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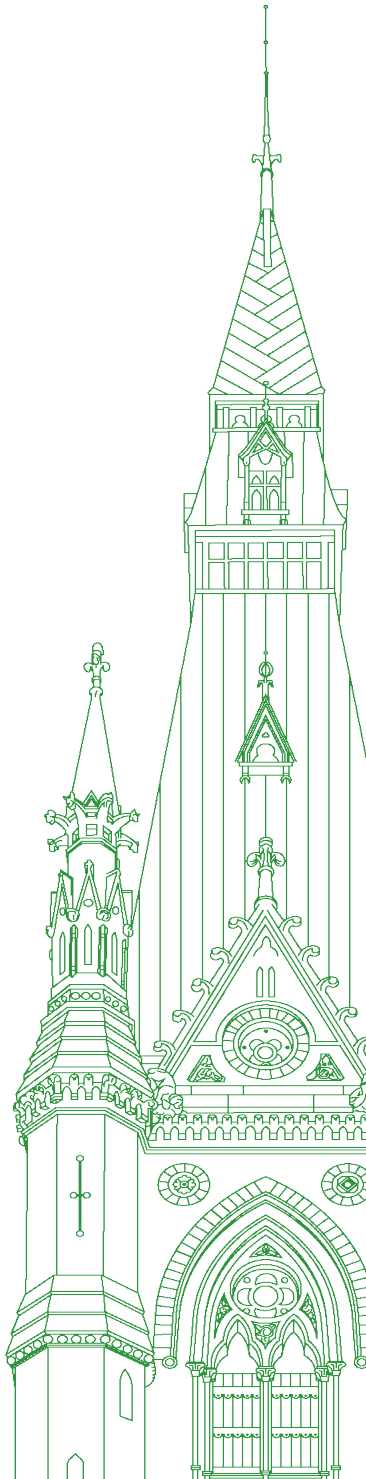

Chair: Mr. Sean Casey

Standing Committee on Health

Wednesday, April 27, 2022

● (1620)

[*English*]

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

Welcome to meeting number 18 of the House of Commons Standing Committee on Health. Today, we're meeting for one hour to hear from witnesses on our study of Canada's health workforce, followed by one hour in camera for drafting instructions.

Before I introduce today's witnesses, I have a few 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 of March 10, 2022, all those attending the meeting in person must wear a mask, except for members who are in their places during proceedings.

For the benefit of our witnesses, first of all, thank you for your patience. Once we commence, I would ask that you wait until you're recognized before speaking. You are, of course, participating by video conference. Click on the microphone icon to activate your mike. I would ask you to mute yourself when you're not speaking. At the bottom of your screen, you have something there for interpretation. You have the choice of floor, English or French.

This is a reminder that all comments should be addressed through the chair, and please don't take screenshots. The proceedings of today's meeting will be made available through the House of Commons website. In accordance with our routine motion, I'm informing the committee that all witnesses have completed their required connection tests in advance of the meeting.

We will now welcome our witnesses who have patiently awaited the commencement of today's meeting. We have, from the Association of Faculties of Medicine of Canada, Dr. Geneviève Moineau, president and chief executive officer. From the Canadian Health Workforce Network, we have Ivy Lynn Bourgeault, director. From Pallium Canada, we have Jeffrey Moat, CEO, and Dr. José Pereira, scientific officer. From the Federation of Medical Regulatory Authorities of Canada, we have Fleur-Ange Lefebvre, executive director and CEO.

Thanks to all of you for your patience. Thank you for your presence.

We will begin with opening remarks in the order in which the witnesses appear on the notice of meeting. Even though we've tested your indulgence with our late start, I would ask you to please try to respect the five-minute timeline. There is a possibility that today's meeting is going to be condensed, and we want to make sure that we have time for questions and that everyone has time to get their statements in. Opening statements will be five minutes.

We're going to start with Dr. Moineau. Welcome to the committee. You have the floor.

Dr. Geneviève Moineau (President and Chief Executive Officer, Association of Faculties of Medicine of Canada): Thank you, Mr. Chair.

Honourable members of the Standing Committee on Health, thank you for inviting me to speak today on behalf of the Association of Faculties of Medicine of Canada. I'll be speaking in English, but I'd be pleased to respond to any questions in both official languages.

I have the pleasure of joining you today from the beautiful Lake Louise, Alberta, Treaty 7 territory, the traditional and ancestral territories of the Stoney Nakoda Nation, the nations of Blackfoot Confederacy, the Dene people and the Métis Nation of Alberta Region 3. The AFMC is located in Ottawa, the unceded, unsurrendered traditional territory of the Anishinabe Algonquin nation.

My name is Dr. Geneviève Moineau. I am the president and CEO of the AFMC. I also practise pediatric emergency medicine at the Children's Hospital of Eastern Ontario, and I am a professor in the department of pediatrics and emergency medicine at the University of Ottawa. The AFMC represents Canada's 17 faculties of medicine, which train and produce the physicians in this country.

The AFMC commends the standing committee for this study on Canada's health workforce. We recognize that solutions around human health resource planning need to include considerations of all health professions. The ultimate goal is that patients receive the right care by the right care provider at the right time.

AFMC is committed to serving the needs of Canadians and has been a long-time advocate for better physician resource planning in Canada. I believe we have valuable information to share with you today in support of this important study.

As you heard from past witnesses, the 2019 Canada community health survey found that approximately 4.6 million Canadians aged 12 and older reported not having a regular health care provider. The pandemic has exacerbated this long-standing deficit. We encourage the federal government to help coordinate change and inspire provincial and territorial leaders to ensure that we have the right number, mix and distribution of physicians to meet societal needs.

There are key considerations that I would like to highlight, based on data the AFMC collects. First, current admissions to medical school are not aligned with population growth in Canada. Second, an increasing number of Canadian medical school graduates have a delay in their entry to residency and, therefore, a delay in providing the care that Canadians need. Third, we are currently not responding to the need for family physicians, particularly in rural settings.

