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Chair

Mr. Dean Allison

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● (1105)

[*English*]

The Chair (Mr. Dean Allison (Niagara West—Glanbrook, CPC)): We'll get this meeting started.

Pursuant to Standing Order 108(2), the committee will now commence the study on employment in Canada.

We have five witnesses today. Because of the limited amount of time, we ask that you limit your presentations to seven minutes. We'll try to give you a one-minute warning, and then we'll cut you off so that the others can make their presentations. Then, of course, the committee will ask questions after that.

I understand you have organized yourselves in the order that you're going to present, which is very impressive.

We're going to start with HEAL, followed by the Canadian Pharmacists Association, the Canadian Medical Association, the Canadian Nurses Association, and, last but not least, the Canadian Healthcare Association.

First of all, I want to thank you all for taking the time to be here today.

We look forward to your comments. We'll get started with the organization HEAL.

Ms. Pamela Fralick (Chief Executive Officer, The Canadian Physiotherapy Association, Health Action Lobby): First of all, thank you.

[*Translation*]

Thank you for this opportunity to speak to you today.

[*English*]

Our intent is to reflect the concerns of the health system vis-à-vis the issues under scrutiny by this committee and to bring that whole arena to your attention. We have both common messages, supported by all—

The Chair: Sorry, apparently we're having a translation problem.

Let's start again. Sorry

Ms. Pamela Fralick: We are presenting common messages that are very important to all of us—

The Chair: Let's just hold. We're getting someone else's committee meeting. That could be problematic.

[*Technical difficulty—Editor*]

● (1106)

(Pause)

● (1111)

The Chair: Thank you for your patience. Now that those voices have gone away in my head, we can start again.

Ms. Fralick, if you'd start again, there are about two minutes left. No, no, you have the full seven minutes.

Ms. Pamela Fralick: Thank you.

For the record, please let me thank you once again for the opportunity to speak with you today.

The intent of those of us in front of you today is to bring to your attention the concerns of the health system vis-à-vis the issues under scrutiny by this committee. We have some common messages that are supported by all who are here before you, as well as some additional messages specific to the constituents being represented.

I'm going to open this briefing with a presentation—very brief, of course—from the Health Action Lobby. And in the event that you're not familiar with HEAL, it is a coalition of 30 national health associations, including those here today in front of you.

Collectively, I must tell you, they have identified health human resources as a key priority, and for most of the members I would say the priority issue of the day. The biggest problem, however, is that we don't know enough about it, and that is why we want especially to bring it to your attention in terms of the interests of this committee. We don't have the data, the information, that we need. The limited efforts that have taken place in Canada in this area have, by and large, been uncoordinated, not connected with one another, and many of the key players, we feel—and referring here to health providers—have not really been valued as significant contributors to both understanding and solving the problem. So HEAL wants to contribute to that understanding and to finding the solutions.

We did circulate to you a document in advance, and I'm going to highlight just a couple of points from that in the event that you've not had a chance to review it with all the many materials you're receiving.

There are three broad recommendations that HEAL feels are critically important for this country to consider if we are to make a dent in the issue of health human resources.

The first is a recommendation around the establishment of an ongoing mechanism to support and promote the exchange of information and policy capacity building among national health organizations on cross-cutting health human resources policy issues and data collection. This speaks to the limitation of the current situation that I referred to a moment ago.

The second of the recommendations is a need for the establishment of a mechanism to provide for routine consultations and exchanges between national health organizations and the federal government on health human resources policy and related issues. It simply isn't happening to the sufficient levels that we need.

And the third of these critical recommendations that HEAL has made calls for the establishment of a fact-finding task force to carry out a rapid assessment of the trends, the prospects, the key issues of the various health disciplines, and this includes the capacity of the educational infrastructure to absorb increased enrolment at both the entry or undergraduate levels and post-graduate levels as well as the availability of practicum opportunities.

HEAL has gone further in its work to bring some concrete contributions to this discussion, and that is all contained in the report you've received. We feel that there are three themes that must guide this country's approach to a healthy, vibrant, and effective health workforce: patient-centred care, planning, and the career life cycle. Moreover, we've agreed on 10 key principles that must underpin these three themes. Again, you've been provided with the detailed information, but I would like to make brief reference to three of these principles.

The first is the number one principle in the document. It refers to needs-based planning—population needs-based planning. In this country we've focused on the supply side of the equation, the number of personnel or equipment that is needed. However, today we must look at things differently. Planners must adopt a needs-based approach, which is not looking at costs but rather investments to the health system. It should anticipate the current and emerging health service needs of the populations that are determined by demographic, epidemiological, cultural, and geographic factors and that take into account the evolving delivery models and technological change. There is, of course, also that very important interface between the publicly funded health system, the private health system, and the public health system.

We cite four strategic directions that we feel can contribute to advancing this particular issue. We need an in-depth analysis of population surveys and epidemiological data—there is some out there, but it needs to be used and we need more—benchmarking based on regional variations, a review of the specialty mix within and between disciples, and the development of leadership for system change.

The second principle I want to cite briefly refers to a need for inclusive policy planning and decision-making processes and it supports the comments I've just made.

● (1115)

Policy planning and decision-making in the area of health human resources must include representation from all stakeholders involved. Yes, with governments, but also regional health authorities, educational and regulatory authorities, and of course practising professionals. The strategic directions we suggest that might support that include the establishment of some kind of a Canadian coordinating office for health human resources, distinct and at arm's length from the government, bringing neutrality and objectivity to the issue.

We recommend the provision of exchanges between the provider community and the FPT, federal-provincial-territorial advisory committees. We also recommend the promotion of provider representation at regional and institutional governance bodies. Finally, we recommend the promotion of inter-sectoral discussions on healthy public policy.

The final note I'd like to bring to your attention before passing on to my colleagues is a call for healthy workplaces. We speak especially in the healthy workforce of the difficulty of recruiting and retaining people, of worker morale. It is a difficult field to attract people to despite the advancements that have been made in the last couple of years. Health care administrators and decision-makers must recognize the importance of healthy workplaces and collaborate with health care providers to implement strategies to support their health and safety.

We do recommend the need for some best practice approaches, educational programs, and the need to promote a cultural shift to encourage help-seeking behaviours among health professionals themselves.

I know you'll have many questions, but at this point I will end my comments and turn to my colleagues from the Canadian Pharmacists Association for the next presentation.

Thank you. Merci.

The Chair: Thank you very much.

You've set the bar high. You are under your seven minutes. We'll see if everyone else can do that.

We'll move on to the Canadian Pharmacists Association.

Mr. Brian Stowe (President, Canadian Pharmacists Association): Thank you.

Good morning, ladies and gentlemen. Thank you for the opportunity to present to you today along with our G4 and HEAL colleagues.

My name is Brian Stowe. I am president of the Canadian Pharmacists Association and an independent pharmacy owner here in Ottawa, at Carleton University. I am joined by my colleague, Janet Cooper, who is our senior director of professional affairs.

The Canadian Pharmacists Association, or CPhA, is the national voluntary organization of pharmacists. We are committed to providing leadership for the profession of pharmacy and to improving the health of Canadians.

You have been provided with a brief that outlines our recommendations and key issues. CPhA is involved in numerous initiatives to address HHR challenges, in particular those faced by pharmacists and pharmacy technicians.

Before I focus on the recommendations, let me give you some brief background.

Canada's 29,000 pharmacists represent the third-largest health care professional group. More than one-third of our pharmacists are under the age of 35. International pharmacy graduates, or IPGs, are a significant part of the pharmacy workforce, estimated at 20% to 30% of all pharmacists practising today.

Pharmacists are the medication experts of the health care system. The roles of pharmacists and pharmacy technicians are evolving to better meet the pharmaceutical care needs of Canadians, and in particular with respect to primary care.

Licensing standards for pharmacists assure Canadians of appropriate and safe practices. The Pharmacy Examining Board of Canada assesses the qualifications of both Canadian and foreign graduates. Pharmacist mobility across Canada is facilitated by a mutual recognition agreement.

International pharmacy graduates specifically must meet the same standards of practice and have the knowledge and skills of Canadian-trained pharmacists. A key challenge for IPGs is learning how to "be a pharmacist" in Canada.

In the late 1990s, shortages in the pharmacist workforce became evident. It is now estimated that Canada has an unfilled demand for between 1,500 and 2,500 pharmacists in our current workplace.

