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Chair

The Honourable Andrew Telegdi

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● (1110)

[*English*]

The Chair (Hon. Andrew Telegdi (Kitchener—Waterloo, Lib.)): The meeting of the citizenship and immigration committee is called to order. Today we will be dealing with recognition of the international experience and credentials of immigrants.

The way we're going to do it is that every group will make a presentation for seven minutes, after which we're going to have a round of questions from each party of seven minutes for the first round, and then switch back and forth between parties, opposition party and government. The question period is going to be five minutes for questions and answers.

I'm hoping everybody will keep that dialogue going. There are a lot of people we're going to be asking questions of.

Let's start off with Alfred Dean, the president of the Canadian Dental Association.

Dr. Alfred Dean (President, Canadian Dental Association): Mr. Chairman, members of the committee, good morning. My name is Alfred Dean. I'm the president of the Canadian Dental Association and I'd like to thank you for inviting me to speak to you today about the integration of foreign-trained professionals into the Canadian workforce.

Also joining me as members of our delegation are Mr. Irwin Fefergrad, the registrar of the Royal College of Dental Surgeons of Ontario, and Dr. Benoit Soucy, the Canadian Dental Association's director of membership and professional services. I look forward to their assistance and perspective during the question and answer period.

The issue of how foreign credentials are recognized in Canada is an important one. I imagine that for government there are two main pressure points. One is the shortage of certain health care providers that has led to access-to-care problems, and the second is from the population of foreign-trained professionals themselves. In dentistry we are fortunate that we are not currently experiencing major manpower problems and we have the opportunity to prevent them.

We recognize that it is important for foreign-trained professionals to have a good sense of the certification process before they decide to come to Canada. The Canadian Dental Association has made this information available through its website for several years and we receive numerous requests from foreign-trained dentists each year. In considering possible changes to the recognition of foreign credentials, one thing is paramount: we cannot compromise patient safety or Canadian standards of care. And in fact it is more far-reaching than standards of care, but also includes appropriateness of care, which includes important cultural and language issues. This by no means suggests that we are unwilling to look for ways to make the process more understandable, smoother, and, if appropriate, less time-consuming.

How do we know that practising professionals are meeting the high standards that Canadians deserve and expect? In dentistry it has been through a solid four-part process of education, accreditation, certification, and licensure. This process ensures that licensed Canadian dentists have the training and skill that are needed to deliver safe and effective dental care.

Education is delivered at ten dental schools across Canada. The schools offer either a DDS or DMD program, which are equivalent general practice degrees. Many also offer specialty programs in one or more of the nine recognized Canadian dental specialties. As well, a number of universities offer qualifying programs or degree completion opportunities. These programs were created specifically to meet the needs of foreign-trained dentists in order to assist them in integrating into Canadian dentistry. The limited available positions are allotted to candidates on a competition basis, based in large part on their scores on an eligibility exam.

This is similar to the procedure for Canadian students who complete a dental aptitude test as part of their admission requirements to dental schools and must compete against other students for the finite seats in dentistry.

When we speak of accreditation in dentistry, we are talking about it at the institutional level, not the individual dentists. The Commission on DentalAccreditation of Canada, or CDAC, is responsible for accrediting all dental and dental hygiene programs as well as some of the dental assisting programs. Accreditation is a lengthy, involved, and expensive process that requires regular site visits and considerable expertise. CDAC has a reciprocal agreement with the American Dental Association. As a result, schools accredited by one are also recognized by the other.

With regard to certification of general dentists, this is done through the National Dental Examining Board of Canada, and, as the name suggests, it is national in scope. The NDEB has undergone extensive changes in its processes over the last few years in order to achieve a system of examination that is fair and effective and that is recognized as one of the best worldwide. It is accepted as a basis for licensure by all of the provincial regulatory authorities for dentistry in Canada, which allows NDEB-certified dentists to apply for licensure in any province without having to undergo further testing of their qualifications.

● (1115)

Dental specialists, such as orthodontists or periodontists, are certified by the Royal College of Dentists of Canada and an NDEB certificate is required prior to certification as a specialist. That brings me to licensure.

Each province has a dental regulatory authority that licenses and regulates all general dentists and specialists in that province. In addition to licensure, these bodies are also responsible for the maintenance of quality assurance programs and for investigating complaints about dentists and taking appropriate action.

This four-part system effectively ensures the ongoing monitoring of the way Canadian dentists practice, from their entry into a dental program to their retirement.

To consider methods that might expedite this process, we need an understanding of some of the limitations. For example, a natural place to look is at the qualifying or degree completion programs. Why not just open up more spots so we could move more foreign-trained dentists through quickly? But this is not as easy as it sounds. The universities are already near the breaking point. Chronic underfunding makes it difficult for them to maintain faculty and facilities needed to keep current programs operational, let alone expand. As well, we must keep in mind that many more Canadians would study dentistry if more domestic positions were available, so we must also consider their needs.

Another possibility is to expand our reciprocal agreements with other countries. Again, money is a huge factor. It is very expensive to examine educational programs and conduct site visits overseas. As well, there are political and ethical concerns. We must be careful not to wantonly steal highly skilled labour from less privileged countries.

● (1120)

Hon. David Anderson (Victoria, Lib.): Mr. Chairman, I suggest that these are pretty important issues that are going to be very important for our report, and maybe we could be a little bit lax in the time limit.

The Chair: I was.

Dr. Alfred Dean: We're also aware of the existence of credential assessment services, which would seem to be a relatively easy and inexpensive way to determine whether a graduate of a foreign program could be considered for licensure in Canada. Unfortunately again, the reality is less than promising.

The National Dental Examining Board, which I spoke about earlier, conducted test cases through credential assessment organizations, and the results were dangerously inadequate. Graduates of all test case schools were deemed to be equivalent to Canadian grads despite an enormous variance in the quality of their education. In fact, even graduates from schools with no clinical training at all were given passing marks.

There's no doubt this is a complex problem. To examine these issues, the Canadian Dental Association brought together a wide range of stakeholders for a one-day forum in January 2004. The forum included representatives of the Commission on Dental Accreditation of Canada, the deans of the dental schools, the provincial regulatory authorities, the specialty groups, the National Dental Examining Board of Canada, and others. These are the groups that governments need to be familiar with and consult as we look together for best practices in the recognition of foreign-trained dentists. This group identified a number of key areas for further examination.

One area was flexibility, especially in the qualifying and degree completion programs. Ideally, there should be some method to identify candidates who might require less than two years of additional training and customize a program for them. Again, this would require the investment of time and money in order to avoid overtaxing the already stretched resources of our faculties.

We should train more residents. If manpower problems arise in the future, it is ethical and responsible to look first at training more Canadian residents to meet this need. This is by no means exclusionary. Canada is a country of immigrants, and dentistry proudly reflects that diversity.

On expansion of reciprocity, earlier I identified some of the possible problems with this approach; however, the potential remains. What is needed is a better knowledge base of the pros and the cons for both Canada and the other countries.

Following that initial forum, a number of other meetings have taken place, spearheaded by both the regulatory communities and the dental associations. Interest and participation have been very good. Stakeholders from provincial associations, dental academia, the dental commission, and representatives of both federal and provincial governments have come to listen and be heard on these important issues.

To wrap up, I would like to thank you again for listening to my remarks. This is a huge policy area, one that has clearly become a priority for this government. I applaud you for consulting with the many groups you will hear from during your hearings. I encourage you to continue to consult with the Canadian Dental Association on a move-forward basis.

As I've said, my colleagues and I are available to answer any questions you may have.

Thank you very much.

The Chair: Thank you.

We're going to go on to Ms. Lemay from the Canadian Council of Professional Engineers.

[*Translation*]

Ms. Marie Lemay (Chief Executive Officer, Canadian Council of Professional Engineers): Thank you, Mr. Chairman.

Good morning, members of the committee.

[*English*]

My name is Marie Lemay, and I'm the chief executive officer of the Canadian Council of Professional Engineers. I'm also a civil engineer. I'm glad to have with me today Deborah Wolfe. She's our director of education, outreach, and research at the Canadian Council of Professional Engineers, and is also a civil engineer.

Almost a year ago we appeared before the CIC committee to speak to the issues regarding foreign credential recognition. We're pleased to speak again on the issue to the members of the committee, as this is a very important issue for the engineering profession. During our deliberations today I will highlight and review the significant strides that the engineering profession has taken since December 2001 to resolve the issue of foreign credential recognition within our profession and the process by which we've exceeded government's demands. I will also make a call for action, because we believe that the time has come.

Before I begin, I want to make something very clear. The Canadian Council of Professional Engineers, the organization I represent, is the federation of regulators. Our members are the licensing bodies. We do not represent the interest of the individual engineer. The mandate of the licensing body is the protection of the public. Any notion that the engineering licensing bodies are guided by economic self-interest or that they exist to protect the interest of their existing members is wrong.

The engineering profession wants to help immigrants to settle and become integrated in the engineering field. Let me add that international engineering graduates are well represented in Canada. According to our 2002 national survey, 12%, or 19,000, of Canada's 160,000 professional engineers received their education in another country.

● (1125)

[*Translation*]

CIC has long played an important role in the process of selecting immigrants who have studied engineering abroad. In 1981, they signed a memorandum of understanding with the Canada Employment Insurance Commission. Pursuant to the terms of this agreement, CIC provided advice to visa officers in the form of assessments, indicating the probability of qualified workers obtaining a permit, if that person had identified engineering as their field. This kind of assessment is not licensure.

[*English*]

Rather, it was an indication of the likelihood of a potential immigrant's application for licensure. This contact was also an opportunity to provide information to international engineering graduates. I say “was” because the relationship with CIC changed as a result of Bill C-11.

