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Chair

Mrs. Joy Smith

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● (1530)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): Good afternoon, ladies and gentlemen. I want to welcome you to this study.

I understand that we have a lot of witnesses today to listen to, so I'm going to extend the time a little bit for the witnesses. I believe we have six who will be presenting.

Dr. Bennett.

Hon. Carolyn Bennett (St. Paul's, Lib.): I wanted to apologize to the witnesses on behalf of the committee. To have seven witnesses in one hour is unacceptable. It doesn't allow us to do our work.

I believe that in the future the clerk needs to ask the committee what we would prefer. We might have been asked to have an extra session or to add time enough to do a proper piece of work. We don't have enough time for the officials to give us a portrait of what's been done and what they hope to do. If this is the way we're going to conduct the study, we might as well stop right now. We won't be able to do good work. I want to see a work plan, and we may have to have a steering committee meeting.

I don't know if Shelagh Jane Woods is going to speak. Aboriginal health human resources is one of the most important things we're going to have to address, and she's tucked under the whole Department of Health.

The Chair: The sooner we get started, the sooner we get the testimony. I will extend it.

Hon. Carolyn Bennett: I know these witnesses were booked because we were supposed to hear the department on Tuesday, and the bill went over time. They should have been called and asked if they wanted to rebook when they'd have more time to present and a better opportunity to persuade the committee.

This is no way to proceed. If we're going to skate across the surface, we might as well just write the report now, because most of us know what would be in it. If we're actually going to drill down and find some real solutions, then you have to give us the time to do the work. By the time their opening statements are done, we'll be done.

The Chair: The other solution to that—

Hon. Carolyn Bennett: I can read opening statements.

The Chair: Dr. Bennett, could I just get a word in, please? The other solution would be to bump up our work plan to right after the Easter break and just have witnesses and questions today.

What is the will of the committee?

Hon. Carolyn Bennett: I was angry when I thought they were only here for two hours, and now I realize they're only here for an hour. This was impossible when it was two hours. It's insulting to have to do it in an hour.

The Chair: Dr. Bennett, if we could get this resolved, we won't waste time.

I'm asking the will of the committee. Everyone wants to hear full testimony, and we want to have a chance to ask questions. We also need the chance to do some business, but the option would be to hear witnesses today, do the questioning, and bump up the business plan for the first day back.

Could I have some discussion on this?

Dr. Carrie.

Mr. Colin Carrie (Oshawa, CPC): I was going to suggest going the two hours. I believe Madame Davidson had a suggestion as well.

Mrs. Patricia Davidson (Sarnia—Lambton, CPC): I was going to suggest that it's important to hear from the individual witnesses. If the department people are all from Ottawa, why don't we hear from them on another day? Maybe they're not all from Ottawa, but if they are we could hear from the witnesses who have travelled.

● (1535)

The Chair: We're happy to have you all here, and everyone is anxious to hear your testimony and ask you questions.

Who would like to bump up the business for the first day back on Tuesday and hear witnesses today?

Some hon. members: Agreed.

The Chair: Today we will hear all the witnesses and have all the questions. We will do the business plan the following day.

Pursuant to Standing Order 108(2), we are studying health human resources. I would like to hear, first of all, from the Department of Health.

Ms. McDade.

Ms. Kathryn McDade (Director General, Health Care Policy Directorate, Strategic Policy Branch, Department of Health): Thank you, Chair.

On behalf of Health Canada, I would like to thank the committee for the opportunity to participate in your study of health human resources.

I'd like to provide you with a brief overview of Health Canada's investments in health human resources. In doing so, I will try to focus in particular on some of the specific interests that are identified in the terms of reference for the committee's study, including recruitment and retention, team-based health care, accreditation of foreign-trained professionals, and aboriginal peoples.

Health human resources has been a priority for Health Canada since 2003, at which time Canada's first ministers made a commitment to work together to secure and maintain a stable and optimal health workforce in Canada. First ministers recognize that having an adequate supply and distribution of health care providers across the country is a key factor in enabling Canadians to access the health services they need. To support this commitment, Health Canada has made targeted investments and played a policy leadership role through collaboration with governments, professions, health care organizations, and other federal departments. All of our investments are intended to complement the quite significant investments that provincial and territorial governments make in health human resources in the context of their responsibility for delivery of health care services to the vast majority of Canadians.

Health Canada has made investments in three key health human resource initiatives. First is the pan-Canadian health human resource strategy, which is funded at $20 million annually. Second is the internationally educated health professionals initiative, with annual funding of $18 million. Third is the aboriginal health human resources initiative, a five-year initiative with total funding of $100 million.

[*Translation*]

I would like to provide you with a brief overview of the objectives and accomplishments to date of each of these initiatives. Along with my colleague, Shelagh Jane Woods, I would be pleased to provide additional details during the question and answer portion of this afternoon's session, or in writing, as the Committee wishes.

The Pan-Canadian Health Human Resources Strategy has the broad objective of helping to ensure the availability of appropriate, skilled and competent health care professionals to deliver safe and effective health services.

[*English*]

Under the strategy, Health Canada provides contribution funding to a wide range of partners to support development of health human resource data and forecasting models, policy research, and the identification and dissemination of innovative models and practices. Our funds are not used for direct HHR investments, such as training of health care providers, salaries, or other workforce costs.

The federal-provincial-territorial advisory committee on health delivery and human resources has been instrumental in developing the strategy and in implementing it. This is a federal-provincial-territorial committee that provides policy and strategic advice to the conference of deputy ministers, and is also a forum for collaboration on shared priorities.

A significant proportion of the projects that have been funded under the strategy have focused on recruitment and retention of health professionals. We've worked with undergraduate medical education programs to adapt curriculae to encourage more medical students to enter family practice. We've invested in post-licensure professional development and training programs to assist the health workforce to adopt new delivery methods. In order to increase retention of health workers, including nurses, we've invested in pilot projects and other initiatives to strengthen employment practices in the health sector.

[*Translation*]

To ensure that health care providers have the necessary skills to deliver health services in a changing health system, Health Canada has worked with provincial and territorial governments and other stakeholders on projects to promote inter-professional education and a more collaborative approach to care.

● (1540)

[*English*]

We've invested in more than 32 interprofessional-practice projects, which have increased awareness and sharing of best practices related to collaborative care, have increased the number of institutions providing mandatory interprofessional education courses, have increased the number of educators who are able to teach interprofessional practice models, and have increased the number of health professionals trained for collaborative practice.

I'd like to turn now to the second of Health Canada's key HHR initiatives, which is the internationally educated health professionals initiative, or IEHPI.

Internationally educated health professionals are a significant component of the health workforce. For example, 23% of Canada's doctors and 7% of our nurses were trained outside the country. It's well documented that these professionals can face significant challenges in integrating into the workforce.

In 2005, the Government of Canada launched the IEHPI with funding of $75 million over five years. The general goal of the initiative is to reduce barriers for internationally educated professionals and to promote access to information and pathfinding, competency assessment, training, orientation, and other supports for integration into the workforce. The bulk of IEHPI funding, about 80% of the total, is directed to provincial and territorial governments through bilateral agreements with Health Canada. The remainder supports pan-Canadian initiatives.

Provinces and territories have used their portion of the funding in a range of programs. They have developed innovative initiatives in the areas of credential assessment, bridge training, career counselling and information services, and orientation. Just to give a couple of quick examples, one is a new one-stop information counselling and pathfinding service that's been established in the province of Ontario. It has served over 3,000 clients to date. The second I would cite is a new competency assessment program for internationally educated nurses that was originally developed in Alberta and has now been implemented in all the western provinces and in Nova Scotia.

The pan-Canadian portion of IEHPI funding has supported the development of a widely subscribed orientation program on the Canadian health system. At the moment, it is supporting the development of national assessment approaches for both international medical graduates and internationally educated nurses.

[*Translation*]

Some of the most persistent and critical health workforce challenges are around health care delivery to Aboriginal peoples.

Health Canada recognizes that Aboriginal peoples access their health care services from all levels of government — provincial/territorial and federal. We recognize that all health systems are facing shortages of qualified health personnel, and that there is at the same time a great need for both more Aboriginal health practitioners and more non-Aboriginal practitioners with some cultural competency in the care of Aboriginal patients.

[*English*]

The Government of Canada has been working to enhance and improve aboriginal health human resources for some time. In 2005, the government announced a new targeted investment of $100 million, over five years, for the aboriginal health human resources initiative, which is helping to develop and implement health human resource strategies that respond to the unique needs and diversity of aboriginal peoples.

The AHHRI is in its final year, and we are seeing some early results from our investments. For example, over the four-year period, between 2005-06 and 2008-09, we increased the number of aboriginal students receiving bursaries and scholarships for health career studies to a total of 1,398 students. Working with our partners, we've developed a number of tools to be used by Canada's 17 medical schools to help decrease barriers to admission and increase enrolment of aboriginal medical students.

A mid-term program review of the AHHRI is currently under way. It will give us more information on resources, implementation of activities, and outcomes. The review is expected to be completed by the end of May of this year. It will allow us to capture best practices and to formulate lessons learned in aboriginal health human resources.

