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Mrs. Joy Smith

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● (1100)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): We'll get started. We have some very dynamic individuals here today, and we're pleased to have you join us.

On video, we have Dr. Julio Montaner....

I think we just lost Dr. Montaner, so we will get back to him.

We have, from the Canadian College of Health Leaders, Ray Racette, president and chief executive officer. From St. Boniface Hospital, we have Dr. Michael Tétreault, president and chief executive officer of St. Boniface Hospital. Some very innovative ideas are going to be forthcoming from both these individuals this morning.

From the University of Manitoba and the Concordia and Joint Replacement Group, we have Dr. Eric Bohm, associate professor. He has a PowerPoint presentation in English. We have had unanimous consent for that to happen.

We also have Dr. Christopher Fotti, a doctor from the Pritchard Farm Health Centre, a very innovative project that has happened in my riding. He will be presenting as well.

Can you hear me, Dr. Montaner?

Dr. Julio Montaner (Director, British Columbia Centre for Excellence in HIV/AIDS): Yes, I can hear you. Thank you.

The Chair: Dr. Montaner, I'm sorry that our video feed went in and out and we lost you for a couple of moments. If you have something you would like to say at some point, just let me know by raising your hand.

I don't know if you heard all the guests we have this morning. Did you hear that?

Dr. Julio Montaner: I can hear you all right.

The Chair: We are going to hear a presentation from each individual and then we'll have questions and answers.

Dr. Bohm, do you have your video all set up and ready to go?

Dr. Eric Bohm (Associate Professor, Concordia Joint Replacement Group, University of Manitoba): I do, yes.

The Chair: Would you begin, please?

Dr. Eric Bohm: Thank you very much. My apologies again for the English-only version. I'll leave it for translation.

I'd like to take the next few minutes to speak to you about innovative orthopedic health care delivery and device development.

I'm one of four surgeons who work at the Concordia Hip and Knee Institute. We specialize in primary and revision hip and knee replacements.

We have a multidisciplinary pre-hab and education team to help prepare patients for surgery. We have a digital radiology suite with RSA capabilities for research and follow-up. We have an implant retrieval and analysis laboratory and an implant ware and testing laboratory. We have quite an active clinical research group. We also participate in access and quality of care initiatives within the Winnipeg Regional Health Authority. We have also recently started into orthopedic device innovation. All of this happens under one roof at the Hip and Knee Institute.

I want to talk a little bit about health system performance and tie in some manufacturing theory and how we've improved that. I'll give some examples around physician assistance, wait times for joint replacement, and quality of joint replacement at the time of hip fracture surgery.

Health system performance can be considered as access to care, appropriateness with the correct intervention for the correct patient at the correct time, effectiveness, both cost and clinical, as well as safety.

This is a drawing of our wait list for hip and knee replacement surgery back in 2005. You can see that of patients who had undergone surgery, many of them fell past that benchmark of 26 weeks, which is represented by the yellow line in the middle of the graph. So we really needed to fix this.

The theory of constraints tells you to identify bottlenecks in the process and apply resources to relieve that bottleneck, so that's what we started to do. We looked to find where the bottlenecks were.

In a typical eight-hour day, one orthopedic surgeon could do three joint replacements. There are quite a few steps involved in doing a joint replacement. You need to bring the patient into the room, get the room set up, anesthetize the patient, and then there's positioning, prepping, draping, and so forth. Actually putting in the joint replacement only consumed about two and a half hours in total out of that eight-hour day.

It was quite obvious to us that the surgeon was the bottleneck, and we needed to do something to improve that productivity. We looked at increasing productivity by employing physician assistants. Among many of the things they can do, they're excellent assistants in the OR. They can help with positioning, prepping, draping, and closure during the procedure.

What we did is started running what we call double rooms. We would have one surgeon with two rooms, and each room would have a physician assistant, an anesthesiologist, and a nursing team. This would allow the surgeon to get started in the first room while in the second room the patient was being brought into the room, the equipment set up, and so forth. When the surgeon was finished in the first room, he or she could walk over to the second room and do the next case. This allowed us to significantly improve our surgical throughput. We went from three patients a day up to seven patients a day.

That was really the only way for us to increase our primary joint replacement volumes, because we didn't have any more days in the week to operate. We were already busy Monday to Friday. So this is how we increased our volumes. We saw a 42% increase in our volumes, and our median wait times back then dropped from 44 weeks down to 30 weeks.

Another thing we looked at is hip fracture care. Back in 2005, Manitoba was not doing a very good job in getting hip fracture patients into surgery in a timely fashion. The national benchmark was 48 hours. Only 53% of our patients were making it into surgery within 48 hours. This compared rather poorly, I would say, to the national average of 65%, so we needed to do something.

We applied some Lean thinking to this problem. We determined what the customer values. The customer is the patient with the hip fracture, and I can tell you they valued getting into the surgery and having it done quickly. We identified the non-value-added things we were doing and aligned the activities to meet that goal of surgery within 48 hours.

First of all, we sought to understand the problem. We implemented some standardized tracking methods to determine where the delays were. We identified things such as Plavix, which is a blood thinner. We found patients were being delayed for surgery five to seven days for the Plavix to wear off.

On the issue of mandatory internal medicine consultation, it was the practice back then to have an internal medicine doctor see every single patient with a hip fracture when it really wasn't necessary. Fitness for surgery could be decided with the anesthesiologist and the orthopedic surgeon working together. Issues around OR time and surgeon availability were also apparent.

We sorted out the issue of Plavix with our anesthesia colleagues and their standards committee. We ran several grand rounds sessions to help convey the importance of the impact of delay on mortality and that reducing delay will improve mortality. We discussed the issue of Plavix and the mandatory medicine consultation. We modified some of the OR booking rules to allow these patients to get into surgery quickly. We had direct written communication of the sites and physicians, and we improved repatriation of patients to their home hospital.

● (1105)

This seemed to be quite effective. This is data showing the mean time to surgery, length of stay, and mortality before the intervention. You can see that patients waited an average three and a half days; length of stay was almost 30 days in hospital; and in-hospital mortality was 6.4%.

After we introduced those changes, we dropped our mean time to surgery to 1.8 days; the length of stay decreased to a little less than 25 days; and we dropped the in-hospital mortality to 5%. These were all statistically significant, so a good effect on length of time to surgery and on mortality.

I'm happy to report that we've improved significantly across Canada. In the last report, 87% of Manitoba patients received timely hip fracture surgery. This compares quite favourably to 80% for the rest of Canada.

We've also done some work with the regional joint replacement registry to improve the outcomes of hip and knee replacement surgery. We applied some principles of Lean Six Sigma, and it really depended upon the data and facts, collecting good data and reporting it back to the providers to improve care.

Our regional joint registry consists of preoperative data collected from patients, functional scores, and medical comorbidities. We collect data during the operation itself, on the procedure, details, the implant used, and so forth. One year after the operation we ask patients how they are doing, how their function is, had they any complications, what their satisfaction is, and whether they have had a revision. So we're asking patients about their outcome and interaction with the health care system.

This data is compiled into a yearly report that goes to the region, to the site, and to the surgeon, so they can each compare themselves to their peers as a whole.

I will draw your attention to one of the metrics we report on, and that is patient satisfaction. We have created a fictitious report for a surgeon to show that 83% of their knee patients were satisfied, yet 7% were unsatisfied. This data can be taken back to improve the quality of the care a surgeon delivers to patients—very useful information.

Another example of the results of this registry is a steady reduction in revision rates. You can see that we started the registry back in 2004. At the start of 2005 and up to 2009, we've seen a steady reduction in early revision rates of hip and knee replacements. This is a better outcome for patients and less cost to the health care system.

To innovate health care delivery, I truly think it is important to understand what the customer wants, what the patient needs—to measure it properly, report it clearly, and align care in order to deliver what is important. I also think it's important to hold health care providers accountable.

I'll talk briefly about the Orthopaedic Innovation Centre. In 2011, we received $2.5 million in a Western Economic Diversification grant. Our mandate is to create, commercialize, and license orthopedic medical technology in a multidisciplinary environment. We currently have 10 researchers utilizing grant-funded equipment.

It's been a very interesting journey for us. We found there is very good support of initial innovation and a little less so of product development and commercialization, which we're working on now. There is a smaller pool of venture capital in Canada compared to elsewhere. There are some intellectual property policies in academic centres that I think need to be updated. There are, of course, health care budgetary constraints, and always the risk of brain drain to the U.S., but we're certainly enjoying this new aspect of our work.

For future work, I think it's important that we strengthen the Canadian Joint Replacement Registry. I talked about a regional registry; there is a Canadian Joint Replacement Registry. We don't have mandatory data collection yet, but we're getting there. Once we move there with regular, clear, and concise reporting, we can improve the care for Canadians. I also think it's important to link with Health Canada for post-market surveillance of new implants, to see if they're failing.

Promoting integrated data-driven models of care is important. There are many good examples across Canada of this. In the orthopedic world, the Arthritis Alliance of Canada has developed a framework. The Bone and Joint Decade Canada has done a lot of good work around hip and knee replacements and hip fracture care.

I think that continued orthopedic device innovation, linking registry data with retrievable data, testing data to improve implants and implant design, and continuing to improve a climate for commercialization are important as well.

If I can leave you with one hopefully humorous thought, it's on the importance of data, because if you don't measure, you don't know what you're doing. Here I have a picture of me and one of our nurses in Nicaragua about a month ago. We were doing some medical relief work down there, and the Americans who joined us brought down some “greens” they thought they could leave for the Nicaraguans, but they weren't quite the right size. So if you don't measure, you don't know what you're doing.

I thank you for your attention, and I would be happy to entertain your questions.

● (1110)

The Chair: Thank you very much, Dr. Bohm. That was a very compelling presentation.

I would like to now go to Ray Racette, president and chief executive officer of the Canadian College of Health Leaders.

Go ahead please, Ray.

Mr. Ray Racette (President and Chief Executive Officer, Canadian College of Health Leaders): Madam Chair and members of the Standing Committee on Health, it is a real honour to appear before you as a witness. The remarks I will be sharing with you this morning are really my own personal insights from working as a leader for over 30 years in health care administration, and also from working with the Canadian College of Health Leaders on both a national and international basis. In my remarks, I'm using that as a lens to provide some insights.

