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Tuesday, April 28, 2009

Chair

Mrs. Joy Smith

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● (1530)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): Good afternoon, ladies and gentlemen.

Thank you so much to our witnesses for joining our committee. We certainly very much value your input.

Prior to starting with our witnesses, I am going to just take one moment. A motion has been submitted by Judy Wasylycia-Leis. I know she needs the will and consent of the committee; otherwise, she is going to need to have this on the docket for 48 hours.

Ms. Wasylycia-Leis, would you like to speak to your motion for a moment?

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

I'd like to request unanimous consent from the committee to deal with the motion before you today. It has, of course, to do with the swine influenza, and it provides a mechanism whereby the health committee could be involved when the situation demands that kind of committee collaboration. I say when it demands; I mean, in fact, that right now we are having regular briefings from the government, from the Public Health Agency of Canada, and the communication has been good. We've been in the loop—and that's on an all-party basis—with daily meetings. We also know that the Public Health Agency of Canada has been effectively dealing with the issues and is certainly following its mandate of providing ongoing surveillance around the swine influenza and coordination of the necessary public health response.

My suggestion is that we empower the chair to convene meetings as necessary on an emergency basis as this issue progresses and as we receive more information or requests from the Public Health Agency of Canada.

The Chair: Ms. Murray.

Ms. Joyce Murray (Vancouver Quadra, Lib.): Thank you, Madam Chair.

I think all members of the committee share the deep concern that was just expressed; however, we will be opposing this motion for the reason that there is a motion under discussion by the House leaders currently to deal with this, which we think is a more comprehensive approach than one meeting by the health committee.

I would like to read this proposed motion, which is being discussed and negotiated as we speak. It proceeds as follows:

> That in order to reinforce the confidence that all Canadians should have in Canada's public health system at this time, when concern is growing in many countries about the risk of a new international influenza outbreak, a special surveillance committee of parliamentarians is hereby established, with all the powers given to standing committees by the Standing Orders, consisting of 11 members of the House of Commons, including five from the Conservative Party, three from the Liberal party, two from the Bloc Québécois, and one from the New Democratic Party, with a chair to be elected from among the government members, for the purpose of monitoring all developments in respect of the influenza situation and ensuring that the public receives the timely, accurate, and useful information needed to react appropriately to evolving events. To that end, the parties should select their representatives on this committee at least in part based on their expertise in public health matters. The committee should receive daily briefings from senior government officials, in camera when necessary, on all matters that it deems to be relevant to protecting and promoting the public interest.

That's being debated.

Madam Chair, I propose that this motion before us be withdrawn until such time as the proposed Liberal motion that the House leaders are debating has come to its conclusion.

The Chair: Thank you, Ms. Murray.

Ms. Wasylycia-Leis.

Ms. Judy Wasylycia-Leis: Thank you, Madam Chairperson.

This motion stands on its own for the work of the health committee. Given the reaction, I think, to the Liberal motion presented yesterday and the idea of another whole structure, another semi-permanent subcommittee—sub or not—it was felt that it's the last thing we need, and that in fact what we need is a mechanism by which, if necessary, the health committee is consulted.

The committee is now made up of all parties and has good expertise from all parties. It was felt that there's no need to reinvent the wheel and set up another whole structure just to do this. In fact, between the regular briefings we're getting, the work of the Public Health Agency of Canada, and the work of our own committee, we have provisions to deal with the unfolding situation with respect to the swine influenza.

● (1535)

The Chair: Thank you.

Just for clarification, Ms. Murray, my understanding is that that particular motion was taken to the House yesterday and was denied. Is that correct or incorrect?

A voice: Yes, it was.

The Chair: Ms. Wasylycia-Leis.

Ms. Judy Wasylycia-Leis: Just a point of information. The motion that's just been read by my colleague from the Liberal Party was presented to the House for unanimous consent and it was denied. It is still going to the House leaders' meeting as we speak, and as I understand it, they will have a full discussion, but they will also take into account the fact that our committee has this motion before it, which might provide an alternative to the suggestion being made.

The Chair: Thank you.

Mr. Carrie.

Mr. Colin Carrie (Oshawa, CPC): Thank you very much, Madam Chair.

I think the government can support this motion and would be happy to move it forward.

The Chair: Monsieur Malo, you're next.

[*Translation*]

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

Ultimately, there's nothing compelling about this motion, since it gives you the power to convene a meeting of the committee.

However—and I often repeat this to colleagues around the table—there is nothing, at any time, preventing members, together at a meeting, from determining what will be on the agenda. Whether we adopt this motion or not, it will still be time later for committee members to convene an emergency meeting on this situation, if the need is felt.

Of course, Madam Chair, we can give you the power to do so, but the power will ultimately belong to the members of this committee. That's it.

[*English*]

The Chair: Dr. Bennett.

Hon. Carolyn Bennett (St. Paul's, Lib.): Time and time again, I think we have learned that trying to develop work plans by motion is not a good way to go, and we need to be able to have a constructive discussion about how we would go forward.

I think this motion is totally inadequate to allow the supervision of this outbreak in a comprehensive way. We need to find a way that should the level rise to level 5, level 6 on a weekend, we can have updates. We need a way of going forward.

I hope the House leaders will make a decision about that, but the idea that this motion moves us any further forward to an active supervision of this outbreak is not good enough, I think, in terms of the Liberal position. We don't need a motion to call public health officials, but we also have been, I think up until now, heartened by the fact that when I spoke to the minister on Sunday and asked for a briefing on Monday, we got it.

We then spent two hours this morning trying to get an update, a briefing for today, and finally got it. I don't want to spend two hours of every day trying to negotiate with the minister's office about whether we get a briefing or not. We want an ongoing way that we can do this so that we can know on the weekend if there's a way that members....

Madam Chair, today in the briefing what we heard from Dr. Grondin was so important, in terms of just how we as parliamentarians can accidentally use the words “travel advisory” instead of a “travel warning”. These kinds of things make it hugely important that we all be on the same page at all times. An extra meeting here or there is not going to do the job of having parliamentarians seriously in the loop at every decision taken.

I was told this morning by the minister's office that nothing had changed since the briefing yesterday and we didn't need one. In fact, the WHO had raised the level up to level 4. In fact, Canada had issued a travel warning, and therefore we had to fight back.

I do not want to spend my time as a parliamentarian fighting with the minister's office to get briefings. I want something formal and I want it ongoing, and this motion goes nowhere near what we need.

● (1540)

The Chair: Thank you, Dr. Bennett.

You did not get consent of the committee, so you'll have to withdraw it, Ms. Wasylycia-Leis.

Ms. Judy Wasylycia-Leis: I'm not withdrawing it, Madam Chair. I'll wait 48 hours.

The Chair: Bring it back in 48 hours. We were just trying to get it done today, and that is not going to happen. So bring it back and you'll have the 48 hours' notice. Thank you for the motion; it was very good.

Now I would like to go to the witnesses. We have some very dynamic witnesses today. We have representation from the Canadian Federation of Nurses Unions, the Canadian Medical Association, the Canadian Nurses Association, the Royal College of Physicians and Surgeons of Canada, and the Canadian Chiropractic Association.

We will begin with the Canadian Federation of Nurses Unions and Linda Silas, president.

You may give a 10-minute presentation, and after all the presentations are made we'll go to questions.

Ms. Linda Silas (President, Canadian Federation of Nurses Unions): My name is Linda Silas. I'm the president of the Canadian Federation of Nurses Unions and a proud nurse from New Brunswick. We represent nine nurses' unions across the country, and we have excellent working relationships with the Fédération interprofessionnelle de la santé du Québec. As you know, over 80% of nurses in Canada are unionized. We thank the Standing Committee on Health for the opportunity to share our views.

I realized this morning when preparing my notes that I've been in this job for six years and have presented more or less the same recommendations and more or less the same data on a yearly basis to more or less the same committee or committee members. The federal government itself has spent millions on HHR sector studies. The evidence is clear: there is a nursing shortage and it's not getting any better. Nurses across the continuum of care, in hospitals, long-term care, home care, and in our communities, are living the symptoms of the shortage every day, and we need action on a long-term basis.

CFNU's first recommendation is the creation of a national observatory on HHR. Provinces are spending health care dollars competing with each other to attract nurses and other health care workers from one jurisdiction to the other. There's not one jurisdiction in Canada that's currently producing a nursing surplus. The existing federal-provincial-territorial Advisory Committee on Health Delivery and Human Resources would need to have its mandate expanded and membership expanded to include active participation from stakeholders in order to have realistic and attainable goals. Or maybe a better idea is to start afresh with the national observatory on HHR that stakeholders have been requesting for a number of years.

We stress again the engagement of stakeholders, the only way to ensure appropriate and accountable actions, targets, and timeframes. We have to remind ourselves once again that health care is not only a government issue, it's everyone's issue.

Our second recommendation is to continue and increase the data collection and reporting on HHR. This role must be filled by the federal government. Repeating the national survey of work and health of nurses conducted by CIHI and Statistics Canada and expanding it to other health care professionals is a must. It will also measure the impact of change in policy and practice from the perspective of the workforce.

Third, fund innovative projects related to retention and recruitment in HHR in Canada and across the continuum of care. Forty-nine per cent of nurses retire before the age of 65. That's compared to 43% of any other field. We cannot afford to lose this experience in patient care. For example, CFNU receives support from HRSDC for a project in Cape Breton to provide an opportunity for nurses to upgrade their skill set and meet a serious nursing shortage in critical care while remaining in the rural region. We also had a project in Saskatchewan where valued, experienced, and seasoned nurses were allowed to work on a mentorship program. This year we received funding from Health Canada for nine pilot projects to apply evidence-based retention recruitment strategies. This is a start.

This kind of innovation in the workplace, supported by macro-level resources, will ensure retention of a skilled workforce. How often do you hear and see federal funding applied and evaluated directly in the workplace? This is the only way to make real and sustainable change.

