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Mrs. Joy Smith

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● (1530)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): Good afternoon everybody and welcome back. Nice to see everybody back from the break. We call it a break but we come back more tired than when we were here during session. It's so busy during break, isn't it?

I would like very much to welcome our guests today. We're studying technological innovation. It's a very important study. We have with us from the Canadian Doctors for Medicare, Dr. Danyaal Raza, board member; and from the Public Health Association of BC, Dr. Marjorie MacDonald, president.

Dr. MacDonald, I understand you have a PowerPoint.

I'm going to begin with you today. You have 10 minutes to make a presentation.

Dr. Marjorie MacDonald (President, Public Health Association of BC): Thank you very much. I really appreciate the opportunity to present to this committee today.

My name is Marjorie MacDonald and I'm representing the Public Health Association of British Columbia. I would like to acknowledge my colleague and vice-president, Dr. John Millar, who did much of the background work for this presentation. He was not able to come today to do this presentation, so I am doing it in his place. I hope I can do as good a job as he might.

The Public Health Association of BC is very concerned that health care financing in this country is becoming unsustainable because health care expenditures may begin to be outstripping government revenues. At the current rates of increase, it's predicted that expenditures will increase from about 40% of provincial spending currently to about 80% in the year 2030. So something does need to be done to address this issue now.

With respect to health care sustainability, there are three interrelated burning platforms that I want to speak about. These are all interconnected, and of course, they then connect to the solutions that I want to talk about as well.

The first of these is that the general health of the population is decreasing, and at the same time there are rising inequities in health status for some population groups in the country. The prevalence of chronic conditions has increased considerably over the past decade. The burden of most of these is preventable. For example, there's been an increase in the prevalence of heart disease by about 80%, some cancers by about 50%, diabetes by about 78%. Perhaps more worrisome is the fact that the prevalence of chronic diseases among the disadvantaged and marginalized segments of the population is much higher, so that is something that we do need to worry about. With the increasing prevalence of chronic disease, that can lead to decreased productivity of the labour force and a reduction in economic competitiveness.

The second thing is poor patient experience and quality of care. We've been hearing a lot that people have been complaining that their experience in the system has deteriorated and the quality of the care they are getting is not what it used to be. Most of the care for chronic conditions in this country is provided through a primary care system that was developed a long time ago to address the primarily acute conditions that were prevalent at that time, before the shifting transition to more chronic diseases in the population. Many arguments have been made that this really is the wrong business model.

In Canada our primary care system falls below a standard of care that's been achieved in high-performing systems in other locations, and leads to unnecessary hospitalization and expenditures. Related to that we know there's lack of access and attachment to a primary care provider for many people in the country. There are complaints about lack of coordination and continuity of care in the system. Information flows are impaired. Patients need to return to their physicians more than once to get prescriptions refilled, to get their lab test results. There is the lack of interoperable electronic health records, so information is not accessible from one segment of the system to another. People have short office visits with one problem per visit. That doesn't work when there's significant co-morbidity and very complex problems. In addition, it makes it difficult to deliver evidence-based prevention and care with this kind of system. It also means there's limited accountability back to the community and to patients, and limited patient engagement in governance of this system.

● (1535)

The third thing is the increasing cost of health care. I'm sure this committee has heard about that many times.

Government revenues are declining overall. There's the belief that small government is better government, that lowering taxes is a good thing, and that the industry needs to be deregulated. There is concern in the system about waste, errors, and inefficiencies. We know that the population is aging and that with an aging population the prevalence of chronic diseases is increased. With that, there's an increased burden of chronic diseases, as I've already mentioned, and much of that burden is preventable.

With these three interrelated problems, the solution is also a triple aim solution: to improve population health and reduce inequities, to improve patient care, and to reduce costs.

With respect to improving population health, a very important solution is to increase the investment in prevention, both primary prevention and secondary prevention. We have evidence now emerging that prevention can be very effective in reducing costs in the longer term. It will improve population health and thereby increase productivity.

To do this, however, we will need to address the social determinants of health. We need to address things like poverty and inequities, food security and food safety, homelessness, and early childhood development. That's a very complex task and raises many challenges.

I am going to go back and talk for a minute very briefly about some of the evidence that prevention is effective. Recent economic analyses have shown that a prevention strategy that's based on enabling healthier behaviour and creating safer and supportive environments and living conditions can slow the growth and the prevalence of disease and injuries and alleviate the demand on a limited primary care capacity.