This is at a time when concerns about the safe, appropriate, and cost-effective use of medication is at an all-time high, and when numerous reports, including those of Romanow and Kirby, have pointed to a role for pharmacists in optimizing pharmaceutical care.

The FPT governments have identified pharmacy as one of seven health professions to receive priority HHR action.

Work is now under way to improve planning in the pharmacy sector. A new study titled "Moving Forward—Pharmacy Human Resources for the Future" is a joint initiative led by CPhA and funded by HRSDC. As well, CIHI is developing a database of licensed pharmacists in Canada.

Today we offer you the following recommendations to support a coordinated approach to health human resources and to address specific challenges facing the pharmacy profession.

1. A pan-Canadian HHR strategy must emphasize patient safety and quality care and take a population needs-based planning approach.

2. A pharmacy-specific human resources plan must be developed to ensure a strong pharmacy workforce to meet the present and future pharmaceutical care needs of Canadians. This plan must be integrated into overall HHR planning.

3. Research and better data are needed. The "Moving Forward" study and the CIHI database will greatly improve this situation.

4. We all need to be open and committed to interdisciplinary care, with pharmacists contributing their expertise.

5. Current licensing standards for pharmacists need to assure Canadians of appropriate and safe pharmacy practice; a bar must not be lowered in an effort to license foreign-trained pharmacists.

6. Further initiatives are, however, needed to support qualified international graduates to become licensed and to integrate into pharmacy practice in Canada. This includes expanding the availability of bridging programs for these students.

7. In the longer term, Canada must become more self-sufficient in meeting its health workforce needs and should not depend on international graduates to make up our shortfall.

8. I would now like to speak on behalf of my colleagues from G4 and HEAL.

Health care providers must be at the table to support needs-based HHR planning. We want meaningful and ongoing engagement to exchange information and to support best practices and capacity building among governments, health professionals, and other stakeholders on cross-cutting HHR issues.

● (1120)

Finally, a permanent national HHR body such as an agency, institute, or centre needs to be set up to support a truly integrated approach to meeting the needs of Canadians. All stakeholders need to be involved. Such an organization would address a broad range of issues, including scopes of practice, integration of internationally trained health professionals, and healthy workplaces. This body should also support research on population health needs assessment and planning.

Thank you for your attention. Janet and I will be pleased to answer any questions you might have.

The Chair: Thank you, Mr. Stowe and Ms. Cooper, for the presentation.

We're now going to move on to the Canadian Medical Association, and I believe we have Mr. McMillan.

Dr. Colin McMillan (President, Canadian Medical Association): Thank you, Mr. Chair.

Ladies and gentlemen, good afternoon.

It's a pleasure, as a full-time practising physician from the province of Prince Edward Island, to address you today on behalf of the Canadian Medical Association, with our fellow professionals.

I have with me today Mr. William Tholl, our secretary general, and it is our understanding that our colleagues will deal with a variety of other issues in relation to the mandate of your committee.

What I hope to do today is to concentrate on three areas. One is national standards for medical education and the practice of medicine in Canada. The second is the integration of international medical graduates into the medical workforce. The third is the recognition of foreign medical credentials.

Before expanding on these areas, however, I want to briefly update your committee on the current status of the workforce of physicians in Canada. Accompanying our submission to the committee is what we refer to as the GAP graph. This graph shows Canada's physicians-to-population ratio in comparison to other areas, particularly the OECD average. At present, Canada ranks 26th out of 29 OECD countries in the physician-to-population ratio. For the past decade, Canada's ratio has stood at 2.1 physicians per 1,000, one-third below the OECD average of 3.

This gap tells us that poor human health resource planning in the 1990s has led to an inadequate supply of physicians currently. While there have been some improvements, our projections show that a significant gap will be maintained when it comes to physician-to-population ratios.

As a general rule, Canadian physicians tend to be older than the general working population and a good proportion of them will be retiring. Adding to this are the increased demands of an aging population. Advances in technology could create a perfect storm with respect to our physician supply.

Therefore, Chair, I would submit that physician shortages will continue to undermine any and all efforts to improve timely access to quality care from physicians. The lessons of the past show clearly that there is a need for effective pan-Canadian health human resources planning, as our other colleagues have indicated.

As to the three major issues of the day, one is national standards. We believe that medicine has worked hard to maintain national standards for both medical education and the practice of medicine in Canada, and while the application of the standard is open to interpretation, it has provided both transparency and uniformity in what is required to practise medicine in our country at all levels.

These standards will help ensure that all Canadians have access to the highest quality of medical care, no matter where they reside.

The second area I would like to touch on with you is the area of international medical graduates. To begin with, I would try to address a couple of common myths. The first is that Canada is a closed shop to foreign graduates, and secondly, that the Canadian medical community is a barrier to their integration.

Ladies and gentlemen, the facts are otherwise. International medical graduates comprise at least one-fourth of our active physicians in many parts of the country. Each year at least 400 international medical graduates are newly licensed to practice in this country.

At present, we and other groups, including the licensing authorities—the faculties of medicine and other groups—all support improvements to integrate the international medical graduates into the Canadian medical workforce.

We have historically relied, and will continue to rely, on the tremendous contributions of international medical graduates, and the medical community has consistently called for, and will continue to call for, further resources to integrate these graduates into our community.

The reality is, however, that we train fewer physicians than we need, and not only is our capacity inadequate in the undergraduate level, but also at the graduate level. And we are failing to provide enough resources to meet the demands of training Canadian medical graduates, let alone addressing the needs of the foreign graduates.

We feel the solution to this quandary is to develop short, medium, and long-term strategies for integrating international medical graduates into the medical workforce.

In the short term, the federal government could provide funding to clear the backlog of qualified international medical graduates—maybe as many as 1,100.

In the medium term, all governments at all levels need to work with key stakeholders in the development of sufficient health, education, and training opportunities.

And in the long term, we feel Canada must adopt a policy of self-sufficiency in the education and training of all health professionals in Canada.

A recent pilot project in Ontario was funded to allow international medical graduates to qualify and work as physician assistants in supervised medical practices. We think the federal government should support such initiatives.

The last area is that of foreign medical credentials. At present, the CMA supports the creation of a Canadian agency for the assessment and recognition of foreign credentials. With the appropriate mandate, we believe such an agency could play an important and needed role. We propose that it should promote and facilitate the adoption and awareness of our national standards for certification and licensure.

● (1125)

It should also develop procedures for the assessment of credentials of internationally trained professionals. These might include: one, the facilitation of international exchanges with regulatory bodies; two, the development of an evaluation framework to assess the fairness, accessibility, coherence, transparency, and vigorousness of the process to assess foreign credentials; and finally, the development of template materials to promote international sharing of information about career prospects in Canada for various occupations, even before immigration.

In summary, our message to the committee is threefold: one, the importance of national standards; two, we need a more comprehensive strategy for international medical graduates, one that increases and enhances opportunities for all Canadians to have access to medical education at both the graduate and post-graduate level; and finally, that the federal government can play an important role in the area of foreign medical credentials by promoting awareness of standards and facilitating the sharing of best practices.

Mr. Chair, I appreciate the opportunity to present to you today with my fellow professionals. I look forward to your questions.

● (1130)

The Chair: Thank you, Doctor. We appreciate that.

We're going to move on to the Canadian Nurses Association. We have Mrs. Little.

Mrs. Lisa Little (Senior Nurse Consultant, Health Human Resources Planning, Canadian Nurses Association): Thank you.

Good morning, Chair and members of the committee. My name is Lisa Little and I am here today on behalf of the Canadian Nurses Association.

We appreciate the committee scheduling this panel of national groups representing health professionals and employers. Our collective purpose this morning is to highlight issues of the health workforce pertaining to employability. CNA will speak to the issue of mobility of workers. Our perspective has three dimensions: mobility between urban and rural, from one province or territory to another, and across international borders.

First let me offer some demographic information about the registered nursing workforce related to the three types of mobility. There are over 250,000 registered nurses in Canada. Of those nurses, 40% are eligible to retire within the next five years and 18% of nurses work in non-urban areas, compared to 22% of the Canadian population.

Saskatchewan, Prince Edward Island, and Newfoundland and Labrador lose 30% of their nursing graduates to work in other provinces and territories across the country. As many as two in ten nurses leave the country within three years of graduation, and most go to the U.S. for full-time employment. According to Industry Canada, during the 1990s Canada witnessed a gross outflow of over 27,000 registered nurses through permanent emigration to the United States.

