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Chair

Mrs. Joy Smith

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● (0900)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): Good morning, everyone. We have quorum this morning, so I would ask everyone to gather together so we can start our committee business.

Pursuant to Standing Order 108(2), a study on health human resources, we have with us today, from the Northern Ontario School of Medicine, Dr. Roger Strasser; from the Society of Rural Physicians of Canada, we have Dr. John Wootton; from the Rural Ontario Medical Program, we have Dr. Peter Wells. Welcome to you all. I notice we also have with us Lee Teperman, who is from the Society of Rural Physicians of Canada, and we have Michelle Hunter, who is the manager from the Rural Ontario Medical Program. Welcome as well.

We're going to have five minutes of presentation from each organization, and after that is finished we will go on.

We will begin with the Northern Ontario School of Medicine and Dr. Roger Strasser. Thank you very much.

Dr. Roger Strasser (Doctor, Northern Ontario School of Medicine): Thank you very much.

First let me express my appreciation of the committee and for the opportunity to come and be with you today.

When I made some inquiries yesterday as to what you were interested in, in health human resources in rural areas, and I started talking about some of the issues, it kind of felt like I was going to be talking about my life's work.

In my brief introduction, I thought I'd tell you about who I am, introduce the Northern Ontario School of Medicine and the various initiatives we have there, mention my involvement with the World Health Organization and on an international expert panel, and then talk about my experience from previous times in Australia. I come originally from Australia.

Currently, I am the dean of the Northern Ontario School of Medicine, and I've been in that position, in fact, as the founding dean, since 2002. Before I came, there was no Northern Ontario School of Medicine.

Prior to that, I was in Australia. I was the head of the Monash University school of rural health. Monash University is a very large university with a very large medical school in metropolitan Melbourne. Melbourne is a big city like Toronto and Montreal, and I was the head of a rural branch of Monash University school of medicine.

I also was involved as the inaugural chair of an international working party on rural practice for WONCA, the World Organization of Family Doctors.

As I mentioned already, I'm a member of an expert panel advising the World Health Organization on developing recommendations on the retention and recruitment of health workers in rural areas.

I also am an advisor to the World Bank on the scaling up of the training of rural health workers.

I have brought a folder of information on the Northern Ontario School of Medicine. Unfortunately, most of it is in English, so it can't be submitted to the committee, but there's a folder available for each committee member, to look at when you have an opportunity.

The Northern Ontario School of Medicine serves as the faculty of medicine of two universities, Lakehead University in Thunder Bay and Laurentian University in Sudbury. As I imagine you're aware, those two communities are 1,000 kilometres apart. Northern Ontario is geographically vast, the size of Germany and France put together. The school was established with a social accountability mandate. That's a commitment to be responsive to the needs of the people in the communities of northern Ontario. There's also a commitment to innovation.

The education and training activities of the school are based on research evidence that shows three factors are most strongly associated with going into rural practice after education and training. The first is a rural upbringing, that is, having grown up in a rural area. The second factor is positive clinical and educational experiences as part of undergraduate education; that's in the MD program. The third factor is targeted training for rural practice at the post-graduate level—having residency programs that prepare the residents to practise in rural areas. At Northern Ontario School of Medicine, we're doing all of that. We've developed a distinctive model of medical education and health research that we call distributed community engaged learning. We have over 70 different locations across northern Ontario where our students and residents may undertake part of the clinical learning. We have a four-year MD program. The curriculum for that is very much grounded in northern Ontario and really prepares the graduate to have the knowledge and skills he or she needs and the inclination to pursue a medical career in northern Ontario or similar northern rural, remote, aboriginal, and francophone sorts of environments.

We also have residency programs in family medicine and eight major rural college specialties—again, very much with an emphasis on generalism.

We also have an accredited continuing education professional development program, which is largely available using electronic communications, so that many of the sessions are available by video conferencing and webcasting. We make heavy use of electronic communications.

Also, we are involved in education beyond strictly medical education. In the health sciences, we have a dietetic internship program. We're involved in education of physiotherapists and occupational therapists in northern Ontario. In collaboration with the University of Toronto Faculty of Medicine and the Michener Institute in Toronto, we have just established a physician assistant education program in northern Ontario as well.

● (0905)

We have a strong emphasis on interprofessional education. On the research programs at the school, the focus is on addressing research questions, the answer for which makes a difference to the health of the people in communities in northern Ontario. Again, the social accountability mandate really is the guiding light for the development and for all of the activities of the school.

The school admitted our first class—it's a four-year MD program—which had its official opening in 2005. We had our first graduates just last year, in 2009. So it's early days to talk about the outcomes.

In terms of the classes, for each of the intakes so far, roughly 90% of each class are students who have grown up in northern Ontario. Usually between 40% to 50% of the class are from rural and remote areas. We have a proportion of aboriginal medical students each year and francophone medical students. What we do is aim to represent the population distribution of northern Ontario in each class, and we've been fairly successful with that. We've done that in a way that does not sacrifice academic standards, so the grade point average of each class has been of the order of 3.7 on a four-point scale, which is very similar to the other medical schools in Canada.

The first group of students, of course, have now graduated. They're all matched in the first round of the national match into residency programs, and that's the first time that's occurred in Canada for over 10 years—a whole class matched in the first round. I think that's an indication that our students, our graduates, compare very favourably to the students and graduates of other medical schools, because the residency program directors wanted them in their programs. Seventy percent of those graduates are now pursuing mostly rural family medicine residency. To put that into perspective, that's more than double the national average of students going into family medicine residency. In our case, it's mostly rural family medicine. The other 30% of the graduates are mostly undertaking general specialty residency programs.

The early signs are certainly encouraging. The other indicator is that there's a national exam—the Medical Council of Canada exam—and our students, as a whole group, placed number six out of seventeen medical schools, in looking at their scores. In the section on clinical decision-making, they actually had the highest score of all the medical schools in Canada. So we take that as positive indicators of early success, really, for the Northern Ontario School of Medicine.

Just briefly, as I said, I wanted to mention the World Health Organization. We're just in the latter stages of completing guidelines and recommendations that will be presented, I think, to the World Health Assembly in May. There are four categories of these recommendations—I'm one of the members of the expert panel—and once this is finalized, it might be of interest to this committee to receive a copy and to review that document.

● (0910)

The Chair: We'd like very much to have that, Dr. Strasser, if you could submit it to us.

Dr. Roger Strasser: I can organize that.

The Chair: Thank you. I'll make sure all the members have it.

Dr. Roger Strasser: I will just give you an idea of the four categories: education, regulation, financial incentives, and personal/professional support. I can tell you more if you'd like to know.