As leaders, we certainly take great pride in many aspects of our health system. There are many things we do well. A lot of these things we don't talk about; we're just busy doing what we're doing. But we also recognize that our health system is under a lot of strain. The strain is coming because our population is aging quickly, and we're also facing a growing prevalence of chronic illness. Our system was not designed for that type of patient. We were designed primarily around acute care and physician care, and we haven't really evolved our system sufficiently to handle those patients.

You might wonder why that is a big deal. It's a big deal because we're still a young country. If we look at ourselves compared to Europe, we're much younger, but if we look at Canada in 30 years' time, we'll be older than Europe. So if we're struggling at being young, we have to make changes to prepare for what is also coming.

This challenge we face is occurring despite considerable effort on many fronts, including the work of organizations, regions, health providers, and staff to improve service. If we look at the leadership agenda in the country, it's all focused on improvement, change, and safety. There's no question that governments have committed funding levels to support improvement, so why are we in this situation where we're struggling? It's an important question. I think the more important question is, how do we get out of struggling? How do we move forward? That, to me, is the more important question looking forward.

Why are we here? There are lots of reasons, but I want to focus on three things that I think have created a bit of the dynamic we face. First off, by virtue of how governments insure health services, we have focused health delivery primarily on hospitals or acute care and physician services, and, consequently, that's where care is funnelled to. We have some things that are insured outside of that, but primarily our major insurance platform is geared to those two venues.

As a consequence, what do we see today? We see hospitals being congested, often patients in the wrong setting. I think Ontario has said that 25% of their hospital beds are occupied by patients who are in the wrong setting. We often hear this expressed in terms of emergency department waits. Those are consequences of hospitals being congested, and then the patients can't move where they need to move. Also, we have patients waiting to see a physician. We have physician shortages, so of course patients are queueing up to see physicians, either family doctors or specialists. These two venues are also the most expensive, and we have patients concentrated there. If we look at that, that's an important factor to consider as well.

Secondly, I think it is fair to say that the consumer—and when I say "consumer", I'm talking about patients, clients, or whatever terms we choose to use—is largely marginalized in our decision-making. We have quite a paternalistic system. Patients could assume more responsibility if they were enabled to do so and if we respected them in a way where they were actually engaged as a team member in health care. We have a lot of work to do on that. We do some things well, but there's a lot that we could do better.

Also, our health system is fragmented. There are many structural and professional divisions across the country. There is limited coordination of effort across the country, resulting in inefficiencies, duplication, and inconsistencies. Dr. Bohm's presentation...that's unique and is being developed for Manitoba, but it's probably being developed in different ways in other parts of the country—everybody trying to achieve the same thing. We lack a national health agenda for a $200 billion industry. We should be concerned with that.

How do we then look at improving efficiency and performance of our health system? We could start by talking about countries that have similar values—that's very important—that are serving an older population, that are achieving better outcomes at lower cost, because that's really the agenda we're trying to tackle.

Let's look at a country such as Sweden. Sweden is a country that we have visited many times for study tours. Let's see how they've tackled all three of those issues that I mentioned.

First off, the backbone of the Swedish health system is primary care and not acute care, and every citizen is connected to a primary care network. That primary care network links very closely with hospitals so that patients can move in and out quite easily. There's a lot of information sharing, a lot of knowledge transfer, so when the patient is admitted, their history of what happened in primary care moves in. When they get discharged, what happened in the hospital visit and the discharge orders move out. It's very smooth.

There's an electronic health record that connects primary care to acute care, so that information sharing is smooth. The primary care units are team-based and patients can have appointments with any member of the team quite readily.

● (1115)

The role of acute care, though, not to be undermined, is very important, but it's focused. The hospital care is very specialized. Hospital capacity is protected: it's used for hospital care. Patients who require care in other settings move along very smoothly, so the hospitals do not get backlogged caring for patients who are in the wrong setting.

The hospitals are very efficient. They utilize Lean tools, as was discussed earlier, to streamline their processes in the nursing units, emergency departments, and clinical and diagnostic areas.

There is a national focus on improving the quality and safety of care to the elderly. This is very important, because Sweden has the oldest population in Europe. The population is much older than in Canada. There's a major effort to care for the elderly in their homes rather than in institutions. The average length of stay in nursing homes in Sweden is one year, and that reflects the effort to keep people at home as long as they can. Also, palliative care is strongly supported in the home setting.

In terms of a national agenda, patient safety and quality of care are part of the national agenda. I'll give you one example where they have really done very well, and that's that whole issue of hospital-acquired pressure ulcers or bedsores. In Sweden, the incidence of patients who get them during hospital care is 5%. In Canada, it's between 20% and 25%. We perform very poorly on that front, relative to other countries.

There's also a very strong national focus in Sweden on medication safety for the elderly, because we know that many of our hospital admissions and emergency visits are due to medication issues with patients who end up having to be admitted because they're not taking their medications right and so forth.

Infection control is very strong in Sweden. We struggle with handwashing in Canada. The handwashing compliance level in Sweden is almost 100%. But it's not just that; in patient care settings, nothing below the elbow is allowed in the patient rooms: no sleeves, no jewellery, no gel nails. We have debates on that in Canada, but in Sweden you're absolutely forbidden to have gel nails and jewellery and anything below the elbow in patient rooms. Their infection rates are very low. Their standards are very high and their consistency rate is very high.

When you look at how their system works, it's clearly evident that it was designed with the patient in mind. We have a lot of difficulty with handing patients off from one sector to another. In Sweden it's very smooth, because patient movement is orchestrated between the sectors and the patient just moves.

When we talk to them about alternative level of care patients, hospital patients in the wrong setting, they do not have that issue, and they look at us as if to say, "Well, what are you talking about?"

There is a very strong commitment to efficiency in processes through the use of Lean thinking. They actively tender for services if they're struggling with an area that they want to improve. They can do projects where they'll tender for those services—to the private or public sector—and they use that as a way of getting improvement.

They view industry differently than we do. We tend to view industry as vendors; they sell us commodities. They view industry as knowledge brokers. These companies are global companies working in hundreds of systems. Their view is that they can get innovation from those companies because of their scope of exposure, so they view them as a knowledge partner. That's also very important.

Consumers are actively engaged in personal wellness, but they're actively engaged in selecting their care options. Patient choice reform in Sweden is a very strong movement, where the patient can choose providers. For many of the services where they choose to go, the money goes with that choice. That incents providers to offer high quality to attract a patient who then brings them funding.

The last issue I would say about Sweden is they spend a lot less than we do, but they have better outcomes, and it's quite remarkable, considering that it's an older population. Their insured basket of goods includes dental care for the young and the elderly, a national pharmacare program, a national primary care network, and home care, all insured and they're spending less money. They've achieved that with 97% public funding.

● (1120)

It's a publicly funded health system. They view health as a business and they're planning to the year 2025.

The Chair: Thank you very much, Mr. Racette.

Now you realize the committee is going to be lobbying to go on a field trip to Sweden, and this is not good, right?

Thank you so very much. It was a very insightful message.

I'll now go to Dr. Fotti, who is here as an individual.

Dr. Christopher Fotti (Pritchard Farm Health Centre, As an Individual): Thanks, everyone, for having me out today, and my thanks to my clinic doctors and staff.

I met Joy when I started to create a new clinic just outside of Winnipeg. We are a 10-physician clinic just outside the perimeter, only a couple of minutes from East St. Paul, Manitoba. Why did I want to make a clinic there? Well, I live in the neighbourhood, so it was a great idea for a short commute to work, plus I realized that there was little health care in the area. People had to go all the way to Winnipeg even to get blood work and see their doctors. We're on a main artery that comes into the city, so in the morning and evening there's constant traffic coming by our site, and people can stop there and receive their health care needs.

When we started, we wanted to have a very modern clinic. We wanted to make use of all the available technologies and be prepared to use newer technologies. We all understand that technological advances are very helpful for the patients—they improve patient care and efficiency, and they produce better outcomes for the patients. So when we designed our clinic, we had that in mind. When you come into our clinic, it's a reasonably nice-looking clinic. It's fully computerized, fully electronic. We interface with our labs and everything that way. It's very helpful for all of us. We wanted to do that because we wanted to be very progressive in this area.

We have nine family doctors. Actually, we have only eight right now, but the ninth is starting in February 2013. We have one specialist, whose training is in auto-immune and skin diseases. She is also trained in general internal medicine, and she does some private cosmetic stuff. The really nice thing is that in our family practice setting we also have specialist backup, people we can talk to in the hallway for hallway consultations, and formal consultations for our patients. That really improves the stream for the patients. For example, if I have a question, I can go ask our specialist. She might not be able to see the patient at that moment, but she can give me some information on starting a treatment or an investigation that will speed things up when she does see the patient.

One of the other things we wanted was not to, I want to say, be “just” a family practice clinic, but we wanted to work collaboratively at our clinic. If I have a question about something, I can ask one of the other family doctors down the hall. So if you are at the clinic, quite often you might see two or three of us going into a patient room to look at a case. Three brains are better than one. Sometimes that will speed things up and maybe reduce unnecessary consultations.

One of the other nice things about our clinic doctors is that many have specialized interests. We all do full-practice family care in the office, but we also have some people who do very specialized care. For example, I do respiratory medicine. I'm on the College of Family Physicians of Canada's Respiratory Medicine Program Committee. So in my clinic, when one of the other doctors has a respiratory patient who might benefit from some of the additional knowledge I have, then I'll see that patient for him. We have one doctor in our clinic right now, and another one starting in February, who does obstetric care. If you want to be at the clinic for the whole time for your obstetric care, then this doctor can take care of you and deliver your baby. And it'll be the same thing with the new doctor who's coming on. If I have obstetric patients of my own, usually we'll see those patients up to about 28 weeks before we pass them on. This reduces the burden on the obstetricians and gynecologists—they don't have to do all the regular prenatal care. But if I need advice or guidance, I can rely on this doctor in our clinic with her advanced knowledge.

Four of our doctors do hospital care as well. They admit patients. They admit unassigned patients to hospital. That also helps with transition. If our clinic patients are in hospital, it's very easy to transition over, which also keeps them in the loop as we try to make changes in the hospital system to improve the flow of patient care.

One of our doctors has an interest in sports medicine. That's also a very helpful thing. We have quite an array of physicians doing full-service family care, but we also have people who, though not specialists, have special interests and some additional training in other areas. Again, that really improves the flow of the clinic.