Of course we have to talk about child care. Most of our population are women and child-bearing, so we have a fourth recommendation on supporting the creation of a child care program that addresses the need for shift work.

Our fifth and last recommendation is the creation of a federal HHR fund to support education and lifelong learning. As CFNU mentioned before, the federal government can use the EI program to provide educational support to health care workers entering nursing and for nurses to expand their scope of practice through job laddering and specialty training. This would complement support given to the building trades apprenticeship program that already exists under EI. These strategies would help attract more aboriginal Canadians to the health care workforce and would help underserved communities, supporting local residents to enter and progress in the health care profession, and would bring best investments to build sustainable services in those regions.

As a conclusion, what is the price of inaction? A high workload leads to a high turnover rate, and turnover is really expensive in our profession. It can be up to $64,000 per nurse. A shortage means the present workforce is doing a large amount of overtime, a costly solution for an inadequate supply of nurses. In 2005 it was 18 million hours of overtime, 144% more overtime than was worked in 1987.

● (1545)

Currently, CFNU is updating this study, but the preliminary reports are suggesting that the numbers are even worse. Let's remember that 66% of young nurses are showing signs of burn-out.

The extensive and growing body of research showing the relationship between nurse staffing levels and patient outcomes should be the most compelling reason for government and policy-makers to address the nursing shortage. But using the shortage as an excuse to bring in less skilled, less knowledgeable workers—similar to what the Canadian Blood Services is trying to do today—is plainly dangerous and should not be supported by any policy-maker concerned about public policy.

We thank the committee for undertaking this important study. Hopefully, we will meet again next year to provide you with a progress report and not a whole bunch of further recommendations. This problem is ongoing, and we all need to stay very focused on this issue.

Merci beaucoup.

The Chair: Thank you so very much for that insightful presentation.

Now we'll go to Dr. Ouellet from the Canadian Medical Association.

[*Translation*]

Dr. Robert Ouellet (President, Canadian Medical Association): Thank you very much.

Good afternoon, everyone.

I am Dr. Robert Ouellet. I'm a radiologist from Laval, Quebec, at least when my duties as president of the Canadian Medical Association allow me.

It is essential to address the labour shortage in the health sector in Canada if we want to transform the Canadian health system into a truly patient-centred system. The research conducted as part of the Canadian Medical Association's health care transformation initiative shows that the European countries that have universal access and do not have significant wait times all have a higher physician-to-population ratio than ours.

[*English*]

During the 2008 federal election campaign, four of the five parties represented in the House of Commons heard the CMA's warning about serious shortages in the health care workforce. They all promised to act. We haven't seen action on that front yet.

The CMA is here today to present a plan of action in three specific areas: capacity, the retention of Canadian physicians, and innovation. In our brief, you'll find 12 practical recommendations within the jurisdiction of the federal government.

Canada lags behind other countries in our capacity to educate and train physicians.

[*Translation*]

Currently, between four and five million Canadians do not have a family doctor. The problem doesn't just affect the rural areas. We're talking about places like Barrie, Ontario, as the honourable member from that riding very well knows. The same problem exists in Quebec.

More than one-half of Canadian physicians are over 55 years of age, and I am one of them. Many of them will be retiring soon or will be reducing their workload. Most are no longer accepting new patients.

At the same time, medical progress and better living habits are enabling Canadians to live better and longer, which further increases demand for health professionals. As you know, chronic diseases are increasingly a burden.

● (1550)

[*English*]

But with better coordination among jurisdictions to allow HHR planning on a national scale, we can respond to these challenges. Canada's doctors and other health professionals are ready to assist policy-makers in their planning and coordination to better meet the health care needs of Canadians.

International medical graduates, or IMGs, also play a huge role in Canada's supply of doctors. Close to one-quarter of all physicians in Canada are IMGs, and the CMA fully supports bringing into practice the qualified IMGs already in Canada. However, poaching doctors from countries that cannot afford to lose them is not an acceptable solution to our physician shortage. Canada must strive for greater self-sufficiency in the education and training of physicians.

[*Translation*]

The Canadian Medical Association also believes that the same evaluation standards must be applied to foreign graduates as to the graduates of Canadian medical faculties. The CMA further recommends that greater funding be made available to the provinces so that they can offer mentoring programs to foreign graduates to enable them to obtain their licences.

[*English*]

It is also important to note that up to 1,500 Canadians are studying medicine abroad. Two-thirds of these homegrown IMGs want to come home to complete their post-graduate training. We must increase training opportunities so that we don't lose Canadians who have studied medicine to other countries. We must understand that Canada's teaching centres are bursting at the seams as they try to meet demand. This must be addressed.

[*Translation*]

Competition to attract physicians is raising a few challenges for us here in Canada and internationally. The new Agreement on Internal Trade within Canada and other agreements will ease the movement of health professionals from region to region, but could make it even more difficult to retain physicians in under-serviced areas. The international demand for medical staff has never been as great. Canada must continue to strive to retain the health professionals it has trained and to facilitate a return to Canada by physicians wishing to return and practise here.

[*English*]

While Canada must do more to increase both our supply and retention of HHR, we must also support innovation in order to better use existing health resources. Collaborative models of care and advances in information technology can help create a more efficient health care system that provides higher-quality care. In fact, new collaborative care initiatives are popping up across the country to the great benefit of patients.

[*Translation*]

Information technologies can help create a more efficient health system, but Canada lags far behind the other OECD countries in the adoption of electronic medical records. Recent investments in Canada Health Infoway will help, but an estimated $500 million should be invested to equip all points of care in the communities.

[*English*]

Canada's doctors believe we can build a health care system where all Canadians can get timely access to quality care services regardless of their ability to pay. To do this, we must shift our attitude and implement new strategies, new ideas, and new thinking. This is what the CMA's ongoing health care transformation project is all about.

[*Translation*]

A national health human resources strategy is the turning point for our efforts to build a patient-centred system. All we're lacking is action.

Thank you.

● (1555)

[*English*]

The Chair: Thank you so much, Dr. Ouellet.

We will now go to the Canadian Nurses Association, to Kaaren Neufeld, the president of that association.

Welcome.

Ms. Kaaren Neufeld (President, Canadian Nurses Association): Thank you. Good afternoon. My name is Kaaren Neufeld and I am the president of the Canadian Nurses Association, which represents some 136,000 registered nurses and nurse practitioners across Canada. Thank you for the opportunity to present to you as you are studying health human resources.

The brief I'm presenting to you today is organized into three main areas. I want to talk about the RN shortage, health and safety in the workplace, and national-level HHR planning. However, first I want to acknowledge the federal government's commendable leadership so far in health human resources, particularly with regard to a number of issues: the health accord in 2000, the allocation of $85 million to the renewal of health human resources, the annual $20 million it committed to the national health human resource strategy in 2003, the creation of a 10-year plan in 2004, and the creation of the framework for collaborative pan-Canadian HHR planning.

However, challenges remain, as we all know. I will discuss the nursing shortage first.

In 2002, CNA used past workforce patterns to project a shortage of 78,000 registered nurses by 2011 and 113,000 RNs by 2016. Next month, CNA will release its new report on Canada's RN workforce, entitled *Tested Solutions for Eliminating Canada's Registered Nurse Shortage*. This report will estimate the number of nurses we'll need in clinical care in Canada from 2007 to 2022. We will use those numbers to estimate how far we'll fall short of those estimates.

More importantly, this time the report will highlight what we can do about the shortage by quantifying the impact of six specific policy scenarios that can reduce or even eliminate the shortage. One of the key solutions to the nursing crisis outlined in this report lies in more effective and efficient use of existing resources, including better use of technology, changing work processes, and addressing workplace issues that lead to absenteeism and turnover.

For example, one employer in Ottawa found that 30% of the work RNs were doing could be done by staff who did not have a registered nurse's skills or knowledge. The facility added support staff to complement its workforce of registered nurses and thereby reduced the time nurses were spending on non-nursing duties.

In light of the successes of this initiative and many others like it, the Canadian Nurses Association recommends that the government establish a formal mechanism or tool to promote the sharing and adoption of innovative yet practical solutions to the health workforce crisis.

Now I'd like to turn to the second point in this brief: the issue of workplace health and safety and its impact on health professionals. Four years ago, the national survey of the work and health of nurses ranked nursing as one of the sickest professions in Canada. Nurses' absenteeism due to illness and injury was 58% higher than the average found in the labour force overall. A similar study for physicians found that almost one-quarter of physicians had been depressed in the past year.

Those surveys were just a snapshot in time. We don't know if these trends have continued since then, and we don't know if the investments in workplaces have made a difference, so the Canadian Nurses Association recommends that the federal government fund an ongoing national survey of the work and health of nurses, and that the survey be expanded to include other health professionals as well. We also recommend that the government implement a national occupational health and safety strategy for the health workforce.

I come now to my third point, which is national-level planning in health human resources. Although provinces and territories are primarily responsible for health care deliveries, CNA and the Health Action Lobby believe that the health workforce is a national resource. Health professionals and students of health programs are mobile. The federal, provincial, and territorial governments themselves recognized this when they recently revised chapter 7 of the Agreement on Internal Trade. In addition, research shows that factors affecting the recruitment and retention of nurses do not differ greatly from one province or territory to another.

The federal government invested $12 million in six sector studies, including nurses, physicians, and pharmacists. They produced concrete strategies addressing the health workforce crisis. Unfortunately, very little action has been taken on these reports.

Similarly, federal, provincial, and territorial governments developed the framework for collaborative pan-Canadian HHR planning. Progress is slow, and CNA is concerned that implementation of the action plan is not receiving the attention and support it needs from governments.

● (1600)

The Canadian Nurses Association recommends that annual funding for the pan-Canadian HHR strategy continue for at least another decade and be increased to $40 million per year to support the activities identified in the action plan of the framework for collaborative pan-Canadian HHR planning.

