government promote the role of the post-secondary education sector to help meet our shared goals?

Ms. Janet Morrison: That's a great question.

I'm always taken aback when I hear some of the data in this space. You and I are very conversant with the facts that half of adult residents in Peel report living with a chronic health condition, that South Asians in particular are 15% to 20% more likely to develop diabetes and that the diabetes risk amongst Black women has skyrocketed over recent years.

There is programming within the post-secondary sector at both the college and the university level that's really focused on education and awareness campaigns, on adjusting perspective but also lifestyle. Across the continuum of care, we need to get people moving. We need to support people in exercising. Our programs in kinesiology, athletic therapy and osteopathy, for example, are all really intended to support residents before they're diagnosed with chronicity, or certainly afterwards.

I think that colleges, institutes, polytechnics and universities can work collaboratively to make sure we have the right talent to be proactive and upstream in resourcing the system—hopefully, before it becomes overburdened.

● (1700)

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

[*Translation*]

Go ahead, Mr. Garon. You have two and a half minutes.

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

Dr. Boucher, the Canada health transfer used to account for 35% of the costs of the system. This percentage has decreased to 22%, and it will decrease further to 18%.

I grew up in a small town near Senneterre, Abitibi. Today, people no longer have access to a family doctor, and the hospital is closed. They no longer have access to delivery rooms. In fact, access to health services is very difficult for families.

In your opinion, if the Canada health transfer were restored to a level that would cover 35% of the system's costs, what would the impact be in terms of actual services for Quebec families living in the regions?

Dr. Anne-Louise Boucher: That's an excellent question.

I think we will have to be imaginative, because investing money won't necessarily make it possible to get the necessary labour. However, it could facilitate continuing education, as Ms. Morrison mentioned.

There are also other factors to consider. We are in the 21st century, and we must adopt modern ways of doing things.

I am thinking in particular of telemedicine and networking. Doctors can travel to the regions, but the structure of the health care system must allow citizens to have access to care and specialists. We can't ask a number of specialists to move to Abitibi or to sparsely populated areas, because they won't be able to keep their skills up to date if they aren't exposed to certain cases.

However, online medical consultations as well as telemedicine networking and access to specialists by telephone, both for doctor-patient consultations and for doctor-to-doctor consultations, are factors that would improve service delivery in rural and remote areas.

However, there are costs associated with that. An increase in health transfers to the provinces would allow for better access in all regions, while taking into account workforce needs. You don't create the workforce, and you can't multiply the existing workforce. However, new doctors can be trained through programs. The problem of workforce shortage isn't only in the health care sector, but also in many other areas.

We need to have systems that allow access to health care. At least we need to have support for health care professionals, specialists and other stakeholders.

Through modern computer, technological or robotic means, doctors can perform remote auscultation, ultrasound, medical manipulation and surgery. However, it's important to bear in mind the costs of these new ways of doing things. This would require, among other things, an increase in health transfers.

The Chair: Thank you, Dr. Boucher and Mr. Garon.

[*English*]

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

Mr. Don Davies: Thank you.

Dr. Peachey, we've heard from various witnesses before this committee that in Canada we appear to be drowning in data, but we don't seem to be able to marshal it on a national scale when it comes to managing the health care professional human resource crisis in this country.

Do you have any insights or advice to give this committee on how we can better use data to more efficiently deal with this issue?

Dr. David Peachey: I think the issue is this: there are really good data out there, but, as you indicated, the data frequently don't get used. Sometimes the data holders are not aware of how good their data are. As data start to get used, people start to get excited about them.

On the question about where we go from here and how the data are used, I think you can look at it in a variety of ways. Go back to the patient-centric care question that came up earlier. The data would suggest, by all sorts of parameters, that it simply isn't happening. The reality is, when we started this several years ago, we only did physician resource plans, until we realized that just perpetuates the medical model. Now we turn down physician resource plans and only do clinical and preventative services plans, and 50% of that work—it takes six to nine months at the start of a project—is based on acquiring and looking at the data. It's not purely a metric exercise, because you have to have a qualitative component, as well.

The data are generally better than most people think. They're just not being used. You can say that about services planning or how we analyze physician compensation. It goes everywhere. You're absolutely right. The data are sitting there almost begging to be used.

● (1705)

Mr. Don Davies: You've probably seen a bit of the problem we face. Some people are fixated on health care being delivered provincially, but, of course, the federal government plays a role in this. It's almost like squeezing a balloon with water in it. If we fix a human resource issue in one part of the country, we could end up affecting another.

