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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, ladies and gentlemen.

I would like to welcome you to the health committee. We're doing another study this morning on HHR.

This morning we're not going to have opening remarks. What we're going to do is go directly into the questions and answers.

We've been doing our study on HHR, health human resources. It is very important that we try to get as many people in our committee as we can. Some of you I see here again; you've been here before. We're trying to make sure that we encapsulate all the areas of health human resources.

Today with us, ladies and gentlemen, pursuant to standing order 108(2) on human health resources, we have Dr. Joshua Tepper, from the advisory committee on health delivery and human resources. You're the provincial co-chair. Welcome.

From the Department of Health we have Shelagh Jane Woods, director general of the primary health care and public health directorate, first nations and Inuit health branch. With her we have Debra Gillis, director of the first nations and Inuit health branch in the primary health care and public health directorate, and Abby Hoffman, associate deputy minister, strategic policy branch.

Welcome. We're very glad you're here from the Department of Health.

From Statistics Canada we welcome Jeff Latimer, director. Jeff, welcome. You're from the health statistics division. We're very happy to have you here. We also have Sylvain Tremblay, senior analyst and chief of the Canadian community health survey, health statistics division, and Gary Catlin, director general of the health, justice, and special surveys branch.

We feel very honoured to have you here as witnesses.

I must say at the onset, ladies and gentlemen, that at 10:30 we'll have to go into our business part, so this presentation will last until 10:30.

That said, we will begin straightaway with the questions and answers. Dr. Bennett will begin..

Hon. Carolyn Bennett (St. Paul's, Lib.): Thank you all for coming.

In some ways we've been operating in the dark as a committee in that we don't really know the strategy, so we're pleased to have the federal co-chair and the provincial co-chair.

I think what we're struggling with is that any strategy should include what, by when, and how. I think we've heard bits and pieces, but I wonder if you would outline what the strategy is in terms of what your targets are, how we get there, how we are going to do this thing in terms of having enough health professionals to do the job, both paid and unpaid, and in terms of the aging demographic. Tell me a little bit more.

We would love it if you would table with the committee anything you have from 2004, when human health resources was a very important part of the accord. How far have you come, where are you going, and what are the provinces and the federal government doing? Could you just lay it out for us?

I think the reason we invited Statistics Canada was that the cost recovery approach seems to be getting in the way of communities being able to plan. We're pleased that the health statistics division and the community health survey are here, but I think we know that the determinants of health—poverty, violence, the environment, shelter, equity, education—are also hugely important for communities to be able to plan. How do communities get the data they need in order to properly plan in terms of the future of health human resources needed for that community, not only on the demographics side, but on the determinants and in terms of the broadest possible definition of health?

Particularly, Josh, I think what we talked about on Tuesday was that in lots of countries statisticians and epidemiologists at the service of individual communities, clinics, or whatever, become very important. If you measure, it gets noticed, and if it gets noticed, it gets done. On the day after Florence Nightingale's birthday we could get to how we incorporate these kinds of epidemiologists and statisticians right on the ground, rather than having somebody do it off the side of their desk.

● (0905)

The Chair: Who'd like to start?

Go ahead, Dr. Tepper.

Dr. Joshua Tepper (Provincial Co-Chair, Advisory Committee on Health Delivery and Human Resources): Thank you very much for the opportunity to present today and for the opportunity to take what will be a first attempt to answer some of the questions you've laid out.

This is an area that I think is very close to governments provincially and territorially across the country, as well as to the federal government, which is probably the country's sixth-largest employer of health human resources and a very important vested player at the table.

I would say that a lot has changed in the last six to seven years. Where we were in the middle and late 1990s is no longer where we are now. We're in a very different situation in terms of data and in terms of the actions that have been taken across the systems.

Data are only half the story; what you do with the data is the other half, and actions that have been taken have increased the supply in very dramatic ways. There isn't a jurisdiction with educational capacity that hasn't increased that capacity quite dramatically across a large number of health care providers, from technicians to nurses and physicians.

There's been a huge change in not just the number, but also in who and how these providers are and what they do. We have the introduction of physician assistants in numerous jurisdictions, nurse practitioners, anesthesia assistants, clinical radiation specialists. The range and the roles of the health care providers in the system are fundamentally different from what they were just five or six years ago, as well as the overall supply.

How these people, these larger numbers with an increased scope of practice and a greater role, are working in the health care system is also fundamentally different from what it was before. It's much more team-based, much more patient-centred, much more driven by quality and by evidence, all of which is an opportunity to work to full scope of practice, to increase the quality of care, and to make the best use of the resources that we have in this increasing supply and in this range of numbers.

Compensation models and IT have followed in varying degrees across the jurisdictions as well.

So we have more, we have different, and we have them working in very different ways.

We also have a lot more data than we've ever had before. That data are coming from a variety of different mechanisms locally, regionally, provincially, and nationally. I think what's much more important is how we think about the data, and how we use the data is very different.

I actually did a very short and unsuccessful stint as a data modeller. I wasn't as bright as the folks at the end of the table, but our models used to be remarkably simple. If we have six general surgeons, and they are 50, in 20 years—punch it into Excel—they will be 70. If we have three of them in rural and three of them in urban and one in between, that means we need six more general surgeons. It's just a very strong supply.

One of the most important contributions that ACHDHR has done is to create a needs-based framework for thinking about HHR, which has led almost every jurisdiction in Canada to develop a new way of thinking and modelling. Every jurisdiction now has invested, I would say, often millions of dollars—I know in Ontario alone it's been several million—in developing not data alone, but actually different ways of using those data to do best predictions of what the population is going to need. Rather than driving this through saying, "Okay, we used to have ten plastic surgeons in downtown Toronto or downtown Calgary. Five of them plan on retiring; let's bring five more in", we're actually looking at the needs of the population and then working back to look at the supply of a variety of health care providers. I think ACHDHR's framework has been absolutely influential in driving that forward.

Again, I would say that every jurisdiction has now driven far forward from where we were at the end of 1990s in terms of resources and in the sophistication of these models. It's also done nationally. I know we have a very robust nurse practitioner modelling. The CMA and others have done very robust physician modelling. There's been good modelling around other rehabilitation specialists as well, so it's a much more robust setting than we had.

I mentioned the framework, which I think was critical, because putting out a common template is very important. I would say that ACHDHR has been able to do two other things. One is it's been able to provide a forum that really brings together researchers, educators, and, as of about a year and a half ago, basically every major national player through an organization called HEAL, which is—

● (0910)

The Chair: Dr. Tepper, I've already given you two extra minutes.

Dr. Joshua Tepper: I apologize. Somebody just needs to wave me down, and I'll be quiet.

The Chair: I am always lenient on time with presenters. Perhaps you could watch for the red button—

Dr. Joshua Tepper: Perfect. I apologize for not understanding. There's no need to be lenient.

The Chair: —and then just wrap it up.

Thank you.

[*Translation*]

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

I want to thank our witnesses for being here today.

Since the beginning of this study on human resources, one thing has been of particular interest to the Bloc Québécois, and that is the fact that health falls under provincial jurisdiction exclusively. I understand that the Standing Committee on Health is interested in studying health, but you understand the complexities that this leads to. Which leads me to my question for Mr. Tepper and Ms. Garrison. How did you carry out your consultation, and how do you see the role of the provinces in that consultation?