We recommend that the federal government create a pan-Canadian HHR institute or observatory. The concept of an HHR institute was put forth by several of the sector studies that I mentioned a few moments ago, as well as by CMA and others.

Health human resources institutes and observatories have been implemented in Europe, Africa, Latin America, and the Caribbean. In Canada, the observatory would bring together researchers, governments, employers, health professionals, unions, and international organizations to monitor and analyze trends in health outcomes, health policy, and HHR to provide evidence-based advice to policy makers. It would also spread information about promising advances in HHR activities across the country and would coordinate HHR research.

In conclusion, we understand that these are difficult economic times, but having a healthy, stable, and sufficient supply of health professionals is necessary to keep Canadians healthy and productive.

CNA's upcoming report on the shortage of registered nurses in Canada will show that the shortage can be resolved, but it requires both political will and resources on the part of the federal government. CNA has invited all MPs to the release of this report on May 11, and we urge the committee to attend.

Thank you for your time today and for this opportunity for CNA to continue to work with the federal government on this important issue.

The Chair: Thank you so much for your presentation.

We'll now go to the Royal College of Physicians and Surgeons of Canada, to Dr. Andrew Padmos.

Dr. Andrew Padmos (Chief Executive Officer, Royal College of Physicians and Surgeons of Canada): Thank you, Madam Chair, honourable members, and colleagues. It is a pleasure to appear in front of you today. My name is Andrew Padmos. I'm the CEO of the Royal College and a hematologist by training. I continue a small but very important clinical practice in hematology in Halifax, Nova Scotia, where I recently lived before moving to Ottawa.

The Royal College was created by a special act of Parliament in 1929 to ensure the highest standards for the training, evaluation, and practice of medical and surgical specialists. We now supervise the training and certification of 61 specialties and subspecialties and represent a population of 43,000 specialists out of the approximately 70,000 members of the medical workforce in Canada.

I would like to commend the work done by governments, health planners, and policy-makers at the federal level in addressing health human resources shortages. My colleagues have mentioned several specific projects. These have improved our understanding, but they have unfortunately not eliminated the shortages and the misdeployment of health human resources across this country. Many citizens, including members of our families and our circles, have suffered from these shortages on a daily basis.

Our analysis in our brief addresses five areas that the committee has identified as important. The first concerns the supply in the medical workforce. These comments are not confined to physicians, however. They are echoed in literally all of the health professions and consider all of the health care providers that make up our important resource in the health system.

Some particular factors make the issues more concerning for physician members of the workforce. Among them, we're aging at a rapid rate, and the number of our members in the medical workforce who have become age 50 or over is up 9.3% since the year 2000. Probably more important, in terms of the number of services provided, we know that the new members of the medical workforce have commitments to a better work-life balance that limit their productivity, and it is often said that for every retiring physician we need to find and train two replacements.

One of the things that is of particular concern and I think is relevant to today's news, the news that's not related to swine flu virus, is the concern over loss of capital in human health research. Our government has made small, incremental, and augmented changes to the health research funding that pale in comparison to the significant additional investment in other countries, particularly the U.K. and the U.S.A. Even today, President Obama of the United States announced a commitment of 3% or more of gross domestic product to the research and scientific agenda in that country, and this is important in retaining the best and the brightest of our physician workforce, our other health care providers, and our medical scientists.

Our recommendations resonate with those made by colleagues. We commend the federal government and recommend its further investment in training, education, and continuing professional development of medical and other health professionals. We would like to see the Conservative federal election campaign promise to invest additional millions of dollars a year for four years to create additional residency training spots in teaching hospitals. We suggest that commitment should be extended by a further 10 years.

We also recommend that the government expand and sustain Canada's investment in both biomedical and psycho-social research for the health system in order not only to improve health care but to retain leading health, scientific, and biomedical researchers who are otherwise going to follow investments made elsewhere and leave our country.

Anyone who has worked at the front lines of health care knows that it is truly a teamwork-based operation, and our members fully support that.

● (1605)

We commend federal-provincial-territorial initiatives to enhance interprofessional education and collaborative practice. We would also like to acknowledge that other health professionals need support so that their work can ensure that Canadians can access more and better specialty care.

For this, we recommend the federal government support the enhanced supply, deployment, and evaluation of such other health professionals as physician assistants and advanced clinical nurses, including nurse practitioners and clinical nurse specialists.

We follow our colleagues in the Canadian Medical Association in identifying internationally educated health professionals as a crucial component of the medical workforce and the health workforce. We suggest targeted funding to expand medical school capacity and postgraduate medical education positions to develop and augment the incorporation of international medical graduates into our practice.

We also identify that not all Canadians have the luxury of living in urban environments where sophisticated health care services are readily available. For northern, rural, or remote areas, we recommend the federal government study the feasibility of creating a special federal infrastructure fund to provide exceptional relief and assistance to rural and remote communities that lack, or are losing, adequate health services.

I'd also like to identify aboriginal peoples and other federal groups as worthy recipients of federal targeted funding. The funding should integrate the framework for aboriginal core competencies developed by the Indigenous Physicians Association of Canada and the Royal College of Physicians and Surgeons into medical curricula in medical schools across Canada. I'd also like to point out that we should have scholarship programs and we should recruit and place first nations, Inuit, and Métis health professionals in practice.

Last, I'd like to return to the recommendation that appears to be common among all groups. At the risk of identifying Madam Silas' concerns in a light fashion, a repetition of the same thing with no discernible result is a definition of insanity. However, I do hope that we're able to see progress on the idea of the federal government working with provinces to establish a pan-Canadian HHR observatory or institute to address the manifest gaps and deficiencies in data research and analysis and to disseminate knowledge about health outcomes, including those outcomes that relate to the amended Agreement on Internal Trade, which we feel will certainly have deleterious results on migration and distribution of health professionals in the short term.

Madam Chair, thank you for the opportunity to present to you today. We commend these recommendations to your committee.

● (1610)

The Chair: Thank you, Doctor.

We'll now go to Richard Valade, president of the Canadian Chiropractic Association.

Dr. Richard Valade (President, Canadian Chiropractic Association): Thank you.

Good afternoon, everyone, ladies and gentlemen, members of the Standing Committee on Health.

My name is Richard Valade. I am a doctor of chiropractic and the president of the Canadian Chiropractic Association. With me today I have Dr. Deborah Kopansky-Giles. She's a chiropractor on the staff of St. Michael's Hospital in Toronto. We thank you for the opportunity to be here today.

We in the chiropractic profession feel strongly that our services are not being properly utilized for the public good. Chiropractic has been rigorously evaluated by the scientific community so that we now have a solid body of evidence that chiropractic care is effective for neuromusculoskeletal disorders such as back pain, neck pain, and headaches. But it's not being used as much as it should be.

We are well aware that the delivery and administration of health care takes place primarily at the provincial and territorial levels. Provinces make decisions about what services their residents are offered. So we know that it's pointless to ask this committee to comment about decisions that are made provincially and territorially. Instead, we confine our remarks to those cases where federal resources are applied directly to health.

We feel that we can do much more to help people whose health services are paid directly from the federal purse. There are some obvious cases. First, the service provided to members of the Canadian Forces is inconsistent. Did you know that a soldier in Afghanistan cannot get any chiropractic care to relieve back or neck pain, but at the same time, back at home, members of his or her family have access to care for back and neck pain through the public service health care plan? It is regrettable that soldiers in the field do not have the choice of highly effective, non-invasive chiropractic care for their back and neck pain. Chiropractic is well established to provide prevention of injury and to relieve major and minor injury to muscles, nerves, and joints, and it is appropriate to those who serve in rocky, unpleasant, and harsh terrain. We feel there is much that we can do to make reasonable health services available in the places where our soldiers serve their country.

The chiropractic profession is represented by several officers currently serving in the Canadian Forces. Dr. Denis Tondreau and Dr. Lison Gagné both serve as active reservists. They are both fully prepared to offer their skills as doctors of chiropractic while on duty at no charge, and yet there is no precedent to allow them to do that. In the past, they have both used their skills to aid their colleagues in spite of there being no regulation to support their work in the forces. Dr. Tondreau served in Afghanistan in 2008 and was welcomed and supported by the medical chief of staff at the base for his chiropractic skills to treat his injured colleagues. However, he could not get his orders changed to reflect his service as a chiropractor. We think this type of situation needs to be rectified. In fact, we think that chiropractors should be in uniform and actively serving in the forces. However, it would be a step forward if service personnel even had reasonable access to chiropractic care, so they wouldn't be second-class citizens compared to their families in Canada.

Dr. Tondreau most recently was deployed to Sierra Leone in November 2008.

Dr. Gagné has been in the Canadian Reserve Force since 2007. During training, Dr. Gagné attempted to alleviate her colleagues' musculoskeletal ailments, an area in which chiropractic excels. However, she was met with hostility from her superior officer and was told not to use chiropractic skills to treat people, regardless of positive results. Most recently, Dr. Gagné trained in Mississippi in January 2009, and she awaits deployment overseas with hopes of utilizing her chiropractic skills for the benefit of her colleagues.

This system in the Department of National Defence is especially concerning when one looks at the RCMP, which has long recognized the value of chiropractic care. For some years, RCMP members have had 2.5 times as many acute care treatments available to them as the Canadian Forces makes available to its members at home here in Canada. The RCMP is currently exploring ways to improve and enhance services and rehabilitation for acute and chronic pain. The RCMP is considerably ahead of the forces in making comprehensive care available to their members.

● (1615)

In terms of Canada's use of chiropractic care, we are significantly behind the United States military. In the United States, the Department of Veterans Affairs calculates that the number one reason veterans seek care when returning from Iran and Afghanistan is lower back pain. In addition, over 20% of U.S. military treatment facilities employ doctors of chiropractic for treatment of military-related injuries.