● (1125)

One of the other things we wanted to do was to make sure that our clinic was accessible. Definitely that's one of the most important things.

Actually, I do have a document here. The college told me they sent it to everybody on the health committee earlier, but if anybody would like this bilingual document called, “The Patient's Medical Home”, you can just let me know and I will have them send it to you. The basic idea behind “The Patient's Medical Home” is that everyone have access to a family doctor in a timely fashion and access to alternative care, for example, after-hours care and things like that.

When we set up our clinic—

The Chair: Excuse me, Dr. Fotti. Before I forget, can you be so kind as to send a copy to the clerk? We'll make sure they're distributed properly. We get so much information coming to our offices that the members may or may not have seen that, and it is important for them to see it.

● (1130)

Dr. Christopher Fotti: Yes, just let me know how many you need. They are more than happy to send it out, but they just don't want to send out a whole bunch if they don't know....

The whole idea with the “Patient's Home” is that everyone have access to a family doctor in a timely fashion and that the medical home also interact with other health care professionals—specialists' services, dieticians, social workers, and all those things, to try to streamline and improve patient care.

All our doctors have same-day slots, which means there is a very good chance that if you phone in the morning because you need to be seen, you will be seen by your doctor that day or the next day. In many clinics that's not the case. I'm sure many of you have experienced or have heard from friends and family that they call their doctor because they think they have a urinary tract infection and they get an appointment for a month or two later. That doesn't really do anybody any good, and then, of course, people end up in the emergency room and in other more inappropriate care settings for issues like that.

We've been maintaining that, and it's been working very well. Our patients are very satisfied that, for the most part, they can be seen rather quickly.

One of the other things we wanted to do was to provide alternative care, after-hours care, for our patients, and for patients in the community as well. We decided to have walk-in hours for any patient who wanted to come in—and obviously for our clinic patients. We do our walk-in hours in the evening. We do those from 5 to 9, and we'll be starting up the Saturday walk-in soon. So, for example, if you phoned in and you couldn't get in to see me because my schedule was too busy, you could come to the walk-in at night and still get care within the same day.

We've alerted all the urgent cares and hospitals and ERs that we are open during those hours, and sometimes they redirect patients who don't need emergency room care to come see us. Our hope is to improve care for our patients, to improve care for the patients in the community, and to reduce the impact on other health care services, so that, for example, patients who really do need to be in the emergency room aren't waiting with a bunch of patients who don't really need to be in an emergency room. That has been working very well for us.

Like many clinics, we have a pharmacy and a lab in-house. Our pharmacist collaborates with us. We're often running in and out of her office and her store to ask her questions. Even for patients that she's not even seeing to dispense medications, she'll give us guidance as to what to do.

We're expecting the X-ray clinic to open up next door in the next week or so. They are fully electronic, with X-ray, EKG, and spirometry, and we've set it up so that they actually data-link into our system. So if I order an X-ray, you can go next door and get your X-ray and it pops back into my computer before you come back. If I'm not sure about that X-ray, we have access to the radiologist 24/7, so I can just pick up the phone and hit the speed dial number and the radiologist, for the most part, will be able to look at the film with me, wherever it is they're looking at it on their system, and give us guidance on what the image may represent.

Again, we've expanded to have more services, but we've done so by using electronic and technological items as well as we can. Our clinic is fully electronic, so everything is often just shifting through data ports. Patients will be able to book online appointments soon and go from there.

We tried to follow the model in “The Patient's Medical Home”—and we'll definitely send that out to everybody—and so far, it seems we are working well for the community. Patients have a lot of access to us. Patients can get in quickly to see us. We're working well with lots of other services to streamline things, and that is definitely the way of the future.

Maybe the last thing I'll say is that my business partner and I both teach at the university as well, which is also an important component of this—to teach student learners, whether they be physicians, nurses, or anyone else, and to have them in our clinics. It's good for us. It's good to keep us up to date on things. Students keep you on your toes, for sure. It's also good to expose the students to various health care models.

Most of our new doctors were students we taught. Most of the doctors who started at our clinic had zero patients when they started. Within four or five weeks, all of those doctors were maxed out. They had taken all the patients they could take. For the last doctor we hired, when we advertised, it took just over two weeks for her to max out with over 1,000 patients. It just goes to show you that there's still a lot of work that needs to be done. There are a lot of people who still need doctors.

Thank you.

● (1135)

The Chair: Thank you, Dr. Fotti. I know that it's really an amazing place, and the feedback I've heard from so many people has just been amazing.

I just want to say that one of my staffers who went—she changed doctors and went to your clinic, actually—was diagnosed with something rather serious. She'd been going to some place forever and they hadn't caught it, because there wasn't that symmetry between all the specialists.

Thank you for sharing that with all of us today. We appreciate it very much.

Now we will go to Dr. Montaner. We're looking forward to hearing you.

Dr. Julio Montaner: Thank you, Madam Chair.

Let me first introduce my partner in this presentation, Dr. Thomas Kerr, from the B.C. Centre for Excellence. He's the director of the urban health program here at the centre at St. Paul's Hospital and the University of British Columbia.

The theme I would like to discuss for you relates to the efforts we have made over the last couple of decades to control HIV and AIDS in the province of British Columbia.

Here on the west coast, we have been affected by the worst HIV epidemic in the country. As Dr. Racette indicated, our health system is under significant stress, and sustainability of these efforts is a serious consideration. We agree wholeheartedly with Dr. Bohm's closing remarks that accurately monitoring our epidemic is essential for understanding what's happening. But at the end of the day, if we don't do something about it, monitoring is not going to cut it for us.

The B.C. Centre for Excellence is unique, in the sense that it's mandated not only to distribute antiretroviral therapies throughout the province to all eligible individuals, fully free of charge, but to also support laboratory monitoring. And we have a mandate to monitor health outcomes related to HIV.

Back in 1995, research conducted at the centre and elsewhere showed that by using three-drug combination therapy, we could arrest the course of the disease. What happens is that it shuts down the replication of the virus, and in a matter of weeks, the amount of virus circulating in blood goes to undetectable levels. As a result, immunity recovers, the patient doesn't get sick, and we restore the person's normal life. Today, a 20-year-old individual who starts on this regimen will expect five decades of normal life. We have really changed the outcome of HIV from a rapidly lethal disease to a disease that can be completely managed as a long-term, chronic management proposition.

As a result of that, morbidity and mortality in the province of British Columbia have decreased by greater than 90%, which goes a great deal to contributing to decreasing the burden on our hospitals and our health care system. Treatment has been deemed to be highly cost-effective for this reason, and as a result, the province continues to support free treatment for all in need.

During the years 1996 to 2000, we briskly rolled out antiretroviral therapy in the province. As a result of our monitoring efforts, we saw unexpectedly that the number of new HIV infections in the province decreased by approximately 40%. This was an unexpected event at the time, but it was a tip for us that the treatment not only prevents disease progression, but, in addition, and most importantly, it can stop HIV transmission.

We looked then at this phenomenon in the mother-to-child transmission setting. We found that by treating the mothers, we could stop transmission to the babies by nearly 100%. In more recent work we've done, in collaboration with others, we have shown that the same principle applies when you treat an injection drug user or when you treat a member of an HIV-discordant couple, in which one member of the couple is HIV-positive and the other is HIV-negative.

The province of British Columbia, therefore, has embarked, for a number of years now, on a new strategy, which we call seek and treat. We're seeking out individuals by facilitating and normalizing HIV testing, and we are screening the population for HIV so that we can chip away at the recurrent statistic that 25% of people infected with HIV are unaware of the infection. The Public Health Agency of Canada, year after year, reports the same number, yet we have not changed our guidelines regarding HIV testing.

We are advocating a national strategy on HIV testing such that the testing can be generalized so that we can identify those individuals and do the best for them, and in doing so, stop HIV transmission. By approaching the problem in this way, British Columbia, in addition to decreasing morbidity and mortality by greater than 90%, has now decreased new HIV infections by greater than 66%.

● (1140)

Let me emphasize that we are the only jurisdiction in the country that has seen a meaningful decrease in the number of new HIV diagnoses per year in the last two decades, at a time when Saskatchewan has seen a fivefold increase in the number of cases and Manitoba has a threefold increase in the number of cases. There is also a rising number of cases in Newfoundland and in your own great city of Ottawa. First nations individuals are five times overrepresented in this epidemic.

Madam Chair, we think we have a solution at the Canadian level. The United States has actually formally embraced this approach. We would like to recommend that HIV treatment and prevention be made a national priority for this country immediately.

I will let Dr. Kerr discuss how this should be enforced among injection drug users.

Thank you.

The Chair: Dr. Kerr, you have three minutes.

We look forward to hearing from you.

Dr. Thomas Kerr (Director, Urban Health Research Initiative, British Columbia Centre for Excellence in HIV/AIDS): Three minutes? I was under the impression I had five minutes.

The Chair: You have four minutes.

Dr. Thomas Kerr: I would like to just take some time to discuss some issues of relevance on the information provided by Dr. Montaner. As he has pointed out, and as I'm sure many of you know, a significant majority of new infections occurring in Canada are among individuals who use illicit drugs. Currently the fastest-growing epidemic of HIV infection in Canada is occurring among drugs users in Saskatchewan.

It is very clear now that if we are going to succeed in controlling the HIV epidemic in Canada, we must address illicit drug use. This requires adhering to principles of evidence-based medicine, supporting innovation, and improving efficiency.

The federal government has certainly dedicated some attention to drug use through its national strategy and bills specific to criminal justice measures. I do not want to discuss the relative merits of this approach, but I will say that one consequence of the approach being taken is that, as a country, we appear to be falling behind other countries when it comes to implementing and expanding innovative preventive and treatment measures focused on drug use and the prevention of HIV infection among drug users.

There is now a substantial body of scientific literature that indicates very clearly that substance use programming should be based on a continuum of services that includes not only abstinence-based programs, but programs that engage people who are active in their drug use with so-called “harm reduction” programs.

The scientific evidence in support of harm reduction is so strong that the United Nations and the World Health Organization have issued technical guidance documents that state that these programs are essential. We know that these programs facilitate prevention by providing materials that reduce the likelihood of disease transmission, but they also prevent HIV infection by engaging HIV-positive individuals in treatment for HIV disease.

Accordingly, in Vancouver we followed this approach, and while roughly 19% of all injection drug users were infected in the downtown east side in 1997, that rate has dropped to less than 1%.