With those numbers as a backdrop, let me now turn to the issues related to mobility in terms of urban and rural. One of the characteristics of working in rural and remote areas is professional isolation—limited opportunities to network with peers and experts for advice and guidance on evidence and research to inform practice. Further, professionals working in non-urban areas face challenges accessing continuing education. These challenges include distance, cost, as well as lack of replacements.

Research conducted by the Canadian Medical Association and the Canadian Nurses Association identified effective strategies in promoting recruitment of workers to rural and remote areas of Canada. These strategies include investments in electronic information and communications to support work in rural Canada. This is particularly important in light of the recent report by CIHI highlighting the health disparities and mortality rates between rural and urban Canadians.

I will now speak to the issue of interprovincial mobility. Nursing is a mobile workforce. As I previously mentioned, three of the provinces in this country lose 30% of their graduates to other provinces. You should note that this movement of workers is a feature of other health professions as well. Newfoundland, Quebec, and Saskatchewan are net losers of physicians, while Ontario, Alberta, Manitoba, and British Columbia benefit from interprovincial inflow of physicians. You can see this from the graphs I have provided in the speaking notes.

The issue, of course, lies in the fact that each province does its own planning related to education and employment. Each independently projects future health needs. The value of uncoordinated efforts in the area of employability is diminishing. Canada needs to pull together to recognize the growing mobility of health professionals and others. We were pleased to read the recent announcement by governments identifying interprovincial mobility as a policy priority. This has implications for professional bodies, and we encourage this committee to recommend that governments engage appropriate stakeholders to ensure this happens in a timely manner.

Finally, I will speak to the issue of mobility across international borders. The Organization for Economic Cooperation and Development predicts that Canada and the United States will face the worst nurse shortage of all OECD nations within a decade from the perspective of employability. Canadian-educated nurses are an attractive commodity for the U.S. and other recruiters. The projected shortage in the U.S. is one million registered nurses by 2012. This poses a tremendous threat to the Canadian nursing workforce and the health system.

Of the current registered nursing workforce, 6% are internationally educated nurses. CNA projects that proportion will not increase over time due to the global nursing shortage and the U.S. appetite for internationally educated nurses. Federal, provincial, and territorial governments and individual employers are competing with one another in this arena as well. Canada needs a coordinated retention strategy to keep as many nurses as possible in light of the global nursing and U.S. shortage. We must also look to repatriate Canadian nurses from countries they emigrated to in the 1990s.

● (1135)

In summary, CNA supports the call for a pan-Canadian approach to health human resource planning that considers the mobility of nurses and the technologies needed to recruit and retain nurses in all areas of the country.

Thank you. I'm quite willing to take questions when appropriate.

The Chair: Thank you, Ms. Little. We appreciate that.

We're going to move to our last presenter, Ms. Sholzberg-Gray from the Canadian Healthcare Association.

[*Translation*]

Ms. Sharon Sholzberg-Gray (President and Chief Executive Officer, Canadian Healthcare Association): On behalf of the Canadian Healthcare Association, I would like to say that I am very happy to be with you today.

[*English*]

I'd just like to explain that the Canadian Healthcare Association is the federation of provincial and territorial hospital and health organizations across Canada. Through our members, we represent a broad continuum of services. Here we include acute care, home and community care, long-term care, public health, mental health, palliative care, and so on. Our members are the regional health authorities, hospitals, and facilities and agencies that serve Canadians and are governed by trustees who act in the public interest. Together our network comprises over 900 hospitals and more than 4,500 health facilities.

Having heard from my colleagues representing various professions—and of course from the Health Action Lobby, to which we belong—I'd now like to offer the employer perspective on health human resources, as my members are the employers of many of those who work in the health system.

Broadly defined, our board has defined that our goal is to achieve a stable health workforce with the right number, mix, and distribution of health providers in order to provide access to high-quality care for all Canadians.

We all know why it's so important to address employability issues in the health system. We all know that health is the number one issue for Canadians. But maybe we don't know that the health system in Canada is a major employer. It employs 1.1 million people. One in ten Canadians is employed in the health system. They constitute a highly educated and skilled workforce, greatly contributing to not only the health of Canadians but to our country's tax base as well.

What might not always be known also is that the cost of labour, the contribution of labour, is a major component of our health system. Now, we ought to look at this as a cost, and of course we have to look at it as an investment, but employers naturally always look at the bottom line—as do governments, I'm afraid. What we'd really like to say is that without health human resources, and without making the investments in these costs, we won't have the health system that we value so much.

We all know about the global health shortage; you've heard my colleagues talk about it. We all know, of course, that if we don't deal with health human resource shortages, we won't be able to meet health needs and sustain our publicly funded system, without which we'll lose an important area of competitive advantage for Canadians. Therefore, the federal government must play a leadership role in dealing with HHR issues, and I'd like to address a few of those issues.

First, you heard my colleague mention the need for a pan-Canadian planning mechanism, one that would bring together key stakeholders, key players, including government, so that we can anticipate and plan for future needs and changes in the health system. This is absolutely essential. This body has to link health, labour, immigration, and education policies. Without that we won't be able to meet needs in the health system of the future. It doesn't matter whether we call it a mechanism, a body, or a strategy, we have to have this approach.

I'd like to touch on a few other issues that are particularly important from the employer perspective. First, there's the whole issue of entry to practice. Here we're talking about improving the supply of health providers. There are a number of facets to it, including entry-to-practice credentials. We're pleased that there is now a process for an FPT table, where people are discussing the minimum entry-to-practice requirements for a number of provider groups and professional groups.

We're also pleased that health employers are going to be consulted—or at least we hope they are—about any changes to credentialing for entry to practice. We realize that with a shortage of health workers, if we do anything...and that's not to say we shouldn't. But if we do anything to increase the minimum entry-to-practice credentials, there are issues of shortages of workers and so on; we need periods to integrate and restructure, that type of thing. In any event, we need to stress that employers have to be at the table when these decisions are made, because they hire the people who provide the care.

The other issue is education system capacity. Frankly, we think the federal government has to contribute to this, as do the provinces. We need to increase enrolments for health professions and health disciplines. We also need to supply extra funds for the infrastructure developments needed to accommodate these increased enrolments. We can't forget about that.

We also have to pay for the price, I think, of having appropriate clinical and placement opportunities for health human resources. Nobody can provide health care to Canadians without the opportunity to have a clinical setting, and this includes medical residency positions. There's a role for the federal government to play in helping to fund these training opportunities in the health system across this country.

● (1140)

You've already heard my colleagues talking about foreign-trained providers. The Canadian Healthcare Association believes that Canada must ultimately be self-sufficient, but that doesn't mean we shouldn't work to integrate as much as possible those people who have the credentials to work in the Canadian health system.

We've heard about the data, and we'd like to hear mentioned in particular the work of the Canadian Institute for Health Information in helping to provide data. But the job isn't entirely done. Frankly, if we have this pan-Canadian mechanism that we're talking about, we're going to need more and more data to be able to meet the health needs of the future. So a pan-Canadian approach is absolutely essential.

We think if we make progress in these various areas dealing with entry-to-practise credentials, clinical and placement training opportunities, and the educational sector, making sure we work together to achieve our common goals, we can make progress in meeting the health needs of Canadians.

We've often said that money is needed to support a health system, but we've all heard today that it isn't money alone; it's health human resources. On the other hand, whenever we say it isn't about the money, we also have to have the appropriate resources devoted to achieving the objectives we all agree to.

The Chair: Thank you very much.

If I can encourage all my colleagues to be as succinct with their times as the presentations, we'll be able to move through this fairly quickly.

We're going to start our first round of seven minutes with Mr. D'Amours.

[*Translation*]

Mr. Jean-Claude D'Amours (Madawaska—Restigouche, Lib.): Thank you, Mr. Chair.

First of all, I would like to thank each and every one of you for taking the trouble to come and discuss with us today a very important issue, which you clearly identified, that is, health professionals and their employability.

My riding is located in rural New Brunswick. I have been told that there is an ongoing high turnover problem and that it is very difficult to keep our professionals in Canada. It is a vicious circle. If we lose our professionals because they are going to the United States, we have to find other professionals from abroad to fill the positions that ours have left.

I would like to ask several questions, but I am going to ask them one at a time and I will see how much time I have left. Obviously, I do not expect you to come up with miracle solutions for us today, but do you think there are more effective ways of doing things so that the health professionals that you represent might be more interested in settling in Canada's rural regions and providing their services in these areas? As we know, it is often very difficult to find pharmacists and family doctors. It is even more difficult to find specialists. The same thing goes for nurses.