In closing, I would note that although the three initiatives I've described very briefly today are relatively new, they are contributing to our progress in addressing some of the most compelling HHR challenges that confront governments, including several of the challenges the committee has identified in its terms of reference.

Thank you, Madam Chair.

● (1545)

The Chair: Thank you very much, Ms. McDade. You made some very insightful comments, and I know that the committee is looking forward to asking you some questions after we hear from everybody else.

From the Department of Citizenship and Immigration, we have Ms. Corinne Prince St-Amand, who is the director general of foreign credentials. Ms. St-Amand, please take the floor.

[*Translation*]

Ms. Corinne Prince St-Amand (Director General, Foreign Credentials Referral Office, Department of Citizenship and Immigration): Thank you, Madam Chair.

My name is Corinne Prince St-Amand and I am Executive Director of the Foreign Credentials Referral Office at Citizenship and Immigration Canada.

I want to thank the Committee for this opportunity to provide an overview of CIC's role in health human resources. Today I will focus primarily on the accreditation of foreign trained professionals.

[*English*]

CIC is involved in health human resources in a number of ways, from the selection of immigrants to their overall integration into society to helping internationally trained individuals get their credentials recognized.

I will focus this afternoon on the theme of your study as it relates to the accreditation of health professionals.

I think we all recognize that immigration has been and continues to be vital to Canada's growth and economic strength. However, recognizing the foreign credentials of internationally trained individuals continues to be a challenge across the country.

In Canada, the provinces and territories are responsible for assessing and recognizing credentials. The system involves many jurisdictions and stakeholders, including five provincial assessment agencies, over 200 post-secondary educational institutions, and more than 440 regulatory bodies.

In fact, over 53 provincial and territorial ministries are involved in this issue, and the issue spans immigration, labour market, health, and education ministries. There are literally thousands of players on this file when you include employers who are also important assessors of credentials and work experience in non-regulated occupations.

The federal government has an important role to play, which complements and supports the provincial and territorial roles, and that is to ensure that newcomers are able to put their talents, skills, and resources to work once they arrive in Canada.

[*Translation*]

To that end, in May 2007, the Government of Canada established the Foreign Credentials Referral Office to help internationally trained and educated individuals find authoritative and accurate information about the Canadian labour market and Canada's credential assessment and recognition processes.

[*English*]

The Foreign Credentials Referral Office provides a coordinated focus at the federal level to work with the provinces, with the regulatory bodies, and with employers to coordinate federal-provincial efforts, to share best practices across the country and across the myriad of players that I've mentioned, and to try to avoid overlap and duplication on an issue that is extremely complex.

Since it was launched in 2007, in-person services are now available across the country through 330 Service Canada centres. We have helped 46,000 people to date get the information they need. Our website has received over 550,000 visits, the majority from overseas, so people are starting to get the information they need before they arrive in Canada.

Prior to the establishment of the Foreign Credentials Referral Office at Citizenship and Immigration Canada, Human Resources and Skills Development Canada laid the foundation for consistent foreign credential referral processes by developing partnerships with provinces, territories, and other stakeholders. They also established an overseas platform as a pilot, to give skilled immigrants the information they need to start preparing to enter the Canadian labour market.

Our two departments will continue to work together as the Foreign Credentials Referral Office assumes responsibility for the overseas platform in the near future.

Provincial, territorial, and municipal governments also offer services to newcomers in many ways, including through the “Going to Canada” immigration portal. This tool helps prospective immigrants access in one place the services and information they need and reduces the requirement to navigate through a series of websites.

● (1550)

[*Translation*]

The Prime Minister, provincial premiers and territorial leaders recognize the importance of foreign qualification recognition to the economic health of the country. They have tasked the Forum of Labour Market Ministries, with the support of Immigration Ministries, to develop a pan-Canadian framework by September of this year.

[*English*]

To support the efforts from the first ministers, the Foreign Credentials Referral Office received additional funding in budget 2009, some $13.7 million over two years, to contribute to the development of a pan-Canadian qualifications framework by harmonizing standards and clearing pathways to foreign qualification recognition for high-priority, regulated occupations. Many, we expect, will be in the health field, beginning overseas.

The sooner prospective immigrants know the steps they need to take, the sooner Canada can benefit from their contribution to society and our economy. To address the physician shortage across the country, some progress has been made in several provinces by way of ensuring internationally trained medical graduates receive the certification they need to practise in Canada. For example, in 2008, more doctors were licensed than ever before in Ontario, with the number of foreign-trained physicians reaching a record high as well. Compared to 2007, this represents a 43% increase in the number of internationally trained medical graduates who have been licensed. Since 2004, statistics have shown a steady increase year after year in the number of licences awarded to such professionals in Ontario. In Alberta, 40% of doctors licensed in 2008 were internationally trained medical graduates, which is also the highest percentage ever for that province.

Thank you, Madam Chair. I hope this has provided you with an overview of CIC's role in health human resources.

The Chair: Thank you very much. It certainly has been very helpful.

Let's go on to the Department of Human Resources and Skills Development, Ms. Carol White, the director general of labour market integration.

Ms. Carol White (Director General, Labour Market Integration, Department of Human Resources and Skills Development): Thank you, Madam Chair.

I'm Carol White, director general of the labour market integration directorate at Human Resources and Skills Development Canada. Our area of responsibility is foreign credential recognition, labour mobility, and labour market information.

[*Translation*]

On behalf of RHSDC, I would like to thank the Committee for the opportunity to participate in a study of health human resources.

In my remarks, I would like to provide a brief overview of HRSDC's investments and activities as they relate to the labour market integration of health human resources, particularly the recognition of foreign-trained professionals.

[*English*]

HRSDC recognizes it cannot achieve its objective—which is having the best-educated, most skilled, and most flexible workforce in the world—by working alone, given that provincial and territorial governments and regulatory bodies have the primary jurisdiction over regulated occupations, including those in the health professions.

I want to speak first about labour mobility. Labour mobility is the freedom of workers to practise their occupation or trade wherever opportunities exist.

[*Translation*]

The Agreement on Internal Trade provides the basis for improving labour mobility for regulated occupations; including 29 health professions.

On January 16, 2009, first ministers signed a new agreement which included a series of amendments to the labour mobility chapter that will enhance the mobility of Canada's health human resources.

[*English*]

This marks a significant milestone. As of April 1, 2009, the credentials of Canadians' health care workers are to be recognized across provincial and territorial boundaries. This revised chapter of the agreement on internal trade states that any worker certified for an occupation by a regulatory authority by one province or territory is to be certified for that occupation by all others. Any exception to this mobility must be justified to meet a legitimate objective, such as the protection of public health or safety.

With full mobility in place, governments now have an added responsibility to ensure there is a consistent evaluation and entry point into the Canadian labour market. HRSDC's foreign credential recognition program provides contribution funding and works with provinces, territories, stakeholders, and other partners to facilitate the assessment and recognition of qualifications acquired in other countries.

● (1555)

[*Translation*]

Priorities for funding under the program include projects that are national in scope, that address priority occupations and sectors or those that have been identified as a priority by provincial/territorial governments. For any national project, there must also be clear evidence of provincial/territorial involvement and support.

[*English*]

Typical project activities that are funded through this contribution program are research and analysis, planning and process development, design and development of tools that will assist regulators in assessing the credentials and qualifications of the internationally trained, activations of systems to assess credentials, the development and dissemination of information, and partnership development and related implementation activities.

Since 2003 the foreign credential recognition program has made direct investments of over $11.8 million in health-related occupations. This amounts to approximately 19% of the program's overall $63.5 million grants and contributions funding since 2003. These investments have funded 28 different projects and represent 11% of all projects funded through this program.

[*Translation*]

Managers of the program maintain a regular dialog with Health Canada and committees of experts in the health sector in order to ensure the strategic investment of program funds and the prevention of funding duplication. Input and feedback from Health Canada officials are sollicited on health-related project proposals received by the program.

[*English*]

The foreign credential recognition program has made significant progress in strengthening the foreign credential recognition capacity of regulated and non-regulated occupations, and has facilitated strategic foreign credential recognition partnerships and initiatives across Canada and overseas. Many of these investments have directly contributed to the efforts of medical professions to address the recommendations made by the Canadian task force on licensure of international medical graduates in 2004.

The foreign credential recognition program began work with regulated professions in three priority occupations, two in the health sector, including physicians and nurses. Since that time our work has expanded to nine other health occupations. To give you a brief example of some of the kinds of projects we've funded, we made investments with the Medical Council of Canada to provide international medical graduates with increased access to the assessment and evaluation tools before coming to Canada.

The Medical Council of Canada developed an Internet-based self-assessment evaluation examination to help international medical graduates determine their readiness to challenge the assessment process for physicians in Canada. The availability of this MCC evaluation examination has increased approximately threefold since 2004 and it is now available in 20 locations, 12 of them outside of Canada.

The Medical Council of Canada has also created the physician credentials registry of Canada using funds from this program. International medical graduates can apply online to have their educational and training credentials verified while still in their country of origin.

