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Chair

Mrs. Joy Smith

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● (1535)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): Order.

Good afternoon, committee members.

To the witnesses, we welcome you. I have just a couple of quick things to deal with before we start with your presentations. But we certainly do welcome you here today from the Canadian Institute for Health Information, Health Council of Canada, Canadian Health Services Research Foundation, and Canadian Institutes of Health Research.

Again, thank you so much for joining us. If you will just bear with me for about five minutes, we will go through a couple of things.

Committee, in front of you is a request for a budget to pay for the witnesses—close your ears, witnesses—and this is what we have to consider: that the proposed budget in the amount of $111,700 for the study on health human resources be adopted, and that the chair present the said budget to the budget subcommittee of the liaison committee.

If you're all agreed, could I have the go-ahead for the committee right now to adopt the budget?

Some hon. members: Agreed.

The Chair: In terms of the main estimates, the supply period will end on June 23, so on May 12 we will have agencies appear. We'll talk about that next meeting, I think.

We'll go to the witnesses now, and we'll begin with the Canadian Institute for Health Information. Jean-Marie Berthelot is the vice-president of programs and executive director of the Quebec office, and Francine Anne Roy is the director of health resources information.

Jean-Marie, would you please begin? Thank you.

Mr. Jean-Marie Berthelot (Vice-President, Programs, and Executive Director, Quebec Office, Canadian Institute for Health Information): Merci. Good afternoon.

On behalf of CIHI, the Canadian Institute for Health Information, I would like to thank you for inviting us to participate in this round table on health human resources.

[*Translation*]

CIHI—that is the English acronym—is an independent, not-for-profit corporation that provides essential information on Canada's health system and the health of Canadians. Established in 1994, we are funded by federal, provincial and territorial governments. We report to an independent board of directors representing government health departments, regional health authorities, hospitals and health sector leaders across the country.

CIHI works in partnership with stakeholders to create and maintain a broad range of data bases, measurement tools and standards on health information. We produce reports on health care services, population health, health spending and health human resources.

While it is not our mandate to make policy recommendations, we hope our impartial information will assist you with your work.

[*English*]

More than one million people in Canada—6% of the total Canadian workforce—are employed directly in the health care sector. Women represent about 80% of this health care workforce.

CIHI has been collecting detailed information on physicians and nurses since its inception. In response to the pan-Canadian health human resources strategy that Kathryn McDade from Health Canada discussed with this committee, CIHI has created new databases that provide detailed demographic and workforce information on occupational therapists, pharmacists, physiotherapists, medical laboratory technologists, and medical radiation technologists. CIHI also collects aggregate data for an additional 17 health occupations, including chiropractors, midwives, and psychologists.

We did distribute to members a copy of the report that includes a profile of those 24 professions. And since our most comprehensive data are on physicians and nurses, the majority of my remarks will focus on these professionals.

In terms of demographics, the number of physicians in Canada has increased slightly faster than the population since 2003. In 2007, the latest year available, there were nearly 64,000 active physicians in Canada. The number of new physicians entering practice has also been increasing since 2003.

The average age of physicians in Canada was nearly 50 in 2007, with one in five physicians aged 60 or older. Their retirement patterns tend to be different from many other workers in Canada. Many studies have revealed that physicians tend to phase slowly into retirement rather than just leave at a precise age.

Younger physicians and female physicians, regardless of age, tend to practise differently from their older peers. They place more emphasis on work-life balance.

While Canada has a smaller ratio of doctors per 1,000 inhabitants than the OECD average, it has a higher ratio of nurses. This is likely due to differences in models of care. Central European countries tend to have more physicians, while the British model, which more closely resembles Canada's, relies more heavily on nurses.

● (1540)

[*Translation*]

Regulated nurses represent the largest group of regulated health professionals in Canada, with more than 332,000 members. The growth rate of this entire workforce was 7.5% between 2003 and 2007. During this time, the Canadian population grew at a rate just above 4%. The average age of regulated nurses is 45, about 5 years younger than physicians. Almost 22% of them were 55 or older in 2007.

With respect to inter and intraprovincial migration, a CIHI study on migration patterns of health professionals in Canada shows that more than 18% of them moved between 1996 and 2001, which is about the same percentage as for the general Canadian workforce during that time. This data is based on the 2001 census.

Our study also found that migration happens primarily within a province. Health professionals tend to relocate to where there is an economic boom—just like the Canadian workforce in general.

What about movement in and out of the country? For the fourth year in a row, the number of physicians who reported returning to Canada in 2007 was greater than the number who reported leaving. When it comes to internationally-educated professionals, our data show the proportion of regulated nurses educated abroad has been relatively stable over the past 30 years, at around 7% of the nursing workforce. The rate of international medical graduates was nearly 23% in 2007—down from 33% in the late 1970s. We have noted, since then, a gradual decline in the number of internationally-educated physicians in the physician workforce in Canada.

[*English*]

As an organization dedicated to improving, standardizing, and providing information on health and health services in Canada, CIHI appreciates your interest in its work on health human resources.

I would be pleased to answer any questions you may have in the official language of your choice.

Thank you. Merci.

The Chair: Thank you so very much.

We're going to listen to all of the presenters and then we will go into our first seven-minute round very shortly once we've heard all of those presentations. Thank you for your presentation.

Dr. Jeanne Besner is next, and she is chair of the Health Council of Canada.

Thank you, Dr. Besner.

[*Translation*]

Dr. Jeanne Besner (Chair, Health Council of Canada): Good afternoon. I am very pleased to be here to represent the Health Council of Canada.

[*English*]

I believe that members of the committee have received our briefing note, so I am just going to speak to a few of the points that were made in there.

In my day job I am a researcher in Calgary and have been for the last eight years, looking at the whole area of health human resources, workforce optimization, service delivery models, and so on. So I will pepper some of the health council comments with some of my own observations and experiences drawn from that research.

We noted in our report that in June 2008 we had commented that ensuring that we had the right number of health care providers in the right place was a central component of both of the health accords. One of the elements of the 2004 accords was the development of a pan-Canadian framework for health human resources planning that all of the members and jurisdictions had agreed on.

I think it is important to note that it was a needs-based health human resources planning framework that was to take us away from a supply-based model of planning for health human resources.

Certainly in my own experience and observation, we have not moved very far in the whole approach to needs-based planning, but in our research, my team and I have certainly tried to develop that. One of the things that has become very clear is that when you begin to look at the needs of the population, and much of our research has been done in acute care, a very high proportion of the bed-days in adult hospitals—about 42% in Calgary—is for individuals over the age of 65, many of whom have multiple chronic diseases. Yet our research has indicated a huge gap of knowledge in the health professionals who are providing service to that population relative to the gerontological risk factor assessment and so on. There is evidence that this lack of understanding of risk factors in particular types of populations, regardless of their specific diseases, in fact leads to avoidable complications of care and less than optimal quality of care. So I think the whole focus on needs-based planning, certainly in my opinion, is very important.

It is also clear to us that while we talk a lot about shortages of nurses, physicians, and so on, the shortages that exist may be worse than we think or not as bad as we think, but there is a lot of evidence, at least in nursing, which has been one of the areas where we've done a lot of work, that the under-utilization of health professionals is really part of the whole supply problem. We have registered nurses in many cases doing work that could be done by licensed practical nurses, health care aides, janitors, housekeepers, and others if the service delivery model were different from what it is.

So we do have to think a lot about how we structure delivery of care as well as look at whether or not the people who are delivering care are actually working to the full extent of their knowledge and skills. While most of our research has been done in acute care, some of it is also currently occurring in primary care networks, family practice networks, and so on. There is evidence there as well of under-utilization of health professionals and the potential to move to a very different place if we think differently about many of the issues we are looking at.

Also, in our “Value for Money” reports, we have talked about whether or not we are using our health human resources to provide cost-effective services. Again I could provide a lot of evidence of the fact that I think we are not. By really focusing on the needs of populations, the risk factors, the management of people versus the management of diseases, we could perhaps prevent a lot of the readmissions, for example, that we see occurring over and over again. So based on my own experience I think there's lots of room there for doing things quite differently.

In our reports we have quoted one of the respondents to our “Value for Money” website who said that “it seems governments and institutions are in a race to cut funding and positions based on today's circumstances”. That is something that we saw in the 1990s. We cut a lot of positions—and nursing was one example—and those were the result of very short-sighted decisions, because those cuts are what has caused the shortage that we have today.

I think as we move into another economic crisis we are going to have to be very careful to think about what we are doing if we consider any cuts.

● (1545)

We also need to match the resources we have to the policy agendas we are talking about. We talk about improving population health, moving to more disease prevention, and so on, yet we're utilizing most of our health care providers in the disease management basket, rather than looking at which of our health care providers really could add and advance the health promotion agenda, the population focus, and so on.