On the last point, just as I said, I'm originally from Australia and was very much involved in developing rural health initiatives in Australia, including the national rural health strategy. Australia was the first country in the world to have a national rural health strategy, and that initiative of having a national rural health strategy I think has had major benefits for Australia in improving the numbers and the skills and the mix in the rural health force in Australia. So that's something I'd encourage this committee to consider.

That's my five minutes.

The Chair: I've stretched that a bit, Doctor.

It was very interesting what you had to say, and our guests here on this panel are here for a reason. It helps us a great deal to have your insightful comments, so thank you.

We'll now go to Dr. John Wootton, president-elect for the Society of Rural Physicians of Canada.

[*Translation*]

Dr. John Wootton (President-elect, Society of Rural Physicians of Canada): Thank you very much. I appreciate this opportunity.

I will give my presentation mostly in English, but I can answer your questions in French if you wish me to.

I practice in the Outaouais region, on the Quebec side, about an hour from here. So I am the closest from Ottawa.

[*English*]

The Society of Rural Physicians is a national organization that brings together physicians who share a common style of practice and common challenges across rural Canada and northern Canada. They recognized some years ago that by sharing their stories they were able to have a larger voice than their individual voices in their communities.

What they have been able to articulate are some common themes about the populations they serve. Those of you who represent rural communities will know that Canadians in rural Canada are older than the average, they're engaged in riskier activities, they're more isolated, more sparsely distributed, and therefore more difficult to serve. They're more economically disadvantaged, and those of you familiar with the principles of population health will know that's a major determinant of their health status. And from the cross-sectional studies that have been done, they're in poorer health to begin with and have significant challenges to overcome. Some indicators of well-known risk factors such as smoking and obesity are very present in rural Canada and in some—particularly first nations—communities, they have devastating health consequences.

That's the portrait of rural populations, and it's the reason I think this committee is interested in rural health issues. There are major challenges in a country the size of Canada—much as my colleague, Dr. Strasser, discussed about Australia—on how to organize the system and how to give it the appropriate support in order to be able to achieve what is perhaps not best described as equal access, but equitable access, to services.

This requires action at many different levels. If the last 20 years is any indication, there have been actions at different levels, but I would characterize them as being somewhat disconnected and certainly not part of a national rural health strategy. There are elements of a strategy, but they lack the strategy for which they are an element of, if one can put it that way. And one of the things that is required for us to move forward is to identify the critical elements of a national rural health strategy that would allow us to move forward.

There clearly are many players. Many of the levers to improve rural health are economic in nature. Many of them are social or societal. Many are educational. Many of the things are out of the sphere of the health care system. So many government departments are involved.

With respect to access to services from a community level, what I hear most often from communities is a discussion about the challenges of health human resources. In health human resources in Canada—particularly in rural areas—there are shortages at the physician level, there are shortages at the nursing level, and there are shortages in all the other professional levels. Communities are struggling to outbid each other with incentives and the attractiveness with which they present their communities. It's a lose-lose proposition for many rural communities who start off with few resources and are forced to use them as incentives.

That really begs the question for me, because my experience in rural Canada is that if you have a workforce that understands the challenge, that is appropriately trained, that is appropriately exposed, they will work in rural communities willingly. If the model is ever-larger incentives, which are clearly part of the package, they aren't the fundamental thing that will improve things in rural Canada.

● (0915)

We need to pay attention to the messages coming from our communities. We need to understand the kind of health worker we need, we need to understand the kinds of teams we need, and we need to understand how those teams can be trained. If we are to seriously address the issues facing the distribution of this workforce, we need to mandate some organizations to actually have some authority to get the training done at the appropriate level for the long-term solution.

If we continue to depend on individual interest and the size of the incentives, we will be continually faced with putting out fires and band-aid solutions, and we won't have a durable infrastructure that can solve the problem in the long term.

I'd encourage the committee to use the expertise that does exist in rural Canada at many levels. There is a great deal of understanding of their communities and a great willingness to come together to produce recommendations for consideration by the different levels of government. The different levels of government must be encouraged to work together to find solutions that are long term in nature and not stopgap.

The Society of Rural Physicians has been working in this community-focused way for 20 years and will continue to do so. Hopefully we'll be able to provide you with assistance and recommendations as we go along.

Thank you.

The Chair: Thank you, Dr. Wootton.

Now we'll go to the Rural Ontario Medical Program and Dr. Peter Wells.

Dr. Peter Wells (Executive Director, Rural Ontario Medical Program): Good morning. Bonjour.

Thank you to the committee for inviting the three of us to speak to you this morning. It's a privilege and an honour to be able to be here.

What I hope to do in this five minutes is to provide you with a very brief overview of what the rural Ontario medical program is all about and what we do. In the package that you will be receiving perhaps later, because it will need translation, you will find more detail, but I hope to really be able to hit the highlights for you.

Training equals recruitment and retention of physicians. Early on, I try to tell people that there's a take-home point in any presentation I do. This is the take-home point, which Dr. Strasser mentioned earlier but it's worth repeating: after a rural background, training and location of training—both at the undergraduate and the post-graduate levels—are the biggest determinants of where people will elect to practise and set up practice.

That's not something we just made up. There is a large body of research to support that, including the WONCA policy on training for rural practice, published in 1995.

ROMP is an organization that began in 1988. We're located in Collingwood, Ontario, but cover a large area of south central Ontario. We're a training organization for community practice. Our intent is to create generalists who come out into community practice.

It's worth noting the economic impact of that kind of training. One doctor, studies estimate, produces a $500,000 to $1 million impact on the local economy in our communities. That would be true across Canada.

So what is the ROMP vision? We all have to have a vision or an idea of what we're going to do. Certainly our concept is that we want to start in high school, so we send our current trainees into high schools to try to encourage students from more rural settings to consider a health career. That doesn't just include medicine, but the allied health professionals as well.

So we try to start in high school. Certainly in medical school we try to get students out early on, because, again, research suggests that the earlier and longer duration of exposure you have, the more likelihood of success in recruiting to communities. That really sets the foundation and plants the seeds for those students to consider coming back for longer-term rotations later in their clerkship training, and then indeed in their residency training.

To complete that circle we try to make sure we can get those students placed in communities that need their particular services, that they'll be happy. Other speakers have talked about the success of those placements being multi-factoral; it's not just training, but spousal support, and so on. Once we have them located into those communities, we try to recruit them back into a teaching role. So it's a bit of a self-fulfilling circle that we're trying to achieve.

It is important to also note that we're trying to encourage retention by providing clinical teaching. The opportunity to teach allows the connectiveness that will help with retention. So although we're talking about recruitment, I also have to emphasize retention. Retention is a huge factor. Once you have people in the community, how are you going to keep them there? You really want to keep them there. If you start losing the folks you planted there, you're defeating your own purpose. Education and providing continuing medical education are all factors in keeping physicians in the community.