The new regulations effectively remove the role of the engineering profession in the selection process of IEGs—and I'll refer to IEGs, or international engineering graduates. Immigration officers in issuing countries no longer have input from experts within the profession on an applicant's qualification. As a result, many are arriving in Canada with more false expectations and are encountering settlement difficulties. So instead of taking the opportunity of using an existing contact to enhance the information given, that link was severed.

To illustrate the impact of the regulatory change in Bill C-11, here are some numbers. In the three years leading to the changes in the regulation, CCPE did 23,000 assessments. That means there were 23,000 qualified immigrants who were self-identifying as engineers. In 2002, the year in which the regulation came into effect, that number fell to 6,700; in 2003 it dropped to 1,500; and in 2004 it was under 1,000.

These people are still coming into the country. The incentive that the IEGs previously had to contact the profession prior to immigration is removed. In the absence of the contact, they're arriving in Canada with more false expectations about their eligibility to practise within the profession, and limited knowledge about the licensing process or the regulatory climate that benefits public safety.

[*Translation*]

Since 2001, we have maintained that with a skills-based model, peers must assess the education of international engineering graduates, in order to establish a Canadian equivalence. If Canada wishes to remain competitive on the international scene, we must have strategies to guarantee that skilled workers who immigrate to Canada will be able to adapt to our regulatory context. If not, settlement difficulties will ensue.

[*English*]

Members of the committee may justifiably ask what we have done to improve our end. Beginning with dialogues with the former minister of citizenship and immigration, the Honourable Denis Coderre, the federal government asked that CCPE and its constituent members develop a framework that would link the educational assessment to licensure—in other words, make that assessment of qualifications more meaningful.

CCPE and its members, the twelve provincial and territorial regulatory bodies, agreed to provide a one-stop education assessment link to the provincial and territorial licensing process. So we've done our part, and now we're asking the government to restore the role of the engineering profession in the immigration selection process. With the changes the profession has agreed to, the assessment would be linked to issuing the licence and would provide value to the immigrants.

But rather than just meeting the challenge posed to us by the former minister, and recognizing that immigration and settlement processes are distinct, CCPE went further. In January 2003, with full funding from the former HRDC, we launched a holistic and comprehensive project examining the licensure, settlement, and employment landscape for international engineering graduates. It's called "From Consideration to Integration", and is referred to as FC2I. We felt we had the possibility of looking at the issue horizontally, to cut through the multi-jurisdictional nightmare that immigration and settlement can be. We believed we could make a difference as a profession.

FC2I is a three-phase project. In phase one, the work focused on understanding the IEG's experience overseas and in Canada. We called it the picture, or what was happening where and when, and who was doing what.

In phase two, the steering committee analyzed the information. We looked at the integration process and where it required improvement, we began to build consensus among stakeholders, and we looked at possible solutions. After consulting with more than 200 people and dozens of different stakeholders, 17 recommendations were presented to the CCPE board of directors at their annual meeting last May, in 2004. All 17 were approved unanimously. The recommendations fall into four categories: research, employment, communication, and licensing.

We're now ready to commence phase three of the project, and that is implementation of 17 recommendations that will directly affect the IEGs and Canadians at large, since we all benefit when skilled immigrants participate in society to their fullest potential. However, additional financial resources will be required by the federal government for many of these projects.

We've listened to government. We've engaged in a dialogue with ministers of cabinet. We've testified at every opportunity before parliamentarycommittees, to explain, to hear your concerns, and finally to promote the recommendations, in the hope that these efforts would translate into results.

We've mobilized the entire engineering profession. That's twelve regulatory bodies that agree. That's like twelve provinces and territories agreeing. You, of all people, should know how difficult that can be. So we built a consensus. Now what we need are resources from the government toimplement these recommendations. And we also need something very important: recognition that the engineering profession has madesignificant progress in tackling this multi-stakeholder issue. We need to build on the work that's been done—and believe me, there's been a lot of hard work done by a large number of people from different groups, including the international engineering graduates themselves; the settlement agencies; the employers; the governments, provincial and federal; academia; and the profession.

Further delay and further deliberation and consultation will only serve to quell momentum, and could potentially mean all this work would simply collect dust. I made a personal commitment to my colleagues when we started this project that, if they agreed to put in the time and resources toward understanding and addressing this crucial issue, this would not happen. We came, we listened, we went away, and with the support of government, we were able to agree on seventeen recommendations not only supported but also developed by, the engineering licensing bodies and, very importantly, their partners in the integration of IEGs.

I want to leave you with this message. The engineering profession has responded to the call from government, and more. Now it's time for action, not for consultations. Let's get on with it. We know what needs to be done now, so help us do it. We're there.

We ask that in its final report the committee recommend the inclusion of the engineering profession in the immigration selection process. By doing this, you will provide the conduit, the link, to the engineering profession for the IEGs.

● (1130)

[*Translation*]

We will provide international engineering graduates with precise information and an assessment of their education that will be tied to the licensing procedure. This will allow them to become familiar with the process that governs the engineering profession in Canada, and to be better prepared to immigrate. This will also allow them to make informed decisions and to avoid disappointment when they arrive in Canada. We are also asking that financial resources be devoted to the implementation of the recommendations in our report, *From Consideration to Integration*, of which the members of the committee have received a copy.

[*English*]

We firmly believe that a federal commitment, matched by dollars to support the implementation of the detailed recommendation in the FC2I report—and you have copies of phase one, phase two, and the implementation plan in front of you—will help to make Canada a better country for this and future generations.

I thank you very much for your attention.

The Chair: Thank you very much.

Next we have, from the Canadian Medical Association, Dr. Schumacher.

Dr. Albert Schumacher (President, Canadian Medical Association): Thank you, Mr. Chair.

Good morning. I'm the president of the Canadian Medical Association and a family physician from Windsor, Ontario. With me today is Dr. Todd Watkins, director of the office of professional services at the CMA. He's also a family physician.

It's now estimated that some 4.5 million Canadians have trouble finding a family physician, while more than 3 million do not have regular access to one. I'd like to note that Ms. Ablonczy has joined those ranks very recently with the retirement of her family doctor. I wish her success in re-establishing a relationship with one.

Long waiting lists for consultations and specialized diagnostic and therapeutic services attest to the shortage of specialists. At the same time, the average age of physicians in Canada is 48 years, and 32% of them are 55 years of age and older. Almost 4,000 physicians are likely to retire in the next two years. This is indeed a perfect storm that's brewing in health human resources in Canada.

The message I hope to leave you today is that the valuable participation of international medical graduates in our medical workforce must be part of a coordinated pan-Canadian plan that strives to address the double imperatives of immigration policies that are fair and polices that in the short, medium, and longer term will ensure a greater self-sufficiency in the education and the training of physicians in Canada.

Today I'm going to focus on three things: first, to clarify some of the myths about international medical graduates in Canada; second, to stress the need for greater capacity in Canada's medical education and training infrastructure; and finally, to emphasize the importance of a national standard for licensure.

Let's talk about the myths.

If you were to believe what you read or hear in the media, you might gather that it's next to impossible for international medical graduates to enter the practice of medicine in Canada. Nothing could be further from the truth. As of last month, almost one quarter of the physicians working in our health care system had received their medical degrees in a country other than Canada. This proportion has declined by only 2% since the 1960s. Estimates peg the number of IMGs arriving in Canada with prearranged employment who are licensed to practise each year at about 400. Quite simply, our health care system could not function without the critical contributions of these qualified international graduates.

Also, many of the IMGs access the post-graduate training system in Canada. As of December 2004 there were 316 IMGs who were either Canadian citizens or permanent residents in their first year of postgraduate residency training. This represents about 15% of the total of first year trainees.

In the past few years, only a few provinces have greatly expanded the opportunities for accessing the clinical skills of IMGs in providing supplementary training and practice opportunities. I would note that the initiatives of the federal government announced by the Hon. Hedy Fry in March 2004 have been very helpful. Some $3 million announced at that time was provided to assist provinces and territories in assessing IMGs. It will add at least 100 internationally trained physicians into the system. I'm optimistic that her continued collaborative efforts with the medical community will result in further positive changes.

Has Canada closed its borders to IMGs? Hardly. Can more be done to achieve absolute fairness? Absolutely.

Let's talk about capacity. I can't stress to you strongly enough the need to increase the capacity of Canada's undergraduate medical education and postgraduate training system. There are some who think the fastest and least expensive way of meeting our medical workforce requirements is to simply recruit medical graduates from other countries. It is, however, no substitute for a made-in-Canada solution for the long term. As a long-term policy it fails to recognize the fact that countries from which we poach these IMGs can ill afford to lose them. We are simply not pulling our weight as a nation in educating and training future physicians.

Our national medical organizations have recommended a 2007 target of 2,500 first-year medical positions. Unfortunately, in June 2004 Canada graduated just 1,770 physicians.

Expanded capacity will work to the benefit of both Canadians aspiring to attain a medical education and international graduates. For example, in 2004, 657 IMGs entered the second iteration of our residency match, but just 87, or 13%, were successful in getting a spot.

We need not only to expand the capacity within academic health sciences centres themselves, but to recruit and support clinical teachers out in our communities. This is crucial, especially for the IMG assessment programs that are now being rolled out.

● (1135)

Most importantly, an enhanced training and education infrastructure will help to meet the future health needs of Canadians. The goal that had been identified in a 2004 first ministers agreement specified $250 million a year, beginning in 2009-10, through the next five years, primarily for health human resource training and hiring. However, Bill C-39, which was recently tabled to implement provisions of the 10-year plan by creating the wait times reduction fund, falls short of what Canadians deserve and expect. Specifically, it stipulates that these dollars may be used for multiple purposes.

The failure to recognize the critical shortage of health care professionals by dedicating specific dollars to the issue now could mean the promised investments may never be made to enhance health human resources. The temptation will be to continue to rely on beggar thy neighbour policies. However, Canada can and must do more to pull its own weight.