What's the role of the federal government in coordinating a national approach to addressing this issue?

The Chair: Please answer as succinctly as you can.

Dr. David Peachey: I think the approach is to undertake the analyses required to use a single methodology across jurisdictions. Using that single methodology would enable us to bring the information together and start to look at it nationally. As long as we have 13 autonomous health care systems, that's not going to happen.

The Chair: Thank you, Dr. Davies.

Next, we have Ms. Goodridge for five minutes.

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

Thank you to the witnesses for their testimony today. It's always spectacular to have such a different perspective on some of these issues.

I don't see Ms. Hernandez on the screen. I think she might have dropped off, which is unfortunate. I was going to plug—and perhaps, Montana, you can share this with her—the brand new hospital on the 4 Wing Cold Lake base. If that's something she is interested in, we have an amazing brand new health centre on the 4 Wing base. I would love to have her come back a bit closer to home.

You were talking about the residency seats, and about how so many residencies go unfilled. My riding is Fort McMurray—Cold Lake. I have a lot of rural, northern and isolated communities. We would absolutely love to have residents learning first-hand in our communities. I know there are some challenges with that.

Have you any thoughts on how we could improve and increase the number of residents in some of these rural communities?

Mr. Montana Hackett: Absolutely, and, yes, Santanna had to step out. She actually had to get to another space to talk about this exact issue.

When it comes to engaging residents and medical students in more rural areas, ultimately if you look at it from the perspective of “as early up in the pipeline as possible”, of course, the best way to recruit people to a region is to recruit the people from that region, so the opportunities for people from rural locations to matriculate into medical school has to be looked at.

From the perspective of the federal government, that's about lowering the barrier in terms of cost, in terms of opportunity for people from that region to get the required education to be able to apply and then get in. We've seen medical school admissions start to look at this, but upstream there need to be much more work on this as well.

In terms of getting current residents in these spaces, ultimately it's about investing in having the education available in those spaces.

Santanna mentioned one of the big things about rural medicine is they are quite often playing short-handed in that they don't have the same resources. For example, I did one of my clinical rotations up in Wiarton, which is not too rural compared to places in northern Ontario, but there were still decisions we had to make in management where we didn't, for example, have a CT scanner that we could use immediately, or all of the things in blood work that we can normally do.

Making these places more attractive for physicians of different stripes by making sure these resources are available to them is one piece, and also partnering with the medical schools and investing in more spots maybe in those places would be one fantastic thing to do as well. Ultimately, they are trying to allocate spots in the residencies the best that can based on the regions that they occupy. At the end of the day, we only have so many medical schools and only fewer spots.

Those are a couple of things we can do.

● (1710)

Mrs. Laila Goodridge: Fantastic.

I have heard from some of my friends who studied medicine that because the medical schools are in bigger centres, once students get used to the fact that you can visit any kind of restaurant at any time of the day, moving back to some of those rural communities becomes a little less attractive, but I'll put in a plug for my community that Fort McMurray has direct flights from Toronto so you can get home very regularly.

Dr. Sahgal, I saw you nodding along. Do you have anything you would like to add?

Dr. Arjun Sahgal: I would just say the point that was brought up was that equipping these rural communities with services so that physicians can do their jobs will reduce the stress on the physicians and that will improve burnout rates. We have to remember that if the system is not providing that CAT scan, it's still the physician who has the medical responsibility for the patient. If something goes wrong, it is not the hospital or the system that may be blamed, but we get blamed. It's not just a matter of a lawsuit. It's our own moral blame that we put on ourselves. That stress is something that most professionals don't really understand, when we couldn't get a test and a person died right in front of us.

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

Ms. Goodridge, you do an amazingly effective job of recruitment and selling your riding. Well done.

Mr. Jowhari, please, for five minutes.

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

Thank you to all the witnesses.

I'm going to start with Mr. Hackett. Many of us over the last hour or so have talked about the residency match. Can you briefly explain how the matching process works? How is it distributed among graduates from our own universities, internationally accredited individuals who come here, and a lot of my friends who go to the U.S. and get their medical degree and come back here and have to do the residency? Who sets these targets? How are these targets set? Who plays a role, from a government point of view, in setting up these targets? How can the federal government help?

Mr. Montana Hackett: I can absolutely answer the six questions, yes. I appreciate it.

When it comes to how the actual residency matching process works, essentially in our final year of medical school we go through an electives process where we choose specific locations and programs that we want to visit and rotate through. We accumulate the different pieces of our application and then submit a final rank order of our preferred programs in those specific locations and then apply to the places we want to apply to.