Is our program successful? I want to highlight just a couple of things. In our area of south central Ontario, we have over 1,000 preceptors registered to date. That's a huge resource for us. We have 53 months of learning in place since we began, and 800 community recruits in south central Ontario between 2003 and 2008.

In addition, we work with all six medical schools in Ontario. That requires a fair degree of collaboration. So we're really a collaborative program. We want to partner with schools, and we do indeed partner with all six schools in providing various services for them.

You can ask yourself if training works. I've said it works, but where is the proof? We have done some research to look back on our track record. Again, we have worked with all six medical schools, and obviously some relationships are more long-standing, but they're all certainly successful. In fact, 47% of our trainees practise in rural or underserved areas, so that's really quite remarkable just in and of itself.

● (0920)

In the targeted training programs whereby we locate trainees to a particular community, that post-graduate training in family medicine would last two years, and 85% of our ROMP residents are actually practising in the local area where they trained. That's really quite an outstanding figure. I think it speaks not only to the success we're having but also to the success that programs like the Northern Ontario School of Medicine will have.

I'm going to reiterate that you want to retain those people and those who are already there. Dr. Wootton mentioned how incentives for someone to come to a community are self-defeating. I would echo that in the sense that if you have incentives to recruit somebody to your community, then the physicians who are already there are going to start asking, well, if you're bringing them in and providing them with all the incentives, I've been here for 25 years and what have you done for me? So it can be a very divisive tool, and we would not want to look at this kind of suggestion in health human resource planning.

We do need more research in this area to look at the early careerists and how we can retain them. Are we keeping them? Once we've been successful in placing them—and I've given you some statistics on that—are we able to retain them in that community, and are we getting them back into teaching and providing more training for the students coming behind them?

We have four recommendations for your consideration. First, we're suggesting holding a national conference on interprovincial collaboration of the organizations working in this field. Although the Rural Ontario Medical Program is essentially one of three programs in Ontario, there are sister programs in other provinces, and a national conference would allow us to address common needs across the country and develop a common response. It would also allow us to be able to share best practices so that we're not trying to reinvent the wheel. It may also come up with some practical suggestions, including, for example, the creation of a college of rural medicine. This is an area of federal jurisdiction, so it would be right up your alley, hopefully.

Our second suggestion or recommendation is that the Rural Ontario Medical Program and RPAP, the Alberta Rural Physician Action Plan, our sister organization in Alberta, both collaborate on our registered website called practicaldoc.ca. It's very early days yet. We're just putting together the skeleton, and the meat remains to be put on the bones. It's a portal for national retention. So we envision it being a tool for faculty development, continuing medical education, and research administration. We hope it will be open to all provinces. Most recently, B.C. has expressed an interest in joining our collaborative work. Currently we have no funding for any of this work and are just doing it out of our existing infrastructure. Certainly it is one area that could be looked at.

The third recommendation is for a national learner placement program, and we're envisioning that as interprovincial and international learner placement. For example, within our program, the ministry of health in Ontario funds us to place learners in Ontario from the six medical schools. It does nothing that's not available to students anywhere across Canada or indeed any international medical graduates or Canadian medical students being educated abroad, for example, in Ireland, Australia, etc. So we are continually asked to place learners from outside of Ontario. They may be Ontario residents who want to come back to Ontario but are training in B.C., or they may be people from B.C. who are training in Ontario and want to go back to B.C. We think there is an opportunity for distributing these students around and allowing international medical graduates to come here for training and to see our country, and for interprovincial movement of learners. We think that is important and could be a shared resource.

The example I would give is that there are probably at least 2,500 medical students in Ontario, many of them vying for distributed medical training sites. As the medical schools are ramping up their acceptance of medical students because of societal pressures, then we need to get those students placed.

The fourth recommendation is to hold a health ministers conference on funding for community education, recruitment, and retention. You could support the administration of that conference.

Thank you.

● (0925)

The Chair: Thank you very much, Dr. Wells.

We're now going to go into the seven-minute Q and A, but we will be dispersing at 10:30 for in camera committee business.

There's going to be shared time between Dr. Duncan and Ms. Murray. Ms. Murray is first.

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

I'm very interested in the overlaps or cooperation between those working on the issues of aboriginal health and rural health. At our last committee meeting we had a row of experts giving testimony about the aboriginal aspect. So when you are giving us health statistics for rural areas, do the data include aboriginals in the rural areas?

Regarding the issues of recruitment and retention you're talking about, I am curious whether you see recruitment and retention of health human resources for aboriginal communities as a subset of your work, or are these two areas treated as separate areas of study and analysis and recommendation?

I note that among the four main initiatives of the pan-Canadian health human resources strategy, one is health human resource projects, but there isn't a rural component to those initiatives. I'm trying to get a sense of this. Are they completely separate in terms of the fundamentals you're addressing, or how can the work on the aboriginal side be combined or complemented with that on the rural side so that it's more effective overall? Your comments on that would be welcome.

● (0930)

Dr. John Wootton: I'll just make a first comment.

Roger is working in a more northern area than I am, but I have worked in Sioux Lookout in his area. Fundamentally, from a health human resources perspective, I think there's a great deal of similarity. There are a lot of physicians and nurses who move from isolated communities in the north to rural communities farther south. They don't go as far south as Toronto, but coming south for them is a big change.

However, in terms of the specifics and content of the two, it's quite different. The Society of Rural Physicians is collaborating with a first nations physician group to produce a textbook on northern health, because so many aspects of it are different in terms of specifics. So it's a subset on the clinical side.

On the training side, it's probably not. The main characteristic of physicians who work in rural Canada is the level of responsibility they take on. They're isolated, but they can be just as isolated here in Shawville in a snow storm as they can be up north if the planes can't fly.

So in terms of the infrastructure and the training level, there's a great deal of similarity. However, when you branch out into individual communities, things start to be quite different.

Dr. Roger Strasser: The first comment to make in looking at the health status statistics is that if you remove the aboriginal health statistics the data still shows that the health status of people in rural and remote areas is worse than the general population. When you ask what's behind it, sometimes there's an assumption that it's the poor state of aboriginal health in rural areas that drags down the whole picture. That's not the case.

There are specific issues, and John mentioned some of those, around lifestyle and the occupations of people in rural areas and so on, that contribute to the health statistics of people in rural and remote areas. They overlap with aboriginal...but they are distinct from the factors that contribute to the poor state of aboriginal health in this country.

I'm not sure who you spoke to last time, but those who have an interest in aboriginal health will tell you that there are as many aboriginal people living in urban and semi-rural areas as there are in rural and remote parts of the country. Aboriginal health is not just about rural and remote; it's also about urban and metropolitan.

Having said that, in northern Ontario we have over 100 first nations. They are amongst the most socially and educationally disadvantaged communities, and certainly in terms of health status, amongst the worst in the country.