[*Translation*]

Despite the progress of all governments, barriers to effective labour market integration for foreign-trained health professionals remain. Successful labour market integration requires that Canada has the right processes, information and resources in place to recognize the knowledge, skills and experience of immigrants.

[*English*]

In response, on January 16, 2009, first ministers directed the federal-provincial-territorial forum of labour market ministers to take concerted action to ensure that the assessment and recognition of foreign qualifications is consistent, timely, fair, and transparent across Canada.

By September 2009 labour market ministers will develop a principles-based pan-Canadian framework for foreign qualification assessment and recognition, along with an implementation plan to put the framework into effect.

First ministers have agreed to complete this work under aggressive timelines so as to ensure that initial subset of priority regulated occupations is achieving service standards by 2010. Where appropriate and practical, these service standards will enable the assessment of international qualifications to be completed within at least one year of the applicant's seeking licensure or registration.

The phased implementation plan will be guided by an agreed-to set of priority occupations. Health occupations are expected to be heavily represented amongst these priority occupations.

In closing, I would like to recognize the department's efforts to create an integrated system of fair and objective assessment processes and to increase consistency between jurisdictions with respect to recognition and registration processes for internationally trained professionals while also improving labour mobility across Canada.

Thank you, Madam Chair.

● (1600)

The Chair: Thank you very much. This has been very interesting. I have to thank Dr. Bennett too for her suggestion to have this extended.

I would like to now go to our physicians. This is quite exciting to hear right from the ground, the grassroots, and I've heard a lot about all of you.

Dr. Mary Fernando, we'll start with you.

Dr. Mary Fernando (Physician, As an Individual): Thank you. I would like to thank the committee for allowing me the opportunity to participate in your study.

My recommendation, and it's one I've worked on for a number of years now, is that to retain physicians and to protect our investment in the doctors we train, Canada should change federal tax laws to allow provinces to negotiate pensions for physicians. No physician in Canada presently can receive pensions.

There's a shortage of physicians, as you know. The two crucial facts about this shortage are, first, it's getting worse, and second, it's dangerous for patients. If we compare where Canada stood in 2004, when we had three million Canadians without family physicians, to today, we now have five million Canadians without family physicians. Or if we compare our OECD ranking for physician numbers, it has moved down from 16th to 26th.

Second, the shortage is dangerous for patients. An OECD study of 21 countries over 25 years showed that decreasing physician numbers increases premature mortality, infant mortality, perinatal mortality, and decreases life expectancy.

The problem for the federal government is that the federal government provides health funding for the provinces, but the federal government has a limited ability to ensure that this funding will successfully increase physician numbers.

There are migration pressures in the recent economic downturn. The average age of physicians in Canada is about 50, and many have lost 30% to 40% of their retirement savings in the present financial downturn. And the U.S. is expecting a 200,000 shortfall of its physician force by 2020. Further, President Obama is making it more financially rewarding to practise in the U.S. by initiatives such as decreasing malpractice and overhead costs and increasing reimbursement rates for primary care physicians. This combination of increased U.S. physician shortages and incomes with the reduction in Canadian physicians' savings has a potential to result in a tsunami of physician shortages in Canada.

Historical analysis shows that recessions are correlated with the exodus of physicians from Canada. I just want to make sure you have the chart in front of you. Perfect. If we take a look at these recessionary periods in the past and place them on a migration chart of Canadian physicians—this is the pie chart—we see a perfect correlation and a definite and unmistakable pattern. Recessions cause a serious exodus of physicians from Canada.

The solution is to act proactively with a solution that only the federal government can provide. It is time to make an historic change and allow physicians to obtain pensions. What is needed to implement this solution? My research shows that Canada is the only country that does not allow its publicly funded physician force to contribute to pensions. The federal government must change tax laws and deem physicians eligible for pensions. I've been told that by deeming physicians eligible for pensions, provincial agreements remain in place.

An overwhelming majority of Canadian physicians support pensions. In 2005 the general council of the Canadian Medical Association passed my motion to request that the federal government change tax laws to allow self-employed physicians to contribute to pensions.

A previous *Medical Post* poll found that 91% of physicians wanted pensions. Moreover, 76% considered it to be the most important negotiation strategy. A February 2009 *Medical Post* poll showed that 88% of physicians across Canada support pensions. The *Medical Post* is also starting an old-fashioned newspaper campaign to get pensions for physicians.

In summary, altering federal tax law to allow physicians to negotiate for pensions is a retention initiative that is strongly supported by physicians and protects the investments Canada has made in training physicians by reversing the historical trend of physician losses as a result of recessions.

For those of us who believe that access to health care is a basic human right, ensuring Canadians have access to physicians by retaining them with pensions is the right thing to do.

I hope this committee will act on this recommendation and coordinate with the CMA and myself to change federal tax laws, and do so in a way that provincial agreements are not impacted.

I thank you.

● (1605)

The Chair: I thank you, Doctor, for those very insightful comments.

We'll now go to Dr. Merrilee Fullerton.

Dr. Merrilee Fullerton (Physician, As an Individual): Thank you very much, and good afternoon.

When I began practising medicine two decades ago, there was concern about a physician surplus in Ontario and Canada. The boomer generation was predicted to be the healthiest of all previous generations, and the need for physician services was expected to drop. Scientific advances were going to keep people healthier, shorten hospital stays, and improve patient outcomes. The growing cost of Canadian health care was a concern even then and attributed in part to physician services.

In response, medical school positions were cut across the country, hospital beds were eliminated, and hospital wings mothballed. At the same time, practice patterns changed. More years of university education prior to medical school were mandated, and an additional year of training was added to the family medicine residency. Taken together, these separate actions all combined to create our current physician shortage.

Attempts have been made to fix this shortage recently. Medical training positions have been restored to previous levels and more, but it will take several years to repair the damage. Changing demographics, technological and pharmaceutical advances, and increasing patient expectations also play a part in current and future shortages of human health resources. Some of my numbers are very similar to Dr. Fernando's, and I'm not going to repeat those. We know that there are five million people waiting in Canada for a family physician. One million of them are in Ontario.

Let's look forward. Over the next 20 years we can expect a doubling of the number of people over the age of 65, a significant increase in the need for chronic acute care as well as long-term care, and double the number of serious chronic diseases such as cancer, diabetes, heart disease, and dementia, including Alzheimer's. A serious nursing shortage is predicted, in the range of 113,000 by the year 2016. That's a number coming from the Canadian Nursing Association. As well, there's increased competition from other countries, as Dr. Fernando has said, for our human health resources.

As a front-line physician, I see first-hand the difficulties these shortages are creating for my patients and the providers I work with. Almost daily I'm asked whether I know of any family physicians accepting new patients. I used to be able to give a couple of names, but now I don't know anyone. The family health teams in my area have wait lists. Some patients who are officially rostered—that means signed up with a doctor officially—tell me that they are waiting weeks for an appointment: two or three weeks, just to get in. They may have a family doctor rostered to them, but they can't get in to see them in a timely way.

Patients are having difficulty meeting disability insurance requirements because of lengthy wait times for specialists and diagnostics. They're at risk of losing their disability insurance because they can't access the resources they need to access.

Neurosurgical and orthopedic patients wait for diagnostics, such as MRI and CT, for many months. Then they wait again for months to see the specialist. This leads to increased anxiety on the part of the patient and the physician, not to mention potential deterioration and quality-of-life issues during the wait, which requires continued evaluation.

Waits for other diagnostics are rising in my area; patients are waiting months for a simple ultrasound. Some of this has to do with the lack of diagnostic technicians. It's not just physicians, not just nurses; it's the technicians for the diagnostics as well.

In family practice, multi-senior generations present unique and complicated problems. What I mean by multi-senior generations is that the patient is in their 90s and the children are in their 70s. In these cases, the provider needs to do more to arrange simple types of care. This, of course, requires additional staffing and resources, and it's very time-consuming in an office setting.

More patients are coming to me, even friends, neighbours, and acquaintances, and telling me about their dissatisfaction with the lengthy wait for care. I don't mean necessarily MRIs, CTs, and all the wait lists we see in the newspaper; this is just to get in to their family doctor, if they have one.

Staff may be discouraged that they cannot provide more timely care. We see morale suffering in the front lines.

● (1610)

While we look to other professionals and team care to improve the current situation, there are shortages of many other providers, including pharmacists and some of the others I've mentioned.

We can take steps to turn the tide. There are solutions, but you need to hear from us, and I thank the committee so much for inviting us here today.

As with anything else, the first step is to recognize the magnitude and the enormity of the problem. On that, the committee's work is crucial. We must develop a strategy to move forward to address the many challenges, only a few of which I've outlined, and ensure that all Canadians have timely access to quality health care.

I believe this strategy could include a cultural shift towards engaging patients and empowering them to take responsibility in their own care, including information technology improvements. I don't mean that we send things to the pharmacists so that they can get the prescription right; I mean linking patients to physicians and their staff in a direct way. We live in a modern world with modern communications. There's no reason why that can't happen, and it doesn't only have to happen with government help; it can happen with other groups.