Let's talk about national standards. As a national organization representing Canada's physicians, we have a direct interest in working with the government to ensure that Canadians have access to health care when they need it. The CMA has a role in medical and health education in the accreditation of undergraduate medical education and the accreditation of training programs in some 15 other health disciplines. However, the CMA is not the regulator. We do not grant credentials nor license physicians. Regulation of medicine falls under the purview of provincial and territorial colleges of physicians and credentials are granted by the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada, and the Collège des médecins du Québec.

If medicine has a lesson to offer other professions and occupations it is in the value of having a national standard. While health is a constitutional responsibility of the provinces and territories, medicine has been able to realize a national standard for portable eligibility for licensure across Canada.

Without a doubt, a national standard has provided a significant degree of transparency and uniformity about what is required to practise medicine here. This not only promotes a concordance between the programs offered by our 16, and soon to be 17, medical schools, but also provides a basis for the assessment of international programs.

On the latter point, the Institute for International Medical Education has a database that contains information on more than 1,800 medical schools in 165 countries around the world.

Let me conclude. During the pre-budget hearings last fall I submitted to the Standing Committee on Finance our plan to address health human resource shortages. As was the case then, international medical graduates are a critical part of the CMA plan, a plan that has at its core the belief that Canada must adopt the policy of increased self-sufficiency in the production of physicians in Canada. This will involve increased opportunities for Canadians to pursue medical education in Canada; enhanced opportunities for practising physicians like myself to return for additional training; strategies to retain physicians in practice in Canada; and finally, increasing the opportunities for international medical graduates who are permanent residents or citizens of Canada to access the post-graduate training positions leading to licensure and certification to practise medicine here.

This set of imperatives needs to be balanced against a need for fairness—fairness to ensure those who need to obtain further medical training are able to do so both as international medical graduates and Canadian graduates, and fairness to young Canadians who deserve a chance to pursue a career in medicine.

I appreciate the opportunity of entering into a dialogue with the members of this committee and I look forward to your questions.

Thank you, Mr. Chair.

● (1140)

The Chair: Thank you very much.

We are going to go to the first seven-minute round.

Ms. Ablonczy.

Mrs. Diane Ablonczy (Calgary—Nose Hill, CPC): Thank you, Mr. Chairman.

I'd like to use my seven minutes to ask each of you a brief question. I'll try to be brief. If you can be brief we'll probably get through the three of you.

First of all, for the dental association, Dr. Dean mentioned that there are no major manpower problems in the profession. I'd like to ask you how that is determined, who determines it, and what is the basis for that statement.

Dr. Benoit Soucy (Director, Membership and Professional Services, Canadian Dental Association): For the last ten years we've had a research project on human resources in dentistry and in oral health in general, including the five occupations that are involved in oral health, that has been run with the successive incarnations of Human Resources Development Canada.

From the provision that we get with that program we have a sufficient number at this point.

The forecast is that all provinces, except for Quebec, will run into shortages as we move toward 2015.

● (1145)

Mrs. Diane Ablonczy: I wonder if you could table that report with the committee, or if our research could obtain it, because I'd like to have a look at it.

Dr. Benoit Soucy: Yes.

Mrs. Diane Ablonczy: Thank you for that.

With respect to the engineering profession, the word on the street is that this profession has done a very good job of assisting newcomers to enter the profession and have some certainty about what is required. You also mention a labour market study that was done. Was this also with HRDC?

Ms. Marie Lemay: The survey I referred to was an internal study. There was funding from HRDC, yes, but it wasn't a labour market study, it was a survey on the profession. What we're looking to do is to have.... Actually, one of the recommendations is to have a labour market study done.

Mrs. Diane Ablonczy: So there hasn't been one?

Ms. Marie Lemay: No.

Mrs. Diane Ablonczy: That's scary.

Ms. Marie Lemay: It is, very much so.

Mrs. Diane Ablonczy: You mention that federal funding is urgently required to establish the database of recognized engineering institutions and degrees to do this labour market study, which I thought was an additional one but turns out to be maybe the first one, and the working-in-Canada seminar for newcomers to the profession. Can you give us some idea of the dollars involved?

Ms. Marie Lemay: I think I'll turn this over to Deborah, because she will have the numbers.

Mrs. Deborah Wolfe (Director, Education, Outreach and Research, Canadian Council of Professional Engineers): In regard to the database we're talking about, we already have a lot of information both at CCPE and among the regulatory bodies, so we're looking at a two-phased project just to figure out how we're going to put that together. The first phase would probably be in the $200,000 range, but the second phase would be the more expensive part because it would involve software. We haven't scoped the project yet, so we can imagine it would be somewhere in the $500,000 to $1 million range; it would depend.

The working-in-Canada seminar, we actually have been working with Manitoba on that, and it looks like it might be around $200,000 altogether for the project that would develop that aspect of it and some other aspects of the recommendations.

Mrs. Diane Ablonczy: So we're looking here at something in the order of $2 million to start?

Mrs. Deborah Wolfe: To start, yes. It's not a short-term type of thing. We need to do certain parts of the solution before we can get to the rest. I think it's more the long-term sustained funding for different pieces of the solution.

Mrs. Diane Ablonczy: So from start to finish we're talking $2 million?

Mrs. Deborah Wolfe: I think it would be at least that.

Ms. Marie Lemay: If you don't mind me adding, the one thing I think you have to be very careful of, and us too, is that these projects are long term and the danger is that we say we'll put some funding for the next five years or three years, but this is something for which if we don't fund it and work at it until it's solved, we'll just see it pop up again. I don't know how many times we'll have a chance, as we have right now with the engineering profession, where you have everybody behind it, and the settlement agencies and the IEGs.

So in terms of the sustained funding, when we're talking dollars this is to start in some of the projects, but things will grow out of that, so there needs to be sustained funding for the regulated professions on the government's part.

Mrs. Diane Ablonczy: Thank you for that.

It gives us some idea of what we're looking at, which, in terms of the government spending in total, is minuscule, I would suggest.

With respect to the medical profession, the statement that Dr. Schumacher made that stood out for me was, "I can't stress to you strongly enough the need to increase the capacity of Canada's undergraduate medical education and postgraduate training system." You talked about you're tracking toward 2,300 new positions, first-year positions. Can you give us some idea of the state of the union on this whole matter and again what kinds of dollars we might be looking at?

Dr. Albert Schumacher: Thank you.

Where we are today, to fill those in more completely, is we graduated 1,770 physicians in June of this year. The good news is our medical schools have, individually, province by province, been expanding and we entered 2,200 first-year medical students this September gone by. So that's the good news. With the addition of the Northern Ontario Medical School, it will be 2,250.

The national medical organizations, as a conservative estimate, say we need 2,500 physicians. That's to get to the 80% self-sufficiency. Great Britain, which is ahead of us on the curve in this, has expanded their capacity such that for the same population as Canada's they are now training 3,000 physicians a year. So if one wanted to look at that target.... Understand that Canada, of all the developed first world nations, has the lowest physician-to-population ratio. Most western European OECD countries run a ratio of 2.9 physicians per 1,000 population. The United States runs at between 2.4 and 2.5. Canada is at 2.1, and to make up that 2.1 number, we include all the residents in training. Without them it's only 1.9. So that gives you some idea of the scope of the hole in the ground.

● (1150)

Mrs. Diane Ablonczy: What would need to be done to bring that number up? You said the schools are expanding and we have a new school coming on board.

Dr. Albert Schumacher: We need either bigger schools or brand-new ones. The federal government in 1966 allocated $500 million toward the creation of four new medical schools. The schools in Calgary and Sherbrooke and at McMaster and Memorial were all created using that bricks-and-mortar money. That is one possibility. It may be time to renew that.

As important and even more important for the short term, we need to go back to creating 120 new first-year resident spots for every one of our 100 graduates, because that will do several things. It will give our own graduates a better choice of what they want to do and where they want to do it. It will keep them from going abroad to find a resident training spot. The second thing is it will allow people to re-enter the system more easily, such as Canadians who are already practising and who want to go back and do speciality training. It will allow people to change their mind and switch specialities midstream. At the end of it, it will recreate the extra 400 spots we used to have across the country 20 years ago, which have now been whittled down, as you heard, to about 75 or 80 extra ones. That will help deal with those 800 people who applied for first-year resident spots, of which only 75 or 80 were matched. That's what we need for the very short term.

I think the federal government can buy those spots. They can make those federal resident training spots if they like, and they can buy them around the country, to pay the salaries of the people in the training, plus the programs, the teachers, and the administration to go with it.

Mrs. Diane Ablonczy: That makes sense.

Thank you.

The Chair: Thank you very much.

Madam Faille.

[*Translation*]

Ms. Meili Faille (Vaudreuil-Soulanges, BQ): I will give my turn to my colleague.

Mr. Roger Clavet (Louis-Hébert, BQ): Thank you, Mr. Chairman.

I'm going to ask questions of each of the witnesses, as did my colleague from the Conservative Party.

First of all, I would like to say to the Canadian Dental Association that I would have appreciated receiving written documentation. I did not receive any information on the Canadian Dental Association and I could very well choose not to put a question to its representatives, but as I represent all of my constituents, I will ask them one.

Could you tell us how many immigrants are practising oral surgery? Is this number increasing? Are any efforts being made to recruit such people or are things going well enough within that profession that we do not need to go and search for such expertise abroad?

[*English*]

Dr. Alfred Dean: Currently, within the profession, about 15% of the dentists in this country represent foreign-trained people.

The other part of your question was are we encouraging people to come and train in this country. We have a system, as I spoke about earlier, for upgrading foreign-trained dentists. The problem is, as our medical colleagues have just alluded to, that you have a competition for very few spots. So while the profession may very well want to increase the number of foreign-trained dentists who become licensed in this country, it becomes very difficult if you have 600 people competing for 25 or 40 positions. That is part of the problem, as our colleagues here just alluded to.