We then hopefully get interviews at those places, interview, then submit our final order of preference and then the programs also submit their final order of preference for candidates.

Those orders, as well as our applications, go to an organization called CaRMS, the Canadian Resident Matching Service. They do a great job of running an algorithm that matches the student and the program, based on those factors that I outlined.

When it comes to the role government plays—I believe that was the next part of your question, with how government—

Mr. Majid Jowhari: Your testimony indicated that it is the government that determines the number of spots. Which level of government makes that decision?

Mr. Montana Hackett: That is at the provincial government's discretion. Essentially how it works is there is supposed to be a health and human resources allocation for these spots where they look at the needs of the communities, the need for specific types of physicians in those places as well as predefined spots that determine the specialists, and those spots are then available to make application to.

Unfortunately, my understanding is that this doesn't happen as much as it needs to, so oftentimes we're applying to processes that are out of date, and the positions we're applying to are not necessarily ones that represent the need at that particular time. How government is implicated in that is through running that model but also funding the spots based on the needs of the community.

That is the provincial context, but, as was mentioned before, the federal government has to look at the needs of our pan-Canadian system in a way that the provincial governments can't always do in their own contexts, so that they're leading what we need as a country and giving the provinces the tools they can use to fill their specific needs based on the context that the federal government is working in.

● (1715)

Mr. Majid Jowhari: Thank you.

Would you recommend that the federal government tie some of its transfer funding to setting some of those targets specifically in support of the provinces opening up some of these slots?

Mr. Montana Hackett: It's a tricky question. I think, ultimately, it's something that should be looked at, but it also depends on how that's done. The provinces in and of themselves know their context best, or should, and they should be collaborating with the specific regions, the communities and the medical schools in those regions. At the end of the day, like I said, if there is an opportunity to establish some national priorities, and if those priorities have to be fulfilled by attaching that to a transfer, then I think that's something that should be looked into, but of course, the devil's in the details when it comes to something like that.

Mr. Majid Jowhari: With 30 seconds left, I'm going to quickly go to Dr. Sahgal.

Thank you very much for the great work that you and your team are doing at Sunnybrook. I have a very good friend, Dr. Pirouzmand, who is also at Sunnybrook.

You touched on technology, and I know you've been working on a newer technology, MR-Linac, which is supposed to expedite the process of imaging. Can you touch on that and say how it is going to help us clear some of those backlogs?

Dr. Arjun Sahgal: The MR-Linac technology was one we brought here as the first in Canada to try to gain a technological platform to reduce the number of treatments. Instead of six weeks of radiation, now we can do it in one week.

What's important here is how we got that technology. We had to raise money through philanthropy. We had government grants. We basically went to our hospital system and begged them for some money, and they were totally happy to provide innovative funding. It is a conjunction of philanthropy, government grants and hospital budget that brought it together. There are not that many places that can do it like Sunnybrook did, so although we did do something amazing here at Sunnybrook, it's not something that can necessarily be emulated all across the country, which is where the fairness comes in in terms of resource allocation.

The Chair: Thank you, Dr. Sahgal and Mr. Jowhari.

Next is Mr. Lake for five minutes, please.

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

This is a great meeting, and I wish I had a 10-hour round to ask questions right now.

We've been talking a lot about problems and challenges over multiple meetings on this, and I feel like sometimes we don't spend enough time talking about potential solutions, and I'm thinking a little bit about measurability and what success looks like.

Maybe I'll ask that as a fairly broad, open question starting with Dr. Gratzer. What might success look like? Can you give any examples of success?

Dr. David Gratzer: You have two questions here, and one is how we would measure it. I think that's an excellent question because, if we don't have metrics, how do we know if what we're doing is meaningful? I would suggest that, over time, national metrics on burnout would be appropriate, which would also bring accountability to the federal government and the provincial ones.

You're also asking where we can look for ideas and experimentation, and here's something important to consider when we think about burnout. We don't necessarily want to be too creative or too innovative; let's plagiarize ideas from our jurisdiction and other jurisdictions where they found innovative ways to help people, particularly physicians.

Again, I've touched on a couple of these things, and I don't want to use up all of your time, but communities of practice and finding ways for physicians to feel more efficient are good examples. Make it easier to access care as well, given the stigma, particularly within physician bodies, to accessing care.

Hon. Mike Lake: Dr. Sahgal, you talked about efficiency and I wrote down, tools to "let the doctors be doctors", which just seems like it was echoed throughout the conversation today.