[*English*]

Dr. Joshua Tepper: In all of our activities—and I will watch for the red light diligently—and in all of the work that we produce, we have a very robust consultation process. Often it's web-based, often followed up with opportunities for key stakeholders to come and present and speak to the committee itself. Certainly the framework itself went through numerous iterations of consultations through the web, through paper, and through forums that were pulled together and shared in large stakeholder multi-party groups. We have always had a very consultative approach to this, and that has only increased over time.

To your specific question around provincial role and autonomy, I think it's something we're quite conscious of. Quebec sits at our table but does not necessarily contribute financially; however, they are a very active player, and we learn a tremendous amount from their observer status, to be honest. They're leaders in numerous ways in health human resources. We're very careful, in the types of activities we pick for ACHDHR, to be respectful of individual jurisdictional roles and responsibilities. The types of things we select for the pan-Canadian activities are carefully selected, and every jurisdiction always has an opportunity to participate in different levels or ways. Often Quebec takes more of an observer role in these, but their comments are always welcomed and documented, and their valuable insights are always incorporated into the final documents if they so wish.

I apologize if I didn't answer the question.

[*Translation*]

Mr. Nicolas Dufour: Yes, that's fine. I have to tell you that I understand very well.

Of course, as you say, people do want to discuss the good things that Quebec has done so as to give a hand up to the rest of Canada regarding human resources. We know that because of federal cuts in the 1990s, Quebec had to make some difficult choices but was able to manage anyway given its very strong public health care system. We heard it said a few times that certain parties may have wanted to establish a national strategy or to broaden federal powers somewhat regarding human resources. Aren't you afraid that this might cause a direct conflict, since it is an exclusively provincial jurisdiction? Quebec's role for the moment, if I understand correctly, is more that of an observer, an advisor if you will, at the table. Are you not scared that this could cause friction with the Government of Quebec?

● (0915)

[*English*]

Dr. Joshua Tepper: I would say no more so with Quebec than with any other jurisdiction. I would argue that when we get into these conversations, because the field of health and health education is a provincial jurisdiction, the reality is that on almost all topics there is a large degree of provincial and territorial divergence.

The number of opportunities to truly get everybody on the same page in a seamless way is extremely small, because we increasingly have very different systems, health needs, and structures in each jurisdiction, but I would say that there is surprisingly little conflict. It's much more of a sharing of best practices, to be honest. I would actually argue that the real enrichment comes from the table.

The most important part of the meeting, in my humble view, is that we set out about probably a third of our meeting to go around and have every party, including the health professional representatives and associations, talk about the pressing issues. We have it broken down and reported on a specific template in a consistent manner so that we're all reporting in similar ways on similar things.

Knowledge translation and examples of best practices are a huge focus for what we do; that still allows us to respect the individual jurisdictions and what they do. I know B.C., for example, just decided to take an action on Canadians studying abroad that is very different from what the rest of Canada is doing, and now they're having some fun experiences with that. Each jurisdiction is going to play a little bit differently, and there's certainly an opportunity and respect for that.

[*Translation*]

Mr. Nicolas Dufour: The problems in the health care sector are extremely different from coast to coast, as some like to say.

My question is for the Statistics Canada representative. Do you have any data on the number of physicians and nurses from 2000 on? Has there been a decline in the number of physicians and nurses? Could you break this data down by province so that we can see which province had the greatest increase in the number of doctors and nurses, or the greatest decrease?

[*English*]

The Chair: Would you like to take that, Mr. Latimer?

Mr. Jeff Latimer (Director, Health Statistics Division, Statistics Canada): We're just discussing, actually, who would be best to answer the question. Thank you very much.

The Chair: Talk among yourselves and let us know.

Mr. Nicolas Dufour: That was a good question.

[*Translation*]

Mr. Sylvain Tremblay (Senior Analyst, Chief, Canadian Community Health Survey, Health Statistics Division, Statistics Canada): Currently, there are no Statistics Canada surveys on that. The Canadian Institute for Health Information covers the whole area of human resources. So this is more akin to a shared responsibility. The tracking of human resources in the health care sector is done by the CIHI.

Mr. Nicolas Dufour: Thank you very much.

I have no further questions, Madam Chair.

[*English*]

Dr. Joshua Tepper: Madam Chair, I can probably arrange to get those data to you by end of day. If you get me an email, I'll provide you a jurisdiction-by-jurisdiction multi-year trend line for physicians across the country. I'll just grab your email on the way out. I should be able to get it to you by the end of the day at five o'clock.

[*Translation*]

Mr. Nicolas Dufour: That's fine.

[*English*]

The Chair: Thank you, Dr. Tepper. We really appreciate it.

Mr. Dufour, is that the end of your questions, then?

Go ahead, Ms. Leslie.

Ms. Megan Leslie (Halifax, NDP): Thank you, Madam Chair.

Welcome. This question is to the advisory committee, but perhaps also to Health Canada.

If you have a look at the transcripts, you'll see that witnesses have said the provincial-territorial advisory committee hasn't been as inclusive as it could be, in particular when it comes to health care professions and tapping into their knowledge to have more of a vision of interprofessional dialogue and collaboration.

A lot of other witnesses have also said that what we really need is a new mechanism, a new body perhaps, to bring together health professionals, government, workers, unions, etc., to work a bit more collaboratively on this. I'm wondering what your perspective is on this idea, and if you see barriers or pitfalls to that approach. It sounds like a good idea at face value.

● (0920)

Dr. Joshua Tepper: This idea is far from new. This was something I worked on back in my days working for Health Canada as part of Task Force Two, the body that initially put forward this idea under Tom Ward, the deputy minister from out east. He championed this idea. This has been around for a long time.

You made two separate points, one about inclusivity and how ACHDHR functions, and the second about the observatory idea.

I'll say that ACHDHR has worked very hard in the last year and a half to completely restructure itself. We used to have a nursing committee and a physician committee, for example. We got rid of that and we now have an interprofessional committee. We used to have a variety of individual groups, but it wasn't representative of all the health care groups, so we changed our membership to allow HEAL, which represents basically every major organization you could think about, to have a full role at the table. We meet with their co-chairs. They represent about 34 groups, but it goes up every day. I can give you the list of members of HEAL, but they're a very inclusive group. They have full members. They send out minutes. We get full reports back, so we've really changed that.

We also open up each of our meetings to outside groups—whether it's the oncologists who came in one time or somebody else—who feel they need to be heard, or have a presentation, or have an idea. They often get time on our agenda very easily, so we're quite inclusive of that. Then all our products are developed with the input of HEAL, which sits at our table, and then they go out for broader consultation. Often we use HEAL, but not just HEAL, to circulate it. We go to the Canadian Medical Forum, for example. Everybody in the Canadian Medical Forum is also part of HEAL, but we'll channel it in multiple ways. Most of our nursing organizations, unions, etc., are all part of HEAL, but we'll go straight to them as well. We try to capture it not just through HEAL, but in different ways. We have the researchers sitting at the table; CIHI is an example.

