HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

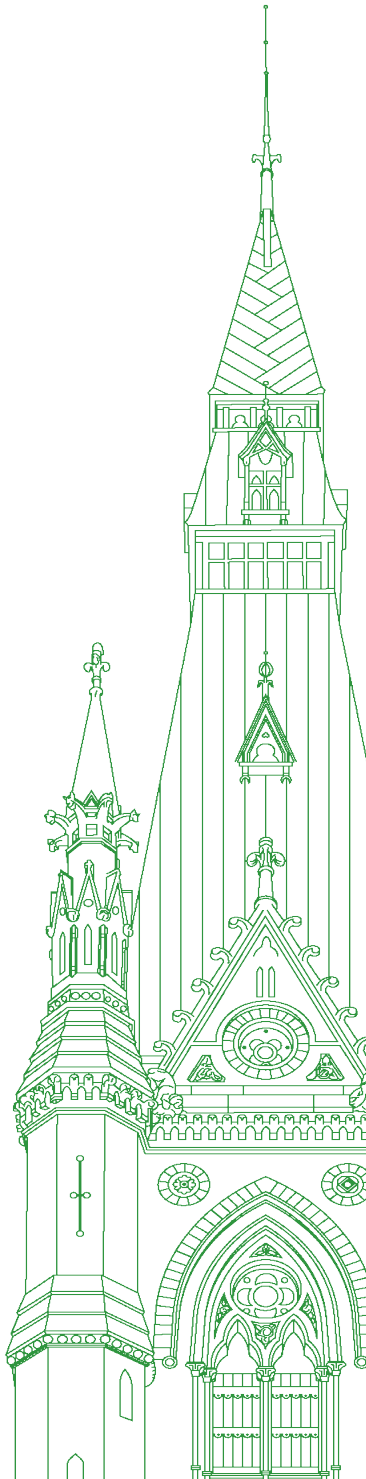
44th PARLIAMENT, 1st SESSION

Standing Committee on Health

EVIDENCE

NUMBER 020

Monday, May 9, 2022



Chair: Mr. Sean Casey

Standing Committee on Health

Monday, May 9, 2022

● (1530)

[*English*]

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

Welcome to meeting number 20 of the House of Commons Standing Committee on Health. Today we're going to meet for two hours to hear from witnesses for our study of Canada's health workforce.

Before I introduce today's witnesses, I have a few regular reminders to give 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 at their places during proceedings.

I believe most, if not all, of the witnesses with us today have been with us before, but I have a couple of reminders for them, if I could. Please wait until I recognize you by name before speaking. Click on your microphone icon to activate your mike. Please mute it when you're not speaking. You will see on your screen that you have the choice at the bottom of the screen of the floor, English or French.

Furthermore, please not take screenshots or pictures of your screen. Everything we're doing here will be made available via the House of Commons website.

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

I would like now to welcome the witnesses who are with us this afternoon for two hours. From the Canadian Medical Association, we have Dr. Katharine Smart, president; from the Canadian Nurses Association, we have Tim Guest, chief executive officer; and from the College of Family Physicians of Canada, we have Dr. Brady Bouchard, president, and Dr. Francine Lemire, executive director and CEO.

Thank you all for taking the time to appear today. I know that for some of you it isn't your first time, but there was a will among many committee members to have a further discussion on the road map work you were undertaking. It's not that the questions will be limited to the road map, but that's the reason for calling some of you back.

We will now proceed with opening remarks, beginning with Dr. Smart for the next five minutes. Thanks for being with us.

Dr. Katharine Smart (President, Canadian Medical Association): Thank you.

I am Dr. Katharine Smart, president of the Canadian Medical Association and a pediatrician based in Yukon. I'm speaking to you today from the traditional territory of the Kwanlin Dün first nation and the Ta'an Kwäch'än Council.

Thank you for this opportunity to address, once again, the growing health human resource emergency. This discussion remains critical.

Canada's health workforce is weathering a storm longer and fiercer than any in collective memory. Health workers are still depleted, distressed and leaving the profession. I'm so pleased to see my fellow health worker leaders appearing here today, those being The College of Family Physicians of Canada and the Canadian Nurses Association. We are unified in the belief that there is no health care system without health care workers.

We come to you today with solutions—transformational ideas and reminders of existing commitments—that can mitigate the current HHR crisis, address backlogs, expand access to primary care, attend to mental and digital health and improve virtual care and data.

First, bring in retention incentives for health workers to improve health care access in areas of need. Health care workers in underserved communities and particular care settings are burned out and exiting their careers, which is creating serious resource constraints. Current commitments to incentives are a start, but more needs to be done.

Second, release the pressure of administrative burdens that health care workers face. Heavy workload compounded by administrative burdens is often the kindling to provider burnout and worsening mental health. A commitment of $300 million over three years through a federal fund could support jurisdictions to improve the well-being of health care workers through administrative and mental health supports in primary and secondary care settings.

It is time to scale up collaborative, interprofessional primary care. Too few Canadians can access primary care when it's needed. It's time the federal government deliver on the $3.2-billion commitment to increase patient access to family doctors and primary care teams.

Primary care reform is health-system innovation that would move us from illness treatment to a focus on keeping Canadians well and out of emergency departments. It would move us from fee-for-service payment structures to blended or capitation payment models, allowing for more in-depth consultations instead of incentivizing short visits, which may be insufficient to address complex patient needs.

Many of the challenges with Canada's health care systems, from funding to efficiencies to patient outcomes, can be solved in concert under one umbrella with a team-based, interprofessional, primary care model. Designed around the patient journey, primary care allows Canadians and their families to navigate the myriad health services when and where they need it. Imagine that.

To add to that, an investment of $400 million over four years can expand the government's existing work through the FPT virtual care and digital table. The pandemic created an almost-overnight digital health revolution, with Canadians accessing care virtually. It cannot replace in-person care, but it has its place.

The CMA strongly urges the government to initiate a parliamentary review on the regulatory barriers to the mobility and deployment of Canada's health workforce under the Canadian Free Trade Agreement. The current regulatory licensing frameworks have to move to a pan-Canadian licensure model, allowing health professionals to work where they would like and where the needs are the greatest.

Mr. Chair, we cannot discuss the HHR crisis without addressing the mental health of health workers. Long-term sustainable supports are needed now. Through the $4.5-billion election promise in targeted mental health funding, we recommend the creation of a pan-Canadian mental health strategy for health care workers modelled on the federal government's 2019 action plan to support the mental wellness of Canada's public safety personnel.

Finally, let's talk about data. Canada cannot plan for our workforce supply needs or distribution if we do not appropriately collect data. With an investment of $50 million over four years, we can enhance health workforce data standardization and collection processes across provinces and territories and establish a centre of excellence through an existing agency to centrally house the data and uphold jurisdictional planning efforts.

The innovative thinking presented today puts people at the very centre of the solution, ensuring that current and future generations of health care workers have the supports they need to join and remain in their profession. There is a duty to address the emergency before us immediately. From there, we can look forward to long-term, integrated health human resources planning. We have to care for those who care for Canadians.

I look forward to hearing from my health leader colleagues on the realities facing the nurses and family physicians they represent.

Thank you.

● (1535)

The Chair: Thank you, Dr. Smart.

Next we're going to hear from the Canadian Nurses Association via their chief executive officer, Mr. Guest.

You have the floor for the next five minutes.

Mr. Tim Guest (Chief Executive Officer, Canadian Nurses Association): Thank you, Mr. Chair and members of the committee.

As you know, my name is Tim Guest. I am a registered nurse and I am the chief executive officer of the Canadian Nurses Association. I want to acknowledge today that I am speaking to you from Mi'kma'ki, the ancestral and unceded territory of the Mi'kmaq.

The Canadian Nurses Association is grateful for the opportunity to appear again on this important study alongside our colleagues, the Canadian Medical Association and the College of Family Physicians of Canada. We continue to hope that the committee's work will lead to meaningful and much-needed action to address Canada's health workforce crisis.

I'd first like to recognize that today marks a very special occasion as we celebrate the start of National Nursing Week and Indigenous Nurses Day. This week, we recognize the important contribution of nurses. Their knowledge, expertise, leadership and compassionate care are an inspiration to us all as they continue to answer the call despite the crisis they face.

Nurses and health care workers are at a breaking point. This is an urgent national issue, and pan-Canadian collaboration is needed to address this multi-faceted crisis.

CNA is grateful for the opportunity to collaborate with the Canadian Medical Association and the College of Family Physicians of Canada in developing a road map of solutions. I want to highlight three key elements from that road map for you today.

First, this is a crisis of retention more than of recruitment. In the short term, we need to stop the bleeding and help keep nurses and health care workers in their jobs. Canada needs to implement retention strategies and improve nurses' well-being. If no effective strategies are put in place to retain the nurses we have now, no other strategy will make a difference. Nurses need mental health supports, and their workloads need to be reasonable to make sure they will stay. Funding for retention bonuses for late-career nurses and federal income tax relief for health care workers can also help. Also, student loan forgiveness shouldn't be exclusive for those practising in rural and remote areas since we are also seeing shortages in urban centres. Hiring more cleaning or support staff could also be effective to allow nurses more time to provide nursing care.

Second, in the medium term, we need to increase system capacity to educate and train health care workers and accelerate the licensing and employment of internationally educated health care workers. Internationally educated nurses, or IENs, report great difficulty in practising in Canada. Barriers include immigration status, long processing times and registration costs. Targeted federal funding could help increase resources for regulatory bodies. Funding could also help offset licensing costs for IENs. Although IENs already living in Canada should be a part of addressing the crisis, they are not a quick-fix solution. CNA also urges caution on the recruitment of IENs currently living in other countries due to the global shortage of nurses. A special focus on ethical recruitment is important.

Finally, in the long term, Canada needs to urgently improve workforce mobility data collection and to establish a dedicated mental health strategy for health care workers to ensure they are supported during crises. As members of a female-dominated profession, nurses are often care providers for their children and family while they are experiencing burnout at work. However, access to mental health supports is lacking, especially in comparison to that available in other public sector jobs, including male-dominated professions such as fire and police services. In 2019, for example, the federal government launched an action plan to help address the mental wellness of public safety officers.

Furthermore, we agree with our colleagues from the Canadian Medical Association and the College of Family Physicians of Canada on the importance of scaling up primary care in Canada, and on the need for further supports for primary care practitioners, including physicians and nurses. We need to strengthen patient-partnered care and respond to the evolving needs of the population by advancing primary care through an interprofessional approach.

