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Chair

Mr. Rick Casson

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● (1530)

[*English*]

The Chair (Mr. Rick Casson (Lethbridge, CPC)): I call the meeting to order. Today we continue our study of the health services provided to Canadian Forces personnel, with an emphasis on post-traumatic stress disorder.

We have two panels today. We will start with the Auditor General, Sheila Fraser, and the Assistant Auditor General, Wendy Loschiuk. We welcome you both.

We have an hour booked for you. We know we have another bell today for votes at 5:15, so we're going to have to stick to a pretty tight schedule.

Welcome, Ms. Fraser. You've been to many of these committee meetings, so you know the drill. You have some time to make a presentation, and then there will be a round of questioning. The floor is yours.

Ms. Sheila Fraser (Auditor General of Canada, Office of the Auditor General of Canada): Thank you, Mr. Chair.

We thank you for this opportunity to present the results of chapter 4 of our October 2007 report, "Military Health Care—National Defence". As you mentioned, I am accompanied by Wendy Loschiuk, who was the principal responsible for the audits of National Defence when we did this work. Ms. Loschiuk has recently been promoted to Assistant Auditor General.

At the time of our audit, National Defence and the Canadian Forces were providing medical and dental care to over 63,500 Canadian Forces personnel on 37 military installations across Canada and abroad. Members of the Canadian Forces are excluded from the Canada Health Act. The provision of their health care falls under the National Defence Act. If a military member needs medical services, it is the responsibility of National Defence to ensure that the services are provided.

National Defence spent about $500 million on medical and dental care for its members last year, and costs have been rising.

[*Translation*]

In this audit, we looked at how National Defence ensures that its military personnel in Canada receive quality health care. We did not look at medical care outside Canada on deployments such as Afghanistan. Nor did we examine medical treatment or practices.

We found that National Defence has little information to assess the performance or cost of the military health care system. The Department needs better information to manage the system, and, in particular, to help monitor whether it is delivering quality medical care to military personnel.

It is important to note that, when surveyed by the Department, military members said that overall they were satisfied that the military health care system responded to their needs. National Defence has been improving access to medical care and the continuity of care for its military personnel as part of its ongoing Rx 2000 reforms.

[*English*]

The Canadian Forces spectrum of care policy states that National Defence is committed to providing Canadian Forces members with health care comparable to what other Canadians receive. But we found that the department was unable to demonstrate how it could assure itself that the care it did provide met its standards and expectations of quality health care practices.

We were also concerned about the lack of information needed to ensure that only licensed or certified military medical professionals were treating patients. National Defence has informed us that it is working on documenting the status of its health care professionals and is developing a policy on mandatory maintenance of a provincial licence.

As I understand, this committee is particularly interested in the issues affecting mental health care. We found that mental health care services have been reformed to better target needs. A 2002 survey on mental illness in the Canadian Forces found that only 25% of respondents who had reported symptoms of mental health problems or disorders considered that they had received sufficient help. Since then, National Defence has restructured its approach and is implementing a new model nationwide. This model uses a best practice whereby medical personnel and qualified professionals in social work and addictions counselling work collaboratively to treat patients.

The department is also conducting enhanced post-deployment screening of military personnel returning from overseas service to detect any resulting physical and psychological effects.

[*Translation*]

Unfortunately, the Department has not been able to staff its mental health services with all the professionals required. Due to this resource shortage, the system cannot meet all the demands for mental health services. As a result, members are being sent to private practitioners, where it becomes difficult for the Department to monitor their care.

Our audit also focused on several other issues that we explain in the Chapter. We found that few military medical professionals were completing the Department's Maintenance of Clinical Skills program.

We also found that while the cost of the military health care system is rising, National Defence lacks the information to know whether these costs and levels of service at its medical clinics are appropriate to needs.

Finally, we found that, 10 years after the Department had identified a need for oversight of its health care system, there is still no mechanism to bring together all parties, that is senior military officials, senior health care management and military members who could provide guidance and a basis for accountability.

● (1535)

[*English*]

Mr. Chair, National Defence has agreed with our recommendations and has developed an action plan to address the concerns raised in the chapter. I am pleased to see that the department has defined the outcomes it is working toward in the action plan and has set target completion dates. Your committee may wish to have the department report on its progress and the results it is achieving.

That concludes our opening statement, Mr. Chair. We would be pleased to answer any questions the committee members may have.

Thank you.

The Chair: Thank you, Ms. Fraser.

Mr. Coderre will start, and this is a seven-minute round.

[*Translation*]

Hon. Denis Coderre (Bourassa, Lib.): Good afternoon, Ms. Fraser. Thank you for being here. I had the pleasure of hearing you talk about this matter at a meeting of another committee.

In light of everything we've heard about your report from the outset, it appears there is a data compilation problem. We don't really know how things are working. In addition, certain military members have the feeling that there is an internal confidentiality problem. When it comes to treatment for mental health problems, people may automatically not seek treatment, as was observed in the 2002 survey, because of confidentiality problems.

Do you have something to say on that subject? In your opinion, how is information handled at National Defence?

Ms. Sheila Fraser: We didn't look specifically at data confidentiality. In fact, most files are still in paper form. That makes information management more of a problem. It was very difficult to get data on the system as a whole, since it's in paper form. We didn't specifically study the confidentiality issue. Nor was it reported to us as a concern.

Hon. Denis Coderre: There's often talk about problems of shortages of resources and professionals. There's also a structural problem. I would like to talk about accreditation. You refer in your report to certification. Is it possible that doctors who currently conduct assessments aren't properly accredited to do so?

Ms. Sheila Fraser: Mr. Chairman, there is that kind of risk because National Defence doesn't have a system in place to ensure that doctors are all certified. We conducted an audit of certifications, and we didn't find any doctors who weren't entitled to practise. However, it was our auditors who did that work. The department itself doesn't have a system to give itself that assurance, although we're told they're going to put one in place.

[*English*]

Hon. Denis Coderre: When you were auditing what's going on under the Canadian Forces, did you specifically take a look at the aspects of the structure, the way decisions are made or the way we manage the issue of health care inside the department?

My understanding is that we have an amazing general who's in charge, General Jaeger, but she has several departments to take care of at the same time. Do you believe that maybe one of the issues is an issue of structure right now?

Ms. Sheila Fraser: Mr. Chair, I'll ask Ms. Loschiuk to respond to that question.

● (1540)

Ms. Wendy Loschiuk (Assistant Auditor General, Office of the Auditor General of Canada): Thank you.

We didn't look specifically at how the health care system was managed. We were very interested, of course, in understanding the process of management at the base level, where the base surgeon is responsible for seeing that all of the health care services are provided, and how that information is then rolled up to NDHQ. That's where we found problems, because not all of that information is generally put together.

But we also did notice—and we've pointed it out at the end of the chapter, in paragraphs 4.65 and 4.66—that the system appears to have no mechanism in place whereby people can sit down and examine just what is being delivered, and all parties can then have the opportunity to say, “This is how we feel things should be delivered.” We're talking about a mechanism where soldiers, sailors, etc., can say, “Yes, this is what we would like to see.” The medical professionals could also sit down and say, “This is how, from our medical standpoint, rather than our management standpoint, we would like to see things.” And clearly, it's the same for the operational senior management, who need to have soldiers, sailors, etc., healthy and ready to work.

Such a mechanism, I think, would put a little more accountability into the system and into the process and make sure people are getting what they're asking for.

Hon. Denis Coderre: Does the lack of accountability explain why it seems that the way we spend is a bit out of control? Right now, under the Canadian Forces it costs more than the civil system of health care. Does that explain why we have those kinds of numbers right now?

Ms. Wendy Loschiuk: I think there are a lot of reasons why the health care system is a little more expensive. There are certain things that the system here is required to do that perhaps other systems don't pay for—for example, a lot of the training. But it would be helpful to have an accountability mechanism, where the services that are provided and the level of services could have perhaps a second look. In that regard, such a mechanism may help—

Hon. Denis Coderre: So we don't have enough checks and balances? Is that what you're saying?

Ms. Wendy Loschiuk: It would provide some checks and balances.

Hon. Denis Coderre: One of the main problems, of course, is that we have the policies of our geography. At the physical and mental level it's pretty tough, but when you have rural versus urban, what's your say on that? There's clearly an issue. It costs more. There is a lack of resources, and you have to make a difference between what's going on through cities.... There are great places like Valcartier, Gagetown, and Moncton. At the civil level we don't even have enough resources to have those clinics. What do you say about that?

Ms. Sheila Fraser: Again, we didn't look specifically at that issue. We did note the difficulty in getting certain professionals, largely mental health care professionals. I think that would be true probably in some of the smaller areas that probably even in the public system have difficulty getting those kinds of professionals. But we didn't go into the strategies the department might have in place to recruit or to bring in people.

The only real comment we have is that when we do the comparisons, there are a number of medical professionals who come in on contract, and that was really the only place we looked at. It was in regard to the cost element and the lack of good information to determine if the level of cost is the appropriate one or not.

Hon. Denis Coderre: Thank you.

The Chair: Thank you.

Mr. Bachand.

[*Translation*]

Mr. Claude Bachand (Saint-Jean, BQ): Thank you, Mr. Chairman.

I in turn would like to welcome the Auditor General and the staff of her office. These are people whom we see regularly.