My question is addressed to you all. Do you have any suggestions or solutions to propose in order to improve the situation?

[*English*]

Mrs. Lisa Little: Thank you, yes.

I referred to previous work done by the Canadian Medical Association and the Canadian Nurses Association around a framework for rurality. A number of strategies were identified there on what works to attract and retain people in rural Canada. Basically it needs to look at both professional and personal factors.

Professional factors include having access to other health professionals and being able to network with your peers, which implies access to such things as broadband, the Internet, and new research through technology, as opposed to the physical access you often get in a large academic centre.

Personal factors include focusing on housing for them and looking after family supports and spouses who may be coming, in terms of employment for them and their families. It's a big package. There's no one thing. It's not money alone that attracts them to rural areas; it's a combination of a number of things.

● (1145)

The Chair: Doctor.

Dr. Colin McMillan :

Through you, Mr. Chair, thank you for your question.

We've been looking at this actively. There are a number of things currently under way in our profession and others that are trying to address the issues you raise.

The two issues I would raise briefly are that, first, it's a dual problem of recruitment and then retention. There seems to be some evidence that if you train health care professionals—particularly doctors—who come from rural and remote areas, and have some training there, you can improve recruitment and retention.

There is a new medical school in northern Ontario, which just started, that is designed to do this. There are some outreach training programs now under way that actually train people in those communities with technological hookups to the medical school.

As we speak, there is a project from the University of Sherbrooke to train rural physicians in New Brunswick. There is a second project in the planning stage at Dalhousie University being designed to do the same in your native province.

The second point you touched on in your question at the beginning was the issue of the outflow of physicians to other countries, particularly to the United States. We have some data now that seems to show that for the first time last year, the net inflow of doctors from the United States into Canada was positive, rather than the other way around.

We think we know some reasons for this, so we've set up communications with the American Medical Association to get data on how many Canadians are practising in the United States, where they're practising, and how many of them might be interested in coming back to Canada.

One of the proposals we're looking at is a one time only financial incentive for this to happen.

Mr. Brian Stowe: In terms of this, you mentioned pharmacists. As I mentioned, one of the challenges is that 30% of our workforce are international pharmacy graduates. Of course, there's a cultural background that these pharmacists come from, and many end up in the urban areas because that's where they find their community. I think that's part of what's driving some of our challenges in bringing pharmacists out to the rural areas.

Back when I went to pharmacy school, there was a geographical distribution model. If you came from a small town, as I did, you received a more favourable step into the pharmacy program. But I think they discontinued that a number of years ago.

[*Translation*]

Mr. Jean-Claude D'Amours: Thank you, your answers were very interesting.

Ms. Little, a little while ago, you talked about the integration of families in rural settings.

Have any recommendations already been made by your professionals as a whole to tell the rural regions what they expect to find there with regard to quality and family life? Has this process been initiated? If so, would it be possible to receive some written documentation showing what the current needs of professionals are and what they are expecting?

[*English*]

Mrs. Lisa Little: I would refer you to the document. We would be pleased to send a copy of the "Framework for Morality", which we did with the Canadian Medical Association. It's a study we conducted a number of years ago about the recruitment and retention of professionals in rural and remote areas. We would be pleased to provide a copy, and it's published on our website.

The Chair: That's time.

Thank you very much.

Moving along to Mr. Lessard, you have seven minutes, please.

[*Translation*]

Mr. Yves Lessard (Chambly—Borduas, BQ): Thank you, Mr. Chair.

It is my turn to welcome you. Having the opportunity to meet all of you together is quite special. The entire, or almost entire, range of the whole health network is represented here today.

As much as I could, I have read your documents. I think that the Health Action Lobby was the only one to send us any. I was able to skim through the others. First, as far as the handling and analysis of needs is concerned, I notice that there is little mention of prevention. I may be mistaken, but that is what caught my attention.

Then, you quite rightly rank in first place the problem of numbers of workers. However, there does not seem to me to be any analysis of what caused this problem. Knowing some of the causes might help to guide us better in the future.

Furthermore, the financial participation of the Canadian government, in terms of support to the provinces for health, has fallen by almost 10% over the past 15 years. You will agree that health and social services are the responsibility of the provinces. Which leads me to my second question.

Have you considered this aspect with the provinces, either with your associations or with the provincial corporations? I assume that you have done so. I would like to know what their thoughts are.

Finally, you seem very concerned about the idea that there should be supervision, a Canadian overview with regard to management of health and social services. I remind you that this is a provincial responsibility. Nevertheless, if the basic assumption is made that some elements should be handled by the federal government, is that a guarantee of success? We may think, for example, of the monumental failure of the management of the aboriginal reserves by the Canadian government. And this is a federal jurisdiction.

I come back to my first point, namely prevention. Out of 720 aboriginal communities, over 280 do not have drinking water.

You say that a Canadian agency should be created, but do you take into account the fact that, in terms of distribution of resources, analysis and perspectives, what the Canadian government had to manage proved to be a failure as far as health is concerned?

● (1150)

[*English*]

The Chair: Ms. Sholzberg-Gray.

Ms. Sharon Sholzberg-Gray: I'll try to address all of your issues.

On the issue of prevention, I think every association sitting at this table understands that we need to have a healthy population and to maintain the health of the population. That will ultimately be the best way to reduce the demands on our health system. Of course, that's going to require the participation of health workers as well, particularly in the primary health care system that is going to keep people well, the public health system, and those kinds of things. Those are still health workers.

I'm sure if you look at any of our pre-budget briefs to your colleagues on the finance committee, you'll see that the Canadian Healthcare Association and others focus on the importance of keeping people healthy, managing chronic diseases, and those kinds of things. That's understood.

We're talking about a planning mechanism to meet the needs of the future. That's going to be one of the important focuses of the attention of the health system, and it always should be. We're still going to need the appropriate workers to do that. But when people are ill and need the attention of the health system, we need workers to take care of their needs as well. It's the health system of the future that we're talking about preparing for when we're talking about some kind of pan-Canadian mechanism.

You mentioned the issue of provincial jurisdiction and the federal responsibility for aboriginal people, which is not working now—look at the health status there. We're talking about whether federal funding is adequate or not. Those are issues we tend to deal with at the finance committee. The truth is there is a federal role in the area of health human resources.

We've just heard all about mobility, not only among provinces but around the world. My association is a federation, and provincial hospitals or health care associations belong to it. All they say at our board table is, "You just raised the ante by having a tremendously generous remuneration policy. Now we're going to lose 30% of our front-line providers to you."

Unless we have an integrated approach and a way of stopping that from happening, we're going to be training people in one province to go to work in another. We've heard that before, so we need to coordinate. That doesn't mean the federal government runs it; it means there's a table or mechanism where everybody is together to agree to a pan-Canadian approach using appropriate research and data.

By the way, there is a lot of research on the retention of the appropriate workforce. For instance, in healthy workplaces you value each worker and share work properly; there's an absence of violence; there's support from management—frankly, my members have to play their rightful roles; people have control over their practices; and there's recognition of the work they do. In other words, a healthy, broadly defined workplace environment is the responsibility of the employers, but it's also the responsibility of governments that could help perhaps set the tone as to what constitutes the kind of environment to retain and recruit health workers for the future.

I think it's important to note that the involvement of the federal government is no guarantee of success, but certainly contributing and being at the table is important. It's not just the provinces alone, it's everybody together. I think that's the message we'd like to leave.

● (1155)

The Chair: Thank you very much.

That's all your time, Mr. Lessard.

We'll move on to Ms. Savoie for seven minutes please.

Ms. Denise Savoie (Victoria, NDP): Thank you.

Thank you very much for your presentations.

It's shocking to think that British Columbia is the recipient of the inflow of health professionals, yet I know that in my riding and in many places in British Columbia people have extreme difficulty getting their own doctors. There are many orphan patients. This is a huge problem.

It's somewhat difficult in a way, because we're looking at the problem, if not in an arbitrary way through this employability study, at least severed from the whole package. I guess that relates to my first question.

To what extent do you think the reduction in the shortage of doctors and nurses could be addressed? I'll put aside the increased training that's required. Could it be reduced if, for example, we had a more integrated system, where a community health clinic did triage so the medical doctor didn't have to deal with everything from a cut on the hand to cancer assessment, where there was the possibility of having different community clinics with different expertise where patients could be triaged? I'm wondering to what extent that might help reduce the shortage, in your assessment.