I think we need to consider home monitoring and understand that this change involves technologies as well. It's already starting to happen. We see people doing blood glucose monitoring from home. The elderly patient does not have to drive in a snowstorm to the doctor's office, pay for parking, and wait. There are other ways to practise medicine, and family practice and physicians are crucial to that.

If the committee would do me the indulgence of remembering some of these things, I would very much appreciate it.

Thank you so much for inviting me today. *Merci beaucoup*.

The Chair: I can tell you, Dr. Fullerton, that not only will we remember it, but every word you have said is also recorded. We all, as a committee, selected this topic to be studied. This is not just a very brief thing; it's a very intense study, and we are very concerned. All members around this table are very concerned about it.

I want to thank you. Some of your insightful comments were just great. You think you've heard it all, and then people like you come in and we've got new ones again, so thank you.

We'll now go to Dr. Peter Kuling. Welcome.

Dr. Peter Kuling (Physician, As an Individual): Good afternoon.

My name is Dr. Peter Kuling. Thank you for this opportunity to appear before you to discuss the committee's study on health human resources.

I've spent most of my career practising family medicine in Prince Albert, Saskatchewan. There, I had an office and a hospital practice, where I did obstetrics, emergency, and both minor surgery and surgical assists. I had a predominantly aboriginal practice with very complex medical problems.

For the past ten years I have practised in the Ottawa area, again providing both office and hospital care. Now I train new family physicians, both Canadian and international medical graduates. This is all part of my role as the medical director of the Ottawa Hospital's interdisciplinary academic family health team. As someone on the front lines caring for patients while also training my eventual replacement, I see what has been called the perfect storm of demographics facing medicine every day.

Research done by the Canadian Medical Association backs up what I see. Most physicians work 50 hours a week, but 70% of them work an additional 30 hours on call. Only half of physicians are satisfied with their work-life balance. In fact, physicians have twice the suicide risk of the general population. One in four physicians experience mental health issues, with female physicians being especially at risk.

My typical work week involves seeing patients in the clinic and in the hospital and doing both resident and medical student teaching as well as administrative duties. However, I also have two rotating call schedules: one covering the hospital service, which is a predominantly geriatric population with dementia and medical and pyschosocial problems, and the other is my obstetric and newborn practice. This past week I delivered four babies after hours. One night I was the hospital from three in the afternoon until midnight. The next night I was in the hospital from ten p.m. until seven in the morning. Even with these two disrupted nights on obstetrical call, I continued my usual weekday clinics, teaching, and administration.

My work-life balance is better here than it was in Saskatchewan. In a rural setting even physicians who are not on call get called. They get called out at night to assist their colleagues. In my case, in Prince Albert, it was to deal with an overburdened emergency room, or an ambulance transfer of a patient, or assisting in the OR, or for an emergency surgery, or a number of other issues.

I have to tell you a story. I had a physician couple who are friends of mine from Prince Albert come to visit me in Ottawa. They're both physicians, and they have separate phone lines on each side of the bed. When they arrived in Ottawa, they were visibly exhausted. In fact they slept most of the weekend and then went back to Prince Albert. Why? Well, over the previous 30 days, one or both of them were out of their bed every night between midnight and six in the morning caring for patients. Did I add that they also have three children?

I'm not trying to pass on a sob story about physicians. The overwhelming majority of my physician colleagues love to care for patients, as I do. That's why we got into this work. However, the current reality is that the number of hours worked by doctors in clinics, hospitals, and offices across the country is not sustainable. The impact of hours on the health of physicians is devastating.

Our failure as a nation to develop a sustainable physician supply and an appropriate health workforce planning policy is driving physicians to alter, restrict, and, worst of all, abandon treating patients altogether.

● (1615)

We must never forget that all of this has an impact on our patients. We have too few physicians trying to do their best, caring for too many patients. This was made all too clear for me very recently when I came to our office and saw patients lining up in the cold weather outside our door before it was opened. They were lining up because one of my physicians decided to increase his patient population by taking five new patients a month. On the first day of the month, there's a lineup outside our door.

We simply must build a national strategy to ensure that all Canadians have access to a family physician, while also incorporating measures to improve access to specialty care. Such a strategy must recognize that the new and next generations of doctors are not working and will not work the ridiculous hours that physicians of my generation work.

Primary care physicians can and are providing excellent front-line care by working with allied health care providers in collaborative team environments. We must support these initiatives with strong workforce strategies or risk that the number of patients without a family physician will increase, and this will further clog our emergency rooms and our hospitals.

The core of any health care system is access to a primary care physician. With a strong, clear strategy we can strengthen that core while building a healthy physician workforce with a better work-life balance, because healthier physicians will lead to healthier patients.

Thank you.

● (1620)

The Chair: And I thank you. That was very compelling testimony, Dr. Kuling. Thank you very much.

We're now going to go into two rounds of questions. The first round is going to be seven minutes. I'm going to ask, with the indulgence of the committee, if we could go until quarter past five. I have some business I have to talk to you about before the break.

Does the committee agree to suspend at quarter past five? Is that agreeable?

Some hon. members: Agreed.

The Chair: Great. We're now going to go to questions. We will start with another doctor, Dr. Bennett.

Hon. Carolyn Bennett: Thanks very much, and thanks to everybody for coming.

I hope the doctors will understand, but I think we have to set the tone for what actually exists. I thank the officials for their remarks, but I want to know what the strategy is. In any strategy I've ever been part of, it's what, by when, and how. I haven't heard a strategy in terms of how we're going to close the gap for these five million Canadians who don't have a family doctor.

What timeline will it take until every Canadian has a family doctor? What do we know about pediatric nephrologists, pediatric neurologists...? What about the things we know we will increasingly need in geriatrics? What do we know could be increased by primary care reform and physicians being able to see more patients? I see a lot of programs, but I don't see a strategy.

Then I guess what I want to know is, on the FPT committee, what kind of reporting happens? How are the provinces doing? I don't think a strategy is just poaching doctors from province to province. What actually is the plan for the FPT committee? Do they have a strategy?

These words are a bit concerning: “These funds are not used for 'direct' HHR investments”. They're for data, but I didn't hear any. They're for policy research, but I don't know what that means. And “the identification and dissemination of innovative models....”

I would just like to know how you think we're doing on this in terms of reaching the goal of sufficient health human resources. There's a global health shortage. We're hearing this big sucking sound from the States.

What are we going to do as a country? What is the role of the federal government in working with the provinces and territories for us to get there?

I don't know if that stuff exists somewhere, and if you could table it with the committee, but I would like to know, by next year, in your strategy, will it be six million without a family doctor, or seven million, or will it be four million, if things went according to plan?

The Chair: Who would like to take that question?

Ms. McDade, you're a brave woman.

● (1625)

Ms. Kathryn McDade: Thank you.

That was actually several questions, and I'll try not to mangle the several responses.

Dr. Bennett, I will start from the end of your question. In respect of what progress is being made, I will acknowledge upfront that there is no hard national target for reducing the number of Canadians without a family physician, or, put another way, a hard target for the supply of health professionals.

Hon. Carolyn Bennett: In the aging nursing force, the average age is 50. How are we going to get it down? Do you have strategies for this?

Ms. Kathryn McDade: Maybe we should talk a bit about the numbers, and then flip over on the strategies. I heard you ask about the federal role and federal strategies, but I think you also asked more broadly about provincial-territorial strategies. I think at least two witnesses acknowledged that there has been considerable progress in the number of health professionals employed and the number who are in the pipeline. We have many who are still in training, and we expect the vast majority to go into practice.

You mentioned pediatric nephrology. I don't have here in front of me a full suite of statistics on the health professions, but between 2003 and 2007—the most recent years for which CIHI data are available—the total number of physicians increased by 7.1%. The comparable number for registered nurses is 11.7%. These are people actually in practice, employed.

Hon. Carolyn Bennett: But you're counting me.

Ms. Kathryn McDade: Well, I don't know if CIHI counts non-practising physicians, but you make a good point.

Hon. Carolyn Bennett: Jean Charest made that point in 2004, at the FMM.

Ms. Kathryn McDade: I can give you more written information on the methodology behind the data, but I take your point that there may be non-practising physicians counted.

In respect of the pipeline and who's in it, there has been a significant increase in the number of undergraduate medical seats. Over the period 2002 to 2008, there was an increase of 31%. That's a six-year period; that's not insignificant. These are undergraduate medical seats, people at the beginning of their training. It will be many years, as Dr. Fullerton said, until they're actually in practice. But there is progress.

On the issue of physicians leaving and returning to Canada, for the first time in the last couple years we've been in a slight net inflow position, so we no longer have more physicians leaving the country, Canadian-trained physicians, than we have coming back from practice or from studies in other jurisdictions. That's positive.

As for a national strategy, which I think is the core, what is the health human resource strategy? There is a pan-Canadian HHR planning framework, which I'd be happy to share with the clerk, that was approved by federal-provincial-territorial ministers in 2005. It acknowledges that provinces and territories retain responsibility for a whole range of measures that will actually affect health care delivery on the ground. But it makes shared commitments in particular areas: more rapid integration of internationally educated health professionals, as well as changes to both inter-professional education and inter-professional practice, which most experts acknowledge is an indirect way of dealing with the supply shortage. So there is a set of measures in the framework that's a combination of provincial-territorial activities and shared activities.