In terms of the observatory idea, again it's been around for a while. I think it certainly can have merit. There was a brief effort by a group called CPRN to revive it about two and a quarter years ago. I think the large challenge that's been addressed in the past is the jurisdictional and territorial issue and the large and increasing differences among the different jurisdictions, as well as what the interface would be with the large number of players, such as the Health Council of Canada, which was in some ways the answer to the observatory idea when it was created, if you go back in history. Their first two or three reports were predominantly focused on HHR at the time, because that was a bit of their impetus. You have CIHR and CHSR. If you have a lot of groups already at play here, that doesn't mean there can't be a value added from an additional field.

I think one of the things that stakeholders and organizations probably have said, and that I'm very sensitive to and respectful of, is that ultimately we are a table that reports to the deputy ministers of health federal, provincially, territorially. Ultimately we take a lot of our direction from the table, so it is ultimately the federal government and provincial or territorial governments. What I think you're hearing from other groups is that they would like an arm's-length body, with either no or very limited participation of the federal government and the provincial and territorial governments. I've had some email exchanges with Nick Busing and people. The goal is to have something outside of government, and there are pros and cons to that.

The Chair: Does anybody else have comments on this for Ms. Leslie as well?

A voice: Everyone nods.

The Chair: That's fine. I just interrupted you so that other people can get a chance.

Go ahead, Ms. Hoffman.

Ms. Abby Hoffman (Associate Assistant Deputy Minister, Strategic Policy Branch, Department of Health): Since you posed your question both to the advisory committee and to Health Canada, I think there's a connection with the concept of having a gathering point for virtually every interest—governmental, non-governmental, professional, public, and so on—to have a huge conversation about the major challenges and issues in this sector.

Your question relates a little bit to Dr. Bennett's question right at the outset about whether there's what I'll call a grand plan whereby progress is being tracked and reported upon, and so on. The nature of the country is such that there can be a grand plan around collaboration, but not necessarily a grand plan that's a strategic, detailed, step-by-step list of what we're going to work on first, and everybody's to get on board and work on the same things at the same time. That's not the reality of the health sector generally, nor is it specifically the reality in the area of health human resources.

I don't want to put words in their mouths, but I think some who are proponents of the observatory concept have a sense that if everybody could gather around the same table, we could get to this grand plan. I'm not sure that's reflective of the political realities of the country or of the health care sector in particular.

Could there be some amendments to the representation at the advisory committee table? Yes, but as Dr. Tepper has pointed out, that is a committee whose principal reporting relationship is to government, and if the non-governmental players want to have their own forum, that's a little bit of a different proposition.

The approach up to this point has been to incorporate stakeholders, professional organizations, and so on at a certain level in the advisory committee, and then as needed in those various subcommittees, working groups, and task groups that work on particular issues that flow from the pan-Canadian framework.

● (0925)

The Chair: Please be very brief.

Ms. Megan Leslie: For what your vision is, would there need to be a formal changing of the mandate of the federal-provincial-territorial committee, or is it something that you envision as organic?

Dr. Joshua Tepper: It has been pretty organic. When we added HEAL and when we changed our committees structure to be interprofessional and not siloed, when we changed it to do more modelling and not just data collection, for the most part we've just done that. For a couple of groups we have sought deputies' approval, but for the most part we have the autonomy to do it. Certainly we have the flexibility to receive any group that asks. If the nursing groups or whoever seeks a table, we're very open in our agendas and we don't go higher.

The Chair: Thank you, Dr. Tepper.

Now we'll go to Ms. McLeod.

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

It's good to have you all here in terms of the wrap-up. It has been a bit of a long study. I think we had many important things that happened along the way that stalled us a little bit, but it is an important study, and we're looking forward to getting it completed.

To begin, I'm going to Ms. Woods.

I'm not sure if you've paid careful attention to the testimony of different witnesses who have come forward, but is there anything that you would like to conclude or comment on in terms of some general summary statements?

Ms. Shelagh Jane Woods (Director General, Primary Health Care and Public Health Directorate, First Nations and Inuit Health Branch, Department of Health): What I would say is that we're a small part of this. We're the aboriginal health human resources initiative, but we are also members of the advisory committee on health delivery and human resources.

I would add to what Dr. Tepper said by saying that we feel there's really good representation of aboriginal interests at that committee. I know this is a bit off topic, but just to try to answer that, several years ago we were able to make the point that we thought it would be useful to have an aboriginal representative, and we have done so. I think that has worked very much in our favour.

I'm sorry; you'll have to remind me exactly what the question was.

Mrs. Cathy McLeod: It was just a summary I wanted, but I think we heard that there are gaps in research and data collection in the area of aboriginal HHR. Are we going to make any progress in terms of collecting data, and what are the challenges?

Ms. Shelagh Jane Woods: I think we are.

I'll ask Debra Gillis to give you some more of the detail, but I would say in opening that it's one of the things that we turned our minds to very early. In fact, it's something that bedevilled us for many years when we had our small Indian and Inuit health careers program, before the AHHRI.

We recognized right away that gathering data, as in all aspects of our work, is a very difficult issue, compounded in our case by issues like self-identification. If somebody doesn't want to identify as aboriginal, they don't have to, so it's very hard to get accurate counts, there are different ways of keeping data in different provincial and territorial systems. Those are the kinds of things we deal with all the time.

We have set some work under way, and I'll ask Debra Gillis to give you a little bit more of the detail on that.

● (0930)

Ms. Debra Gillis (Director, Primary Health Care, Primary Health Care and Public Health Directorate, First Nations and Inuit Health Branch, Department of Health): I'll follow up on what Shelagh Jane was saying. We started off by saying that we really needed to identify the numbers, at least, of the basic health professions—doctors, nurses, etc.—but we also needed to work at developing what would be a minimum data set of information.

We brought together first nations, Inuit, and Métis leaders from across the country. CIHI was involved. The department was involved from a pan-Canadian perspective, because they had been working on some of this.

We did come up with a framework for a minimum data set, but as Shelagh Jane said, the information is held in many different places, such as the Canadian Nurses Association, and you can't really compel people to identify their aboriginal identity.

As a first step, we've been using the Statistics Canada census data. We've done a detailed analysis of that and are using it as a baseline. We've done analysis of the 1996, 2001, and 2006 census data as our initial baseline to identify some trends. That has been incredibly helpful.

We can tell you how many people working in the health field have identified themselves as aboriginal, and whether or not they're first nations, Inuit, or Métis. We know in which province they're working and what the major occupations are. For example, we know that as of 2006, aboriginal people made up 2.1% of the health care workforce in Canada. There were over 21,000 aboriginal people who identified themselves as working in the health system. We know that the number of registered nurses increased by 65% between 2001 and 2006.

It's been a wealth of information, and we're beginning to mine that better with Statistics Canada's help and through working with HRSDC. We're now looking at trying to link those data with education files and are doing much more detailed work.

That will definitely help us as we're planning and going forward. We're also beginning to collect information at the community level on the numbers of people who are working in the community and what their occupations are at the small community level so that we have a better idea of exactly the numbers of people who are working at the community level.

We're really making inroads that we hadn't made before.