I have another question specifically related to training.

The Chair: Go ahead, Doctor.

Dr. Colin McMillan : Thank you for your question.

In principle, I think we agree with you that this is the wave of the future—that we certainly do need more doctors and more nurses—but I would make two points. First, in relation to needs, it has to be the needs of the population and the needs of the patient and not simply numbers, so we have to have a good analysis locally, regionally, provincially, and nationally as to what the needs of the health care system are, and then have the providers match those needs. That's a big challenge, a big issue, but it's part of the national framework we're discussing.

The second thing you touch on is the notion of collaborative practice. It is our feeling, certainly in my area of cardiovascular medicine, that although we have shortages, and shortages will remain for the foreseeable future, there is going to have to be some element of collaborative practice among all the health care professionals in those fields, a collaborative practice that matches the needs of the patients and the population. We have established a number of principles for that, including deciding who does what, when, and under what conditions. It is really a work in progress, but it very much fits in with what you're talking about.

● (1200)

The Chair: Ms. Cooper is next.

Ms. Janet Cooper (Senior Director, Professional Affairs, Canadian Pharmacists Association): Thank you.

I am speaking next to our colleague from the CMA. It certainly is an issue with pharmacists, and within the communities we are seeing some huge changes in pharmacy practice at the primary care level. We have pharmacists who are graduating and practising, and probably one of the biggest concerns is that their expertise is not being utilized. Certainly with the challenges in drug therapy that we have now, whether in costs or safety or effectiveness, we're looking at the need for greater collaborative practice and interprofessional work.

To do that, we also have to look at what pharmacists are doing day to day. One of those things will be actually looking at the role that pharmacy technicians are playing. They're not regulated, but they could be taking on a lot of the technical aspects of pharmacy practice that pharmacists are spending too much time on now; it scopes a practice for a number of professionals, then, as well as the assistants who help us.

The Chair: Ms. Fralick is next.

Ms. Pamela Fralick: Thank you.

I will add one comment. In deference to the professions you see in front of you here, I would remind all the committee members that I'm here reflecting the voices of another 26 or so professions that cannot be here and reflecting as well the roles they play in the health system. All our discussions must focus on those other professions as well.

I want to make sure as well that the committee is familiar with an initiative funded by the government under the Primary Health Care Transition Fund. It is called EICP, for enhancing interdisciplinary collaboration in primary health care. It's one of the five nationally funded initiatives. It just concluded its work officially a few weeks ago. This was an initiative to establish the guiding principles and framework pieces for collaborative interdisciplinary care.

Around the table were sitting physicians, nurses, pharmacists, psychologists, dieticians, physiotherapists, occupational therapists, etc., and they've done a huge piece of work to contribute to that ability to enhance collaborative care moving forward.

Thank you.

The Chair: We have a minute and a half left.

Ms. Denise Savoie: Very quickly, then, aside from funding this kind of initiative...I'm surprised that we're still funding an initiative and that this isn't happening on a broader scope. I'm wondering if there's anything more we can do.

The second quick question relates to credentials and foreign doctors. I understand from speaking to people in British Columbia that there's a problem in residency, a lack of residency. I'm post-secondary training critic for the NDP. I'm wondering to what extent the government could be infusing more funds specifically to the transfers of education, but relating to residencies, to increase those possibilities.

Dr. Colin McMillan : Briefly, Mr. Chair, that's really the core of the problem. It's really what we call capacity within the training centres to fit these graduates, even if you had the funding and the qualifications. You're exactly dead-on; yes.

The Chair: Thank you.

We have a quick supplemental there.

Ms. Sharon Sholzberg-Gray: I just wanted to note that it's not only clinical practice positions for physicians; residencies are important, but every front-line provider needs a placement. There is an integration of foreign workers, and, frankly, current workers too, and that's an area that needs funding.

The Chair: Thank you very much.

We're going to move to Mr. Brown, the last questioner in this round. You have seven minutes, sir.

Mr. Patrick Brown (Barrie, CPC): Thank you, Mr. Chair.

Thank you for being here today.

I come from a community where the doctor shortage is very severe, and it's a pleasant coincidence that you're here today, the same week as the PAIRO tour, where underserviced communities get to go to medical schools around the province to make their pitches. I was in Kingston on Monday night, trying to make a pitch on behalf of our hospital at the PAIRO event there.

To give you an example of a typical Canadian community, in Barrie we number 135,000 and one-quarter of our population doesn't have a family doctor. Consistently, our doctor shortages are 27 to 30, and we have a very active recruitment effort. We spend $220,000 through donations by the local communities of Barrie and surrounding municipalities simply on recruitment efforts—moving expenses, gadgets we give out at conferences.

When I was there on Monday night at the PAIRO event, I was thinking about how we're competing among friends. We're competing against other municipalities that face the same shortages. We're all spending money, giving out trinkets, and telling people how great our cities are and how great a place it is to live.

I wanted to know what advice you could give us about federal solutions in the three areas that I see to be particularly problematic in my community. I imagine they are similar to those in other communities.

The one you've already touched on is the foreign-trained physicians. The stat that the CMA gave in the pre-budget consultations in 2005 was that there were 600 currently who haven't been integrated into medical practice. I know in my riding there are five who approached my office, and I've heard concerns from these foreign-trained doctors on the grounds that the equivalency exams are too expensive and they can't afford them, or the prospects of residency spots are difficult.

We talk a lot about the urban-rural divide, where there are more doctor spots in urban areas and less in small towns and rural communities. A concern I see there is that when medical students go to school, they develop roots, they develop friends, they develop a level of comfort in the larger cities. I look at Kingston, where there is not an apparent doctor shortage. It is the same size as my community, yet I'm 30 doctors short in Barrie.

What opportunities are there to encourage more rotations, more residencies, more medical experiences in small towns and rural areas, where we can develop a sense of familiarity with those areas?

With regard to retention, the stat that the CMA gave us was that 3,887 doctors were a net loss between 1991 and 2004. I see that in my community, particularly with an aging medical profession. I've seen many good doctors retire. What can we do toward greater retention? I know we've looked at that in the different ways we spend money and try to make doctors as welcome and encouraged to stay in practice in Barrie. What federal solutions do you see?

I see a tendency that whenever we look at the doctor shortage, we pass it off. I know when I was a city councillor, when our hospital came to city council asking for help, some said, “Don't worry about that, it's the province or the federal government's responsibility”. Then there's a tendency on the federal level to say, “Don't worry, that's a local problem or a provincial problem”. We all seem to be passing the buck, but this really is a national concern.

I saw one survey in my riding where this was ranked in the top three issues. What solutions can you think of at the federal level that we could get involved in to make a tangible difference?

● (1205)

Dr. Colin McMillan : Mr. Chair, through you to Mr. Brown, if I had all the answers, I probably wouldn't be sitting here right now, but the questions you raise are germane and I shall try to at least offer some things we're looking at and possible solutions.

In relation to the foreign graduate situation, it is very complex, but we think that even though there are a large number of foreign graduates in the country, or foreign-trained physicians, not all of whom would qualify under any circumstances from some areas to ever practice, there is a substantial number above the current ones who could.

I think this is an area the federal government could look at. If we can get some federal funding, and maybe some capacity within the system, the sort of thing my colleague here referred to, then I think we could get more than 400 per year, fully trained and qualified in the short term, to get in the system, to help areas like your own.

As far as your own individual recruitment and retention issue is concerned, one of the things you might look at in relation to your discussions with the medical school is maybe talk about having a campus in Barrie, like they do in Prince George in B.C. and other areas. My daughter just trained in Newfoundland, and some of the best training—and this was recognized at her graduation—was in rural and remote areas that are part of the Memorial campus. They are now noticing, in some of the literature that's recently been reported about the province of Newfoundland, that they are now getting more applicants, more medical students, and more trainees from rural and remote areas of Newfoundland who are going to medical school, not only in Newfoundland but they are going back to those areas.

Maybe a campus in Barrie might be something you could look at, with a welcome mat and the sorts of incentives you were talking about.

As far as the net losses are concerned, again I made reference in a previous question to the fact that we think we may be on the cusp of reversing this. We don't know why. It may be economic and demographic, but we think there's a real possibility there, that there are a number of full-time, active physicians in the United States, more than 1,000 of whom have kept their licences in Canada, who we could entice back on the short term.