I took a brief look at the content of the report you prepared in 2007, Ms. Fraser. Could you tell me whether you yourself decided to prepare that report or whether you were asked to do so? Sometimes your services are solicited, and you accept, but I imagine that you yourself took the initiative in this case.

Ms. Sheila Fraser: Yes, it was our own decision.

Mr. Claude Bachand: Can you explain to us why the dental plan was not a selected issue? It's nevertheless an important component. You only looked at health. May we expect that you will eventually address the dental plan question?

Ms. Sheila Fraser: We decided not to include it in this audit simply because it's a slightly different system and the medical care system in itself was already a big subject to cover.

● (1545)

Mr. Claude Bachand: Could we hope that you will conduct a study on the dental plan in the near future?

Ms. Sheila Fraser: That's always possible.

Mr. Claude Bachand: One thing intrigued me, and that's the fact that the department appears to offer a private insurance plan to the Canadian Forces as a whole. Every member is insured by Blue Cross in the event the military clinic is not available. From what I read in my notes, it costs approximately $66 million a year, whereas the total cost of health services is $500 million a year.

Do you think this practice should be somewhat restricted, or do you think it's normal? Obviously, we'd need clinics open 24 hours a day, and that's not always possible. So when these people are sick, they're sent to receive care at locations that are under provincial jurisdiction. They use their insurance in those cases. I'd like to hear your comments on that subject.

Ms. Sheila Fraser: That stems from the fact that the Canada Health Act does not provide for military members to receive provincial health care. They must have private insurance to access that care. That may be due in part to a shortage of professionals who work for National Defence, or simply for other laboratory services and so on. We also didn't audit the analysis they conducted of this new model or whether they had assessed the alternative cost that that would have added if they offered the services themselves. Perhaps you can ask the departmental representatives if they have done that kind of analysis.

Mr. Claude Bachand: Very well.

Now I'd like us to talk about the distribution of doctors. We know a little about that in Quebec, since we sometimes have to ensure that doctors practise in certain areas where they don't necessarily want to go. Sometimes they prefer to live in Montreal or in other urban centres. I was surprised to learn that there is a major difference between the number of cases handled by one doctor and the number handled by another. One doctor may see as many as 100 patients a day, and another 40.

Wouldn't it be beneficial for the department to require a fairer distribution for the Canadian Forces as a whole?

Ms. Sheila Fraser: Indeed, we see that there should be far more data in order to manage the system and identify places where doctors are more available. Perhaps they could do a better distribution. Once again, that goes back to management of the system as a whole and to the lack of basic information. Obviously there is information on a clinic-by-clinic basis, but there is an information shortage in the system as a whole. The department is talking about putting a system in place, but that will take a few more years. It also appears that they won't necessarily put the entire system in place as a result of budget cuts.

Mr. Claude Bachand: I'm also surprised to see that nearly 40% of all doctors don't see any patients at all: they are assigned to administrative duties. That seems to me to be a poor distribution of the workload. Usually, a doctor is a doctor. For example, a doctor at the Hôpital du Haut-Richelieu in Saint-Jean-sur-Richelieu won't spend 40% of his time doing administrative work.

Don't you think that's a bit high?

Ms. Sheila Fraser: We noted it because we think it's worth examining. A number of doctors are working on policy development, for example. They spend all their time on administration. That doesn't necessarily mean that they work with patients for one part of their time and do administrative duties for another. I also think it's up to the department to review that percentage, in view of the shortage of doctors and of what it would cost to hire doctors on a contract basis to provide services to military members.

● (1550)

Mr. Claude Bachand: Now I'd like to ask a question which you may perhaps not be in a position to answer. In Canada, the real health services experts are the provinces. I know that one provision of the National Defence Act states that health care must be provided by the Canadian Armed Forces. If we said it would be better to transfer the entire issue of health and dental health to the provincial public sector, and if we reached a federal-provincial agreement, with transfers of tax points or cash, how would you react? Are you going to answer that that's a political decision and that you can't comment on it?

Ms. Sheila Fraser: I see you already know the answer. I'll also say that it must be acknowledged that National Defence has fairly specific needs. Those people want military members to have immediate access to the required services. I think that one of the barriers to simply transferring care delivery to the provincial system is that military members would like to continue receiving services when they want them. Another of the problems that was noted in the 2002 surveys was continuity of service. National Defence has worked very hard to ensure continuity and availability of services.

[*English*]

The Chair: Thank you.

We'll go to Ms. Black.

Ms. Dawn Black (New Westminster—Coquitlam, NDP): Thank you, Mr. Chair.

Welcome to the committee again. It's nice to see you again.

As you know, the study we're undertaking right now is on health care with an emphasis on mental health care. I note that in your opening remarks you talked about a 2002 survey. I'm wondering if that is the one Dr. Brunet did. He came to our committee last week. You mentioned that only 25% of the respondents in that study, who had reported symptoms of mental health problems or disorders, considered that they had received sufficient help with them.

One of the other figures Dr. Brunet gave us from his study, if it is the same study, showed that 57% of those members of the Canadian Forces who had a recognizable mental health problem had not received any treatment. I am wondering if you're aware of that research.

Ms. Sheila Fraser: The survey we mention is done by Statistics Canada, and it is the same.

Ms. Dawn Black: It is based on that study.

Ms. Sheila Fraser: Yes, that's right.

Ms. Dawn Black: I'm wondering if you're aware that 57% of the people who were identified with a disorder did not receive—

Ms. Sheila Fraser: Yes, I'll let Ms. Loschiuk respond to that.

Ms. Wendy Loschiuk: As I understand it, the study you're speaking of used the same data Statistics Canada used back in 2002. Of course, those findings are from that timeframe. I really couldn't give you an update. You'd have to ask the department where the situation stands today.

Ms. Dawn Black: You were also very concerned about the credentials of medical practitioners. Does that also include mental health practitioners? Did you look at that specifically?

Ms. Sheila Fraser: We didn't break down the practitioners by area of specialty, but, for example, we looked across the whole system at the health care practitioners, be they doctors, nurses, or whatever. The department, at the time of the audit, at least, did not have a system in place to ensure that the practitioners were appropriately certified or licensed.

We did a check of all the doctors to make sure there were no issues there, and we found that was fine, but we didn't go through, for example, all the nurses to make sure they had the proper credentials. I understand that now the department has put in place a system that will require annual certification of the professionals.

Ms. Dawn Black: Is that in both physical and mental health?

Ms. Sheila Fraser: Yes, that's my understanding.

Ms. Dawn Black: Good.

Did you find any differences in the performance of delivery or spending on mental health services as compared to general health services? Did you look at that?

Ms. Sheila Fraser: Again, we didn't break it out specifically.

● (1555)

Ms. Dawn Black: I understand that in your next study—the study you've just taken was in Canada—you will look at services provided outside Canada. Is that correct? If it is correct, will your staff travel to Kandahar airfield, or have they already?

Ms. Sheila Fraser: We are looking at the supply chain, the support to deployed operations. That will be tabled in May, we hope. Yes, the staff did go to Kandahar.

Ms. Dawn Black: You looked at both mental health services and —

Ms. Sheila Fraser: We did not look at the health services. It's more the supply chain for goods going in and the supports to the operations there. We didn't look at health care for the moment anyway.

Ms. Dawn Black: You have finished with your health study. Thanks very much for that clarification.

Would you have any recommendations for this committee on where we should target our questioning, our studies, or which people we should talk to?

Ms. Sheila Fraser: Certainly focus on mental health care, because we didn't go into a lot of the detail on that. I'm a little reluctant to give any advice on that.

The main issue we found in this was that the department just didn't have the information systems to be able to manage this program well. Even patient charts are still paper. So to try to get information even about how many military members are suffering from mental health care issues, whether they are being treated by the public sector rather than professionals within.... That sort of information can be pulled together on an ad hoc basis, but you can't get that kind of information to be able to really understand what is happening, to see the trends that are happening right across. So we think it is really critical that the department get the proper systems in place.

It would be good for the committee to try to ask them when they are going to have those things in place, because until they do it's going to be very difficult for them to be able to manage it program-wide, rather than clinic by clinic.

Ms. Dawn Black: So it is a technological issue, then?

Ms. Sheila Fraser: It's easy to say it's a technological issue, but it's really about managing the program differently; rather than managing clinic by clinic, managing the program as a whole, trying to see where the anomalies are. We even talked about caseloads between the various practitioners to identify those kinds of things, to assess whether or not the costs were appropriate, and even to do more regular surveying of members or those sorts of things. I think the program needs much more attention in that area—and, yes, of course, technology will help enable it, but you need to want to manage it that way and to understand that you have to go to a much broader spectrum than just going individually.

Ms. Dawn Black: You talked about the caseloads. Did you find great variance between areas of the country in terms of the caseloads that individual practitioners were carrying?

Ms. Sheila Fraser: We did, and I'll ask Ms. Loschiuk to perhaps provide the specifics.

Ms. Wendy Loschiuk: Yes, we did. When we looked at how the different clinics had been staffed and why they had been staffed, we did note that some of the clinics had a lot of people coming in. Some doctors might see as many as 100 patients over a certain period of time, as I believe the chapter shows, whereas if you went to another part of the country, the workload was a lot less. We didn't explain why. We weren't able to get information as to why that was, but we did ask why clinics weren't staffed in a similar fashion, according to population. We also asked the department if they could show us information on whether an analysis had been done on the expected caseload. But they weren't able to do that; I don't think information on that was really available, which is another area that would be helpful for them to know. But as a result of having to work with a model based on the information they had, you did see these anomalies.