● (1540)

In conclusion, when it comes to looking at how we provide better health care in Canada, we need to look first at our health workforce. They are the backbone of the Canadian health care system. They make everything else work. Retaining and caring for them is at the heart of resolving many of the challenges that our health care system faces.

Thank you, Mr. Chair. I'll be happy to take questions.

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

Finally, we're going to hear from the College of Family Physicians of Canada, with Dr. Brady Bouchard, president.

Welcome to the committee. You have the floor.

Dr. Brady Bouchard (President, College of Family Physicians of Canada): Thank you.

Mr. Chair and members of the committee, thank you for inviting us back to speak with you again so soon after recently meeting on April 4. This reinforces to us the committee's interest in the acute crisis facing Canada's health workforce.

My thanks go also to my CMA and CNA colleagues for working together with the CFPC in a spirit of collaboration on an issue that is truly important to the well-being of Canadians.

My name is Brady Bouchard. I'm a family physician and the president of the College of Family Physicians of Canada.

I am joining you today from Treaty 6 territory and the homeland of the Métis. I'm joined by Dr. Francine Lemire, executive director and CEO of the CFPC. Francine delivered our remarks at the earlier meeting, and I will speak today and present in English. We will be pleased to respond to questions in both official languages.

We appreciate the committee's interest in the road map document that we developed with our colleagues at the CMA and CNA and appreciate the summaries provided by the previous speakers. This document is more relevant than ever. Over the last week, there were several high-profile articles noting the alarming trends in filling family medicine residency positions.

The 2022 Canadian Residency Matching Service match data continues the slow but steady increase in unfilled family medicine residency spots. Now is the time to address the root causes of that to ensure long-term sustainability.

CaRMS matches the approximately 6,000 medical trainees to the training programs for different medical specialties. In the 2022 match, 1,569 family medicine residency positions were available. Of those, 225 are currently unfilled after the first round—14%. This number has never been higher.

As a practising family physician still in the relatively early stages of my career, I can tell you that family medicine is a fantastic specialty, but these numbers don't lie. There are increasing pressures on our specialty right now that are making it less attractive to medical students.

Practising physicians are reporting record levels of stress and burnout, and some are beginning to retire early, reduce their clinical commitments or leave the profession altogether. With the cohort of new graduates set to be reduced, the potential future implications are significant. This should be a concern to everyone in Canada because of the fundamental role that family doctors fill in our health care system.

The road map developed with the CMA and the CNA provides a series of actions that can be taken to reinforce our health workforce. The CFPC supports these recommendations and stands behind this pragmatic and actionable plan that will support Canadian family medicine and health care in general, but for that to be true, the plan needs to be carried out.

From the perspective of family medicine, there are two areas of focus in the road map to focus on.

The first is the recommendations in support of currently practising family doctors. Our members have highlighted for us that the number one issue that would make a difference right now is to reduce the administrative burden they are carrying. That means reducing the amount of time and energy they are spending on things like the general clinic administration, record-keeping and paperwork that take away from direct patient care. Letting family doctors do what they do best—caring for their patients and coordinating care—will help reduce burnout, increase satisfaction and retain our practising docs.

The second area, made obvious by my comments about CaRMS, is about changing the practice model of family medicine in the long term so that the specialty again becomes an attractive first choice for our doctors of the future. Newly graduating medical students want to work in teams, where their skills are put to best use and they have the resources they need to care for their patients but are also able to find that work-life balance that is sorely lacking for so many of us.

This is why the CFPC strongly supports the recommendation to adopt the primary care integration fund, which will allow practices across Canada to evolve into high-functioning collaborative teams and, in turn, improve access to care for all in Canada. Progress on this front has been made, but we need to see a standardized, well-supported approach that leaves no province, territory or community behind.

We look forward to the upcoming question-and-answer section of this meeting. Thank you again for your time and interest.

● (1545)

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

We're going to move right to those questions and answers now, beginning with the Conservatives for six minutes, please.

You have the floor, Dr. Ellis.

Mr. Stephen Ellis (Cumberland—Colchester, CPC): Thank you, Mr. Chair, and thank you to all the witnesses for returning. I apologize for not being there in person, but I guess you guys aren't there either, so it doesn't really matter.

That being said, I want to say happy National Nurses Week to all the nurses out there, who I know are tuned in and listening intently to us—all my former colleagues. Not to be disparaging to physicians, but as we know, if we didn't have bedside nursing, the whole system would grind to a halt very quickly, which really leads me to one of my questions.

Perhaps I'll start with Dr. Smart.

We have seen a tiny bit of movement in terms of retention about the loan forgiveness commitment from the government. Obviously I think the road map is very comprehensive. If we could pick one thing out of this, what would the number one priority be?

Dr. Katharine Smart: Thank you for the question. It's a difficult one, because there are clearly so many issues.

From my perspective, probably the biggest crisis in front of us where there are some options, but what we could work on, is the crisis in primary care. When that part of the system is not working, it directly leads into the overload we're seeing on secondary care systems like emergency departments and specialist access, etc. That's the beginning of the challenge.

The challenge in primary care impacts physicians, nurses and other health care professionals, as well. If we can start to understand what that is.... I think you've heard from the witnesses today and in our briefs that we provided to you what those problems and issues are that are preventing that system from operating well. That will be the beginning of the systems transformation that we need to get things back on track.

We need to understand that we need to be committed to the team-based care. That's what everybody wants across health professions. We need to address the administrative burden, and that primary care applies to physicians.

We are hearing examples of how nurses are also pulled into these other duties in hospitals that aren't appropriate. It's looking at getting the right people to do the right things and getting people on track, recognizing that this old way of doing things is not working. It's not going to attract or retain people in family medicine. This problem is only going to grow if we don't get serious about transforming that system.

If I had to pick one thing—which, like I said, is hard to do, because it's all very important—that piece is very foundational in terms of how the rest of the things roll forward. The other aspect to that is the national licensure, because that impacts the sustainability of primary care in rural and remote settings, and being able to make sure that physicians in those communities can get relief is critical to retaining them.

● (1550)

Mr. Stephen Ellis: Thanks, Dr. Smart.

Through you, Mr. Chair, I have two specific questions. One is for Mr. Guest and one is for Dr. Bouchard.

Mr. Guest, you talked specifically about nursing training. How many more nursing spots do we need in Canada to increase that training amount? Do we have any idea now?

We've talked about the need for 60,000 or 70,000 nurses. How many training spots do we need to begin to catch up with the numbers we need?

Mr. Tim Guest: It's an interesting question that is difficult to answer, largely because we don't have enough data to tell us where we need the people and what skill sets we need. That adds to the challenge to really know.

We know that there are more people interested in going into nursing programs and becoming nurses than there are seats to take them. The exact number, I would say, is a shot in the dark at the moment without an adequate national data strategy.

Mr. Stephen Ellis: Thanks, Mr. Guest.

That rolls into some of the data collection that we all know we desperately need.

Finally, Mr. Chair, through you to Dr. Bouchard, we've talked a lot about administrative burden, that we need to help with it and need to have people doing the jobs they're trained to do.

Are there specific examples you could give the committee about the administrative burden in, say, a family doctor's office and how we might be able to reduce it?

Dr. Brady Bouchard: The administrative and paperwork burdens vary across the country. There are many examples to give.

One is how our EMRs—electronic medical records—function across the country, the varied number we have and the different vendors. Integration between the EMRs would certainly help. There's a lot of manual faxing that goes back and forth, tracking down additional results. To be quite honest, there are repeated lab tests and diagnostic tests, because you can't track down results. That would be one concrete example.

The other one is integration between family physicians and all the specialists they refer to. Most of that is done via fax. There's back-and-forth with specific forms or different types of forms. If we had an integrated EMR system, either a single source system or systems that talk to each other, it would greatly decrease that burden.

Mr. Stephen Ellis: Thank you for that.

Mr. Chair, I think I have a few seconds left.

Dr. Smart, can you talk quickly about the pan-Canadian licence? Do you have any concerns about that adding to the administrative burden in the sense of another layer of government?

Dr. Katharine Smart: That's an important question. Our vision for it is not that; it's that it would be a seamless process with all of the provinces and territories participating. You might want to think of it as one-stop shopping, so to speak, if those agreements were in place.

The goal is not to increase the burden on physicians in pursuing their licence, rather to streamline it and recognize that the requirements are essentially the same now. There are all these administrative steps that people have and costs to pursue licences. If we were able to streamline that, it could make the administrative aspect and the cost less, bringing that burden down and giving us much more workforce, deployability and flexibility.

● (1555)

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

We're going to go to the Liberals and Ms. Sidhu, please, for six minutes.

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

Thank you to all of the witnesses for appearing today.

Like you, I also want to recognize that this week is National Nursing Week and Indigenous Nurses Day. I want to thank all Canadian nurses for their tireless work.

My first question is for Mr. Guest. We all heard at the committee that nurses are leaving their profession. What kinds of resources and supports do we need to give them so they will not leave this profession?

Mr. Tim Guest: I think it's multi-faceted. We hear from nurses that one of the reasons they're choosing to consider leaving the profession is their workplace environments. They're talking about having to work short of people, having excessive workloads where they're looking after twice as many patients as they normally should be. They're complaining about feeling like the quality of care has deteriorated, along with those environments. They're talking about situations where they're being asked to work 24-hour shifts. We wouldn't allow a pilot to fly a plane doing a 24-hour shift, yet in some places we'll allow a nurse to work 24 hours. We're hearing a lot about burnout issues that are continuing to impact nurses, a significant deterioration in the self-reported mental health status of nurses, which was already an issue prior to the pandemic and has drastically worsened.

We need to address some of those situations in workplaces that are creating stress, and there also need to be mental health supports and other supports to help clinicians to get past the very challenging experiences they have faced during the pandemic This would be very similar to the supports that have been put in place for first responders, like PTSD supports and some of those mental health supports, to help clinicians deal with some of the tragic things they have experienced.

Ms. Sonia Sidhu: Thank you, Mr. Guest.

My next question is for Dr. Smart. We need to increase the number of trained health care workers. The budget proposes $115 million, with $30 million ongoing, to expand the foreign credential recognition program and clear the way for 11,000 internationally trained professionals. How do you think that working with the provinces and territories will help lessen the burden?

Dr. Katharine Smart: I think it's really important that we try to bring the health care professionals who are already in Canada into our system, We know there are many examples of physicians, nurses and other health care providers who are already here in Canada, who have really struggled to access the system for multiple reasons. I think this funding could go to try to streamline that process.