I think it is important that we have a national plan that begins to look at what our real shortages are, where they exist, and so on, but we should do that in light of the policy directives. Where do we want to be ten years from now? Are we educating the right number and types of providers to take us to that place at that time?

We've noted on page three the lack of data on outcomes. It is important to link the health human resource agenda to the kinds of outcomes we're trying to achieve. If we really begin to talk about improving health, well-being, self-care capacity, and so on, that speaks to the need for a different kind of provider mix from what we have when we focus primarily on morbidity or mortality outcomes.

There's no question in my mind that we really need to talk about what collaborative practice models mean for Canada. We've talked a lot about team-based care for a number of years, but the collaborative practice model, using Health Canada's definition, places particular focus on patients and families being part of the decision-making process, being engaged in their care, and ensuring that the services provided to them are very well matched to their needs, goals, and so on. We have a lot of evidence that the system is far more provider-centric than client-family-centred. That's another area where by moving forward with a clear vision of where we want to go, we could make a lot of improvements in the delivery of health care.

I'll stop there. There will be an opportunity for questions later if you have any.

Thank you for giving us the opportunity of presenting.

● (1550)

The Chair: Thank you so very much. You certainly brought up some new items there. I'm sure the committee will have a lot of questions.

We'll now go to Maureen O'Neil, president and chief executive officer of the Canadian Health Services Research Foundation. That's a big title.

Ms. Maureen O'Neil (President and Chief Executive Officer, Canadian Health Services Research Foundation): Good afternoon, Madam Chair.

[*Translation*]

Thank you for the opportunity to speak with you this afternoon. The committee has a complex and multi-faceted problem to explore. The solutions are equally complex. If the answer was simply "more"—more money, more resources—we wouldn't be talking today, I am sure.

The Canadian Health Services Research Foundation was created in 1997 to support research on health services, and to help decision-makers use existing research better, to the benefit of patients. Today, I would like to share several telling stories that show how our partnerships and research are building solutions in the area of health human resources, and how I think we could make even more of a difference for patients in the future.

[*English*]

A few years ago we partnered with a number of groups, including the Ontario Hospital Association's Change Foundation, to commission research that would address critical health human resource questions. Then the Canadian nursing workforce was a significant issue, and it still is. We've heard that already, both from Jeanne Besner and from CIHI. In fact, the study in 2002 by the Canadian Nurses Association suggested that if we continued with past workforce utilization patterns of registered nurses, Canada would have a significant shortage of RNs by 2011, and of course even more, 113,000, by 2016.

We had to set out to address two questions. First, what was the actual impact of the working environment on the health of the nursing workforce, and hence potentially on patient outcomes? Second, what effective solutions could be implemented to improve the quality of the nursing work environment and patient outcomes as well? It's not only the numbers of people you have in any category, it's also the way in which they're organized, the nature of their workplaces, the way in which they work with one another, that determine whether the number makes any actual sense.

So the researchers commissioned by CHSRF and its partners looked across the published literature and conducted extensive interviews with nurses, health system managers, government employees, and educators. The report that was based on this work, *Commitment and Care*, identified problems that were familiar, and you're probably going to hear a lot more about them. You've already heard some of this from other witnesses this afternoon—issues of work pressure, job security, support from managers and colleagues, safety in the workplace. Jeanne Besner mentioned the difficult decisions and wrong decisions that were taken during the last period of contraction in the Canadian economy and in public funding. Nurses suffered particularly from that, with lots of them being put on part-time, having benefits reduced. So it was a bad atmosphere for work.

At the same time, the researchers discovered that when they looked closely, they saw a lot of creative solutions within the health care systems in Canada and abroad, local innovations that deserve to be heard about much more broadly. For example, there were the so-called magnet hospitals, hospitals with reputations for being excellent nursing workplaces with stable nurse staffing and high job satisfaction, which could be imitated by others.

The report also highlighted, for example, the B.C. Ministry of Health, which launched a program in 2001 to relieve senior nurses of 20% to 30% of their patient care in return for mentoring the new, inexperienced nurses. Innovative solutions like these and others matter a lot, not just to nurses but to patients, because the research shows us that nurses' job satisfaction is one of the strongest determinants of patients' overall satisfaction with the health care system. If you spent any time in a hospital you'd know that's who's there, that's who's doing the work.

The evidence also shows—and this is a little frightening if you're a patient—that good team relations affect patients, even their levels of mortality. So if you have an unhappy team gathered around your bed you should probably be worrying, because there's evidence that there are far better patient outcomes when there's good collaboration between and among nurses and with physicians.

At the Hamilton Health Sciences Centre they've successfully initiated nursing resource teams that will send in backup as different units in the hospital become overwhelmed, so there's a team there to help out when things get particularly hot in one area or when one area is suffering from staffing shortages.

This sounds very micro, but the fact is that changes in health care do have to happen at a very micro level, at the level between the people providing the care and the patients.

● (1555)

[*Translation*]

I have another very interesting example, that of the Agence de la santé et des services sociaux de la Montérégie. This agency is using research to understand the needs of the population they serve, and transform the way services are delivered to patients. Through its research efforts, the agency has identified 15 major health and social problems as the determinants of the service offer. It then began by treating the health problems and organized services around these problems.

It then created interdisciplinary teams for each of the problems. These teams mapped out service continuums that would help to prevent the problem, treat it, and provide support to susceptible populations. This approach targets the health and social service requirements of specific populations and engages a wide range of health professionals and services.

The result has been an organization with a strong public health orientation and a determined focus on research evidence as a foundation for all management and clinical decisions.

[*English*]

We've learned about these innovations through the course of our programming and through the partnerships we've had. The research I mentioned on nursing and nurses was funded through a ten-year nursing research fund, a program that ends this year.

I mentioned the region of Montérégie. The leaders in that health region in Quebec are participants in a number of programs. Participants included nine of their senior managers and their CEO. They have been fellows of our executive training for research application program. It is also a ten-year program, funded by Health Canada, and it develops capacity and leadership to optimize the use of research evidence in managing Canadian health care.

These stories should serve as a source of encouragement as well as for any cause for concern. These successful initiatives should be commonplace in Canada's health care system. Sadly, they're not. As a country, we need to devote more resources to supporting the kinds of innovations that are good for health care professionals and also, and more importantly, good for patients.

As we know, the numbers show that we're spending more and more on health care, but we devote minuscule resources to support studying and sharing lessons about how we organize, manage, and deliver care. According to the Canadian Institute for Health Information, we're now spending about $172 billion. We spent that in 2008. By comparison, the combined budgets of the Canadian Health Services Research Foundation and the health services research funding of the Canadian Institutes of Health Research add up to less than $50 million, so the amount of money we're devoting to thinking about and looking at actual health service delivery comes to around $50 million out of a budget of about $172 billion. If you're asking yourselves how quickly we are going to come to the practical improvements that are required to have a more innovative publicly financed health care system, we're going to have to look again at these numbers.

We also need to devote a lot more time and energy to sharing the stories of the innovations, not only with health care professionals but also with policy-makers, politicians, and the public. Everybody has a role to play in advancing systems-level innovation, because we know that's the way we're going to have a much stronger health care system for all Canadians.

Thank you.

● (1600)

The Chair: Thank you very much. That was a very insightful presentation and very much appreciated.

I will now go to Dr. Beaudet, from the Canadian Institutes of Health Research.

Thank you.

[*Translation*]

Mr. Alain Beaudet (President, Canadian Institutes of Health Research): Thank you, Madam Chair.

[*English*]

Hon. members of Parliament, I appreciate the opportunity to bring the perspective of the Canadian Institutes of Health Research to your study of health human resources.

CIHR is the Government of Canada's agency responsible for the funding of health research and training. Our mandate, as defined in our founding act, is to excel according to internationally accepted standards of scientific excellence in the creation of new knowledge and its translation into improved health for Canadians, more effective health services and products, and a strengthened Canadian health care system.

CIHR provides leadership and supports nearly 12,000 health researchers and trainees across Canada. These should be seen as an integral and essential part of the Canadian health workforce.

[*Translation*]

We in the Canadian Institutes of Health Research are convinced that research is the cornerstone for the well-being of Canadians and for an effective health system tailored to meet our needs and based on solid scientific information.

[*English*]

Your investments in health research lead to improved health for Canadians. Let me give you two examples.

In Canada, the death rate after a heart attack has decreased by more than half in the past decade, due to innovations in treatment and to improvements in health systems to provide timely care. As another example, when the SARS outbreak occurred in 2003, CIHR mobilized a team of 58 Canadian researchers to sequence the genome of the virus behind SARS, studies that would then lead to results in the areas of diagnostics, treatment, and vaccination.