Medical school admissions should align to the population growth to meet societal needs. While the Canadian population has increased by 12% since 2010, admissions to our medical schools have only increased by 6%.

Not only are admissions not increasing at the same rate as the Canadian population, but we continue to see Canadian medical students unable to secure a residency position on their year of graduation. For each medical graduate produced in Canada, public funds are expended. When these graduates go unmatched, there are delays to their entering practice and providing care to Canadians.

Increasing the number of residency positions to ensure, at a minimum, that there's 110 residency positions for each 100 graduates will reduce the number of unmatched Canadian medical graduates. Federal and provincial leaders must work together to ensure that Canada has the right number of residency positions for the system and adequate flexibility to ensure the success of our learners.

Additional family medicine residency positions should focus on the capacity for training in rural communities to further meet the urgent needs of Canadians.

The AFMC recommends that the Government of Canada work with provincial and territorial governments to increase admissions to medical school to match population growth and that all graduates of Canadian medical schools have access to residency positions upon graduation.

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

● (1625)

[*Translation*]

Thank you very much.

[*English*]

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

Next we're going to hear from the Canadian Health Workforce Network.

Ivy Lynn Bourgeault, you have the floor.

Dr. Ivy Lynn Bourgeault (Director, Canadian Health Workforce Network): Thank you, Mr. Chair and committee members, for the invitation to speak on the issue of Canada's health workforce, an issue of critical importance.

I'm coming to you from Ottawa, the traditional, unceded and unsurrendered territory of the Algonquin Anishinabe people, to whom I pay respect.

My name is Ivy Bourgeault. I am speaking on behalf of the Canadian Health Workforce Network, a pan-Canadian knowledge exchange network of researchers and knowledge users—

The Chair: Ms. Bourgeault, I'm sorry. We had a technical issue with the translation, which was resolved in the time it took me to interrupt you.

Please, go ahead.

Dr. Ivy Lynn Bourgeault: Would you like me to begin again?

The Chair: Is everyone okay with her just picking up where she left off?

Please, go ahead, from the point where I interrupted you, not from the top.

Dr. Ivy Lynn Bourgeault: My name is Ivy Bourgeault and I'm speaking on behalf of the Canadian Health Workforce Network, a pan-Canadian knowledge-exchange network of researchers and knowledge users dedicated to bringing the best evidence to provide solutions to health workforce challenges.

Let me begin by stating plainly that, if Canada's health workforce were a patient, it would be in critical condition. It needs immediate attention. The committee has heard from many who have provided testimony to date that the pandemic has caused unprecedented burnout, distress and record-level vacancies due to health and safety concerns, unsustainable workloads, cancelled vacations and forced redeployment.

Then there's the violence.

In this committee's 2019 report, you noted that health workers are four times more likely to face workplace violence than those in any other profession, yet most of it goes unreported due to a culture of acceptance. Recognizing that this requires action beyond this committee, we are still waiting for the recommended public awareness campaign and pan-Canadian prevention framework. We are still waiting, also, for the much-needed update to the pan-Canadian health workforce strategy to address staffing shortages, which this committee recognized exacerbates the violence health workers experience.

COVID-19 has traumatized Canada's health workforce, but most of these challenges predate the pandemic. The pandemic has sharply exposed the lack of clear answers to the most basic questions about Canada's health workforce. For example, we know little about how many health providers work in critical sectors such as home care, long-term care and mental health care.

Canada lags well behind comparable OECD countries in terms of health workforce data and decision-making tools. Health workforce research receives less than 3% of health services and policy research funds, and less than 1% of all national health research funds. Other OECD countries provide nationwide support for evidence-based decisions, but here in Canada we are left to make critical decisions in the dark.

This lack of very basic human resources knowledge is particularly egregious because health workers account for more than 10% of all employed Canadians and over two-thirds of health care spending in Canada, which amounted to $175 billion in 2019 or nearly 8% of Canada's total GDP. Recognizing these facts, all levels of government, including the federal government, play an essential role in sound policy development, strategic health workforce planning and health system stewardship.

To date, more than 65 health care organizations and 300 health workforce experts and organizational leaders have signed on to a call to action for the federal government to take a lead in supporting provinces, territories, regions, hospitals, health authorities and training programs in investing in better health workforce data and decision-making tools.

In our brief to the committee we put forward a set of promising evidence-informed solutions for consideration. Our preferred option, based on existing Canadian models and leading international practices, is for the federal government to create a dedicated coordinating health workforce agency with a mandate to enhance existing data infrastructure and decision-support tools for strategic planning, policy and management across Canada. This would be done in a similar fashion to the way the Public Health Agency of Canada was created after our last SARS crisis—a crisis dwarfed by COVID-19.

In addition to addressing needed data and decision-making infrastructure, an agency could address the immediate challenges by gathering and sharing leading evidence-informed practices to retain health workers and foster the return of those who recently left, while also informing Canadian-focused recruitment strategies—the new three Rs of health workforce management—retain, return and recruit.

Those working in health care today need to know that a better future lies ahead. They are tired, and a great resignation looms large. Patients in critical condition require follow-up care, ongoing monitoring and support as well as measures to prevent critical illness from happening again. This is exactly what we need for the health workforce.

The public understands this. Overall, nine out of 10 Canadians in a public opinion poll from this past March said they were concerned about the mental health of health care workers. Eight out of 10 were also concerned about what this meant for their access to and the quality of health care.

Action is needed now. The status quo must be seen for what it is—the most expensive and the least tenable option going forward.

I'd be pleased to address any of these or other points of the committee. Thank you again for this opportunity.

● (1630)

The Chair: Thank you, Ms. Bourgeault.

Next we're going to hear from Pallium Canada, Jeffrey Moat, CEO.

Mr. Moat, you have the floor.

Mr. Jeffrey Moat (Chief Executive Officer, Pallium Canada): Thank you, Mr. Chair and to this committee, for this opportunity to speak with you today. I will be joined by Dr. José Pereira in sharing our remarks with you. I am the chief executive officer of Pallium Canada.