In northern Ontario, with our social accountability mandate, we have a focus on aboriginal health and aboriginal issues. There are a number of elements to that. We are working very hard at developing and continuing strong relationships with aboriginal organizations, people, and communities. We have aboriginal people on our board of directors, involved in the governance of the school. We have aboriginal people involved in all aspects of the development and delivery of our curriculum and the running of the school, including elders who are members of our senior leadership group. We have aboriginal people who are our learners, medical students, and residents. In fact in our first intake of students, 11% of the class were aboriginal medical students, the highest percentage ever in a medical class in Canada.

We have a strong focus on aboriginal issues and aboriginal health, with the intent that our students and graduates have an understanding of the history, tradition, culture, social, and health issues of aboriginal people and that they are responsive to that. We have a thread that runs through our whole curriculum on aboriginal health. In the first year our students have four weeks where they're living and learning in aboriginal communities. That's an immersion experience for them, where they're really learning from the community.

I think it's important to understand that in rural and remote areas the aboriginal communities and their health issues are very much a part of the big picture of rural and remote health issues, but there are also specific dimensions that are cultural, historical and so on, that affect aboriginal people and communities.

● (0935)

The Chair: Thank you, Dr. Strasser.

Monsieur Malo.

[*Translation*]

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

Yesterday, along with my colleague Mr. Dufour and the leader of the Bloc Québécois, Gilles Duceppe, I talked to a number of medical students. In our discussions, one of them told us that most places set aside for aboriginal students in medical schools remain unused.

I would simply like to know your position in this regard, particularly Dr. Strasser. I understand that the system established at the Northern Ontario School of Medicine works. I think the places set aside for aboriginal students are being used. I would like to have your comments on this.

With your permission, Madam Chair, I will now ask my second question. Dr. Strasser talked about his involvement with an international panel on the practice of medicine in rural areas. I would like to have more details on what is being done in that regard elsewhere in the world.

[*English*]

Dr. Roger Strasser: Thank you for the question.

The first question was about designated places set aside for aboriginal people to be medical students. Essentially, as we were starting to develop the plan for our medical school, there was heated debate amongst the aboriginal people themselves about whether we should have designated seats put aside for aboriginal people. There were those who said, "Well, unless there are designated seats, our people won't get into medical school." Others said, "No, we shouldn't do that, because it gives the impression that these aboriginal students are getting in through the back door and the standards are lower, and that creates a stigma for them."

The approach we have at Northern Ontario School of Medicine is a sort of middle ground. We have a class size of 56 students each year, and two seats are set aside for aboriginal students. But we see that as a floor, not a ceiling, and we've never had as few as two students in a class. We have a target approach and aim to reflect the population distribution of northern Ontario in each class. So we've been successful in having somewhere between three and six aboriginal people in the class, which then translates to between 5% and 11% of the class.

Other medical schools, as you've heard, have designated seats and they're not necessarily filled. That's partly because there needs to be an active process to encourage aboriginal people to want to apply to become medical students in that school. So we have an aboriginal admissions stream. We actually start in the elementary schools to encourage students to think about becoming doctors and health professions in the future.

When our medical students are in those first nations communities, they go into the schools and talk about themselves, university, medical school, and so on. We have a high school program where aboriginal students come in and spend a week. It's a summer science camp. They spend a week on the university campus making the connection between the science they study at high school and health. Thanks to television, in recent years we've had a CSI theme, and this has been very popular with the students.

So you have to work hard to encourage aboriginal students to see themselves as potentially future physicians, to study and get the grades, and to fund their way into medical school. You have to look at the whole picture and develop a pipeline, a pathway of aboriginal people into medical school.

Your second question, as I understood it, is that you'd like to know more about the World Health Organization report. I'm an expert panel member giving advice on that. This report has a focus on the retention and recruitment of health workers in rural and remote areas worldwide. As I said, there are four categories of recommendations. The first one is education, and there are five recommendations. The first is to recruit students from rural backgrounds.

The second is to establish medical and health science schools outside of major cities, similar to the Northern Ontario School of Medicine and the success we've had. There are other examples around the world of medical schools and health science schools that have been established in rural areas, or at least in locations that are not in metropolitan and major urban areas.

The third recommendation is that all students should have clinical experience in rural settings—do clinical rotations in the rural clinical setting.

The fourth is that the curriculum should include a focus on rural health and rural practice. There is a defined set of knowledge and skills that rural practitioners require. Dr. Wootton mentioned before that rural practitioners are extended generalists, so it's important that all medical students develop the knowledge and understanding that a special skill set goes with being a rural practitioner, and help them to understand that, with a potential future career in mind.

The fifth recommendation in education is continued education and professional development to help rural practitioners keep up to date and maintain and update their skills while they're in practice. As you can imagine, in a small community it's hard to get away from the community to access education. You have to get a locum, travel, and so on. So providing education that's tailored to the needs of the practitioners, and accessible, usually using alternate communications, is a great benefit.

● (0940)

So that covers that recommendation.

More quickly, the other recommendations include, under regulations, an enhanced guide for practice, recognizing that rural practitioners, whether they're nurses, doctors, pharmacists, or physiotherapists, are actually extended generalists, and the regulations recognizing and supporting that, in terms of the legislation.

Another recommendation is supporting different types of health workers. These include nurse practitioners—"physician assistants" is the language used in Canada. There is demonstrated value in having a spectrum of different types of health workers providing care in rural areas.

Compulsory service is another. In some countries, new graduates are required to do one or two years of service in a rural area. This has been shown to enhance both retention and recruitment.

Also recommended are financial supports in the way of subsidy during education, with a return of service requirements. There are programs like this in Canada as well. Financial incentives are mostly around bonuses for staying in rural practice and supports for setting up as rural practitioners. There is a series of those.

The last group is personal and professional support, ensuring, in terms of living conditions, that the rural practitioners have good places to live, that they have a safe and supported work environment, that they're supported by the system and by specialists in the urban areas—outreach support.

● (0945)

The Chair: Thank you, Dr. Strasser.

I'm sorry to interrupt you; you'll have a chance. We've gone way over, and some people will miss out on their questions. I've gone over on everybody.

So if you could just pick up on that—

Hon. Carolyn Bennett (St. Paul's, Lib.): Can we table the WHO...?

The Chair: Excuse me. We'll now go to—

Hon. Carolyn Bennett: Madam Chair, in regard to the WHO report that Dr. Strasser was walking us through, can we make sure it's tabled?

The Chair: Could we do that, Dr. Strasser?

Thank you so much.

Thank you, Dr. Bennett.

We'll now go to Ms. Hughes.

Mrs. Carol Hughes (Algoma—Manitoulin—Kapuskasing, NDP): Thank you very much. I'm glad to see you all here.