[*Translation*]

Mr. Roger Clavet: Thank you, Mr. Dean.

My next question is for the Canadian Medical Association. I am one of the millions of Canadians and Quebeckers who do not have a family doctor. I arrived in Ottawa six months ago, and I'm still looking for a family doctor. I find it deplorable, and even embarrassing, to live in a country where one does not have access to a general practitioner, and I'm left with the impression that there are people who have even greater need of a doctor than would a member of Parliament.

If we are to believe what we see in the press, you are saying that it is almost impossible for a person who has studied medicine overseas to work in their profession in Canada, and you talk about it as if it were a myth. Personally, I am convinced that that is not the case. In my riding office, we have received requests from Brazilian anesthetists living in Quebec, and who are going to move away after having waited for three years.

I do not know if the problem is poorly presented, but in your document, the first solution that you propose is to increase the number of doctors we have here and to better train them, and the last is to increase the opportunities for foreign-trained doctors to practise here. That seems to be last on your priority list.

I believe that if we consulted the population, we would see that at this point in time, people are not asking for excellence in medicine, they are demanding access. Are you not putting the cart before the horse?

People are demanding doctors, and it is a matter of great urgency. Some people feel it would be easier to consult a veterinarian, and some are even thinking of doing so.

● (1155)

[*English*]

Dr. Albert Schumacher: You're absolutely right. The two things are, however, married together. There is the short-term solution, in which the international medical graduates will become very important. In fact, if you created those extra 400 one- or two-year training spots, and if half of those went into family practice, you could literally, in two years, produce 200 new family physicians across the country. That's a start.

However, at the same time, the restrictions go into qualifications, credentials, and standards. Remember that in Canada, to practise as a specialist you have to pass your fellowship exams, whether in Quebec or in the rest of the country. You cannot practise as a specialist in this country without passing those. In the United States, you can. Our standards are even higher than those in the States.

The first time that Canadian-trained physicians who have spent their entire time training in Canada sit those exams, there is a 10% failure rate, and they can't write them again for another year. So if we're looking at trying to compromise on standards, we haven't gone there yet. We want to be sure that if you're in a car accident tonight in Ottawa, in Red Deer, or in Chicoutimi, the general surgeon who will save your life tonight has exactly the same qualifications and standards in any of those three places. We've been able to maintain that until now.

One of the reasons for looking at credentialing is to make sure people who come from abroad have adequate time to train here—it may be as little as a year, or it may be as long as four years—and those spots are available for them, as they used to be twenty years ago.

[*Translation*]

Mr. Roger Clavet: My final question is for the Canadian Council of Professional Engineers. I must congratulate you on your presentation and on the efforts you have made to really become involved in the recognition of foreign diplomas. It is clear that you have studied the issue in depth.

Currently, in Quebec, the eligibility criteria for engineers seem rather broad and flexible, so that one need not be either a Canadian citizen or have landed immigrant status in order to become a member of the Ordre des ingénieurs du Québec. Is Quebec's manner of recognizing foreign credentials working well?

Ms. Marie Lemay: Yes, it works well. We decided to do a global analysis of this project because in the past, we had broken it down or done a partial analysis.

You have to understand that licensure is a provincial responsibility, but that all of the organizations that help with integration in the universities are involved in the process. In the course of this project, we realized that some parts of the system function very well. Some have even served as examples to their provinces, who wanted to follow in their footsteps. We also found shortcomings that needed to be dealt with. We referred to this as our safety net. We wanted to be sure that we were identifying the problems and facing them square on, even though some of the groups' recommendations did not concern the profession. For example, it is not up to us necessarily to offer language classes, but we had to identify the problem. We did not want to be narrow-minded in our analysis, because believe me, this is one of the reasons why the issue has never really been tackled. There are therefore all kinds of recommendations.

To answer your question, I would say that Quebec is doing very good things that may have been taken as examples by other provinces, and the reverse is also true. This is the most interesting aspect of the process.

Mr. Roger Clavet: Thank you.

[*English*]

The Chair: Thank you.

Mr. Siksay.

Mr. Bill Siksay (Burnaby—Douglas, NDP): Thank you, Mr. Chair.

Thank you for your presentations this morning.

Ms. Lemay, in your presentation I detected a certain amount of frustration with the circumstances of the situation, and I don't think I was particularly perspicacious in that observation. My question has something to do with how we keep hearing about the complicated nature of this issue—how so many government departments, so many professional organizations, the universities, the provinces, all have something to say about this. If you could do some reflection on the kind of contact you have with government—the coordination efforts and that kind of thing—is there an effective means of doing that? Is that one of the barriers? A Liberal member of Parliament has a private member's bill to say there should be some kind of infrastructure or secretariat to coordinate the efforts on this. Would that be helpful? Would that address some of the frustrations you've experienced in this process?

● (1200)

Ms. Marie Lemay: Well, I think any measure that will bring the different stakeholders to work together and exchange at any level is a positive thing.

You have to remember that we were among the first to come to the government with an idea of doing a project, looking for some funding to help to support us to come up with a project. We have received very positive feedback from the government and they've tried to support us so far with this project. They saw the uniqueness, I think, of the approach.

There were some conditions to it, like getting the buy-in from the 12 provinces, because where the rubber hits the road is in the provinces. It's not me at the national level; it's going to be the provinces that will issue the permits. I can come up with nice recommendations, sitting in my office with four folks at the national level, but if they're not implemented, they'll be a nice little report that will sit on the shelf. Our approach was different. We did it from the bottom up. We started with the licensing bodies and the stakeholders, and I think that's why the government saw it as a little bit different.

So to answer your question, I can say it was very supportive.

The fear and the frustration right now are that we're doing all this—I'm pleased to see there's some acknowledgement here today—but there doesn't seem to be acknowledgement that there's some work being done. It's very hard to keep momentum and to keep the buy-in from all these folks if somewhere they don't see that the government and others are acknowledging that there's some good work being done and saying let's help and let's support it.

We still see things in the papers. We won't stop that. Some knowledgeable people are saying things in the paper when they should know better, so that's difficult. That's getting a little frustrating. In the consultation process we have some answers, so we want to get moving.

It's not a simple problem. There's no simple answer. We made a plan and we just have to tackle it step by step and not stop.

Mr. Bill Siksay: So you're at the point of having some fairly specific recommendations for the next step and some idea of the cost. Where do you go with that? Who do you approach in government to say you need this money and you have this specific plan? Whose desk is it sitting on? How does that work?

Ms. Marie Lemay: There are two departments. The Department of Human Resources has been very good in supporting us. We're still working with them for some of the requests for funding just on the project, and I have no reason to think it will be different from now on. The other department is CIC, and that's the whole selection process I talked about originally. That's something where we've been totally removed, and now that we're getting everything fixed and that the process will be in place, that link has to be recreated, and that's with CIC. So right there you have two different departments.

That's at the federal level, but then our members are taking these recommendations and moving them in the provinces. They're dealing with their provincial governments and things are happening. That's what's really exciting, that this thing is moving, but we can't just sit back and say okay, it's moving. We really have to keep it moving.

So there are different levels. For the federal government it's the Department of Human Resources and the Department of Citizenship and Immigration for us, and as far as the provinces are concerned, it's our provincial licensing bodies.

Mr. Bill Siksay: Does this take up a huge amount of time of your organization? I'm sure it's not the only thing on your agenda. Can you just tell me something about the distribution of work around that?

Ms. Marie Lemay: I'm not going to look to my right, because this lady has spent probably the last two years on this project.

It's been a very important issue for the profession. I can't even quantify the hours we've put in. Actually, we could if we wanted to because we've done it, gone through some of the process, with Human Resources, but that would be the minimum. At every level of the profession, whether it's at our level, national, or the provincial level, there's been a huge amount of time put into this issue.

That's why I' m so passionate about it. I want to see it happen and I really believe that my colleagues who agreed to jump in and work with this believe the same thing. We want to see it come to an end at one point.

Mr. Bill Siksay: I just wonder if I could ask the folks from the medical and dental associations something on the structural issue. Is there something you, with your experience in dealing with this, can suggest that would be helpful, in terms of a secretariat or that kind of thing, in making contact with the government?

● (1205)

Dr. Albert Schumacher: One of the things we've called for is a coordinating office for health human resource planning, not just physicians. You can multiply the numbers I talked about for doctors by five for nurses. We don't have a national plan even within the country for training to make sure we have enough rural people and enough aboriginals in the mix in the proportion at which they should be represented. I think that how we use, recruit, and attract international medical graduates can be part of that.

Right now the way we get to 1,770 or 2,500 is that you add up what each province is doing and come out with a number at the end. That's not planning; that's basic arithmetic.

I think there is a place on the Canadian level to have an office that does that, not only to make sure our own mix within the profession is correct as far as demography, rurality, and ethnicity—I'm looking at first nations—are concerned but to make sure that's in place as well for international graduates.

Mr. Bill Siksay: Okay.

Dr. Alfred Dean: What I would say is in my opinion there's a pretty good system in place right now. It's fair and it's transparent. It treats everybody equally.

As you heard earlier, we really don't have a shortage right now, but as we move to that 2015 date....

Look, maybe I'm just a simple country boy practising in Cape Breton, but it seems to me that we have a pretty rich country here. If we can't produce what we need within our own resources, I think that's a pretty sad statement for Canada. Then, as part of an immigration policy, because we don't want to close doors to people, it's a discussion about what's fair for folks coming from different countries, so that Canadians get the treatment they need, they deserve, and they expect. For me, it's very simple.

The Chair: Thank you. The time is up.

Dr. Fry.

Hon. Hedy Fry (Vancouver Centre, Lib.): Thank you.

I want to thank everyone for coming. I know the work that Marie and Deborah have done on this, and of course you've highlighted the complexity of the issue.