Let us consider another example: our first nations aboriginal population. Canada's history in dealing with first nations is a blot on our reputation as a dignified and enlightened country. First nations people suffer many health problems, and in many cases their levels of diabetes are higher and their overall levels of health lower than they are in other Canadian populations.

What we see is a highly inconsistent approach to chiropractic services available to the first nations people. Services vary widely, depending on such factors as the province of residence, the particular nation or group they belong to, and the arrangements they have made. This is not the Canada that reflects the values of the Canada Health Act's national principles of portability, accessibility, universality, comprehensiveness, and public administration.

In contrast, as an example of successful first nations care, the Joe Sylvester clinic in Anishnawbe Health Toronto is a pro-service, multidisciplinary clinic that has been offering health care to Toronto urban aboriginal communities since 1996. Health care professionals available at the clinic include chiropractors, physicians, nurses, traditional native healers, and complementary and alternative health care providers.

In this unique setting, comprehensive, traditional, and conventional care is delivered in the spirit of true multidisciplinary cooperation. Dr. Kopansky-Giles has first-hand experience with this clinic.

Building on this example, we would like to see first nations people have equal access to qualified, comprehensive health care services.

Chiropractors are second to none in keeping people healthy and efficient at a very reasonable cost. Essentially, we believe federal populations should have equitable access to chiropractic without gatekeeping. People who have sore necks, sore backs, or headaches should get care right away, get back in action right away, and lose as little time as possible from work and family.

The chiropractic profession prides itself that patients have quick access to practitioners and quick access to treatment. We feel this is a healthier way for the population to stay alive, focused, and engaged. In the long run we feel that not allowing people to become debilitated is a much better way to have a healthy Canada.

We now turn to a very solid example of how care should be offered across the full spectrum of a federally serviced population. It is a wonderful case study of cooperation and efficient service that can serve as a beacon for the best use of health dollars.

St. Michael's Hospital in Toronto offers chiropractic services in one of Canada's first hospital-based chiropractic care clinics. This clinic incorporates the expertise of a health care team of chiropractors, medical doctors, and physiotherapists to deliver comprehensive, appropriate, and high-quality care.

The St. Michael's Hospital department of family and community medicines welcomed the clinic to the hospital in 2004. The initiative was made possible by the Ontario Ministry of Health and Long-Term Care's primary health care transition fund. This successful example of interprofessional collaboration has benefited the hospital, the staff, and, most importantly, the patients.

Because we regard this initiative so highly, we thought it best to send the practitioner who knows most about it to join us here today so that the committee members can explore the working of a program that runs so smoothly and so well.

This finishes my oral comments. Both Dr. Kopansky-Giles and I will be pleased to answer any questions you may have regarding any issue related to our profession's submission.

Thank you.

The Chair: Thank you, Dr. Valade, for your insightful presentation.

We are now going to go to our committee for questions. Our first round is seven minutes per person for questions and answers. We'll start with Ms. Murray.

Ms. Joyce Murray: Thank you, Madam Chair.

What a wealth of comments and suggestions. Thank you for that.

I have four questions. I'll try to make them quick, and I'll lay them out first so that there will be time for you to answer.

Dr. Padmos, do you have any assessment or estimate of the impact of cuts to the research granting councils or the absence of funding to Genome Canada? How might that impact human health resources in the coming years?

Dr. Ouellet, you talked about patient-centred care. I took a look at your presentation. What I didn't see was any recommendation around the kind of continuous quality improvement initiatives that I know have been very successful in British Columbia, Deming-based frameworks for quality and process improvement. They've been used by the Vancouver health authority at Vancouver General Hospital. I'm interested in your comment on the role of that kind of initiative in increasing quality and productivity.

Ms. Neufeld, thank you for your list of all the very positive initiatives that have happened in the early years of the 2000s. It's too bad there wasn't much after 2005.

You talked about the health human resources observatory, and I'd like your comment on the possibility of that observatory including complementary and alternative modalities. CIHI leaders told me they don't even collect information about naturopathic physicians and traditional Chinese doctors, and probably chiropractors, because there's no level playing field from a regulatory perspective. How can we address that?

Dr. Valade, this committee will be making recommendations through the study. What would you like to see as a recommendation to the federal government on how we can rapidly increase the number of collaborative clinics and practices and facilities that integrate complementary and alternative modalities?

Thank you.

● (1620)

The Chair: We'll start with Dr. Ouellet, and we'll just keep on going as you answer. You have roughly about four minutes for everybody.

Thank you.

Dr. Robert Ouellet: Thank you.

This year we're trying to do a blueprint of what the Canadian health system should be. We're looking at every initiative that exists here in Canada and elsewhere to try to improve it. One of them is, of course, quality improvement.

We need to improve efficiency, but quality has to be implemented. The problem is that we have many pockets of very nice initiatives in the country, but we need to put them together and implement it on a larger scale. There are very nice experiences in Canada, but they're not widespread. We need to work on that, and this is part of our project.

The Chair: Okay. I think we'll go to Kaaren Neufeld.

Ms. Kaaren Neufeld: Thank you.

I'm imagining the HHR observatory as an institute that will be a gathering place for people to come together. The CNA really believes in health promotion and illness prevention, and naturopaths and other professionals would have a role to play there. I think it would be important for us to consider the full spectrum of services that Canadians wish to access and, as we set up an observatory and an institute, to involve the full spectrum of individuals to help it grow and develop into something new. Certainly one should consider all the groups that are providing health services to Canadians.

The Chair: Dr. Padmos is next.

Dr. Andrew Padmos: Thank you for your question about the impact of cuts to research. I think there are several.

One is that because of the poor funding environment, young people, whether physicians, nurses, or other health professionals, are not taking up careers in research, either full time or part time, to augment their practice impact.

Second, research teams are being wound up as we speak, and those individuals quickly move to other locations, most of them outside Canada, where such funding does exist.

Third, over the long term I think we create a negative impression of the value of research, and as a country we do not have the benefit of joining with other partners in collaboration on solving really universal health problems.

● (1625)

The Chair: Thank you.

Dr. Valade.

Dr. Richard Valade: Madam Chair, I will let Dr. Kopansky-Giles answer that question.

The Chair: Thank you.

Dr. Deborah Kopansky-Giles (Associate Professor, Canadian Memorial Chiropractic College, Canadian Chiropractic Association): Thank you very much, Vice-Chair, for asking that question, which is a really pertinent question, particularly in today's environment.

We know that Health Canada has a strategy to increase collaboration all the way from interprofessional education to interprofessional collaboration. There has been funding dedicated to that. However, there isn't funding dedicated to specifically giving project funding for those innovative projects that are actually producing very creative types of practitioners working together outside of the typical mainstream health providers. We have demonstrated at St. Michael's Hospital very clearly that chiropractic rightly fits in that environment, and we've gotten great feedback from our physicians, who work with us very closely, that we actually helped reduce their workload and improved their quality of work life by reducing the amount of time they spend on musculoskeletal patients where they feel they don't have a significant amount to offer those patients.

I think your question asked what should we do to improve collaboration. To do that you have to actually put in place a significant funding across Canada to help different facilities develop those proposals. The primary health care transition fund was an example of that, but it was the seed funding for pilot projects, which didn't provide any sustainable funding mechanism. We'd really urge the committee to implement, or make recommendations on, sustainable projects that have been successful, such as ours.

Thank you.

The Chair: Thank you very much.

Now we'll go to Monsieur Malo.

[*Translation*]

Mr. Luc Malo: Thank you very much, Madam Chair.

First I would like to thank you for being here with us.

I have a comment for Dr. Valade. Thank you for telling us about a number of very specific cases concerning populations that are directly served by the federal government. A little later in our study, we'll come back with workers from those areas and we'll be able to pass on a number of your questions to those people to enhance the study we are conducting.

Madam Chair, last Tuesday and today, we heard witnesses tell us about the situation of nurses. They told us about overwork, changes to ways of doing things and continuing education.

I'm going to ask you the same question I asked the witnesses we heard from last Tuesday. Don't you think that the right forum to state those problems isn't Parliament, but that it would be preferable to speak directly to the stakeholders in Quebec and the provinces, who are the ones who govern education, ways of doing things, health, practices? Have you also made those observations to people who, in everyday life, work or have direct responsibility for the delivery of health services?

[*English*]

The Chair: Who are you addressing your question to specifically, Monsieur Malo?

Mr. Luc Malo: Who would like to answer?

The Chair: It is open.

Ms. Silas.

[*Translation*]

Ms. Linda Silas: I'll start, Mr. Malo.

First, you're completely right: the distribution or delivery of health care is done by the provinces and territories. For our part, we see the federal government in the role of leader and facilitator in introducing new solutions. Before introducing our two projects in Saskatchewan and Nova Scotia, we conducted a study of employers in Canada's health care services. They told us that there were some good ideas, but they lacked funding and researchers. The federal government was thus able to provide that in Cape Breton and Saskatchewan, and those projects have had an impact in the other regions. That's where we see that the federal government can play a role as leader and facilitator.

Of course, it can also contribute financially because employers alone are already limited in what they know and in their budgets. They therefore can't innovate. They also have to work with the entire team.

● (1630)

Mr. Luc Malo: Talking about—

[*English*]

The Chair: Mr. Malo, I think Dr. Kopansky wanted to also comment.

Thank you.

Dr. Deborah Kopansky-Giles: Thank you very much.

It's an excellent question you've just asked all of us to consider answering, because we are commonly asked the question, "Why don't you just go to the provinces and have the provinces solve those issues?" But we have a perfect example through the primary health care transition fund, where a federal amount of money led to innovative, excellent programs that were distributed provincially and have produced excellent results about collaboration, for example.