So in addition to the foreign graduates, there are the Canadians in the United States, and then there is another group, the number of which we're not too sure about, who are actually training outside of Canada, who we think we'd like to get back in. A very large number of students who are Canadians trained in the Caribbean and Ireland. So we're looking at that as well.

These are some of the solutions we're actively looking at, but the short answer might be, maybe you need a campus in Barrie for one of your medical schools.

● (1210)

The Chair: Dr. Tholl.

Dr. William Tholl (Secretary General and Chief Executive Officer, Canadian Medical Association): Thank you, Mr. Chair.

Just to elaborate a little bit on the welcome back mat, we've done some preliminary analysis of the physicians, 10,000 or so who did go down to the United States between 1993 and roughly 2001, and we think the following four or five factors are at play.

One, they are tired of the malpractice situation down in the United States, where you have malpractice fees that are ten times what they are in Canada, and going up.

Two, they are tired of 1-800 control medicine, being told by the HMOs what they can and can't do.

Three, they are getting older and they've paid off the debt. The debt these days for medical students is in the neighbourhood of a large or medium-sized mortgage on a house, so they've paid off their debt.

Four, their grandchildren are a little older.

And five, they're looking forward to retiring and they want a medicare system to retire in.

The Chair: Thank you.

That's all the time we have. We're going to move now into our second round, which will be five minutes of questions, and we're going to move to Ms. Brown.

Ms. Bonnie Brown (Oakville, Lib.): Thank you, Mr. Chairman.

You'll recall that I think two of our presenters talked about the need for an all-Canadian planning mechanism or consultation body, something that will collect the facts and do needs-based planning, not dollars-based planning. I can see that happening, but I'm wondering if either presenter has thought about how that might happen.

Are they looking for the federal government to create a new body with new facilities, etc., for such a council to meet at, with a necessary staff, etc.? If that's the case, have they predicted how much that would cost the federal government?

Secondly, if we don't need a brand-new creation, could it be attached to some other existing body, like CIHI, which is the provider of most facts anyway, or some other federal institution?

Dr. William Tholl: Mr. Chair, through you, ideally what we'd want to see is the creation of a health sector table much like what exists in other areas, like engineering, forestry, and mining. We've generally run into a brick wall with respect to applications for that, largely having to do with federal-provincial-territorial responsibilities.

Failing that, what we've discussed is turning Health Action Lobby into such a round table. It already exists. It already has 30 organizations, 30 professions, represented around it.

No, we don't imagine having to establish a new institute, or a new agency or a new office. This could be housed, depending upon what the primary purpose would be, either within the Canadian Institutes of Health Research, if it's needs-based planning, the Canadian Institute for Health Information, if it's primarily data gathering and dissemination, or it could be under the Health Council of Canada. The problem there is you have two provinces that aren't participating: Alberta and Quebec.

We would see this as minimalist in terms of machinery issues.

The Chair: We'll go to Ms. Cooper.

Ms. Janet Cooper: Thank you.

We haven't actually costed it out or anything like that. One of the things we looked at was having something like the Canadian Patient Safety Institute, which was set up very recently by the federal government to look at a lot of the safety challenges in health care.

There does need to be some kind of mechanism. Actually the FPT governments have done a lot in the past few years with Health Canada having the health human resources strategies division. There is also the advisory committee on health delivery and human resources, which is looking at a lot of the same issues we're looking at.

The problem is that right now that's a government committee, and the health care professionals at our organizations and in our stakeholders and in other stakeholders aren't part of that education system. So it's kind of happening in its own silo. We're talking about some kind of mechanism—perhaps a centre, an institute—to bring the different stakeholders together, to look at this issue from the different perspectives.

The Chair: Thank you.

Could we have Ms. Fralick and then Ms. Sholzberg-Gray, please?

Ms. Pamela Fralick: Thank you.

I'm fully supportive of the comments made by my colleagues.

The one thing I might add that could be of interest to you is that two or three years ago, as the discussions were unfolding about the establishment of the health council, HEAL hoped that it would in fact be the body, but of course being more of an FPT animal it didn't quite have what we feel such a centre, forum, or institution should have.

HEAL did not go as far as figuring out the specific costs. If we can engage someone at the federal level to have that conversation, we'd probably be happy to do that. I agree with Mr. Tholl that it would not be as onerous a task as one might think.

We did, however, come up with a checklist of guiding principles for such a body. That is available on our website. I would be happy to send that over to the clerk for distribution to this committee. It might help you formulate your thinking.

● (1215)

The Chair: Ms. Sholzberg-Gray, go ahead, please.

Ms. Sharon Sholzberg-Gray: Just to add to that discussion, as you all know, there have been a number of labour sector studies for various health disciplines or health professions. There was a nursing one, a physician one, a pharmacist one, a home care one. The Canadian Healthcare Association was involved in all of these, sometimes on the steering committee, sometimes on the management committee. They were sometimes concerned that they were working in silos, and while we were all trying to plan for the future, the assumptions on which we were planning were different and really needed to be more integrated than not. Frankly, that's why we kept meeting throughout this process, doing various sector studies, seeing how we could get together so we weren't operating in silos.

So what we're really seeing is some kind of mechanism to bring together all of the various information gathering, research processes, planning processes, and what not, not in a way that steps on anyone's jurisdiction, but in a way that understands that people are mobile and can move from province to province, region to region. We need to address those issues as well as needs across the country.

I think a number of us are working on next steps and seeing whether we can get together the funds. We're putting our information together, for a concept paper on various models for this kind of national or pan-Canadian mechanism, even though various principles associated with it have been put forward by a number of us over the years. It really emanated from those labour sector studies that operated individually.

The Chair: Thank you.

Thank you, Ms. Brown.

We're going to move to the next questioner, Mr. Lessard, for five minutes.

[*Translation*]

Mr. Yves Lessard: Thank you, Mr. Speaker.

We agree that a major helping hand is needed where health workers as a whole are concerned. Mr. McMillan said earlier that the problem was twofold: we need to recruit and maintain professionals.

You are very deserving. I worked in the health network for 30 years. I watched it being built and also fall apart. This is why I want to be sure I understand the message you are sending us today and to see whether it is practicable. The only convergence that I see in your presentations is that of saying that some authority that is responsible for supervising and coordinating our actions must be created. Ms. Fralick said earlier that everyone thought that the Health Council was going to do it, but this is not the case.

Should we not conclude that this should be done elsewhere?

I come back to areas of jurisdiction. The solution to the problem on which you are working so hard seems to me to be political in nature. Ms. Sholzberg-Gray represents 4,500 institutions and 1,100,000 workers, but these people are under provincial jurisdiction, for example, that of Quebec, under the authority of the personnel department of the provinces, etc. In Ottawa, however, 10,000 public servants are concerned with health and do not manage any hospitals.

Is the problem not political? I would not like you to think that we have understood. We agree with the objective sought, which is to remedy the situation and lend a helping hand. But I would like us to get on the right track, because we will have to discuss this among ourselves again. This is why I asked you whether you had worked in this connection with the corporations and associations in the provinces and Quebec.

[*English*]

The Chair: Ms. Fralick, and then Ms. Little.

Ms. Pamela Fralick: Initially I will just clarify that my earlier comments about the Health Council and the work of HEAL referred to the work prior to the Health Council being established. In other words, what we were lobbying for was the same sort of mechanism we're talking about here today. In fact, we're saying that the Health Council did not meet our needs in that regard. This is not to take away from the good work they've been trying to do, but it is a different body than we would envision.

In terms of the politics of the situation, I know everyone is chomping at the bit to speak to that. All I would say is that the Health Council is that political body that perhaps you're referring to, and we see it as not being the full picture and not able to do what we think needs to be done. We believe there is a need for a body separate from the political process, certainly with connections, but separate and inclusive of the other voices that need to be part of understanding the problem and the solution, and hopefully able, frankly, to transcend the politics.

One thing I neglected to mention when I referred to the EICP initiative is that it certainly had political involvement, because it was funded through Health Canada, through the federal government. However, the work was carried out by the health provider associations, and we are able to transcend political barriers. To see the progress made even in the understanding in the work amongst those health professions was really quite remarkable over the two and a half years of the project. So we feel that this body that we envision needs to be outside the overt political influence, perhaps, that currently exists.

I'll leave it at that. As I say, I know my colleagues wish to jump into the conversation.

● (1220)

Mrs. Lisa Little: I think the other aspect, when you talk politics, is some of the language that we've used around this, recognizing that health is primarily a provincial-territorial matter. We have not been promoting the notion of this being a supervisory body that would oversee or take over the mandate of provincial and territorial governments. What we're talking about is a mechanism to work in partnership with provincial and territorial governments.