Mrs. Cathy McLeod: My next question is directed to Joshua. I was interested in your comments, first of all, about physician assistants and nurse practitioners, and also about how your group actually shares best practices with the provinces and all the players.

Could you talk a little bit about the physician assistant role in particular? Where is it rolling out? How are best practices getting shared within your organization? Also, I understand that nurse practitioners in some provinces have real challenges in terms of how their actual role is going to integrate into the system.

Dr. Joshua Tepper: To answer your first part, I would say knowledge translation occurs in at least two ways. One is that at every meeting, as I said, we do a round table. It's structured according to a template. One of the areas in the template is new roles and scopes of practices, and each jurisdiction provides an update. The other thing is that when we see a specific area or an emerging trend, we might do a bit more of what you might call a deep dive, or have a specific paper on that area. That would be for new roles or healthy work environments, or for data and modelling. In data and modelling we might hold a specific conference just to bring people together. Two or three times a year we do a crosscut, and when there's an emerging trend, we do a deep dive.

All new roles and all evolutions in health care, whether it's a PA, an NP, or a physiotherapist who can order x-rays, run into challenges from the established group, and it's not always from the doctors. Every group that starts to work in new and different ways faces a challenge. The NPs and PAs are increasingly being looked at or implemented in different jurisdictions across Canada. With PAs, Manitoba was the first. Ontario, B.C., and I think Nova Scotia are now following behind. With NPs, Ontario is leading, but now B.C. and a few others are following. We've got well over 1,000 NPs now in Ontario, and probably closer to 1,400, so we've changed our scopes.

Then you can look at the other end. We don't talk a lot about it, but there is traditional Chinese medicine. Ontario and B.C. have both regulated and have really started to put that profession forward. In an increasingly multicultural country, it's very important. Quebec and Alberta have regulated acupuncturists, though not the full traditional TCM model.

Again, it depends on how you look at this. I'd be happy if you had some specific questions around PAs or NPs or one other area, and I'd do a bit of a deep dive for you.

● (0935)

The Chair: Thank you, Dr. Tepper.

We'll now go to five-minute rounds. I've been extremely generous with the time in order to get in as many questions as possible.

It will be a five-minute question and answer now, and we'll begin with Dr. Bennett.

Hon. Carolyn Bennett: I want to explore some of the concerns that were expressed in the last round table about psychologists and the difference across the country in terms of their scope of practice. I thought 10 years ago that scope of practice was an outmoded view, and that we were supposed to be moving to core competencies based not only on the letters after your name, but also on your geography, IT backup, and all of those things. Certain people have a core competency that can be augmented in various ways.

How far are we from being able to have that conversation across the country, and being able to move in a way that isn't hard lines on scope of practice toward a much more flexible approach of letting people do what they're good at and what they've had extra training in?

Dr. Joshua Tepper: Having the conversation is easy; creating the change is hard.

We've changed the name around scope of practice, but we have not done nearly enough in moving to the core competency model. It's a ping-pong game between the health education system, which says it's willing to train to a competency model if the regulatory bodies will approve their licences afterwards, and the regulatory bodies, which say they'll approve on a competency model if the education system starts to produce them. There are a lot of turf and silo aspects, so it has not moved nearly as far or as fast as it should.

Ms. Joyce Murray (Vancouver Quadra, Lib.): Thank you for being here to help us complete our study.

I have two questions. One is related to what Dr. Tepper was just talking about. We heard last session that change is necessary and has to be based on collaborative teams. We also heard that data are essential. I think I wasn't hearing collaborative teams as being the core of what your organization is addressing; the collaborative team model is very different from the model of identifying the needs for certain specific practitioners individually.

The other question I have is about international doctors. I've been briefed about the transitional licensing law in Ontario for international doctors, with the view that it could be a way to engage those doctors before they are fully qualified to work in Canada by having them assist physicians. The physicians get paid for the supervision. The international doctors get employment in their field at a pay rate that makes it affordable to go through the hoops. It is an important way to address the international medical graduate system. I would like somebody to talk to me about that as well.

● (0940)

Dr. Joshua Tepper: I will be brief, Madam Chair.

I have three quick points. One, I was unfair to point out only the education and the regulatory bodies as culpable in my last comments. Government owns a lot of it too, in our legislative and regulatory frameworks, as do many parts of the system, so to move to a competency model will take major efforts by all parties, and a real intent has not been seen.

On the issue of teamwork, it is absolutely a big focus for our group. We actually have a specific committee, called the interprofessional committee, that has now been created to replace the physician committee and the nursing committee and the allied; however, the actual on-the-ground issues of how you compensate different people in different models and which areas of the health care system get picked for funding, whether it's primary care or specialist care, become jurisdictional issues.

In Ontario we did family health teams and anesthesia care teams. Other jurisdictions might pick cardiovascular surgery or emergency departments to focus their initiatives. As a framework it's data collection, principles, and sharing best practices; where there is a pan-Canadian approach, we do have a specific interprofessional committee.

The IMG transitional licence is something that I'm quite familiar with as a proposal. I don't know if time will allow me to fully go into it. There's a lot of complexity and patient safety issues, but we're finding a lot of other options for international medical graduates.

I would also say that international medical graduates in Ontario—you mentioned Ontario specifically—have gone from roughly 75 a year in training to over 200 new ones in training a year, and currently there are almost 1,000 international medical graduates in training a year. We've actually seen a decrease in the number of IMGs who need to be assessed for training. We used to process 1,000 a year; we're down to about 550 a year, so we're catching up.

The Chair: Thank you, Dr. Tepper.

We'll now go to Ms. Davidson.

Mrs. Patricia Davidson (Sarnia—Lambton, CPC): Thanks very much, Madam Chair, and thank you to our panel here this morning.

I'm sure you've all been following the presentations we've had so far on this study, and as my colleague has said, it has been a long study and it has been rather drawn out. It's a challenge for all of us here now, I think, to try to draw it all together and put together the many things we've heard.

I'd like to ask Ms. Woods the first questions, if I could.

We heard a lot from the first nations and the Inuit health organizations about special challenges they face, and definitely data collection was one. We've heard a bit of information about that, but I have a question on the data collection first. Do we need a lot more data collection, and is there a timeframe involved with putting that together? Do we have enough at this point to make any recommendations or to try to develop a strategy? That's my first question.

We also heard that there were challenges in the Inuit and first nation communities about pay scales and the high levels of burnout because of a lot of different circumstances. We heard there were extreme challenges with the education portion, especially with the math and sciences, and that those challenges were a deterrent to those who wished to get into the field.

In terms of the education issues, is anything being done through your department to coordinate efforts to improve that situation?

Ms. Shelagh Jane Woods: Let me start with the last part and, as always, I'll turn it over to Debra for specific details.

Let me say that none of these things are surprises to us. We have been working all these issues all the way through and, as I said earlier, even before we had the aboriginal health human resources initiative, we had begun to turn our minds to all of these things. We have begun to address all of them.

The educational barriers are one of those areas where we could easily have spent all the money that we had by going into the schools and trying to get kids to take maths and sciences. That's not our responsibility. We really are looking at the workforce.