To go to your point, Dr. Bennett, about the federal role in this, in all of the areas I talked about—whether it's data, policy research, best practices—projects have been undertaken that are intended to support this national planning framework. I wouldn't call it a strategy, but a national HHR planning framework.

I don't know if I've missed any aspects of your question, but I've tried to answer all of them.

● (1630)

The Chair: Thank you, Ms. McDade.

Monsieur Malo.

[*Translation*]

Mr. Luc Malo (Verchères—Les Patriotes, BQ): Thank you very much, Madam Chair.

Madam Prince St-Amand, my question is directed to you. You have seven minutes to answer.

You stated in your presentation that thousands of organizations and individuals are involved in the foreign-trained workers accreditation process.

Could you explain in concrete terms how it works, what a trained individual has to do in order to be able to work here?

[*English*]

The Chair: Who would like to take that one?

Ms. Corinne Prince St-Amand.

Ms. Corinne Prince St-Amand: Thank you very much for the question.

I mentioned that there are many players involved in the assessment and recognition of credentials in this country. We have to think about it in terms of the regulated occupations as well as the non-regulated occupations.

In terms of regulated occupations, the over 440 regulatory bodies across the country are key players. There are also five provincial assessment bodies in the country that do credential assessment and recognition on behalf of some regulatory bodies and the individuals themselves. If they'd like to get their credentials assessed against Canadian standards, they can go to one of these five assessment bodies and pay a fee to get an assessment of what the equivalency would be in Canadian terms.

There is a project currently under way at HRSDC to develop a sixth assessment agency for the four Atlantic provinces. That project has been approved by the four Atlantic premiers, and discussions are under way about which province that provincial assessment agency will be situated in.

There are also over 200 post-secondary educational institutions that assess individuals' credentials for the purposes of further study. If you are a student living in France and you would like to come to Quebec to study at the Université du Québec, you need to see what the courses you have taken in France are equivalent to, or what existing diplomas or degrees you will be credited with before you are able to undertake further studies at a Canadian college or university.

There are virtually thousands of players in this field when you add individual employers who are faced every day with individuals' curricula vitae coming across their desks—often in other languages—with their credentials attached. The employer sits there and has to determine and decipher whether that individual has the skills and competencies to do the work the employer is looking for.

So it's not necessarily in terms of credential assessment for the purposes of licensure, as regulatory bodies are performing those tasks in the regulated occupations. Many of the health occupations are regulated. But in the world we work in, we're looking at both regulated and non-regulated occupations. It's important to assist employers as well with tools to assist these provincial assessment agencies that are in many cases dealing with those non-regulated occupations.

There are also more than 53 provincial and territorial ministries. When you think about the issue of credential recognition in this country and look across Canada province by province, including the territories, the issue is led in many jurisdictions by one of four ministries or a combination of ministries. It could be the immigration ministry, and it some provinces it is. It could be the labour market ministry. It could be the education ministry. There's always an interest in the health occupations to be played by the provincial health ministries. In my opening comments I was trying to give the committee a sense of the complexity of the issue by naming the thousands of individual players in the field.

● (1635)

The Chair: You have more time, Monsieur Malo.

[*Translation*]

Mr. Luc Malo: Would Ms. White like to comment?

[*English*]

Ms. Carol White: Yes. I would like to add that the very complex nature of federal credential and qualification recognition in this country has led first ministers to make the commitment to develop a pan-Canadian framework so that we can begin to work together as governments to develop assessment methods that are fair, transparent, and timely.

Individuals need to know how long it's going to take for their credentials to be assessed, what they may need to do in addition to the assessment so that they can become accredited, and if, for example, they are not to become accredited for whatever reason, what other opportunities there are for them in professions that may be related to the one they have their experience or their training in.

We think it's a significant commitment made by first ministers. We also think the agreement on internal trade succeeded because first ministers and all governments contributed and worked together on that initiative. We see the same kind of commitment with this pan-Canadian framework on credential recognition.

The Chair: Ms. St-Amand.

Ms. Corinne Prince St-Amand: Just to build on what Carol said about the first ministers' commitment, to respond to Monsieur Malo as well as to respond in part to Dr. Bennett's question earlier, first ministers, as Carol has said, have asked for the framework by September of this year.

In leading up to the first ministers meeting in January of this year, the forum of labour market ministers, right up to the ministerial level, all agreed that not only would they recommend to their premiers as well as to the Prime Minister what was needed and what labour market ministers were needed to be directed to do, but they also outlined a timeframe, and that was that within 12 months of the receipt of a full application for licensure, internationally trained individuals would have an answer as to whether they would be able to be licensed or not.

If they would not be able to be licensed, they would be provided with information on what further was needed. If they had no chance at all in being licensed, they would be given information on alternative occupations where they could use their experience, their expertise, and their training in an associated field.

So this is an important issue, in that for the very first time the issue of foreign qualification recognition has been squarely on the agenda of the premiers and the Prime Minister, and for the very first time we have seen a clear timeline and target that we are looking to achieve.

They also indicated that, where possible, the credential assessment and recognition processes would begin overseas. Again, we feel that beginning overseas will save some time in the process. Instead of allowing physicians to come to Canada and spend two to three years trying to figure out the system and having to perform other duties or other employment, they could in fact use the time in the immigration process while they were still in their home country to get at these issues in advance. That would save them from moving to Canada with their families and not being able to practise their profession. It would also save the country in terms of economics.

● (1640)

The Chair: Ms. McDade, I think you wanted to add a couple of comments as well. Then we'll go on to our next question.

Ms. Kathryn McDade: Thank you, Madam Chair.

Very quickly, because I know the time is running out, I just wanted to note that even prior to the commitment by first ministers, which Ms. White has indicated was only in January of this year, governments were working together under the advisory committee on health delivery and human resources on an integration and common assessment framework for both doctors and nurses. The framework on the common assessment for international medical graduates is under way. A business case has basically been developed and will be moving forward for approval. On internationally educated nurses, the work is at a more preliminary stage, but there again, there is a commitment by all governments to work on a national assessment service for nurses.

So in those two key professions, there's work that well predates what my colleagues have described being done by first ministers.

The Chair: Thank you so much.

Now we'll go to Ms. Hughes.

Mrs. Carol Hughes (Algoma—Manitoulin—Kapuskasing, NDP): Thank you.

I certainly appreciate the fact that you're here, and I certainly have a lot of concerns with regard to the health care sector. I have a sister who has Alzheimer's disease, and I know what it's like not having a place for her. I know that we're going to be seeing many more people with Alzheimer's.

I'd like a response to my question from the physicians as well, aside from some of the other comments. We've all heard reports of provincial recruitment and competition for all sorts of health professionals. Many smaller cities, let alone rural communities, are virtually bidding for health professionals. What is the department's assessment of the impact of the April 1 change to cross-border internal mobility? With the shortages, there have been fears expressed that lifting cross-border restrictions will see HHR migration to wealthier larger provinces and urban centres. I'm just wondering if this concern has been validated.

The other thing I was interested in knowing as well is in regard to the comment that there are 1,398 aboriginal students receiving financial assistance. I'm just wondering if you have a breakdown of the professions there.

The Chair: Who would like to answer that particular question?

Ms. McDade.

Ms. Kathryn McDade: I can try.

I'm sorry, Ms. Hughes, but I didn't catch the statistic on student financial assistance that you gave.

Mrs. Carol Hughes: You mentioned there were 1,398 aboriginal students receiving financial assistance to help them become medical professionals. I'm just wondering what the breakdown of those professions is, if you happen to have that.

Ms. Kathryn McDade: I'll turn that over to my colleague, as I don't know if we have it here.

Ms. Shelagh Jane Woods (Director General, Primary Health and Public Health Directorate, First Nations and Inuit Health Branch, Department of Health): I don't have it here, but I can tell you a little bit more about it, which is that it covers a whole range of professions. The aboriginal health human resources initiative that Kathryn referred to provides bursary and scholarship money to first nations, Inuit, and Métis in a very broad range of health-related occupations. So there are a number of medical students and nurses—you can pretty well name the profession—in the health field who are receiving assistance. I would be happy to get you the statistics.

Mrs. Carol Hughes: Yes, we would like to see those.

The Chair: Dr. Fullerton, did you want to make a comment on that?

Dr. Merrilee Fullerton: Yes. Regarding your question about mobility and licensing, one of the issues we found is that doctors who are willing to go to remote areas—even for six months or several months at a time—to do locum work are unable to get licensed in the province they're needed in. So the concern may be less about doctors moving to wealthier provinces. Ontario, as you know, is not doing all that well right now, and the other provinces are also having their difficulties.

I think the main impetus for mobility in licensure is to allow relief so that physicians can go and assist in another area, which would make life easier for them. What happens is that it's a domino affect. Doctors can't get the support they need there, so what happens is that they don't want to go to a remote area to work because they can't even get away for a holiday. But if you can provide more mobility for other physicians to potentially relieve the physicians already working in those areas, you will get, I think, an improved chance of people going to those areas as physicians.