These examples—and there are countless others—depend upon the creation of basic scientific knowledge and equally upon the successful application of that knowledge in the clinical setting. Both aspects are crucial for health improvement. We must have the capacity not only to do the research, but also to translate the results of research into better care and into an efficient, sustainable health care system, as Ms. O'Neil just told us.

[*Translation*]

This leads me to the issue of human resources, the matter before you today. It is absolutely essential that health researchers, be they scientists or health professionals, be taken into account. And we must recognize that that has not always been the case up until now.

Who are these health researchers? They are, first of all, scientists, holders of a Ph.D. and their students, doctoral and post-doctoral. These people work in the area of basic research or in the more applied sectors of health research: epidemiology, health system organization—as Ms. O'Neil just mentioned—health economics, etc. And don't you think that these researchers are confined to the university ivory towers: too often we forget that more than 80% of health research in Canada, all sectors included, is conducted on hospital campuses. Then we have the health professionals: doctors, nurses, physiotherapists, occupational therapists, psychologists. More often than not, these people split their time between clinical duties and research. They are the key to this transfer of knowledge to clinical practice and health care organization.

● (1605)

[*English*]

But you should be aware that Canada's patient-oriented research capacity is rapidly deteriorating. In the case of physicians—and the situation is even worse for nurses—only a small proportion of them devotes a substantial amount of time to research, and this proportion is not growing.

As you see here on this graph, it is not a map of arms of mass destruction, but it does show you the total number of physicians in Canada—and we're talking about specialists. These are the ones who actually spend less than 5% of their time doing research. Now, the ones who really count, the ones who spend at least 20% of their time actually doing research, are represented by this very dark blue line here at the bottom.

Clinicians' time for research is not protected, and it's not appropriately valued and compensated. How can we compete with the increasing demands of care in the face of insufficient human resources? Time for research is never taken into consideration when staffing the health sector. There are difficulties in attracting and retaining clinician researchers; and insufficient opportunities and unclear career paths discourage the ones who have the talent and taste for it. Yet these clinician researchers are absolutely critical, not only to improving health and health care, but also to ensuring that health care professionals are trained under the scientific backdrop necessary to ensure evidence-based practice.

We need to ensure a system of renewal that prepares new health professionals for research careers. We must ensure that the system appropriately values these promising health researchers, along with creating an environment that is scientifically and intellectually stimulating. And that's what we're trying to do at CIHR. I feel very strongly that as an organization, we need to focus more time and resources on patient-oriented research.

Over the coming years, CIHR will lead a new patient-oriented research strategy to strengthen the culture of knowledge-based care at all levels of the health care system.

[*Translation*]

Our objective is not only to develop significant human resources in this sector, but also to better exploit our universal health care system. We want to know how to use—and once again, I am repeating what was said by Ms. O'Neil—the resources provided by this system: data banks, medical records that will soon be in electronic form, we hope, to provide better follow-up on patients and improve the viability and cost-effectiveness of the system itself. We have a unique opportunity to develop a niche of excellence at the international level, which will enable us not only to better serve our citizenry, but also to retain and strengthen the health industry. It is up to us to take our health care expenditures and turn them into an investment.

[*English*]

If we make a better effort at this, the result will be internationally recognized clinical research expertise. We will produce ground-breaking Canadian studies and, more importantly, we will improve the delivery of health care to Canadians.

To conclude, CIHR has a responsibility to provide research leadership in building the environment and the people to strengthen Canada's research infrastructure and capacity. We will fulfill our mandate. We need your continued support.

My message to you today is that research in the hospital setting is not a luxury, but the key to improved health care. One cannot plan for health human resources without integrating research at every level; it is essential to the quality and outcomes of health care.

Merci beaucoup.

● (1610)

The Chair: Thank you very much.

I need to tell you that this committee is very involved in this particular study, and we find it extremely important. What you say is taken under very careful consideration.

We're going to go into two rounds of questioning, and the first round is going to be seven minutes per person for the question and answer.

We'll start with Ms. Murray.

Ms. Joyce Murray (Vancouver Quadra, Lib.): It's very humbling to be a committee member and part of a team responsible to add value in the whole area of human health resources, and to be able to hear from people like you who are leaders in the field and who have spent their careers knowing about some piece of it. It's hugely complex. My first career was in growing the health of forests, not an area associated with health care. So it's a humbling experience.

I'm going to focus in on the area of prevention, because in my view that's an area in which we can do far more than we do, and I think the amount of funds that go into health repair and the amount that go into prevention of health problems are out of balance.

I have one more personal biographical detail. I have three grown children, and I have never been in a hospital other than to visit someone else, so I have the good fortune of being very healthy. Prevention is the key, from my experience and my thinking, and that's what I wanted to ask about.

In terms of the comments that were made on research, can somebody comment on whether you believe there is adequate research into complementary and alternative professionals like naturopathic physicians and the care they provide and the modalities they use?

The Chair: Who would like to start off with that question?

Mr. Alain Beaudet: I'm happy to take it.

Your question is a very interesting one. I think it reflects the huge changes in society. You remember that until 1999, our agency was called the Medical Research Council. It is now called the Canadian Institutes of Health Research. I think this shift in focus from medical to health is a very important one. I think it's a reflection of what's happening in society. We're starting to realize that health is much more than patients in hospitals. Health is also promotion of health. It's also prevention of disease.

Is there enough research in that area? No. Are we putting more money in that area? Yes. What is the problem, and why aren't we doing more faster and building capacity? It is new. It is not difficult to find biochemists out there who will apply for research grants for biomedical research, but it's more difficult to find the people who have the talent and the know-how to do the type of evaluation research that's needed in these sectors.

We really have to take it upstream and train the researchers of tomorrow. We're very aware of the importance of these issues, and particularly, I would say, with an aging population and in the realm of chronic diseases. If we don't do something about preventing chronic diseases—

Ms. Joyce Murray: I have a couple of other topics, but thank you very much for that. I know that the practitioners and the associations are very interested in seeing more government-supported research, and I'm sure they would be happy to bring some of the capacity forward should the funds be available.

I have another question. The word "patient" was used a lot—patient-centred care, patient-centred outcomes, and so on. There is the issue of complementary and alternative practitioners being part of the continuity of care so that we don't have to be patients. I think a huge percentage of people use those services and stay away from being patients and stay out of hospitals, and that's not recognized as being an important preventative. From a health human resources perspective, what is being done, and is enough being done? I'd like your comment on bringing naturopathic physicians, traditional Chinese doctors, acupuncturists, homeopaths, and so on into primary care as part of the health human resources team. Do you see that being a priority? Do you think that's being adequately supported?

● (1615)

The Chair: Who would like to take that question?

Dr. Besner.

Dr. Jeanne Besner: Is it a priority? I can't answer that. Where the needs of patients' families determine they should be members of the team, there should be more opportunity than what we have. But we also need to use the opportunities we have to do more prevention.

All members of the team working to full scope and focusing on what they ought to be focusing on perhaps is an example. If you look at depression among women of childbearing age, in one of the family practices in which I was doing some work it tended to be the number-one billable code in that age group. When we introduced nurses into the family practice, we really started focusing on the importance of having them assess the extent to which the depression was interfering with parenting in women who were depressed. It can put children at risk of neglect, abuse, and so on if the depression is severe enough.

It's a way of beginning to look at the many opportunities to introduce primary prevention. The woman's depression needs to be treated, but the children's well-being also needs to be attended to. So you begin to look at more than one member of the health care team working in a particular context, and shift your focus away from just managing the disease—depression—to look at the issues that surround the needs of that patient's family. Then there are more opportunities to look at all the other health care providers who could become part of the care team and manage people far better, so we don't have people constantly on the treadmill of treatment, illness, and so on.

The Chair: Thank you, Dr. Besner.

Monsieur Malo.

[*Translation*]

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

I would also like to thank the witnesses for coming here this afternoon. I would like to make a few points with respect to your presentations.

Ms. Besner, you told us that, in your opinion, we were not using our resources well, that nurses should have more responsibilities and that we needed to change the way we do things in order to take into account the fact that patients now want to be more involved in their health care.

Ms. O'Neil, you told us that the working environment of nurses needed to be examined to create greater job satisfaction. You talked about stress and the fact that relations with superiors were sometimes difficult.

You have made all of these statements before a federal health committee. But do you not find that you are speaking to the wrong people, because the stakeholders most able to effect changes in this sector are to be found in other parliaments? The way I see it, your observations are based on rigorous, serious studies that were carried out using certain scientific research models. Have you apprised these stakeholders who, in my opinion, would be more appropriate, of these findings?

Dr. Jeanne Besner: As far as I'm concerned, I can say yes. However, that has not changed much to date. We try to bring up these issues in every possible forum.