I want to take this opportunity to acknowledge that the land from which I am presenting, the city of Ottawa, is the traditional, unceded and unsurrendered territory of the Algonquin Anishinabe people.

For over 20 years, Pallium Canada, a national non-profit organization that was established in Alberta and now has its head office in Ottawa, has been equipping frontline health care workers with the essential skills needed to provide palliative care to Canadians. The ability to provide a palliative care approach when and where it is needed is essential for all health human resources in a modern, agile and increasingly diverse workforce, yet most health care professionals receive little to no training in palliative care during their formal health education.

Pallium's flexible and adaptable interprofessional training solutions meet both the team and individual learning needs of all health care professionals, including physicians, nurses, social workers, personal support workers, paramedics and others. Pallium has developed training specifically targeted to health care leaders so that they have the knowledge necessary to support the success of the health care teams they lead.

Pallium's LEAP programs—LEAP is an acronym, by the way, for learning essential approaches to palliative care—have been proven to increase palliative care knowledge and skills and empower health care providers to make changes in their practice and improve the palliative care they provide to patients. The interprofessional design of LEAP courses also creates a common understanding and culture among health care teams and has been shown to increase job satisfaction and enjoyment.

As a national, evidence-based, accredited training program, LEAP supports health human resource labour mobility and responds to identified workforce mental health needs. This is something that was recently highlighted in Ontario's long-term care staffing study, which identifies the ability to provide palliative care as a key challenge for long-term care staff that negatively impacts their mental health and well-being.

This lack of palliative care skills among health human resources in Canada has too often led to unnecessary pain and suffering for Canadians and grief for the families and loved ones who can't access the palliative care they need. If the pandemic hasn't made a strong enough case for the need for better skills training in palliative care, then I'm not sure what will. Past calls to improve these essential skills have been too often ignored.

The good news is that solutions, such as LEAP programming, have already been paid for by Canadian taxpayers. There needs to be a commitment to spread and scale such solutions so that health human resources have the competencies and confidence to provide better palliative care to more Canadians.

Dr. Pereira.

Dr. José Pereira (Scientific Officer, Pallium Canada): Thank you very much.

Honourable members, good afternoon, and thank you for the opportunity to make the case for health workforce preparedness in palliative and end-of-life care.

I'm Dr. José Pereira and I've been a palliative care physician, educator and researcher in Canada for over 25 years. I'm currently professor and director of the division of palliative care in the department of family medicine at McMaster University. I'm also scientific officer and co-founder of Pallium Canada.

Advanced progressive cancer and non-cancer illnesses continue to exact a very high toll on Canadians in terms of quality of life, suffering and health care costs. A large body of evidence shows that palliative care can reduce this burden by improving quality of life, reducing hospital admissions and emergency room visits, and reducing health care costs.

While there have been noteworthy improvements over the last two decades with respect to access to palliative care services and the integration of palliative care in the curricula of health professionals, many gaps remain. Despite what some may say, not all Canadians have access to timely, high-quality palliative care when they need it. One of the main reasons for this is the lack of health workforce preparedness to provide palliative care.

These workforce issues relate to both specialist-level palliative care and primary-level—also known as generalist-level—palliative care. If equipped with core palliative care competencies, clinicians and other professionals across many fields, such as primary care, long-term care, cancer care, cardiology and nephrology, to name just a few, are also able to initiate a palliative care approach.

There are currently not enough palliative care specialists and funded positions for palliative care clinicians in many Canadian jurisdictions. Moreover, many palliative care clinicians, including me, are nearing or contemplating retirement. In a study that I co-authored in 2015, we found only 265 physicians in Ontario who practised mainly palliative care. Emerging standards call for at least double that number.

There are not enough funded training positions for palliative care physicians. In my own division of palliative care at McMaster University, for example, we have the capacity to train up to six or eight new palliative care specialists every year but receive funding for only one trainee a year.

In my clinical work, I often see palliative care being activated only in the last days or even hours of life, when it's too late. This is demoralizing when there are evidence and experience to support early palliative care initiated many months before that, alongside treatments to control the diseases. Again, a root cause is lack of core palliative care knowledge and competencies across the health workforce.

In a large 2015 study involving primary care professionals across several OECD countries, only 42% of Canadian primary care doctors said that their practices were prepared to provide primary palliative care to their own patients, largely related to lack of education or experience. This was one of the lowest rates across the 10 countries studied, and it's not only in primary care. We see similar findings across studies and different speciality areas.

In a recent Canadian study, palliative care clinical rotations were mandatory in only two medical schools, not offered at all in two and only optional in 13. At the postgraduate level, only 60% of family medicine trainees and only 31% of internal medicine residents completed such rotations.

The good news is that there is evidence that core training can make a difference. In a large study that we did involving over 4,000 doctors, nurses, social workers and pharmacists who completed Pallium Canada's LEAP courses, we found that these courses improved advance care planning and goals of care discussions, improved pain and symptom management, improved opioid use and improved teamwork for up to four months after the courses.

We look forward to a future where these workforce training needs are addressed and long-term investments are made in palliative care training to increase specialist-level and generalist-level palliative care in Canada, and to spread and scale up across all care settings existing, proven, Canadian-made education programs.

Thank you very much.

● (1635)

The Chair: Thank you, Dr. Pereira and Mr. Moat.

Next, we're going to go to Ms. Lefebvre, please.

Dr. Fleur-Ange Lefebvre (Executive Director and Chief Executive Officer, Federation of Medical Regulatory Authorities of Canada): Good afternoon, Mr. Chair and committee members. I thank you for the opportunity to appear before you today. I also have the privilege of speaking to you from the same indigenous lands as those who spoke before me this afternoon.