We all know there is no silver bullet, and given our constitutionality that says the provinces have a role, that is their role, especially in medicine: to decide how many medical schools there are, who is going to go, and where they work, when they work, and how many doctors work. There is an ability to link this.

HRSDC has funded your three studies, and I think that was important. I want to just point out that in your second-phase study—because you only brought out your third-phase study fairly recently, so there's really no opportunity to analyze that fully yet—you talked about something I want you to comment on a little bit: the cultural and language divide that can impede an international engineering graduate's ability to integrate into the engineering workforce.

The second one is the employee getting a foot in the door of the employers. I'm reading here where you said there is no clear research to indicate the most effective way to link IEGs and potential employers.

I just want you to comment on both of those things, because it's not really only about getting the credential and giving somebody a licence to go out and work. There are these other factors.

You know the citizenship and immigration department has put $20 million a year, now, into the linkages of the expanded language training. But tell me how you see this link between the employer.... We're talking private employers with the doctors—or the province is the employer, really—but with engineers, we're talking about private sector business employers. How do you see us getting that done? That is the conundrum that everybody has; I actually link the two. So that's a question I want to ask.

I'm just going to ask the Canadian Medical Association a question—and I want to again thank you for all the work you've done, Todd, on the IMG task force that was set up with the provinces. The provinces are key players in this.

Dr. Schumacher talked about the $25 million a year that was agreed on in the first ministers conference for health human resources. The $250 million therefore means that the federal government and the provinces have come together with an idea that they will work together to enhance this movement. How do you see that rolling out? What indication do you have from the provinces that they're committed to putting that money into health human resources in an appropriate manner?

It's expensive to link a doctor into a training spot. What is it, $60,000 a year per physician, or $90,000 for a specialist physician? So we're talking about a lot of money. I want you to comment on that $250 million a year that came out of the first ministers meeting, given that the province is the employer of physicians.

I'm very satisfied. I have been working with the dentists, and I think you are identifying that you currently do not have a critical shortage but that you will have a shortage by 2015, which means we have to be able to work with you to identify how to deal with that. But currently I want Ms. Lemay and either Dr. Watkins or Dr. Schumacher to talk about those two issues.

● (1210)

Ms. Marie Lemay: Well, Dr. Fry, you've definitely identified two key issues.

I will ask Deborah to elaborate on them, but I just want to tell you that things have been happening even since you've had the report. So that's what is interesting. She can talk to you a little bit about the provisional licence concept and a really interesting pilot project that's happening in Manitoba. It's on a small scale, but that's how we're looking at addressing this: you try with small pilot projects, you try to get ideas, and then you can share that experience. That's the beauty of the approach of our project. She can talk to you a little bit about the language.

Deborah.

Mrs. Deborah Wolfe: The cultural and language divide is key. Employers tend to be able to understand the technical skills engineers have. It's the aspect of whether those individuals fit into the workplace. Do they understand our codes, our culture, our climate—our climate isn't the same as that of some places a lot of immigrants are coming from—and also the interactions between different individuals? That's what their one year of Canadian experience requirement is. To be licensed you have to have the education, four years of engineering experience, and then some other things.

That one year of Canadian experience can be very difficult for individuals to get, and so one of the recommendations in the project was to have a provisional license in each of the provinces and territories, which means that all of the requirements for licensure except for the one year of Canadian experience is checked off. Give them a provisional license that says to the employer that the regulatory body says this individual is qualified but just needs some experience here in Canada.

When we started this project there was one province, Ontario, that was just about to bring this online. Now they're still struggling, because it hasn't been taken up much. The employers aren't aware of it yet.

Hon. Hedy Fry: That's a big problem.

Mrs. Deborah Wolfe: Yes. They've been seeking funding from the Ministry of Training, Colleges and Universities in Ontario to bring that to the employers, to explain it to them. Now, two years later in the project, four of our jurisdictions have that in their processes. Legislation was required in some cases to change it. I think this is a very good piece of progress that we've seen. The others are looking at whether it will solve some of the problems.

On the other side, you were talking about there being no effective research on the best way to get IEGs into the workforce, and that's absolutely the case. We hear from immigrants themselves that all they need is a chance to be in a workplace for three months: " If I can prove myself for three months, I will be able to stay there forever. I can do it." So what they're saying is the internship is all they need.

What we're hearing from groups that ran internships is that there are so many problems in them with sustainability. In medicine it's not the same thing, or in dentistry, but in engineering the economic cycles really impact the employment of engineers. If you have a down cycle it will be difficult to find internship spots.

In Manitoba the project we were talking about is called IEEQ, the Internationally Educated Engineer Qualification Project. We take individuals of whom the licensing body says "you just need a few exams to come up to the speed of a Canadian engineer, and then we can go through the rest of the process." They say, "If you're interested, let's go into this project." It's eight months at the University of Manitoba, with special classes on culture and workplace. The working-in-Canada seminar is part of that. There are also classes with students in the Canadian program. Whether they're from Canada or wherever doesn't matter; they're in with other students. It's eight months in class, four months in the workplace.

They're in their second group of students at this point. In the first group there were eight. Three of them failed out for various reasons, which says that this is a valid process—there were problems with those individuals. Of the remaining five, four now have permanent jobs, and one is back at school taking his master's program. He wanted to go further in an academic dierction. That's a huge success.

● (1215)

Hon. Hedy Fry: And that's in Manitoba?

Mrs. Deborah Wolfe: That's in Manitoba. They now have their second crew. It's 14 students. We're looking at helping with HRSDC to provide funding, because that provides mentoring, an alternative way to be licensed, working in Canada, and also getting into the internship. That we think is a holistic model. Not every IEG would need it, because some will say they can get a job on their own, and they can. Some of them need more of the technical and academic help, and help getting their foot into the workplace.

The Chair: Thank you.

We're going to go back in the next round, when you get to the next round, for CMA.

Hon. Hedy Fry: They haven't answered.

The Chair: I know, but we've gone over a minute now. I don't want to get into trouble with the other side of the table.

Ms. Grewal.

Mrs. Nina Grewal (Fleetwood—Port Kells, CPC): Thank you, Mr. Chair.

Thank you all for your presentations.

My question, or I should say my observation, is that highly trained and skilled practitioners educated in other countries are precluded from practising in Canada because their credentials or qualifications are found unacceptable by Canadian professional associations or governing bodies, in the sense, for example, that the Canadian Medical Association requires that medical school graduates from other continents go back to medical school for a year or years when they are landed in Canada.

Immigrants cannot afford this luxury and wind up working at low-paying jobs. They have to support their families and house themselves. This is at a time when we have a critical shortage of medical practitioners. Are the professional associations looking at ways and means to ensure that medical and dental skills are portable and that qualifications and credentials may be tested and approved on a faster track? Will we soon see a day when a national system of accrediting immigrant doctors and dentists will be in place without requiring the applicant to go back to medical or dental school?

Dr. Albert Schumacher: If I can start at that, as I mentioned, one of the difficulties we have is that there are 1,800 medical schools out there in the world. Some of them are very good, regardless of what country they're in, and some of them aren't very good, and we see some of those on television. We have our hands full in Canada making sure that our 16 medical schools have all their programs up to date. Sometimes we put Canadian programs on probation when they don't have enough hours or there isn't enough teaching volume. These are things we take very seriously in this country. It is very difficult for us to go out beyond our borders to assess that.

What we've tried to do, and we did very well in the past, is we would hope that when international medical graduates arrived we'd have enough capacity in the system to put them into jobs that are sustainable. I don't want to say they are well-paying jobs. In Ontario a first-year resident makes $42,000 a year and a fifth-year resident makes $60,000 a year. If you can put people into those kinds of training programs, whether it is for six months, a year, or whether it's for four years in some cases, I think that's a route to go. I would hope that most people wouldn't have to go through an entire four years of post-graduate training. Making those spots available is what we need to do, and that's where the federal money needs to go.

Remember, last year they increased medical school spots up from 1,590 to 1,770 graduates, but somebody forgot to increase the resident numbers. The match this year was very tight for Canadians, and there was very little left over. What we're seeing is that we need it funded so when people do arrive who are qualified.... I'm telling you there are almost 800 people in this country who applied last year who are qualified to do post-graduate training in Canada and we only had space for 75 of them. What we're all saying is we think we should be able to accommodate 400 this year, the other 400 next year, and then ultimately those spots will become available for Canadians.

Dr. Irwin Fefergrad (Royal College of Dental Surgeons of Ontario, Canadian Dental Association): Good morning. It's an excellent question, if I may reply.

I'm a regulator in the province of Ontario. It means that I care about the standards of practice. I register people, as you've heard from my colleagues.

The story about dentistry in Canada is an absolutely good news story. Like our colleagues in engineering, the association, the regulators across the country, and each of the faculties have been meeting over the last year and a half in order to try to make sure that we do remove and reduce barriers for foreign-trained applicants. In fact, we do have protocols now in place that will assist this happening.

We're also working very closely in Ontario with the Ontario government, and Minister Chambers has created a special study, as you know, under the honourable George Thomson to make recommendations on reducing barriers. We've been a major part of that.

While we don't deal as a regulator with the issues of numbers and while we deal with standards, we're confident there are ways for foreign-trained applicants to fast-track, such as in the qualifying program. As you know, this is a program where someone who is foreign-trained can come into the country and in a very short time, in two years as opposed to the four-year program, be qualified. As well, for those who are specialists who already have general qualifications here, we've developed a fast track for them, and we will continue to work together.

Like the engineers, we feel that the impetus is there and the energy is there. We hope the support is there from governments that need to supply the universities with funding in order to assist with this. As well, we hope there is some cohesive funding available so that the applicant who's coming, once he or she is abroad, will be given a message with all the information that will make it very clear as to what the requirements are.

● (1220)

The Chair: Thank you very much.