Does that make sense to you?

● (1645)

The Chair: Yes.

Dr. Fernando.

Dr. Mary Fernando: Thank you.

I think that if you look at the numbers for mobility between provinces, they're quite small compared with the numbers of physicians we send out of the country. For example—and I have documents here to give you some numbers—we have sent 19,000 Canadian-trained physicians to the States in the last 30 years.

I also want to point out something very important. When we train physicians, there's no guarantee we will keep them. Very importantly, the CIHI figures are under-estimates. For example, if you use the CIHI figures for physicians going out of the country and coming back into the country over the last 30 years, we're missing about 4,000 physicians. However, strangely enough, we have over 9,000 physicians, I think, practising at this point in the States alone. So we are not catching physicians as they leave.

I think that's a far more serious problem. That's where the majority of our physician losses come from.

Mrs. Carol Hughes: Thank you.

Did you want to add something?

Dr. Peter Kuling: I think I heard you mention two other points. One was on the mobility between rich provinces and poor provinces. There is no doubt that the richer fee schedules do take the new graduates to their province and rob from the other provinces. That's very clear. I see that with the new residents I train who are looking for a province to practise in.

There is no standard across the country to make sure that rich and poor provinces.... They do steal from one another, and that is a problem.

The second part that I also heard you mention is that rural practice is suffering. Rural practice is suffering. It's very difficult to get relief physicians for a vacation, but it's also very difficult in rural practice to carry on your day-to-day activities. And there are many rural communities that are doing everything—they're standing on their heads—trying to recruit physicians into their small communities.

The problem here is that there is no relief on a day-to-day basis, and I think there has to be some sort of strategy to amalgamate small communities so that you could take a Wednesday off or you could not be on call for maybe two or three nights in the week so you could catch up on your sleep. So there is a real issue there, too.

Mrs. Carol Hughes: Do I still have a few minutes?

The Chair: You have one more minute, Ms. Hughes.

Mrs. Carol Hughes: Concerning the comments from Health Canada and HRDC on current thinking on attracting and retraining health professionals to rural and isolated communities, I'm just wondering where the federal thinking is leading at this point.

The Chair: Who would like to take that question?

Ms. Woods, would you like to do that one, please?

Ms. Shelagh Jane Woods: Sure. Could you just repeat the question?

Mrs. Carol Hughes: Basically we're trying to figure out where the federal thinking is with regard to whether there is advancement, or what the thoughts are with regard to trying to attract physicians and retraining physicians specifically for rural communities and isolated communities.

Ms. Shelagh Jane Woods: There are a couple of things. I work in the first nations and Inuit health branch. We have regional offices, and each one of those has one or more physicians. There are now a number of first nations health authorities. Each one of those has a physician or physicians attached to it.

As you can imagine, the kinds of difficulties that we've heard about are, if anything, magnified in the first nations context. We're not always a competitive employer. We can't pay as much as wealthier jurisdictions. The conditions are extremely difficult. So in many cases the branch and the regional offices resort to innovative practices such as they can.

Because provinces are really responsible for the provision of primary care, when it comes to primary care we make arrangements, for example, in Manitoba with the northern medical unit of the University of Manitoba to supply the doctors. Because it's not practical to say each community or even each large grouping of communities will have a full-time doctor, we have a whole roster of physicians who will spend a certain amount of time in a certain community. They're associated with universities, or they have their own practices, so it's done on a part-time basis. We're realists: we know we won't be able to attract full-time physicians for most of these places.

On the training and development side, we're quite excited about the recent developments in adapting the curriculum for medical students to give them sensitivity to an awareness of aboriginal needs—cultural competency is what we like to call it—and all of the 17 medical schools in Canada have agreed to adopt this new curriculum and adapt it and work it into their own.

Over time we see that is more welcoming, not only to the many aboriginal students who are picking up medical studies, but also to the non-aboriginal practitioners. And the reality is that aboriginal people will be served in large measure by non-aboriginal practitioners, particularly in urban settings. So we're trying to enhance and increase the number of people who have that kind of cultural competency, if you will, an ability to medically treat patients in the way they would like to be treated. So we think this will make a big difference over time.

The other thing is, of course, often as people get exposed to this, they become very interested in it, so part of it is really awareness-building.

● (1650)

The Chair: Thank you so very much.

Now we'll go to Dr. Carrie.

I'll give you the floor, Dr. Carrie. I'm hoping that everyone will listen carefully to this.

Mr. Colin Carrie: Thank you very much, Madam Chair. I'd like to split my questioning with my colleague from Kamloops.

I'd like to talk to the officials a bit about the foreign credentials program. I'm very proud that we made the investment, and I do think it's overdue.

I come from Oshawa, and we're very underserved. A friend of mine actually married a western-trained physician-surgeon from China, who was having problems getting accredited here. She ended up going back to school here for traditional Chinese medicine. I thought it was quite ironic that we had a western-trained physician-surgeon who came here to learn traditional Chinese medicine. She's practising that right now. She seems to be quite happy. She doesn't have the hours of Dr. Kuling.

I think it's a little discouraging. Do we keep statistics on where most of the foreign health care workers come from?

You mentioned the Medical Council of Canada, which has assessment offices. How many different languages are there in these assessment offices?

You mentioned that there are 12 offices outside Canada. We talk about poaching from other countries. How many health care professionals, when they come here, actually end up working in their fields?

If we find that most of the health care professionals are coming from certain countries, are we able to set up offices overseas?

Can you answer those questions in three minutes?

Ms. Corinne Prince St-Amand: I'll try my best, and I would like to actually split my answer with my colleague from HRSDC, because I think the statistic that you referenced was a project that has been funded from HRSDC's foreign credential recognition program, funding to the Medical Council of Canada.

You mentioned China, and I'm glad you did, because the foreign credentials referral office is, as I said in my opening statement, going to be taking over the overseas component of a pilot that HRSDC has currently in place. The Association of Canadian Community Colleges is being funded to actually have offices in three countries around the world—three of our top source countries, actually. They have offices in the Philippines, in Manila; in China, in Guangzhou; and in India, in New Delhi. They also are currently offering itinerant services. So from the Guangzhou office, we have itinerant service in Beijing as well as in Shanghai. And in India, there is itinerant service in Chandigarh as well as Ahmadabad.

What is offered overseas is information, pathfinding, and referral, to try to get ahead of this issue I raised earlier about immigrants coming to this country and just only then beginning their employment search, their pathway to credential assessment and recognition. So individuals are offered up to a two-day session where they are getting information on employment in the Canadian provinces and territories. They've decided where they would like to land, and they can focus their queries on that particular province and the cities within that province. They're getting information on the process of credential assessment and recognition and the fact that if they are a physician, if they're going to land in Toronto, they're going to have to see a different regulatory body than if they would like to land in Vancouver.

They are actually completing an action plan in that two-day session, where they are learning about social insurance numbers. They can have access to a website that is actually an HRSDC product called “The Working in Canada Tool”, which has up-to-date information not only on all of the regulatory bodies and the national associations, but also on live employment opportunities coming off the job bank. So they can actually connect with a potential employer while they are in their home country.

There have been some really successful cases where individuals are connecting with employers overseas, landing at the airport and starting work the next day. That really is the vision. That is the strategy to really speed up this process: beginning to do as much of the credential assessment, as much of the job search, as much of the language assessment, all overseas, while they're still in their home country, waiting in the various times they are given to complete their medical checks, security checks, etc., using that window of opportunity in the immigration process to do as much there as possible.

● (1655)

The Chair: I understand this is a very important question. I also have noted that Dr. Fullerton and Dr. Kuling would like to make some comments on it as well.

Dr. Fullerton.

Dr. Merrilee Fullerton: Yes, thank you, Madam Chair.

I think we tend to focus on the IMGs, the international medical graduates, as being a solution to our physician and health resource problems here. They are a small part of that solution. Certainly I can understand why we're focused on them, because it's certainly going to help in the short term. But I'd like to reiterate Dr. Kuling's point, which was we really do need a more sustained, self-sufficient source of physicians. From my readings and my understandings, the studies indicate that when IMGs tend to arrive here, they will locate often in rural areas because that's where their positions are, but they eventually, after a few years only, are often migrating to the cities, to the urban centres. There are good statistics to show that, but I don't have them in front of me here today.

So as much as we would look to the IMGs as being a solution, they're a small part of the solution, and I'm hoping that we're coming up with a better long-term strategy for this. I also don't agree with the ethics of taking away physicians from other countries, just as we wouldn't want 200,000 physicians, every single physician we produce here, to be drained to the United States.

So I think we have to be cognizant of the big picture, and I appreciate that. Thank you.

● (1700)

The Chair: Dr. Kuling, you also have some comments.

Dr. Peter Kuling: I think of the residents I have been directly involved in training just in the past two years. I've had residents from Tibet, Pakistan, Iraq, Egypt, and the Caribbean, and all very excellent. But I get the end product; they come for their assessment and their verification period. It's certainly not quite as easy, as you would understand, to grant a license immediately. All of these foreign-trained physicians were very grateful to have at least a two-year residency to understand the culture and the way we do things—the medications, the treatments, and so forth—and meet our Canadian standard so that they provide safe care.