I want to highlight a few things before I start. First, I am not a physician. Second, members of the Federation of Medical Regulatory Authorities of Canada have delegated statutory authority to regulate physicians to serve the public interest, and, third, as a voluntary, member-based organization representing all 13 provincial and territorial medical regulatory authorities, or MRAs, FMRAC facilitates discussion and collaborative efforts of its members towards the goal of improved regulation.

HESA has undertaken this study in recognition of the exhaustion and burnout among health care professionals, including physicians. Over the past few years, the MRAs have seen an increase in the number of physicians who have come to their attention because of burnout, mental health and substance abuse disorders. MRAs are mandated to protect the public, and their responsibilities rarely if ever include advocacy for the profession. However, they do include administration of a quality assurance program for identified physicians. While this is hard to quantify, FMRAC believes that the exhaustion and burnout of physicians across Canada are significant enough that they are having a negative impact on the quality of care that Canadians are receiving. In other words, physician health is a patient safety issue.

Your study intends to examine how the federal government can facilitate the recruitment and retention of health care professionals. The only way to do this is to approach the situation by putting the patient smack in the middle of this discussion.

I'm going to address four issues.

First is virtual care. FMRAC defines virtual care as the provision of care by means of electronic communication in which the patient and the physician are at different locations. MRAs believe virtual care may enable more access to care across Canada. However, physicians are expected to provide all elements of good medical care. The standard of care expected is the same whether the patient is seen in person or by virtual means. Importantly, meeting the standard of care inevitably requires access to in-person care for many conditions. This means that virtual care can be leveraged only so far.

Second is international medical graduates or IMGs. IMGs seek to come to Canada from many countries with very many different training programs. Supporting pathways to licensure for IMGs represents a meaningful opportunity to help address health human resource shortages, provided the right review and assessment protocols are established and/or maintained

Graduates of Canadian medical schools, as Dr. Moineau can very well describe, go through thorough accredited undergraduate and postgraduate training, with regular assessments along the way before being promoted to the next level of education. They also must pass national certification exams before being issued a licence to practise in any part of Canada. These are all steps along the way to ensuring the public that the physicians who treat them are qualified to do so.

MRAs also have mechanisms in place to assess the international graduates. There are limited resources available, and scaling these programs up to a broader national level would require a lot more resources, but doing that could have a significant impact on the challenges Canada is facing today. It would, in our opinion, be unconscionable to bypass the appropriate review and assessment of each IMG candidate on the route to licensure simply to increase the number of physicians available, because even a handful of incompetent physicians could have a dramatically negative impact on the health and safety of tens of thousands of Canadians

Third is a national registry of physicians and other health care providers. The MRAs are the single source of truth when it comes to data about physicians who are licensed to practise in this country. Their data are held in each province and territory.

Having a national registry or list of all the physicians could be a very useful tool for the regulators themselves—as many health care workers are licensed in more than one jurisdiction—but also for health human resources planning, especially if it includes information about a practitioner's scope of activities.

Such a registry requires significant developmental resources and an ongoing commitment to keeping the database up to date and relevant to governments, regulators, researchers and policy-makers. Two important tools are already available for medicine—a unique identifier for universal data collection, and a common portal for licensure applications.

In addition to a national registry, the federal government may wish to look at the U.S. National Practitioner Data Bank. There's more information about that in the document I submitted.

● (1640)

Finally, on other health care providers, FMRAC and the MRAs welcome other regulated health care professionals, such as physician assistants, nurse practitioners, anaesthesia assistants, associate physicians and others, into the system, as they can assist in meeting the health care needs of the people of Canada.

For all health care professionals, the main tenets will be the identification of the required competencies, the appropriate training to achieve those competencies and, finally, the relevant assessments in the right settings to ensure that those competencies have indeed been achieved.

In closing, thank you for allowing me to present to the health committee today. I am happy to answer your questions and listen to your comments in both English and French.

Thank you.

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

We're now going to begin with questions, starting with the Conservatives and Mr. Barrett.

● (1645)

Mr. Michael Barrett (Leeds—Grenville—Thousand Islands and Rideau Lakes, CPC): Thank you very much, Chair.

I thank the witnesses for joining us today.

Chair, I have one item of business that I'd like to do before handing my time over to Dr. Ellis.

I'm seeking the unanimous consent of the committee, through you, that the following motion be adopted. I move:

> That the Standing Committee on Health report to the House that it supports the full participation of Taiwan in the World Health Assembly (WHA) and the World Health Organization (WHO).

As the 48 hours' notice wasn't provided, Mr. Chair, it requires the unanimous consent of the committee.

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

As you pointed out, the requisite notice wasn't provided, but that can be waived with the unanimous consent of the committee.

I think we have two questions. First of all, is the committee prepared to entertain the motion absent the required 48 hours' notice? Do we have agreement on that?

Some hon. members: Agreed.

The Chair: We have agreement.

Now that you've heard the motion, is it the will of the committee to adopt the motion, or will there be debate?

(Motion agreed to)

The Chair: Go ahead, Mr. Barrett.

Mr. Michael Barrett: Thank you, Chair.

With a minute and 12 seconds used, I'd like to turn my time over to Dr. Ellis.

The Chair: Dr. Ellis.

Mr. Stephen Ellis (Cumberland—Colchester, CPC): Thank you, Mr. Chair.

Thank you, Mr. Barrett. You're very kind.

I'll jump right in it, since we're already running significantly behind. I think that's the most germane thing.

I would like to start with Dr. Moineau, if I could.

We talked about pairing admissions to medical school and residency spots in trying to keep up with the growth in the Canadian population. We know that we've fallen significantly behind. Does your association have, in real numbers, any idea of how many extra medical students we would need at the current time to make up the difference, and what that might look like going forward?

Dr. Geneviève Moineau: Thank you for the question.

We are in the process of confirming what those numbers are, as well as what the capacity of our 17 medical schools is at the present time. We would certainly be able to provide you with this information in very short order.

Mr. Stephen Ellis: Thanks, Dr. Moineau.