We also know that harm reduction programs facilitate entry into abstinence-based programs, including detoxification.

But despite these well-established facts, we are not adhering to international standards or optimizing our HIV prevention and treatment efforts. If we share the goals of preventing HIV infection, promoting the use of addiction treatment and abstinence from drugs, then it's clear we should be supporting the scale-up of harm reduction programs in Canada.

It is also clear that we are falling behind in terms of innovation and addiction treatment in the use of electronic systems to prevent harms with drug use. Recently the federal health minister elected not to stand in the way of production of generic copies of Oxycontin. I won't discuss the merits of this decision, but rather I'd like to focus on a systems-level gap that, if addressed, could offset much of the risk posed by Oxycontin misuse.

The Province of British Columbia has implemented a province-wide PharmaNet system that allows pharmacists and doctors to see exactly what medications an individual has been prescribed, including opiates. This is very helpful when assessing the risks posed by prescription opiate use in double-doctoring. However, this type of system is not available in many provinces where opiate misuse remains a major problem.

Another area where we could do more to promote innovation is by supporting the implementation and testing of new medications for addiction. For example, Vivitrol is an FDA-approved opiate receptor antagonist that has been shown to be very effective in the treatment of opiate addiction and recent alcohol addiction. Yet Vivitrol remains unavailable in Canada and we have faced substantial difficulty in obtaining access to the drug in order to test it in a randomized controlled trial—

● (1145)

The Chair: I'm sorry, Dr. Kerr, you're over time now.

Dr. Thomas Kerr: In summary—

The Chair: My apologies. Could you summarize very quickly?

Dr. Thomas Kerr: —despite the fact that addiction and HIV remain major challenges, we are falling behind. More can be done to support innovation in systems, policy, research, and program development.

Thank you.

The Chair: Thank you very much.

We'll now go to St. Boniface Hospital, to Dr. Tétreault, president and chief executive officer.

Dr. Michel Tétreault (President and Chief Executive Officer, St. Boniface Hospital): Good morning, Madam Chair and members.

[*Translation*]

I want to thank the members who are here today.

[*English*]

It's a privilege to be here, so I want to thank you for that.

I got a bit worried when I saw the title of this session. It said “Technological Innovation”. What I want to talk about isn't rockets; it's delivery of health care. I guess the technology we're employing tends to be forgotten a bit, and that's the human mind, the human brain, and the human heart. That's the technology we're trying to harness at St. Boniface Hospital.

I will talk about four years of efforts into improving our care and getting results at a cost that we as taxpayers can all afford.

You do have a PowerPoint. I'm not going to show it to you; I would rather speak with you.

We do have four overarching objectives. We call them true north directions. They are, in order: to satisfy patients; to engage the staff; to reduce harm or do no harm; and to manage our resources. Our belief—and the more we do, the more we believe this—is that to satisfy patients we must engage staff. If we do that, we will reduce harm. In fact, by managing the resources—I will talk about the results in a few minutes—it will kind of fall out of that. That has been our experience over the last four years.

Some people think it's presumptuous to say we're on the road to perfect care. I think we will be close in about three or four CEOs—and I have no intention of retiring any time soon. However, if you think of what is acceptable, it is zero preventable harm, and it is only perfect care that will cut it. We want to make sure we don't forget that.

I will try to be very brief on the story of the Grey Nuns who founded St. Boniface Hospital more than 140 years ago. They came to Winnipeg, then called the new colony, from Montreal, because it was an order in Montreal, by canoe. It took 56 days. They landed about 150 metres from where our hospital is today. They were women of courage and determination, but they were also the fifth congregation to be asked by the bishop to come to the new colony. The four preceding them had not found a way to say yes. We believe the Grey Nuns actually showed a spirit of innovation in going where others didn't necessarily dare to go.

I do have the privilege—this is one of the things we found out by asking our people to improve the work, and to work with us on taking their knowledge and competence and applying it to improvement. I know how privileged I am to work with 4,000 extraordinarily competent, committed, caring, and compassionate people.

Why did we do this? Frankly, it was out of frustration. We have been a leading organization in quality improvement for many years in the country, or we are seen as that. When we are honest and look at the hard facts...we weren't really getting anywhere. Our CMO calls it "patchy improvement", so once in a while we get a world-class improvement. We went without very serious infections from central lines in our ICUs—not one—for about 15 months. That's world-class. In the same ICU, we got nowhere on infections due to ventilators. It was kind of hit and miss. Even when we hit, more often than not, if you looked back a year later, we were back to where we started. We were frustrated with that. We were lucky to have some excellent examples of how Lean transformation can improve quality and reduce costs.

In Winnipeg, there's a shop called StandardAero that has been doing this for 25 years. They went from a very ordinary aero—not even standard—to world leaders in what they do, which is to fix aircraft engines. We also saw a place called ThedaCare in Appleton, Wisconsin, of all places, that is a world leader at Lean transformation. I visited one of their units that had implemented 752 significant improvements in the last year. Their target for this year, on that one unit, is 1,000. To give you a bit of a comparison, our target for this year at this hospital is 1,000 improvements, and we will be very happy if we get there.

How did we do this? The first thing is we went to our board of directors and said we were tired of having 15 priorities. Eight years ago, we had 15 in our strategic plan; four years ago we had nine. We proposed that there would be one priority at St. Boniface Hospital, and that would be quality. We were brave enough to say, We actually think we know how to attempt this, and that is through Lean transformation." They said, "Thou shalt do this and never stop."

So it's not a project and it's not a trial; it's something we are fully committed to. If you want to be part of St. Boniface Hospital's executive or leadership team, you have to fully commit to this.

● (1150)

I am a physician. We also had to spend money we did not have. That was a risk. I will talk to you about how that has paid off for us. The return on investment is great. We did have some very fortunate occurrences with business partners. Bob Hamaberg, the CEO of StandardAero, was my executive coach, pro bono, when they started this 25 years ago. He does this for two reasons. One is that he believes in the inherent moral value, but he is also a very successful businessman. He believes that high-quality care at an affordable cost is a marked competitive advantage compared to his competitors south of the border.

What do we do? Every month we do multiple improvement events. We have done over 100 of these events. You take front-line staff and managers and you give them time to think. We agree on what a problem is, and we give them time to thoroughly analyze it to look at what we do, how it could be made better, what we want to accomplish, and how in that week they are going to experiment with change. What are they going to try to make it better? Then they say, over the next three months this is what we're going to do and this is the expected result. We measure that constantly. We obviously also do projects. Some things are just good ideas that as leaders we have to learn to support and say we're just going to do it. We call them "just do its". Our goal is to develop 4,000 problem-solvers at St. Boniface Hospital—4,000 improvement agents.

Results? Satisfied patients. We have been measuring patient satisfaction. Not many hospitals do this. We do it continuously and report on it every month. Twice in the last year we hit our highest-ever patient satisfaction scores. Nearly 87% of our patients said the care at St. Boniface Hospital was either very good or excellent. We don't count "good" as satisfied. On "engaged staff", we measure staff engagement. We use a firm called Aon Hewitt, which does an international survey. We haven't hit our goal. Our goal was to be in the top 10% of employers in the country in terms of staff engagement. We have gone more than halfway between where we started, which was that 41% of our staff were fully engaged, which is in the remedial zone, by the way. This year's result was that 58% of our staff are fully engaged. To be in the top 10%, we have to get to 65%. We believe the more we engage our staff in improving what they do, the more they will be engaged.

On the reduction of harm, a measure is put out by the Canadian Institute for Health Information called the hospital standardized mortality ratio. When we started doing that measure, we were exactly average in Canada for teaching hospitals. The average was one; we were at one. We have reduced that. Our target was a 10% reduction year over year. We have reduced that by 30% in three years. We're now at 0.7 on our most recent result. I believe our patients are doing better. We have managed to reduce the time that patients are in hospital by 18%. That's equivalent to a 30-bed hospital unit in our place. We didn't have to build it. We didn't have to staff it. We already had the buildings and the staff. That represents 4% more patients by volume. Those patients were 4% sicker. That doesn't look like a lot—4%—correct? It allowed us to treat 1,150 more patients with the same budget as the preceding year. That is worth $4.6 million.

Finally, on the financial side, our target is to improve our financial performance by 1% year over year every year—1% in the first year, 2% in the second, and 3% in the third. Two years ago, we hit 1%, which was $3 million worth of financial improvement. Last year, we hit $6.2 million. This year, our target is $9.6 million, and I think we might just hit it. In two years, it will be $15 million. It's a $200 billion health industry. If everyone managed that, that's $2 billion per year, and $4 billion next year.

Finally, we are here to propose something we believe in, which is a learning centre for Lean in health care in Canada. We do have partners in the Asper School Of Business at the University of Manitoba and a École des hautes études commerciales de Montréal, and they want to do this with us. Rather than my flying around the country, we believe that by bringing people to see us, to see what can be done, and how it can be attempted—we're not perfect; we can't tell people what to do, but they can at least look—we can collectively make a dent in improving quality and decreasing cost.

Thank you very much, Madam Chair.

● (1155)

The Chair: Thank you. This has been an absolutely awesome morning, listening to all these wonderful ideas. Each and every presenter has made a major contribution this morning.

What we are going to do is go into the seven-minute Q and A round. I will be watching the time.

From the NDP, we will begin with Ms. Davies.

Ms. Libby Davies (Vancouver East, NDP): Thank you very much, Madam Chair.

Thank you to all of the witnesses for being here today, especially from Vancouver. We know you had to get up early in the morning to be ready to go at 8 a.m. Thank you for doing that.

This has been a really interesting study. We've had great presentations, and today's is no exception. I am fascinated to hear you say, Mr. Racette, that we lack a national health agenda for a $200 billion industry. Your information about what's going on in Sweden is an eye-opener. If there's any particular document that you think we should look at, I'd love to see it, as I'm sure other members of the committee would, just to see what they are doing there, especially around the question of jurisdiction. We've heard that incredible things are taking place.

I'm reminded that one witness told us that Canada is a country of pilot projects, which makes your comment, Mr. Racette, even more compelling. We have great things going on, but they're very scattered. It strikes me as a very difficult situation, because if you're a Canadian, you're a Canadian no matter where you live, and you should be able to expect the same high quality of care and access no matter where you are in this country. So thank you for everything you've told us today.