As a result, we've collaborated with the Department of Indian Affairs. We've tried to make available to them, and with them, materials promoting the value of taking maths and sciences if you want to take health careers. We have an arrangement with that National Aboriginal Achievement Foundation. They do extremely well-attended career fairs on reserves, in communities, and in large cities that draw in aboriginal high school students and show them the joys and the beauties of health careers.

Those are really good opportunities to emphasize the importance of continuing in your math and science studies, so I think we've begun to address that. The fact that we're seeing more and more people signing up for health careers is evidence that we're beginning to get somewhere on that one.

The challenges on the pay scales are very complex. Those are very difficult, particularly as they relate to people who are employed by the first nations. We hold no sway over what the first nations can pay. We can't tell them what they must pay this professional or that professional.

Where possible, we pass on any increases that we get, such as the increases that we get every year on our contribution agreements, which is how we fund the first nations. We pass those along, and they can then top up the pay of their health care workers. In the last year we asked the Assembly of First Nations to begin to do some more detailed work on pay scales. We'll maintain a keen interest in that as it goes forward.

Maybe I'll ask Debra if she could answer some of the specific challenges on data collection, although I think she did provide quite a bit of information at the beginning.

● (0945)

Ms. Debra Gillis: I'll add one point about the data collection. I think you're really asking if we have the information now to plan and say how many of these we will need. That becomes very difficult when you're looking at a smaller population, and we're also working within a provincial health system.

In many communities, even if we could take some of the modelling methods to establish how many nurses you need, when you translate that down to a very small community of, let's say, 600 and use traditional needs-based modelling, you may actually end up with one-quarter or one-half of a nurse, depending. Then it becomes very difficult, because you can't hire half a nurse or a quarter of a nurse in a remote or isolated area.

So sometimes the traditional methods don't work. That's why we're starting to work with the communities and first nations nationwide and region-wide in developing a health human resource planning tool they could use in the community—a tool that's based on the pan-Canadian framework and based on needs-based planning—so that they can start taking a look at the resources they have within their communities and ask what the best mix is of the resources that they have for their needs. Do the people have the right education? We have this many nurses and this many of these other paraprofessionals; maybe we need more of this or more of that. This is to help them plan at the community level, because traditional data modelling methods just don't work in those small areas.

The Chair: Thank you very much.

Now we'll go to Monsieur Dufour.

[*Translation*]

Mr. Nicolas Dufour: Thank you very much, Madam Chair.

I would like to discuss foreign physicians with Mr. Tepper and Ms. Garrison. You had very little time to answer my colleagues' question.

According to you, have more foreign physicians been brought into the public health care system? Have you seen any measures that have been particularly successful? I am thinking of one initiative in particular I was discussing with my colleague Ms. Demers earlier. She was telling me that there is a very good program in Alberta. We have also met on a few occasions with people there to discuss the integration of foreign physicians.

What is your philosophy in this regard? Do you have any concrete examples of initiatives which have been particularly fruitful?

[*English*]

Dr. Joshua Tepper: All jurisdictions in the last decade, I would say, have made significant changes to the integration of international medical graduates. The level of movement reflects to some degree how many international medical graduates are in that jurisdiction. For example, Ontario—this was true as of a few years ago—has more international medical graduates arriving each year physically than the rest of Canada combined, and therefore when you take a look at Manitoba, which doubled their number of international medical graduate positions from two to four, it's just a different scale from when Ontario goes from 75 to 200. It's just the nature of where the demographic arrivals are.

Each jurisdiction has taken a slightly different approach in how they assess, integrate, and license, as well as on whether there are any practice or other restrictions and on how they integrate them into the workforce. I think there have been a number of very good models. One of the things Ontario has done is allow physician assistant models to be IMGs, which gives them a really nice entry into the workforce, and many of those people then go on very successfully to get full licences. You mentioned Alberta's program. Quebec has seen a large surge as well in its educational capacity and how they have done it.

What ACHDHR has managed to facilitate for the first time a common entry criteria and assessment process for international medical graduates going into education and training. This is a big accomplishment showing where the pan-Canadian approach works well. This is a huge accomplishment, the result of about three years of work by all jurisdictions and the Medical Council of Canada, etc. Coming up with this common standard with the exam banks, etc., would be another big pan-Canadian success story,

● (0950)

[*Translation*]

Mr. Nicolas Dufour: If I understand what you are saying correctly, currently the provinces have managed overall to integrate foreign doctors very well because of the latitude they have in the health care area.

[*English*]

Dr. Joshua Tepper: I think it's hard. The term “international medical graduates” represents a huge group of people, and the people who self-identify as international medical graduates are all very different. It is a very heterogeneous group. Medical education systems are very different around the world. There are people who will say they went to medical school, but they have never seen a patient because their education system, as it is structured, may give them an MD but doesn't actually give them any clinical experience. There are other people who say they are doctors, but they may not have actually practised in 15 years, for whatever reasons. The integration of these very different people with different educational backgrounds and different practice experiences is a very mixed bag. We have to be careful with broadly using the term “IMGs” broadly. We have to understand the range of people who are captured within that term.

What I would say is that all jurisdictions have tried very hard and have seen a quantitative increase in their numbers—quite a substantial increase—and I'm happy to provide at least some of the data. I don't have access to all of them, but I can provide data about the increase in many jurisdictions, not just of total doctors—to your previous question—but of the specific IMG subset and the increased trend line. I believe I can get that for you for several jurisdictions.

[*Translation*]

Mr. Nicolas Dufour: Thank you very much.

Ms. Woods, we have heard a lot of witnesses talk about the measures we should put in place so as to increase the number of doctors for the Innu and first nations peoples. You have very little time to answer my question, but what initiative has struck you? What do you think you can do?

Ms. Shelagh Jane Woods: Mr. Dufour, all I can tell you is that a great deal of money has been allocated to support medical students. To date, over 60 people are receiving funds from us. That is our first initiative to support doctors and increase those numbers.

Mr. Nicolas Dufour: Thank you.

[*English*]

The Chair: Thank you, Monsieur Dufour.

We'll now go to Ms. McLeod.

Mrs. Cathy McLeod: Thank you, Madam Chair. I would like to understand a little bit more in terms of the advisory committee on health delivery and human resources. You talked about it quite extensively, but how often do you meet? How many subcommittees are there? Could you share that?

I'm also very curious to know about your interprofessional committee—what it's doing, where it's going. Is it supporting all professionals who are members?

● (0955)

Mrs. Margo Craig Garrison (Federal Co-Chair, Advisory Committee on Health Delivery and Human Resources): I'd like to take that question.

I'm Margo Craig Garrison. I'm the federal co-chair at the moment, and have been since January. I defer to Dr. Tepper, in many instances, because he has much broader experience than I do. I am also working at Health Canada. I am the director of health human resources policy in the strategic policy branch.

To answer your question, the committee is composed of membership from all of the jurisdictions, plus an assortment of other organizations. HEAL is the one that you've heard mentioned here already today. We also have representation from the Canadian Institute for Health Information, the Canadian Institutes of Health Research, and Human Resources and Skills Development Canada. There's a local regional health authority involved, as well as representation from aboriginal communities and from the first nations and Inuit health branch.

The committee meets generally about three times a year. There are regular conference calls in between, particularly if there's an issue that requires the attention of the members.