With regard to “short order”, I come from the medical field where that might mean five minutes, but in the federal government it might mean 15 years. What does it mean in your world, if I could push you on that a bit?

Dr. Geneviève Moineau: It means within the very next few weeks.

Mr. Stephen Ellis: Okay, that's terrific. Thanks for propriating it to the committee here.

As a follow-on question to that, will that include data on matching medical schools with residencies? Can you speak to what that gap is at the current time? That seems to be a significant problem.

Dr. Geneviève Moineau: We are currently midway through the match for this year, but we know that there is a gap of at least 100 positions at the moment, and that's without any increases in the number of medical school positions.

We could certainly, again, provide you with an accurate number based on the match that's under way right now, which will be completed by the end of May. We could add that information to a subsequent package that is forwarded to the standing committee.

Mr. Stephen Ellis: Great. Thanks, Dr. Moineau.

To be clear, for perhaps those people who don't understand the system, that means there are 100 medical students trained in Canada who now cannot become physicians because they don't have a position as a resident.

Dr. Geneviève Moineau: Upon their year of graduation.... That's correct.

Mr. Stephen Ellis: Do we have any idea of how many of those types of individuals—I'll use that terminology—are in Canada now and perhaps have given up on the match?

Is that kind of data available?

Dr. Geneviève Moineau: These are graduates of Canadian medical schools, so they are in Canada.

The issue is that there's a wastage of time in their not graduating and moving on to residency in that year. Many of them eventually match, but just to have to delay that by a year is really very unfortunate, both for the health care system, because we want those individuals to be able to finish their training and to become independent practitioners, but also for those trainees as well.

Mr. Stephen Ellis: Understood, and thanks for that. Is there any idea of how many of those individuals have never been matched? Are there 50 of them or a thousand of them over the years? Are there a hundred a year over the last 10 years?

● (1650)

Dr. Geneviève Moineau: There would definitely be more than 50 over the last several years. That information is a little harder to obtain, but we can certainly give you a range if that would be helpful to you.

Mr. Stephen Ellis: That's great. Thanks, Dr. Moineau. I appreciate it.

I have a question for the palliative care group, Pallium, if I may.

It's interesting, you know. Palliative care certainly is an institution that's near and dear to my heart, as a family doctor, and is certainly germane in terms of things like MAID, etc. There was a commitment of about $6 billion in funding over 10 years in budget 2017.

Can you talk more about how much money organizations like Pallium have received and what is the difficulty in deploying that money and educating people around palliative care?

Mr. Jeffrey Moat: Thank you, Dr. Ellis, for that question.

The short answer to your question is very little. We've actually done some homework to understand just how much of this investment has been spent on palliative care.

According to the Office of the Parliamentary Budget Officer, when the officer was asked to identify federal investments in palliative care and MAID since Canada legalized medical assistance in dying in December 2020, this is what was shared. As we know, based on a common set of principles on shared health priorities, the federal government subsequently signed bilateral funding agreements with each province and territory, and each province and territory developed an action plan. That's usually appended to the bilateral agreement and specifies how the federal transfers would be used. However, only six provinces identified initiatives specific to palliative care: B.C., Alberta, Saskatchewan, Manitoba, New Brunswick and Newfoundland.

According to the provinces' bilateral agreements, the total funding for palliative care initiatives for these six provinces was estimated at $170 million, and that's to the end of 2021-22, but we're not given any details on how these funds were spent. Unfortunately, the specific amounts allocated to palliative care are not available for the remaining provinces and territories, because health is a provincial jurisdiction. As we know, Health Canada doesn't have access to or the authority to request program-specific accounting.

The long and the short of it, Dr. Ellis, is that we simply don't know how much and how exactly this money has been spent, which is disappointing.

Dr. Pereira, would you like to add anything to that?

Dr. José Pereira: It's interesting, because—

The Chair: Very briefly, Dr. Pereira, please, as we're well past time. Please be succinct.

Dr. José Pereira: Thank you.

We visited about eight provinces and territories between 2019 and early 2020, and the response was always, "It's important and it's part of our strategic plan, but we don't have funding to support it."

The Chair: Thank you.

Thank you, Dr. Ellis.

Next we have Dr. Powlowski, please, for six minutes.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): We're here to examine the health care workforce shortage and what we can do about it now. As somebody who graduated from medical school in 1986, I've been doing this a long time, and you know what? Nothing has changed. We had a shortage of people, particularly in under-serviced areas, 35 years ago. We still have that shortage.

The answer has always seemed clearly to me to be in front of our noses: foreign graduates. There have always been a lot of foreign graduates in Canada. I've certainly known enough of them in my time who find it very hard to get licensed in Canada. There has been this mismatch. There's been a need and there's been a desire of foreign-trained doctors to work in under-serviced areas. What is the problem?

I've asked this of a few people here, I think. I'm not sure what the problem is.

Certainly, I have some suspicion that it's medical protectionism. Organizations like the CMA and the OMA are dominated by doctors from big cities. When you work in big cities, which I've done a little bit—I've done far more work in under-serviced areas—you want patients. You're competing for patients. You want to maintain your salary. I somewhat suspect that the problem is doctors not wanting to make it easy to license foreign-trained doctors.

The other possibility is that the provinces realize that more billing numbers equal higher health care costs.

I throw that out there as two possibilities. I wanted to ask Ms. Lefebvre from the federal regulatory authority for her views on this matter. What has been the barrier to licensing more foreign graduates?

Dr. Fleur-Ange Lefebvre: Thank you for that question, which I knew was coming, so this is good.

We have been asked this several times before. There are two things. First of all, I cannot speak on the payers' approach to this. The regulatory authorities do not issue billing numbers. They issue a licence to qualify physicians. IMGs, as I said, come from all over the place and from very different training systems. Canadian graduates undergo really thorough assessments in real life with patients in real, live health care situations.