There is a lack of vision with respect to what we call the scope of practice, whether it be for nurses, doctors or others, throughout Canada. We can effect change little by little, and that is what I am trying to do in my own sector, in Calgary. I do this one day at a time, one unit at a time. The fact remains, however, that at this rate bringing about change at the national level will take centuries.

I feel we need to adopt a Canada-wide vision and start discussing the roles of our health care providers. We have to envision changes that can be made on a broad scale, so that this happens earlier rather than later. In my opinion, this is very important.

● (1620)

[*English*]

The Chair: Ms. O'Neil, please go ahead.

[*Translation*]

Ms. Maureen O'Neil: Thank you very much for your question. We are here at the committee because you invited us, and not to lobby about our research findings. I mentioned that we had worked with the Ontario Hospital Association and that we were very involved with the British Columbia Ministry of Health.

It is true that, in Canada, we are often afraid to make comparisons between the provinces. This is what CIHI does, but that makes everybody very nervous. However, this is what we need to do. Canadians need to know how things would unfold, depending on whether they lived in Ontario, in Montreal, or in Alberta, if they were diagnosed with a certain type of cancer. Provinces are not all that interested in doing these types of comparisons. However, with respect to innovation, we know that the OECD countries are quite prepared to draw comparisons among themselves.

If we want to progress, we really need to know what is happening. You are right in saying that we have 13 different health systems in Canada. As Dr. Besner said, it would take a very long time to change things. We do, however, have to make changes in each health system. For this reason, research is very important, because it enables us to compare the various systems.

I do not know whether or not Canadians living in Ontario are aware of what's going on in primary health care in Quebec, and vice versa. As citizens, our taxes pay half of the health care expenditures in each province. So we really need to know what is happening elsewhere and whether we have the health system we need.

[*English*]

The Chair: Thank you, Ms. O'Neil.

I think Monsieur Berthelot would like to make a comment.

[*Translation*]

Mr. Jean-Marie Berthelot: Thank you for inviting us to the committee.

You touched on the very essence of our CIHI mandate, which is to provide a mechanism enabling the various provincial governments to compare themselves with each other. The CIHI mandate is to work in cooperation with the provinces. To do this, we have a bilateral agreement that governs our relationship with each provincial government.

You asked us how we make sure that the information gets to the provincial governments. The institute is not necessarily invited to the National Assembly or to the legislative assemblies, but it does ensure that every Ministry of Health, or, for instance, the Institut national de santé publique du Québec, receives information produced by CIHI and can use it in its political system in order to further its causes.

The objective is to produce data enabling us to note the differences between the systems, and not to say that one system is better than the other. Each system may prove to be better or worse than another one when it comes to certain issues. We want to enable people who develop provincial or local health policies, whether it be at the CLSC level or within a regional district, to have access to this information.

Mr. Luc Malo: That somewhat answers the question raised by Ms. O'Neil, who appears to say that—

[*English*]

The Chair: Excuse me, Monsieur Malo. Before we go to the next question, I notice Dr. Beaudet would like to make a comment.

Mr. Luc Malo: It was a complementary question.

The Chair: Okay.

Dr. Beaudet, go ahead.

[*Translation*]

Mr. Alain Beaudet: I would simply like to make a brief comment.

You are perfectly right. This is a matter which, when it comes to health care, is clearly under provincial jurisdiction. If we want to conduct effective clinical research in health services, epidemiology in particular, we have no choice but to work closely with the provinces. Moreover, this is why we work closely with the health research organizations in each of the provinces. In Quebec, this would be the Fonds de la recherche en santé du Québec; in Alberta, it is the Alberta Heritage Foundation for Medical Research; in British Columbia, this is the Michael Smith Foundation for Health Research, etc. The purpose is to harmonize our research policies and ensure the effectiveness of health research policies that we are trying to develop.

● (1625)

[*English*]

The Chair: Ms. Wasylycia-Leis.

Ms. Judy Wasylycia-Leis (Winnipeg North, NDP): Thank you, Madam Chairperson.

Thanks to all of you for actually kick-starting our study, which begs for your input and advice in terms of the macro issues at stake.

I think you've all said, in one way or another, that we have very much a crisis in terms of health human resources, whether it's in terms of shortages, under-utilizations, or difficult working conditions, and that of course leads to long waiting lists, a lack of confidence in our health care system, and could break our medicare model.

We've had studies for twenty years now that I've been around. I think we need to hear from you, as a committee, what do we recommend, where do we start to look, in terms of a strategy that will finally lift itself up off the page and go somewhere?

First of all, do you all agree that we need some sort of a national approach to this issue that has due regard for the uniqueness of Quebec but that coordinates, which is something that I think was supposed to come out of the 2003-2004 ministers meeting? I think that's how the Health Council got its start. Do you agree that we need this kind of a strategy? What are the elements of it? How do we make that happen here in the federal government?

Maybe, Jeanne, you could start.

Dr. Jeanne Besner: Yes, obviously, I do think that we would be better off to have a pan-Canadian strategy.

I think the research studies done in Alberta or in Quebec or wherever in many instances have applicability elsewhere. Context is very important when we're talking about professional practice and so on. We need to use what we know works in one area and then try it in other places, in other contexts, and make sure, by replicating or adapting what we know in other contexts, that we get it right eventually.

There's a lot that we know about what we could be trying differently that I don't think is going to be very different in any of our provincial jurisdictions, but we need to bring it to a level of national discussion so that we can work together and make sure that what we apply in fact does work in a number of different contexts, is the right way to go. Then we will have the basis from which to begin to think about our long-range planning, whether we have the right number or the right types, and so on and so forth. Doing it just one little tiny bit at a time, one research project, whatever, is simply not very cost-effective, I don't think.

Ms. Judy Wasylycia-Leis: Jean-Marie, Maureen, I'm sure you'd like to comment on this.

Ms. Maureen O'Neil: Thanks.

Yes, I think there is a need for a national vision, even though I recognize that we have at least 13 health jurisdictions. For one thing, when we're talking about health professionals and service providers, they move around, as we know. They aren't all staying in one spot; in fact it is important to understand where they are.

I think there's something even more profound, in a sense. You expressed the frustration of having seen so many of these discussions on what's going to be done and how we can innovate within a publicly funded health care system so that people are proud of it. I think one of the first hurdles to get over is Canadians thinking that they have the best health care system in the world. They don't, actually. We would like it to be the best, but if we look at international comparisons, we see that there are other publicly funded health care systems that do things differently and that, in some cases, do things better.

I think your committee has a very important role to play in terms of saying that we want to have the best system in the country, and here are the things that will help make it better. I think the Health Council's call for comments on what value for money means is extremely important. I think CIHI's continuing putting out of statistics on how things are working is really important. But we also have to recognize that for provincial governments, doing almost anything in the health area is so toxic politically, I think, people will do a few things, take a deep breath, and hope that they get through to the next election without suffering from doing anything terribly innovative. I think that acts as a brake on actually getting things done.

So the big question is how to create an atmosphere in Canada... recognizing, of course, that it's primarily a provincial jurisdiction. But don't forget that in five years we're going to be renegotiating the Canada health transfer. That's a small amount of the money that flows into health care, but this is coming up.

This next while is an ideal time to be focusing on these questions that are felt across the country. Even though some people may say that these are not national questions—their resolution does not sit completely with the federal government—Canadians across the country are experiencing difficulties nonetheless. They want to have better systems, want to retain the accessibility they have.

The puzzle is how to generate that debate. How do we build out from the issue of health human resources—in other words, the providers? As we know, since the Hall royal commission, which agreed on a payment system but agreed not to touch the organization of services, everybody's been struggling with how to innovate in the organization of services. How do we actually have payment systems that pay for more than doctors in primary health care, or sometimes nurse practitioners, or the doctors and nurses in hospitals, and some of the other professionals, some of whom have been mentioned today?

I think your committee has a real opportunity. The question is how broadly do you cast the question? Do you look at health human resources after defining and recognizing that innovation is required and that the federal government doesn't hold all the levers on it—which, of course, everybody knows? How do you pose your question in a way that generates useful discussion and that doesn't fall into the trap that we see so often at particularly the provincial level when anything happens? Whether it's the Chaoulli decision in Quebec or whether it's B.C. opening up to more private clinics, whenever it comes up, suddenly the camps form in a not particularly helpful way, with “No Two-Tier Up Here” banners over here and “Only What We've Got Now” banners over there.

We never seem to be able to move off the dime. But you have an opportunity to think more broadly about this.

● (1630)

The Chair: Thank you, Ms. O'Neil.

Ms. McLeod.

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): Thank you, Madam Chair.

First of all, I want to compliment all of the presenters today. I think Canada has the benefit of your organizations, which are respected certainly internationally in terms of how we work.