I'm from a rural area. I represent Algoma—Manitoulin—Kapuskasing, and I was at the graduation class of the Northern Ontario School of Medicine. I am a very close friend of and deal a lot with Dr. Maurianne Reade, who provides residential training in Mindemoya. I'm glad we're seeing the input from you here today.

You talked about incentives; just about every one of you touched base on that issue. There are pluses to incentives, but there are the negatives as well. The NDP put forward a proposal that would encourage doctors to go into the rural areas by helping them pay off some of their loans if they would commit to staying. This is a good thing in a way, because it would get doctors there; however, it doesn't deal with the issue of whether, once the incentive is paid out, they would leave or stay.

The other thing we've talked about as well is the opportunity for the government to ensure, if there are some disparities with respect to staffing in the hospitals, that in areas with fewer than 30,000 residents there be at least one nurse practitioner put in. I think we actually need somewhat more, but that is something we saw as a need.

Staffing is a big issue. You've touched base with respect to some of the suggestions you're making in moving this forward. The Canadian Federation of Medical Students was here yesterday. They talked about the downfall of incentives, but also about the impact of having grants so that there are incentives for students and about how to get more of the rural students there, because normally they're the ones who will stay.

Could you provide us with some feedback on that and maybe indicate some of the downfalls you're seeing—what's working, what's really not working, and where government should come in?

The Chair: Who would like to take that question?

Dr. Wootton.

Dr. John Wootton: I can speak from the experience in Quebec.

The incentive structure that works best, in my mind, is one that is tied to the characteristics of the practice. In other words, the major thing that distinguishes a rural physician from his urban colleague is —and the word is best in French—*la polyvalence de la pratique*: the fact that the physician is responsible for patients who are sick in hospital and who may be in the intensive care unit, or they may be obstetrical patients; the physician will also have an office practice and may be on duty in the emergency room and have to deal with trauma.

It's the broad range of responsibility and the training required to get there that justifies a differential. This is better than pure geography, because if people have an incentive program that is based purely on geography, it carries a negative connotation that the community does not have other things to provide and that therefore they need an incentive just to change their geographical location.

Many countries have the same level of responsibility incentives for other health professionals. I believe in Australia the rural nurses have incentives to establish in rural areas. This is lacking in Canada, because a lot of the enhanced responsibility that rural nurses or rural pharmacists have is not recognized by their negotiating bodies, and there really isn't a structure for this.

The effect of incentives has to be recognized throughout the whole career of the physician. Big lump sums up front, as was mentioned, cause division within the community when long-established physicians see themselves not being recognized.

● (0950)

Dr. Roger Strasser: To add to that, I think it is important to look at a type of "whole systems" approach, to look at the various elements and have incentives that support not only doctors but the whole health team, because that's what is needed in rural communities.

There are a couple of limitations with the kinds of specific incentives you're talking about. One, particularly when the initiative is taken by the community, is that some communities have more resources than others, and often the communities that are more remote and have the least resources have the least capacity really to provide the incentives. A systems approach that ensures that there is comparability across the communities is important. Sometimes that can be quite distorted.

Another is that when the incentive time runs out, there is a tendency for the physicians to decide that they're not going to stay in the community any longer. There was a crisis in a town called Geraldton in northwestern Ontario a few years ago when incentive payments for five physicians ran out and they all left, more or less at the same time.

The solution to this is not just about how the incentives are provided, although certainly retention incentives and rewarding the *polyvalence* of the practitioners who provide the full round of services—I would call it extended generalism in English—is important. There's a community element to this. It's really important for the community to recognize their role in hosting the doctor, and in fact the whole family. And for other health professionals it's the same sort of thing. When a doctor or a nurse comes to a community, it's actually a whole family. The incentives need to ensure that the needs of the spouse and the children are covered as well, so that the physician becomes a member of the community and wants to stay because of feeling part of the community. That's another systems element that's very important to assist retention as well as recruitment.

The Chair: Thank you, Dr. Strasser.

We'll now go to Mr. Brown.

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

I have some questions for the Rural Ontario Medical Program. Michelle and Peter, it's great to see you here. I've had the pleasure of attending some of the PAIRO tours that you're involved in. My colleague, Ms. Bennett, has spoken to one of your conferences before. Certainly you have a great reputation for helping get doctors into the community in underserviced areas.

I want to understand the setting right now in underserviced Ontario before I get into what some of the possible solutions are. I spoke to our physician recruiter in Simcoe County, and I understand that in Barrie alone, under the changes with incentive grants, we're going to have 17 doctors who no longer get incentive grants—that's 17 doctors in our community, taking patients, playing a vital role.

I understand that this change is going to make it remarkably more difficult for many parts of Ontario to recruit doctors. I understand there is an incentive grant of $40,000 that is on the precipice of being gone, and a $15,000 incentive grant. Could you share with the committee how these changes by the provincial Ontario government are going to affect recruitment in Ontario?

The Chair: Who would like to start?

Dr. Wells.

Dr. Peter Wells: I'll start. Then I'll turn it over to Michelle.

The program you are referring to is the underserviced area program, UAP. The intent of the program is to try to allow communities some funding to be able to provide for recruitment. That is being reallocated, in essence, and it's fairly complicated. I don't know that we necessarily need to go into the details here, but when you're looking at trying to provide incentives, I would take a whole systems approach, much like Dr. Strasser, and say we need to support undergraduate medicine, which in Ontario is not supported very well. Medical students, who are paying high tuition and so on, are not supported in coming out to do part of their education, and the research suggests the earlier and longer, the better your success rate, in providing communities with some infrastructure support directly to be able to support clinical teaching activities in all aspects. Allied health professionals as well as doctors are important.

Michelle is better able to answer your direct question about the program.

● (0955)

Ms. Michelle Hunter (Manager, Rural Ontario Medical Program): Thank you.

If you are looking at the programs that are currently running in communities such as Barrie, or if you look to the west, to Kitchener—Waterloo, down into southwestern Ontario or south-eastern Ontario, they are going to be losing their incentive grants. The free tuition program will collapse on April 2. Those moneys have been reallocated into alternative funding programs hitting more rural and remote communities.

I would refer to Dr. Wootton's comments on whether it is a matter of geography or it is an incentives program better focused on responsibility. The *polyvalence* they have mentioned is probably the program you are looking at. You are looking at supporting physicians with a broader scope of practice. If that is rewarded, then these communities have the opportunity to recruit and sustain physicians.

Mr. Patrick Brown: I understand there have also been negative changes to the return of service agreement in the sense that we have a significant interest in foreign doctors and foreign accreditation. I understand that with the changes, which I suspect will come April 2, a foreign-trained doctor doing his return of service could have done it in Simcoe County. Now it's going to be a free-for-all anywhere in Ontario, other than Ottawa and Toronto, so it'll be increasingly difficult for small towns and rural areas to get return of service contracts, because now they can go a few minutes north of Toronto.