Our approach to this is that IMGs, in order to come to Canada, for the most part—and not all of them—have to undergo a similar kind of in-practice assessment. It is expensive to run, and it's a competitive process. There are probably many more qualified IMGs than those who actually secure a spot for that. Once they had gone through that 12-week process, they would then get a provisional licence under supervision, and there are steps to move them from a provisional to a full unrestricted licence.

You have had presentations from the CMA and the Royal College. The Royal College is developing different mechanisms with the hope of getting these people assessed a little bit faster.

Medical education is a complex and very expensive system. I think it's time to ramp this up, but in order to ramp it up, you must also have the capacity to do the assessments, and right now that is quite challenging.

● (1655)

Mr. Marcus Powlowski: Can I interrupt you there?

This is the first I've heard of this 12-week assessment. Excuse my ignorance, but what is that? Do all colleges of physicians and surgeons across Canada allow this option or only some? How does this work exactly?

Dr. Fleur-Ange Lefebvre: More than half of them do. It's called the "practice-ready assessment". It was designed primarily for physicians who had come into Canada to work either as general internists or as family physicians. In order to assess the specialist and the subspecialist physicians, you almost need a specially designed program for them, and that's again quite a bit more challenging.

Mr. Marcus Powlowski: Do I get you right that there are not enough positions for these practice-ready assessments, so a lot of foreign graduates don't get to enter into the process to be evaluated?

Dr. Fleur-Ange Lefebvre: That's correct. Because of resources, it is a competitive process, so we have way more applicants who would probably qualify if there were an unlimited number of assessment positions.

Mr. Marcus Powlowski: Do you know how many positions there are in Canada each year?

Dr. Fleur-Ange Lefebvre: I could find that for you. I don't have it at my fingertips. It's relatively modest, but it depends on the jurisdiction. Approximately 25%—and I would say over 25% but I think I will stick to 25%—of practising physicians in Canada are international medical graduates, so many of them do get through.

Mr. Marcus Powlowski: When you say modest, just give me a ballpark figure. Are we talking thousands or hundreds?

Dr. Fleur-Ange Lefebvre: It's hundreds.

Mr. Marcus Powlowski: Could you get us that information?

If the federal government were to put more money into opening more practice-ready assessments, do you think we would be able to do that rapidly in order to evaluate the skill of foreign-trained doctors and get a lot more people out there quickly?

Dr. Fleur-Ange Lefebvre: It would be wonderful to be able to say yes to that, but because the other resources it requires are human resources—practising physicians assessing incoming international medical graduates—I think that other side of the coin would have to be factored into this. It would involve some discussion, but I would be hopeful.

The Chair: Thank you, Dr. Powlowski.

[*Translation*]

Thank you, Dr. Lefebvre.

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 being here today.

I will start with a question for Dr. Moineau.

Dr. Moineau, you eloquently mentioned that 4.6 million Canadians are having difficulty accessing a doctor or local medical services right now. This brings us back to the need to have better planning and to have a better capacity to train doctors and send them to hospitals in the regions. Not surprisingly, there is the issue of funding.

This week, in committee, we heard from representatives of the Fédération des médecins omnipraticiens du Québec. They told us that, in order to improve the conditions under which doctors practise and to make them more available in the regions, there was an immediate and significant need to increase health transfers to the provinces. Previously, these transfers covered up to 35% of system costs, but this has been reduced to 22% and could well decrease to 18%.

Would this additional funding help the provinces to carry out better long-term planning?

● (1700)

Dr. Geneviève Moineau: Thank you very much for the question.

In fact, it is not within the authority of the Association of Faculties of Medicine of Canada to comment directly on this. What I can say, though, is that it's really important to think about how general practitioners are paid for their work and for the care they provide, if we're going to be able to meet the needs of the population. The provinces should really address the inequity that sometimes exists in health care reimbursements.

Mr. Jean-Denis Garon: I understand that this is a provincial jurisdiction. I understand your reluctance. Having said that, I think the issue of the shortage of family doctors is a medical school issue, Dr. Moineau. When the representatives of the Fédération des médecins omnipraticiens du Québec appeared before the committee, they told us that the value of the profession of family doctor needed to be promoted. They said that medical schools sometimes have trouble attracting candidates to general medicine rather than to certain specialties.

It is therefore important to make major changes in technology and practice conditions and to facilitate work in the regions. We were told that better, more sustainable and predictable funding through the provinces could help faculties make this change.

What are your thoughts on that?

Dr. Geneviève Moineau: I agree with you that it's important for medical schools to accept students who are ready to become general practitioners. We are looking at this issue a lot. Whether in Quebec or in the other provinces, it's a really important aspect.

In fact, it's the faculties that decide who enters or is accepted into the profession. We need to make sure that we are accepting individuals who are willing to practise general medicine, general practitioner medicine, and practice in the regions.

Let me make a comment on the previous conversation. We believe it's important that young people living in the regions be able to receive their medical education in the regions, in all the provinces of Canada. This will help us ensure that there will be more doctors practising in the regions. There is still a lot of work to be done in this regard, but it's one of our goals for medical schools.

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

I'd now like to turn to Dr. Bourgeault briefly.

I read your brief, which is very interesting and contains several possible solutions. That said, I note that several of your proposals are aimed at centralizing the collection and management of health information at the federal level. I remember, for example, the years of the Romanow commission. At that time, the Canadian Institute for Health Information was created. This centralization caused major problems with membership, particularly in Quebec, and ultimately there were delays in the information-gathering process.

Would you be more open to a decentralized approach, one that would be more respectful of provincial jurisdictions, but that could allow for a great deal of co-operation? I'm thinking, for example, of a working group that would give the provincial and Quebec governments a lot of leeway.

[*English*]

Dr. Ivy Lynn Bourgeault: Thank you. I really appreciate that question.

It's important to recognize what we're proposing to be centralized, which is data to be standardized. Right now, the data collected by medical regulatory authorities, even on the medical profession represented by my colleagues here, which Dr. Lefebvre has noted is excellent information, is not data that goes to the Canadian Institute for Health Information. The data collected by the Association of Faculties of Medicine of Canada—and it's extensive—on medical students also doesn't align with the data collected by medical regulatory authorities and what goes to the Canadian Institute of Health Information, so our proposal is to have standardized data.