For example, one study has shown for every 10% increase in public health spending, deaths from cardiovascular disease declined by 3.2%. This represented an increase in spending of only $312,000 U.S. at the local health agency level. To achieve the same reduction in cardiovascular disease deaths through clinical care interventions, we would have to invest $5.5 million. That's 27 times greater than public health spending, so there is a good return on investment for prevention strategies.

I don't think I'm going to talk about the next slide, because I might go over my 10 minutes if I do, but essentially it's a graph to demonstrate that enhancing prevention can, not initially but over the long term, reduce costs.

To address the second aim, it is important to develop and transform the primary care system in this country to a community-based primary health care system. To do this, there are six basic requirements that are based on the evidence.

We need to provide services within a defined geographic population so that everyone in the area has access to services. We need to provide a comprehensive range of services beyond what's provided now in our primary care system. We need to be able to address the social determinants of health; clinical prevention; the complex care co-morbidities; and end-of-life care.

What that requires, then, is that we do a much better job of bringing together a network of professionals: general practitioners, nurse practitioners, pharmacists, public health professionals, mental health and addictions professionals, and social agencies. We don't see very many primary care organizations in the country now that are able to offer that network of services and professionals.

We need alternative funding arrangements to provide incentives to enhance prevention, to encourage collaboration, and to use data and data systems that can inform care. A blended funding model is often suggested as the strategy to go forward.

Also, we need electronic data systems. These are essential to be able to achieve the benefits and efficiencies and to be able to access individual patient data as well as population health information in order to inform care.

We also need a shared governance structure that allows people in the community a say in what they need and a say in how their services and care are provided.

● (1540)

I'll turn now to possible government responses.

I've just noticed an error in my presentation. I meant to indicate that small increases in taxation have some public support, not strong public support.

A recent report by the Canadian Centre for Policy Alternatives in B.C. illustrated that small increases in taxation would produce a minimal burden on individuals and yet provide a significant revenue stream that could be used for health and social services.

Another would be healthy public policies. These are policies that go beyond the health care system and governance of the health care system to include a whole-of-government approach. The purview of some of these strategies and policies are outside the health care system at large.

For example, one strategy would be an obesity reduction plan. We need strong leadership at the federal level to promote government action to reduce calorie consumption. We could do such things as change agricultural policies, have point-of-consumption notices of caloric content in food. We could tax sugar sweetened beverages, ban marketing of junk food and beverages to children, and implement a salt reduction strategy. All of these things could lead to a reduction in the burden of chronic diseases.

Early childhood development and care, poverty reduction strategies, all of those things would be very important.

I don't have time to go any further into all of those, but more details are available on request in our larger report prepared by Dr. Millar. It is available if anyone is interested.

In all of these strategies, what is very important is measuring, monitoring, and recording. What gets measured gets done. So we need to develop common metrics, a coordinated pan-Canadian strategy that would develop indicators and databases to measure progress on these strategies. This type of thing is already the responsibility of CIHI, the Canadian Institute for Health Information, so infrastructure's already available and in place to begin this.

I'll just leave it there. I'll take any questions.

● (1545)

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

We will now go to Dr. Raza from the Canadian Doctors for Medicare, please.

Dr. Danyaal Raza (Board Member, Canadian Doctors for Medicare): Thank you and good afternoon.

My name is Dr. Danyaal Raza and I'm a family doctor here in Ottawa. I'm here today on behalf of Canadian Doctors for Medicare. We are a physician-led organization supported by thousands of Canadians, and we advocate for the improvement of our public health care system.

Thank you for the opportunity to appear before this committee and for allowing us to contribute to your study on health and innovation.

As a physician, I see the effect that innovation has on a personal level in my practice and with my patients. Today I'd like to start with a focus on the human side of innovation and the critical role it plays in making the best use of the technology that we have. I'll then discuss why it's an area where Canada has been falling behind despite our investments in research and technology. I'll end by encouraging the committee of the important role the federal government can play in encouraging health care innovation through the renewal of our health accord in 2014.

Canadians are fortunate to have access to some of the most cutting-edge technology available, but its utility in and of itself is limited. Its potential to improve the health of Canadians is only realized if the professionals using it are finding smart ways to put it to best use for patients.