It's very expensive to go through the process. I'm now speaking specifically of medicine, because that's what I am more familiar with. We know there are issues with the cost of pursuing that training. There are issues with having enough access to the apprenticeship model we use, because foreign-trained physicians need to spend some time with a Canadian provider for practice readiness assessment, which is often unpaid work. Access to Canadian physicians who can provide that support and help integrate and orient people into our system is limited, so that is a barrier too. Then there's the cost. The regulatory aspect, again, of then having their documents assessed through our regulatory bodies and then being licensed is very expensive.

Those, I think, are all processes that could be simplified, streamlined and supported, as well as financial supports for those health care providers who are foreign-trained physicians themselves as they're going through that process, which would then allow folks to be successfully onboarded into our system. Right now, because the regulatory aspects of it are so varied, it's very difficult, and many people are never able to actually complete the process and remain outside the practice of medicine. I believe this is a challenge across health professions. If those dollars could be invested into better understanding how we can streamline that process and support people, I think we would have more chance of successfully integrating those health care professionals into our system.

● (1600)

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

My next question is for Dr. Bouchard. How does Canada compare with other countries when it comes to foreign credentials and medical school acceptance? You said that the matching number is very low.

Dr. Brady Bouchard: I think the entry into residency in different countries is significantly different and thus difficult to compare. I would certainly say, as you mentioned, that the number we're worried about is matching Canadian medical graduates into family medicine residencies in Canada. That's the worrying trend over recent years as far as training enough family physicians into the future is concerned. Dr. Smart already touched on increasing the credential pipeline for international medical graduates—absolutely, I agree with that. I would also point out there are a significant number of Canadians studying abroad who have finished their medical degree abroad and are then unable to match into a residency here. It's about both having more residency positions and also making family medicine a more attractive specialty.

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

[*Translation*]

I will now give the floor to Mr. Garon, from the Bloc Québécois, for six minutes.

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

With the witnesses appearing today, I would like to take the opportunity to say hello and thank you to all the health care workers in Quebec for their outstanding work during the pandemic. This of course applies to all the members of the associations who represent them.

To begin, let me say how much I liked your presentation. It gave a timeline, a graphical tool to help us understand your plan and its time frame. That makes my work easier, so thank you very much.

After reading your brief, I went ahead and made a list of the budget measures that would be required to implement the plan you suggested. You recommend $300 million in incentives for retention of health care workers, $300 million over three years for administrative costs $3.2 billion to increase access to primary care, $4.5 billion for a national mental health strategy for health care workers, and a certain amount for workforce data. With the $2 billion just earmarked in the last budget for delayed surgeries, the figure is $10.75 billion, or close to $11 billion in additional funding required over five years to address the problems exacerbated by the pandemic, and which we had quantified. I am thinking for instance of the issue of staff retention.

Looking at these figures, I wonder if it would not be better to simply grant the provinces' request to increase their funding under the Canada health transfer, on an unconditional basis. This would be less expensive to administer and would give the provinces all the flexibility they need, given the large amounts involved.

What do you think of that, Dr. Smart?

[*English*]

Dr. Katharine Smart: I think we definitely find ourselves in a challenge now as to how we try to leverage some of these ideas, which are pan-Canadian issues, and to get some momentum on solving issues that impact everyone, as opposed to continuing to be completely siloed with the current 13, arguably 14, health care systems that we have.

We absolutely appreciate that the provinces need to deliver on health care, and there's that important role, and more local knowledge is important, but we also struggle with being able to take and learn from lessons of what's working and scaling it in other jurisdictions, and what we end up with is no real transformative change happening.

We absolutely support the idea of increasing the Canada health transfer so that the provinces would have more predictability in terms of the sustainability of funding that's available to them. That said, we also see that several of these problems we've outlined are pan-Canadian problems and may be more efficiently handled by having solutions that every province and territory can collaborate on and move forward together on, rather than re-creating solutions in each province and territory and not learning or scaling things that do work. We also recognize that this has been our pattern of funding now for many years, and we have not seen significant health care transformation.

I think our real concern is how we move past the status quo. We've been talking about integrated team-based care for 20 years, but we haven't seen any really high-level commitment towards making that the system of care, so how do we get past the status quo? How do we get the provinces, territories and federal government co-operating towards the action that's needed to transform the system? How do we move forward out of this crisis mode? I think the worry is that more of the same is not going to get us there.

● (1605)

[*Translation*]

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

I have a question for Mr. Guest.

We have talked a lot about immigration. We have to do more to attract health care workers to Canada. I have talked with some Liberal colleagues about this. I know this is very important to all my colleagues around the table.

Quebec is unique in that it selects its own economic immigrants. I know this is a priority for the Quebec government.

I would like to know if the approach you are suggesting today to the federal government to attract health care workers to Canada was also suggested to the Quebec government. Did you approach the Quebec government to stress the importance of this issue since it is within its jurisdiction?

[*English*]

Mr. Tim Guest: We have had communication with all of the provincial and territorial departments of health. We've included the communication that we've sent to the federal government to all 13 provinces and territories, recommending the same approaches to them all.

I would say that when there's a need for us to reach out, we do. We tend to focus at the national level in a federal way and support our colleagues at the Quebec Nurses' Association to advocate locally with the government and the Province of Quebec. We tend not to interfere in those processes, but we had very much provided information to all of the provinces and territories related to our recommendations long before the road map was in place.

[*Translation*]

Mr. Jean-Denis Garon: Mr. Guest, you are not the first person to say that we need better information and data in order to implement our health policies.

What kind of data collection mechanism do you have in mind? Are you thinking of something more collaborative, with the provinces collaborating with each other, or something highly centralized in the federal government? What is your main idea?

[*English*]

Mr. Tim Guest: Thank you for the additional question.

We are not as specific in recommending the final outcome of how the data collection occurs. What's more important is that it be expeditious and there be national standards in the data that's collected, so that we have information that tells us something.

Currently we see siloed information. It doesn't have the same meaning, and it's very difficult for us to make informed decisions across the country with respect to what our needs are.

We suggest a number of options. We supported recommendations that have already been put forward. It could be a new organization that the federal government creates. It could support a not-for-profit organization similar to the Canadian Partnership Against Cancer.

Largely, we don't have a specific recommendation as to what the structure should be; it's more about the outcome and that the outcome happens quickly.

[*Translation*]

The Chair: Thank you, Mr. Garon.

[*English*]

Thank you, Mr. Guest.

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

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

Thank you, witnesses. Happy National Nursing Week, and happy Indigenous Nurses Day.

I want to congratulate and thank all of you for bringing solutions to the table. I think we've had a really good description of the problems during this study. What we really need to focus on is how we can address the problem that I think everyone is very well apprised of now.

I'm going to start with you, Dr. Bouchard. In your view, how would national licensure help with improving access to primary care? I know that it would help doctors move, but how would that actually help with the issue before the committee?

Dr. Brady Bouchard: I think it would help in a number of ways, a few of which Dr. Smart touched on already.

One of them is certainly around locum availability. We hear that from our members constantly, that current disparities in staffing across the country often leave them unable to take a break from their practice—to get a locum in to cover their practice while they're away. A national licensure would certainly provide mobility to allow that to happen. These are short-term locums specifically right now. It can take a long time, in addition to the money, to get registration in a particular province.

The other one that we often hear about is regarding border towns. We have a number of communities across the country, some closer than others to borders, and some particularly far away from their tertiary referral centres, where getting locums could happen maybe an hour down the road, versus trying to get somebody from elsewhere in the province. That would help with that.

My hometown, Lloydminster, is cut right in half on the Saskatchewan-Alberta border, and right now you need two licences to practice there on a daily basis. It's not just locums.

Those are two that I would mention for sure.

● (1610)

Mr. Don Davies: Thanks, Dr. Bouchard.

Dr. Smart, I'm going pivot to you to elaborate on that. I know we've spoken before about virtual care and how that might play into national licensure, so I'm going to ask you to comment on that.

Furthermore, you mentioned that a mental health strategy would be a key component to dealing with this. What should that consist of?

Dr. Katharine Smart: I'll start with the licensure issue first.

With regard to access to care, we know that one of the things that's really challenging right now too is also streamlined access to specialist care. That also impacts primary care providers as well, because a major source of burnout for family doctors is being unable to get their patients the care they need in a timely manner. I think we can support family physicians by streamlining the process they need to go through to access those consultations and collaborative care for their patients.

Virtual care is a tool to allow for that. It's also a tool that creates more flexibility in who can be providing the care to whom, so that we can better leverage different availabilities and wait times from across the country, which we don't do now. I think good access to virtual care is also important for family physicians in their ongoing continuity of care for their patients. It gives them more flexibility in how they meet the needs of their patients and in what context, so that they can better utilize their time and their patients' time. This means that if something doesn't need to be done in person, a lot of people prefer it to be done virtually. There's also an impact on the patient who has to take time off work, park and wait in your waiting room versus having a quick virtual appointment. Sometimes for those ongoing things between the longer appointments in a patient-doctor relationship, it can be quite efficient.

I think there are ways of utilizing virtual care to improve the doctor-patient experience to allow family doctors to deliver the right care through the right mode at the right time for their patients, which strengthens that doctor-patient relationship and then also access to specialists. Utilizing virtual care, I think, can make things easier for family doctors and also get them the support they need, given the increasing complexity and aging population, to continue to do their work.

That's particularly relevant for those of us who practice in rural and remote parts of the country, where the burden of travel for families can be substantial to access that care. Often the same things can be achieved collaboratively in utilizing virtual care. I think there are lots of pros to that. The other aspect of that is that increasing access virtually can also support continuing professional development for physicians, which is another challenge when you live in rural and remote places. There are many aspects to it that are positive.

With regard to the mental health piece, we know that the mental health of physicians has dramatically declined during the pandemic. We're hearing that over 50% of physicians have severe burnout; it's almost doubled from the beginning of the pandemic. A significant portion of physicians are reporting clinical mental health concerns.

I think we need to have more access to mental health care for doctors so they can address those issues. We need to destigmatize that. We do have some ongoing challenges where those types of health issues need to be reported to regulatory colleges, which can be a barrier for doctors seeking that care. We need to destigmatize mental health and recognize physicians are people and that they have these issues, just like anyone in the population. We need to normalize that and support them, and then make sure that those supports are readily available where they are and in an easy way so that it's not a barrier to their reaching out.

The government could be supporting those programs and making sure that they're available to doctors so that we can access that care and be in our top form so that we can continue to care for the patients when they need us.

Mr. Don Davies: Thanks.

Dr. Bouchard, I have a quick question. Is there a viable IT solution to the data problem you described?

Dr. Brady Bouchard: Not currently.