Ms. Dawn Black: Thank you very much.

The Chair: Thank you.

Over to Mr. Hawn.

Mr. Laurie Hawn (Edmonton Centre, CPC): Thank you, Mr. Chair.

And thank you to both of you for being here. I have a number of fairly short questions, but I first want clarification on something that was in Dr. Brunet's report, that is, the 57% of people who had not sought or had not been in contact with mental health professionals—not those who had sought it and were satisfied with the result. That may be a little bit different.

We have talked about doubling the number of mental health professionals, or one of the recommendations was a plan to double those by 2009, from 229 to 447. Can you give an assessment of the impact of that? Would that increase be enough? I know it's hard to give a very definitive answer on that, but what's your assessment of it?

Ms. Sheila Fraser: Again, I think it would be more appropriate for the department to answer that, but certainly, I think one could expect it to reduce, perhaps, the contract dollars being spent to have professionals within the system, because there is currently fairly significant contracting of those services.

Mr. Laurie Hawn: Following on what Mr. Bachand mentioned, that 40% of doctors are not providing care and that there's a balance between providing care and information management when one of the shortfalls of the system is, as you mentioned, information management, how do we reconcile those?

Personally, I have a problem with doctors doing a lot of information management. Obviously, there needs to be input there, but is the answer to have more medical administrators versus MDs doing that sort of task?

● (1600)

Ms. Sheila Fraser: I think the department should certainly look at what the doctors are doing and whether it is possible to have people other than doctors doing those tasks. I'm sure the department can respond more than I can, but they will tell you that they are involved in policy development and things like that. Obviously, you do need some medical professionals in those areas, but I think what we were trying to encourage was an assessment to see whether there are doctors doing tasks that could be done by others, which would then free them up to be able to do the clinical work.

Mr. Laurie Hawn: We also talked about credentials, and certification or licensing. That's an issue in Canada with the provincial requirements for licensing and the portability of military doctors. Is there a policy case to be made for CF doctors having portability? I know it's not something DND can solve, but for the medical establishment, if we are to have portability of licences nationally for military doctors, or even nurses, and so on....

Ms. Sheila Fraser: In fact, I understand they're not required to have licences in the provinces where they are working currently, as long as they work for National Defence. So registration, for example, with the College of Physicians and Surgeons—we have it here in section 4.44—is sort of an indicator of confidence. We checked just to see whether they were actually licensed and registered anywhere, and we found no problems with the medical doctors. But that was work the audit team did. We would have expected the department itself to know that people were licensed in some place and had all the qualifications necessary to actually practise medicine.

Mr. Laurie Hawn: I think maybe a wrinkle in that is when there's a military doctor in a place like Cold Lake who is also doing work in a civilian hospital. That would require provincial licensing.

Ms. Sheila Fraser: That's right.

Mr. Laurie Hawn: That may be more the issue we're talking about.

Is your concern about credentials or is it about certification, and is there a difference between the two? If somebody has a valid MD, and they're licensed somewhere—

Ms. Sheila Fraser: That's fine. We're not concerned if someone is working in, say, Petawawa and has been licensed in New Brunswick. That is not our concern. It is whether the people who are there are actually qualified, I guess, to practise medicine, and we certainly would have expected the department to have known that.

Mr. Laurie Hawn: Yes, okay.

One issue, again, that was brought up was the potential for having provincial provision of this kind of service and your comments on the open deployability of military doctors, which would mean that they would need to be military. It is also important to have doctors who speak the patient's language, and I don't mean French or English, I mean military language. Would that be an important factor?

Ms. Sheila Fraser: I would presume that it would be important. Again, it's really a question of policy. We wouldn't comment on that. But as I mentioned earlier, I think the whole question of accessibility to care when needed and the question of continuity of care were certainly two issues that had been brought up in the past and that the department had worked very hard to address.

Mr. Laurie Hawn: Could you comment on the overall effectiveness of the CF action plan that fell out of your report and so on? Do you have any views on how effective that has been or might be?

● (1605)

Ms. Sheila Fraser: To be quite honest, not really. Again, the information systems just aren't in place to do that. I think we see that the department has agreed with the recommendations, has certainly indicated that they take this seriously, and has put an action plan in place. So I guess we can say that we are cautiously optimistic that these issues will be addressed.

Mr. Laurie Hawn: The other thing you talked about was a concern for maintaining medical skills. There were some shortfalls in that area. Is that a function of not enough people, too big a workload—which is probably the same thing—or again, lack of data management and that sort of thing?

Ms. Sheila Fraser: I think it was difficult for us. It was probably, in part, because of workload. Again, there is a program available so people can get experience, the necessary experience, to keep their skills up to date. Not enough of them are actually going through and completing that program. So again, it's something that needs to be tracked by the department to understand why they aren't doing this, what the rate of success is, and whether they need to modify their program in some way to make sure that people are getting the training they require to stay up to date.

The Chair: Thanks, Laurie.

That ends the first round. We'll start our five-minute round. We'll get as deep into it as we can with the time we have.

We'll go to Mr. Rota.

Mr. Anthony Rota (Nipissing—Timiskaming, Lib.): Thank you. Thank you for being here today.

I have a quick question. It was mentioned that about 40% of MDs—and that's the one that really stuck out—aren't doing physician's work; they're doing administrative work. That would be fine if there were a surplus of MDs, but there is a shortage, and the military is contracting out.

Were you able to assess why these physicians, who are trained as caregivers, as MDs, were shifting over to doing administrative work? Was it just part of their day-to-day procedure, or was it that they were becoming managers and administrators and doing that type of work for career advancement or just because of work preference? What was the cause of that shift?

Ms. Sheila Fraser: I'll ask Ms. Loschiuk to respond.

Ms. Wendy Loschiuk: When we looked at, basically, where are the doctors and what are they doing, our concern at that time was, why is there a shortage of doctors? We were able to find that a certain number of them were applying direct hands-on patient care in the clinics, but there's also a requirement in the department to run this health care system, to have some of the doctors doing standards, doing policy, doing other types of administrative work. How many you need to do this is a very difficult question to answer.

We weren't really able to compare it to anything. It's a difficult assessment to make, because you have to look at the system by itself. So I think it's something that we really urge the department to have a look at: why are 40% of your doctors doing non-patient care, which requires you to then go out and hire civilians, hire people on contract to do the patient care?

As to why doctors are choosing to go into that field, we didn't go into that area in particular. There are all sorts of career reasons for it, and operational reasons as well, but you'd have to ask the department whether or not that's the optimum level.

Mr. Anthony Rota: So it's not as simple as saying you need more administrators or more people in a certain area. It just kind of morphed in there and has become part of the fabric or the culture, but there's no identifying how it got there. Am I reading that correctly?

Ms. Sheila Fraser: That's not the kind of work we did as to how it got there. We certainly didn't do any kind of analysis to see if this has increased or decreased over time, but we would certainly encourage the department to go back and look at that 40% and ask whether there's any way it can be reduced and have some of those doctors actually go back into patient care.

Mr. Anthony Rota: I'm going to go back to the certification, because it sounds as though a lot of us read exactly the same thing out of this report.

When a doctor is certified, he or she becomes a doctor and is in place. But with most professional designations, as time goes on, there is updating and just learning the new techniques of what's going on, where you should be at. Is that something you looked at? Did you see whether the certification these people had, had been updated over the years, or that they had kept up-to-date with modern developments in the field of medicine?

In this case, I guess what we're looking at is more in regard to mental illness. Was there anything in the psychiatric area where people were keeping up-to-date with what we're looking at as post-traumatic stress disorder or mental issues? Was that kept up-to-date, or was it just certified once and then we weren't sure exactly where they were? Maybe you can explain to me how you looked at certification.

● (1610)

Ms. Sheila Fraser: Our concern was that the department wasn't able to assure there weren't unlicensed medical professionals providing service. So we went and looked for the doctors to see if they were all certified or licensed. But we didn't go back, then, to say, okay, what are the credentials that are needed in this and have they followed all the training within a certain province. We didn't go that far.

The department itself, though, does have a training program that they have arranged with the provincial health care system so that people can go and work in hospitals—I presume in emergency wards or whatever—to keep their skills up to date. That was one area as well where we found that people weren't completing that, weren't doing that as much as was expected. So that's another area where the department needs to have better information and a better understanding of why this program that they have put in place is not producing all the results. Is it because these doctors are overworked, or the medical professionals generally are overworked, and aren't able to be freed up to go and do this? So there needs to be, again, more analysis.

Perhaps Ms. Loschiuk wants to add something.

The Chair: Actually, we're out of time for that portion. Keep that thought and we'll try to get to it.

Ms. Gallant, and then Mr. Bouchard.

Mrs. Cheryl Gallant (Renfrew—Nipissing—Pembroke, CPC): Thank you, Mr. Chairman. I'll be sharing my time with Dr. Lunney, if there is any time left over.

To quote part of your report:

> While the expenditure for health care for other Canadians in 2006 was estimated at about $4,500, the expenditure per military member was estimated at more than $8,600 (in the 2005–06 fiscal year).