In the recently released federal-provincial-territorial pan-Canadian planning framework for HHR, they talk about intersectoral and interdisciplinary multi-stakeholder planning, but they don't outline a mechanism for that. That's what we're trying to promote, something that would work in partnership with them that would provide analytical support to their planning process.

Many of the smaller provinces don't have the capacity to do the kind of HHR planning that large provinces like Ontario and their government have. So we see this as a real value perhaps as a starting point in helping those smaller governments to understand the planning process, where all the data fits in, where the research fits in, and how they're affected by the other provinces, from a mobility perspective and other aspects. So certainly we see this as a partnership, not a supervisory body.

The Chair: That's all the time. Sorry, Ms. Cooper. I'll catch you next time.

We're going to move to Ms. Savoie for five minutes.

Ms. Denise Savoie: Thank you.

In many fields we hear from students who are struggling under huge student debt, and you mentioned that for medical students it's the equivalent of holding a small mortgage. I wonder if there's anything, in your opinion, that the federal government could be doing in that respect.

Dr. William Tholl: Through you, Mr. Chair, yes, there are two very specific things. One is to look at forgiving Canada student loans until such time as doctors have finished their clinical training, i.e. their residency training. Right now they have to start repaying their loans. Two, open up the terms and conditions for the loans in terms of making them more accessible, particularly to those with limited means.

Ms. Denise Savoie: Thank you. That's an interesting answer.

I guess the corollary to that is do you think there is any reason...? All post-secondary education is subsidized to some extent, and the rest is paid through tuition fees. To what extent would it be useful to have some requirements of residency, for example, if there's a shortage in rural areas, or simply residency in Canada—although I'm hearing that outflow is disappearing? To what extent could we federally, or indeed provincially, impose some residency requirements in exchange for that education that's obtained in Canada and partially subsidized by Canadians?

Dr. Colin McMillan : We traditionally have never done that.

Ms. Denise Savoie: No, I know that.

Dr. Colin McMillan : As the proportional share of the educational cost is borne more by the trainee than the institution, I think this poses some fairly serious human rights and ethical questions, and traditionally we've not looked at it that way.

● (1225)

Ms. Denise Savoie: So you would say that the greatest portion of costs is paid by the students, as opposed to the part that's subsidized?

Dr. William Tholl: A higher percentage, at any rate.

And, Mr. Chair, if I may, coercive measures, return-of-service measures, have proven not to be effective. All you need to do is look at DND and the challenges it currently is having in terms of recruiting and retaining physicians in the military, where you start counting the clock—your four-year payback—and then look forward to leaving. That instills the wrong culture—one of leaving, rather than staying.

Mr. Brian Stowe: I just wanted to add that this is a national political issue, and it is good to give a better system for repayment of your loans, but maybe we need to look at the tuition fees that these students are being asked to pay.

Like it or not, we used to have a system when I went to school where anybody could go to university. Now we have tuition fees in pharmacy of $8,000 per student, and really, we don't have the same universal access we had years ago.

The second thing we need to look at is expanding the enrolment in these areas. It frustrates me to no end that in Ontario we license 600 pharmacists every year; 300 of them come from outside the country. I have kids who may try to get into pharmacy some year, and their ability to get into those limited spaces is maybe going to keep them away from this profession. Meanwhile, we're taking these pharmacists from outside the country.

Why are we doing that? Why aren't we having our own kids in these institutions?

Ms. Denise Savoie: I guess these caps to some extent were somehow arbitrarily imposed on enrolment. Nobody was looking at the demographics; hence, some of the problems we're facing.

In answering the question you referred to loan remission or loan forgiveness in some ways, but we're still talking loans. In some cases the fact that there are these high loans to pay is still a disincentive.

Going back to rural areas, as one of my colleagues was referring to, is there something up front, when the student needs it, that could be done in terms of tuition fees federally, aside from going the loan route?

Dr. William Tholl: There are two points. One is just to observe. There are only three professions where tuition fees, at least in Ontario, were not capped, and those were dentistry, the legal profession, and medicine. So that's one of the reasons it's not $9,000; it's now $14,000 or $15,000.

Ms. Denise Savoie: So they've just been deregulated.

Dr. William Tholl: They were deregulated. The top was blown off.

What can governments do? I've already indicated the two things I would suggest the federal government do in terms of its responsibilities. Fee setting is not the federal government's responsibility.

I can tell you what we're doing at the Canadian Medical Association. We're making very preferential interest rates available to students, so if they're going to get into debt, we advise them on how to manage that debt and get out of it as quickly as possible.

Ms. Denise Savoie: Do I have a minute?

The Chair: That's it for time.

We'll move on to the last questioner of the second round, and that will be Mr. Storseth.

Mr. Brian Storseth (Westlock—St. Paul, CPC): Thank you very much, Mr. Chairman.

I want to thank you all for coming and giving such concise testimony. I also want to thank Dr. McMillan for coming and providing some insights that I haven't heard in regard to rural recruitment and retention.

Obviously, doctor recruitment and retention is a major issue in my rural community in northeastern Alberta, but I want to shift the focus a little bit to the pharmacy aspect of things, because it's also a very major issue. These people are a vital component of our rural communities. I believe they're having to put in time and hours above and beyond what you would have to do in an urban community to give the same level of service.

I was very interested, in looking at your Pharmacy Examining Board of Canada, which obviously looks after the licensing requirements and qualifications of your industry, to note that you have an MRA signed, I believe, with nine provincial jurisdictions. I wanted to get your input on how you feel this has been working within the pharmacy industry.

Has it increased mobility by taking down some of the barriers within the industry? Is the industry seeing it as a success?

Ms. Janet Cooper: We've actually, just in the last few months, started looking. We had funding from HRSDC to look at a lot of these issues. Prior to this, only medicine and nursing had funding to look at health human resource issues. Now some of the other professions are getting money, and pharmacy, fortunately, is one of them, but there certainly need to be more.

I don't think there's really been any study yet on how that MRA that was signed five years ago has worked. We do know it takes a lot less time. Alberta is a fairly attractive province for pharmacists, and I don't think they're a big exporter of pharmacists. Some other provinces, like Saskatchewan, export a lot of their pharmacy graduates. Still, the challenge in rural areas is huge. The pharmacists there, when they want to sell their stores, often can't find anybody to sell them to, or they can't get anybody to come in and do a locum so that they can actually take some time off. It is a big challenge, but we don't yet have the data, and that's one of the things that we need across the profession—better data. We're starting to collect that, and we'll be able to tell you more in a year from now about just what the really big challenges are.

It certainly is a concern in smaller towns and rural areas to actually have a pharmacist, because often that might be the only health care provider who's there. They may not have a family physician, but at least if they have a pharmacist, it is somewhat of a help.

● (1230)

Mr. Brian Stowe: Just anecdotally, I get the impression that where it was initially going to provide immediate benefit was in moving in these international pharmacy graduates. They were getting licensed in Saskatchewan and then moving straight into Ontario. I heard first-hand of these cases, that now it would be easier to get around the Ontario restrictions so that the chain pharmacies could bring them into Ontario. I think, again, it comes back to the international pharmacy graduates.

I want to reinforce that this isn't our solution, bringing pharmacists here. I was down at a conference in Brazil. We're bringing pharmacists in from South Africa, where pharmacists are trying to mount an educational program against HIV. It isn't responsible action by Canada to pull these pharmacists from these countries to solve our human resource problems here.

Mr. Brian Storseth: Indeed, I'm asking here more about the availability for mobility across the different provinces. We've asked the physicians. Do you see any potential solutions for our rural pharmacy needs?

Ms. Janet Cooper: We were actually part of the work that CNA and CMA did on looking at rurality, and Lisa spoke to what a lot of the issues are. There is a shortage. Often in small communities they're independently owned pharmacies as well, and a lot of the larger chains and franchises have a lot more opportunities to recruit—incentives and those types of things.

One of the things that came up is that if you can bring pharmacists from those smaller communities in to train, there's a lot better chance that they will go back to those smaller communities. As Brian said, a lot of the faculties don't look at the geographic population within the province any more. That may be something they need to look at again.

The Chair: Brian, 30 seconds.

Mr. Brian Storseth: I want to ask HEAL a question. Under section B you talk about strategic directions, recognizing regional centres of excellence. I just want to get you to expand a bit on both, where you see that fitting into your vision.