I believe we do have the answers to our more modestly defined HHR issues. In our first presentation, we heard about some things around medical residency and how that's a little bit of a gap. You're right about tinkering around that bottleneck, but I really appreciate the comments that solutions to the HHR issues lie a lot in systems change.

I actually have a couple of quicker questions. The first one is for Dr. Beaudet.

Absolutely, research is incredible in terms of supporting and informing practice, but we have a lot of research out there that is not actually translating into practice. I guess I'd appreciate a few comments in that area.

Mr. Alain Beaudet: You're right, and as I said at the beginning, it's fully part of our mandate not only to create new knowledge, but to ensure that it is properly translated into better health and better health care. And quite frankly, I think we haven't delivered as well on the second part, and it's more difficult to do that.

That's exactly what we're trying to achieve in our second strategic plan, which is just about to be launched. It has a big focus on what I call patient-oriented research, but it goes more broadly to the patient because it does include primary care and it does include prevention. But we're talking not only about bringing the results from the bench to the bedside, but also about ensuring we have high-level evaluation of new treatments, of new policies, of new practices, of new drugs. And once they're evaluated, we need to ensure that the results of the evaluation are actually properly disseminated, and that this dissemination results in the proper uptake and a change in practice.

This is a continuum where the health professionals play a key role. The thing is, we don't have enough, and the ones we have who have the training do not have the time. So we need to protect their time and we need to train more to do that. I believe it's the only way we'll be able to do it in an efficient manner.

We clearly want to focus on that in the years to come.

● (1635)

Mrs. Cathy McLeod: Also, if you look at CIHI, I think they bring in 15,000 people through video conferences.

Looking at HHR, we talked briefly about some Canadian statistics. You might not want to share them today, but I think our international comparisons become important in terms of some of those issues. Are we favourably or unfavourably compared? I know every system in every country is different, but do you have any quick comments in terms of that area?

Mr. Jean-Marie Berthelot: I think that was already in the briefing notes. It depends on the way the care is organized.

In Canada we have a higher number of nurses per 100,000 inhabitants than many of the continental European countries; however, we have fewer doctors. But when we compare ourselves to something a bit more like the British system, or even with the Americans, we're maybe not that far behind. So I think it's very difficult to answer the question of whether we have enough of this or enough of that. It goes beyond physicians and nurses. It depends on how the care is organized. It depends on the scope of practice. The scope of practice of a physician is not the same, depending on the country. The scope of practice of a nurse is not the same. So it's very difficult to make the judgment about whether we are advantaged or disadvantaged compared to other countries.

What we can say is that on average we have fewer physicians than the OECD, but this is because of the model of care. We have more nurses. In terms of the trends over time, there has not been a lot of change in terms of the number of physicians per 100,000 inhabitants in the country. That's relatively stable. In terms of nurses, we saw a relatively significant decrease in the 1990s when the government had a large deficit. We are now seeing an increase. We're not at the level we were before the 1990 reduction.

Mrs. Cathy McLeod: Certainly I appreciated Maureen O'Neil's comments regarding the political bravery, not just at a provincial-federal level, but even within our professional organizations.

Again, the foundation of our system is within the prevention and the primary health care system, and, yes, our acute care systems.

Does anyone have any more comments in terms of that particular issue, on scope of practice or...? Again, I believe the answers are there. We just need to have the bravery to pull all the threads together.

The Chair: Ms. O'Neil.

Ms. Maureen O'Neil: Thank you.

I think many of the answers are there, and this is also why international comparisons can be so helpful, to look at how other countries actually organize the services, not just at how many positions they have or at how many nurses or how many physiotherapists, but at how they are actually organized and how they are financed.

I think one of the important questions to try to get at is how the way in which the money flows from a provincial government to hospitals and to health regions either encourages organizing in the way that is most effective for positive outcomes or does not. Does the way the money flows inhibit innovation in the way services get organized or does it not? Does it create barriers? This is going to be different in different places.

In health care, you can't escape getting down to this level of detail to understand where the actual levers for change are. Why is it that we have spent, from the federal level, $800 million over a number of years for primary health care transition, and yet when we look around and ask ourselves in which province primary health care has really been reorganized—and we know primary health care is crucial if we want to grapple with greater efficiencies down the road—it's very hard to do. What are the barriers? Why is it so hard?

The difficulty, I think, is that these things are linked together, but in order to have discussions, you have to pick them apart and say, “Aha. If we wanted to do things differently, then we would not want to be setting a whole bunch of rules for hospitals and how they spend their money. Maybe we would want to give them a block budget, or maybe their budget should be part of a health region.”

These things sound so arcane, and yet if you're looking for ways to change things and looking for ways to answer the question of why things don't get done, you have to get to that level of detail and then, in a sense, step into the shoes of the health minister from the province and ask whether you would really have wanted to take that on, because every time you make a change, it disrupts somebody's day out there. If you find it's less efficient to have an emergency department in a small hospital, you can guarantee that the minister's going to hear a lot about it if you do what might be a more efficient thing.

We all have to keep trying. We always have to keep working on these things. Not coming to grips with the fundamental political economy and the desire to keep on doing things the same way is preventing the actual implementation of research findings around organization of services that have been well known for years.

● (1640)

The Chair: Thank you, Ms. O'Neil.

We're now going to go into our second round of five minutes. I wish we had even more time, but your comments are really great, and I thank you for them.

We'll start with Dr. Bennett.

Hon. Carolyn Bennett (St. Paul's, Lib.): Thank you very much.

Again, I concur that this was a really helpful beginning, but it's also confounding in terms of how we actually do this chicken-and-egg thing of whether we are going to change the way we do things or we are going to decide we need doctor-patient ratios and nurse-patient ratios in the same old way of doing things, regardless of OECD numbers or all of that. If we actually decide to change and work on teams, how could it look different?

I would love to hear from Dr. Beaudet. Is it possible to keep up in medicine or in nursing if you're not teaching? The most important thing that happens to all of us is having some whippersnapper say, "How come you're still doing this, and why aren't you doing that?"

If you were dreaming in technicolor about what this would look like in terms of collaborative care that was truly patient-centred, where we were always doing evidence-based practice or practice-based evidence, what would it look like, and would we still be talking about scopes of practice? Because it's very different in Nunavut from what it is in downtown Toronto. I think the new phrase "core competencies" means that if you're on a team, some people are going to have a little bit better knowledge of this or that or whatever.

From the Alberta bone and joint to some of the community health centres, to some of the things that are really best practices, should we be doing our work based on skating to where the puck's going to be, or do we do the work that also needs to be done but focus on foreign trade in medical drugs, more slots, and more training?

For a comprehensive approach to HHR, I guess I want to know how you would have organized our study if you were actually going to get to write the report.

The Chair: Dr. Beaudet, would you like to tackle that one?

Mr. Alain Beaudet: It is a difficult question, but then I love to dream in technicolor, so I'll have a shot at it.

I would say break the silos. Again, it's very much from the perspective of research-based practice, and to me it's a practice that uses the levers of research. Break the silos between the scientists and the physicians and the nurses and the engineers and the project managers and the bio-statisticians. They're all in their little worlds. We still train them along disciplinary lines. We have to stop that and we have to think in terms of multi-disciplinary teams working together. That would be what—

Hon. Carolyn Bennett: So that's the first recommendation of the report, that we would have interdisciplinary training in universities?

Mr. Alain Beaudet: It's very important. I think it's critical if you want to actually bring the research and the practice into practice, because otherwise you'll never have the respect of where the research comes from.

The second point is that everything we do should be in terms of building in mechanisms to monitor what we're doing. I'll give you just a simple example: electronic records. We're getting there, finally.

● (1645)

Hon. Carolyn Bennett: Google is.

Mr. Alain Beaudet: Yes; it's about time.

Let's make sure from the start that these will be built in such a way that they will be accessible for research purposes, and that the question of protection of personal information is ensured from the start, so that we're not told in ten years that we can't access those because of the Privacy Act.

Let's build them in such a way that we actually can access part of them for research purposes; that we use them from monitoring what we're doing; that we use them for long-term monitoring of side effects; that we use them not only for research purposes, but that we make sure they ensure a flow so that the practitioner can access the record and have the feedback from the research results, and change the practice through the same vehicle.

In what we're building, think about monitoring and think about the future use of the results of the research.

The Chair: Thank you, Dr. Beaudet.

Mr. Uppal, please.

Mr. Tim Uppal (Edmonton—Sherwood Park, CPC): Thank you very much.

Thank you for coming here and adding to our study.

I just want to get back a little bit to what I guess would be federal and provincial differences there. A couple of times we had mentioned nurses that were laid off in difficult times at the provincial level. Those are obviously provincial decisions. I know that in Alberta, when we went through it, it was a big deal. Now you're saying that there is a shortage, and some of that has to do with those shortages. Those are provincial decisions.