An excellent way to standardize data would be to have a system of pan-Canadian registration, and this is really important. We are not suggesting that health workforce planning be undertaken at a national level. That's not an appropriate level for that to happen. What we are suggesting is that there would be standardized data collected in the same way that StatsCan collects standardized data through the census on the population, and that then the provinces, territories, regions, hospitals and medical institutions could do some planning.

Right now, the data is siloed across jurisdictions, across organizations within a profession and also across the professions. If we could bring those together, that's what we're talking about with data infrastructure. In our conversation with folks in Quebec, they said they would very much welcome that and the development of tools to help them to do much better planning at a local level, which is the most appropriate place for it.

I hope that has answered your question.

● (1705)

[*Translation*]

Mr. Jean-Denis Garon: Thank you.

The Chair: Thank you, Mr. Garon.

[*English*]

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

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

Thank you to the witnesses for your excellent testimony.

Dr. Moineau, I'd like to start with you.

In a 2018 article from University Affairs, you were quoted as saying this: “The deans have clearly identified the unmatched Canadian medical graduate as a top priority.” You've already spoken to this a bit, but I'm wondering what the direction is since that was written four years ago.

Has the number of Canadian medical graduates who are unsuccessful in matching to a residency requirement each year decreased or increased since that article was published?

Dr. Geneviève Moineau: Thank you for the question.

As you identify, this was the recommendation that came out in 2018. In fact, we did have a significant positive response to that, in that we had three provinces that actually changed their policy around how the match was structured, which enabled a significant decrease in the number of unmatched.

However, unfortunately, those numbers have started creeping up again. The major issue that remains is that we do not have the appropriate buffer between the number of graduates of Canadian medical schools and the number of residency positions.

We know that when we have a buffer of at least 10 positions—so again, for 100 graduates—there is the opportunity for about 110 residency positions, and these are positions in all specialties, in family medicine and all the other specialties. That allows a match for just about everybody. Back in 2009, we had 11 unmatched Canadian graduates across the country. We're really hoping to be able to get back to those types of numbers and not the nearly 100 that we have now. It really requires the provinces to be able to get to that ratio. We're hoping that your committee and the federal government will support encouraging the provinces to get to that level of residency numbers in each jurisdiction.

Mr. Don Davies: Thank you.

In terms of graduates overall, which you've commented on, we know that Canada graduated about 7.5 medical students per 100,000 in 2020. That was in the bottom five of OECD countries—I believe there are 38 OECD countries—so we're not doing well internationally. What advice would you give this committee about how we can increase the number of seats in medical schools?

Dr. Geneviève Moineau: Again, we would seek your support in encouraging provinces to increase their numbers, both of medical school spots—positions for students—and, as well, of residency positions. You have to align those, and we suggest an alignment of 1:1.1. There are some provinces that have made some announcements already that are in the right direction, but we really need to see this across all provinces that currently house medical schools.

Mr. Don Davies: Thank you.

Dr. Bourgeault, perhaps I can turn to you. In an op-ed from May 2021, which you co-authored with CFNU president Linda Silas, you said the following:

> Most Canadians probably don't realize that we lack data on the most basic components of our health workforce.
>
> We lack data about the scope of work of health care workers, and about the diversity of the workforce, such as Indigenous or racial identity and language of service. We don't know how different health teams work together or how can they be recruited, trained and retained where they are most needed.
>
> In some critical sectors, such as home care, long-term care and mental health care, we don't even know how many workers there are.

You've spoken about data being siloed and about provinces and territories operating independently. What's the problem with provinces not knowing what's happening in the province next door, and how do you think national data collection, which you've described, would assist in that?

● (1710)

Dr. Ivy Lynn Bourgeault: Thank you for that question and for quoting from the article.

I think moving towards pan-Canadian coordination of the collection of data would allow us to plan across different sectors. We're having a conversation about professions, but professions work in sectors. Physicians work in palliative care, as my colleagues have noted here. Folks work in long-term care and mental health care. The types of dashboards they're creating in other OECD countries are looking at this with an interprofessional and sector focus.

Those types of data enhancements would really help local decision-makers in a variety of different organizations. It's not just the provinces, territories, regions and hospitals, and so on. They would want to have access, to say, “Do we have enough?” and “How should we go about planning different models of care?”

We have no idea. I cannot tell you how many personal support workers there are in Canada. I can't tell you how many addictions counsellors there are in Canada. We absolutely need to have that information.

Here's the data story. The Canadian Institute of Health Information gets data on physicians from a for-profit company. They don't get it from the medical regulatory authorities. For all of the other professions, they get it from medical regulatory authorities for a select number. The Canadian Institute of Health Information has to negotiate data-sharing agreements with dozens of regulatory authorities for the different professions that are regulated. Then they have to collect all of that data, none of which aligns. They have to match that all up, so they spend all of their time negotiating data-sharing agreements and then all of their time trying to make a mountain out of the mess that there is.

The data we have is on gender as binary—male or female—as well as age and province. You cannot do any health workforce planning with that type of data. We can do better than this. We have the amazing Statistics Canada, an agency that collects things nationally, on a pan-Canadian basis. What's very interesting about the data from StatsCan is that it's based on the national occupational codes, and none of that aligns with regulatory authority data.

I'll give you just one example. I know the Canadian occupational projection system—COPS—has been noted in this committee. COPS suggests that there are 75,000 family physicians in Canada. We know there are about 45,000 physicians in Canada, so an error of 30,000 is pretty remarkable. Federal funds go into the COPS system. Federal funds go into a national occupational code that doesn't work at all for health workers. I'm not a decision-maker, but I can't imagine what it must be like making decisions when you have absolutely no tools.

Given the questions the committee has asked our colleagues here, that should be readily accessible. We should have early warning systems for unmatched medical graduates and for shortages of personal support workers.