Also, we have the example about enhancing the interprofessional or interdisciplinary education initiative. That was a federal initiative that has transcended to provinces. For example, at the University of Toronto they have embarked on a major initiative for interprofessional education. Effective September 2009, every health science student across 10 faculties will have to have 20 credits in interprofessional education to graduate. This was a federal initiative that is actually going to have a local effect.

We've seen the benefits of that. We're engaged actively in these IPE projects. In fact, the team I lead at St. Michael's Hospital, where I actually chair our working group on interprofessional education for our department, has won two awards from the University of Toronto on these initiatives in the last year.

So yes, I think there is a very strong role for you to play in actually guiding provinces to look at issues more broadly that transcend local jurisdictions.

Thank you.

[*Translation*]

Mr. Luc Malo: I have a question for Dr. Ouellet.

[*English*]

The Chair: I'm sorry, Monsieur Malo, you asked such a great question that everybody wants to answer.

Ms. Neufeld, you wanted to comment.

Ms. Kaaren Neufeld: Thank you.

The Chair: And then Dr. Padmos after that.

Ms. Kaaren Neufeld: I will be brief. I just want to reiterate the importance of the leadership role. You probably do know that when you combine the Department of National Defence, Corrections Canada, Veterans Affairs, and FNIHB, the federal government is the fifth largest employer of health care workers in this country, so it has a wonderful opportunity to really show leadership in the kinds of initiatives we need to see go forward.

Dr. Andrew Padmos: Thank you, Madam Chair.

We and our colleagues in other national and pan-Canadian organizations regularly interact with our colleagues in provincial agencies and departments. We learn and share much with each other.

But I would echo Kaaren's comments that leadership is really of the essence here. The problems are too important to be relegated to a narrow bureaucratic framework that is concerned about stepping on interprovincial barriers. I think our citizens, whatever province they come from, are looking for national pan-Canadian and federal leadership in this area.

The Chair: Mr. Malo, you have less than a minute.

[*Translation*]

Mr. Luc Malo: From what I understand, the provinces can't lead on their own. It's the federal government that has to provide that impetus, based on what I understand from our panelists.

I have a question for you, Dr. Ouellet: have you determined how much money you're requesting to optimize the mentorship program for foreign workers?

Dr. Robert Ouellet: The answer is yes. I have to see where I put that. It's $5 million over five years for mentoring for people who have studied outside Canada. We think we need that money to help people.

We're still talking about doctors who have studied outside Canada and who are driving taxis or delivering pizzas. This phenomenon occurs; it's true. However, we want instead to train people who are able to be trained in order to help reduce the current shortage of physicians. However, we have to have ways of doing that, and we're trying to find solutions, such as mentoring. Some are almost ready to do it, but they need a little support. This solution could help reduce the shortage of physicians. It wouldn't involve taking all the courses over, but rather completing training. In some cases, some don't need much more to pass their exams.

What we absolutely want is to have people who meet the same standards as we do. We don't want to accept physicians who don't meet standards. No one would want that. We're completely ready to encourage these foreign graduates to come, but we want them to be properly trained. That's why we're requesting federal government support.

[*English*]

The Chair: Thank you, Dr. Ouellet.

Ms. Wasylycia-Leis.

● (1635)

Ms. Judy Wasylycia-Leis: Thanks, Madam Chairperson. Thanks to all of you.

At our last session we heard from a number of umbrella organizations, and they seemed to suggest that our major focus as a committee should be on looking at scope of practice and the service delivery model. I don't disagree with that and I think there is a lot to be gained from it, but I'm a little worried about what Canadians are saying now about the shortage of doctors, nurses, and technologists, and some of you have talked about that.

In my view, we're reaching a crisis situation where in fact if we don't do something urgent, all the analysis of our service delivery models in the world won't do anything to deal with people's need to have access now to quality health care services.

I want to ask specifically, starting with Linda and then Kaaren first, with nurses, what specific recommendation do you make for the federal government so we can get away from this jurisdictional football and start to give some clear direction to the federal government for things that we could do? I think, Linda, you touched on EI. I need to hear more about what we can do to change the EI system to make it useful for training of nurses. I'd like to hear a little bit more about the idea of this observatory, and if it's such a common-sense idea, why isn't it happening?

Then I'd also like at some point to hear from Andrew about the whole impact of the interprovincial trade agreement on what we're trying to achieve.

But let me start first with the crisis and what we could be doing immediately.

Linda.

Ms. Linda Silas: I will take the example of EI, which we've been working on since 1999. I'm not sure if the committee knows, but if you're a plumber in this country, you can apply with your employer to take an apprenticeship program under EI, get your education, your salary paid, and then you get the next level of being a plumber. But if you're under a category of a professional, that is not available.

So if I look at LPNs, licensed practical nurses, in lay terms they are assisting nurses. A lot of them would like to become registered nurses. But you need to leave your job; you have to go to a full-time, four-year program, and there's no bridge funding or anything that could help them. A lot of registered nurses are from the old school program, the two-year or three-year program. They would like to do their baccalaureate program—again, no bridge funding—or, even better, to go as a nurse practitioner—again, no bridge funding. It's those kinds of issues that we could apply under EI immediately if we modify the apprenticeship program.

When we look at the shortage and the service delivery model, yes, it's a crisis. I've just been to Saskatchewan and Manitoba, and I arrived with Kaaren on a flight this morning. We have nurse practitioners in both of those provinces who are eager to work in their full scope of practice and they're not allowed to because of either a provincial regulation or the team they're working in. So I get very nervous when I hear a different health care worker as a physician's assistant. Well, we're going to introduce something else when what we currently have is not even put into practice. I have issues and concerns with that.

Even if Andrew is a specialist in the blood sector, thank God, and not in psychiatry...I'm not completely insane, to put it on the record; I'm just very determined, Andrew.

Thank you.

Ms. Judy Wasylycia-Leis: Thank you.

Kaaren.

Ms. Kaaren Neufeld: Thank you very much for the question.

The observatory is an opportunity, as I indicated, for researchers, governments, employers, health professionals, for us, to be able to come together and to really take stock of the innovative practices that are there that can be applied to provide new models of care.

The Canadian Nurses Association just recently published a paper on wait times, where we pulled together all of the information that showed the new models of care, whether it's nurse practitioners working in personal care homes...so long-term care situations, not just in primary care, but certainly also in primary care—to show the difference that can be made when a family practice nurse is able to work to her full scope in primary care.

Those are just short examples of innovations. The idea of the observatory is really a knowledge translation opportunity where you can bring people together who have the opportunity to spend that time thinking about these innovations, because it is the application of them into new, novel situations, whether it's in the north or whether it's within a provincial setting, that is going to make the difference. We need to provide that opportunity for health professionals, for international organizations, for researchers, for governance for us to come together.

● (1640)

Ms. Judy Wasylycia-Leis: Does everybody on this panel agree that one recommendation of our committee should be for the establishment of a national institute on health human resources, or, i.e., an observatory? Does everybody agree?

Voices: Agreed.

Ms. Judy Wasylycia-Leis: There is no disagreement at all.

Before I lose my time, Andrew, we let these amendments on the AIT happen without giving it too much thought in terms of the impact on the health care system. I think we need to figure out from you what we need to do to change that, or reconsider it, or know how bad it is.

The Chair: Dr. Kopansky, I think you wanted to make a comment on this.

Dr. Deborah Kopansky-Giles: Yes, thank you very much.

I just want to make a comment on the last bit before we move to a new topic. I want to completely support the honourable members on the importance of the observatory.

I also want to point out as well that I really do support the spirit that the observatory has to include all health professionals within their full scope of practice. We have a blueprint for health care in Ontario. The blueprint includes not even half of the regulated health professionals in the province. There is a blueprint plan, and funding, that doesn't even include half the health professionals.

These are the issues for people who are not on the main front lines of health care. So I fully support inclusion.

Dr. Andrew Padmos: Thank you.

I'll address the question about the Agreement on Internal Trade. The concern, in the short term, is the increased mobility of physicians in their primary jurisdiction who may be operating without addressing a full scope of practice. For example, we have a specialist in obstetrics and gynecology who is certified to cover that entire field, but there may be individuals who are in a practice location whose practice is only gynecology. The issue is that if that individual finds it easy to move without examination or scrutiny to another location, they may be able to represent themselves as covering all the dimensions of practice without having the experience or the credibility to do so.

In this respect, we will see a further maldistribution of physicians across the country. We think this is short term. We are not in any way supportive of restricting the mobility of any health professional or physician on that basis. But we caution that we see the potential for disruption in practice—loss of continuity as physicians migrate from less attractive to more attractive locations.

It is a reality in this country that if you go north of Vancouver you will not find a Royal College-certified specialist. They don't exist. Those are seen as less attractive environments, and therefore internationally educated health professionals migrate to those in order to satisfy the local requirements for registration and licensure. That means we have a huge potential problem on our hands.

The Chair: Thank you, Dr. Padmos.

We'll now go to Dr. Carrie.

Mr. Colin Carrie: Thank you very much, Madam Chair.

I want to thank all the witnesses for being here.

I must say that I do like what I'm hearing as far as working on collaborative care. I've heard Dr. Ouellet, Dr. Padmos, Ms. Neufeld on innovation, yet practical solutions, and Dr. Valade's examples of collaborative care. I thought maybe we'd start with this side and work across.

I have two questions. The government does want to decrease things like wait times. How would, for example, chiropractors help decrease wait times or help deal with the burden on the health care system? The second question is, what benefits do you see for the health care system with greater collaboration?

Maybe we can start on this side and move across, with the chiropractors first.

Thank you.

Dr. Richard Valade: As you all know, chiropractors specialize in neuromusculoskeletal problems, which probably represent 30% of what's seen, at any given time, at a medical doctor's office. If 30% of the people seen in a day could be directed to a chiropractor, that would definitely decrease wait times. It would open up the time for medical doctors to see patients with other kinds of problems. Definitely our profession specializes in neuromusculoskeletal problems.