It was testified in a previous meeting, prior to your arrival, that physicians and hospitals charge our soldiers a higher rate than they would somebody at an OHIP rate. Is the difference that our soldiers are being charged more in a civilian hospital—and their health care overall—a consequence of what is necessary to treat a soldier, or is it that perhaps in civilian society the proper funding isn't there, so that soldiers are getting what it costs to properly treat them, where there is a shortage of doctors and spaces perhaps?

Ms. Sheila Fraser: We noted a number of factors in the report that could explain the higher cost. One is simply the availability of the services. National Defence do not want their military members waiting days, weeks, and months to have treatment. So they have a much higher proportion of doctors to the population than you find in the public health care system. We say on page 15 that we found there were four times more physicians per 1,000 military members as compared to the civilian system. But 40% of those doctors are doing administrative services.

There's the physician workload we talked about earlier. There's quite a variety in workload across the country. The costs to train medical staff are included in the department's costs, which again is not the case in the public health care system. Then there's the cost of physicians on contract, which is higher than in the public system. They are paid more than even National Defence's own doctors.

Those are some of the elements. I think everyone can appreciate that the cost to provide service in National Defence will likely be higher than in the public health care system. But we expected that the department would have be able to do that analysis and say why it was costing more. Could it be because they are receiving services from the provincial health systems and they're treated as being out of province, so—you're right—the cost is higher? Is the $8,600 an appropriate level? It's that sort of information.

We make no judgment as to whether it is too high or not high enough. But we expected the department to have that kind of information and to be tracking that information to see if those costs are reasonable.

● (1615)

Mrs. Cheryl Gallant: With that in mind, is it not a greater benefit to the taxpayer for the military to hire more doctors? Was that part of your assessment?

Ms. Sheila Fraser: If you simply looked at the cost of a physician on contract compared to a physician within the military, of course it would be beneficial to hire more physicians.

Mrs. Cheryl Gallant: This Ontario government keeps a lid on health costs by limiting the number of doctors who practise. Part of the reason it's difficult to recruit doctors in the military is because there just aren't the number of doctors graduating and being licensed to handle civilian patients, let alone the Canadian Forces.

Is there any system in the checks and balances that you were looking at for DND to allocate funds and set them aside to fund spaces in medical schools or in residencies specifically for medical doctors?

Ms. Sheila Fraser: That's not something we looked at. We didn't look at the whole human resources component of how they go about recruiting and retaining medical doctors. That could actually be an interesting audit to look at.

Mrs. Cheryl Gallant: So we have a compounding problem here. I'm referring to Base Petawawa. The Province of Ontario, for example, does not fund enough medical school and residency placements to accredit doctors who've already passed all their exams to care for civilian patients. Then there aren't enough psychiatrists in the military to treat PTSD patients, so they are medically released back into the civilian system where there are not enough psychiatrists to begin with. So it really has a snowball effect.

My other colleagues mentioned the issue of portability of certification. What response have you received from DND as to their plans to fix this problem?

The Chair: We'll have to come back to that as well. The time has expired.

Mr. Bouchard.

[*Translation*]

Mr. Robert Bouchard (Chicoutimi—Le Fjord, BQ): Thank you, Mr. Chairman.

I too want to thank you for being with us, madam.

Yesterday, a witness told us how it was important to introduce a systematic screening system for mental health cases. As it was stated earlier, 57% of military members have not met with a mental health professional. He also told us that it would cost very little for National Defence to set up such a system.

Do you share that view?

Ms. Sheila Fraser: From what I understood at a previous meeting, National Defence systematically interviews all soldiers returning from Afghanistan, particularly when they return and a few months later. However, we didn't really examine that question as part of our audit. That would definitely be a question to ask the National Defence representatives.

Mr. Robert Bouchard: You also told us that, in a survey conducted in 2002, only 25% of respondents said they were satisfied with the services they had received.

Do you think that's a satisfactory or poor result?

Ms. Sheila Fraser: I think we can conclude that it's a poor result and that the departmental people also felt it wasn't satisfactory. They subsequently adopted a number of measures, a new approach, to improve mental health services. However, I don't believe they've conducted another survey. It would be good for them to do so systematically in order to check whether forces members' satisfaction with mental health services is improving.

Mr. Robert Bouchard: You also say that no mechanisms have been implemented to bring all stakeholders together. Do you have an idea of the reason why nothing has been done in that direction after so many years?

Ms. Sheila Fraser: I don't really have an answer, but that's an excellent question, which concerns a number of our audits. If it were possible to answer that question, we would see more progress on a number of fronts.

● (1620)

Mr. Robert Bouchard: Thank you.

[*English*]

The Chair: Thank you.

Perhaps this is the venue to bring all those people together, which you suggest. We have that list you mentioned, and I'm sure we are going to have some from all of those here to help us with this.

I think we have time for one more spot, and then we'll make a quick change.

Mr. Cannis.

Mr. John Cannis (Scarborough Centre, Lib.): Thank you.

Guests, welcome.

In the expenditure for the health services, in paragraph 2, I assume it includes the family members of military staff as well in terms of health services.

Ms. Sheila Fraser: No, because technically family members are not covered under National Defence policy. They would only be covered if it was judged necessary, I believe, for the treatment of the member, but family members are not covered other than that.

Mr. John Cannis: Okay.

In your presentation in paragraph 5, you state that:

> It is important to note that, when surveyed by the Department, military members said that overall they were satisfied that the military health care system responded to their needs.

Then I go back to paragraph 4, where you say you found that "National Defence has little information to assess the performance or cost of the military health care system".

One contradicts the other. Can you place it for us?

Ms. Sheila Fraser: The survey that was done was really about the quality or the level of satisfaction of the members. What we're talking about in the report is really management information, to be able to manage caseloads, to be able to manage deployment of people, to have trends in the health care issues, to look at the costs. To really manage a system that costs about $500 million a year, you need good management information, and that's just not present right now.

Mr. John Cannis: My last question is very short, Mr. Chairman.

You state here at the end that you finally "found that 10 years after the Department had identified a need for oversight of its health care system, there is still no mechanism...." Why is that so? I think that's part of the problem. Nobody is here to blame current or past governments, Mr. Chairman, but why? It's my understanding, anyway, some years ago—I've been around—that there was an effort undertaken.

Why, and what obstacles are before us, and how can we overcome these obstacles to make sure at least more progress can be made? Notice that I use the words "more progress", meaning that there is progress.

Ms. Sheila Fraser: I think that would be a great question for the department.

The Chair: I think the department is sitting behind you, taking some notes on all of this.

Thanks to Mr. Cannis and Mr. Bouchard for being brief.

We have two minutes, that's all, I'm afraid, Mr. Lunney, and then we're going to have to break.

Mr. James Lunney (Nanaimo—Alberni, CPC): I want to welcome you to the committee. You've already answered a lot of questions. That's twice today. We had you at the environment committee earlier in the day, along with Ambassador Mamedov. So welcome again.

At the environment committee the Auditor General was welcomed as a Canadian folk hero. We certainly want to recognize the good work of the Office of the Auditor General.

A quick observation, though, goes back to a question by Monsieur Bachand. One of the members opposite was asking about $66 million being spent outside of the military for health care services versus $500 million, roughly, inside. It seems to me that the Canadian average for publicly paid care is about two-thirds, and one-third of health care dollars are roughly spent on private care in the national system. So maybe if that's roughly 12% or 14%, perhaps we're doing better in the military than in the general health care services all together.

I do note that in some of your comments there was some good news—an 85% overall satisfaction rate—which probably compares favourably and maybe better than outside, and wait times are shorter in the military. So there is some good news that came in your report as well.

Ms. Sheila Fraser: Absolutely, and I think we know with regard to mental health care that after that survey in 2002, the department recognized it needed to improve, so it put measures in place to try to do that. I think what it needs now is to have a validation that what it has done has given it the results it expects.

● (1625)

Mr. James Lunney: Just a final one. The CMA was here on the Hill this week. One of the things they're pushing for is some money from the federal government for electronic records. It certainly seems that might be a recommendation the committee might want to follow up on. An investment in electronic health records might be a great help.

Ms. Sheila Fraser: As a point of interest, we are working with provincial auditors general in the majority of the provinces to audit the whole question of electronic health records across the country, because a lot of funding is going into that. Is it being managed appropriately, is a question for all of us.

The Chair: Thank you.

Thank you both very much for being here. This committee, as I am sure all Canadians do, looks forward to your reports as they come out, and we wish you well. Continue doing the good work you do for this country. Thank you.

We'll make a quick change to the second panel.

● (Pause) ●

The Chair: Welcome to our second panel, and welcome back, General Jaeger and Colonel Fillion. I see you have a statement prepared and distributed. There will be time to offer that to us, and then there will be rounds of questioning.

There are bells at a quarter after five for a vote, so we'll get in as many questions as we can. The floor is yours.

Brigadier-General Hilary Jaeger (Commander of the Canadian Forces Health Services Group, Director General of Health Services and Canadian Forces Surgeon General, Department of National Defence): Mr. Chair, members of the committee, thank you for this opportunity to appear once again, this time to address the Auditor General's report on military health care. I am sorry I am not mentally agile enough to have incorporated any more details about some of those excellent questions in my opening remarks, but I am sure many of them will be brought out during the question period.