As a federal association, how are you guys dealing with the provinces, and how successful are you with the information you're exchanging with them? Are they listening to what you're saying? Do you find that you're being successful?

The Chair: Who would like to take that question?

Mr. John Abbott, please.

Mr. John Abbott (Chief Executive Officer, Health Council of Canada): In terms of the work we do at the Health Council of Canada, we're very dependent on the provinces, territories, and the federal government for a lot of the information and the insights that they can bring to bear, because they're in the field and are responsible for delivering most of the services.

In terms of then responding to our findings and our recommendations from time to time, there's less take-up, to be fair to us and to be kind to them. Part of that is they're constantly moving and the agendas are moving, and they're moving very quickly.

Some of the work we do is a bit of a retrospective: this is what you've committed to in the accords, here is where we are today, and we're trying to project. There's a bit of a disconnect.

If I can use one example where the jurisdictions did come together a number of years ago, it was around medical school enrolments. They agreed. They made a decision. In retrospect, we could argue it might have been the wrong decision.

Governments can act and do act when they feel it is in their interest to do so, collectively. So the accords are an example of that. We think, when they look at wait times and other issues, when it's viewed as critical to the public interest, the national public interest, they come together.

What we need, and are trying to implement through our process here and the work others are doing, is to say human resources planning in the health care field is another call to develop and define as a national interest. We need that, or else in five years' time or ten years' time your committee will be asking the same questions.

We have an aging population, and we know the parameters of care that are going to be required. So if we set some objectives and then design the services around that, we can then also design the human resource requirements around that.

The health ministers of Canada are not there today. I think what this committee can do is point them in that direction.

The Chair: Go ahead, Mr. Uppal.

Mr. Tim Uppal: I think Ms. O'Neil has....

The Chair: Ms. O'Neil, yes.

● (1650)

Ms. Maureen O'Neil: I have three examples. In a sense, we're not an organization that's negotiating federally and provincially. We're outside of that. To give an indication, the western health ministers have asked us to work with them on health human resources questions to produce a research synthesis on health human resources, particularly in under-serviced areas. So they've come to us and asked if we would work with them on that. Similarly, Nunavut has asked us if we could put together a team that can help them with the health services organization questions in Nunavut. In a sense we're responding to those requests.

Similarly, in the much more micro-level programs that we're involved in, which I mentioned, that bring together researchers and executives in the health system, we have excellent representation from across the country. People apply to be part of it, and it turns out that there's very good representation from across the country. Actually, we've worked very closely with the Alberta Heritage Foundation for Medical Research and the search program there.

Our relationships aren't part of any kind of negotiating. We're not following up on federal-provincial commitments. Rather, organizations that are provincial get together with us when they want to do something together with us and they either want to combine on their money or they want to combine in terms of expertise.

The Chair: Mr. Berthelot, did you want to comment on that?

Mr. Jean-Marie Berthelot: I just have a small comment. CIHI has a different mandate. We don't do research, and we don't make recommendations. We provide the state of health and the use of health care services. It's really statistics.

I have to say we have excellent collaboration with the provinces. We even have bilateral agreements with each of the provinces. Each of the provinces contributes to our funding. We see that the information we produce is being used by policy-makers effectively to either change legislation or change the way they practise to improve the efficiency of the health care system. But we don't make recommendations. We just provide the facts, and we see that they use them.

The Chair: Thank you very much.

Monsieur Malo.

[*Translation*]

Mr. Luc Malo: Thank you, Madam Chair.

I will ask you three questions and you can have the time remaining to answer them. I'm going to base my question on the comments made by Ms. O'Neil.

You said earlier, Ms. O'Neil, that improvements are made at the local level, that this is where the best practices are developed, but that we have to come up with a way to share the successes. I was under the impression that there were publications, not only here but also international publications that enabled us to do that, that there were forums, that there were conferences. I would simply like to know whether these tools for disseminating information are useful and whether or not they do the job well.

You also made a comment on the scope of our study, which may be a bit too broad. I would like each of you to tell us whether or not we should limit our study. If so, what should be the focus of this study?

The third question is for Mr. Beaudet in particular. Ms. O'Neil said that research was a poor cousin, and that it was under-funded. Do you share this opinion?

All of these questions are for the whole panel.

[*English*]

The Chair: Go ahead, Ms. O'Neil.

[*Translation*]

Ms. Maureen O'Neil: With respect to your question about how to more efficiently share research, not only research but also innovations that take place in our various institutions, I believe that we must hold more forums at both the provincial and even the federal-provincial level so that front-line workers have an opportunity to share their experiences. There are many forums for academics because researchers are much more likely to believe in their importance.

I must say that nursing heads in various hospitals don't have many opportunities to exchange information amongst themselves about what is going on with patients in a hospital. I think that it is here, at the operational level, that we need to organize many more forums between the provinces, in order to discuss change.

I am not talking about researchers exchanging information amongst themselves. Researchers all have many opportunities to talk to one another, but the people working within the system have fewer opportunities. We know this, we organized a forum for teams; we work better in teams, etc. The people who attended the forum came from the workplace. They exchanged ideas amongst themselves. They came from all corners of the country, and it was appreciated because there are very few forums of this type.

● (1655)

[*English*]

The Chair: Go ahead.

Do you have any other comments?

[*Translation*]

Mr. Alain Beaudet: Now then, the first part of your question refers more or less to what you just asked regarding the breadth of vision. With regard to research, we are talking about competitiveness at the national level, about combining our resources and establishing uniform standards of practice across Canada. The availability of mechanisms for recruiting patients for Canada-wide studies will clearly make us much more competitive internationally. I think that everyone wants this, and all the provinces certainly want it.

Your second question is about funding. In 1999, I told you that research was woefully under-funded in Canada. We must recognize that the efforts made in a wide range of fields over the past eight years have been truly remarkable: research chair programs have been created in order to support and to attract researchers of renowned in Canada and abroad. There are Canadian scholarship programs that encourage students to go on to graduate studies; and the recently announced Vanier scholarships have enabled us and will in the future enable us to attract very highly qualified foreign students. Finally, significant investments have been made in infrastructure.

Ten years ago, our infrastructure was sadly lagging behind other industrialized countries. We have erased that gap, and we are once again competitive. The CIHR budgets, since it was created, since the MRC went over to CIHR, have tripled in value. This all adds up to a very significant investment.

Clearly, research—and let me repeat this—involves international competition. It is very clear that Canada will have to carry on with its efforts if it wants to remain competitive at the international level. I must tell you that its competitive position is very good.

[*English*]

The Chair: Thank you.

Please go ahead, Ms. Davidson.

Mrs. Patricia Davidson (Sarnia—Lambton, CPC): Thank you, Madam Chair, and thanks very much to all of our presenters. Every time we hear from somebody, it just becomes more evident what a huge task they've taken on.

It's interesting to hear the different aspects and how the different groups see the issues, the problems, and the solutions. I am interested in a couple of things that were said during your presentations.

Dr. Besner, I think you said we needed to get into needs-based planning, and you talked a bit about underutilization of health professionals. Are you talking about all health professionals? To fix this problem or to make things better, do all health professionals have to be involved?

As well, when we talk about that, are there common issues among some of the different groups, such as technologists, technicians, alternative medicines, and so on, as well as the doctors and nurses we're familiar with? Maybe you could comment on that a bit, please.

Dr. Jeanne Besner: I can't speak to all of the groups, but certainly when we ask a number of different health professionals if they believe they have knowledge and skill that they can bring to the improvement of health outcomes but that are not being tapped into, a majority of them will say yes.

I think it's probably worse in some areas than in others. We've primarily studied nursing up to this point in time. We have done interviews with a number of different professionals; what we've identified across the board is a focus on tasks, and there's a lot of overlap in tasks across many of the health professionals. Giving medications, for example, is not the domain only of pharmacists or physicians or nurses. Patients also give them, and so on, so this focus on tasks blurs a lot of the distinctiveness in terms of the knowledge of various professionals, and role ambiguity is something that has come out in all the work we've done.

When we begin to look at under-utilization, I can only speak to nursing, because I've only studied extensively in nursing. We have baccalaureate-prepared registered nurses now in Canada. When we moved to that, it was different in different provinces, so we can't refer to a particular time, but the expectation when we moved to baccalaureate preparation was that registered nurses would contribute more to the population-focused approaches, disease prevention, and so on. However, when we actually study their practice, they are very biomedicalized, as we call it. They're very much involved in medical management—not that they shouldn't be, but that's primarily what they're doing.