In terms of the subcommittees that we have in place right now, we have one that looks at internationally educated health professionals. That's something that's starting up, which Dr. Tepper referred to. It looks at nurses, physicians, and other internationally educated health professionals. We also have an entry-to-practice subcommittee, which has been long-standing for many years.

In addition, we have a health and education task force, acknowledging the importance of bridging the health and education ministries to support health professional education across the country.

I'm trying to think whether there are any others.

Dr. Joshua Tepper: There's some data modelling.

Mrs. Margo Craig Garrison: Yes. We have a planning and partnerships subcommittee. I should remember that because I'm also the co-chair of it. We look at partnership issues and the broader stakeholder issues, as well as data modelling. Most recently we had a discussion around productivity. There's a lot of activity that takes place under this rather large umbrella.

Dr. Joshua Tepper: There are also time-specific committees that may be looking at a specific issue. If a large change is coming through from an organization or something, we'll strike a committee for six months, a year, or 18 months to deal with that, or if there's direction from the deputies, we'll strike a unique committee.

Mrs. Cathy McLeod: With respect to the newly formed interprofessional committee, can you talk a little bit about who is on it and what the mandate is?

Dr. Joshua Tepper: Probably the easiest thing to do would be to send you the terms of reference and membership. It's open to all members of ACHDHR. It's co-chaired, but I forget who's co-chairing it now.

It has been an evolution from the previous interprofessional—

The Chair: Doctor, I'll just interrupt you for a moment.

If you could send those terms of reference to the clerk, we'll make sure they're distributed to the whole committee. Thank you.

Go ahead, Dr. Tepper and Ms. McLeod.

Mrs. Cathy McLeod: I think I'll switch track. There was some suggestion—I can't remember from which witness now—that we have a number of Canadian physicians trained abroad and coming back. At the same time, we have a number of foreign graduates trained and going back home. They were saying that if there was a bit of a swap with the seats, we would have more capacity to train our Canadians coming home after training abroad.

Dr. Joshua Tepper: There are two slightly different issues there. One is Canadians studying abroad. These are Canadians who might typically go to Australia, Ireland, or some of the U.S. offshore schools for their medical training and then wish to come back for residency. They are considered international medical graduates because they have done their training internationally.

The second group you're talking about are visa trainees. They are usually here for subspecialty training. There has been a lot of discussion about whether these visa trainees from other countries are taking needed capacity. That has been an oft-discussed piece.

Most jurisdictions with medical schools have very hard conversations with their universities to ensure that they are only taking visas where excess capacity is needed. I know that in Ontario we actually have a letter on file to that effect in order to mitigate that situation.

This again has been a long-standing conversation, and each jurisdiction has very hard conversations with their medical schools to make sure that they're not there. Often the visa trainees are in very unique sub-subspecialty areas that are not the type of entrance, core, postgraduate training that CSAs—Canadian students abroad—or other foreign medical graduates would be typically seeking.

We monitor it closely. It is something we watch closely.

● (1000)

Mrs. Cathy McLeod: It looks as though this suggestion was perhaps quite a simplification.

Ms. Abby Hoffman: Could I just add one point to this particular conversation?

It is the case as well that there are a not insignificant number of vacant residency seats each year. They tend to be more in family medicine than in subspecialties, and there tend to be more in some provinces than others, so the notion that there is a zero-sum direct relationship between these visa residents and Canadian-trained physicians, or Canadians who have been trained abroad in competition for the same seats, isn't exactly the case.

There are some residency seats that could be filled, but as you probably heard in other testimony, that matching process is complicated. It's not unreasonable that there's a bit of a surplus, but there are some seats that could be filled by Canadian international medical graduates.

The Chair: Please be brief, Dr. Tepper.

Dr. Joshua Tepper: In responding to Mr. Dufour especially, in no way do I want my comments to be taken as saying there's no more work to do. There is always more work to do. There are always more barriers to break down and more pathways to facilitate, absolutely. The overall trend has been dramatic or substantial, but that does not mean there isn't more to do.

The Chair: Thank you, Dr. Tepper.

It's now Dr. Duncan.

Ms. Kirsty Duncan (Etobicoke North, Lib.): Thank you, Madam Chair, and thank you to all the witnesses.

I'll begin with a question about data. What are public data and what do communities have to pay for?

Mr. Jeff Latimer: Thank you very much for the question.

I can start by telling you what is publicly available at Statistics Canada. Basically, our Canadian community health survey, which is our largest population survey at Statistics Canada, collects data on approximately 66,000 Canadians every year on the determinants of health status and on the utilization of health services.

We release that information to the public at three levels of geography: the national level, the provincial level, and what we call a health region level, corresponding to an administrative level of geography at which provinces and territories manage their health services delivery.

That is available on our website free of charge to any Canadian.

Ms. Kirsty Duncan: If you want to get the data down to the community level, what do you have to pay for and what is the cost?

Mr. Jeff Latimer: Let me just say that first of all, the sample size, which is quite large at 66,000, doesn't necessarily allow us to really produce estimates at a community level. We've designed our survey so that we can produce it at a health region level. Because of our confidentiality rules at Statistics Canada, it's quite difficult for us to actually be able to release information from the Canadian community health survey at the community level. If we look at the confidentiality rules and we feel we can release the data, it's quite likely that the estimates are not reliable at that level of geography anyway.

Ms. Kirsty Duncan: What data do have to be paid for?

Mr. Jeff Latimer: If we are required to do a custom tabulation, which is something that's not available on our website, then we would have to charge for that information.

Ms. Kirsty Duncan: Is it charged by the hour, or how is it charged?

Mr. Jeff Latimer: We follow traditional government cost recovery policies.

Ms. Kirsty Duncan: Okay. Thank you.

I'm going to ask about IMGs. As was discussed, we've heard there are agreements with other countries to provide visas for international medical graduates to complete postgraduate training and then return to their country to practise afterwards.

How many medical residents with visas are currently training in Canada, and what are the fees that they pay? You mentioned that we're tracking them.

Dr. Joshua Tepper: What was the second question? I missed the last three words.

Ms. Kirsty Duncan: You mentioned that this is being watched very carefully, so I'm wondering if you can table with the committee how many visa medical students there are per province, in what fields, and what the fee schedule is, please.

● (1005)

Dr. Joshua Tepper: We'd have to get back to you. That will take some time.

Ms. Kirsty Duncan: Roughly, do we know how many visa residents are currently training in Canada?

Mrs. Margo Craig Garrison: Yes, we do. The statistics that we have from 2009 indicate there are 755 across the country.

Ms. Kirsty Duncan: You said it's 755.

Mrs. Margo Craig Garrison: I don't have that broken down by jurisdiction. That we can provide to you.

Ms. Kirsty Duncan: Thank you. That would be very helpful.

How many IMGs get spots in Canada?

Ms. Abby Hoffman: I think it's in the range of just under 400 Canadian IMGs who....

Dr. Joshua Tepper: I'm sorry, but we're counting the numbers incorrectly. One is an entry-level position. How many entry-level positions there are versus how many are totally in training are very different questions. Most training is for multiple years, so you're compounding it—

Ms. Kirsty Duncan: No. How many entry spots are there?