● (1615)

Mr. Don Davies: And, Mr. Guest from Nurses Association?

The Chair: Give a quick answer, if possible.

Mr. Tim Guest: No, there isn't. Each province and territory is collecting information separately, and we find that we have to sometimes go facility by facility. For individual provinces, some of them don't even know what their workforce data needs are. I think this is more difficult than just a simple IT solution.

The Chair: Thank you, Mr. Guest and Mr. Davies.

Next is Mr. Lake, please, for five minutes.

Hon. Mike Lake (Edmonton—Wetaskiwin, CPC): I'm going to continue on the mental health path here. Last week was Mental Health Week and I had the chance to meet with several stakeholders. I've had the chance to meet most of you individually as well. This is a great panel.

I've been thinking about mental health as it relates to what we're talking about. In my head, I've organized it in three different areas. There was what Dr. Smart talked about a few seconds ago, which is the mental health, directly, of medical experts or medical professionals. But first, of course, you're dealing with the mental health of the broad population as well, and the impact on health broadly. Then you're dealing with the mental health of individuals who are coming and interacting with you, and I can imagine that right now that's particularly difficult in many circumstances. Then, of course, you're dealing with the mental health of professionals.

Is that a good encapsulation? Is there a part of the equation that maybe I'm missing there? Would anyone like to comment?

Dr. Katharine Smart: I can comment on that if you like.

I do think that is a good framework. I agree that those things all interact with each other, absolutely.

I think, again, burnout really directly relates to mental health for many providers. The more you're burnt out in your work, the less joy you find in your work. The more the people around you are burnt out, the more negative those normal interactions we have with each other as colleagues can become. All those things just drive your mental health not being optimal.

Then the other side of that, as you alluded to, is that when our patients are really struggling and we don't have the resources to help them, that is also very challenging.

I think as the needs of Canadians have become more complex, in terms of both an aging population with more complex medical needs and the growing mental health crisis across the country, which is incredibly prevalent—at least one in four Canadians is dealing with concerns with their mental health—and then we're downloading that onto this broken system, that doesn't support people in the way they need. That burden, again, is often borne by individual physicians and other health care professionals who are very distressed at the fact they can't get patients the care they need.

I think those three things all do interact. I think they're circular. I think they build on each other, and if we're not addressing them holistically, I don't think we're going to solve that problem.

Hon. Mike Lake: Dr. Smart, you mentioned the $4.5 billion Canada mental health transfer promise. As I was having conversations with stakeholders last week, more and more concern was raised about the fact that the money hasn't been delivered.

The promise specifically was for $4.5 billion over five years, but for the last fiscal year $250 million was promised, and for this fiscal year it was over $600 million. Of course, in the budget we just didn't see that.

Taking away the whole $4.5 billion, and just thinking about almost a billion dollars that was promised eight months ago in the election campaign for allocation by this point in time for a Canada Mental Health Transfer, how important would that $900+ million be at this point in time to addressing some of the significant issues we're facing?

Dr. Katharine Smart: I think it would be very important. I think we're starting to see growing alignment on what the priorities are and what the challenges are, but it is very difficult to move from this conversation to the action without the resources. I think that next phase of funding and providing the fiscal supports to drive these changes is essential.

Hon. Mike Lake: Dr. Bouchard or Mr. Guest, do you want to weigh in on that? Again, a clear promise was made, a commitment to spend this money right now, almost a billion dollars just last year and this year alone? How important and how far would that money go to addressing some of the concerns we're facing on the mental health side?

Dr. Brady Bouchard: Thank you.

Yes. I will expand on that. Dr. Smart, of course, mentioned that without resources we cannot move either provincially, federally or collaboratively.

I just want to emphasize for the family physicians that we need the resourcing both for ourselves and for our patients, particularly around coming back to team-based care. We can't address patients' medical health and we can't address our own mental health in the five- or ten-minute visits that family practice has traditionally involved. We need that team-based transformation to address mental health as well. It's all interconnected. It's certainly not just the mental health of providers.

● (1620)

The Chair: Thank you, Mr. Lake and Mr. Guest.

Next—

Mr. Tim Guest: As my colleagues did, I would say it's vitally important. I think the one thing I have to add, though, is that the additional money is not going to be the only solution when we are looking at a mental health system that also has vacancies.

Over the last two years with registered nurses and registered psychiatric nurses alone, there has been an over 100% increase in the number of vacancies, so we need to be careful that we don't assume that the additional dollars are going to be the only thing that's going to be needed for a solution to this issue, because we would be sadly mistaken.

The Chair: Thank you.

Next we're going to go to Dr. Powlowski for five minutes.

Go ahead, please.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): Thank you.

I want to thank all of our guests for their recommendations. There's certainly a lot here.

In my mind, the key to getting more doctors into under-serviced areas and getting more nurses across Canada is recommendation 6: training and licensing for international medical graduates and internationally educated nurses. It's the "Action plan to get internationally trained doctors, nurses, and nurse practitioners to work".

Certainly, in under-serviced areas, people don't really mind where you come from as long as you can do the job. I say that having worked in six different countries and all kinds of places in Canada that are under-serviced.

Policy recommendation 6 says to "increase opportunities for experienced foreign-trained IMGs to complete Practice Ready Assessments". I want to ask both Dr. Smart and Dr. Bouchard about this recommendation.

We talked to a witness earlier in this study who suggested.... They thought there were only a couple hundred such positions available across Canada per year. Would having more opportunities for foreign graduates to take part in these practice-ready assessments allow us to get more foreign-graduated doctors licensed?

Dr. Brady Bouchard: There are a number of aspects to this.

Again, as Dr. Smart mentioned, we have all heard of physicians who have trained abroad and now live in Canada. They are Canadian, but they're unable to enter practice. Increasing resources for the practice assessment bodies—the credential bodies that do those assessments in each province—is certainly one path forward, and we would support that.

I think it's important to recognize that Canada must demonstrate a positive working environment for physicians in order to attract them to family medicine. We've broadly outlined a number of concerns around family medicine that we need to address, as well.

Another aspect of this is the concept of ethical recruitment. Certainly, Canadians who have immigrated from abroad and are now in Canada.... I think that's a clear line, and it includes Canadians who have left to study abroad and come back. There's a pool of resources there. We would support increasing training—

Mr. Marcus Powlowski: Sorry, perhaps I could interrupt you there.

Would there have to be more money available for the colleges of physicians and surgeons across Canada? Are they the ones creating the practice-ready assessments? If they had more money, would this open up more positions? Is that part of the roadblock?

Dr. Brady Bouchard: I won't speak for the regulatory colleges themselves. Certainly, we know that doing these practice-ready assessments is a resource-intensive process, so I would assume more resources are required. Sorry, I can't be more specific.

Dr. Francine Lemire (Executive Director and Chief Executive Officer, College of Family Physicians of Canada): I think the bottleneck, if there is a bottleneck, is in the capacity to assess a physician who has come from another country—working with that physician to make sure they are competent to perform in a Canadian environment. That capacity is one of the limiting factors.

● (1625)

Mr. Marcus Powlowski: Our government has promised money in order to make it easier for foreign graduates to get licensed in Canada. Is it as simple as having more money available to the colleges to do these assessments? Is that the answer? Or do physicians not want to do the assessments? Do they not have a lot of trainers? Where is the roadblock, exactly? The government does want to address this, I think. Is it just a matter of more money, or are there other things we'd have to do to get more of these assessments done?

Dr. Smart hasn't said anything.

You look as if you want to say something.

Dr. Katharine Smart: I can comment.

As my other colleagues have said, I think it's challenging in that it's not just one issue. The funding is one aspect of it for sure, but again there's also the challenge around the capacity of having the physician assessors able to take on more of these folks to help them go through the process.

Again, what you're hearing is that we're layering that on top of family physicians who are already quite overburdened in their practice. That's where it can get very challenging in the system, because we're trying to leverage the same people in multiple directions at the same time, and it's hard to keep adding to that.

We really need to be thinking about what that looks like. What is that process? How do we provide support and make that attractive for the physicians who are doing the assessments so that it's something they can fit into their workflow? Then, how do we make sure that it is appropriately funded? Also, the folks going through that assessment need t be funded so that it's something reasonable for them to be able to accomplish. Sometimes they're having to do that with no financial support, and that's a big barrier.

Absolutely, the finances are one piece, but I think, as you're hearing broadly as a theme today, for all of these issues we're talking about, the dollars are not the only issue in any of these problems. There are really significant structural issues. There are significant capacity issues. If we don't think about those two things in parallel, I don't think we're going to solve the issue. More money for something that's not working isn't going to suddenly make it work.

We need, I think, to understand what's working and what's not. How do we scale the things that are working? What substantial system changes need to be made, and then how do we support those new ways of moving forward so that it becomes sustainable?

The Chair: Thank you, Dr. Smart and Dr. Powlowski.

[*Translation*]

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

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

Mr. Guest, I would like to focus on your third strategic recommendation, which I find very interesting. You talked about providing $3.2 billion to the territories, provinces and Quebec to bolster the nursing and medical professions.

What is the time frame for your request of $3.2 billion? Over how many years? That is not indicated in your plan.

[*English*]

Dr. Brady Bouchard: To be honest, I don't have the answer to that, but I will make sure that I get back to you.

[*Translation*]

Mr. Jean-Denis Garon: No problem.

In addition, you did not provide any details on how that $3.2 billion would be transferred. I know you are more focused on the needs of Quebec and the provinces than on the terms and conditions.

Can you provide more details about what the provincial governments could do to bolster the nursing profession, for instance, if those amounts were provided to the provinces and to Quebec?

[*English*]

Mr. Tim Guest: If that question was directed to me, I actually think Dr. Smart would be a better person to answer it, because it's very much focused on primary care. I would defer that to her.

Mr. Jean-Denis Garon: Dr. Smart.

Dr. Katharine Smart: Thank you for the question.

What we're looking for there is this. We heard in the election campaign this figure of $3.2 billion for improved access to primary care, and I think where we see that making an impact is on really trying to address what is making primary care not work today. I think you've heard from us today about what many of those issues are. We'd like to see those dollars directed at moving towards integrated, team-based care and really changing that model of care so that patients have a medical home with a variety of providers who can meet their needs. This, in turn, will create a better working environment for family doctors, make family medicine more attractive and appealing—therefore, retaining the people who are already family doctors in longitudinal practice. At the same time, it will make it a more appealing area of specialization for our new medical graduates, as well as allowing other health care professionals to work at top of scope in a team, which also will increase their job satisfaction. It builds on itself in terms of the success it would bring in that regard and in improving access to care for Canadians.