Is that something we should be concerned about for rural and small town Ontario?

Ms. Michelle Hunter: The return of service contracts exist now for the international medical graduates who receive residency spots. They are asked to comply with the standards. Ontario has changed those so now they can go to Hamilton or Oakville, different boroughs of Toronto, and even to London, Ontario. They can do their return of service there.

It will have an impact on Barrie and on northern Ontario. The international medical graduates will stay closer to their cultural groups, so where are the return of service contracts for the folks who are paying tuition in Ontario and then in family practice residencies? Where are they doing their return of service contracts? If they choose to do one, they will take funding that will send them fairly far afield into northern and rural Ontario.

Mr. Patrick Brown: That is my concern. Both of these changes are going to prove very onerous for parts of Ontario that are underserviced. It is an unfortunate development that I hope will be rectified.

I wanted to get into what I think is a solution. I believe from the testimony we've heard before that the solution lies in more residency spots. I know you play a role in the training, and I wanted to hear from you what it would cost if we were going to see a program across the country to open up more residency spots. What are the costs of training and residency for a medical student? I understand it is a two-year term. What would the cost be for those two years?

One thing I heard earlier this year when we had the College of Physicians and Surgeons in was that we had this list of 700 or 800 people for 175 residency spots every year. I forget what it was. We're turning down all these potential doctors because of the lack of residency spots, so the solution must be in putting in more residency spots, but I suppose there is a significant cost to that. What is that cost?

The Chair: Who would like to try to answer that one?

Dr. Strasser.

Mr. Patrick Brown: What is the cost to your organization for residency?

Dr. Roger Strasser: The first thing to say is that there are more than enough residency positions for Canadian medical graduates, MD graduates from Canadian medical schools, across the country. In fact, in all provinces there is the opportunity for international medical graduates to find their way into the system and become residents and practising physicians in Canada.

Answering the question about cost is quite difficult and complicated because there are various elements to the costs, and generally they're funded through different pathways and not put together into a total package of cost. There are clearly differences in providing the training in the concentrated population centres like Toronto, where you have a critical mass nearby, compared to in the sparsely populated areas in northern Ontario.

● (1000)

The Chair: Mr. Brown, your time is up. I'm sorry, I gave you extra time.

We're now going into the second round of five-minute questions and answers, and if you have shared time, I do have to watch the clock. Be mindful of your colleagues, if you can.

We'll start with Dr. Bennett and Dr. Duncan. Who wants to start first?

Hon. Carolyn Bennett: I'll start. We'll do the questions and then you can answer together.

Dr. Strasser, in Australia the locum system is pretty well developed. I just went and worked for Locums Australia Pty Ltd., and they sent me wherever they wanted. Also, with the Australian Medical Association....

In terms of the CME piece and looking after families, one of the things I heard was that physicians need to be able to know that they can of course get out with their families, and if they're the only game in town, that's pretty hard to do. Is there something we could do to make that better organized? Is there anything we would have to do in terms of licences across provinces such that somebody could do a locum in northern Manitoba with an Ontario licence? How would you organize that? Is there something you would like to give us that we could put in our report?

Kirsty.

Ms. Kirsty Duncan (Etobicoke North, Lib.): Thank you, Madam Chair, and thank you to all of you for coming and for your important work.

I'm really concerned about the disparity between rural and urban areas. I found that rural Canadians have the highest death rates from causes such as circulatory disease, injury, respiratory disease, and suicide, compared with their urban counterparts. If we look, 21% of Canadians live in rural areas, yet 9.4% of physicians work in rural and remote areas.

My questions are these. To what extent are the health disparities between rural and urban Canadians the result of the shortage? And what does it mean in terms of, for example, emergency care, surgical care, and treatment following?

The Chair: Who would like to start? You have three minutes.

Dr. Strasser.

Dr. Roger Strasser: Maybe I'll start. To the question about rural practitioners and locums, it's true there is, I would say, a very well-developed system in Australia. Part of the system in Australia is that rural practitioners have more or less automatic funding to attend programs to upgrade their skills—the CMEs, continuing medical education. So they have relatively well-organized support to get locums, to be able to leave their community and go and do the training. They receive funding from the federal government to cover the cost of undertaking that training. So that's a good example of something you could learn from elsewhere.

On the issue of the lower rural health status and the maldistribution of the workforce, access is the rural health issue. That's the same the world over. Certainly reduced access is one of the factors that contributes to the poorer health status in rural areas, but it's only one of the factors. The social determinants of health, as a whole package, affect the health of people in rural areas just like elsewhere.

The Chair: Who else would like to continue?

Dr. Wootton.

Dr. John Wootton: With reference to the locum licence, the Society of Rural Physicians has long lobbied for a mechanism for locum licence. A rural physician's best replacement is another rural physician, and it's not true that every community is in crisis across the country at the same time. For physicians a change is often as good as a holiday, and many are very interested in seeing other parts of the country, but when it involves buying a licence for an entire year.... For me to cross over to Renfrew to do a locum 20 kilometres away would be a logistical nightmare.

Hopefully AIT is lowering the interprovincial barriers. One aspect of it that could be looked at specifically is a mechanism to allow locum licences and some organization to manage it.

● (1005)

The Chair: We only have about 30 seconds left. Are there any other comments you'd like to make on that, Dr. Wells?

Dr. Peter Wells: I'd like to support the comments about lowering the interprovincial barriers, both from an educational point of view and a locum point of view. For people to be effective teachers, they need locums to do CME, and trainees need the flexibility of being able to train in different parts of the country.

The Chair: Thank you, Dr. Wells.

We'll now go to Ms. McLeod.

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): Thank you, Madam Chair, and I'd like to thank all the presenters for some very valuable information.

I would like to start with the university and the training of our medical students. I believe there are 17 medical schools. You talked about two within Ontario. I know we have UNBC. These are all relatively new programs. Are there any other rural educational universities in the country?

Dr. Roger Strasser: There are 17 medical schools in Canada, of which Northern Ontario School of Medicine is number 17. It is the only new medical school established in Canada in over 30 years. That said, there has been expansion in medical school class size in every province, and in many cases satellite campuses have been established.

You mentioned British Columbia; they were just a year ahead of us, actually. They established a collaboration between UBC and UNBC—the University of Northern British Columbia in Prince George—and also the University of Victoria, so the students there are UBC students doing the UBC curriculum, but almost all of their four years of education take place in northern B.C. or on Vancouver Island.