I am accompanied by Lieutenant-Colonel Joel Fillion, our senior staff officer for mental health. In this role, Joel is responsible for the coordination of many aspects of mental health care within the Canadian Forces health services, including analysis, policy, and program development; training; and resource allocation, to name a few. And to cut through all those words, he is the guy who has to implement the mental health initiative under Project Rx2000, so he's the guy who is beating the bushes trying to find those extra mental health providers for places like Petawawa and Valcartier. It's not an easy job.

[*Translation*]

First of all, the Department of National Defence fully accepts the recommendations outlined in the Auditor General's report. We believe that the report provides a fair and balanced assessment of the sate of our military health care system, which is continuing its transition through a massive reform process.

Madam Fraser is clearly positive in her comments in a number of areas in this report and, in particular, she notes that previous concerns about accessibility and continuity of care have been addressed, that a high percentage of CF members are satisfied with the health care they receive, and that the new model for mental health care is considered a best practice approach.

[*English*]

Various initiatives undertaken in the CF health services reform, such as multidisciplinary collaborative practice and electronic health records, are advocated practices from the 2002 Kirby report entitled *The Health of Canadians—The Federal Role* and in the 2002 Romanow report entitled *Building on Values: The Future of Health Care in Canada*. These practices continue to be advocated today by the Health Council of Canada.

Rx2000 and the Canadian Forces health information system represent very significant reforms, and although work remains to fully implement these initiatives, I am confident many of the changes being put in place will serve us well in addressing the Auditor General's recommendations.

● (1630)

[*Translation*]

As you know, the report itself contains eight recommendations centred on the four key themes of governance, cost of the CF health system, performance management, and credentialing of health care providers. We have a general action plan with expected outcomes and dates for addressing each recommendation. I will focus my remarks today on some specific actions taken to date, which I believe will be of particular interest to this committee.

[*English*]

Prior to the release of the Auditor General's report, the determination of which medical and dental services treatments and items would be provided at public expense to entitled persons fell heavily on the shoulders of health care providers, notably me, sitting in front of you.

Subsequent to the report, and after a review of the terms of reference for the spectrum of care committee, which makes health care entitlement determinations, the Chief of Military Personnel sought and received approval to raise the level of oversight of this committee to the Armed Forces Council, the senior leadership of the Canadian Forces. Having the Armed Forces Council make decisions about CF members' health care entitlements will now better enable the CF health services system to determine whether costs incurred are indeed related, as the Auditor General noted they should be, to patient requirements and operational needs.

The inaugural meeting of this elevated spectrum of care committee took place on February 4 this year. We are continuing to improve our ability to analyze and isolate cost data, although the CF health information system, when fully implemented in 2011, will provide the true conduit for greater cost data generation and decision-making support.

A number of recommendations in the Auditor General's report involve selecting system performance indicators, setting standards of care, and measuring activities against these standards and indicators. A new CF health services performance measurement advisory group was instituted in January this year and has begun to develop a performance measurement framework to define applicable performance indicators and to set benchmarks for these indicators. The list of indicators chosen will be in keeping with the pan-Canadian primary health care and population health indicators, which were recently developed by the Canadian Institute for Health Information.

It is worthwhile noting that CF health services will be among the organizations taking a lead in institutionalizing these practices in a multidisciplinary primary care setting. Data collection in relation to certain mental health indicators has been included in the CF health and lifestyle survey set to take place later this year.

Periodic health examinations, which currently take place every five years but will be accelerated to every two years, have recently been modified to capture more mental health and deployment-related health data. This data will feed into performance indicators as the performance measurement framework unfolds.

For deployments, the initial CF theatre trauma registry, which led to evidence-based modifications to pre-hospital medical training and protocols, has now been replaced with the U.S. joint theatre trauma system, which encompasses a far broader range of data fields and quality indicators. This system also includes a complete quality assurance and improvement framework to stimulate the production and updating of clinical practices based on objective data analysis.

[*Translation*]

In addition, progress includes the development of a CF Health Services Group Quality Improvement program and a chart audit and peer review process, which is being piloted at three bases starting next month. Further refinement and system-wide application will ensue following this effort. As has already been done, CF Health Services is also continuing to measure aspects of quality through mechanisms such as patient satisfaction surveys, survey reports from the Canadian Council on Health Services Accreditation, and internal assessments such as Staff Assistance Visits, or, in other words, inspections.

[*English*]

On the issue of credentialing of health care providers, a national credentialing cell was recently recreated and has achieved licensure verification for 100% of physicians and dentists, 96.7% of pharmacists—that's a very nice detail, but it means that one pharmacist hasn't answered the mail yet—and 79.9% of nurses. A new CF credentialing policy is set for release in the near future.

I am confident that we have made considerable progress, and I take extreme pride in being able to state that we can demonstrate trauma mortality rates in Afghanistan that are as good as those of any other nation working in that part of the world, and indeed as good as those of any leading trauma centre in Canada.

The mission of the Canadian Forces health services group is to provide full spectrum, high-quality health services to Canada's fighting forces wherever they serve. I am confident that our mission is being met, and we are working diligently to objectively demonstrate this.

● (1635)

[*Translation*]

This completes my introductory remarks. I thank you for your interest in the CF Health Services and for the opportunity to appear before this committee, and I look forward, with Lieutenant-Colonel Fillion, to addressing any questions you have.

[*English*]

The Chair: Thank you very much.

We'll get started right into the questioning.

We'll start with Mr. Coderre.

[*Translation*]

Hon. Denis Coderre: Good afternoon, General Jaeger and Colonel Fillion.

[*English*]

General Jaeger, you've accumulated three functions.

[*Translation*]

You are the Surgeon General, you are the Commander of the Canadian Forces Health Services Group, and you are the Director General of Health Services. So you're responsible for everything concerning functional authority for program delivery and everything pertaining to practices.

I'm not doubting the person in question, but from a structural standpoint, is it appropriate to hold those three offices? When authorities created three offices, was it because they wanted each to be occupied by a separate person? Do you have a little too much on your shoulders?

BGen Hilary Jaeger: That's a very interesting question and I thank you for it. The highest level of the CF Health Services system has changed structures a number of times over the past five or six years. When I was a major and lieutenant-colonel, a major-general and three brigadier-generals managed the system. They shared the duties.

At the time of the re-engineering, the number of generals was considerably reduced, such that only one remained, General Auger. In 1999, the Chief of Defence Staff appointed a Director of Health Services who, for the first time, was not a doctor: Major-General Mathieu. She was also the only general. We tried with a surgeon general who was a colonel. After a period of experimentation, the position of surgeon general was created for a general, but there was also the director general and the group commander at the time. General Mathieu and I worked in that context.

After General Mathieu's departure, Commodore Kavanagh and I worked as a team. After Commodore Kavanagh retired, I had to perform all the duties. Last week, we learned that, during the transfer period that will take place this summer, Major-General Devlin will be appointed Director General of Health Services. I will continue to occupy the position of Surgeon General and Commander of the Health Services Group.

Hon. Denis Coderre: For reasons of accountability, when you do your checks and balances, it's always better if... Either you completely change the decision-making structure, or you appoint people to different positions. The oversight policy requires—

BGen Hilary Jaeger: That will enable you to divide the responsibility to—

Hon. Denis Coderre: Yes. We're saying the same thing.

I asked you some specific questions when you appeared before the committee the first time. We were fortunate to hear Colonel Girvin answer questions, particularly concerning those drugs.

First of all, how many soldiers under medication did we send to Kandahar after they suffered post-traumatic stress disorder or any other form of major depressive or general anxiety disorder?

BGen Hilary Jaeger: I regret, sir, but I'm not in a position to give you any detailed figures.

Hon. Denis Coderre: Will you send those figures to the committee?

BGen Hilary Jaeger: I can try, but it's not necessarily easy.

Hon. Denis Coderre: It's important because this is a matter of public interest.

[*English*]

And the reason I'm asking that question is that when Colonel Girvin was saying she thought there were a few.... Basically, I don't feel there is enough follow-up regarding those people who are under medication.

She said, and I quote:

> ...probably the majority of these medications might be, for example, a sleep aid.... I believe probably a lot of them don't take their medication when they go out. In fact, they'll make that decision based on whether or not they think it'll impair them in any way to do their job.

● (1640)

[*Translation*]

It's important to have details on that, general. These are schools of thought. This is consistent with our professional decision, but if we send soldiers under medication to perform transportation duties, in particular, and then they stop taking their medication, I'm concerned about the safety of those individuals and that of the people around them. That's the purpose of my question.

BGen Hilary Jaeger: One of the important aspects of the work of a mental health professional or a doctor posted there is considering all the advantages and disadvantages of an action plan, that is to say whether you should prescribe medication or limit the duties of the position.

[*English*]

Hon. Denis Coderre: The question is on the follow-up. If you have some individuals there, and if we provide the medication and they are not taking it, we need to make sure we have some follow-up on the field for them, right?

BGen Hilary Jaeger: Just to get more precisely to the question you're interested in, it's people who have been deployed into theatre who have subsequently sought some assistance for some kind of problem, who have been prescribed a psychoactive medication while in theatre and then returned to duty outside the wire.

Are you interested in the number of people in that situation?

[*Translation*]

Hon. Denis Coderre: I have one final question.

[*English*]

You said we now have a national accreditation process.