What examples might you point to in that way? Where are the most egregious examples of doctors spending time on things that doctors shouldn't be spending time on?

• (1720)

Dr. Arjun Sahgal: I can tell you just even in terms of my own family life, as my wife works at Women's College where they have an electronic medical record system. She's up for hours just inputting patient medications, making sure she faxes the note to the appropriate physicians and typing in the fax numbers. Our system here at Sunnybrook is a bit different. We don't have that. We use various different strategies that are efficient so that I don't have to spend those four hours after my clinic doing administrative tasks.

If you could tie in part of the funding that gets allocated towards supporting the key initiative of electronic medical records, because it is a key initiative to improve the flow of communication in patient care all across the country, but make sure that there's budget within the system to help us manage the electronic medical records, this will be a huge positive development in the health care for patients across the country.

Hon. Mike Lake: I love the fact that when I talked about efficiency, you brought up your wife and sending faxes. That's awesome.

I was going to go to a different question, but I'm wondering, Dr. Morrison, because you were nodding along, if you have anything to add or if Dr. Peachey has anything to add.

Ms. Janet Morrison: I do think there are ways to measure what progress needs to be made and I'd go back to the internationally trained professionals. We have experience in IEP advancement, regulatory oversight and the reduction of red tape. We have that in non-health care environments—accounting comes immediately to mind. There are ways to measure that. How many are in the pipeline? How long is it taking? Again, this isn't rocket science. I think it's about concerted effort and about a shared sense of urgency nationally.

Dr. David Peachey: If I could add one thing to that, there are a lot of metrics that are very useful and they can be at an individual level across specialty or they can be geographic. One of my favourites is the ambulatory care sensitive condition rates, which are measures of people who are admitted to hospital who likely would not have been admitted to hospital if they had timely access to a primary care physician. It's a pretty good tool to say what's going on.

The Chair: Thank you, Dr. Peachey.

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

Mr. Brendan Hanley (Yukon, Lib.): Thank you very much. I feel very much like Mr. Lake. This has been excellent testimony from all around the table. It's hard to know where to focus one's five minutes.

I do think I will start with Dr. Sahgal.

I find that even though you are in a hyperspecialized practice, you spoke very eloquently about rural needs. We have almost a dichotomy between the need for super specialization, particularly in our modern age, but also the need for that broad spectrum of practice.

Particularly with our rural and remote lens, how can we best optimize that mix between broad generalists in medical practice and finely honed specialists?

Dr. Arjun Sahgal: I think it's new models of care that are important. I think we have to start to look for those ways in which we can balance the specialist being in the big city where we have all the tools to do our work but supporting the rural communities so that care can be delivered there.

The challenge is that we can only do so much and there's a lot of that work that is just part of being the physician but not necessarily remunerated, not necessarily as our physician remuneration but also to the hospital system remuneration. There are a lot of changes that need to be in place in order to do that outreach and maintain that outreach.

I'll give you a quick example of one of my particular areas, which is brain radio surgery, or focused radiation. We went out there on our own and taught all our communities—whether it was Kitchener, Kingston or going up north to Sudbury—and I did lectures with them and I tried to bring technology to them so that they could do the treatments there. When they need the help, we're here when it matters most. They can call in. They can reach me 24-7 and we'll do it, but not all places have physician champions. To foster that model so that rural Canadians have just the same level of access as they could right here takes a lot of work and effort and a new model of care.

• (1725)

Mr. Brendan Hanley: Thank you.

Dr. Peachey, as you may or may not remember, I was in Yukon as a practitioner when you did some extensive data work there that I think shed a lot of light on what the needs were. I wonder if you could talk about some examples of where that deep data search has really clarified the needs around provider mix and how we can really elevate that conversation around the country.

Dr. David Peachey: I'll give one example, of which there are many, and I would be very interested if Dr. Gratzer had a comment on it.

One thing we find constantly wherever we go is that mental health and addictions are a real problem, not in just the incidence and prevalence, but also, people who really need to see a psychiatrist often have unconscionable delays and with serious consequences. On the other hand, in terms of the number of people a psychiatrist perhaps needs to see, he or she doesn't have to see everybody who comes through the door just because of a referral.

In the model we took, we looked at the data on that and started to advocate this, I believe in Manitoba, to enhance the use of clinical psychologists not only in positioning in primary care offices, where a patient coming in who needs that sort of assessment can get it the same day, can just go to the next office. Similarly, clinical psychologists can be a filter for those patients who are referred to psychiatrists, and if the patient needs to be seen tomorrow, the patient gets seen tomorrow. If there can be a delay, you can delay it or you can go back to your family physician.