There have been similar developments in Quebec. An example is the Université de Sherbrooke, which collaborates with the Université du Québec in Chicoutimi. Across in New Brunswick there's Moncton, and there are other Quebec schools. There's Trois-Rivières with the Université de Montréal, and so on. It's a pattern across the country for established medical schools to put satellite campuses in place in rural regional areas. The program the students follow is identical to, or very close to, the program in the urban area.

The Northern Ontario School of Medicine is the only new school established in a rural area with a program curriculum that is really designed in and for the rural setting.

Mrs. Cathy McLeod: It is a relatively new venture to have many of our medical students trained either by satellite or in a northern setting, and hopefully we're going to see some real results. It sounds as though we're heading in a really positive way with the choices these students are making.

You indicated that in the university you're responsible for, a very high percentage of people grew up in a rural area. I know getting into a medical school is very competitive, so do you just allot extra points within your admission process to people who come from rural communities? How have you managed to create such a high percentage of students who grew up in rural communities?

Dr. Roger Strasser: The essential principle is that the best predictor of future behaviour is past behaviour, so we look at grade point average. Any applicant who has a grade point average of more than 3.0 on a four-point scale we will consider. We look for a balanced academic background. If they have a science or math degree, then they have courses in humanities and arts; if they have an arts degree, they have courses in science and math. We don't have any prerequisite courses. We don't use the MCAT, which is an American aptitude test that most of the medical schools in Canada use. We look at their academic score.

They complete a questionnaire, which tells us about where they grew up, where they went to school, and when they had choices in community work and that sort of thing. We also give them what's called a context score. That's really what I think is the answer to your question. If you grew up in northern Ontario, you get the highest score. If you're aboriginal, you get the highest score. If you are francophone, you get the highest score, and so on down.

It's very competitive. We have in the order of 2,000 applications each year for 56 places. That's something like 40:1. We select 400 for interview. Actually, this past weekend in Sudbury and the weekend after Easter in Thunder Bay are the interview weekends. We interview 400. With the interview score plus the other score, we decide who to offer the places to.

● (1010)

Mrs. Cathy McLeod: Perhaps this is a provincial matter, but I would direct this to Dr. Wootton.

I know that in some of our communities there was a decision recently to change the model of how physicians are remunerated from basically a contractual model to fee-for-service. It certainly caused great upset in that the physicians are choosing to move on. I am wondering if there is, Canada-wide, any general research about the preferred remuneration model in rural and urban settings. Can you make a few comments?

The Chair: Be very quick, Dr. Wootton, because we're running out of time.

Dr. John Wootton: The quick answer to that is that there is more appetite for a global capitation-type system, because one of the characteristics of rural areas is that volumes are unpredictable. Emergency rooms, for instance, may be quiet or may be overwhelmed from one day to the other.

Just to add a point about the distributed education point, we're in the middle of a Canadian experiment. The increase in medical school enrollment was not because of a recognition of a rural problem. It was in response to a global recognition, finally, that the Barer-Stoddart report got it wrong and that we actually do need more physicians in Canada. But because the universities are strapped for places, it has generated an interest in distributed education. And it's really important that we capitalize on this.

One of the things the federal government could do is find a way to support those areas where distributed education is occurring. They're outside of the traditional university locus, which is well developed, but they are demonstrating that in terms of solving the rural problem, they have results that nobody can match. That's a place we can work.

The Chair: Thank you, Dr. Wootton.

We'll now go to Monsieur Dufour.

[*Translation*]

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

I want to thank our witnesses for coming today.

I know several of my colleagues are perhaps more interested in provincial initiatives then in what you do. Personally, I take great interest in your initiatives and, specifically, in what the Northern Ontario School of Medicine does. I think the Quebec government has much to learn from the way you manage the school and the actions you took. As you mentioned it, Dr. Strasser, I believe things are starting to move in Quebec. For instance, the department in Chicoutimi and several other Quebec schools are taking measures that are somewhat similar to what you did.

As Mr. Malo mentioned, yesterday we met some people from the Canadian Federation of Medical Students who talked about your school with great admiration.

I would like to know what the comparative retention rates are for physicians working in urban and rural settings. I guess there are major differences that are not only related to the place where the physician was recruited and the location where he got his training. Can you provide us with any data and statistics on the comparative retention rates for these two types of areas?

[*English*]

The Chair: Who would like to take that one?

Dr. Roger Strasser: When you say two types of areas, you mean the urban and the rural areas?

[*Translation*]

Mr. Nicolas Dufour: Exactly. Do physicians in rural practice stay both in rural areas and in family medicine as compared to physicians who got their training in an urban setting?

[*English*]

Dr. Roger Strasser: Okay. Regarding the first, you have to realize that until very recently, the vast majority of medical students came from the big cities. Only 10% or maybe 11% of a medical school class would come from rural areas, so that most medical students had that city view of the country, which was that it's a nice place to visit, but I wouldn't want to live there. Therefore, most medical students wouldn't think about going into rural practice, and that attitude has tended to be encouraged by the main teachers in the medical schools, who are sub-specialists in big teaching hospitals in the cities. Their view is that the best kind of doctor you can be is a doctor like me, a sub-specialist in a teaching hospital.

Medical students everywhere are ambitious high achievers, and they want to be the best kind of physician they can be, so they aspire to be teaching hospital sub-specialists. So the system has been sort of self-perpetuating in its encouragement of medical students, whether they come from the urban or the rural areas, to want to become teaching hospital sub-specialists.

Northern Ontario School of Medicine is still almost brand new, and there are other examples of rural-based medical schools in other countries around the world. Their success rate for recruitment and retention of their graduates in rural areas is very impressive. There are two medical schools in the Philippines from which over 90% of the graduates continue to practise in rural remote areas in parts of the country where most people have very limited services—electricity and water and that kind of stuff. The Philippines is a country that most medical graduates leave the day they graduate. They go to the United States and practise in the United States.

I think there's strong evidence that, as I said, recruiting from rural areas, providing the education in the rural setting, supporting training at the residency level, and then providing support in terms of education and the other incentives and so on that I've mentioned actually provide for recruitment and retention in rural areas. In northern Ontario, before the existence of the Northern Ontario School of Medicine, since the early 1990s, there have been family medicine residency programs in the northwest and the northeast. Over 60% of the doctors who have trained in those programs since the early 1990s are still practising in northern Ontario.

● (1015)

The Chair: Thank you, Dr. Strasser.

We'll now go to Mrs. Davidson.

Mrs. Patricia Davidson (Sarnia—Lambton, CPC): Thank you very much, Madam Chair.

Thank you very much for your testimony here this morning. It's certainly been helpful and very interesting.

One thing I would like to know from each of you is what your definition of rural is, how you determine that. I would also like you to speak on the opportunities that rural Canada can reap from interprofessional interaction, whether we're talking about doctors, nurse practitioners, physician assistants, or our laboratory, imaging, physiotherapy, and occupational therapy people, and whether there are opportunities there for rural and remote areas in Canada. I'll just leave those two to start with.