In some of the work we've done, we've found it very difficult to differentiate the practice of registered nurses from that of licensed practical nurses, because of this focus on tasks. In some of the work we've done, we've begun to identify that part of the reason registered nurses are not doing what they can do is that we don't have enough licensed practical nurses and health care aides in the staff mix.

Then you begin to wonder what difference it would make if we changed the model of service delivery and had collaborative practice models that incorporated all three. We're only beginning to explore that area of research, but I can give you one tiny example of one medical unit in which we've moved to a collaborative practice model. On a day shift, for example, we went from having 9.5 equivalents of registered nurses and two health care aides to six health care aides, five registered nurses, and four licensed practical nurses. You begin to change, and we're having improved outcomes, more job satisfaction, and a whole lot of stuff. Just that one unit begins to give you a sense of the potential that exists for beginning to work differently, but it also highlights a problem in the mix of people available to us: we can't implement that model in as many places as we'd like because we don't have enough licensed practical nurses in Alberta, and so on and so forth.

That is just an early example of experimenting with new models of service delivery through collaborative practice. What does that mean? We have occupational therapists telling us they are asked to come and be part of the care team when one provider has a particular idea about what that OT can do. As one occupational therapist said, “I'm treated as if I am a technician. I'm called in when somebody wants me to perform a particular test, but if I had been brought in a little earlier, I might have prevented the decision to send that patient to long-term care rather than back home”.

Those are just examples.

● (1700)

The Chair: Thank you, Dr. Besner.

Go ahead, Ms. Murray.

Ms. Joyce Murray: Thank you.

I'm going to go back to Dr. Bennett's question about the high-level recommendations you'd give if this were your study and you wanted to point the direction, and I'll also be touching on the comments around under-utilization of resources and pan-Canadian visions.

My context is obviously British Columbia. There we're using midwives because there aren't enough obstetricians, but there is actually research that supports the outcomes midwives get. We're also moving to primary care teams that would include naturopathic physicians, and so on. In B.C., a Chinese doctor is part of a regulated profession, with a college, and in how many other provinces is that the case? Probably fewer than half are in that situation. When we want a pan-Canadian vision and if we want to tap into all our health care professionals, including complementary professions, we've got a big problem.

Do you think it would be beneficial to have a pan-Canadian direction around regulatory and scope-of-practice equivalency across the country, so that Nova Scotia would know what a naturopathic physician is and midwives could do their work and have hospital privileges right across the country? Do you think that's possible? Do you think it would be beneficial? How key is that equivalency in the scope-of-practice and regulatory approach for a pan-Canadian vision, or can we work around that problem?

● (1705)

The Chair: Who would like to take that on?

Ms. O'Neil, thank you. Please go ahead.

Ms. Maureen O'Neil: Certainly that is a vision. I wouldn't, in practical terms, see it happening soon. On the other hand, I think it would be useful to have regular discussions around the key question of how different provinces are regulating, just for the benefit of having those discussions. The federal government would never say, “Now we are going to do this”, but if there were a means of starting those discussions and if they were seen to be taking place, I would think it would be extraordinarily useful. Otherwise, everybody's redoing everybody else's work. However, I know people have spent entire careers working on interprovincial trade and the removal of trade barriers, so I wouldn't see it happening any time soon.

There's another thing. I don't know what the research budget is for this committee, but it would be really interesting to make the point that you can't really talk about health human resources without understanding what the actual organization of the services is going to look like and having a go at pointing out that if services were organized in a certain way, we'd need this many of this kind of profession and that many of that kind. In a sense it is similar to Jeanne's point that at a very micro level, in calculating the cost of running a surgical floor and the nurses to be allocated, you can't say you'll need this many nurses with that training, because it depends who else is there. It would be very important to make the point that it's the way in which services are actually organized and financed that determines how many of which profession you're going to need.

As an illustration, I know the Conference Board of Canada, together with the Ontario Medical Association, was trying out a model in Ontario that just looked at doctors. What's wrong with that model is that it assumes we're only looking at doctors and only looking at the current organization of services, so it gives you just one answer. If you were able to hypothesize a number of different ways of organizing services and then do the modelling, it would make the point very clearly that it's how the services are organized and financed that determines what the spread of different service providers needs to be. It would be a big contribution just to make that point.

The Chair: Dr. Besner, would you like to make a comment before time runs out?

Dr. Jeanne Besner: I agree. I think there are two issues in health human resources. One of them is the scope of practice and the optimized utilization of professionals; the other is the service delivery model and the way in which care is organized. One can't really be fully looked at without the other. We haven't done that at all in most places in Canada.

The Chair: Sorry, your time is done, Ms. Murray.

We'll go to Ms. Wasylycia-Leis now.

Ms. Judy Wasylycia-Leis: Let me just take it into another direction we really haven't touched on.

I agree with and really appreciate all your comments around looking at the whole delivery model, thinking outside the box, multidisciplinary approaches, holistic medicine practices, blah, blah, blah.

The fact of the matter is that we've got a real serious crisis right now in Canada. Canadians are desperately trying to get some answers from us and they're looking to Parliament. We have a health human resources strategy that was just renewed, but based on the analysis of the last five years, that didn't produce much. So what advice can we give to the federal government and the Minister of Health today to put some teeth behind that supposed national health human resources strategy? The strategy has money attached to it in the sense that money was parcelled off from the transfer to be designated for dealing with health human resources. What do we do at least in the short term on that front?

Secondly, do you see a federal role for dealing in the short term with some of the shortages? For example, in the past it was the federal government that built colleges for doctors. These days, everybody sort of washes their hands and says it's not our doing, it's up to the provinces. If we don't get some coordination at the federal level, the whole thing's going to come crashing down before we get a chance to put in place all this stuff we've been talking about for thirty years. So I guess I'd like to hear some short-term recommendations as well in terms of dealing with some of these problems.

● (1710)

Mr. Jean-Marie Berthelot: Well, I don't think it would be a recommendation, but I think we maybe need to think about trying to identify where we would be ten or twenty years from now, even just projecting the number of human resources we have now. I think that's something that we don't do as a country, and it's something we should probably be doing.

Nationally, how many physicians and nurses we have, which is the pool available... With the interprovincial trade agreement now, where professionals can be recognized across the country, that's the pool of people we have to deal with. That's one thing. The second thing is, there's no short-term solution for physicians. It takes a long time to train a physician. It takes a long time to train a nurse. I think we need to maybe do an inventory of all the increases in number of seats in nursing, physicians, and other occupations.

It's my personal evaluation, but I think we would see that there has been progress, at least in terms of the training. It doesn't mean that it addresses today's problems, because it takes a long time to train a specialist. I think we should be careful about acknowledging a lot of effort that has been done by many provincial governments. We talked about the primary care transition fund of $800 million. To be frank, that's not a lot when you're talking about $172 billion a year in terms of spending. However, you see that in many jurisdictions there's group practice, *groupe de médecine familiale* in Quebec. Many provinces have implemented different ways of providing care. In Ontario you have.... What are they called?

Ms. Francine Anne Roy (Director, Health Resources Information, Canadian Institute for Health Information): Nurse practitioners.

Mr. Jean-Marie Berthelot: Nurse practitioners are heading group practice clinics.

There are changes that have been made. However, it's a big workforce, with people who have a lot of skill and need a lot of education. It takes time to change. But in the numbers we produce, we already see an increase in the number in the workforce available. There's an increase above and beyond the population growth. The other issue is how they are organized and how they work, but I think some progress has been made.

The Chair: Yes, Dr. Besner.

Dr. Jeanne Besner: I think one of the things that also was helpful to me, and it may or may not be to you, is there is a pan-Canadian planning framework that identifies all of the elements of health human resources planning that will lead us to the outcomes we want to get at the patient care provider and system level. We have a lot of evidence about different pieces of that puzzle, but the evidence has never been pulled together.

We haven't done the comparisons of the supply in one province versus another and why that is and so on and so forth. I think we have a lot of information that has never been pooled together into a systematic way of looking at where we want to go, but the framework for doing that is there. I know when—

Ms. Judy Wasylycia-Leis: Do you think it's up to our committee to pool this information? Who could do this? Who could do the inventory that projects that stuff?

Dr. Jeanne Besner: I don't know, but I know that when we started our program of research eight years ago, I used that framework to do the literature review. That's how we began to identify where we wanted to zero in on the elements of the research that we felt needed to be done. It identified where the biggest gaps were.

The Chair: Thank you, Dr. Besner. Thank you, Ms. Wasylycia-Leis.

I now go to Mr. Brown.

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

I'm going to focus a bit more specifically on physician levels. That's an acute concern in my riding.

My first question would be for the Canadian Institute of Health Information, because I found some of your statistics interesting. I wanted to know if you've been able to break it down between care outside of hospitals and hospital-based care in terms of some of the shortages. I know that when our hospital goes on a recruitment tour for physicians, the sense in the community is that it's family doctors, family doctors, and family doctors, but I was shocked by the levels of the shortages that exist in fully staffed hospitals. Do you have any statistics or information on the breakdown specifically for hospital shortages?