I want to focus some questions to Dr. Montaner and Dr. Kerr.

I'm familiar with your work, Dr. Montaner. You have an international reputation for the incredible work you've done out of the B.C. Centre for Excellence on HIV/AIDS.

Dr. Kerr, your work with a very high-risk urban population has been quite incredible, and I am very familiar with it.

To be quite crass about it, I'd love you to talk a little about the numbers. We're talking about innovation in health care. What you're doing is preventing infections, and the statistics you give us are quite incredible. Can you translate this into costs and describe how, if we change the focus of what we're doing by looking at the social determinants of health, in working on harm reduction, we are actually saving a huge amount of money? I know this, but I don't have all the info at my fingertips and I'd love you to put it forward.

Secondly, I read something a couple of days ago from you, Dr. Montaner, and I heard you speak about the "seek and treat" program. But I believe you are also suggesting that, based on the success in B.C., we should have a national program of free treatment—"treatment is prevention"—for AIDS medications. Could you also tell us why you are now saying that? What has compelled you to bring this forward?

Thank you. If you'd like to answer those questions....

● (1200)

Dr. Julio Montaner: Thank you, Ms. Davies, for your remarks.

Briefly, there are 3,300 new infections in this country per year. We argued that if we were to embrace a “test and treat” approach—the “seek and treat” approach that we're talking about—we could reduce that number in a matter of two to three years by more than 60%, with concurrent decreases in morbidity and mortality.

A case of HIV costs, in terms of treatment, roughly $15,000 per year. Over a lifetime, that translates into anywhere between $300,000 and $500,000, and that is clearly an average. If we are able to prevent one infection, not only are we preventing morbidity and mortality, but we are also preventing the downstream chain of transmission that the individual could generate.

For that reason, our data, now independently verified by the World Health Organization, shows that investing a little more upfront on testing and engaging in treatment in a supportive fashion, including the harm reduction practice that you are asking for, would be cost-saving. The mathematical model suggests that whatever more you invest today, you recoup in a matter of five years, and after that it is all savings.

I am going to let Dr. Kerr comment on the harm reduction piece.

Dr. Thomas Kerr: Really, what happened in Vancouver is that we had a public health emergency declared because of the epidemics of HIV infection and overdose occurring in that community.

To give you a quick perspective, during the height of this emergency we were experiencing anywhere up to 400 infections. That has now declined to fewer than 40. At that time, the lifetime medical costs associated with those new infections would be in the order of $180 million. Now they are down to something more like $16 million.

Likewise we have seen massive declines in overdose stats and ambulance call-outs for those events. As a result of some innovative approaches, which have also been rigorously evaluated and verified in the scientific literature—such as Vancouver's Insite supervised injection site—overdose deaths have declined substantially. In fact they have declined by over 35% just in the area around that facility.

Clearly what we're saying is we need to take an evidence-based approach to this. If we do, and we're careful, and we evaluate, and scale up those pilots that do work, we can not only prevent a great deal of suffering, but we can also save a lot of money and reduce the burden on our hospitals where currently people who use drugs occupy a great number of acute beds and spend a lot of time in our emergency rooms.

Dr. Julio Montaner: Let me conclude by saying that if this virus was not HIV, and it was called H1N1, SARS, or something else, we would have a national strategy. We're neglecting it because we're discriminating against HIV.

Ms. Libby Davies: Thank you very much.

Do I have any more time?

The Chair: Your time's up. Thank you very much.

Mr. Strahl.

Mr. Mark Strahl (Chilliwack—Fraser Canyon, CPC): My questions are for Dr. Bohm. I was very interested in your presentation. When you sought to start up the Lean program, were additional funds required? Did you need to seek additional funds, or were you able to reprofile or find savings internally in order to set that up?

Dr. Eric Bohm: I gave a couple of examples of a broad application of Lean theory. Dr. Tétreault has more experience in this than I do and maybe can speak a bit more about it.

We didn't find you needed a lot of new resources or money. This was really almost a management philosophy, applying new thought processes to a current problem and how you address it.

I think the important part I keep stressing is coming back to the data piece. I think we were lucky in several ways because we were able to tack on that data capture piece to existing databases. We had a wait list database for hip and knee arthroplasty. We added onto that the outcomes data from our joint registry. It was a matter of adding a few fields and a bit more time from the analyst.

I think what happens is once you demonstrate the value of the data, it's much easier to find those resources to create new data structures.

● (1205)

Mr. Mark Strahl: I remember your PowerPoint where it talked about, I think, a five-day reduction in hospital stays. Have you calculated the savings to the system? I know Dr. Tétreault mentioned it in his centre. Have you calculated what perhaps the annual savings or per patient savings are because you have implemented this Lean system?

Dr. Eric Bohm: No. I haven't run those numbers.

I think when you show these big changes in length of stay, in mortality, the value of it is obvious to people, and it's easier to obtain those resources for the data structure.

Mr. Mark Strahl: Given the success and the ability for you to show the success through the data, is there resistance to adopting this in other centres? If so, why, given that it appears, certainly from the data you have presented, it's a no-brainer?

Dr. Eric Bohm: I think the challenge we've already mentioned is that we almost have 13 health care systems in Canada, and we have many multiple pilot projects going on.

I've been involved with a couple of groups. One is the Arthritis Alliance of Canada. It's made up of a lot of member organizations—the Canadian Orthopaedic Association, the Canadian Rheumatology Association, the Arthritis Society, physiotherapists, and so forth—and they have advanced a model of care framework.

The other group I've been active with is Bone and Joint Decade Canada. That's a purely pan-Canadian group of MSK providers. We've done a lot of work around a tool kit for hip and knee replacement access quality outcomes, and a lot of work on hip fracture care as well.

A lot of things I've presented today are components of those tool kits we've developed. Part of that work involves rolling out the components of those tool kits across Canada, so this work is ongoing across Canada. If you look at what we do, there are components of that across Canada.

Mr. Mark Strahl: You also mentioned that intellectual property policies and medical centres need to be updated. I'm wondering what particular changes you're referring to. What policies need to be updated, and are those federal or provincial regulations?

Dr. Eric Bohm: This is a very new area for us. I mentioned the Orthopaedic Device Innovation Centre, and we're just now going through the machinations of sorting out intellectual property rights to deal with this in our university.

Obviously, if you have investors that come in and want to assist with device development, there are a lot of issues around intellectual property and who owns it and how you divvy it up. We're working with our university and making a lot of progress on this point. I'm speaking mostly about the university and my local experience.

Mr. Mark Strahl: Dr. Racette, you mentioned the Swedish model, and I have some interest in that country. My question is whether they have a federal system where provinces or states are responsible for the delivery of health care services, or whether they have a national central government responsible for delivering health care throughout the country.

Mr. Ray Racette: I should say that I'm not a physician.

Mr. Mark Strahl: I'll call you “doctor” anyway.

Mr. Ray Racette: In Sweden, they don't have a federation like Canada or Australia. But they have a complex system. They have 20 councils, and their role is to look after hospital care, physician care, academic health science centres, and pharmacare. All those things are under one council that has its own taxing powers. They have about 300 municipal councils. They look after all the things that we would say are determinants of health. They have housing, social services, care for the elderly, home care, and care for the disabled. That council has its own taxing powers. In fact, they have two different councils with distinct taxing powers. One council doesn't need to take from acute care to get the resources—they can tax separately for that.

The mandate of the federal government is really to set national priorities, which they do jointly when negotiating with the councils and agreeing on what the national priorities are. The federal funding going in is quite small, less than 10%. Most of the funding comes through the county councils and municipal councils, but it is a complex structure. They still need to negotiate how to maintain a standard approach to health care throughout those councils, all of which have governance structures over them, to deliver a consistent level of care regardless of where you are in Sweden.

They work very hard on getting consensus and establishing priorities. They manage it very carefully and they do a lot of measurement. They can measure care right down to the physician, the hospital, and the county. They have several years of data available, so they can see how their performance changes over time.

● (1210)

Mr. Mark Strahl: Thank you very much.

The Chair: You have a little time, but that's okay.

Mr. Mark Strahl: I'm done, thank you.

The Chair: Okay, thank you so much.

We'll now go to Dr. Fry.

Hon. Hedy Fry (Vancouver Centre, Lib.): Thank you very much, Madam Chair, and I want to congratulate everyone on some really innovative thinking that I heard today.

Dr. Bohm, I think you've done remarkable things by measuring. You're absolutely right: if you don't measure it, you shouldn't be bothered to even start doing innovation or making changes.

Mr. Racette, I wanted to comment on some of the things you talked about. You talked about the lack of a national health care strategy. You talked about health human resource shortages, which stops Canada from innovating the way Sweden has done. They are taking care of chronic and elderly patients in a community care or home care setting, and they're holding up 25% of the beds in the acute care setting at massive cost.

What is the cost per patient per day for acute care? Is it somewhere between $2,000 and $3,000 per patient per day?

Mr. Ray Racette: Well, it depends on the type of hospital. Academic health science centres are quite expensive. A normal community hospital would be in the range of maybe $1,200 a day. As for teaching hospitals, Dr. Tétreault would know. St. Boniface would be—

Dr. Michel Tétreault: It's more like $1,500. But acute cases are much more expensive than patients who stay for a long time.

Hon. Hedy Fry: But staying in the bed is also a huge cost in a hospital.

What are the costs for doing the community and home care in Sweden per capita? Do you have that information?

Mr. Ray Racette: I don't have that. The only thing I can tell you is that we look at two measures related to performance. We look at percentage of GDP investment. We're at around 11.5% or 11.6% right now. They're sitting at below 10%, and it had been around 9% for probably 10 to 15 years. At one time, we were around 9%, but we've grown quite quickly. We also look at the average cost per patient, and the total cost for citizens, to get an average. They're about $500 a person cheaper, and that's with a bigger basket of insured goods.

Hon. Hedy Fry: Thank you.

You talked about fragmentation of care across the country, and we see some great things happening in some provinces, but there is no ability to pull them in and look at those best practices nationally.

You know that the 2004 health accord looked at a jurisdictional flexibility that was agreed on between provinces and the federal government. One of the five objectives was shifting to home and community care, where possible, and using hospitals and physician care only where necessary. That was going to achieve some of the things.

It also looked at a health human resource pan-Canadian strategy. None of those things has come to pass. I think while you give us great recommendations for innovation, it seems as if we have not been able to take those on.