The Chair: Dr. Wootton, do you want to start?

Dr. John Wootton: As far as the definition of rural goes, I would strongly encourage you to steer away from trying to completely understand it, because it's a moving target. If you are a researcher, you need sort of a Statistics Canada definition. If you're a health planner, you need more a style of practice definition. If you're a geographer, the simplest....

When we at the Society of Rural Physicians were first distributing our journal, we sent it to every address that had zeros in its postal code. Some of those were addresses of cottages belonging to people who were working in Toronto. The most useful definition and the hardest one to get to has to do with what I referred to earlier as physicians who have a comparable level of responsibility. That's very hard to tease out from geography or from population size.

As the physician workforce shrinks, a lot of communities find their physicians taking on more and more responsibility, and therefore becoming rural in a sense, although nothing around them has changed. But I think the philosophy of the Society of Rural Physicians' definition is the one that works the best. Some people are clearly rural by virtue of their geography. On the other hand, a physician who works in Whitehorse and who is merely doing psychotherapy in his office does not have the same responsibility as a physician in the same community who may be doing obstetrics and emergency room work, etc.

Dr. Roger Strasser: I was the first chair of rural health in Australia, so I got asked that question a lot around the world. I would say that rural is a bit like beauty or pornography: it's in the eye of the beholder. It's very much a mindset, more or less, as John has said. You then do have to, for different purposes, construct definitions according to what you're looking at. I'd agree with what Dr. Wootton said, that if you're looking at rural health service and rural practitioners, rural practitioners are extended generalists who provide a wide range of services and carry a higher level of clinical responsibility in relative professional isolation. That's true whether you're talking about family doctors, or surgeons, or internists, or pharmacists, or nurses, or nurse practitioners, or physiotherapists. I think that's a useful working definition if you're looking at health human resources.

In terms of interprofessional care and interprofessional education, my observation is that in the cities there's a lot of talk about teamwork and interprofessional collaboration. In the rural areas, particularly the small communities, it actually happens much more often. It's born out of necessity; there aren't enough health care providers. The rural practitioners live in the community they serve, so they're part of the community and they work very well together to meet the needs of the community they serve.

● (1020)

Dr. Peter Wells: I would echo what's been said before. You can look at crazy definitions of rural as the number of Tim Hortons you have and set a level of that. But I really think it is a moving target and probably not worthwhile trying to pin down.

In terms of your question about teamwork, I think in Ontario there are several models of that. Primary care reform has been in place in Ontario for several years. It offers a blended income model where it can be fee-for-service and capitation, which seems to work quite well. There are several different models physicians can choose from, depending on their style of practice. With that is the opportunity to have a family health team, which allows you to partner with allied health colleagues to provide service. I agree with Dr. Strasser that in the rural area it's used much more effectively just because of necessity, and the reality is that primary care workers, who are the ones who access the family health teams, are having huge demands on them. They don't have the resources, multiple layers of specialists, to refer to. So the family health team helps them deliver very comprehensive care to a larger variety of patients and a larger number of patients.

The Chair: Thank you, Dr. Wells.

For the last question we'll now go to Dr. Duncan.

Ms. Kirsty Duncan: Thanks, Madam Chair.

I would like to come back to what I asked before, but I'm going to ask a few questions beforehand.

My question is, what do you see as the federal government's role in bringing a rural lens to health care issues? What are your asks? What would you like to see happen?

The Chair: Who'd like to answer that?

Dr. Wootton.

Dr. John Wootton: One of the things that was mentioned earlier was that we need a mechanism to bring all the stakeholders together, from the community level up through the various professions, to generate the recommendations that have the broadest consensus possible that we can bring to whatever level of government is the appropriate one for the recommendation. I think there isn't an opportunity for this to be solved simply at one level; it has to be solved at many levels.

Dr. Roger Strasser: Just to reinforce that point, I would suggest the development of a national rural health strategy would be a very helpful way to go. I've seen in Australia the leadership from the federal government, which has really improved the quality and the access to health care in rural and remote areas. I can see the same success happening here in Canada.

I would suggest a stepping stone to developing such a national rural health strategy would be to hold a national rural health conference. That's actually how it started in Australia. The first national rural health conference in Australia brought together stakeholders from across the country and developed the first national rural health strategy, and then there have been lots of developments since then. I would recommend a national rural health conference as the basis for developing a national rural health strategy.

Ms. Kirsty Duncan: I'd like to know again what impact the shortage of health professionals means for emergency medicine and surgical care, for example, understanding that this is a widespread worldwide problem, understanding the social determinants of health. Practically, what does it mean in rural areas?

● (1025)

Dr. Roger Strasser: Based on research that I've done over a number of years, I would say that people everywhere—city, country, anywhere—have a security need. They need to know that if they're unlucky enough to be seriously ill or injured, the system is there to save them.

In the urban areas that's a given. There are emergency departments and ambulances going backwards and forwards and so on, so the focus on health concerns is elsewhere. In the remote and rural areas, the people there know they can't take for granted that they have a hospital with an emergency department and the services they need. So that's a major preoccupation.

The research we've done shows that in order to ensure that people have the services they need, you really need to focus on that safety net and how that's provided in their community. There are many different ways of doing that.

We did a major study in Australia looking at 22 different remote communities and how they had their health services organized, and there were many different ones. There were a number of key elements. A key element that might be surprising was community participation. Where the services worked best there was a community representative organization that had a responsibility for the ongoing development of the health service, for recruiting health practitioners and supporting them, and there are all the things I said about the family, etc. But a key component is active community participation.

Ms. Kirsty Duncan: I appreciate that.

How does that effect, for example, rural Newfoundland, where they've closed one hospital and it's an hour-and-a-half drive by ambulance to get to the next hospital, and you have an internist who is covering everything from hematology-oncology to general surgery?

Dr. Roger Strasser: That's a very good question.

Certainly modern developments in communication and transportation have improved the situation. For example, using telehealth, telemedicine, and real-time video conference linking helps to improve access to care in remote settings. However, in that life threatening situation there is the golden hour, and what's important is that in the community you have health practitioners who have the training, the skills, and the support to be able to save people's lives. And then they're supported by the system, using telehealth, transportation, and so on to transport maybe to a larger centre for care.

I think it's a serious concern in the example you gave, in a community where it's more than a hour and a half to the next centre, to lose that urgent care emergency response capability.

The Chair: Thank you, Dr. Strasser.

I want to thank all of our witnesses who came today. It was very useful to our committee. Your insightful comments, being out in the field and knowing what you're doing, have brought an expertise to this committee that is invaluable. I thank you for that.

I'm now going suspend this committee. We're going in camera for our business section.

[*Proceedings continue in camera*]

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