We have 7,000 chiropractors in Canada who are, because of funding, underutilized, but we are a definite player in the game. As a matter of a fact, some of the colleagues I know in Quebec have some contacts with hospitals, and people in emergency try to send patients with neuromusculoskeletal problems to chiropractors' offices. This decreases, big time, the amount of wait times for people in the waiting room.

That's just in the emergency sector. Directly in medical offices, some 60,000 medical doctors in Canada have 30% of their patients consulting for neuromusculoskeletal problems. Just do the math on all the patients who come to their offices. So we are definitely addressing the human resources deficit in this country.

● (1645)

Dr. Deborah Kopansky-Giles: Thanks very much for the question about collaboration.

I would like to expand a little bit upon the really unique, and I believe creative, work that has been funded under the primary health care transition fund. In Ontario, for example, we received approximately $2 million to fund three integration projects. I was a principal investigator for the one that received about $700,000 to fund integration in a hospital setting. It was not just about chiropractors. The ministry actually funded us to look at how an integrated model of care would work in a department of family and community medicine. We also received funding for the same type of study in a community health centre, as well as in family health teams in Ontario.

This covered all three sectors of how services are delivered in Canada. All of these integration projects actually were featured at the primary health care summit that the health ministry put on. They were three of 60 projects that were presented at that national level, receiving that recognition.

We learned very clearly from the establishment of that model that when services are delivered across a team, and that team has eliminated the hierarchical structure such that team members are actually equal players, with their roles appreciated and respected, then patients greatly benefit from the delivery of services.

As well, we did an ethnographic type of study that looked qualitatively at the attitudes and perspectives of the other health care providers, and we saw a major shift in those perspectives over a two-year period with the inclusion of chiropractic services.

At the end of our study, we also did a physician satisfaction survey. We have approximately 45 physicians in our department, and they were 100% supportive of the continuation of chiropractic services. Several of them commented—it's been published in two papers—that they felt it significantly affected their ability to manage their patients appropriately.

The Chair: I'm sorry to interrupt you, but there are other people who want to speak, and we're just about out of time on this issue.

Dr. Padmos, please.

Dr. Andrew Padmos: I'll try to answer both questions, because I think they're related.

The issues on wait times need, I suppose, urgent action, but not exclusive action, on the supply side. They also need action in terms of working smarter. One way we work smarter is by working better together.

Kaaren has mentioned the hand-off of responsibilities to others who are better or less qualified than the primary professionals, but it's that collaborative environment, which is synergistic, which is supportive, which provides great improvement in the safety net for patients, that is most obvious when it's not there. When mistakes are being made and recriminations and blame are being thrown about, we end up with toxic and very difficult work environments that are not good for patient care.

The Chair: Thank you.

We'll begin our next round—this time it's five minutes—with Dr. Duncan.

Ms. Kirsty Duncan (Etobicoke North, Lib.): Thank you, Madam Chair.

Thank you all for coming. It's very good to listen to you.

I'm going to take a different tack. We used to focus strictly on marks when looking for medical students. I know that's changing, but how do you look for students who are going to have the right compassion, empathy, and ethics?

We need foreign-trained graduates, and I'm wondering what the average cost is to become a practitioner here, for someone who was trained overseas. I know it varies by specialty and at what point in the system they come in, but are there numbers on that?

Do we capture data on how many start to take their exams? I come in contact with a lot of people who take the first exam and then can't afford it. I've met about 50 physicians in the last three months who aren't practising—one was a senior house officer in the U.K.

How many spots exist for foreign-trained grads in Canada? I know it differs by field, and a few years ago there were eight spots for pediatricians.

My last point is that we really need foreign-trained physicians. We need their language abilities and cultural understanding. I'll share a story. A gentleman in my riding was frantic. He thought his one-year-old grandson had smallpox, because when he was growing up smallpox still existed. It took me 20 minutes to assure him that the baby did not have smallpox. The physician didn't have the language ability to share that with the family.

We need to find a way around this. We have many languages and cultures, and we have to make sure that when people go to physicians they'll be understood and looked after.

Those are my comments.

● (1650)

The Chair: Who would like to take those on?

Dr. Padmos.

Dr. Andrew Padmos: On medical student selection, the process is more than marks, but marks still count a lot, because there are presently over 10,000 qualified medical applications for approximately 2,500 intake positions. The universities have no option but to put in filters to whittle down the pool of people they're going to interview and test further. Whether they are grade-point averages or scores on the MCAT, marks are unfortunately the easiest tools at hand.

Your point about their personality types is interesting and important. Many schools have a very individual approach to the medical students they like to think they take, and therefore the product they would like to have, but they don't apply those tools except in a more general interview. We're not making the best use of psychological testing of the applicant pool to try to sort out at least those who have a high likelihood of failing to show the personal characteristics that are important.

You asked about the average cost to train international medical graduates. This is highly dependent on where they were trained and in what practice. It differs from specialty versus primary care. Many provinces have special programs to monitor and mentor these practitioners to get them into practice situations to see if they can be licensed. Other international medical graduates—and I remind you that these are all landed immigrant Canadians—are not ready for practice and are waiting for residency training positions to get licences. Approximately 300 positions are reserved in the residency match at the first-year level for these individuals each year.

Ms. Kirsty Duncan: Is that across all disciplines?

Dr. Andrew Padmos: That's across all disciplines, both family medicine and specialties. Some provinces—I believe Alberta and Quebec—have additional reserved positions that are not available in the CaRMS.

In addition, there's a group of IMG physicians who are known as Canadians studying abroad. These are Canadian students who have to leave the country to access medical school. There are 1,500 out there, and about 50% of them are successful in obtaining residency positions in Canada in the match. The other 50%, by and large, are off to the United States because they have a large excess of training positions available.

● (1655)

Ms. Kirsty Duncan: Thank you.

Do we know what the average debt load of a student here in Canada is after graduation?

Dr. Andrew Padmos: Approximately $160,000.

Ms. Kirsty Duncan: That was the number I had. Are these data mapped in any way? After they graduate, where do they practice?

The $160,000 is a major hurdle for some families. I would be interested in seeing that data and how it maps, and then after they finish, where they go to practice.

Dr. Andrew Padmos: There is a registry called CAPER, the Canadian Post-M.D. Education Registry. That tracks where graduates set up practice for a period of time, which specialty, etc.

What we do know is that the debt load of medical students is influencing, probably inappropriately, their choice of speciality. Many of them take what is known in the trade as the EROAD. The EROAD is emergency medicine, radiology, ophthalmology, anesthesia, and dermatology. Those are the specialties most associated with so-called quality of life, and that's a combination of income and availability of time for personal pursuits.

We don't know actually where they go in terms of the location in the country. The Canadian Association of Interns and Residents and the National Physician Survey do attempt to track that data, but I believe it's piecemeal.

The Chair: We're well over time for this question.

Thank you very much, Dr. Padmos, but I must go to Mr. Brown now.

Mr. Patrick Brown (Barrie, CPC): Thank you, Madam Chair. Thank you for all the comments today.

My first question will be for Ms. Silas, from the Canadian Federation of Nurses Unions. It's great to have you back. I remember you speaking at the health committee before.

What effect do you believe the shortage of nurses in the country has to do with the financial challenges the hospitals are in? I know my local hospital is structured in a way so that many of the jobs available are part-time. It almost drives nurses away. I wonder if the employment was structured in a different fashion if that might be one of the ways to lure some of the nursing professionals into the profession for a longer period.

Ms. Linda Silas: Yes, for sure. The hospital budget restriction is an issue across the country, and in your province, too, which I just came from.

The issue of part-time/full-time depends on where you live. Alberta, for example, has a full-time rate of 38% in nursing, which is purely ridiculous, compared to the Maritimes and your province, which is close to 70%—between 65% and 70%.

In dire times the first thing to go is the education budget. They cut that, and we know that what retains nurses and other health care professionals is a possibility of continuing your education. The next thing that goes is they start splitting up jobs and creating more part-time jobs, which increases the casualization and increases the overtime. That's the problem we're trying to solve in the majority of our health care facilities across the country.

Mr. Patrick Brown: This question is for Dr. Ouellet. I enjoyed your presentation. I thought you had some great suggestions. I particularly liked the suggestion on capacity building.

In my riding of Barrie we just set up a satellite campus for the U of T, to start training on July 1, with five and then nine students. It will be a full-time satellite medical campus. The challenge the community has is they're told if you want to do that, you have to raise $6 million on your own to pay for the building. That's tough for a community to do. The community will find a way to do it, but it's obviously not fair.

So suggestions of how you can make it easier for communities, such as a federal loan capacity, like we have in other infrastructure programs, is a noteworthy suggestion.

What I wanted to ask you about is this. You talked about self-sufficiency and repatriating some of these physicians we have abroad. The challenge of self-sufficiency is that it's a long-term goal and it's not going to happen overnight. We have this huge challenge immediately.

An interesting aspect about getting some of these physicians back...there are so many who are practising abroad; I think you're right on that. The challenge is, what if these physicians have the same problem getting into the system? Wouldn't the physician who went to medical school in Ireland or a physician who went to medical school in the Caribbean have the same challenge coming back to Canada, in that there wouldn't be a residency spot available? Wouldn't we run into the same problem we're facing with IMGs?

● (1700)

Dr. Robert Ouellet: They have the same problem because the problem is the lack of residency spots. It shouldn't be like that, because those people are Canadians. They didn't have a spot to train in Canada so they went elsewhere. But we should facilitate their return. They are Canadians who couldn't get into a medical school, and they went away.

Mr. Patrick Brown: Who could make those residency spots available? Here's my frustration. I see it as pointless to run an advertising campaign in the U.S. or anywhere else saying “come back to Canada” if we invite them back and they can't have a residency spot.