That's really where we would like to see that money go. Again, we know that just having more doctors isn't the solution in and of itself, because if those physicians are not satisfied in their work environment, or that work environment is broken, they are going to leave and do other things. That's what we're seeing now. Many family physicians are practising medicine, but they're not practising in a primary care model in a community with a patient roster. Those dollars could go to changing that practice environment so that family doctors actually want to be family doctors, and that people who want to work in these teams providing primary care to Canadians are able to do so longitudinally.

● (1630)

The Chair: Thank you, Dr. Smart.

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

Mr. Don Davies: Thank you.

Mr. Guest, you spoke of the crisis as being one more of retention than recruitment, and I take that at face value, but you also mentioned that workloads were a problem. I'm putting together a vision in my mind from what I've heard, namely that as hospitals have cut cleaning and support staff and admin staff, a lot of those duties have been thrust upon nurses, so I can see that adding to their workload if they're spending a couple hours of their shift doing cleaning and administrative work. I see how bulking up the administrative and cleaning staff would help, but does it also not speak to the fact that we need more nurses on shift as well? If so, can you help me quantify that?

Mr. Tim Guest: I think it's all of that. To add some context, we've added a number of things to nurses' work environment, some of which are related to their doing non-nursing-related tasks. We've seen examples of that. As some organizations have implemented new electronic health records that are more integrated, some of them have reduced clerical supports as physicians do more of their physician orders themselves, and yet there have been tasks left behind that those clerical people were doing that get downloaded onto nurses.

As an example, I hear of nurses needing to clean beds in some facilities at night for admissions because there are no cleaning staff in facilities. There are a couple of examples. Some of the others we're hearing about are that many hospitals across the country are over capacity, which adds to the workloads that nurses are experiencing. What makes it more challenging is that they are sometimes coming into work that day when the workplace is short-staffed already. That's part of the challenge when you have a system that has a significant increase in vacancies that you're not able to fill, yet you haven't adjusted the work with the workforce. We've continued to operate many of our facilities full blast, yet we have a workforce that's depleted and isn't at 100% capacity and are expecting them to continue to do the same work volume.

There needs to be some balance there. Part of that challenge is that it creates additional stress and more of those workers choose to leave because they don't want to come into work not knowing if they're going to have the five patients they should have, or 10, or if they're going to get to go home at the end of the day, or they're going to have to work 16 hours because there's no one coming in to relieve them. Those are the challenges. It's not just about needing to have more of a workforce; it's about needing to look at all of the issues and balancing them all out together.

The Chair: Thank you, Mr. Guest.

We're going to go to Mrs. Goodridge, please, for five minutes.

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

Like many of my colleagues, I would like to start by thanking all of the spectacular nurses who make our health care system run. Here I give a special shout-out to a friend of mine, Katie. You do amazing work and we are very proud of all the work you do for our community.

Specifically, I was reading an article last week from CTV Vancouver, which was talking a little bit about how there are an unknown number of patients in B.C. who can't find a family physician. Yet, in Alberta, because of some of the boards that we have, with the College of Physicians and Surgeons of Alberta having a directory that allows them to show how many doctors are accepting new patients in Alberta, they can give a precise number. Often, at this committee up to this point, we've heard a lot about statistics and how the statistics are haphazard across the country, and I'm wondering, perhaps starting with Dr. Smart, if there any jurisdictions who are doing the statistics piece better or worse.

● (1635)

Dr. Katharine Smart: I don't have a direct answer for that, because I'm not familiar with exactly how each jurisdiction is collecting statistics. I think we see different jurisdictions reporting different numbers and different things at different times, and some things, on the surface, at least, seem to be better than others. It would be hard for me to say exactly where you would want to be looking to for best practice.

I think what needs to happen for sure is standardization across the country in terms of data reporting, and also to make sure that we're talking about the same thing. As an example, when we're talking about surgical backlogs, some of the ways the provinces are generating those data are varied that the data are not always reflective of the on-the-ground experience of patients or physicians. I think part of getting good data collection is really standardizing what we're talking about when we're discussing different data points and making sure that it's reproducible and that we're talking about the same things—an apples to apples comparison.

Mrs. Laila Goodridge: Fantastic.

Perhaps Dr. Bouchard has an answer for that same question.

Dr. Brady Bouchard: Yes. All I would say is that every province is doing it differently. That's why we need some unification around this. Certainly, some provinces are relying on fee-for-service billing data.

I would emphasize on that point as well that a family physician is not a family physician. There are provinces that have made it clear that they think they have enough family physicians, and yet there is a significant proportion of patients who are unattached. Obviously, those both can't be true at the same time. We really need to capture how family physicians, how all health care workers, are practising, whether it's comprehensively or a focused practice in emergency, addictions, etc., in order to know what we need and where we need it.

Mrs. Laila Goodridge: To follow along that same line, if you could design a system, what system would you design to help make sure we had a handle on our health resourcing?

Dr. Brady Bouchard: Thanks for the question. I don't think we would be so prescriptive other than to say that it needs to be national in scope. It needs to be standardized. It needs to be shared data as well in order to inform health workforce planning into the future.

As Mr. Guest said, there are many ways to accomplish this. The issue right now is that we don't have the data, and where we have the data, it is collected in very different ways, in different forms, in different places in the country.

Mrs. Laila Goodridge: Fantastic.

Moving on to a different space, Mr. Guest, I'm wondering if you have any thoughts when it comes to some of the data you're seeing and if there are any jurisdictions that you might be able to point to that are doing it better.

Mr. Tim Guest: I haven't directly had the opportunity to observe how each province and territory is actually collecting data. I can tell you, based on my personal experience, that Nova Scotia has done some really good work in this area, particularly on the non-physician side of the health workforce. They work very directly with their advanced education colleagues. Government is heavily involved in the process. They work collaboratively with the regulators. So there is an example of some that are, I think, doing a fairly good job and where we could replicate some of those processes.

I think Dr. Bouchard's comment was the key: We have 12 or 13 approaches to how we do things. It's not so much about everyone having to do the same things, or someone taking over and doing this for the provinces and territories. It's about the provinces and territories and the federal government coming together and agreeing on a standardized nomenclature for how the data is going to be collected, with a centralized place collecting it for them, so that everyone can access it for better decision-making. I think that's what we believe is the important approach.

Mrs. Laila Goodridge: Wonderful.

I think my time has elapsed.

The Chair: Yes. Thank you, Ms. Goodridge.

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

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

I would echo the thanks to all the witnesses for re-appearing and for bringing the road map that speaks to solutions. Like my colleagues, I'd like to recognize National Nursing Week and Indigenous Nurses Day.

Dr. Smart, the situation is so critical that we urgently need to find solutions and establish recommendations. In addition to the road map that the three organizations have brought to us, you released a statement just today, I believe, on the need for the federal government to lead, in collaboration with provinces and territories, a drive to increase Canada's supply and availability of family doctors. I think this is critical. What I really liked in that statement was that you talked about reimagining family medicine, which goes back to that concept of reforming primary care.

Maybe you could say a few words on this. What does the modern, happy, useful and efficient 21st century family physician look like? Let's project a few months or a couple of years into the future.

● (1640)

Dr. Katharine Smart: I can make some comments, and then, of course, I would love to hear from the two family medicine experts we have here today.

I have really tried to take their approach in this role. The CMA has really tried to take the approach of listening to the people that are experts in family medicine regarding the pebbles in their shoes. What are the things that are preventing them from doing this work?

Every family doctor I have encountered and met through my career has chosen that area of medicine because they really believe in wanting to provide longitudinal continuity of care to families from birth to death. The fact that the system is taking that joy in providing that type of very meaningful care away from them, I think, speaks to the fact that it's fundamentally broken.

Family doctors want to provide that care without having to worry about all of the business aspects of medicine, such as rising inflation, rising costs of providing the primary care infrastructure, rising administrative burdens, inability to spend the time their patients need from them to address complex issues, and not having the team around them to provide comprehensive care.

If we project that to the future, they want to be on a team where their patients have a medical home. That medical home means that the provider that patients need is available to them for the problems they come with, that they are seen as a whole person, that the care is comprehensive around that, and that their job is thinking about patients and what they need. They do not want to think about how to run this small business, how to work through this fee schedule of 18,000 different fee codes and manage all those billings. All of these administrative pieces really detract from the heart of what medicine is, which is a relationship with patients.

If we can get back to that, and really look at addressing the health care issues that Canadians need, we can have a healthier population, a healthier workforce, and a new future for family medicine where it again becomes one of the most desirable areas of practice for new doctors.

Mr. Brendan Hanley: Thank you.

Dr. Bouchard, let's flip that around a bit. In this primary care team, anchored by that happy family physician, tell me about the patient and the client in the middle. How are they going to benefit?

Dr. Brady Bouchard: Dr. Smart did an excellent job of detailing our vision and how we would like to practise.

The benefits to patients are innumerable. Family physicians are trained in complexity care in a complex health system with complex diagnostic and treatment options. We want to be able to work at that top of scope, and have other providers around us in order not to be focusing on the business. If we're able to do that, patients will absolutely benefit, and certainly in longitudinal care.

I would like to have patients attached to my clinic that I see from birth to death, with whom I have an understanding. I understand their context. I understand their family, their values, what they want out of their care and their goals in life. The evidence is out there that we provide better, and certainly more efficient care, for the dollars invested into that.

That's where the primary health care integration fund comes in if we can transform that. That's why it's a time limited fund. If we can get into these team-based practices, it will be more efficient for the health care system, and patients will benefit.

Mr. Brendan Hanley: Thank you.

Back to you, Dr. Smart.

Clearly, there are federal investments committed either in the budget or through the platform commitments; namely, mental health care, primary care, reform, and addressing the backlog. As you have all said, “It's more than just money.”

You spend a lot of time talking with colleagues and associations around the country. How do you see the federal role in igniting change? We're in a federated system. The provinces have control over health care delivery, yet we need a driver. We need to get there.

Dr. Smart, could you comment on how best the federal government can position itself, in 30 seconds or less.

● (1645)

The Chair: Actually, he has used 30 more seconds than he's allowed, so when he said 30 seconds or less, he might have been exaggerating.

Go ahead, Dr. Smart, as concisely as possible.

Dr. Katharine Smart: I think leadership to define that the integrated team-based care is the gold standard and the future. That needs to be the model. Anything less than that is not going to cut it in 2022, so we need to define ourselves from that benchmark moving forward.

The Chair: Well done, thank you.

Mr. Lake, you have five minutes.

Hon. Mike Lake: Thank you. This is a great study.