Dr. Joshua Tepper: Okay. That will change our visa number dramatically.

Ms. Kirsty Duncan: That's what I'd like to know. How many entry spots are there in both categories, please?

Dr. Joshua Tepper: It's good to get clarity.

Mrs. Margo Craig Garrison: I think we'd better verify that and get back to you.

Dr. Joshua Tepper: It's 91 in the first year for visa trainees.

Ms. Kirsty Duncan: There are 91. What is it for IMGs, please?

Dr. Joshua Tepper: I think it was 392.

Ms. Kirsty Duncan: That number of 392 concerns me. We're losing 25%. If 91 are visa trainees, does the 392 include Canadian IMGs as well as IMGs...?

Dr. Joshua Tepper: These are very different groups of physicians at dramatically different stages of training, right?

Ms. Kirsty Duncan: I understand that. I am still asking. Some people coming from abroad—for example, from Britain—are senior health officers or at a higher level, and they cannot get spots in this country.

Dr. Joshua Tepper: But I'm not.... It's a different issue.

Ms. Kirsty Duncan: If they can't get spots and visa students are getting spots, that's of concern. Canadian students have gone abroad to study and cannot get spots, and we're giving 91 places to visa students. This is the first time we've seen these data.

Dr. Joshua Tepper: The only thing I would say is that, again, the areas of training are very different. The difference between a family doctor and a neonatologist who's doing a subspecialty in echo—

Ms. Kirsty Duncan: I understand the difference.

Dr. Joshua Tepper: It's important to realize the capacity isn't totally comparable. That's what we're hearing from the universities.

Ms. Kirsty Duncan: Sorry, Dr. Tepper; could I ask about the fee schedule? What is the cost per year, for example, if we go down to the postgraduate training, versus an IMG versus a visa student? We must have the average data on that.

Dr. Joshua Tepper: It varied dramatically by jurisdiction.

Ms. Kirsty Duncan: What is the range?

Dr. Joshua Tepper: I couldn't tell you for every jurisdiction. I can work on getting it for you. It will take some time.

Ms. Kirsty Duncan: I would like that. We hear that we're watching this closely, and so I would very much like to see those data.

The Chair: When you do get it, Dr. Tepper, if you would be so kind as to share it with all of us, that would be very good.

We'll now go to Ms. Davidson.

Mrs. Patricia Davidson: Thank you very much, Madam Chair.

I'd like to go back to Ms. Hoffman, please. When you were talking about the IMGs and the vacant spaces, I think you made the comment that the matching process was very complicated. Could you explain that a bit more? How do we make it less complicated?

Ms. Abby Hoffman: I wish I could explain it in more detail. I have to be quite candid; I'm not an expert on the CaRMS system. Perhaps Dr. Tepper could talk a bit about it. I simply referenced it with respect to the fact that when the system plays out, at the end of the day there are unoccupied seats.

Mrs. Patricia Davidson: I think that's part of our problem. We're wrestling with the idea of how to improve the status of health human resources across this country and we keep hearing that there are vacancies here and vacancies there, but it's a very complicated process. I think part of our solution has to be how we uncomplicate some of this and how we make things less—

● (1010)

Ms. Abby Hoffman: Before I ask Dr. Tepper to speak about this, I would just note that the residency matching service principally involves the universities, the matching service organization, and the provincial and territorial jurisdictions. This is not something over which any one party has complete control.

Josh, if you would, could you say a bit about it, please?

Dr. Joshua Tepper: Sure.

Please ask the question again so that I answer the right part of your question.

Mrs. Patricia Davidson: One of the previous questions asked about IMGs, vacant spaces, visa spaces, and so on, and the statement was made that the matching process is complicated, the inference being that you couldn't just take the straight number of spaces with the numbers waiting, because the matching process doesn't always fit directly into that. How do we make it less complicated?

Dr. Joshua Tepper: It's actually a fairly organized computer-based algorithm that's used. The same algorithm is used in Canada and the United States. It's actually quite a clean process. The additional capacity is there at the end because we put more capacity into the system than there is need for, and those spots are then used if there is any additional capacity. It's not as if there is additional capacity that goes unfilled. It's a point in time, so we just keep filling it up.

For example, Ontario offers—and I apologize for using an Ontario-specific example, but I know it best—200 spots for international medical graduates, but we often end up with 220, 225, 227, or 230 in our education system because we immediately fill any additional capacity that we have at the end to make sure there is no training spot left open.

We have a dedicated stream of 200, but if there is anything else left open, we immediately open it up wide to make sure it is filled.

Mrs. Patricia Davidson: In earlier testimony I believe you made a comment about B.C. taking a different perspective on Canadians studying abroad.

Dr. Joshua Tepper: This is brand new. It's in the last week or two.

Mrs. Patricia Davidson: Can you elaborate on that?

Dr. Joshua Tepper: I probably would need to get a little bit more detail about what they've done. My understanding—and I would stand to be corrected by a representative from B.C.—is that they have put aside some very specific positions. Currently there are two groups of capacity: Canadian medical graduates and international medical graduates. What I believe B.C. has done is create a new capacity, or a separate pool, just for Canadians studying abroad. That's my understanding.

Mrs. Patricia Davidson: One of the things we heard over and over again was that we needed more interdisciplinary collaboration or communication or working together or agreements, and so on. Do you agree with that?

Dr. Joshua Tepper: Yes, I agree very strongly.

Mrs. Patricia Davidson: How is that going to be accomplished?

Dr. Joshua Tepper: Each jurisdiction is doing it in slightly different ways. The federal government has put millions into this as well. There are basically two focuses: one is on changing the educational system, and one is on changing the practice environment.

There are reams and reams of information. There are websites, materials, pilot projects, established projects, and thousands of providers now working in new interprofessional models across Canada. There are thousands of them. I would say there is almost no large academic health science centre in Canada that is not engaged in interprofessional education to some capacity. We have competency criteria and we have curriculum criteria.

I'm conscious of time and I don't want to just sound as if.... If you give me a focused set of questions, I can probably get the data.

Mrs. Patricia Davidson: At our last meeting we had testimony from occupational therapists, and they said they were underutilized. When we heard from the different disciplines, I'm not sure that they felt there was much of a collaboration.

Dr. Joshua Tepper: Again I'd go back to the comment that I think there is always more work to do. I don't think we're there by any means, but I think where we are now versus five years ago is fundamentally different. There is always more work, and there are always providers in different types of settings who are underutilized. I would support that. I absolutely agree with it.

It is culture change and it is model change. It's huge culture change and economic change. It's a lot of change to build these new models. In different places it is happening in different ways, but it is not 100% there.

● (1015)

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

Now we'll go to Ms. Hughes.

Mrs. Carol Hughes (Algoma—Manitoulin—Kapuskasing, NDP): Thank you, and thanks for your input.

I want to focus a little bit more on aboriginal health and human resources, and especially on the initiative. We heard through a lot of the witnesses that multi-year funding is what is required. You see an extension of two and a half years added, or just mentioned; how difficult is it to plan with regard to getting only a two-and-a-half-year funding plan?

Ms. Shelagh Jane Woods: As far as I know, we have two years of funding and we are accustomed to working under these constraints. We might like a lot of our initiatives to be longer term, but the work goes on.