Now we'll go back to Dr. Fry.

Hon. Hedy Fry: Thank you.

I would like to hear a neater answer to the first question I asked, but I want to throw out another question.

We didn't get to this point of not having enough physicians by chance. I recall in the 1980s that a report—a great academic report—came out of McMaster University that said we would have too many doctors if we continued to put the number into medical school. So provinces at the time that were trying to save money based on $60,000 a year training decided to cut enrollment into medical schools. This is the result of a decision made a long time ago that all of us—I was very involved with the British Columbia Medical Association at the time—said was a bad piece of public policy and a bad bit of advice.

We got here and we're where we are, so this is one of the reasons why I'd like you to talk about that agreement of the $250 million—an agreement between the federal government and the provinces—to look at how it would help human resources.

Dr. Albert Schumacher: Thank you.

The report you refer to was from 1991. It was called the Barer-Stoddart report. About two weeks ago, Michael Decter had to eat his words, because at that time he was the provincial deputy minister who had to implement the 10% cuts in Ontario, so it sort of came around to bite him.

The money you're talking about, and the four-year time period it's allocated for, are a good start, but they're probably not sufficient. If we do the math, one of the difficulties is that even at the provincial level, physicians and the training programs are funded both through the Ministry of Health and Long-Term Care and through the Ministry of Colleges and Universities, so it starts to get murky already.

But let's talk about the 400 resident spots a year. If we say those will cost $75,000 on average—$50,000 for salary, plus $25,000 for teaching and administration—you're going to come up with a number of about $30 million a year to sustain those 400 residents, but that's only for the first-year training program. Residency programs in Canada are two years for family practice; they're five years for specialists. So let's say it's three years on average. You're talking close to a $100-million-per-year investment to create those extra 400 spots in the proper fashion and in the proper manner. It's that kind of sustained funding we need to look at over the long term. That's the place we need to look at—not just for four years, and then the money goes away, and the spots get cut back.

The money being there is good. You asked me if I saw evidence the provinces are playing ball with the recommendations. From their movement on the wait times, on the standards, on the benchmarks we talked about—that we need, right now, for safe and reasonable waiting lists—I have to say no. But at the same time, I also haven't seen one of the federal dollars promised in September move yet, in the last six months, so there's a delay all around, and I think that all are equally culpable. But we need more than just four years; we need a longer-term thing.

The Chair: Thank you very much.

We're going to go to Madame Faille.

[*Translation*]

Ms. Meili Faille: This is more of a comment than a question. I know that Quebec in particular is making progress, and the feedback I have had from professional organizations is encouraging. There are reports, a consultation has been undertaken, for which a report will be tabled soon, and we are making headway.

Immigration is an area of shared jurisdiction. I have also heard positive things about the consultation. I was pleased to hear Ms. Lemay's comment, when she said that there were good examples to be followed. I would encourage the other professional associations to observe what the engineers are doing. I probably have a soft spot for engineers, because I come from a family of engineers. We have helped a number of people who came from other countries, and everything went very well. I would therefore like to thank CIC for the efforts they have made and tell them that they can count on us to support them in the next stage.

I do not really have any questions, as I'm quite well aware of the issues. I will wait for the next steps and the tabling of the report. Roger may have a question.

● (1225)

Mr. Roger Clavet: If I have time, yes, I would like to ask a question on the shortage of human resources in the field of health care. It is clear that our aging population poses a problem. Has the Canadian Medical Association, whose members are aging as well, found a way to counter the considerable impact that this phenomenon will have on health care resources? Have they tried to do anything in this regard? What does the future hold? Once again, supposing that they are competent, would the contribution of foreign doctors not be a possible solution to the aging medical profession in Canada? Could we not try and find young doctors from abroad, at the same time as we make efforts to rejuvenate the profession?

[*English*]

Dr. Albert Schumacher: At the same time, in Canada we are being poached for physicians, and not just from the United States. We have Australia recruiting Canadians; we have Great Britain trying to repatriate physicians; you have hospitals being built in the Middle East where they recruit exclusively Canadians because of our practice efficiencies and the way we work. It's a brain drain that is going across the world, and it's a constant battle. We win; we lose.

The situation in Quebec in some ways is better and in some ways is worse. In Quebec, rather than 15% of the population that doesn't have access to a family doctor, it's closer to 25% that doesn't. On the good news side, Quebec is better able to retain its graduates, for both language and cultural reasons, and in fact Quebec has the lowest number of international medical graduates in medicine. It's only about 12%.

The challenge in Quebec is that Quebec is leading us in feminization of our profession. The graduates the medical schools in Quebec have been producing have for the last five years been about 80% women, and I think that's a good thing. But if we look at our recent manpower numbers and how much physicians are working, we've noted across the country that the average male physician is working about 53 hours a week, not including on-call time. The average female physician is working 46 hours a week, not including on-call time. It's still a considerable amount of work, but when your workforce is 80% women, or will be, that will be an additional factor at play that needs to be factored in when you're coming up with how many you'll need for the future. I think that's an important part to look at as well, and it goes to that early training program to modify it.

Can we do more to make sure the graduates we are getting from abroad get factored into the places we need them to go? Absolutely. One of the bad things in Canada, regardless of what province it is, is that international medical graduates tend to work in our largest urban centres. It's the same thing with where our population comes in. The fact is, our rural areas need those physicians the most, and it can sometimes be a great difficulty not to discriminate against those physicians by saying, "You're an international medical graduate; you have to go up north to Moosonee", or wherever it happens to be. We haven't found a good way to do that, in whatever area of the country. That's something that needs to be grappled with.

At the same time, we have another issue. We have Canadians who went to medical school outside Canada—and this is not just anglophones, this will include francophones—who are having difficulty coming back. The only difference between me and them is that they went to a medical school outside Canada. They often did their residency training in the States. They went to the same high school I did; they went to the same undergraduate school. They would like to come back and they're having trouble getting access to some of those same spots we talked about. They are already culturally, ethically, societally integrated, and I think we have to pay attention, because there are estimates that there are anywhere between 400 and 1,200 of those people out there who would serve a tremendous need to us.

If we're going to target people, first maybe we should somehow look at repatriating them. This is an issue that again goes across both languages and that specifically would probably help us, because those are the physicians who will likely go back to their roots—their rural areas, their hometown communities, where their families are.

● (1230)

The Chair: We went over one and a half minutes there.

I'm going to take a round here, and I'm going to start with the point you raised, Dr. Schumacher.

Can you tell us what percentage of physicians leave Canada to go to practice elsewhere?

Dr. Albert Schumacher: Currently you see about 500 physicians leave the country every year—but that includes people going for residency training to the United States, for example—and you see on average for the last three years a net loss of about 185. In fact, in the last year we had a net loss of fewer than 100. Historically it was as high as 600, one might recall, about 10 or 15 years ago, so it has certainly improved. I think a lot of the efforts different communities are making are going a long way toward that.

What I'd like to see is that initial 500 leaving not being so high, especially when most of them are doing it to get post-graduate training they couldn't otherwise get in Canada.

The Chair: Could you tell me, Dr. Dean, how is the situation in dentistry? What kind of numbers do you have leave per year?

Dr. Alfred Dean: I would say we don't really have a problem, I don't think, in this country with dentists leaving the country. That's not our problem.

As we look forward to the so-called greying of the profession and people retiring, we just know that our faculties need an infusion of capital and resources to take care of what we see as a looming shortage. For us, that's the issue.

The Chair: We've been talking about it being unfair for Canada to poach and that somehow we're taking advantage of other countries. The reality is that when you talk about a brain drain, we have a much bigger problem in this country, and it's called a brain waste. I think that's what Ms. Grewal was getting at as well.

Canadians are mobile. It's their right to be mobile, and other people are mobile as well. In terms of immigration, it really is the lifeblood of this country. Immigration patterns have changed greatly, and so has the pattern of people leaving the country. The biggest chamber of commerce we have, Canadian Chamber of Commerce, is in Hong Kong, and many of those people got trained in Canada. We understand that they're going to go and not necessarily stay in the country.

I guess the reason I mention all that is because the whole pattern of immigration has changed. We might have a faculty member who comes to the University of Ottawa or any of our universities, and his or her spouse might be a dentist, might be a doctor, might be an engineer. If their spouses can't find positions in the country, then the one who is the star performer, let's say, is not going to come.

The immigration patterns have changed, so we're getting them from all over. I guess the challenge for us as a country that needs immigrants because of our demographics—and we desperately need them—is to be able to integrate. I'm really pleased with the progress the engineers are making, and I'm hoping that can serve as a model to help us make sure we have a lot less brain waste, because that's a really tragic kind of situation for everyone involved.

For the next round, we're going to go to Mr. Rahim Jaffer.

Mr. Rahim Jaffer (Edmonton—Strathcona, CPC): I want to follow up with you, Dr. Schumacher. You mentioned Bill C-39 and how that fell short. You also spoke about the residency amounts. I believe you said we need to raise it up to 120 resident spots. Is that correct?

● (1235)

Dr. Albert Schumacher: Yes, that's right, 120%—120 first-year resident spots for each of our 100 graduates.

Mr. Rahim Jaffer: Right.

There was one thing that I was hoping to get some feedback on. I had some discussions, and we talked about this at our last meeting here, with the dean of medicine at the University of Alberta. One of the things he had suggested, and I believe our witness from the last meeting also suggested, is that it would almost make sense to have a pilot project set up with universities to be able to develop specifically.

In the case of what you said about maybe the federal government buying spots for residency in order to address this issue specifically on accreditation, you made the case that we need to expand that anyway for our domestic medical students. But it seems to me that in expanding that, there needs to be a special priority attached to, potentially, these foreign-trained people. So I wonder if you can comment on that and maybe how we should proceed at looking at that as a potential option.