I want to say, first of all that I've had some experience, unfortunately, with the health care system for people close to me and for myself, but it's always been a great experience when we've had something urgent.

I had encephalitis when I was 31. I'll tell you, it was taken very seriously and I was very happy to have the support that I had.

I have a son with autism. I know, Dr. Smart, that's something close to the work that you do. When we've needed help with him, trying to figure out what's going on because he's non-speaking, we've always had fantastic support.

However, in those interactions, I've noticed things that seem inefficient, and we probably all have at different times.

In the times when I didn't have a serious injury—playing hockey, for example—and had to go into the emergency department because I don't know where else to go, I waited for hours because there were more important case. That seems inefficient in the general scheme of things. It doesn't feel like I need to be there, but it's the only place that works. Going to my family doctor, who is fantastic, I see him do a lot of administrative stuff as he's working with me. He's taking notes and things like that. It seems very inefficient.

It seems that a big part of the challenge is people doing things, largely, that someone with different training or less training than the experts—the expert training people have—whether it's doctors, nurses, or others.... They're doing things that they don't need to do.

When you think about those really expensive inefficiencies in the system, such as someone going to emergency who doesn't need to be there, having a doctor taking notes or, as Mr. Guest talked about, nurses doing cleaning, they all seem to be very expensive inefficiencies.

What are the ones that are the easiest for us to address as we think about action coming out of this set of meetings?

Dr. Katharine Smart: Is that question for me?

Hon. Mike Lake: It's for anybody who wants to answer it. It's such a great group.

Dr. Katharine Smart: I'll let someone else talk, because I've talked lots.

Hon. Mike Lake: Dr. Bouchard's unmuted.

Dr. Brady Bouchard: Sure. I'll take a stab at that.

The most essential component of building efficiencies into our system is moving to what the CFPC puts forward as a patient's medical home. That patient's medical home, that team-based care, will vary across the country based on community demands. We're not prescriptive so much about how each clinic is set up and which team members are involved but, exactly as you mentioned, focused on what the community needs are. Getting everybody in that team to work the top of the scope, so that we've using our resources efficiently is where we want to go.

The 10 pillars of the patient's medical home and the resources of the primary care integration fund will get us there.

Hon. Mike Lake: When I think about my own doctor and family doctors, they seem to be running small businesses of a sort. Individually, it's their own small business. My observation is that there's something....

I come from a business background. If I was running a business of a similar size and nature, I would have support staff doing some of the things, and you would think that it would enable me to see more people. The money, the compensation, comes from that and it would almost pay for itself in a sense, if you get the right people doing the right supportive work. It's an observation from the outside.

What gets in the way of that?

Dr. Brady Bouchard: We're on the record as saying that alternative payment models—specifically not running your own business in a fee-for-service practice—is where to go, and I would say a couple of things get in the way of that.

Family physicians are not trained to run a business. We're not trained to hire staff, manage staff, sign contracts and deal with remuneration. We don't want to be doing that. Unfortunately, that ends up, depending on the practice, being a significant portion of your day, when you could be focused on clinical care. It's contributing to burn-out, especially in our urban areas right now, with inflation and increasing commercial overhead costs, medical supply costs and everything else.

I think alternate payment models in a team-based practice are one way to make substantial change to get away from some of the areas that are in the way of providing best care.

The other one is our IT solutions, our electronic medical records software. If we were able to integrate those systems between referral centres, primary care clinics and even hospitals, it would save a huge amount of time for every team member and it would be a sustained win into the future.

● (1650)

Hon. Mike Lake: Thank you.

The Chair: Thank you, Mr. Lake and Dr. Bouchard.

Next is Mr. van Koeverden, please, for five minutes.

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

Through you, Mr. Chair, I have a question that might be a little bit technical. It doesn't require a specific answer or a really technical answer, but I'm really curious if anybody has any reflections on the potential proportions of the contribution that could come to the Canadian health care workforce, whether through nursing, physicians or any level or layer of the workforce, that could come from the various.... I was looking specifically at points 5 and 6 of the joint submission by the CMA, CNA and CFPC, dealing with new training and education infrastructure and also new licensing.

I'm also reflecting on the fact that if there isn't the capacity currently in Canada to educate new nurses and physicians at this time, perhaps creating simpler pathways for internationally trained Canadian nurses and doctors to come back to practise could help.

But what are the proportions there? Does anybody have any reflections on that? Is there one method that will contribute to the lion's share, or are we looking at an equal contribution from those various modalities?

Mr. Tim Guest: I don't mind starting.

The simple answer is not one of them that will be the single solution that's going to be the biggest one getting us out of this situation. It's multi-faceted. It's going to need a multi-faceted approach.

From a nursing perspective, we do know there are a number of internationally educated nurses who are in the country and struggling to get through the regulatory process to be able to be in the workforce, but it's not a massive percentage of the current nursing population that's going to be the solution for getting us out of this. It helps.

I think that in the situation where we're in, everything that helps needs to be considered to deal with what is going to be a massive crisis. We are looking at there being growing vacancies, growing numbers of individuals in the current workforce who are wanting to leave it and a growing list of Canadians needing procedures and treatments that have been delayed for months. That is eventually going to have a negative impact on health outcomes, and we're going to be in worse and worse trouble and depending on the same workforce to help get us out of it.

There needs to be an all-hands-on-deck approach. We need to look at all of those situations, both short-term, like helping internationally educated nurses become regulated or registered to be able to practise.... To be honest, I think they would offer something even if they were in the workforce doing all kinds of things, let alone waiting until they're registered. There are things they could do now to help them adjust and learn the system.

But we need to do all of them.

Mr. Adam van Koeverden: Thank you, Mr. Guest.

Does anybody else have any other reflections on the potential contributions from various modalities, or should I move on to another question?

Dr. Smart.

Dr. Katharine Smart: I think I was just going to echo what Mr. Guest said. I think it is really about leveraging all possibilities. I also agree that no one of those things on its own is going to be the full solution. Nonetheless, they're all opportunities to bring more people into the system. Again, we need to make sure that we have a system that people want to be in, so we need to be doing those things simultaneously.

● (1655)

Mr. Adam van Koeverden: Thank you.

For clarity, I wasn't trying to reduce this to the one thing we can do to solve this massive problem. I was just trying to get an idea of whether we're thinking that 80% of the problem could be solved with these two or three, and then the rest would be sort of rounding errors. But I take the point that it's probably not. We don't know, quite frankly, what the solutions will be until we start employing and engaging them.

I read a relevant reflection this weekend about something totally different, namely that we have all of the solutions and we just have to deploy the solutions. It's not a matter of coming up with new ideas for fighting climate change or creating solutions for human health care resources, or the lack thereof. It's a matter of deploying them.

I have a question regarding the training. Obviously this would be months and years down the road, so it wouldn't address the problem in the next six months. But would more scholarships for people entering this education be a little bit of a cart before the horse type of thing because there are not enough positions?

It also occurs to me that in most lines of work now, there is the capacity to have more people than desks, which could possibly be true, as well, in nursing. We have fewer desks here that could hold everybody in the meeting, but we're managing. So perhaps nursing schools and colleges could be training higher than a general capacity.

Would new scholarships and bursaries for future students encourage more people to get involved?

Dr. Katharine Smart: I'll make a comment from the medical side.

Right now we don't have enough seats in our medical schools for the number of people who want to train to be physicians. They are oversubscribed, and that's why you see many Canadians choosing to go overseas, primarily to Ireland and Australia. Those seem to be the two most popular places for Canadians to train in medicine. That's largely because folks haven't been able to access medical schools here. I think more capacity in our system is important.

I think scholarships are really important when you look at the challenge of improving the diversity in our workforce and allowing the workforce to be more representative of all Canadians. Medical school is incredibly expensive. Some of the things that are prioritized by people who apply in terms of extracurriculars really speak to privilege; they're not things that many Canadians would have been able to do.

From my perspective, a really important part of serving Canadians well as a profession is making sure that our workforce is diverse. I think eliminating financial barriers to allow different types of people from different backgrounds to become physicians is going to be critical for the future.

The Chair: Thank you, Dr. Smart.

[*Translation*]

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

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

Dr. Smart, I was moved by your comments earlier about access to care. Personally, I am very concerned about access to care in the regions. In Senneterre, for instance, in the Abitibi-Temiscamingue region of Quebec, there have been instances where the hospital had to close because of a shortage of doctors and staff.

During the pandemic, we saw a number of significant improvements very quickly, such as telemedicine. The college of physicians was able to change its practice standards quite quickly so that patients could access virtual consultations, which facilitated a smoother flow of services. I understand of course that not all care can be provided this way.

From your point of view, in order for us to use this new consultation method in the longer term, what investments or resources would be needed, and what would have to be done by faculties of medicine in particular?

[*English*]

Dr. Katharine Smart: I think there are a few things. One of the biggest challenges in remote areas, both for patient care and potentially for the idea of decentralizing some aspects of medical education to improve access for rural and remote Canadians, is the Internet itself. I'm speaking to you from Yukon today. The Internet service here is very expensive and not of high quality. I would say it's more than what most people can afford. I personally pay over $200 a month for my Internet, which is sort of a shocking number.

We need to make sure that all Canadians have equitable access to communications technology. This virtual care revolution that happened so quickly because the pandemic has been revolutionary in many ways. We're still figuring out exactly how to leverage that in the best way. I think we're going to see some of those changes come for education as well, and we'll get away from thinking that everything has to happen in the big city at the university.

There are some excellent examples already of distributed medical education across the country. I think we can continue to build on those models. We need to look at what's working and how those are servicing Canadians wanting to be doctors. We're going to have to make sure that the infrastructure is there for people so they can get online effectively and participate in these virtual experiences. I think there's an equity concern there if it's not available to everybody. You start creating two different tiers of access both educationally and in terms of patient care. I think that's an important area to focus on.

● (1700)

The Chair: Than you, Dr. Smart.

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

Mr. Don Davies: Dr. Bouchard and Dr. Lemire, the primary care integration fund seems to be a core piece of your suggestions.

What advice would you give us on the implementation elements that we should bear in mind as we create and administer this fund?

Dr. Francine Lemire: I think that we see the primary care integration fund as a fund that would be put in place for a temporary period of time to enable scaling up of some models of care that already show promise. Examples of this would be groupe de médecine de famille au Québec, Ontario health teams, and primary care networks in Alberta. These are some examples that are models of care that support good integration and team-based care, and they have shown promise in terms of reduced visits to the emergency department, better adherence to preventative measures and better satisfaction by patients and providers alike.