If anybody else wants to answer, it's being used in Alberta. I just want to see if they're overlapping.

Ms. Pamela Fralick: I'll make one comment. We do have the more detailed background document, which expands on each of those, and I was just trying to find the place. But I'll defer to CMA to comment on that for you.

Dr. William Tholl: To give one example, it took a commission of inquiry to determine that in Winnipeg, pediatric cardiac surgical cases weren't going as well as expected, and that kids were dying unnecessarily because there wasn't the critical mass of cases to support a good quality pediatric cardiac surgical program. So now all pediatric cardiac surgeries are being referred to the Capital Health Authority from all Manitoba, all Saskatchewan, all Alberta, and northwestern Ontario to try to create this centre of excellence in care. That would be one example of high-level tertiary and higher-level care services, where we need to see this kind of interprovincial cooperation.

Mr. Brian Storseth: So it is the same kind of—

Dr. William Tholl: Right.

The Chair: Okay, that's all the time.

We're going to move to the third round, and we're getting tight on time, so we're going to move the questions to three minutes so we can get more people in.

Mr. St. Amand, you're away, for three minutes.

Mr. Lloyd St. Amand (Brant, Lib.): Thank you. I'll try to ask a pointed question then, Mr. Chair.

Thank you, each of you, for your cogent presentations this morning and this afternoon.

Certainly the case has been made by all of you that—if I can phrase it this way—within each component of the health care system there is a relative lack of coordination or symmetry, and among the various components there is a relative lack of coordination. Something needs to be done.

I just wondered if—and I'll ask this specifically of Ms. Fralick—one of your recommendations is the establishment of a Canadian coordinating office for health human resources. I have two questions. First, has that ever been attempted, and if so, was it abandoned or suspended at some point? Second, what can we learn from Germany, Belgium, and France with respect to a national office?

● (1235)

Ms. Pamela Fralick: Thank you.

This coordinating office referred to by HEAL is the same entity we've all been talking about this morning, so I won't repeat those comments, but that is what we're talking about. In terms of international information, I don't have a response to that right now, but perhaps one of my colleagues knows more about that international scene.

Bill?

Dr. William Tholl: Thank you, Mr. Chair.

There are two points. One is what we're asking for is that we do no more and no less for people than we do for technologies. Since 1989 we've had a Canadian Coordinating Office for Health Technology Assessment. All we're asking is to start to look at what we can do. Is it possible? Is it feasible? Of course it is. We've done it for technologies and collaborations. Now we only evaluate technologies once and then leave it to the provinces to figure out whether to buy them or not.

As for the European experience, the European Economic Community has eased mobility throughout Europe in terms of licensing and mobility of physicians and others and has created offices, like the one we're suggesting, in The Hague and elsewhere to try to coordinate.

Mr. Lloyd St. Amand: Thank you.

If I have time left—and I hope I do—Mr. Russell has a brief question, I think.

Mr. Todd Russell (Labrador, Lib.): Yes, I do, a very brief question.

I grew up on the south coast of Labrador, in a very small community of 50 people. Seeing a doctor was a major community event. Pharmacist? We didn't know how to spell it or what it was. This is true, and not much has changed to this day.

I know what you are talking about is very important: more professionals in the health care system, trying to take away barriers of all sorts. But living in a rural area, in a very remote area, largely aboriginal, how does your strategy hope to address this issue? In rural and remote Canada, northern Canada, the issue of access has different connotations than it does for people in urban Canada. The issue of wait times has a whole different meaning in rural and northern Canada than it does in urban areas. I notice it's not just about having more people; it's about how we have people stay in these areas. It's a question of resources, particularly when you talk about the employer attracting people. There have to be numerous incentives, it seems, to get people in northern and remote areas. I'd just like some comments on that particular facet.

The Chair: Ms. Sholzberg-Gray.

Ms. Sharon Sholzberg-Gray: I think an example of effort would be the members around our board table who run health systems in Nunavut, the Yukon, and the Northwest Territories. There are a number of solutions. They aren't all involving more health human resources on the scene because it's not necessarily available, but certainly recruitment in tension areas and appropriate workplace environments and incentives and so on....

The other issue is that tele-health and new technology are used a lot, so that we can share information without necessarily being there in person and we can actually take care of people without being there in person. Across this country there are magnificent moves forward in tele-health. I wouldn't want to lose the notion also of centres of excellence, of making sure that people who need to be taken are taken by airplane, by helicopter, and what not to the centre of excellence that can better meet their needs. You can't have a full set of services in every single remote community, but you can meet needs through a combination of tele-health, through a combination of nursing stations. Here we're talking about using people according to their skills and competencies and not worrying too much about scope or practice and competitive professional disciplines and so on.

There are a number of solutions and people are working on them, but I agree it's a specific and extreme challenge, particularly when we're talking about managing the chronic conditions of people on an ongoing basis. I really do think new technology is one of the solutions, together with health care, which means that health professionals—this is the other thing—need to be trained in those technologies in the future.

● (1240)

The Chair: That's all the time we have for this question.

Ms. Yelich, last question, and you have three minutes.

Mrs. Lynne Yelich (Blackstrap, CPC): Thank you.

That was really very interesting. I have a quote by someone from the Fraser Institute and I just want you to comment on it. It says:

> The only way for Canadians to ensure that they have enough doctors to meet demand in the long term is to deregulate the supply of physician services.

I would like a comment from each of you, if you agree or disagree with that.

Dr. William Tholl: Through you, Mr. Chair, there are at least two ways to respond to that. One is deregulate in the sense of taking regulations off that regulate the quality of training. I think that's a non-starter. So maintaining...and maintaining a universal quality standard across the country.

Deregulating supply is an interesting concept. I think the provincial governments whose business it is to fund undergraduate training programs unfortunately still see doctors, nurses, and others as cost centres rather than value centres. I think rather than looking at deregulating supply and forcing down price, I would be looking more at what we're trying to suggest, which is a better approach to planning—needs-based planning.

Mrs. Lynne Yelich: Although we don't have time today, I would like to hear more from you along the lines of the inefficiencies in the whole system, in the deliveries. We all know that we can go down to the health districts and we can see the way they spend money just because they have jurisdictional issues. I think that inefficiencies aren't covered, because it seems like when they address inefficiencies they cut the doctors and the nurses, or else they put the workload on the doctors and the nurses. They're all overworked, so who wants to have a long life in either of those careers when in fact they are making up for the inefficiencies that I think can be done through regulations sometimes? Sometimes the expectations of doctors and nurses, particularly, are almost prohibitive—the documenting they have to do. My experience with nurses is they want to be nurses; they don't want to be always documenting.

I am particularly interested in your comments on that, if you have any.

The Chair: Ms. Little.

Mrs. Lisa Little: I think one of the inefficiencies in the system that can be solved by the federal government is the investment in technology, and particularly around the electronic health record. I was at a meeting last evening and speaking with a person in the community who indicated that his child had left CHEO, the children's hospital in Ottawa. He was now 18 and moved to the adult hospital. There was no transfer of information. He was going there and the health professionals at the adult institution had no record of this child's past history, of his medical condition, of his drug list, nothing. They had to start the process all over again. We hear that time and time again from Canadians. They go in and they have to tell the same story again. They get the same test done again because that physician or that health professional doesn't have access to those results.

I think investment through the Health Infoway in accelerating the electronic health record and getting broadband access out there is a clear will to help inefficiencies in the system.

The Chair: Doctor, do you have a quick comment?

Dr. Colin McMillan : Mr. Chair, I would agree with that. I think we're probably learning a lot about these inefficiencies in our waiting list alliance and in our management of waiting lists, such as in orthopedics in Alberta and Ontario. You're going to be hearing a lot about that.

Mrs. Lynne Yelich: I would like to know, and it can come at another time, at what point you feel you should be in on the credential recognition. Should you be aggressively going out there and putting out what you want as a national body, or can you not do that because you have your provincial body doing it? Can the national body be aggressively looking for people who meet the requirements so that Canada will accept them as doctors?

Dr. Colin McMillan : As a professional association we're not into credentialing, but there are national bodies that do it.

The Chair: That's all the time we have.

I want to thank everyone for being here today and taking the time to make presentations to us. I found it very informative.

We're going to go for a two-minute break so that we can go in camera to deal with some other committee business.

Once again, I want to thank all the individuals here today for taking the time to be here.

[*Proceedings continue in camera*]

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