An e-consultation project here in the Ottawa region is one such example. It's having a dramatic impact on the way patients experience their health care and on their health itself. Before this project began, family physicians seeking specialist input for a complex health issue typically sent a paper referral via fax to the consultant. This e-consultation project is bringing this process into the 21st century. Now an Ottawa primary care physician like myself has the option to do something entirely differently. To a secure online portal, they send the specialist details of their patient's health history along with the questions around the unresolved health issue. Rather than waiting the average three and a half months for a patient to see the specialist, the project has reduced turnaround times of the consultation to less than one week.

In addition to drastically reduced wait times, the e-consult project has resulted in the elimination of 43% of traditional paper referrals that would have been done otherwise by in-person specialist visits. For referrals that were still needed, family doctors were better able to prepare specialists through suggested lab tests and other diagnostic studies.

The project improves access to care, and both primary care physicians and their specialist counterparts feel that they're better able to determine what's best for their patients, and they feel that they're working together efficiently. Clearly this is the kind of innovation that both reduces wait times and saves money, but it also requires that e-consultation now be included in payment models for physicians. It's also a question of how we can spread this practice to other provinces and cities, not just Ottawa.

There are also other innovations that focus on coordination and interdisciplinary collaboration to provide more efficient high quality care for Canadians. Many of you also know about the success of the Alberta Bone and Joint Health Institute, where innovative approaches to hip and knee surgeries resulted in drastically reduced wait times. They decreased from 82 weeks to just 11 weeks. How? Through methods that included centralized intake of patients, assessment diagnosis, non-surgical treatment in single purpose clinics, and the use of multidisciplinary teams.

For example, if a patient needs to improve strength to be a candidate for surgery, a physiotherapist works with them to create a pre-operative strengthening program. Dieticians work with patients who need to make weight or nutritional improvements. Most importantly, there was a willingness to try something new. It took a little bit of investment but the payoffs were huge.

A virtual ward project in Toronto is another innovation that requires changing the way that we work. Patients who are at high risk for being readmitted to a hospital are provided with an around the clock care environment at home similar to that found in hospital. As virtually admitted patients to a hospital, they're able to call their care team with concerns until being transitioned to their regular doctor. It has helped keep patients physically out of hospital, has connected them to community care, and has prevented them from falling between the cracks.

As you can see, innovation isn't just about the newest developments in technology. Often it's about finding better ways to work together and to use the tools and technology already at our disposal. It's fundamentally about changing the way we approach health care, moving towards integration, coordination, and collaboration.

How do we do this, and what can the federal government do to improve the use of innovations in Canada?

Well, to move forward, we also have to look at what we've done so far. The 2004 health accord recognized that investments in science, technology, and research were necessary to support innovation. The federal government made some fruitful investments in this area. But the accord also recognized the importance of new models of care, including prevention and chronic disease management, and it’s in this area of innovation where Canada has been falling behind.

● (1550)

The Senate Standing Committee on Social Affairs, Science and Technology noted the lack of progress in its report “Time for Transformative Change: A Review of the 2004 Health Accord”.

The committee chair, Senator Ogilvie, stated that the system is “replete with silos, with no overall accountability, and that true innovation is rarely recognized and implemented within the system”. He stated:

> It is critical that the additional funding added to the health accord…be largely directed to developing and implementing innovative models that actually deliver a modern whole-life health care opportunity to Canadians.

The committee recommended a number of ways to address this shortcoming, including both federal funding and federally led networks to identify and scale up innovations and best practice models in health care delivery.

Canadian Doctors for Medicare has repeatedly called on the federal government to get more involved in the sharing of health care innovations. Canadians are currently without any signals from the federal government that there will be another health accord despite the need for united action on these priorities. We'd like to ask this committee to support a 2014 health accord in any of its recommendations on this subject, and to make sure that innovations are shared and that all provinces are benefiting from them.

One way to do this is to reverse the shift to a per capita tied-to-growth funding model, where less populous provinces may not have the funds to keep up with technological innovation. We also propose that Canada develop an umbrella for innovation and echo the Senate's call for federal funding and coordination to do so. The creation of a body that looks at innovation from a national perspective instead of piecemeal by province is critical to this effort.