This fund would enable scaling up, assisting and providing support to family practices to get to that model of care, because we know that investments are required up front so that you can reap the benefits at the back end in some of the outcomes that have been described, as well as savings from a health care delivery perspective.

Mr. Don Davies: Thank you.

I'm sorry, did you have more to say?

Dr. Francine Lemire: You and I have discussed this already: make a targeted fund available with the specific purpose of doing some of the things I've just finished talking about, to which the provinces could apply. Hopefully, they'd all be interested in accessing the fund to bring about that scaling-up of innovation.

Mr. Don Davies: Mr. Guest, I'm going to revisit a question that I don't think I put to you properly before.

The question I asked you is whether there is a viable IT solution. I know one problem is that hospitals and provinces aren't talking to each other, and it seems this is a major cause of grief. Is there an IT solution out there for that? That's what I'm asking.

Mr. Tim Guest: To our knowledge, no.

We certainly have seen, across the globe, some countries doing a fairly good job at this. I think there are some examples we can learn from. The United States has a program for doing this. I don't think we have to start from scratch and recreate the wheel. There is information out there and knowledge that we can leverage.

I think the big thing here is.... It's not so much the IT solution itself, but the infrastructure needed to pull it off. A really good example of where this is already happening in the health system in Canada is CIHI. This federal agency has the task of pulling together the health data collected by all of the provinces, which goes in a central repository. It's analyzed and provided back to the health systems so they can use it for planning. That's kind of what we're talking about: an organization to help standardize data collection, which the provinces and territories would flow up so that it could be analyzed and provided back to decision-makers in the provinces and territories for better planning of health human resources strategies, whether that be in the number of educational seats that need to increase, or investment that needs to happen to support clinicians so they can practise some specialty that may need to be grown.

Those are a couple of examples.

The Chair: Thanks, Mr. Guest.

Dr. Ellis, please go ahead. You have five minutes.

Mr. Stephen Ellis: Thank you, Mr. Chair.

I want to say how wonderfully efficient we are today. We've gone through many rounds of questions, which is unusual for us. There were no interruptions from bells, which is also great.

I'll respectfully disagree with one of my colleagues, Mr. Van Koeverden, who talked about whether we have the solutions. Part of the difficulty here is understanding the breadth of this problem and the significant change required. We need people. We need to create physicians and nurses, and that takes time. We also understand there's a tremendous shift away from choosing family medicine as a profession. We heard about the unmatched seats during the CaRMS process, and that is a tremendous change we've seen over the last generation or so. To me, that creates a significant problem.

There are two other comments I would like to make, and then I will farm out some questions.

First, team-based care is exceedingly inefficient. I've practised team-based care at a chronic pain clinic for the last 15 years or so, and the speed with which we're able to see patients is much slower. We have to discuss them and we have to chart them, etc. That's a difficulty.

Second, I'm not entirely sure the government understands how dire the situation is. I'm not entirely certain that every Canadian understands how dire the situation is. Because team-based care is a significant part of the road map here, I would like to ask Dr. Bouchard to comment on the inefficiency of team-based care. There certainly are many cases in family medicine—and I understand that I'm biased because I'm a late-generation family doctor—where you don't necessarily need to see a team. How do you sort that out?

● (1705)

Dr. Brady Bouchard: I think rather than the term “efficiency”, what you're perhaps alluding to is the time per visit or the time per patient. Certainly that would increase in a team-based practice, and it should. Patients are more complex. It takes longer to sort out problems. We were just talking about the mental health burden for providers but also for patients, and that certainly takes more time.

A team-based care model that's implemented well doesn't necessarily equate to increased resources and increased dollars. Different team members working at their top of scope and many team members that are not as highly trained and, to be frank, paid at the same level as family physicians are would be incorporated as part of that, but it's also about the health care savings we see.

Dr. Lemire touched on how even if a team-based primary care clinic or network costs more directly, there would be significant indirect savings from reduced emergency department visits, which are much more expensive, and reduced hospital admissions certainly.

Per visit, per patient coming into clinic, that may change. It may take more time. However, having worked under both models myself, I think patients value—and as a family physician, I certainly value—being able to take that extra time to sort out all of the issues. We hear across the country about one issue per patient and one issue per visit. Patients don't like that, and family physicians don't like that, and I think we can do better.

Mr. Stephen Ellis: Thank you, Doctor.

Dr. Francine Lemire: I'd simply add perhaps that it takes time and energy to work effectively as a team. I have experienced the same thing you've described. You see a patient who has been seen by several different people before they get to you, and that's not efficient. Energy needs to be spent on supporting people to work well as a team. That needs to be a part of it.

Mr. Stephen Ellis: Thank you very much.

Through you, Mr. Chair, to Dr. Lemire, kudos on the amount of work you've done on this particular project over the years. You've seen this through many iterations and many reports. What's your confidence level that we're actually going to be able to get there this time?

I know that's a politically loaded question. I appreciate that, Doctor. I do.

Dr. Francine Lemire: The only thing I will say is that I think all of us here today realize that we are at a point of inflection with regard to how primary care and community-based care are functioning. I think we all realize this now more than ever. I would suggest that we are at an important crossroads, and I sense that there is a genuine will to invest in a future that will not be a repeat of the past.

I am more confident than I have been in the past, but I certainly will not put a percentage on it.

● (1710)

Mr. Stephen Ellis: Well said. What a great way to end, Mr. Chair.

The Chair: Thank you, Dr. Lemire.

Dr. Powlowski, go ahead, please, for five minutes.

Mr. Marcus Powlowski: Having practised medicine for a lot of years and having worked with a lot of nurses over those years and certainly recognizing the key pivotal role of nurses in the health care system, I will ask Mr. Guest some things about the problems facing the nursing profession. Any of us who work in medicine realize how overworked a lot of nurses are, particularly in hospitals, and how they are always being asked to work overtime and extra shifts and they have too much work to do because they're understaffed.

In your recommendation number six, you suggest that, presumably the government, should support and expand opportunities for registration and deployment of internationally educated nurses in order to provide immediate supply into the workforce as is done in provinces such as Manitoba and Ontario.

We haven't been doing this long enough to have talked to people from each of the provinces.

Mr. Guest, could you tell us what Ontario and Manitoba have done?

Mr. Tim Guest: Ontario is more recent. I'll give you an example. They put resources in place very quickly during the pandemic to work with the regulator to expedite getting those individuals through the process. The primary issue we hear with internationally educated nurses is that there are three main issues that cause them to get into the workforce.

The first is their immigration status, which sometimes impacts their ability to access programs. It impacts career laddering opportunities, because they're not necessarily seen as permanent residents yet.

The second one is associated with the cost of going through the regulatory process. Not all individuals have the resources to pay the costs associated. In B.C., as an example, we've seen it can cost up to $15,000 for an internationally educated nurse to be registered in that province.

The third thing is long processing times. We've heard examples in provinces that it can take up to three years for an individual to make their way through that process. One of the things Ontario did was work with the college to expedite that process and provide resources for them, so they had more people to assess individuals.

It's about matching the individual with their capabilities and helping them get registered into the right classification of nursing. What often happens is they find that they're not able to be registered in one and have to start the whole process all over again to be registered in another.

Mr. Marcus Powlowski: From what you're saying, it sounds like it is possible with more resources to license more foreign graduates. Can you tell me approximately how many extra nurses were licensed in Ontario as a result of this expedited process?

Mr. Tim Guest: I can't give you the number off the top of my head, but I can certainly try to get you a clearer number.

Mr. Marcus Powlowski: That would be great.

Is it true that nurses also have to be licensed province by province? Because my wife went to nursing school in the Philippines, I know that of her classmates, some were able to practise in Alberta and some were able to practise in California, yet others couldn't get licensed in Ontario. Does this make any sense? Is Ontario's quality of nursing that much higher than California's and Alberta's? I don't think so.

What about the possibility of national requirements for licensure in nursing? We've heard it from the medical profession. Have you considered it for nursing?

Mr. Tim Guest: Yes, we have. I would say that the medical profession is further ahead on this matter than nurses are. We're advocating for a national nursing identifier, where a nurse would have an identification number that would follow them through their whole career across the country. That is not the case now. It causes much more of a challenge when you're talking about interprovincial mobility.

We saw that in the pandemic, it was a huge issue for the Canadian Armed Forces when they were trying to move some of their resources between provinces. If their resources are registered in Nova Scotia, for example, and they need them in Quebec, they ran into issues with having to have interim processes to get them registered.

There could be mechanisms that could make that interjurisdictional mobility much easier, and a unique national identifier would get us closer.

● (1715)

The Chair: Thank you, Mr. Guest and Mr. Powlowski.

Go ahead, Mr. Barrett, for five minutes.

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

Thanks to all of the witnesses today. I'll take the opportunity to thank our nurses as well, on the occasion of a week of recognition for all their hard work.

I've had the opportunity to speak to some of you at previous meetings. I just wonder at what point the perfect becomes the enemy of the necessary—not even the good—just what we need to have happen so that we don't have more people running for the exits in the health care profession.

I have a couple of examples, and I've raised some of them with you before. We have virtual medicine apps, telemedicine apps, that are available where you can talk to a nurse practitioner and get a script instead of going to a doctor. We have electronic health records, so in the Canadian Forces, for example, it didn't matter which base or which physician's assistant I was talking to, because they punched in my service number and up came my record. I appreciate that, when we're talking about people's medical information, we have to be extremely careful. The highest sensitivity has to be paid to that. But do we not find ourselves where there are solutions out there that we could use, and is this a question of intergovernmental co-operation?

With that framing in mind, I would just ask, what are some things that could be done right now that would address even some of the low-hanging fruit, because I feel we have a lot of very big problems. Are there any short strokes that we can take to solve those as a country?

That question is for all of you, together.

Dr. Brady Bouchard: I'll take a first stab at this.

I would say certainly in the short term something that could be addressed is what we're proposing in the primary care integration fund as an incentive for provinces and practices to move to team-based care.

We know how to do team-based care. We have a model of it. As Dr. Lemire mentioned, it's been out there for quite a while now and we just need to move to those models. That would be an immediate improvement.

As for the two points you raised, certainly a single source, or integrated EMRs—I am unaware of that crossing provincial boundaries—but even within provinces that doesn't exist, at least that I am aware of, essentially anywhere in the country.

To your other point on virtual care, we'd be the first ones to say that virtual care is here to stay. It certainly enabled care early in the pandemic where we couldn't provide care safely elsewhere. That technology will be essential into the future for geographic disparities, for efficiency purposes and patients not waiting in waiting rooms. There are concerns about equity, so we don't want to replace a family physician in a rural community with just virtual care. That's not fair to them, and virtual care can't replace everything in primary care and family medicine.