Dr. Albert Schumacher: You're right, because again, remember, I told you that 1,770 graduated in June, but it's going up by 100 a year already. The provinces are scrambling to find the funding for the extra 100 that they need this year and next year, and so forth, because in four years there are going to be 2,200 graduating. So they have to come up with 400 spots on their own, out of the money they have, and that doesn't include international medical graduates. That's why I'm saying to carve that off and say this is now going to be for international medical-graduate-specific money, resources, and so forth may be an appropriate way to go.

You have to work with them, but you can still designate those spots. Eventually you'll need those for Canadians to match into, too, one day hopefully not too far down the road.

You can target it. The federal government has the opportunity and certainly the ability to do that, and I would suggest that the money come even more constrained and restricted in that regard.

Ms. Helena Guergis (Simcoe—Grey, CPC): I have more of a comment, and I'm hoping that Dr. Schumacher can clarify it for me.

It's my understanding that all of the provinces have their own medical associations, and doctors within Canada have a challenge because they can't move from province to province to practise the way that they would like to be able to do. Is that a barrier here for us in this situation? Do you have any recommendations on how we could work with the provinces to solve that problem?

Dr. Albert Schumacher: It is, and it was a problem during SARS. It's a problem that faces me personally. By my licensure, I was licensed with a one-year rotating internship. I have a licence in Ontario. Without jumping through a couple of other hoops, which I'm sure by now I can negotiate, it is easier for me to go and get a licence in eight different states of the U.S. than to go to any other Canadian province. So I have mobility problems in Canada. If I get really mad at my premier at home, it's easier for me to go across to Michigan than it is anywhere else. This is something we are working on and addressing. For newer graduates, it's not as much of a problem because their certification as family physicians from the Canadian College of Physicians and from the royal college allows greater mobility.

For some of us older physicians—and I include myself now in that, as I'm of that has-been generation—that can still be a potential problem. We need to address that, because we see now, as physicians retire and as they change their practices, we need them to do locums elsewhere, and the locum may not be in their jurisdiction. It may be in Nunavut, it may be in Newfoundland. You need to give access to the people who want them and the people who are there. There shouldn't be a difference of that magnitude in the licensing.

The Chair: The next is Mr. Temelkovski, then Mr. Siksay, then Mr. Anderson, and then we'll look for somebody from the Conservatives.

Mr. Lui Temelkovski (Oak Ridges—Markham, Lib.): Thank you very much, Mr. Chair.

I'd like to thank the witnesses for coming here.

I have a number of questions, and predominantly for the CMA.

How many patients should one doctor have in Canada to look after them well? I'm a small-town boy as well, so I'd like to understand that right from the get-go.

Dr. Albert Schumacher: That's a good question. If we look at the reform to family practice groups that's going on in Ontario, the general number for a family doctor to take adequate care of is about 2,000. There are provisions under some of those contracts to increase that up to 2,700 if one has a nurse-practitioner working with them, but on average the average family doctor working the 53-hour week can probably do 2,000 fairly well.

Unfortunately, many of my colleagues.... In fact the average in my community in Windsor, Ontario, is 2,700, because we just don't have enough.

● (1240)

Mr. Lui Temelkovski: To jump ahead now to the number of people who we think don't have physicians, it's about three million to four and a half million people?

Dr. Albert Schumacher: That's right.

Mr. Lui Temelkovski: You made us aware that the associations are going to increase the number of residencies as well as admittances to schools by 100 per year.

Dr. Albert Schumacher: It's not us who will do that increasing.

Mr. Lui Temelkovski: I don't mean you.

Dr. Albert Schumacher: We're recommending that. We've been recommending that since 1992. We opposed the cutbacks, and say we should be increasing. It hasn't happened yet.

Mr. Lui Temelkovski: Even if it did at 100, how long would that take to fill the shortage?

Dr. Albert Schumacher: A very long time.

Mr. Lui Temelkovski: So we understand each other there, right?

Dr. Albert Schumacher: Yes.

Mr. Lui Temelkovski: Have you considered mentoring foreign-trained doctors who have come here?

Dr. Albert Schumacher: There are projects going on right now, some of them in Ontario, to do that, to match an international medical graduate into an established physician's practice for a period of time to fast-track them. There are pilot projects right now where that's happening. I can't comment yet on the outcome of that.

Remember, though, what it's competing against. We've increased our medical school enrollment and you now have medical students who are out in the same communities, often with the same doctors, where that's almost a full-time relationship, so the teaching is getting fairly crowded across the country and we're constantly recruiting more teachers to help us to do that.

Mr. Lui Temelkovski: I think in the teaching end we might have to fine-tune some of the recognition of these students who have been taught, and practised, in other countries. I don't think that teaching is a problem. I think it's the assessment that's the problem maybe.

Secondly, after that, the second step would be residencies, spaces that would be available, but that's the second thing, and then where they practise. We'll find enough Canadians who don't have doctors to take them.

I want to switch to the PAs, physician assistants. I understand that in Canada the CMA has approved physician assistants, or has worked with them closely now, and they are in the phase where they are recognizing and certifying physician assistants to work beside physicians in Canada.

Dr. Albert Schumacher: The physicians' assistants in Canada up until now have been really limited to the ones the armed forces use. There has now been a move afoot to look at some way of credentialling and certifying those people to work outside the armed forces in the rest of society. The Canadian Medical Association has now participated in the pilot doing that, because we helped to accredit 15 other health professional associations—x-ray technicians, ultrasound technicians, and so forth. This is at the very beginning of happening.

The numbers we're dealing with are very small. I think there are only 200 of these in the entire country, but we're certainly making every effort to explore this.

Mr. Lui Temelkovski: Are you exploring repatriation of PAs from the States as well?

Dr. Albert Schumacher: Obviously that would be a part of it, once we had an approved, accredited way of doing it.

Mr. Lui Temelkovski: When we look at the mathematics of this, it looks as though it's going to take us a number of years to overcome this problem unless we aggressively look at something within a shorter time span, because it won't be done in our generation with 100 more spaces every year. We won't solve the problem.

Dr. Albert Schumacher: Yes, it will take a generation.

Mr. Lui Temelkovski: Are there any aggressive moves on your side to look at this?

Dr. Albert Schumacher: The aggressive move on our side, if you look at the whole family health network primary care reform, is we've been trying to build teams to use nurses and other health care providers as part of our practices. It has taken almost a decade to get the provinces to adequately fund it, where there was no provision to actually pay for social workers, dietitians, nurse practitioners within groups and practices that wanted to use them. That's something that's only really happened across the country in the last year or two, and not on a huge scale.

There is certainly a willingness among the profession to do exactly that. Family doctors want to be able to have nurse practitioners, social workers, dietitians, working in their facilities. There just hasn't been a way to pay for them.

● (1245)

The Chair: Thank you very much.

Mr. Siksay.

Mr. Bill Siksay: Thank you, Mr. Chair.

Dr. Schumacher, you mentioned the difficulties of Canadians who did their training in the United States coming back, repatriating and practising here. I'm sorry; I guess I'm not getting it. Why is that so difficult?

Dr. Albert Schumacher: It's not so much from the United States. They have an easier time, because our medical schools are similarly accredited. The problem is with Canadians going to Ireland, Canadians going to Caribbean medical schools and coming back.

Mr. Bill Siksay: Can you tell me more about why that is such a problem? There are people who seem to have some kind of advantage. In some of those countries, I would expect their medical standards are very similar to ours.

Dr. Albert Schumacher: In fact they are.

Todd, you may want to answer some of this, because you'll have the exact numbers.

The difficulty has been that under our system, I think the courts have basically decided this: that if you're Canadian-born but went to medical school in Ireland, you are not different from an international medical graduate who was not born in Canada. They have no advantage or leg up in even applying for those spots.

So they end up in the second match, not the first match with Canadian graduates. That's been what's tough. They need to have a Canadian spot for at least one year to get a licence here, even though they may have done the other two postgraduate years in the States, and in fact many of them do. The United States has a big capacity to train physicians after graduation; in fact they count heavily on people coming from abroad.

Dr. W. Todd Watkins (Director, Office of Professional Services, Professional Affairs Department, Canadian Medical Association): It's important to understand how the matching system works with respect to residents. Dr. Schumacher alluded to the fact that we had called for a ratio of 120 postgraduate spots for every 100 graduates. That ratio is important, because what it does is allow, in a second round of the match, all of the international medical graduates, including the Canadian students who have gone to Ireland, to have access to the system.

In 2004 there were only 177 spots available in that second round of the match. There were over 800 international medical graduates applying for those spots. There were 114 Canadian graduates who didn't match in the first round, as well as a number of established physicians who wanted to retrain in a certain area, all competing for those 177 spots. That's where the pressure is with respect to providing access for any international medical graduate.

Mr. Bill Siksay: Dr. Schumacher, you mentioned that fellowship exams for specialists are a requirement in Canada but that they don't do that in the United States.

Dr. Albert Schumacher: That's right.

Mr. Bill Siksay: Can you talk about why we have that higher standard? Is that a point where we...? You say we haven't gone to the point of examining the standards yet in trying to address these problems, but why is there that difference?

Dr. Albert Schumacher: This is something we've moved towards as a country now for 75 years. The Royal College of Physicians and Surgeons this year celebrated its 75th anniversary. The idea was to improve the qualifications and standards to make sure they're equal across the country, whether you're in a university setting or a community hospital. We have held them very high.

There are other countries that do the same thing. In Great Britain you have the same sort of standards. In the United States you can hold out your shingle as a specialist if you have done your residency program—in other words, if you're what they call “board eligible”. You don't necessarily have to be “board certified”. Many of the physicians, after they reach that stage, do take the exams and are qualified. In fact, probably to teach at any reputable university you have to get that within a period of time, but it isn't necessarily so. But it's something that here we generally insist upon and have moved toward.