The Health Council of Canada is currently tracking some of the best practices in the country through its innovation portal. With a broader mandate that includes funding and scaling up of those best practices and innovations, it could be part of that solution.

We also suggest a national body tasked with continuously reviewing evidence on new medications, diagnostic tests, and other interventions. By issuing guidance to health care providers on these matters, free of industry bias from pharmaceutical companies and medical device manufacturers, similar to what the National Institute for Health and Clinical Excellence does in the U.K., the quality of Canadian health care would improve and cost savings would be achieved. This is already happening on a smaller scale through the therapeutics initiative in British Columbia. When it comes to innovation, the federal government must be involved in setting standards and applying the best of our knowledge throughout the country.

Although some provinces have shared their innovations, Canadians believe it is up to the federal government to make sure that innovative care is available to all, not just some, and we need a 2014 health accord that makes innovation a funded priority for all Canadians. We urge this committee to consider a strong federal role in innovation that forges partnerships with the provinces to deliver the best in health care for all Canadians.

Thank you for your time.

The Chair: Thank you.

We'll now go to Ms. Davies for the first seven-minute round.

Ms. Libby Davies (Vancouver East, NDP): Thank you very much, Chairperson, and thank you to both witnesses for being here today.

You've given us an excellent overview of the bigger picture of what we're facing in this study on innovation. We've had some terrific examples of innovation that have taken place, but I think both of your presentations today have highlighted the need for us to get beyond the pilot project syndrome and to approach this in a much more national, pan-Canadian way.

In fact, Dr. Raza, I know one of your colleagues. Dr. Ryan Meili from Saskatchewan, wrote a terrific book about this. One of the things that I'd like to use from his book is he talks about the need to scale up at a national level all of this amazing work that goes on locally but often in a very isolated way.

I have a couple of questions.

First of all, on the accords, this is something that we in the NDP have been very interested in, because we've been very disappointed that there hasn't been a willingness from the federal government to show that they're committed to following through on the accords or what will happen when they run out in 2014. I agree with you that we do need to have a new set of health accords, and we do need to have funds that are targeted to improvements in the system. Even just following through on the commitments that were made would be a huge step, but we need to be doing much more than that.

When you talk about a new body to oversee innovation, do you also see that there could be some kind of fund targeted to that, that would be the carrot in terms of encouraging provinces to get on board?

The other question I have is, Dr. MacDonald, in the brief from the Public Health Association of B.C., I'm very impressed with how you focused on what appears to be the simple issue of transforming primary care, the six steps that you outline, and yet it appears so difficult to do it. We know what needs to be done, but it's not happening. In fact, I would say that in Ontario there's a much better system of community health centres than there is in B.C. In B.C. it's very, very patchy. I wonder what suggestion you have that could bring the federal government into that in terms of transforming primary care along the lines that you suggest and making it that kind of multidisciplinary approach that includes prevention, health promotion, focusing on populations that are at risk, and so on.

How can the federal government zero in on the primary care? If each of you would like to address those questions, I'd appreciate it.

● (1555)

Dr. Danyaal Raza: Thank you for the question, Ms. Davies.

As I mentioned during my remarks, we already have some of the infrastructure to do what we're suggesting. The Health Council of Canada has already set up this innovation portal. They're already becoming a repository for best practices. We need to empower them more. We need to provide funding for provinces that are interested in benefiting from the innovations happening in other parts of the country.

We do this on two levels. One is this health services level, but one of the other bodies I mentioned was something equivalent to NICE, the National Institute for Health and Clinical Excellence, which is the U.K. body, in Canada. This is something B.C. has done with the therapeutics initiative. It's a body that assesses the effectiveness of new pharmaceuticals before they become funded by the province's formulary for publicly funded drug plans. After it was started, costs in that drug plan were reduced by 8%. This is with just one province doing this by itself. This is not something that's happening across the country. In fact, this could be part of a national pharmacare strategy as well, which is also something that would be quite innovative for the country.

If I could take a step back and talk about how we see the 2014 health accord collectively, we see this innovation piece as one portion of it, but we think a renewed health accord also has to have a few other important pieces. One I mentioned is getting away from the per capita funding that was announced a little over a year ago, because it penalizes small less populous provinces. If New Brunswick wants to buy an MRI machine, that's quite expensive for that province to do because of its size, and it won't have the additional funding to provide other health services because of the per capita funding.