The other point I would emphasize is that all family physicians, I think, want to work with virtual care, but it should be integrated into longitudinal family practice. All Canadians deserve to see a family physician and their team over time, and that could be through technological solutions or it could be in person.

Mr. Michael Barrett: How much time do I have, Chair?

The Chair: You have one minute.

Mr. Michael Barrett: Does anyone else want to contribute an answer in that one minute?

Mr. Tim Guest: I'd be happy to.

I would also like to add to what Dr. Bouchard talked about.

There is an ability to do more integration of the electronic health records that we have. We have spent millions and millions of dollars across the country implementing systems that were not built with standardization in mind, in that they could speak to each other. They are capable of doing it as technology evolves. We continue to add more of them and make the issue worse, where I think if there were a requirement that all new systems had to be integrated.... Alberta is an example: The entire province is moving all of its hospitals onto a single system. We're seeing similar things across the country.

I've seen examples in Ontario where an individual gets discharged from a hospital, is transferred to a hospital 15 minutes down the road and the entire chart needs to be printed off and sent in paper format with the patient, and it's then re-entered into the system in the adjacent hospital because the systems aren't integrated.

There is an ability to do that. It will be costly, and it would take some will to make it happen.

● (1720)

The Chair: Thank you, Mr. Guest and Mr. Barrett.

Mr. Michael Barrett: Thanks for the answers.

The Chair: We have Ms. Sidhu, please, for five minutes.

Ms. Sonia Sidhu: Thank you, Chair.

My question is for Dr. Smart. You talked about the need to improve virtual data— which is also an area of concern for well-managed health human resources—and to have a pan-Canadian health data strategy to improve the system with good data, and to inform decision-making and to measure progress. Do you have any specific recommendations about how we can improve data collection, especially to the rural communities as well?

Dr. Katharine Smart: To add to what we've already heard when we've been talking about data today, I think it's really important that it be standardized and that it is being used for the right reasons. What we really want to see is a data-driven, outcome-based system so that we're using the data to make sure that we're accountable for the investments we're making in health care, and that it's driving the outcomes we want to see in our system. I think if we design it from that lens, we can then use the data to be monitoring what we're doing and seeing how close we're getting to the outcomes that we want to be seeing, and also to give feedback to the providers in the system about the care they're giving to patients. There are many ways that effective use of data could improve the quality of care and accountability in the system.

I think what's going to be critical and why we feel this needs to be a pan-Canadian approach is to allow for that standardization across the country and to make sure that we're creating those basic standards across the country so that we're all moving in the same direction. I think that's true from the patient data side.

From the human health resource planning side, I think the data is going to be needed so that we can actually know what we're trying to do. I think from what you've heard today, some of why it's hard to answer some of the very specific questions about things like how many nurses and doctors...and where exactly they are, is that we don't know.

The other problem is that sometimes we're not counting the right things. We could probably tell you how many people are licensed as a family doctor in Canada, but how many of those physicians are actually providing primary care in a rostered or longitudinal manner may be more difficult to do. That's why things like saying we need *x* more people is challenging, because if you add a thousand family doctors to a province but none of them actually takes on a patient panel, it's not solving the problem of access to primary care.

I think we need to be really clear about what we're trying to collect with the data. We need to make sure that it's linked to the outcomes that we're wanting in our system, and that the whole point of it is accountability, because we know that investments in the Canadian health care system are a very significant use of our tax dollars.

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

My next question is for all of the witnesses. We heard about the need for more administrative staff to remove health care professionals from the paperwork process. What improvement can be made to this process, and how impactful can these improvements be? What should we do so that health care professionals don't need to do the paperwork when the doctors need to know what has to be placed in there? What is the process we need to result in a tangible outcome/income?

Mr. Tim Guest: I can take a stab at this. I think what we have suggested is an option for the federal government to provide resources to the provinces and territories to be able to add additional capacity into the system so that they have individuals who can do some of those tasks to free up physicians and nurses to do the tasks that only they can do. That's some of what we have suggested. It's a matter of needing additional resources to put those workers in place.

● (1725)

Dr. Francine Lemire: The challenge is that we have different systems that are not talking to each other as we speak right now. The solutions, I think, will need to be adapted to regions and locales to be effective. I don't think there's a one-size-fits-all solution here. I'm trying to think here of my own practice, when I had one, and using my EMRs. I actually had a clerk do the ordering of some of the things that I was doing, and the way the system was working, I think it might be quite difficult. There really is a need to have conversations at the regional level to see what could be farmed out to individuals to provide that clerical help, as Mr. Guest has mentioned. It's difficult to have one solution, unless Dr. Smart or Dr. Bouchard are aware of any one solution to help with this.

Dr. Katharine Smart: No, I would agree. I don't think there's a single solution, but I think some of the things we have heard....

The other thing we have seen to be effective in some settings is having access to a scribe, someone who's working with you, documenting for you, filling out the forms as you go and supporting that work. That can be a way to really bring down that administrative burden as well.

I think there are lots of different strategies. I think it would probably be a matter of picking two or three, trying them to see how they work and then looking at what could be scaled into different environments.

The Chair: Thank you, Dr. Smart.

[*Translation*]

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

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

I have a question for Dr. Lemire.

First of all, hello, Dr. Lemire. I have not had the opportunity to ask you any questions yet.

You talked earlier about a targeted federal fund, which the provinces could access to work on the most effective and promising models developed by the provinces. You referred to family medicine groups in Quebec. I like them very much, I am a patient of one of those groups. Please tell me if I have understood your idea correctly.

Let us assume that the federal government establishes a fund, subject to certain conditions. Quebec develops a model like that, which ultimately proves successful, despite all the financial constraints in Quebec's health care system. Quebec could then request access to a federal fund, subject to certain conditions, to finance its own model, the one it has developed.

Is that correct?

Dr. Francine Lemire: That is one way the fund could be used.

In Quebec, I believe about 70% of family doctors can belong to a family medicine group. You might know the figures better than I do. From what I have heard, it is a promising model, but there is still room for improvement. The fund would make it possible to look at what you are doing now and try to improve the system you have, and allow more family doctors to work as part of a team under this model which, we hope, could be further improved.

Mr. Jean-Denis Garon: Dr. Lemire, I just have a few seconds left.

In a well-funded system in which the federal government increased funding to the provinces and Quebec under the Canada health transfer, the provinces and Quebec would have the means to develop better models. And provinces that are well-funded could of course draw on the models developed by other provinces to make reforms.

What do you think of this approach of providing more funding to the provinces to enable them to develop new models and feed off each other?

Dr. Francine Lemire: That is actually what we are trying to promote. Perhaps you are thinking of a different model. I do not understand your question.

Mr. Jean-Denis Garon: A substantial increase in unconditional health transfers would enable the provinces to develop such models and to feed off each other. The lack of innovation could be partially explained by the provinces' limited funding and the fact that the proportion of health system costs covered by these health transfers has dropped over time from 35% in the past to 21% today.

The Chair: Please be brief, Dr. Lemire, if you will, because the member's speaking time is up.

Dr. Francine Lemire: We think it is important to have funds earmarked for the type of reforms and improvements that are needed. That does not preclude allocating funds more broadly, but at this time we think it is important to allocate funding for the type of improvements we are suggesting.

● (1730)

The Chair: Thank you, Dr. Lemire.

[*English*]

The last person to pose questions in today's session is Mr. Davies.

You have two and a half minutes.

Mr. Don Davies: Thank you.

Picking up on Monsieur Garon's question, we have heard repeatedly that we need a health funding summit involving the provincial and territorial premiers as well as the Prime Minister to discuss the Canada health transfer.

It strikes me that what you're talking about here are some very targeted ideas about how we could put at least $2.25 billion, I think, into the fund to address the health care shortage.

Just by a show of hands, how many of you would like to see a health funding summit for prioritizing initiatives necessary for resolving Canada's health workforce crisis? Do we need that?

Okay. There are people in the room putting their hands up. For the record, everyone put their hands up. Thank you.

In terms of this national licensure, I want to pick up on what my colleague Dr. Powlowski said. There may be different provincial standards for various things, but I can't believe that the qualifications of a doctor or a nurse in New Brunswick deviate from those of a doctor or a nurse in Manitoba or British Columbia.

When you are raising this, is anybody raising jurisdictional issues here? Is any province, in your view, holding up their jurisdiction to prevent this concept of a national licensure, or are you hearing positive results from the provincial colleagues you've talked to?

Dr. Katharine Smart: I can comment on that.

You are right that if you are a Canadian-trained, Canadian-credentialed physician, you are eligible for licensure in any province or territory. It's not an issue that you won't be licensed. You just have to go through the steps to obtain the licence. The requirements for that are the same. That's not always necessarily true if you're internationally trained, but it is if you're Canadian-trained.

I think we're starting to see some shift in terms of people's willingness. Again, the regulatory bodies all have their way of doing things. I think everyone naturally thinks their way of doing things may be the best or the safest. I think we see that protectionism in many aspects of how people work. But I do think the pandemic has shifted that. I think people are starting to see now the need for more co-operation, the need to be able to leverage virtual care, the crisis that the health workforce is in, and the need to sort of back away from some of these more protectionist ideas and to more of a collaborative lens.

It doesn't mean there would be no role for the provincial regulatory bodies. It would be more about creating opportunities to collaborate and reimagine this somewhat. There would still be responsibility for them and a role for them to play. But I think we probably are closer to that reality than we were prepandemic. I think if you had asked people the same question three years ago, they might have said they were really far off from that ever happening. I think we're closer now. I think it's just going to need that kind of final push to get it over the finish line.

In my view, if we were able to pivot an entire country to virtual care essentially within 48 hours, I think we can achieve this as well.

The Chair: Thank you, Dr. Smart and Mr. Davies. That's a very optimistic note on which to end.

I'd like to share with you, witnesses, that this is probably the last panel for this study. Unless there are other suggestions for further witnesses, I expect that we're probably going to be issuing drafting instructions fairly soon. Thank you so much for helping us through this journey with your patience and your very thorough answers. It was greatly appreciated. Thank you as well for your work on the road map. I do expect that it will be a very important element of the report we bring forward.

Colleagues, I have just a couple of things to deal with before we wrap up. Wednesday's meeting will be a do-over of the meeting that was cancelled last Wednesday. It will be with the same witnesses, with committee business at the end to talk about what we're going to do next. We also have the Finnish delegation coming in this Wednesday at noon. We encourage you to be there.

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

Some hon. members: Agreed.

The Chair: We're adjourned