As I said earlier, we did have a small initiative, the Indian and Inuit health careers program, that had existed for a long time before the AHHRI. We were able to roll that forward in with this. Communities and institutions just go ahead and do the planning, but I think it's also important to say that we rely on some of the other existing planning mechanisms within our department, so we've integrated and are integrating health human resources planning into some of the larger planning processes, such as the community-based reporting and the planning tools.

If you'll allow me to use a somewhat simple analogy, we're not putting all of our eggs into the one basket of the AHHRI. We're using it as a mechanism to spread the planning beyond just its narrow confines, so I don't think it's as big a problem as all that.

Mrs. Carol Hughes: We heard over and over again that this certainly plays into the opportunities for students to be able to enrol or to stay enrolled, and not knowing if they can.

As well, with respect to the first nations students, as well as the educational pursuits, full-time study is three years in the university, and the post-secondary through INAC or through the government is considered four credits, so it's three credits versus four credits. We heard that this was problematic for people to be able to get funded. Are you familiar with that at all?

Ms. Shelagh Jane Woods: No, that's not an issue I understand at all. I'm sorry.

Ms. Debra Gillis: In terms of funding for post-secondary education, we have an agreement with the National Aboriginal Achievement Foundation whereby we provide them with funding and they receive applications from first nations, Inuit, and Métis students, which tends to top up, for example, first nations students who may be receiving money through the Indian Affairs post-secondary program. It tops up the money that they have.

So we ourselves don't directly fund. It's a well respected aboriginal organization that has a long history of funding post-secondary education.

I've never heard about the three and four. Students who can demonstrate a need for additional funding to pursue their health careers, based on the amount of money that the NAAF has, will receive money.

Mrs. Carol Hughes: I want to turn to the community health representatives.

We also heard that this organization actually was providing much-needed support to the physicians and nurses in the first nations and Inuit communities. A lot of the witnesses indicated that front-line paraprofessional health care providers who undertake this education and the health promotion activities were no longer being supported by Health Canada.

Why did the government actually choose to no longer provide funding for the paraprofessionals, such as the community health representatives, and does Health Canada provide funding for other types of paraprofessionals who undertake similar tasks?

● (1020)

Ms. Shelagh Jane Woods: To answer directly, we have not stopped funding CHRs. We provide funding to the bands. The CHRs are not employed by us, but by the first nations directly. There are over 600 of them. There's tremendous variation in the roles they play and the things they do. They are associated usually with a number of community-based program activities, but it's the first nation that determines what they will do.

We do support a lot of other community-based paraprofessionals and allied health professionals working in such areas as addictions, mental health, diabetes, maternal and child health, and home and community care. We have no intention of stopping support, because that's a very important cadre of people, and in fact what you'll see in our renewed aboriginal health human resources initiative is that we put more focus on the paraprofessionals and on getting down to the community level to help communities provide opportunities to bring those people up to a level of competency certification so that they will eventually be comparable to people who practise off-reserve.

Mrs. Carol Hughes: We also heard from Dr. Strasser from NOSM about some of the challenges with regard to rural health. I am wondering, Dr. Tepper, whether some similarities have come up in the meetings and discussions you're having. Are there some similarities? What are the differences, and what should we as a group be considering with regard to the deficiencies within rural care? Even the Canadian—

The Chair: Ms. Hughes, I am sorry. I have been trying to get your attention. I have to interrupt you. Your time is up. I apologize, but we have to carry on.

Go ahead, Ms. McLeod.

Mrs. Cathy McLeod: Thank you, Madam Chair.

I'll draw on some of the earlier comments in terms of the general agreement on professional collaboration. I would think it is predominantly related to primary care, but there are also many other areas.

You say we're making some good progress, but have we hit the tipping point? Are we there? How do we get there?

Dr. Joshua Tepper: It's interesting. I am sorry we did not have time to talk about the rural issue, because it is one very close to my heart.

We are not there yet. I would say four or five years ago people were not even talking IPC—

The Chair: Dr. Tepper, if you have some documented information that you could supply to the clerk on the rural issue, I would be very happy to distribute it to the committee.

Dr. Joshua Tepper: I would argue that chapter 7 of Roy Romanow's report, the opening quotation in particular, is very powerful.

The Chair: Thank you. Now we will go on.

Dr. Joshua Tepper: We are not at a tipping point yet by any means. I think we've gone from this being heresy to being something that is now on the table and discussed. We have gone from probably no pilots to some very extensive pilots, for example, with primary care models in several jurisdictions involving millions of patients now. There are entire other models of care around hip and knee replacements, and hundreds of cataract surgeries, etc., are being done in this model, but unfortunately we're not quite at the tipping point yet.

This is a huge culture change for the health system. It is very profound and it requires a realignment of a lot of other parts of the health system: compensation, regulation, in some cases legislation, and in some cases insurance issues, depending on who you talk to.

I believe at least now a discussion is being held, but I think it is incredibly powerful, and the results we're seeing from those who have gone there are incredibly positive.

Mrs. Cathy McLeod: I will pick up on my previous colleague's comments. Rural health care is, of course, important. I represent many rural residents who are struggling. I think Health Canada over time has managed to look at very isolated communities, and through the use of paraprofessionals and other tools and people has managed to meet a need, but perhaps not to a complete extent, and I look at the dental therapist model that was part of Health Canada's approach to supporting aboriginal communities.

I'll give it back to you in terms of rural health care. I think it is important to many of us in this room.

● (1025)

Dr. Joshua Tepper: I think rural health care is something that makes Canada unique except for perhaps only one other country, which is Australia. I am very glad you had a chance to hear from Roger Strasser, who is a tremendous leader in this field.

I would say every jurisdiction has tackled this challenge in different ways, starting with the educational system. British Columbia has put a branch of their school up in Prince George, Ontario has built a whole new school in the north, and New Brunswick and P.E.I. have bought residency positions to put in rural areas. Everybody's worked on education and thought about who's coming, where they're training, and how they're being trained, because it's fundamentally different.

Also, the practice patterns and the practice models and how you think about people working need to be very different as well. You have a completely different scope of practice in rural areas.

I've worked in Iqaluit. I've worked in northern B.C., in Hazelton, and in a lot of these places. I've worked right across northern Ontario, literally probably in a dozen communities, some as small as a thousand people, or probably 650 people in the winter.

As I said, we need very different models and very different education systems to support people there. It really needs to be a focus of your report.

Mrs. Cathy McLeod: Thank you.

If I have time, I have one quick question for Statistics Canada. Apart from the information that's routinely available, how many health-related requests do you get in a year for which you have to charge and do special searches?

Mr. Jeff Latimer: I actually don't have that information, but I can provide it easily today. We can go back to the office and calculate the number of requests we receive. That would not be a problem.

The Chair: If you can direct that to the clerk, we'll get that translated and provide it to all committee members.

That brings to a conclusion our time today.

I have to say that this has been extremely helpful. We have some very knowledgeable people around this committee table. We're so pleased to have you here, and we thank you very much for your input.

I'm going to suspend committee for two minutes, and then we're going to go in camera for business.

[*Proceedings continue in camera*]

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