Whatever discipline in medicine you want to look at, the data that underpin those sorts of decisions can be extracted and they can be used.

Mr. Brendan Hanley: Thank you.

Mr. Chair, do I have any room for Dr. Gratzer to perhaps provide a brief follow-up comment in that regard?

The Chair: Go ahead, succinctly, please.

Dr. David Gratzer: I agree. We have to be smarter about who does what and when.

By the way, I also think that would contribute to better overall well-being if one sees cases that are more aligned with one's skill set as opposed to just anyone who was referred. In some ways, our health care system has not evolved much from the 1950s where a secretary calls a secretary and books an appointment to maybe being replaced by the fax machine, which isn't necessarily replaced by anything just yet, but I think these things are worth considering.

Studies show as an example that nurse practitioners might be able to do better histories than certain specialists, being more available and more thoughtful about detail. These things are good from a system point of view, but also good from a mental health perspective in terms of contributing to well-being.

I remember I worked at a clinic once where they often would ask me to see people who were interested in couples therapy. I had no issues with sitting down with such patients, but we didn't offer couples therapy. It was, in a sense, a waste of their hour to sit with me and talk about these things and it didn't make me feel any better either.

The Chair: Thank you, Dr. Hanley and Dr. Gratzer.

[*Translation*]

Mr. Garon, you have two and a half minutes.

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

Dr. Boucher, I'd first like to thank you for being with us today to share with us your expertise and present your perspective.

You are testifying today before Canadian Parliament's Standing Committee on Health. The people listening to you are parliamentarians who have the power to change things and the duty to improve the quality of life of Canadians and Quebeckers.

In closing, I'd like to know what message you'd like the members to take away from your time before the committee.

Dr. Anne-Louise Boucher: Thank you for the question.

Among the takeaways is the importance of supporting medical practice, which Dr. Sahgal mentioned often. There is no doubt that non-medical, administrative and manual tasks that could be performed in an automated manner must be performed by professionals other than doctors.

Next, technology must be harnessed to provide care to people in rural or remote areas. If this technology were available to specialized doctors who wanted to do telemedicine, it might also encourage students to go into family medicine. Family doctors will consider going to work in the regions if they know they will get support. They won't feel alone and helpless. One stakeholder also mentioned the fear of people complaining to the college.

I am convinced that people in the regions and provinces are more aware of local and regional needs than those who write centralized pan-Canadian guidelines. Of course, we need to have Canadian guidelines and directions, but we really have to leave it to the people in the regions, on the ground, to determine the needs.

● (1730)

Mr. Jean-Denis Garon: Thank you.

In closing, I take it from your brief that your organization is also calling for an increase in the Canada health transfer so that funding is unconditional, stable, predictable and sustainable.

Thank you very much for appearing before the committee.

The Chair: Thank you, Mr. Garon.

[*English*]

The last round of questions will come from Mr. Davies, please, for two and a half minutes.

Mr. Don Davies: Thanks.

Dr. Peachey, Wayne Gretzky famously said that the trick was to go where the puck was headed. I think the corollary to that is that it's important to know where we have come from in order to avoid problems from the past.

I note that in June 2010 this committee tabled a report entitled “Promoting Innovative Solutions to Health Human Resources Challenges.” In 2011, the federal government launched the health human resource strategy to “attract, prepare, deploy and retain highly skilled health care providers to give Canadians access to appropriate, timely, effective care now and in the future.” That was 11 years ago.

In addition to the federal role in providing funding for health care, the government also provides support to the federal/provincial/territorial committee on health workforce. In 2005, it launched the pan-Canadian health human resource strategy that—

[*Translation*]

Mr. Jean-Denis Garon: A point of order, Mr. Chair.

There is no interpretation.

The Chair: Thank you, Mr. Garon.

[*English*]

Mr. Clerk, can you check and see if this is something that we're going to be able to resolve fairly quickly? We're almost at the hour.

[*Translation*]

Mr. Jean-Denis Garon: The interpretation has been restored, Mr. Chair.

The Chair: Great.

[*English*]

Go ahead, Mr. Davies.

Mr. Don Davies: Thanks.