I just wanted to quickly mention, Dr. Fotti, that the “Patient's Home” is a remarkable new way of actually implementing some of what Mr. Racette was talking about. I want to congratulate you, as you have just done exactly what the college is suggesting in terms of the home, thereby looking at a multi-disciplinary team of care—community, home care, using a hospital only when absolutely necessary for acute care. I want to congratulate you on actually making that so, and I'm hoping the college will get that implemented across the country.

Finally, I want to talk quickly to Dr. Montaner and Tom Kerr.

I want to congratulate you, Dr. Montaner, on the Queen's Diamond Jubilee medal you received, and all of the medals and accolades you've received around the world for this remarkable Canadian achievement. I don't know but some people have actually probably overdone it and said that this is probably the closest we've come to Banting and Best in Canada in the past. It's a Canadian innovation, and I know the World Health Organization has looked at the whole treatment as prevention, the heart program in B.C.

Can you tell me what it costs for the whole program in B.C., both the “seek” and then the “treat” that is now free in B.C.? What's the total cost of that?

● (1215)

Dr. Julio Montaner: The cost per year, if you consider drugs and...[*Technical difficulty—Editor*]

The Chair: Dr. Montaner, I'm sorry, we lost the feed.

Can you hear me?

Dr. Julio Montaner: Thank you, Ms. Fry, for your questions and your comments.

The cost of the program in British Columbia at the present time is in the order of $120 million per year, considering that we have 14,000 people infected with HIV in the province and we have approximately 7,000 people actively engaged on antiretroviral therapy. The average cost per patient is in the order of $15,000 per patient for all treatment, and of course it's half of that if you consider the whole bulk of people infected with HIV.

As I said, the return on the investment is actually phenomenal. This has been acknowledged by the World Health Organization, and for that reason, UNAIDS and WHO, among others, have recommended that this approach be actually implemented throughout the world. Steps are being taken for this to happen.

Hon. Hedy Fry: I'm sorry, what is the cost per year in the provincial budget, and hospital costs, etc., prior to seek and treat? What was the cost for taking care of HIV cases in hospital, in emergencies, etc.? What is your total cost that you can give us, Julio, Dr. Montaner?

Dr. Julio Montaner: I cannot give you a figure, but it will be manyfold greater than we are currently spending. In other words, the return on the investment is in the order of three to five to one, because really what we're doing is not only stopping people from becoming sick, but we're putting them back on their feet so that they can continue to contribute to society.

As I said, we have had zero vertical transmission over the last seven years in the province of British Columbia. The childhood epidemic has been eliminated. But in addition to that, by decreasing by 65% the number of new infections, what we're doing is we are eliminating the emergence of new cases, which has an exponential growth as a result of continued transmission.

Hon. Hedy Fry: Thank you, Dr. Montaner.

I wanted to suggest that this could be a part of a national pharmacare strategy, which again was one of the objectives of the 2004 health accord that has never come to pass.

I want to ask Dr. Kerr something. The words “harm reduction” have a huge loaded moral connotation for a lot of people, and yet we heard Dr. Tétreault talking about harm reduction in the hospital—washing your hands so that you don't spread infection.

Can you explain harm reduction in a way that takes away that moral, value-laden judgment?

The Chair: You only have about 30 seconds to do that.

Hon. Hedy Fry: Could you do it in 30 seconds, Thomas?

Dr. Thomas Kerr: Sure. Harm reduction really isn't restricted to drug use. It's surprising that it has carried stigma when it's applied in that area. It's in many other things, including light beer and low-nicotine cigarettes. “Don't drink and drive” campaigns are a form of harm reduction. Really, it seems that it's in Canada that we're struggling with these words; it's not a problem for the United Nations, and it's not a problem for the World Health Organization or the Canadian Medical Association. It's really about evidence-based practice of what works and what doesn't.

The Chair: Thank you, Dr. Kerr.

We will now go to Dr. Carrie.

Mr. Colin Carrie (Oshawa, CPC): Thank you very much, Madam Chair. I want to thank all of the witnesses here today for excellent presentations.

I want to start off my questioning, but I'm going to be sharing it with Mr. Lizon.

Mr. Racette, what is the cost in Canada for a hospital bed per day? Do you have any idea?

Mr. Ray Racette: I don't have it here, but we could probably get it from CIHI, the Canadian Institute of Health Information, and let you know what it is.

Mr. Colin Carrie: Okay.

Is there anything stopping provinces from adopting these difference practices? We heard about a practice in British Columbia. If another province, such as Saskatchewan, wanted to adopt these practices, is anything stopping them from doing so?

● (1220)

Mr. Ray Racette: No, there isn't anything stopping them.

Mr. Colin Carrie: I was just curious.

I liked the talk about different models. You were talking about Sweden. Dr. Fotti, I was very impressed that it seems you are actually doing it on the ground, which I love seeing. You talked about various things, such as this “Patient's Medical Home”. I was talking with witnesses from Canada Health Infoway, who spoke about electronic health records. It seems that you are starting to use this technology in your clinic. You started talking about computerization and about sharing of information.

Could you explain a little more how you do that?

The other thing I want to ask you about is remuneration models in your clinic. It seems that you have all these different professionals perhaps looking at the same patient. In Ontario, there is a fee-for-service type of model. Are you guys doing anything different that seems to work?

Dr. Christopher Fotti: In answer to your last question, we're fee-for-service at my clinic, but when we're doing our hallway consults, all it is is, “Dr. Boroditsky, can you come in and look at this rash with me?” We're not double-billing or anything like that.

When we are utilizing some of our doctors who have special interest in certain areas, that is more like a consultation, but the goal then would be that the outcome will be hopefully improved by our additional expertise in the area. But most of the time, if you see two or three of us going in a room, it's just an “I wouldn't mind having a couple of other opinions” kind of thing. It works quite well.

For our electronic records, nowadays it's purely not good patient care to start without it; that's for sure. Even now, as a business owner, understanding how much more efficiently we can keep track of things.... For example, it's so much harder to lose a test result: either it came into the system or it didn't. In the old days, you could have it falling out of the chart or being stuck in the wrong place and all that kind of stuff. It becomes a lot safer for the patients as well.

The only catch we have, and this may speak to some of the other comments about fragmentation, is that, for example, our electronic record can communicate with most other electronic records, but we have been having a lot of trouble because some of the electronic records that were adopted by the region can't communicate with ours. We still have to have all of them faxed over, converted into a PDF document, and put into the file, and then somebody has to go through it, whereas if the systems communicate properly, they can populate into the appropriate areas in the EMR and you have the information right there at your fingertips.

One of the other issues we have found is in wanting to link with something called eChart. The eChart allows access to all patient lab data that has come through the central system—all of their diagnostics, CT scans, X-ray reports, and everything.

They are deep in: we can access their drugs and immunization history and quite a few other things. It's very handy in the office. If you came in for your CT result and I said I didn't have it yet, I could log on, and it would probably be right there and we could get it for you.

The catch is—we are working with them now to implement it—that their technology is so old that to implement it for our clinic, they have to come in and actually downgrade our Internet and whatnot so that it will work with our system. Now we're not sure, because if we do this, we might have issues integrating with our X-ray department. We may have to downgrade just one or two stations to older technology to use this program.

It would be nice if the technologies worked together in a more collaborative way. It is very fragmented in that way, unfortunately.

Mr. Colin Carrie: Go ahead, Mr. Lizon.

Mr. Wladyslaw Lizon (Mississauga East—Cooksville, CPC): Thank you very much.

I have two minutes, so I'll ask the question quickly.

I have a question for Dr. Bohm. It's not directly connected to your presentation, but what I want to ask you is more on the technical side about knee and hip implants or artificial knees and hips. How have they developed over the years? Where are we heading? What would you like to see in the future for those implants?

Dr. Eric Bohm: That's an interesting question. Thank you.

In the ideal world we would get to the point where we wouldn't have to do hip and knee replacements, where we can prevent the progression of arthritis. That would mean the early detection and treatment of osteoarthritis, and early detection and treatment of inflammatory arthritis, such as rheumatoid arthritis. If they get there, however, the ultimate goal would be to develop a hip or knee implant that patients are completely unaware of, that functions normally, and that lasts patients for the rest of their lives.

There are two main areas we look at now. In knee replacements—you may remember that data I showed you there—about 5% of knee replacement patients aren't happy with the result. It doesn't feel like a normal knee. It clicks and catches, and they have aches and pains. It's a bit unstable and doesn't feel like a normal knee. I think we have a lot of work to develop implants that feel more normal, particularly in knees. The other issue is longevity. These eventually wear out. I had some pictures showing broken implants and rod implants, so there's a lot of work being done right now to improve the bearing surface—that's what we call it—to improve longevity. We've made a lot of headway there.

The last issue that we have to deal with is the ongoing issue of infection. That is, infection at the time of the operation and even late infections five or ten years down the road. I think we'll be developing implants that help reduce the chance of infection. Those are the three main areas.

● (1225)

Mr. Wladyslaw Lizon: Where do we stand in comparison to the rest of the developed world?

Dr. Eric Bohm: In developing implants, we stand behind the rest of the world. We're hoping to change that at Concordia. A lot of the product development happens in the U.S. and in Europe, but I think we have a unique opportunity in Canada because we have a very close community of orthopedic surgeons who tend to work together quite well. We're developing a stronger Canadian joint registry, implant retrieval networks, RSA analysis, and so forth. So we're in a very good position to develop those implants.

The Chair: Thank you very much.

These questions have been very helpful. Thank you, committee.

Dr. Sellah, you're next. I understand you have a motion you're going to read.

Go ahead.

[*Translation*]

Mrs. Djaouida Sellah (Saint-Bruno—Saint-Hubert, NDP): Thank you, Madam Chair.

I would like to give notice of the following motion:

> That the committee spend at least five meetings conducting a study on the social determinants of health in order to review and assess the evidence showing that social conditions play a pivotal role in health; to confirm the social or economic conditions that affect the health of Canadians and, to the extent possible, to quantify that impact; to identify the effects, including financial, of those determinants on Canada's health system; to make recommendations on how to address those determinants to improve the health of Canadians; to make Canada's health care system more sustainable and more affordable; and to report to the House of Commons.

Thank you, Madam Chair.

[*English*]

The Chair: Thank you.

I must tell you that you need 48 hours' notice. We can deal with it on December 4.