BGen Hilary Jaeger: Yes.

[*Translation*]

Hon. Denis Coderre: According to my sources, doctors assessed certain soldiers without authorization. I was told about Dr. Deilgat, who apparently wasn't accredited in Quebec. We may not question his abilities perhaps, but I would like to know how a doctor can assess those soldiers in Quebec without being authorized to practise by the province.

BGen Hilary Jaeger: If a doctor who has a licence authorizing him to practise medicine works solely for the Canadian Forces on federal premises, on the Valcartier base, for example, wheher he has a Quebec licence is not important. For us, a licence from New Brunswick or Ontario would be just as appropriate.

Hon. Denis Coderre: So Canadian Forces doctors might not be authorized to practise in Quebec, in particular, and could nevertheless conduct assessments.

BGen Hilary Jaeger: Yes, if they're assessing military members.

Hon. Denis Coderre: And what if they are off the base?

BGen Hilary Jaeger: In that case, they need a licence from the Province of Quebec.

[*English*]

The Chair: Thank you, Mr. Coderre.

[*Translation*]

Hon. Denis Coderre: Thank you.

[*English*]

The Chair: Thanks, General.

Mr. Bachand.

[*Translation*]

Mr. Claude Bachand: Welcome again, general.

Sometimes we're concerned by the fact that the pace of rotations tends to accelerate. There is a lot of discussion in order to determine whether those rotations should be stretched, in view of the lack of soldiers. One might think it's tempting for the Canadian Forces to ask its psychiatrists or mental health professionals to give soldiers a drug that will keep them in combat, even if that's almost unacceptable.

We want to be assured that the situation is entirely safe for soldiers returning to the front and taking those drugs. In other words, we want to be sure that military members with a mental illness or post-traumatic stress disorder are entirely rehabilitated when they return to the theatre of operations, even if they are taking those drugs.

BGen Hilary Jaeger: With your permission, Mr. Bachand, I'm going to answer in English because that's a little easier for me.

● (1645)

[*English*]

You have to be very careful about what you know for certain and what the research seems to indicate that is not yet definitive. You have to be quite careful to separate those things in your head.

We believe that having had a diagnosis of post-traumatic stress disorder in the past does make you at somewhat higher risk of having a reoccurrence of this disorder if you're subjected to combat stress in the future. It's not 100%; it's not a guarantee.

What we don't know is exactly how big that difference is.

We also know that other kinds of things in your mental health background have a similar effect. I think Dr. Brunet alluded to a history of childhood abuse of any kind being a serious risk factor, which we actually don't screen for—for a whole lot of reasons.

So we know there are risk factors. It really is a matter of serious professional judgment—and they do take their responsibilities very seriously—to assess whether somebody who has been treated and has done well, has returned to duty and is performing well in their job, is well enough to go back into theatre. That's a serious decision. It is not taken lightly.

But if you come out with a blanket policy that says as soon as you have had a mental health diagnosis and have required treatment for a period of time, you can never go back into theatre, well, that's a recipe for perpetuating stigma and for driving the problem underground if I've ever heard one. So we don't do that.

It's case by case. We rely on the best judgment of our mental health professionals on whether people are or are not ready to go back.

[*Translation*]

Mr. Claude Bachand: There's nevertheless risk management, and you have confidence in your doctors. However, a doctor can decide that a military member should not be returned to combat, just as he can take the risk of deciding the contrary. Can it happen that the safety of those around the person who is returned to the front is jeopardized? Do you know whether there have been any cases in which things really went badly after a member returned to the front and had to be sent back to Canada for good?

BGen Hilary Jaeger: I'm not aware of any such situation. We have returned to the front people with mental health histories who had problems and were withdrawn from combat. However, that wasn't sudden. They decided, after a certain number of weeks, that things were not going well and that it was preferable to return to Canada.

Mr. Claude Bachand: So you don't deny that soldiers who were diagnosed with mental health problems and were taking drugs were returned to the front line?

BGen Hilary Jaeger: That has happened. It's true that that can be a risk for the individuals themselves and those around them, but it is also true that a sudden heart attack can put peers in danger as well.

Mr. Claude Bachand: How much time do I have left, Mr. Chairman?

[*English*]

The Chair: You have two minutes.

[*Translation*]

Mr. Claude Bachand: The most important question for me is the distribution of patients. I mentioned to Ms. Fraser earlier that some doctors were seeing up to 100 patients a day, whereas others were seeing 40. That problem may not just affect military members. We have to take measures in Quebec to encourage doctors to settle in the regions, so that they don't all wind up in urban areas.

Have you taken steps to distribute the number of patients more evenly so that every soldier is entitled to the same treatment as the others and so that things are fair?

BGen Hilary Jaeger: It's not easy to assess the number of patients that a doctor sees in a day because they're not all equal. For people who have a sore neck or suffer from a minor knee problem, it's relatively easy. For those who have diabetes or recurring cancer, treatment is much longer.

We can talk about means. In that respect, matters are not completely equal from base to base. At the start of the reform, we determined that there would be 1,500 persons per health care unit. That's a somewhat arbitrary figure.

● (1650)

[*English*]

I'll switch to English.

It was a little arbitrary, and the Auditor General has remarked on that. We know that 1,500 people in a very busy base like St. Jean produce more work than 1,500 people in a relatively quiet base like perhaps Greenwood. We also know that 1,500 fifty-year-old officers in Ottawa produce more work than either of those. So you have to look at the demographics of the base.

We also know that our system of compensating—particularly our contracted physicians—is very inefficient because they're on per diem rates. If you want to run a health care system at the lowest possible cost, you do not pay people per diems. But we're not interested in running assembly-line medicine either. I'm not going to come out with a policy that says you have to see 100 patients a day, because I'm going to get crap. Excuse me. I'm going to get not very good—

The Chair: You said flack, right?

BGen Hilary Jaeger: No. I was going to say something a little less suitable to being televised, but—

Voices: Oh, oh!

The Chair: Thanks, Mr. Bachand.

Ms. Black is next.

Ms. Dawn Black: Thank you very much for presenting at our committee today.

We were in Kandahar as a committee last year, and we saw the medical services there and talked to some of the social workers and doctors. I was certainly quite impressed with their commitment and the level of care they were able to provide in a very small and intense kind of environment.

One of the issues that I'm quite interested in is what happens at the forward operating bases. Our study is specifically around post-traumatic stress disorder, brain injuries, and mental health services. We did go up in a helicopter, but we didn't get all the way to the forward operating base; we had to come back because of the weather.

Can you tell us a little bit about that? What kinds of health services are available there under those kinds of conditions, and what would happen if someone exhibited signs of mental distress in one of the forward operating bases?

BGen Hilary Jaeger: Thanks.

Each of the forward operating bases has a team of medical personnel. Usually the head of that team is a mid-level provider, what we call a physician assistant. It's not well known in Canada, but it's well accepted in the United States. I think you're going to hear more and more about them in the Canadian health care system.

Up to now, we've trained them ourselves, and we're very proud of their capabilities. They are senior NCOs, usually warrant officers, and they will have a team of medical technicians with them that varies in size. They actually have pretty good diagnostic skills, and they have very good radar for what's going on with soldiers because they've been soldiers for a long time.

If they see somebody that they or the chain of command suspects is having difficulty, they will usually observe them. They'll take them into a small tented area, or sometimes it's surrounded by concrete barriers and Hesco Bastion. They will usually observe the guy for one or two days and then make a call on whether he is improving and just needed some rest to get himself back on track or whether he needs to be seen further back.

You don't necessarily make the decision to transport back lightly, because sometimes moving from place to place can be one of the more risky things to do. They'll try to use a helicopter, which is less risky.

On top of the core team at the forward operating bases, headed by the physician assistant, the members of the mental health team, who spend most of their time back at Kandahar airfield—the psychiatrist, the social worker, the mental health nurse—will also make periodic trips from time to time just to get the lay of the land out at the forward operating bases, introduce themselves and sort of walk around, along with, of course, the chaplains, who are a pretty good early warning system as well.

Ms. Dawn Black: We've met with them too.

Can the medical practitioners prescribe medication?

BGen Hilary Jaeger: They have a limited range of medications they can prescribe independently. Psychoactive medications are not really part of that list. If they need to use psychoactive medication, they'd have to refer them back.

Ms. Dawn Black: Thank you very much.

At these meetings I've asked before what changes have been made within the Canadian Forces over the last ten years in terms of mental health services and mental health diagnoses. You've obviously had great experience. I wonder if you could give us some concrete examples or some stories that would give us some examples of how much change has occurred and in what way.

BGen Hilary Jaeger: It's hard to say what hasn't changed. That would be perhaps a shorter answer.

When I started treating military patients in the mid-1980s, I hardly ever saw anybody come in admitting they had a mental health problem. They came in complaining of back pain. They came in because they were drinking too much; they got into fights in the bars. Yes, they had mental health problems, but they would never come in admitting it. That has changed quite radically. There is still reluctance, but it's much less. It has to do with increased awareness. It has to do with the work of a lot of people, like Senator Dallaire.

I know you had questions about confidentiality. The committee may be interested to know that in 2000 there was a complete change. Before 2000, commanding officers had the right to know diagnoses and to sort of pry into people's medical details. A CANFORGEN, a Canadian Forces-wide message, issued in 2000 changed that. I don't think it's a coincidence entirely that a lot of our increased mental health workload has occurred since then. People are more able to come forward.