Dr. Peachey, for my francophone colleague, in June 2010 this committee tabled a report entitled “Promoting Innovative Solutions to Health Human Resources Challenges.” In 2011, 11 years ago, the federal government launched the health human resource strategy to “attract, prepare, deploy and retain highly skilled health care providers to give Canadians access to appropriate, timely, effective care now and in the future.” Seventeen years ago, in 2005, the federal government launched the pan-Canadian health human resource strategy.

Can you give us any insight as to why basically the last 15 years have been unsuccessful in our dealing with the issue of human resources in the health care sector? What advice would you have going forward to avoid the problems?

Dr. David Peachey: I expect the main reason is that there are complexities, as there always will be when it comes to dealing with people and energies, and determining supply and determining need. It can be expensive. The reports that you have listed have fundamentally not gone anywhere, which is why we're still dealing with these things today. I think at the same time there is an enthusiasm to make change and people are not afraid of change anymore.

One of the better committees I have been involved with is a committee on health workforce at Health Canada, which has really strong representation. They have been sideswiped by the pandemic, but their reporting line is to the Conference of Deputy Ministers of Health. I think when there's an opportunity for their voice to be heard, they have many things that can be said. If the CDM can grab it and run with it, then I think we will see change.

The Chair: Thank you, Dr. Peachey and Mr. Davies.

That concludes the time we have for questions, but I would ask my colleagues not to run off. We're going to thank our witnesses and then there are a couple of administrative matters I want to deal with very quickly.

To all of our witnesses, as has been said several times in this session, this has been an extremely thoughtful and informative discussion. We very much appreciate the way you have handled the questions, the depth of your experience and your willingness to share that with us. We are rapidly approaching the end of the witness testimony part of this study. As a couple of my colleagues have indicated, we could do this for another 10 hours, as every time you peel back the layer of the onion, there's something else there. Thanks again for being with us and for a very productive and interesting meeting.

Colleagues, there are two matters I want to raise with you. One, the committee has passed a motion with respect to the 988 suicide prevention line. The passage of that motion is on the record. Therefore, we are now in a position to receive briefs from the public, but we haven't done what we usually do, which is to specify a limit on those briefs. Traditionally our limit is 2,000 words. Is it okay with everyone if we let it be known that the limit for any briefs to be submitted with respect to that item is 2,000 words?

Mr. Barrett.

● (1735)

Mr. Michael Barrett (Leeds—Grenville—Thousand Islands and Rideau Lakes, CPC): Thanks, Mr. Chair.

I would defer to the analysts, based on the limited amount of time that we have. If your recommendation is informed by the same, we support that. There's not a ton of runway before the end of June and there are lots of reports being prepared concurrently.

The Chair: That's exactly where the suggestion came from, Mr. Barrett. That's why I put it out there.

Do we have consensus in the room?

Mr. Majid Jowhari: Yes.

The Chair: Thank you.

I have mentioned the last item, but I want to put this to bed. We are being visited by a delegation of Finnish parliamentarians on May 11. They have asked to speak with the human resources committee and the health committee for one hour on May 11. Even if it's by a show of hands, I want you to indicate whether you would be willing to give an hour, either at noon or 1 p.m., on May 11 to have a chat with the delegation of parliamentarians from Finland.

Lunch will be provided. This won't be a formal meeting of any sort. It will be in person only and you will be provided with biographies ahead of time. There isn't a plan for it to be public or to be recorded. It's simply an exchange of ideas and a Q and A, if you wish.

Is there an appetite for that? That would be my first question. The second question is whether anyone has a strong preference between noon or one o'clock for our one-hour meeting with the Finnish delegation on May 11.

Mr. Davies, go ahead.

Mr. Don Davies: I think that's a great idea.

I wonder what your thoughts are, Mr. Chair. Our normal meeting would begin at 12:30 and, of course, we have question period—pardon me. I'm in Vancouver, so I'm on Vancouver time.

Scratch that. I'm all in favour.

The Chair: Thank you.

There is—

[*Translation*]

Mr. Jean-Denis Garon: Mr. Chair, will there be interpretation services at this event? Is it possible to ensure that?

The Chair: I see the clerk nodding yes.

I don't think it's at all acceptable to have meetings on Parliament Hill without interpretation services.

Mr. Jean-Denis Garon: I agree with you.

Thank you.

The Chair: So I'm confirming that there will be interpretation services.

[*English*]

I see that we have consensus.

Unless there are any strong opinions, I'm going to suggest noon, and the HUMA committee can come in after us. That way, we'll get the best lunch.

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

Some hon. members: Agreed.

The Chair: Thanks, everyone. Have a good evening.

The meeting is adjourned.

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