Our physician recruiter at our hospital doesn't bother to try to recruit IMGs or people who have trained in other medical schools because she says it's a waste of time. She can't get them into the system.

Dr. Robert Ouellet: It depends if you're talking about training them again or having them back if they're fully trained.

Mr. Patrick Brown: I'm talking about Canadians who trained in a medical school abroad.

Dr. Robert Ouellet: Yes, but if they want to specialize or train here, then that's the problem. They need to have a spot. We're lacking in residency spots, and this is why we're asking to increase those numbers. We're asking to increase the facilities and to increase the budget for training those people. You need facilities and people to train them. This is lacking.

Mr. Patrick Brown: What would be the steps necessary to create more residency spots across the country?

Dr. Robert Ouellet: There's some investment in that because you need people to train them, and you need availability in hospitals. Also, you need to pay the trainers. Actually, we're at capacity for who we can train in Canada. We need to increase that capacity.

The Chair: Thank you, Dr. Ouellet.

We'll now go to Monsieur Dufour.

[*Translation*]

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

Thanks to our guests for coming to testify.

Mr. Padmos, you talked about the lack of funding for research, as a result of which young people cannot stay here to continue conducting medical research. It's not just the medical science field that is affected, but all the other sciences as well. I agree with you.

Earlier we talked about young people who want to become doctors. Mr. Ouellet said that one-third of physicians were 55 years of age or more. Ms. Duncan asked a good question on the average debt, which is approximately $160,000. Mr. Padmos said that that debt could influence their choice of specialty.

Does debt only influence the choice of specialty or can it make young people hesitate to study medicine?

[*English*]

The Chair: Who would like to take that one on? Dr. Padmos?

Dr. Andrew Padmos: I think the debt load is more of an influence on choice of specialty training, particularly taking young physicians away from family medicine and primary care and pushing them towards specialties that are seen as having high payoff in order to repay that debt.

I think there is still a gross oversupply of very well-qualified Canadian students who want and deserve to get into medical school. If we doubled our intake of medical students this year, we would still only just be meeting what the U.K. takes into medical school right now. We are very far behind comparative nations in terms of our commitment and investment in medical education.

[*Translation*]

Mr. Nicolas Dufour: I believe Mr. Ouellet has something to say.

Dr. Robert Ouellet: Debt is obviously an important factor, but in spite of everything, many young people nevertheless want to study medicine.

Many people can be good candidates for medicine. At a dinner at our clinic, about 15 of us were talking and said that, if we had to meet today's criteria, no one around the table would go into medicine. And yet there were specialists and general practitioners who were excellent physicians.

That means that perhaps we have to review some of our criteria. A number of people can become doctors in Canada, but unfortunately there aren't enough or capacity to train them. And yet there is a major shortage of physicians. That's why we need help.

● (1705)

[*English*]

The Chair: I think Dr. Kopansky wants to make some comments on that too, Monsieur Dufour.

Dr. Deborah Kopansky-Giles: You actually had two questions. One was about research capacity and funding for research and the other was about the debt load. I also wanted to say earlier that chiropractic students graduate—as there's no real funding or subsidy for chiropractic education—with a debt load of $120,000 to $150,000 as well. But it doesn't entice people to go into research because researchers make very poor money.

So we actually have residency programs where we're training researchers, and it's really hard to entice our chiropractic students to go into research residencies. We have three residency programs. We can only accept five students a year, and of those students, about three of them will go into research. But because of the way research projects are funded, we can't fund a salary for a researcher under a grant anymore, and you can barely get administrative costs covered under research grants. This is an issue I'm facing every day in the research I'm doing.

So I'd like to comment that not only do we have problems with students with debt loads, but they're not going to choose research careers because they can't pay their student loans off that way.

The Chair: Ms. Fréchette, you also wanted to make a comment on that, did you not?

[*Translation*]

Ms. Danielle Fréchette (Director, Health Policy and Governance Support, Royal College of Physicians and Surgeons of Canada): Thank you very much.

Dr. Ouellet said that the debt level upon graduation definitely deters people who come from disadvantaged socio-economic backgrounds from choosing a career in medicine. They cannot contemplate spending 10 years at university. Clearly this is a major barrier to the recruitment of a number of physicians who could meet the needs of various patient categories.

[*English*]

The Chair: Thank you.

Ms. McLeod.

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): Thank you, Madam Chair. I certainly appreciate all of the presentations.

Before I proceed, I just can't let one comment go unremarked. I am also from British Columbia, and last year I attended an amazing conference about health care innovation and the projects that were happening that were funded both federally and provincially. I just wanted to reassure Ms. Murray that great work continues even to this day.

I had to actually just make that particular comment.

I think there are a few things that have stood out for me. One, I really appreciate Dr. Valade's comments around the opportunity within the federal government and where we're going with alternatives, whether it be chiropractors or other services. I think those are very valuable.

I really like the comment around a special fund for rural and remote. At some point we need to do some uptake on that. But there are two areas that I would really like to focus my five minutes on. We hear about—and I think I'm hearing the same—great innovation happening across the country. How are we going to bring it altogether and create that actual change?

We talk about collaborative care. We know we have pockets of great work. What do we need to do to actually make that a reality?

The other piece I can focus on—and I'll open this up to everyone, both of these questions—is the potential use of physician assistants. But I also appreciate that in our primary health care system, the way we pay doctors doesn't really allow for any kind of collaborative care. It's very difficult for nurse practitioners, nurses, to work in a primary care environment with family physicians by virtue of our payment model. So would physician assistants add value, or do we really need to look at a collaborative primary care team? Someone who knew that we were doing this study, who is a physician, said we should have the foreign-trained doctors be physician assistants as a pilot project.

I want to throw all those comments out and open it up to everyone. Again, it's around innovation and how do we actually create change with all the good things that are happening, the interdisciplinary team, and where we go.

● (1710)

The Chair: Who would like to start with that?

Ms. Neufeld.

Ms. Kaaren Neufeld: Thank you, and thank you for the question.

I think when we are talking about innovation and collaborative care in professional teams, the group we need to talk about the most is the patient, the client, and the resident. To me, collaborative care includes having them as the heart of the team, at the head of the team. When you involve patients and families and residents—-the community—in the collaborative care practice, I think that's when change will really start to happen. We need to be able to put in place systems that allow their voice to be heard concerning the types of system-level improvements that we need to make, not just regarding the therapeutic interaction between nurse and patient or doctor and patient, but, rather, at the systems level. I think Canadians are ready to engage in that conversation, and for the Canadian Nurses Association, collaborative care means the involvement of patients and families.

I want to speak very quickly about work that the CNA is doing with the College of Family Physicians of Canada. We are working with them to expand a model of primary care that has taken off in Nova Scotia, where nurses and physicians are working together in an innovative fashion, in such a way that they're able to increase the number of patients the practice is able to see. They're able to go from two-week waiting lists to same-day appointment services. There are a variety of very effective innovations that have been applied, through which change is happening there. So that would be an example we would look to.

The Chair: Dr. Kopansky-Giles, did you want to say something?

Dr. Deborah Kopansky-Giles: I just wanted to comment that I thought your questions were very poignant and really appropriate, especially for the audience and for the witnesses that are here today.

I also wanted to add that it's not just the funding. It's not just giving another bunch of money to people to look at creative projects. There has to be a long-term and sustainable strategy.

In my experience, in the past four years of delivering interprofessional education sessions, where eight health science learners are educated together, we see a lot of things happen. We see, actually, the falling away of barriers, and it's not just a team being plunked together and sharing space. It has to be a team that actually works together, seamlessly, without barriers, and we see that through the educational process.

When we put learners through a week-long or a five-week-long module and they're learning together, they're learning curriculum, and embedded in that curriculum are all kinds of concepts of team-based care and group dynamics and conflict resolution. You see those barriers fall away, and that's when patients really benefit. Those are the types of care and innovative strategies you want to fund. It really has to be that way.

The Chair: We have run out of time. I'm so sorry.

We're going to have to go to our next person.

Ms. Murray.

Ms. Joyce Murray: Thank you, Madam Chair.

I'm going to go back to one of my earlier questions about quality improvement programs based on a framework model. I think those of the witnesses who have been part of that are aware that there's a specific philosophy that brings people together to improve processes and that it's had very good outcomes.

One example that I'm aware of in the Vancouver health authority is a situation in which the number of hours between readiness to be discharged, I believe in the case of maternity, to when the person is actually discharged decreased from ten to one as a benefit of a quality improvement program in that facility.

My question is to all of the witnesses. Have you been involved in essentially a Deming-based quality improvement program, and if so, what would your recommendation be to this committee as to if and how the federal government can encourage the spread of that approach to improving quality and productivity?

Thank you.

● (1715)

The Chair: Who would like to do that?

We'll hear from Dr. Padmos first.

Dr. Andrew Padmos: I'll take a crack at that.

In my role in Nova Scotia, one of the jobs I held was vice-president of research and academic affairs at the Capital District Health Authority. It included the quality portfolio, so I'm familiar with, at a hospital and a health authority level, the commitment to quality that pervades the system. All staff are involved in the accreditation process that Accreditation Canada sponsors and administers. It's comprehensive and it draws all staff into regular reviews and continuous quality improvement initiatives.

In addition, at the hospital level, we participated in programs under the auspices of the Canadian Patient Safety Institute, and many of those, while they may have a safety focus, in fact are about quality. Built into leadership in the hospitals, both medical and nursing, is a commitment to these processes. Many projects, many prizes, and many programs pull out some of the best innovation that's brought to bear, and it's shared through various conferences that take place in Canada on a regular basis.

The Chair: Dr. Kopansky-Giles.

Dr. Deborah Kopansky-Giles: I just wanted to add, too, one of the solutions that you might consider. I'll follow up on the previous speaker's comments about Accreditation Canada.