Is it totally universal? No. We still have some small hospitals in the country where the family doctors with a year of anaesthesia training do the anaesthetics, and it's perfectly appropriate in those situations where it's lower-risk people. Otherwise, the standards across the country are very high. We have 50 different specialty certifications, from nuclear medicine to pediatric cardiology to general surgery, and it's something we're very proud of.

The one good thing about the system, with all the troubles we have, is that you know, if you're in a car accident tonight, you're going to get the best medical care in the world here. That's the one thing we can still hold up high, regardless of how long you wait for your CAT scan. It's those kinds of things that we're not ready to let slip, and we've been shoring up the dike so far.

I would be very reticent to say let's allow people to work for five years and see how it goes, and then if they don't pass the exam, we'll deal with it then. It's very hard, when the community is counting on the person—they've been established—to suddenly say no, time's up, because you didn't pass your exam for the third time. That's a tough one.

● (1250)

Mr. Bill Siksay: Dr. Dean, you mentioned problems with credential assessment services. I wonder if you could say a bit more about the dentists' experience with it and what the problems have been.

Dr. Alfred Dean: It's important to understand first the difference between accreditation and credential assessment. Obviously accreditation, as has been alluded to, is all about the university and assessing the university program. Assessing credentials is about trying to decide if the education an individual coming to this country has gotten is up to a Canadian standard, let's say. That becomes very difficult.

The one time the national dental examining board hired one of these services to go around the world to look at some places.... It's my understanding that what they do is—and I can be corrected by one of my colleagues if I'm telling a lie here—take out the prospectus of the university to see what it says about its dental program. By reading some of that material that comes out of the university, they then say yes, this program would create a good dentist for Canada. But then if you dig deeper and mine down a little further, you find that perhaps they had no clinical training at that spot.

So it's a very tough job and very slippery, I would suggest, to do credential assessments.

The problem with doing accreditation around the world, as was alluded to by the folks from the CMA, is that there's a ton of universities out there with dental programs. The cost of travelling and negotiating with national associations over accreditation of universities is pretty high. I'm not saying it can't be done, and there might be ways around it, but....

The Chair: Thank you.

Mr. Anderson.

Hon. David Anderson: Thank you.

I'd like to thank all of you for putting the issue of immigration qualifications in the wider context. I think it is really important. We obviously must do that with respect to standards in Canada. You've explained that with respect to equity to other Canadians who are applying to medical school or have gone through medical school, or maybe Canadians who have gone abroad.

My final point is to thank you for the comments with respect to the impact overseas. I'm quoting now from Dr. Schumacher: “As a long-term policy it fails to recognize the fact that the countries from which we poach theseIMGs can ill afford to lose them.” That is another major issue that we, and presumably those responsible for CIDA, will have to look at closely as well.

In any event, coming to the issue of accreditation, Dr. Dean has just done a great deal to answer some of my questions, but is there a sort of hierarchy of lists?

To go back to the medical side, you have 16 Canadian schools, soon to be 17, and you have out there another 1,800 schools. But you do know that in the States you can probably list an equal number to the Canadian schools, just adjacent to the border of Canada, and probably another 16 in California and New York alone.

So do you have a sort of hierarchy out there to indicate what the qualification may be, where you do have clinical training, where you know the clinical training is equivalent to Canadian training in terms of hours, or where people are not getting the clinical training but are simply attending a lecture, or in fact perhaps even just being examined on written material without any lecture involved at all? Is there some sort of hierarchy structure that could be looked at by people like ourselves?

● (1255)

Dr. Albert Schumacher: Yes, sir, there is, and I'll take you back on a historical lesson.

If we look back to 20 years ago, we rated medical schools in three categories. We had category 1, split into categories 1a and 1b. Category 1a were North American medical schools—that is, Canada and the United States—and those basically all had the same certification. So Canadians and Americans would have no trouble going across that border with their credentials.

Then there was category 1b, which consisted of what we will call the British medical schools—medical schools in Great Britain, Ireland, South Africa, New Zealand, and Australia. The reason those were rated as category 1b was because they had a very similar system to what we had, especially as far as clinical content within medical schools is concerned. You basically had an internship inside medical school that lasted a whole year, with being on call, with wearing green pyjamas, with starting IVs, and doing all those things.

When you got down to category 2 medical schools, those consisted largely of schools in Europe, Hong Kong, Japan, or ones that didn't fall within that British system. Again, we are going back in time, so I don't want to claim that this is what it's like now, but you often had 400 people sitting in a lecture theatre together for four years who never actually touched a patient. That's how the system was built. You often also had a situation in Europe where physicians, once they graduated, would wait for two years before they even got an internship spot. Literally, they would be driving the taxis there for two years. Those are the ones that one was able to go out and accredit and put into category 2.

Category 3 sort of fell to the rest of the world, the other 1,200 medical schools that you had only heard of but couldn't get to.

That system was found wanting. In fact, there were accusations at the time—and one of the reasons for going away from this—that we were discriminating in favour of recruiting our physicians from all the white, English-speaking countries and giving them preferred access by having that 1a or 1b standard. That was one of the reasons that fell.

If you remember, historically—and British Columbia was a recipient—we used to have huge numbers of physicians from Great Britain and Ireland, who may or may not have fled the National Health Service, who came to Canada and established practice here. They were given equivalency at that time, so they didn't go through any extra training. There was no extra year requirement. They were basically licensed—and you have one of them sitting next to you.

Hon. David Anderson: They had to pass exams. They nevertheless had to get re-examined.

Dr. Albert Schumacher: Sure, they had to pass exams, but there was no residency time period that they had to put in before.

They had to pass exams. They couldn't skip that step. But it was basically made easier.

Currently, two provinces in the country still pursue that policy—Saskatchewan and Newfoundland. In fact, in Saskatchewan about 60% of its practising physicians are international medical graduates. It was the province that heavily recruited from South Africa. In fact, 32% of the international medical graduates in Saskatchewan are from South Africa, and they basically, with the passing of or writing of exams, without any additional training, were able to get licences.

Hon. David Anderson: Without getting into the interesting question of my alma mater, the University of Hong Kong, I'll move on to the McMaster study.

Dr. Albert Schumacher: And Hong Kong was one of those in the 1b category, by the way. I skipped that one.

Hon. David Anderson: Ah, I thought you had another one, a 1c category.

Dr. Albert Schumacher: No, it was 1b.

Hon. David Anderson: You pleased one of the Hong Kong University's alumni, namely myself, by that correction.

On the issue of the McMaster's study, this was a deliberate effort, as I understand it, to restrict the number of medical people practising in Canada, in an effort to restrict the cost of medical services that provincial governments were required to pay. It was accepted on that basis, I believe, quite enthusiastically by province after province.

When did it really end? When did the influence of that report just get thrown out?

Dr. Albert Schumacher: In fact, the influence of that report actually didn't end until about the year 2000, and it was only then that provincial governments one by one started to increase their medical school enrollment. I can remember in my term as president in Ontario it was only during that time that the health minister finally admitted we weren't training enough physicians. That was the turnaround throughout the country.

Hon. David Anderson: Is there any national body of provincial health authorities, as opposed to some federal-provincial conference that we might see? Why I'm asking that question is to know whether there is any body specifically dealing with the practice of medicine within the provinces that would be able to deal with the question you raised about how it's easier for you to practise in eight American states than it would be to practise in nine other Canadian provinces.

● (1300)

Dr. Albert Schumacher: There is a coalition of our regulators, much as is here for the engineers, that sits together, but they have a lot of other issues they need to address. That isn't top of mind. Certainly that group does not have any government representation on it, either provincial or federal.

Again, what we're calling for, as part of that Canadian human resource strategy, is to look at exactly that—a national credential. We'll call it a national licensure for emergency purposes. The next time there's SARS you don't have to call, get special permits, jump through hoops so that if you need more doctors in whatever place, they can go from wherever in Canada to deal with all those issues. We need an office to do that. I don't want to say we need a bricks-and-mortar institution, but we need an office that can do this for us.

The Chair: Last question.

Hon. David Anderson: If federal dollars were moved from their general funding to more specifics, we could perhaps raise that specific item on the agenda of that group of regulators, those provincial bodies.

Dr. Albert Schumacher: We would be happy to receive that. We have advocated for that before, and we would work closely with you to make it happen.

Hon. David Anderson: Thank you.

The Chair: Thank you very much.

This part of our meeting comes to a conclusion. I'd like to thank everybody for sharing your time and expertise with the committee. Let's hope we can move forward.

I want to thank you all for appearing.

We have some committee business that will take about a minute, on the report of the subcommittee on agenda and procedure.

Our clerk tells me that the United Nations High Commissioner for Refugees will not be able to send anybody on the 22nd. One of the options we have is to ask him to come at another time, or, if you want, we can submit questions to them.

Madam Faille.

● (1305)

Ms. Meili Faille: I think it's a serious issue, and we should give them a chance to come and explain to us on the 24th.

The Chair: We don't have any room on the 24th, but we can have the subcommittee deal with that.

[*Translation*]

Ms. Meili Faille: It says here that it would be between 11:30 and 12 o'clock.

[*English*]

The Chair: Which day are you talking about?

Ms. Meili Faille: The 24th.

The Clerk of the Committee: We have the officials from 11 to 11:45 on the 24th to address the topic of the SOS Viet Phi. Then from 11:45 to 12:30 we have clause-by-clause on Bill S-2. Then we have the minister from 12:30 to 1:30 on the 24th.

The Chair: We'll try to figure it out when we get together with the subcommittee. We'll see if we can put him in.

Mr. Lui Temelkovski: Mr. Chair, will that be enough time to go through the clause-by-clause?

The Chair: It should be. It's a fairly simple bill, and we anticipate one simple amendment. So that should be plenty of time.

Shall the report of the subcommittee be carried?

Some hon. members: Agreed.

The Chair: The meeting is adjourned.

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