We undertook the Statistics Canada survey, which has been the subject of a lot of discussion here, precisely to find out what we needed to build. We needed to have some baseline idea of what's going on out there before we designed a program to improve our capabilities.

Ms. Dawn Black: Is that the same study Dr. Brunet talked about, where they identified that 57% of people who exhibited some level of mental distress were not asking for treatment or not accessing it?

● (1655)

BGen Hilary Jaeger: That's the same study that was done in 2002. Statistics Canada did a great job for us in doing an incredible survey. Joel and his team couldn't have...the challenge they have now is to find those almost 200 extra mental health providers...if we hadn't extrapolated from that survey what the real needs were out there.

Ms. Dawn Black: Was that a survey of the Canadian Forces here in Canada, not people on deployment?

BGen Hilary Jaeger: It was a sample of the Canadian Forces. I don't know that it systematically excluded people on deployment.

Ms. Dawn Black: Dr. Brunet told us it did.

BGen Hilary Jaeger: Most of the people who responded were back in Canada, a mix of regular forces and reserves.

Ms. Dawn Black: When you were here at the first meeting at which you presented, General Semianiw spoke of the family as the bedrock of operational effectiveness.

When Lieutenant-Colonel Girvin was at our last meeting, she said that post-traumatic stress disorder most often manifests itself with anger and irritability, and most often it would be a family member who might recognize this.

What does the treatment entail? Does it entail the entire family, or the spouse, or the children, when you're dealing with a member who has post-traumatic stress disorder?

The Chair: I'm sorry. We're going to have to get back to that one.

BGen Hilary Jaeger: We're just warming up.

The Chair: You were just getting going.

Over to Mr. Lunney.

Mr. James Lunney: Mr. Chair, thank you very much. I know time is short, so we'll just fire away here. I'm glad to have you here.

I pick up on your comment about the trauma and mortality rates in Afghanistan. We're justifiably proud of the good work that's being done on the front lines. So we certainly appreciate the great front-line work patching people up that our services are providing over there.

Going back to the Auditor General's remarks here about who's really in charge of health care services, if I understood your response, you mentioned that oversight has been turned to a spectrum of care committee. Could you explain to us who that is?

BGen Hilary Jaeger: I'll do my best. Governance is one of my favourite subjects, so the chance of my running off at the mouth and going off on tangents is fairly high.

The spectrum of care committee is one that has authority over certain aspects of governance. It decides what things will be provided to members of the Canadian Forces at public expense and how much of those things will be provided.

In the past, basically I was given a pot of money and told, “Sort yourself out, and if you have to make trade-offs to make things affordable, just don't make any headlines while you're doing anything.” That was sort of the governance.

We wrote the spectrum of care to get it codified, so that it wasn't arbitrary and people knew what they could expect. Then we actually put in place the committee that would make the decisions about this.

We struggled for a while to get the right level of representation on that committee. You have to understand that the Canadian Forces is not a board of governance culture; it's a chain of command culture. I have a boss, and for most members of the Canadian Forces, as long as they do what their boss tells them to, then what's the problem? The problem is that this is the health care system for the members of the Canadian Forces; it is not just the operation of the Canadian Forces health services group.

So now we have managed to achieve—with the spectrum of care committee, at least—representation at the L1 minus level. So the seconds-in-command, essentially, of the army, navy, and air force sit at the spectrum of care committee, as does my deputy surgeon general as the professional advisor.

The things that get considered by the committee should be brought up from the environments or from the force employers. They get debated. My staff researches what it is likely to cost, how many people are going to need to avail themselves of this service, and is there an evidentiary basis for including this service. The committee comes up with a recommendation, and that is taken forward to the Armed Forces Council.

I know there's a hot debate now about laser eye surgery. I don't know how that one is going to come out. It's not a medically necessary thing to do, but it's something the operators believe vehemently improves operational effectiveness. So they seem to be willing to invest at least some money in laser eye surgery.

● (1700)

Mr. James Lunney: Thank you for that clarification.

I just want to jump back to the last meeting we had, with Dr. Theresa Girvin and Dr. Alain Brunet here, and pick up on the question from Mr. Coderre concerning the reluctance of some officers or soldiers to go on medication, regarding their deployability, and so on.

There was some discussion about EMDR, or eye movement desensitization and reprocessing, as a non-invasive and non-drug approach that seems to get some good results. Could you comment on how widely that's used? With the new personnel coming on, are you seeing promise with this, and is it being used?

BGen Hilary Jaeger: I know that providers at both our clinics and clinics with Veterans Affairs were comfortable with the treatment. I couldn't tell you how widely spread that expertise is—Joel may know—but I do know that it's considered an effective treatment and is being used at many, if not all, of our OTSSCs.

Mr. James Lunney: Okay, I appreciate that.

Over to Mr. Hawn.

Mr. Laurie Hawn: How much time do I have, Mr. Chair?

The Chair: You have three minutes.

Mr. Laurie Hawn: Thank you, sir.

I have just a couple of quick points for clarification. First, do we ever send anybody out to do an operational job, medicated or otherwise, if we're not confident in their ability to conduct the task and do it safely—for their own safety and for the safety of the people around them?

BGen Hilary Jaeger: No, we never do that. The issue is, though, that we're not completely...[*Inaudible—Editor*].

Mr. Laurie Hawn: Okay.

With respect to doctors' qualifications and licensing—again, sort of a value statement—do we have any doctors treating Canadian Forces people who we don't think are qualified to do that?

BGen Hilary Jaeger: Not any more, sir.

Everyone must have seen the newspaper articles about the fellow we found in Petawawa. For us that was not a good—

Ms. Dawn Black: Yes. I was shocked.

BGen Hilary Jaeger: It was mitigated by the fact that he had graduated from medical school, he had completed a family medicine residency, and he had passed the examinations. But he had not received his licence from the College of Physicians and Surgeons of Ontario, and there was some misleading of the recruiters as to what his status was. We found out about two weeks after he had started actual work in Petawawa. We reviewed all the patients he had seen and sort of suspended him, and he's been released from the forces. He's now the College of Physicians and Surgeons of Ontario's problem.

Mr. Laurie Hawn: Okay. That's good.

You mentioned, in terms of certification and so on, that 100% of doctors are now certified, all but one pharmacist—

BGen Hilary Jaeger: All but one pharmacist.

Mr. Laurie Hawn: —and 79.9% of nurses. That's obviously moving to 100% on the nursing side?

BGen Hilary Jaeger: There are more nurses. They're taking a little bit longer to get through.

Mr. Laurie Hawn: Okay.

BGen Hilary Jaeger: It's just a matter of getting through the paperwork.

● (1705)

Mr. Laurie Hawn: You or someone else talked about deployability screening and better data management. That's one thing the Auditor General hit on fairly significantly, the ability to screen effectively pre-deployment, or screening out problems as they arise.

Have we seen improvements in that? Do you see more improvements in that just with better data management? What do we have to do to make it better?

BGen Hilary Jaeger: I think our post-deployment screening is hugely improved. That's the most important one for us, because that's the one that gets people into treatment. It's actually something we didn't do before 2002, which I think was the very beginning of what we call enhanced post-deployment screening. It's actually a whole bunch of scientifically well-justified standard screening instruments that are administered to everybody who comes back. Or it's supposed to be administered to everybody who comes back; we need the cooperation of the chain of command and the people themselves to actually come. So compliance is less than 100%, but it's pretty good.

It's made mandatory for a reason: to help break through the stigma. People can't point at others who are going in for screening and say, for instance, "Oh, you think you have something wrong", because everybody is going in for screening, not just those who might think there's something going on.

So we've made huge strides with post-deployment screening. Pre-deployment is less structured, but there is still lots of screening opportunity formalized for members—including their families—to be interviewed at various levels by such people as the social worker and chaplain before they go overseas.

Mr. Laurie Hawn: Thank you.

The Chair: Thank you.

That completes the first round, a five-minute round to start.

Mr. Rota.

Mr. Anthony Rota: Okay, very good.

I'll be brief because I'll be sharing my time with Mr. Murphy.

I was looking at the Auditor General's report, and one of the areas that concerns me is the contracting out of services and how you choose those people. I'll state one case. I don't want to base everything on one case, but it's something that repeats itself quite often. In this case in particular, an individual went for psychological assessment and help, and the person who was giving him treatment, who was a registered psychologist, basically said, "I don't know how to treat post-traumatic stress disorder. I've never done it before, but let's see what we can do, and we'll see what comes out of it." This is a young kid, about 22 years old. He has his life ahead of him, and he's being told he's going to be used as a guinea pig. I really have a hard time with that.

The question I have is two-pronged, or maybe even three-pronged. He doesn't live near a Canadian Forces base. So what is the treatment for individuals who live outside the range of a CFB? Second, how do we choose these people who are going to treat our young men and women when they come back? And third, who determines, after the treatment is over, whether they can go back into theatre?

This individual has a number of conditions. The psychological affliction is probably one of the biggest things affecting him right now, because it's stopping him from going ahead with the others. He's a soldier. That's what he wants to do for a living and what he's dedicated to doing. Who determines when it's time for him to go back into theatre? Is it the psychologist in the field? Is it someone at the base?

It is a three-pronged question, if you don't mind.