I've been a surveyor for Accreditation Canada for the last nine or ten years. One of the new innovations I see as a surveyor is that when we go into all these environments and do the surveys, we often see fantastic examples of excellent quality improvement, and Accreditation Canada has been making efforts to create these benchmark programs, to make them accessible for other people to share across Canada. I don't think there's enough sharing of that information, because it's a fantastic resource where we see excellent quality improvement going on.

The Chair: Thank you.

Dr. Ouellet.

Dr. Robert Ouellet: I think I've said that we are trying this year to have some kind of project to integrate all those initiatives across Canada and elsewhere, to improve, first, the access, but also the quality. We have seen examples of what is going on in, let's say, the Netherlands or Denmark, where they have put a lot of emphasis on quality, not only on wait times, because they have solved that problem. Quality is a very important aspect.

This year, we want to try to bring in all the initiatives in Canada and try to spread this, again, to every possible location. Quality is very important, but maybe we need to do something else, which is to put in health goals and targets in Canada. Maybe it could be a federal role to say that we should improve work on obesity, let's say, and put in some national goals. That could be very helpful. If we put in goals, then there are some targets. We need to improve the quality of our service, but also the quality of the health of patients, so this is one aspect that could work.

The Chair: Thank you, Dr. Ouellet.

I'm sorry, but we're going to have to go to the next questioner because we've run out of time. Thank you for your comments.

Ms. Hughes.

Mrs. Carol Hughes (Algoma—Manitoulin—Kapuskasing, NDP): Thank you for being here. It's certainly very informative.

I'd like to focus probably a little more on remote rural and aboriginal communities. The issue is retaining doctors and nurses up there. It's often more difficult than it is in the cities, of course, and I'm just wondering if you have some ideas with respect to some of the roadblocks that could probably be removed in order to do this. On that note as well, on the locums, do you see that it would be of assistance to change the way that some of the licences are handed out?

Also, would you see the impact of a national home care program as a positive thing, such that it wouldn't be so onerous on the hospitals and the clinics if there were a national home care program with more of an intervention part?

I'd like your comments on that.

The Chair: Ms. Silas.

● (1720)

Ms. Linda Silas: You would have seen in our brief, on educating your own.... That comes from research, both in rural and aboriginal communities. If we're able to find education programs that are built on career-laddering programs in rural communities, they will stay there. Those are their communities; they will stay there. But if you take me and bring me to the north, I might stay there a year or two and then I'll want to come back. So it's really building those bridges.

I'll say quickly that one of the successes we could have from this committee is, again, the observatory or institute, to answer Cathy's question. There are all kinds of different programs out there, in rural, in home care, that are experienced, but nobody talks about them. If we had one pan-Canadian program led by a federal-provincial-territorial...where we all share a positive experience, we would be able to share experience in rural and northern communities, and then find solutions for the country. But we need one spot, which we do not have today.

Dr. Andrew Padmos: I think the attention for physician services and other health providers in the north is being gradually and incrementally improved through electronic means. I think Telehealth videoconferencing, in bringing more providers closer to the patients, is making a very significant effort.

I think collaborative education is very important here. Many northern communities are serviced by experienced nurses who work in teams with physicians, often at great distance, and they build up trust over the period of time and I think deliver superlative care.

I do think that the medical and health personnel in those areas need special support in terms of dealing with their continuing professional development. They need backfilling support for locum tenants when they're away, to get that continuing professional development. I think we just have to accept it as part of the infrastructure cost to providing northern, rural, and remote health services.

The Chair: We'll have Dr. Ouellet.

Dr. Robert Ouellet: Well, I think Dr. Padmos answered most of the first question, and I was going to talk about IT and the connection, but I will speak a little bit more on your second question about long-term care or home care.

I think we need to invest, in Canada, in long-term care, because for almost 30 years the big problem we have in hospitals—and you've heard that—is chronic patients taking acute beds, and this shouldn't be like that. In Ottawa, today, there are 135 patients in the hospital that are chronic patients in a 900-bed hospital. That's awful because there is a cost to that. We need to invest in long-term care so that those patients can be outside of the hospital, where it costs much less. They will probably have better service, because when you're waiting in an acute bed in a hospital, you don't have the same kind of service that they have in the long-term care program or even in home care.

So maybe with the money they are putting into infrastructure, there could be some money for infrastructure in long-term care in Canada. We need that.

The Chair: Thank you, Dr. Ouellet.

I'm sorry, I'm going to have to go to the next questioner because our time is out, and that's Ms. Davidson.

Mrs. Patricia Davidson (Sarnia—Lambton, CPC): Thanks, Madam Chair, and thanks very much to our presenters here this afternoon.

I just want to take this on a bit of a different tangent, perhaps.

In some of the other meetings I've been at over probably the past year with different professionals in the medical profession, discussing HHR, and with our experiences in my own community with trying to attract physicians, in particular, one of the things that has been said repeatedly is that there are enough resources in this country and there is enough money; it is just horribly mismanaged and underutilized. I'm not sure any of you might agree with that statement, but I want some comments on it.

Kaaren, you talked about the underutilization of nurses, in particular. How receptive are other disciplines to re-utilization of different people within the medical field? We're talking about more than doctors and nurses; we're talking about the whole health perspective.

Would anybody like to comment on those issues?

● (1725)

The Chair: Ms. Neufeld.

Ms. Kaaren Neufeld: Thank you very much for the question.

As you've probably gleaned from the conversation here, the receptivity to working together is growing, and I think it is growing significantly around that whole notion of collaborative care. It's interprofessional care and support workers who need to provide that care, so there is an understanding of the need to look at the full picture.

When the Canadian Nurses Association brings out its next forecast report on May 11, we will talk about some of the policy changes we think can be implemented to address the issue at hand in terms of the shortage, and many—

Mrs. Patricia Davidson: Can I ask you something else if you're bringing that report out? If the issue of how there can be a better utilization of the resources we already have is not identified, how can we truly identify the shortage?

Ms. Kaaren Neufeld: We're talking about a shortage in terms of continuing with the model of care we currently have. If we continue with a model of care that is highly focused on hospital acute care, specific providers, small entry points into the system, then we're going to be short.

If we start looking at new models of care and innovative ways of practice, like home care—moving more of the care into the community and home—national pharmacare programs, as well as looking at the impact those changes will make, we can see how we can much more effectively and efficiently use the current resources we have.

The Chair: Mrs. Davidson, you have another minute.

Mrs. Patricia Davidson: Dr. Ouellet, please.

Dr. Robert Ouellet: I think you're absolutely right. We are putting a lot of money into our system. We have a lot of resources, but we're maybe not using them properly. There was a study showing that Canada is 30th out of 30 countries for the money we invest and the results we get. There is room for improvement.

And we're trying to do that. It's part of our project to fund hospitals differently—instead of block funding based on activity. There would be an incentive to do more or to be more efficient. When we say “to do more”, it's not that people will work more than they do but that they will be working more efficiently. That's the big difference.

We all agree on having collaborative care. We need to do that because we have a shortage of doctors and nurses. We need to work together. We're completely in agreement with that. We just have to see how it can work.

There are many initiatives that are working right now, and we have to keep going.

The Chair: Ms. Fréchette, I think you wanted to make a comment on that, and then we're going to have your closing comments. Our time is just about up.

Ms. Danielle Fréchette: Thank you.

I think everyone agrees that folks want to work together. But everyone is working at a breakneck pace. Because everyone is focusing on meeting the needs of patients, there's not enough time to really sit back and look at how we can improve the system and spend our dollars more wisely. That is why I think everyone has come today with a unified ask for an observatory, where we can dedicate some resources and talent to optimize on what we know we can do best and how we can do it better and together.

The Chair: I want to thank the witnesses very, very much for coming today. Your comments are invaluable. You'll find this is a really good committee. This committee works together extremely well. We may have our differences of opinion from time to time, but this is a very collaborative committee. Your comments are taken very seriously. They are discussed, and we're trying to put them in policies in a very relevant manner.

We're just about finished. I want to do two things.

Ms. Wasylycia-Leis, could you quickly bring your motion forward?

Ms. Judy Wasylycia-Leis: Madam Chairperson, there have been discussions with all parties and I believe you will find unanimous consent to introduce the following motion:

> That the Chair of the Standing Committee on Health, following consultations with representatives from each of the recognized parties, convene meetings of the Standing Committee on Health to discuss the outbreak of Swine Influenza at regular intervals as necessary.

The Chair: Do I have unanimous consent of the committee?

Hon. Carolyn Bennett: I'd like the chance to speak first.

The Chair: I'm sorry, Dr. Bennett, go ahead.

Hon. Carolyn Bennett: I would like it on the record that this is not to replace the regular briefings we have committed to and that we have by e-mail. I also want to make it clear, in terms of weekends and our availability as members of Parliament, that whether it's through the clerk or through the minister's office, there be a way of getting in touch with members of Parliament should the situation change and we require a briefing. I just want to make sure that this doesn't supercede the excellent beginning we've had, in terms of the briefings yesterday and today, and that we go forward.

This bulks this up a little bit in terms of being fleet of foot. Then we will have to decide, on each of these meetings, whether they're in camera and whether there is certain sensitive information for which we would have to be sworn.

I just want to make sure that this is our consent in theory. But in practice, I'd really like to get some of this sorted out with the minister's office in terms of the good beginning we've had.

We were concerned this morning, as I said, that there seemed to be a bit of push-back, so I am really firm that if we, as Liberals, agree to this, we don't want to be going backwards from the way we have begun.

● (1730)

The Chair: I think that is fully understood and agreed upon in this committee.

Monsieur Malo, you wanted a moment. No comment? Okay.

Is the committee in agreement with Ms. Wasylycia-Leis's motion?

(Motion agreed to)

The Chair: Thank you.

I want to remind you that there is no meeting on Thursday, but those meetings on the swine flu will be ongoing as we need them.

Thank you again to the guests.

The meeting is adjourned.

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