Go ahead. You still have time for questions.

[*Translation*]

Mrs. Djaouida Sellah: Thank you.

My question is for Dr. Fotti. I listened to your presentation very carefully. I think what you're doing is wonderful because your approach is aligned with what we're trying to get now, patient-centred care.

I would just like you to clarify something for me. Is your clinic similar to Quebec's family medicine groups, or FMGs, introduced by the province as a pilot project? If so, I'd like to know whether you receive any funding from the local government. In Quebec, for instance, we had a bad experience with Rockland MD radiology clinics. It cost us dearly, and we wouldn't want to get into a situation where we're robbing Peter to pay Paul. I also heard you say you were helping out hospital systems. I'd like you to elaborate a bit more on how you do that.

Thank you.

[*English*]

Dr. Christopher Fotti: Thank you.

My clinic model is fee-for-service. We don't get any support or funding through any public sources, with the exception, in Manitoba, of the electronic medical record program. The idea is for physician offices to convert from paper to electronic records. We do receive some funding from them to maintain and implement our electronic records, but the income for physicians and the clinic is through fee-for-service billing.

I know alternative funded models are also a very important part of this document, because there is a lot of good evidence that if the physicians are remunerated more in an alternative funding arrangement, like bloc funding or something along that line, they don't have to worry about seeing so many patients.

We're quite lucky that all of our doctors make a good living, so we don't need to see 40 or 50 patients a day. We all probably see around 20 to 30 patients a day, which over a regular work day does give enough time, for the most part, to address patient issues in a proper fashion. Obviously, the more people you see, the less that is true.

In some fee-for-service clinics, the doctors may be seeing 40 or 50 patients a day. Unless you're working until 10 o'clock at night, that means the time is short with the patients. So you definitely have to find that balance.

We don't receive any direct funding other than for the electronic records. For a hospital kind of disposition, our patients have access to us after hours. For that matter, any patient in the area has access to us after hours for our walk-in.

I do a lot of emergency room work, too. In an emergency room, if I'm not sure that the patient is going to get followed up properly or that the test they need, but not urgently, will get done or not, I tend to order it in the emergency room to be on the safe side.

When we have our own patients, I know that if you come in to see us, I can get you to see your regular doctor tomorrow morning, if needed, to follow up on things, or come back in a week and follow up on whatever treatment we started, as opposed to jumping the gun and having to do more unnecessary tests in hospital. Again, in a hospital emergency room, if the doctor is not sure you're going to get proper follow-up treatment, you tend to do more in the emergency room than you probably would otherwise.

● (1230)

[*Translation*]

Mrs. Djaouida Sellah: I gather, then, from your answer that your clinic model isn't really the same as Quebec's FMG model. As you mentioned, when you're in a packed emergency room, you can recommend that patients go to a clinic for more lab work and better follow-up. Is that right?

[*English*]

Dr. Christopher Fotti: Yes, that's correct.

The Chair: One more minute.

[*Translation*]

Mrs. Djaouida Sellah: I will use my time to ask Dr. Kerr a quick question.

You started talking about prevention for drug users. I want to give you a chance to elaborate on that.

[*English*]

Dr. Thomas Kerr: I think we have to distinguish between two types of prevention. One is primary prevention, where we try to prevent people from initiating drug use in the first place. In that regard, we're doing poorly. We invest in programs that have been shown repeatedly to be ineffective, particularly programs that try to create fear among young people by telling them that if they start using drugs they'll live a very short life. Those programs have been well evaluated and shown not to be effective.

The primary prevention programs that do work are the ones that intervene early on in children's lives, in unhealthy family environments and such.

The secondary prevention that I was referring to is more about preventing disease and death and other comorbidities among people who are already using drugs. That's where we are really doing a miserable job. The evidence is in Saskatchewan, where we have an epidemic that's out of control for which there are effective preventative measures that—

The Chair: I am sorry, Dr. Kerr. I have to cut you off. You're way over time, but thank you for what you have said. I know it's hard to live within the time constraints, but I try to be fair to everybody.

We'll now go to Mrs. Block and Mr. Lobb. Mrs. Block, will you start?

Mrs. Kelly Block (Saskatoon—Rosetown—Biggar, CPC): Thank you very much, Madam Chair, and I'd like to thank all of our witnesses for being here today.

I want to focus my questions to you, Dr. Fotti, just in terms of the...I guess it's a medical clinic you created. I want to establish what the difference is between your clinic.... Your website states you're trying to offer excellent care “in a spa-like but technologically advanced setting”. Can you just describe that a little bit more for me?

Dr. Christopher Fotti: Yes. When we designed our clinic we wanted it to be a nice place to work. In some of the other clinics I worked at in the past, you went into work and you got depressed a little bit because of the paint scheme and all that kind of thing. When we did our clinic, we put a little bit of extra design into it. We get a lot of comments, including a recent comment I had from one of my patients who's dying of cancer. He was coming in to get some more pain medicine. He doesn't have a heck of a lot more time—a few more months. He's in with his wife and his son, and he said, “You know what? When I come here everybody seems happy. It looks nice.” He said, “I don't feel like I'm going to see my doctor to get pain medicine for the cancer that's going to take my life.” He said he feels like he's just coming to talk to a friend.

So we get a lot of comments from our patients that the setting, the visuality of the clinic, makes them feel at ease, and sometime it makes the office experience, where you have to give bad news and all that kind of thing, a little bit easier. Plus it's just nice to work in a nice place.

● (1235)

Mrs. Kelly Block: I have just one other quick question and then I'll turn it over to my colleague. You may have mentioned this in your opening remarks, but I just want to go back and find out. What kinds of technologies does your office have that perhaps other family physicians' offices may not have?

Dr. Christopher Fotti: I think a lot of family physicians' offices probably have somewhat similar technologies, but we're all fully electronic. All our records are fully electronic. All the interface is electronic. Our interface with our pharmacy is all electronic. We have portable ultrasounds and Dopplers. We do some more specialized tests in the clinic, such as ankle brachial indexes for perfusion to the feet. Then we partnered with some other businesses to get the X-ray clinic, which is technically next door to our clinic, and not only just to have it but so that it links to us electronically instantly, so that we can instantly review test results and things like that.

A lot of clinics may have X-rays and other kinds of things there, but that sort of instant electronic communication may not be there, and that's very key. If I see you as a walk-in and I think you need an X-ray to help me make a diagnosis—maybe I think you have a fractured hip or something like that—you can get your X-ray. If I'm not sure, I can talk to the radiologist right then and there. If your hip's fractured, then you're not really for the walk-in, but we'll get you off to the hospital with all that information already done.

Mrs. Kelly Block: Thank you.

Mr. Ben Lobb (Huron—Bruce, CPC): My question is for Dr. Bohm.

When I first started my working career, I worked in the auto industry. Obviously, Lean initiatives and Six Sigma are ingrained in the corporate identity. From the shop floor worker who starts day one, it's safety, and then it's pretty well on to Six Sigma and Lean and finding initiatives to improve efficiency.

Can you give us a better idea of how ingrained this is coast to coast in the medical profession, the health care industry? What is it going to take to help continue to develop these opportunities for improvement?

Dr. Eric Bohm: It's a good question. Thank you.

From my perception, what I see is pockets of this sort of philosophy developing across Canada. There are small pilot projects. I think you've heard about that already today. Hospital organizations are embracing this. I think we're seeing pockets of that across Canada. There is some progress towards tying these people together into larger groups to share their experiences and their challenges, and to help promote that uptake across.

I do think it's a challenge. Michel and I were talking about this last night in the taxi, actually. It's almost a cultural shift. You're embracing a new way of delivering care, of tracking outcomes, of reporting on outcomes, and changing the care you deliver and acting on the data. We were talking about how you start that culture change. I think that's the most important thing and the biggest challenge. I think we'll get there with these groups of people working together.

Mr. Ben Lobb: I was glad to see that you put the book *Theory of Constraints* up there. That's pretty well every manufacturer's bible, I think, in the industry, so I was glad to see that you put that in there.

Dr. Eric Bohm: And it's so simple.

Mr. Ben Lobb: Yes.

I have just one quick question for Dr. Fotti. I know my time's running short.

One of the concerns I have with Infoway and the digital initiative we have coast to coast here is just what you touched on: the integration of all the different systems. We've heard different witnesses give conflicting testimony. But I also heard from the software industry, and I know that this is a big issue. You've already felt it in your own practice. What can we do to get ahead of this pending problem?

● (1240)

Dr. Christopher Fotti: That's a good question, and I don't think there's a very simple answer.

The best way would be for everyone, as a whole, to negotiate for either one system or systems that can fully communicate properly with each other. Right now we're just so fragmented. Our system can actually communicate with their system, so we could actually transfer your records from my records to the other vendor with no problem. The records would go in and populate appropriate spaces and all that, but they don't have the technology to do it the other way around. So whether you're using one vendor or you're using multiple vendors, the vendors' mandate, when you're getting them to quote for your areas and regions, has to communicate with all of these different types of things, and list out eChart and X-rays and whatever it is you think is important for your area. It has to communicate.

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

Now we'll go to Dr. Morin, please.

[*Translation*]

Mr. Dany Morin (Chicoutimi—Le Fjord, NDP): Thank you very much, Madam Chair.

My first question is for Dr. Tétreault.

Thank you kindly for your presentation. I found it fascinating. I also want to commend you for the great work you're doing in your hospital.

In your presentation, you offered a number of solutions and initiatives that I think fall more within the province's domain. I would like to hear what the Government of Canada can do, within its jurisdiction, to support your mission and your initiatives, while respecting provincial authority, of course.

Dr. Michel Tétreault: Thank you for your question.

I am suggesting support for research and education provided by university partners on a subject such as Lean transformation in health care. As I understand it, that is not solely a provincial responsibility.

Yesterday, I was having breakfast with the dean of the University of Manitoba's Asper School of Business. The reason I met with him was to ask him to set up the partnership, to encourage people to come and benefit from learning opportunities, and to send us research candidates, all for the purpose of broadening what we know about this field. We have questions about how we're doing things today, what is working and what isn't. People in the business and health worlds need to come together so we can learn together.

The ultimate goal is to incorporate this more business-oriented learning into the curriculum taught to every health professional. The business educators at Montreal's HEC and the Asper School of Business want to develop curriculum on health-related business practices for their candidates. And I think the federal government could contribute to that.