I run a training centre that we are committed in the next three years to triple in size, tripling the number of residents. Right now, we are faced with trying to get capital funds to expand our centre—nothing fancy, just for examination rooms where we can see patients and observe and teach and so forth. Our frustration is that we have to go to the government and have to hit five different silos of funding provincially. There is no coordination. Everybody increases medical school enrolments and brings in IMGs, and we're at the very end, where we have to the residency training. Nobody has thought out how to expand our current teaching facilities so that we can actually accommodate this.

I see a crisis looming there. We're playing off all different kinds of silos in this.

The Chair: Dr. Fernando, please.

Dr. Mary Fernando: To address what Mary was saying about IMGs, I would like to table a study by, I believe, the Canadian Medical Association that shows that the average duration of IMG practice, after they have been trained in Canada, is three years.

The second thing I would like to table shows.... If we aren't even able to keep our own physicians, we have a problem. We are second only to India as a supplier for the American medical market—second only to India. We train world-class physicians. Quite frankly, my issue is why we don't give them pensions and keep them here or give them more money—you pick it; pick whatever you want. If you think we can afford more money from a public purse, do that. But we can't keep training doctors and shipping them out while having IMGs come and stay here for three years.

Would you like both of these documents?

The Chair: Yes, please, if you would, table them; I'd really appreciate it. We'll distribute them among all our committee members.

Unfortunately, we've run out of time. We'll have to put you down for the next question, if that's okay, Ms. McLeod.

Could we please now go to our next round? This is a five-minute round for questions and answers.

Dr. Bennett, please. Are you sharing your time with...?

[*Translation*]

Mr. Luc Malo: We will not have enough time for a full round since we only have ten minutes left.

[*English*]

The Chair: We'll do the best we can.

[*Translation*]

Mr. Luc Malo: Maybe we could allow three minutes.

[*English*]

The Chair: Three minutes per round?

Hon. Carolyn Bennett: We can go a bit longer. The committee could decide to just have a five-minute round, and we'll go until we're done. Do you really have 15 minutes of business, Madam Chair?

The Chair: I did, but I'm flexible on it. What is the committee's...?

There's actually two hours' worth.

Anyway, we could do the next round. We'll go to 5:30. I'll take five minutes with you to tell you what I need you to do for the next meeting, then, and we'll dispense with the other.

Dr. Bennett, are you sharing your time?-

● (1705)

Hon. Carolyn Bennett: Yes, I'm sharing my time with the physicians. I'm going give them all of my time, because they don't often get a chance to ask the officials questions. We don't often have these kinds of interesting mixed panels.

If Dr. Kuling or Dr. Fullerton or Dr. Fernando had questions for the officials, I would enjoy hearing them.

The Chair: Dr. Kuling, you're up first.

Dr. Peter Kuling: I would love to ask that question to the officials. It's nice to have the strategy in which.... It's two questions, or one question and basically part of my last comments. We've had a strategy of increasing medical enrolments and we've had a strategy of trying to streamline international medical graduates coming into Canada, gaining acceptance, and getting into our training programs.

Is there a strategy to roll that all the way through their training, with all the capital investment required and the HR teachers? We need teachers to assess and train and to get them licensed and into practice. What types of meetings are ongoing with the provinces, so that I just have to go to one person to say yes, we can triple our unit; yes, we want to hire three more teachers and accommodate these new students? Have you taken it from A all the way through, or is the ball dropped once they're here and have become Canadian citizens and we have recognized their credentials?

The Chair: Who would like to answer that?

Ms. Kathryn McDade: I'll try that one, Madam Chair.

The honest answer is that there is not engagement at the federal-provincial-territorial level on issues related to capital funding for hospitals and universities. That responsibility for both undergraduate medical education—and I know you're focusing primarily on residency training—but also of course for ongoing professional development does rest squarely with the provincial governments.

Hon. Carolyn Bennett: They can apply for Canadian Foundation for Innovation money if they're doing research like Peter is.

Ms. Kathryn McDade: The specific questions you're asking around how many places I need to go to to put together the capital funding, or put together the combination of the capital funding, the support for teaching resources, and maybe on top of that the support for clinical resources in the clinical setting, that responsibility for those on-the-ground choices and decisions is clearly made by provincial-territorial governments, and no, there is not engagement on that level of health care delivery decision-making.

Along the lines of Dr. Bennett's intervention, although there isn't a federal role in the decision-making, there's rarely very clearly a federal role on the financial side in terms of supporting many of those decisions. At the broadest level, our primary support for medical education and for employment of the health care workforce is via the Canada health transfer, which is the major federal transfer that supports health care delivery. In that context, as you well know, the federal government committed some time ago, in 2004, to a significant increase in that transfer and to an annual escalator of 6% that is built in to the transfer. That was recently confirmed by the government. At that level the federal government is not uninvolved; it has a role in financing provincial health care delivery.

Dr. Bennett mentioned the Canadian Foundation for Innovation. There's a whole tier of support for research and development, whether it's through CFI, through dedicated research chairs, through the work of CIHR, and we could go on and on. Some of those are not within the responsibility of Health Canada, so I wouldn't be in a position to provide details, but that would be my general answer.

The Chair: Dr. Fernando is next.

Our time is just about up.

Dr. Mary Fernando: Jumping off from what you just said in terms of being a major financial contributor to health, as the federal government is pouring money into increasing training, into IMGs, into the health care system in various ways, what is your policy for retention? I want to come back to the fact that we train enough, but we don't keep them. Unless we answer that question, it's like pouring money into a sieve. I can understand the federal frustration of pouring money in and not getting the numbers one would expect. On a public purse we cannot compete with the mammoth we live beside. We need a retention strategy.

● (1710)

The Chair: Who would like to answer that question?

Ms. McDade.

Ms. Kathryn McDade: I assume you'd like me to be brief, as much as I possibly can.

The Chair: Yes, please.

Ms. Kathryn McDade: At the level of health care delivery and the retention of individual physicians, with the exception of my colleague who is responsible for first nations and Inuit health care, in the vast majority of cases those decisions on specific policies and incentives rest with the provincial-territorial governments. So whether it's compensation, enhancements, relocation assistance, return of service agreements for students who are still in studies and incurring student financial—

Dr. Mary Fernando: The federal government does prevent the provinces from using pensions as a retention matter.

Ms. Kathryn McDade: On the pension issue, with apologies, I'm not a tax law specialist and I'm not going to try to comment on pension law.

In closing, in my comments I did outline a number of ways, from policy research, data perspective, and innovative models, in which the federal government has supported provincial-territorial governments in addressing the challenge around recruitment and retention. I'm not going to go through all of them again. I think they're set out in the notes.

The Chair: Thank you.

Dr. Fullerton, you had a comment.

Dr. Merrilee Fullerton: Very briefly, it appears in the modern era in which we find ourselves that you cannot talk people numbers in human resources alone. You must talk along with IT and new communications. To have human resource groups here but not have, somehow, an interface with a group for Internet technology is just old. I think we have to understand that you must use both.

The Chair: Thank you.

We now go to Mr. Brown.

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

I'm a bit frustrated by the whole issue of physician shortages. In my riding there are 30,000 people without a family doctor. It tends to be one of the things I hear most at the door or at my office. One thing in particular that is a bit frustrating is that I know of eleven foreign doctors in my riding who seem to have similar challenges. So I'd like to delve a little bit more into a few of the comments mentioned today.

First, when people ask me about what we're doing, I obviously reference the foreign credential office, but it doesn't seem to be of significant benefit to people in this predicament. For the eleven doctors that I know of, the challenges relate directly to the fact that the cost of books ranges from $1,000 to $2,000, and they're making minimum wage and can barely afford the books. What, if anything, is being done to help with the process of going through that equivalency exam for new Canadians?

Secondly, the bigger challenge that foreign doctors appear to face in my riding is that they can't get a residency spot even after they've been successful in the equivalency exam.

Is there anything the foreign credential office does to assist in those two particular circumstances: with the cost of the books for the equivalency exam and the cost of the exam itself, and the next steps after they pass the equivalency exam?

The Chair: Who would like to answer that? I share Mr. Brown's sentiments.

Ms. McDade.

Ms. Kathryn McDade: On the issue of financial assistance related to the equivalency and additional training, I'd have to get back to you on whether there is a specific mechanism. If there is one, it would be student financial assistance, and it would be an HRSDC mechanism. I'm afraid I don't know that. None of us are actually responsible for student financial assistance and probably don't know that area well enough to respond.

Mr. Patrick Brown: They're not really students any more. These are people who have been practising in their countries for 10 or 15 years.

The Chair: I'll just intercede here. Dr. Kuling, I think you wanted to make some comments on this.

Dr. Peter Kuling: Yes.

I have tremendous respect for the training and the experience that these international medical graduates have gone through. When I think of those residents I've just told you about, the ones I've trained, they were all practising in their previous environments. But I can't name one of them who would have been safe to practise without going through the two-year residency program with me. It might be hard to understand, but being a physician in Iraq is a lot different from being a physician in Canada.