Mr. Jean-Marie Berthelot: Well, "shortage" is a relative term, so CIHI doesn't make statements about if there or is there not a shortage. We have information about where are the physicians' main locations of practice. I don't have the data with me, but we could provide information about how it varies by health region, by city, and by riding, if you want, in terms of the proportion of physicians working in the community versus those mainly working in hospitals. Some physicians would work in both or many of them would work in both. That we could do, but I don't have any information about—

● (1715)

Mr. Patrick Brown: If that information could be passed on to the committee, I'm sure it would be appreciated.

Mr. Jean-Marie Berthelot: Yes.

Mr. Patrick Brown: In terms of the Health Council, I know that one of the working groups was on health human resources, and that's terrific. Do you know if that working group looked at—I know Judy was a little bit into this—any collection of data, province by province, on how medical enrolment is changing and whether we are going to see some positive trends in the future based on increased enrollment? In Ontario, there's that medical school in Thunder Bay, and there's obviously talk elsewhere of medical enrollment expansion. Do you have any national picture of the direction in which we're heading?

Mr. John Abbott: The answer is that we don't, but we do know, just by some of the information that's come our way, that different provinces are starting to add capacity to their medical schools.

One comment, more of a personal one versus being the Health Council's, is that from the committee's perspective, one issue or a case study to look at is whether Canada can be or should be self-sufficient in its medical doctors. Nobody's ever really answered that question.

If you develop one or two or three scenarios and try to get to the answer there, it would tease out a lot of the issues in terms of how we conduct care, roles of physicians versus roles of nurses, and what have you, because the fact that in 2009 we're still having to recruit offshore—literally—begs the question.

Mr. Patrick Brown: Here's my challenge. I always hear that we have to recruit offshore, but when I asked Dr. Murdoch, who works at the U of T medical school, how many applications they had for their 25 foreign spots, he said they had 11,000 applications. So the notion that it's one of our tools for success doesn't appear to be the case, because if it were a tool for success, we could solve it there alone.

What I'm more interested in is the working group specifically related to physicians. What areas has the working group focused on in terms of physicians?

Dr. Jeanne Besner: We didn't.

Mr. Jean-Marie Berthelot: If I can add to that, we know how many physicians are enrolled in these faculties. We know how many spots there are in the faculties of medicine in the country and we report the trend. This is part of this report, on page 30. We do update the statistics on a yearly basis. That was a flagship report, so it's two years behind, but we do have that information. It's made available and it can be traced.

In terms of internationally trained physicians, what we see is that we rely less on them than we have in the past. The number of internationally trained physicians in the physician workforce has been relatively stable, at about 13,000 to 14,000 out of 64,000 physicians, for probably the last ten years.

The issue of being self-sufficient is very complex, because there's also the right to a better future for people who live outside Canada. I think the ethical issues there relate to when Canada may be recruiting in countries where there is a shortage of physicians, countries in development, but we need to acknowledge that about one out of five Canadians are not born in Canada, and we have about one out of 85 doctors that are trained outside of Canada. I think we need to be careful about saying that we would need to have an objective of zero internationally trained physicians. That may not be appropriate.

Mr. Patrick Brown: Don't get me wrong. I'd love to see more internationally trained physicians.

The Chair: I'm sorry, but you're over time.

Go ahead, Ms. Wong.

Mrs. Alice Wong (Richmond, CPC): First of all, I am really fascinated by this committee. Maybe I should have chosen this one.

Thank you very much for coming. My background is in entrepreneurship education, but then I happen to have served in a college that had two years of nursing, moving into four years. A lot of students were coming from overseas. A lot of them were immigrants. I have some questions in that area specifically, especially regarding nursing. Coming from B.C., I can only use the B.C. models in my comments and questions.

First of all, regarding nursing education, we heard there is a shortage of nurses, but I also heard that there's a shortage of nursing educators. There could be very complex reasons, and I don't know whether you have looked at that area. Very often funding is one area, but there is also a lack of nurses wishing to go into academia, where they do train nurses and they do research as well. We have a pool of people, a resource of people who really have the experience. I don't know whether your study has even touched on the area of resources in nursing education and the model that could be used to utilize such rich resources. That's question number one.

Question number two is related to foreign-trained medical professionals. It is true that we are losing some of our physicians to overseas, because they offer better working conditions and other things, but at the same time we have an influx of people who really have that training and just need the foreign credential recognition and the extra training. Again going back to the B.C. model, several colleges that have now been upgraded to universities are offering one-year special programs for foreign-trained nurses with a degree. What they're preparing them for is the background in practical areas in the province and the language they need to write the RN exam, the registered nursing exam. Has that even been touched? Dr. Besner, in your studies about nursing, I don't know whether that has been considered as one of the possible solutions to the shortages.

My third question is about mobility. I agree 100% that shortage is a relative term. Even within the same province there's a shortage of physicians or nurses in the north, but in certain areas nurses or other professional practitioners are still waiting for jobs. It is the distribution as well. I don't know whether you have looked at that as part of your research.

I have tons of questions, because I'm new to this committee. I don't know whether I'll be coming back again, but I just wanted to ask.

Thank you.

● (1720)

The Chair: Who would like to tackle that one?

Go ahead, Dr. Besner, and then Mr. Berthelot.

Dr. Jeanne Besner: In terms of your question around models of nursing education, we recognize that there is a shortage of nursing faculty. The faculty is aging, and so on. There is beginning to be work looking at different models, such clinical scholars and so on. We know that in nursing we have an approach to clinical education that is very different from the approach in medicine, so we need to start looking at those. My team and I personally haven't, but work is going on in that area.

A lot of work is currently being done in looking at the assessment of internationally educated nurses and whether it's equitable to the process that Canadian nursing students go through. It is beginning to emerge. You've identified a lot of issues with internationally educated nurses in terms of cultural adaptation and language, but there is work going on. I don't know if it's particular to the western provinces, but there is work going on through the Mount Royal College. It's an assessment project that was funded by Health Canada.

I can't answer your question about distribution. There are a lot of differences across the country in terms of the mix of different kinds of providers who are available to staff service delivery models and so on. There's a lot of difference across the country.

Mrs. Alice Wong: I think that some of the measures that both the provincial governments and federal government have done include encouraging new grads to go to areas where there's a greater demand for nurses or physicians. Have you looked at that?

Dr. Jeanne Besner: Yes.

Mrs. Alice Wong: I hope it's working, because in B.C. we're doing that. The federal government definitely is encouraging medical students, as well as nursing students, in areas where we can even waive their student loans. Those are some of the incentives.

Talking about provincial differences, again, I think the Prime Minister has spoken to all of the different provinces about foreign credential recognition.

The Chair: Be very quick, Ms. Wong. Time is running out.

Mrs. Alice Wong: So there is also the matter of foreign credential recognition across the provinces.

A voice: Yes.

Mrs. Alice Wong: If you can practise in B.C., why can't you practise in Ontario? That's my question.

The Chair: Go ahead.

Dr. Jeanne Besner: That's under way.

The Chair: That's under way, is it?

Dr. Jeanne Besner: Yes, it is.

● (1725)

The Chair: Would anybody else like to make a comment on that?

Mr. Jean-Marie Berthelot: In terms of mobility, we have done a study using census population data, looking at 30 health professions, to see how these professions move within provinces between rural and urban areas. We're updating it now with the 2006 data now available, which provides a lot of information on that.

We also produce information about the rate of nurses and physicians by health regions, so you can look at rural versus urban health regions. We're looking at the professionals who provide care, because in large centres there are a lot of professionals who are working in education. That's been provided, and it's done so across the country for all health regions.

The Chair: Good. Thank you.

This has been an extremely useful afternoon. Your coming to the committee to give us your insights and ideas has been of paramount importance to us. As I said earlier, this committee is going into a very detailed study on this issue, and some of the things you said today caused us here at the table to see some gaps that we need to fill at the rest of the committee's meetings.

I want to thank you very much for being here today.

I just have one more thing to talk to the committee about, and then we will adjourn.

Mr. Jean-Marie Berthelot: Thank you very much.

The Chair: Committee members, just to tell you, the main estimates will end on June 23. The agencies that we have appearing so far on May 12 are the Canadian Institutes of Health Research, the Assisted Human Reproduction Agency of Canada, the Patented Medicine Prices Review Board, and the Hazardous Materials Information Review Commission. And, as you know, on May 14 the Minister of Health will be attending.

If you have anything else you want added to that meeting on main estimates, could you just think about it and then hand your request to the clerk?

Thank you. The meeting is adjourned.

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