Mr. Dany Morin: Thank you very much.

[*English*]

My next question will be to Mr. Racette.

In your presentation you briefly talk about a national health agenda. Could you describe in more detail what it would include?

Mr. Ray Racette: The majority of the national agenda is on quality and safety, so it's identifying a number of patient safety or quality issues that nationally they want to work on. The safety of medication for the elderly is very large. Care of the elderly is a very large national agenda. They're already old, but they're also aging, so how do they manage that?

There is the use of technologies. We talked about Lean. They are a very savvy system, in terms of being very efficient with their processes.

One of their big issues is how to manage wait-lists, but when they talk about wait-lists, they're not talking about five things; they're talking about wait-lists for every type of specialist, every type of thing that somebody will need to queue for. So their goal, really, is to be very smooth and very short on wait-lists, regardless of what they are for. They have a requirement that if they don't meet wait-lists within 30 days, that patient can be cared for in another country and they have to pay for it.

Those are the types of things they work on within the national agenda.

Mr. Dany Morin: What I'm mostly interested in is whether we in Canada could have a federal national health agenda, or whether that can apply only to Sweden and we cannot have a similar agenda or strategy here.

Mr. Ray Racette: You could look at another country that has the same kind of constitution as Canada—Australia. In the first place, in the Australia Constitution Act of 1901, they established the role of the federal and the state governments. They have the same distribution of powers, but they have standing structures in place that create linkages. Or you could talk about a national agenda. They have a standing committee on health, which is made up of all the federal and state ministers of health. They meet on a regular basis, not just occasionally.

Second, the deputy ministers of health, federal and state, all meet through the Australian Health Ministers' Advisory Council. They advise the ministers, but together they have been able to achieve a national consensus on the reform agenda for Australia. They have one issue that we don't have in Canada—in Australia the states cannot tax for health care, whereas in Canada the provinces can. You can imagine how hard it was for them to create a discussion in which the federal power owns all the taxing powers, while the states own all the responsibility for delivery. Despite that bigger difference than what we have in Canada, they were able to achieve structures that allowed the discussion to occur.

● (1245)

Mr. Dany Morin: That's interesting.

I was highly surprised when you mentioned that in Sweden they spend less but they get more bang out of their buck. Are there ways we can also be more efficient in Canada, some concrete ways? If we're talking about federal jurisdiction, all the better, but how come our health systems are so rusted?

Mr. Ray Racette: They have been able to create capacity across all the settings. They look at the home as a setting of care. They look at housing as a setting of care. They look at all the different options where they have patients, and they work very hard on making sure the patient is in the right setting. They have to balance a few things, cost and quality and safety, but because they look at all the opportunities for where the patient can be, and they insure in all of them, they do a much better job of putting the patient in the right setting.

We struggle in some ways because we only insure in certain settings. Patients want to be in settings where they don't need to pay out of pocket, and many of those settings are already congested. They have done a better job of looking at all their opportunities for where the patient could be, and they have created options for the patients to be in those settings. In particular, they maximize care in the home. Their hospital beds are only slightly less costly than ours. And their nursing home beds are a lot lower—patients are really cared for where they can't be in the home setting. We know the patients value that, but the system also supports it if the patient can be there.

Mr. Dany Morin: You mentioned that in Sweden 97% is public funding. We see a new trend in Canada of having individual patients pay more in several ways. Compare the two approaches, and give me your opinion on where private money is appropriate or if we should stick to public funding.

Mr. Ray Racette: They've been able to demonstrate that you can have a complete system and do it on essentially 100% public funding, so there is evidence that you can actually make it work in a heavily public funded system.

In Canada, 30% of our spending is private, and that is growing as the public system gets more constrained. But one area they fund that we don't is dental care. They provide dental care to the age of 19. They know that if you start off with good oral health, as you go into your adult years, you will be healthier for the rest of your life. We have that on the private side, and people who don't have private insurance end up losing on that proposition.

They do some things like that. They do the same with the elderly regarding oral care. When you are on a pension, you often can't afford it. They are quite strategic about what they invest in to keep people healthy. Their thinking on some of this public policy is pretty good.

The Chair: Thank you, Mr. Racette.

I am going to ask some questions now of the panel. This has been a very interesting panel today, very diverse on a number of levels.

Dr. Montaner and Dr. Kerr, thank you for your presentations today. I want to also congratulate you, Dr. Montaner, on your Queen's Diamond Jubilee Medal. It is well deserved. Congratulations.

I was very amazed, because I've known some of you very well over a very long period of time and have seen the kinds of things you're doing. This committee has been very brave in doing innovative study. What we attempted to do in the beginning was to look at processes all across our country to see and share the most innovative processes. It's like—I don't know if you've studied this—Ausubel's advanced organizers. The theory states that you piggyback on ideas and you understand where those ideas come from.

Along the way we've talked a lot about preventive medicine, in other words, dealing with people to live healthy lifestyles. We have an aging demographic, as you know. We have a population of children who are obese, so that is something that we have looked at. The committee has also looked at end-of-life issues, if someone is chronically ill, staying home as long as they can.

We've also found out that across the country the lines are blurred. It used to be that the doctors did one thing, the nurses did one thing, and the patient was sort of left out there. Now it has become a more collaborative circle where the patient is very much engaged in their health care. We've also seen in some of the northern areas that emergency responders, who we will have at the committee in due course, have taken on the issues when they make home care visits. They do IVs and things like that because there's nobody else around to do that. That happens up north in Nunavut and places like that.

What we are trying to do is look outside the paradigms that we generally had. I think today is just a classic example of people who have honoured us by coming here today and sharing best practices.

Dr. Bohm, one thing I know about is your clinic at the Concordia Hip and Knee Institute, which does amazing things with hips and knees. You had the same stream—I don't think you talked about it—where the doctors are so involved in terms of the design of better hip and knee replacements. I've actually gone into your labs.

Colleagues, if you go into their labs, they have rows and rows of hips and knees. I don't know if I ever want my hip and knee replaced. You look at that, and they're so interested in making it even better.

Could you speak a bit to that collaboration? It's quite unique.

● (1250)

Dr. Eric Bohm: Thank you for the opportunity. It's hard to cover everything we do in 10 minutes. We do have a very active collaboration between clinicians, surgeons, physical therapists, and our engineering colleagues as well.

We've developed several areas of interest. One is an implant retrieval and analysis laboratory. You can imagine that as new implants are developed, they can be tested in the laboratory but be put into patients and fail for some reason you haven't thought of. When we take these implants out, because we do the bulk of the revision work in Manitoba, we're able to put these implants into our retrieval lab and our engineers can actually look at them, look at reasons for failure, and we can learn from that.

The Chair: There's a collaboration with the surgeons as well on that, right?

Dr. Eric Bohm: Absolutely. We're very involved and have discussions. Our offices are beside each other, so I can walk down the hallway and talk to our Ph.D.s about the case I just did and how I thought it failed, and we can analyze it.

The other component, of course, is the testing of new implants and product development. We have some wear testing machines that we just got up and running two days ago. It's very exciting. We have a lot of laboratory equipment for testing and measuring of implants and surface wear and those kinds of things, again developed and supported by Western Economic Diversification. It's quite a good collaboration.

The Chair: Dr. Fotti, it seems that there's a synergy between your best practices at the Pritchard Farm Health Centre and with Concordia. You're doing different things, but the thread that I hear there is one of collaboration and being right on-site with people with different specialties, or special interests, as you put it.

I was talking to a doctor, a neurosurgeon, who has a child with cystic fibrosis. This boy is transitioning from being in a child setting to an adult setting for his medical care because he's turning 18.

I don't think the committee got a picture of the component you put in there, what you called a “spa setting”. That was kind of interesting, that when you go in there it has that setting, and it's done so cheaply. You even have pictures that are donated by people, who buy them from a local artist, and there are huge windows. Could you speak to that?

A lot of people I've talked to feel that their anxiety level comes down when they go into that clinic. Could you speak a little more on that? We've never had that described to our committee.

● (1255)

Dr. Christopher Fotti: Yes, certainly.

When we designed the clinic we wanted it to function very well and be a nice pleasant place to be in to work. I can relay the story of my patient with cancer that you've alluded to.

When people come in, if it doesn't look like a hospital emergency room or a doctor's office, they feel more comfortable. When people are really sick, something like that does put a smile on someone's face or makes them feel a little better about coming. I think that's a great thing.

The Chair: Seniors are happy that you don't have elevators. They've told me that they hate those elevators and they love the big windows.

This is a component that we don't generally talk about in health care, and I think it's important.

Dr. Christopher Fotti: Yes, I think it's pretty important overall for everyone, including the staff. If we have good staff and good doctors, and if it's a pleasant place to be in, we'll have less turnover. That's what you want for the patients ultimately.

The Chair: You're from St. Boniface, Dr. Tétreault. I feel very compelled to ask you about your assessment. You don't hide the fact that you want to get better every year. Could you elaborate a little more in the time that we have, the next minute actually, about the checks and balances in your own hospital and asking the patients how they feel about patient care? I know a lot of us have gone into hospitals where we wish somebody would ask us.

Dr. Michel Tétreault: Having been a patient myself of one of Dr. Bohm's colleagues—after five months in a wheelchair I walked here from my hotel this morning—I have to say they do great work. That's the voice of the customer, but I don't want to end up in his retrieval lab somehow.

We actually did a school for 28 people from Quebec, Belgium, and Switzerland last summer, and the comment that came back the most often was, “You guys measure everything.” So we do. That has been said today, but it is essential if we want to get better. Yes, the only ambition we have is to be a better hospital next year than we are this year, and a better hospital the year after that.

One thing that I think is critically important...and we're part of a Lean network of 60 organizations—sadly, only about five Canadian organizations—but not everyone in that network does what we do, which is our default position. It is that any improvement work we do will include a patient or family member, unless there's a specific reason not to. That has been extremely powerful for us, so it's not only measuring, but it's also listening to the people who know.

The Chair: Thank you so much.

I must say, Mr. Racette, that you've always been so innovative in your thinking.

Dr. Montaner and Dr. Kerr, I learned a lot this morning from what you said, and I really appreciate that your results speak for themselves.

I think we've had an amazing committee this morning. I want to thank my colleagues for their very insightful questions, and I want to thank again our very learned guests for coming today.

With that, the meeting is adjourned.

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