BGen Hilary Jaeger: I will try to start from the end first.

The authority for sending them back into theatre, medically speaking, would be the base surgeon of the base he's affiliated with. That is normally a general practitioner, but he or she would never—not never, but it would be extremely rare—act against the advice of a specialist. It's probably more likely that the general practitioner, the base surgeon, based on military experience, would be more reluctant. We frequently have specialists who say they think the person is fine, and the general practitioner isn't comfortable with it. We always put ourselves in this position: if I'm the only doctor for an operating base or in Kandahar, do I want to be responsible for what might happen to this guy? So that's the easier part.

How you provide services in remote areas and....

● (1710)

Mr. Anthony Rota: I'm in North Bay. That's not that remote. There's a base there, and it's close by. Petawawa's the nearest, and that's where he was based.

BGen Hilary Jaeger: Petawawa's the nearest, and it is under-serviced, from the point of view of mental health resources as well.

It's a very fine line, and it really is a matter of professional judgment. The primary care physician is very important in deciding. There's a difference between our contracted physicians, who are working for Joel and who are on contract permanently, and the fee-for-service providers, who are used for a variety of things. In some areas we still, for mental health, have fee-for-service providers. It sounds like this psychologist was probably one of the fee-for-service providers, not part of our collaborative practice team in our health setting.

It's very unfortunate that he would say something like that, because, of course, PTSD is not that rare across the Canadian population. He didn't happen to be comfortable treating it. I give him points for identifying that, but that should have been communicated not to the patient but to the referring physician so he or she could perhaps make a more appropriate referral.

We often find ourselves—I'll be honest—in the position of asking about the point at which any resource is better than no resource. We can't create the perfect mental health system out of thin air. If there aren't resources in the area to tap into, then you have to ask whether we should move the patient. That has pros and cons. We know we can find the right resources in Ottawa, but that's not necessarily an attractive option either.

Again, on a case-by-case basis, all these pros and cons have to be looked at, and you try to find the right resources for the patient.

The Chair: Thank you. That's smack on.

We'll have time to get back to you in the next round.

Over to the government, for five minutes.

[*Translation*]

Mr. Jacques Gourde (Lotbinière—Chutes-de-la-Chaudière, CPC): Thank you very much, Mr. Chairman.

Post-traumatic stress disorder troubles me very much. Roughly 10 years ago, I employed a former military member who had suffered from that disorder. Another young person employed by me enrolled in the Armed Forces.

During their training, are our military members made aware of post-traumatic stress disorder? During a mission, a military member may feel that he is starting to have mental problems. Sometimes the disorder arises afterwards. Let's suppose that a military member leaves for six months and that, at the end of four months, he is no longer mentally able to endure the mission. Can he withdraw or must he absolutely stay until the end of the mission?

BGen Hilary Jaeger: As regards your first question, there is basic training on stress problems, which includes post-traumatic stress disorder. That's part of the basic training of all military members at the base in Saint-Jean.

[*English*]

Basic military training includes training in the effects of stress and post-traumatic stress disorder.

When you're on a mission, if you think you're having any kind of health problem whatsoever, you are not obliged to continue. You, yourself, can't decide that you're going home. What you do is present to your.... If you're out of the forward operating base, you would go to see your medical technician or your physician's assistant. If you were back at Kandahar airfield, you would go to the primary care clinic associated with the hospital at Kandahar airfield and describe the symptoms you're having: for example, I can't get to sleep; my heart is pounding all the time; I feel sick to my stomach; I'm having nightmares. Describe any of the symptoms you want. There's no law that says you came here four months ago and you have two months left to go and you're not getting out of here until then. The health care staff will make the judgment as to whether you can be treated in theatre and supported there or whether you need to go somewhere else.

[*Translation*]

Mr. Jacques Gourde: Thank you.

[*English*]

The Chair: Go ahead.

Mr. James Lunney: Do I still have time?

Mr. Rick Casson: A little bit.

Mr. James Lunney: Thanks. I wasn't expecting it to come my way.

I wanted to pick up on another comment you had made about multidisciplinary primary care programs. You mentioned there were programs piloted at three bases. Is this the same program we're talking about here? Could you expand on that? Could you describe this to us?

BGen Hilary Jaeger: I think my French in my remarks was not terribly perfect.

What we were trialing on three bases is in fact a systematic peer review process, wherein a certain number of files of each practitioner would be reviewed on a periodic basis for quality assurance reasons.

● (1715)

Mr. James Lunney: Okay. Thanks for clarifying that.

I just want to come back briefly to my question about EMDR. I had a feeling that perhaps Lieutenant-Colonel Fillion wanted to comment on that.

Did you have any comment on EMDR?

Lieutenant-Colonel Joel Fillion (Senior Staff Officer, Mental Health, Department of National Defence): Yes. In fact, what I would say is that we don't have the specific numbers of how many people are using these techniques.

I think all those who provide service to the different clients who are being referred to them will use their own skill sets and the skills they have acquired. So it will happen that some might not have been trained in EMDR and some have. Most of the people who have been trained will, most of the time, use these techniques if they feel it is the best fit for the clients.

I do know that in most of the major clinics, providers are using EMDR.

Mr. James Lunney: You don't have any comment in terms of the satisfaction rate of people having this type of therapy versus other types.

LCol Joel Fillion: No, we do not.

Mr. James Lunney: Thank you.

The Chair: Very good. Thank you.

Mr. Bouchard.

[*Translation*]

Mr. Robert Bouchard: Thank you, Mr. Chairman.

Thank you for testifying. I asked the Auditor General two questions. The first concerned the system. Ten years after the department identified a need for oversight of its health care system, there is still no mechanism in place for bringing all stakeholders together.

Is that mechanism recommended by the Auditor General important for you?

BGen Hilary Jaeger: I'm anxious to see it myself. I think this is a return to governance issues, which goes beyond a chain of command.

Personally, my chain of command is working very well. It's starting to move little by little. About four or five months ago, they didn't know they were responsible for giving us priorities and for reporting on what we had accomplished with regard to those priorities.

[*English*]

So we really didn't have a system that clearly told us where our efforts should be; it was up to us to decide where the priority of effort should be in the health services system. If you look at the difference between the CEO of a hospital and the board of governors of the hospital, it's the board of governors that says what the priorities are and sets the strategic plan for the hospital. The CEO's job is to implement those.

I have been the CEO and the president, as have my predecessors. We would like to move away from being the president of the board; we would prefer being the CEO.

[*Translation*]

Mr. Robert Bouchard: That's good.

[*English*]

The Chair: Mr. Murphy, I'll give you just a couple of minutes, as I hear the bells ringing.

Hon. Shawn Murphy (Charlottetown, Lib.): Thank you very much, Mr. Chairman.

I have just one question, if I may.

Brigadier-General, when I read the report and listen to your evidence—and of course you were before the public accounts committee discussing this before—the one figure that strikes me is the large percentage of your trained medical professionals not providing care to our forces. It is significant—at least I think it's significant. It suggests to me a systems problem. But you're dealing with a tremendously challenging situation. You're organizing and implementing the health system for 65,000 people spread out all over the world. It's basically an all rural, rather than urban, system. You're in an environment that is extremely competitive. The IT seems to be an issue; the measurement seems to be an issue; the governance seems to be an issue. And of course you have to operate in a command and control environment, which is not normal.

But as far as the whole health system is concerned—and this really is a specialty unto itself now, as a lot of the people doing this are not physicians or surgeons, but are trained in this area—do you feel you have the people around you who are really up to scratch in the whole area of modern health management? I say this because it is an extremely important issue with the challenges you face, which I think are very high. The whole recruitment issue is brutal, for example, and I don't think it's going to get any better over the next five or ten years.

● (1720)

BGen Hilary Jaeger: Thanks for that question. It's very interesting.

First of all, I'd like to clarify that the 40% in administration—of which I, of course, am one—are uniformed physicians; the 40% is not the overall percentage of physicians providing care to members of the Canadian Forces. So when you look at whom you can replace with a civilian, you can't really replace the more senior people. All of the people in these supervisory roles are uniformed providers: the lieutenant-colonels and colonels, all of whom count toward that 40%. Also, my public health experts, my occupational health experts, and the people who review recruits' medical files to see if the recruits are fit to come into the forces, are counted as administrative positions, but those jobs can only be done by physicians.

Regarding the management side, we've had a tremendous improvement in the professionals. We do have a separate occupation, as health care administration is a separate occupation. It feeds into another classification, known as health services operations officers. General Mathieu was the first person to start as a health care administrator and then command the system. We are fully part of the Canadian College of Health Service Executives. We participate in their professional development programs. We encourage the attainment of certified health executive designation through the college to improve our baseline level of health care management and capability.

We can still do better, but compared with the situation when I first joined, when, to be honest, a health care administrator was somebody who wanted to be a pilot and failed, or who wanted to be an infantryman and was hurt and couldn't be an infantryman any more, we have come light years from those days.

The Chair: Good.

Thank you very much.

Hon. Denis Coderre: On a point of clarification, Mr. Chair, it's been a while since I asked for the number of troops on medication. Through the chair, I am expecting you to get those numbers. It is imperative for our own understanding of the issue.

Thank you.

The Chair: We'll make sure of that.

Thank you very much for being here again, and thanks for your contribution to the study.

The meeting is adjourned.

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