● (1715)

Mr. Patrick Brown: I completely understand that.

Dr. Peter Kuling: These were all practising physicians, some of them with as much as ten years of experience. None of them are practice-ready at that point.

Mr. Patrick Brown: My question is about how difficult it is to get a residency spot.

Dr. Peter Kuling: Agreed. I would love to triple my site, but it's not easy.

Mr. Patrick Brown: What, if anything, is being done to assist with the difficulties financially of writing an equivalency exam? And once these people have written the equivalency exam, what are we doing to remove barriers to getting a residency spot?

Dr. Peter Kuling: Agreed. That's not my area. I accept them once they're there.

The Chair: Ms. McDade.

Ms. Kathryn McDade: I don't have a statistic for you, but in my answer to Dr. Bennett's question, I did quote the statistic from CIHI that there has been a 31% increase in undergraduate medical seats.

I can't tell you, because I don't have the number in front of me, what the relevant increase in residency seats is, but obviously the expectation of the provinces and of the clinician trainers is that the vast majority of those undergraduates will move on to residency.

As you point out, there is also room in the residency matching service for international medical graduates who didn't do their undergrad training in Canada, so there's no question that there are increases in the availability of those seats. I don't have a number in front of me, but whether it's for Canadian-trained undergraduate medical students or for international medical graduates, there has been an increase—there has to be—at the residency end to accommodate those undergraduate students.

Mr. Patrick Brown: Do you have any estimates on how—

The Chair: I'm going to intercede here for just a minute, because time is up. I just want to say that we are bringing in experts on recruitment, and they will have the answers to those questions in our subsequent meetings. We can understand that you don't have the complete answer, but I hope that's helpful.

Let's go now to Monsieur Dufour.

[*Translation*]

Mr. Nicolas Dufour (Repentigny, BQ): Thank you very much, Madam Chair.

I must say that I liked the exchange between the physicians and the officials from Health Canada. The time they had to put their questions to Health Canada was probably too short. So I would like to give them more time to ask their questions and to hear the answers of the officials.

[*English*]

The Chair: Who would like to answer that? Dr. Kuling.

Dr. Peter Kuling: I heard the answer from the officials about the federal-provincial sharing for ensuring that when we increase medical school enrolment there are enough residency spots, and capital, teachers, buildings, and exam rooms.

What I haven't heard is whether the federal government—I know they fund the provincial—are actually holding the provinces' feet to the fire to make sure that this sort of planning occurs. Because otherwise you're planning in a void. You're planning all this increased funding for increased spots and all the rest, and you get different provinces around the country that may or may not plug that into my teaching centre or an equivalent teaching centre somewhere else.

I'm still frustrated, and I wonder if there's some mechanism whereby the federal government can hold Ontario, Saskatchewan, or Newfoundland accountable and ensure that there are training centres at that other end. I'm feeling that frustration at the other end.

The Chair: Ms. McDade.

Ms. Kathryn McDade: Thank you for the question.

What I would say is that there isn't accountability at the level that you're describing. So, no, there is not any federal intervention with the provinces of Saskatchewan and Quebec or other jurisdictions with respect to specific decisions they're taking about your centre or any other medical or teaching facility. That's not the context in which major transfers are provided to provincial and territorial jurisdictions for health or other social programs as well. So not at that level.

At the broader level of shared principles around supporting recruitment and retention, moving to inter-professional practice and more rapid integration of international medical graduates, that's the document I referred to earlier—the HHR collaborative planning framework. There are shared commitments. There are principles underlying the way the governments will work together, and those principles support the very areas you're talking about. However, it wouldn't be accurate to say with the level of detail you're talking about that the federal government has any accountability relationships with the provinces.

● (1720)

Dr. Peter Kuling: Thank you.

The Chair: Mr. Dufour.

[*Translation*]

Mr. Nicolas Dufour: Other witnesses would like to comment.

[*English*]

The Chair: Okay. Anybody else?

Dr. Merrilee Fullerton: I would just like to ask if there is any national approach to education, because part of the equation here is demand. The other part of it is supply. When we have large numbers of people seeking to increase health care more and more, there are many things that they can do as individuals through the education system. I know that's provincial, but is there any program nationwide to educate people, not in terms of the shortages, but in terms of first aid, in terms of care that they can provide—

Hon. Carolyn Bennett: Self-care.

Dr. Merrilee Fullerton: Self-care, yes. Again, I understand that health is provincial, but is there any national plan for something like that?

Ms. Kathryn McDade: I'm not personally aware of any federal investment in education at the level of self-care and first aid, but I'd hasten to add that through the Public Health Agency of Canada—I can't speak to the details, not being from that organization—there are obviously a whole range of health promotion and health prevention initiatives. I apologize that I can't give a more precise answer, but I don't know the programs well enough.

The Chair: Dr. Bennett.

Hon. Carolyn Bennett: B.C. had a really nice one that had a chance of rolling out across the country. We should look at it.

The Chair: Dr. Fernando, I believe you had a question you wanted to ask.

Dr. Mary Fernando: No, thank you.

The Chair: Okay, I just wanted to give you the opportunity.

We'll now go to Ms. McLeod.

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): Thank you, Madam Chair. I didn't think we were going to get this far.

My take-home so far from the discussions that we've had is that first of all, I don't think we've had near enough opportunity to hear from Shelagh Woods. The whole aboriginal issue probably has its own context, which we need to perhaps look at in the future.

Obviously, we haven't had nearly enough time to talk about the opportunity for technology to support human resource issues, for primary care teams to support human resource issues, and what incentives will actually be effective in terms of human resource issues and maintaining our practice professionals.

I had the opportunity to go to a conference in Clearwater, British Columbia, on health human resources. They had the Minister of Health there, and Health Match B.C., and the academic institutes. It was funny, because it seemed they were completely disconnected from the thought that the federal government had any role to play. That was quite interesting for me.

When I listened to the Minister of Health for B.C., it was about having new seats and really getting things together, and then when you talk to the CMA, it's that the residency seats just aren't there. So there's that disconnect—which you suggested is a huge issue—in terms of medical residency seats.

To get to a question, Carol White spoke about the interprovincial mobility as of April 1. I was just wanting to understand a few more details. Right now, can an RN in Ontario immediately go to B.C.? Can a doctor? I would presume nurse practitioners can't, because there are varying standards. Could you tell me more about that?

Ms. Carol White: Actually, we brought Brendan Walsh with us, who is our special advisor on labour mobility. He'd be happy to respond to your questions.

Mrs. Cathy McLeod: Mr. Walsh.

Mr. Brendan Walsh (Manager, Labour Mobility, Department of Human Resources and Skills Development): I guess the short answer is that we're getting there. With the new agreement, the new chapter for labour mobility, that is one of the objectives of the agreement, that if you're certified in a regulated profession in one province, you're to be certified in another.

I think we'll start to see the outcomes of that commitment happening over the coming weeks and months as provinces, with this date of April 1, make the decision for each of the professions that they regulate on whether they will recognize people from other provinces or not.

There are some allowances in the agreement that will allow a province to take an exception against recognizing workers, but we're confident that given the high degree of commonality in standards across Canada, most of the professions you mentioned will see their workers be certified either immediately, in most provinces, or over the coming weeks and months as provinces each make that decision.

● (1725)

Mrs. Cathy McLeod: So if you're nursing in Ontario, it would be perhaps simply a matter of a quick registration with the college in British Columbia.

Mr. Brendan Walsh: That's right. You'd still have to be registered and certified in the other province, but it should effectively be seamless, without any delays, additional costs, or reassessment, unless a province can prove that there is a need for that because of a broader scope of practice.

Mrs. Cathy McLeod: If I have a minute—

The Chair: Did you have another question, Ms. McLeod?

Mrs. Cathy McLeod: I think Dr. Kuling also wanted to comment.

The Chair: Dr. Kuling.

Dr. Peter Kuling: I would love nothing better than to go back and help my colleagues in Prince Albert once in a while, because I still have a fondness for that area, that practice, and that style of practice. The barrier used to be recognition, and it is no longer; they recognize my credentials here and in Saskatchewan.

But there's another barrier. If I want to go and work a one-week relief in my former community of Prince Albert, I have to pay for a full-year licence with the college. I don't get a prorated one-week licence; I pay a full year's licence. Guess what? I'm not going to go. I would have to go for at least three months to make it worth while. That's been a barrier.

I don't know if I'm allowed, Madam Chair, to ask through you to Mr. Walsh—

The Chair: Dr. Kuling, to be quite frank, we're running out of time.

Dr. Peter Kuling: Fair enough.

The Chair: I have to thank the witnesses very much for coming today. It's been very enriching and very insightful. We really appreciate the input all of you have made into our committee.

I'm going to ask the committee to stay a couple of minutes. I have to give you some information. If we could say goodbye to our wonderful witnesses, I'm going to suspend for one minute.

I'll ask that everybody please leave the room, so we can get on to committee business.

[*Proceedings continue in camera*]

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