The Chair: Ms. Bourgeault, this testimony is absolutely fascinating, but well past time.

Please, wrap up.

Dr. Ivy Lynn Bourgeault: I'll conclude there. I could speak on this for hours.

The Chair: Do you know what? We'd love to listen to it.

Mr. Don Davies: Mr. Chair, perhaps we could remind the witnesses that they are able to provide written submissions, because I think this is really riveting and relevant information. I think all committee members would benefit from any additional written information the witnesses might provide.

The Chair: Mr. Davies is absolutely right.

In fact, I've already heard from some members who aren't going to get a chance to ask you questions that they might like to correspond with you. If the committee is okay with written questions and answers to supplement what's been said today, there clearly is an appetite for that in this room. I see there are heads nodding all around.

It is absolutely fascinating. It's too bad that we don't have more time. However, we do have a little more, and the next person to pose questions is Ms. Goodridge, for five minutes.

● (1715)

Mrs. Laila Goodridge (Fort McMurray—Cold Lake, CPC): Thank you so much to all of the witnesses for your testimony and for being with us today. I think I can speak for all members of the committee in saying that the passion you have shared and your testimony are definitely important.

To Ms. Bourgeault specifically, some of what you were getting at with the data is really succinct, and anything you can provide to us in writing would be very helpful. In my own home province of Alberta, I think AHS had at one point over 1,300 different databases, and not all of them talked to one another. That is kind of ironic for a province that has one unique health system.

I was wondering—

The Chair: I'm sorry, Ms. Goodridge. I have to interrupt. The bells are ringing, and the rules require that we get the unanimous consent of the committee to continue the meeting.

Is it the will of the committee to at least have Ms. Goodridge finish her round, if not further? What's the feeling in the room?

Some hon. members: Agreed.

The Chair: Ms. Goodridge, go ahead.

You have your full five minutes and then we're going to wrap it up.

Mrs. Laila Goodridge: Fantastic. I will speak a little bit faster.

Dr. Bourgeault, do you have any jurisdictions in Canada you could point to that are better with data compared to others?

Dr. Ivy Lynn Bourgeault: Thank you for the question. As a former Albertan, and where my family lives, in rural Alberta, I'll give a bit of a shout-out to them.

I am quite familiar with the data, the richness of data in Alberta, but there is the inability to align it. One thing that I will give a shout-out to Alberta for is that they have a registry of health care aides, which is what they call them. That, I think, is a really promising practice. I think we could use the opportunity, for professions we don't collect data on right now, to move directly towards a pan-Canadian system, as Madame Lefebvre said, in regard to pan-Canadian registration.

The other jurisdiction I will point out that has invested in standardized data across professions is Ontario, with the creation of the health professions database. They have created a minimum data standard, and what that means is.... What are the questions we're going to ask and the data elements that we need? It's insufficient. We have no data in Ontario in terms of indigenous identity or racial identity. However, they do a fairly good job, for example, on ability to provide services in another language—official languages being critically important in ensuring that people can access services in French and English. So—

Mrs. Laila Goodridge: Fantastic. Because we don't have much time, I'm going to shift gears a little bit. I'm sorry about that. Again, anything you can provide to us in writing would be helpful.

Dr. Moineau, when you were talking about how there are so many students who are not placed, could you point to any jurisdictions that are doing a better job at having placements compared with the rest of the country?

Dr. Geneviève Moineau: The provinces that have increased that ratio, where there are more residency positions than there are graduates of Canadian medical schools, are doing better. I could provide you with that information by jurisdiction. There are some provinces that have taken that into consideration and are doing better.

The issue is that, when we look at this in a pan-Canadian way, up until recently, we were still at a ratio where for each 100 graduates, we had barely 101 to 103 positions. That's just too tight.

I can certainly provide you with that information.

Mrs. Laila Goodridge: Fantastic. Thank you.

To go on to questions around Pallium, I'm wondering if you can point to any provinces or territories that are doing a better job when it comes to palliative care.

● (1720)

Dr. José Pereira: Certainly. Thank you very much for the question.

Canada is a patchwork, and in many provinces, in different areas of palliative care, you'll see centres of excellence but also many gaps.

Having trained in Alberta, I want to give a shout-out to Alberta, because I think for a long time Alberta has done a very good job. I think we're going to be seeing more coming out of Alberta. In Alberta as well, in terms of supporting hospice care and training for hospices, I would say they are leaders.

Again, it's a patchwork. If you go across the country, some places have enough palliative care units and palliative care specialists to man them and others haven't, so it really is very variable across the country.

Mrs. Laila Goodridge: Fantastic. Perhaps you could provide us, in writing, with where those centres of excellence are in terms of different aspects and specific jurisdictions, just to help us with formulating our recommendations.

Dr. José Pereira: Will do.

Mrs. Laila Goodridge: Mr. Moat, do you have anything to add?

Mr. Jeffrey Moat: I was going to say that I think what we'll do, as part of that information, is include some of the work that Pallium is doing with a number of health care systems across the country to develop our country's first national palliative care atlas. This will be an incredible decision-making tool for health care leadership and administrators to identify areas of strength and areas of gaps when it comes to palliative care service delivery.

Mrs. Laila Goodridge: Thank you.

Very quickly, I know I'm at the end of my time, but I just really want to thank both of you for the work you do with palliative care. It's so very important, and not enough is done in that space. Thank you so much.

The Chair: Thank you, Mrs. Goodridge.

As per the agreement of the committee, that completes the time we have for questions. We had asked you for an hour. You waited for an hour and then you gave us an hour, and we'd like to have a whole lot more, so you may be hearing from some of the members in writing.

Thank you very much for being with us, and thanks for your patience. It will be of great assistance to us.

Colleagues, before we adjourn, I will ask you to please send us some more names of witnesses for meetings on the COVID study, because we're running low on those.

With that, given that the bells are ringing, we are adjourned. Thank you very much, everyone.