We'd also like to see the federal government enforce the Canada Health Act. Every day we hear about more and more clinics that are charging illegal user fees. Helios Wellness Clinic in Calgary has been in the news. There's an inquiry regarding patients paying $10,000 membership fees to be members of this clinic and then jumping the line for colon cancer screening in a public system. The Cambie clinic in Vancouver is a private for-profit orthopedic centre, and it's been found to be illegally billing patients for publicly insured services. These are all violations of the Canada Health Act. We need to add some accountability to a health accord and make funding conditional on enforcing the Canada Health Act.

We also need to develop a shared set of priorities through the 2014 health accord. Writing cheques isn't enough; we need some national unity on this issue.

● (1600)

Dr. Marjorie MacDonald: It's a difficult question because of the fact that in Canada, health care is a provincial responsibility, so transforming the primary health care system is particularly difficult for that reason, and the role of the federal government then is somewhat difficult. As does my colleague here, I think the health accord itself could be a useful strategy. Tying primary care reform to the health transfers may be a strategy. As far as coming together with the provinces and the federal and territorial governments to come to some unity on this goes, I'm not really sure I necessarily have the answer because of the way our federal-provincial system is structured. That is going to be a significant barrier. It will require collaboration and lots of discussion bringing together various interest groups, like my colleague's group, the Canadian Medical Association, the Canadian Nurses Association, the Public Health Association, and a variety of groups to have some discussions about how we might move this forward.

The Chair: Thank you, Dr. MacDonald.

We'll go to Dr. Carrie now.

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

I would like to thank the witnesses for their presentations today.

I want to delve a little deeper. I don't think you had enough time to explain everything that you wanted to put into this study on technological innovation.

Dr. Raza, would you be able to explain for the committee how much your organization spends per year on technological innovation?

Dr. Danyaal Raza: Our organization is an advocacy organization. We're made up of a volunteer board of directors, and we have a very small staff. I think we have one and a half staff. We all practise medicine in our own settings, so we don't spend any money as an organization on technological innovation directly.

Mr. Colin Carrie: What unique innovative technologies has your organization developed?

Dr. Danyaal Raza: We're here in front of the committee because we're an organization that represents physicians across the country who are interested in improving public health care. We work in different settings that are employing these innovations. We're acting as a listening board for colleagues across the country to talk about these innovations and to present them to a number of audiences, including the committee today. That's our role in promoting them.

Mr. Colin Carrie: Thank you very much for that.

Dr. MacDonald, could you let the committee know how much your organization spends every year on technological innovation?

Dr. Marjorie MacDonald: Like Dr. Raza, we are an advocacy organization as well. It's a volunteer organization with a volunteer board. We have a very small budget. We do not spend any money on technological innovation.

Our role is to promote and protect the health of the public, so we make recommendations around what we as an organization believe will make a difference in doing that. I can't say we have spent any money on that or have a budget to do that.

Mr. Colin Carrie: Has your organization come up with any unique technological innovations that you could share with the committee today?

Dr. Marjorie MacDonald: That's not our role. We don't do that. We do not develop technologies.

Mr. Colin Carrie: Okay, but your members, do they utilize these technologies?

Dr. Marjorie MacDonald: Yes. Our members are primarily public health practitioners and leaders, and so in their roles as health care providers they may in fact utilize technologies.

Mr. Colin Carrie: Dr. Raza brought up the e-consultation that I guess some of his colleagues are using. We've heard from a number of witnesses who are doing things like telehealth, things along those lines. Do you and your members benefit or do they utilize some of these technologies like telehealth or anything along those lines?

● (1605)

Dr. Marjorie MacDonald: Some of them may well do that. We would certainly be supportive of those kinds of technologies. We believe it is very important to develop electronic health records and other electronic data systems that can be used to support practitioners in their work. Other than that, no.

Mr. Colin Carrie: You mentioned the challenges that the health care system has, the jurisdictional issues with the provinces being the ones responsible for the delivery of health care. I know they're working through the federation to try to come up with some agreements on where they'd like to go with it. What the federal government does, a lot of times, we do fund research. We've heard from partners and people who have come forward, witnesses, about their partnerships with the federal government research agencies.

I was wondering, with your organization, do you benefit from any government funding? Do you work with CIHR?

Dr. Marjorie MacDonald: Yes. Many of our members do as individual members. I myself am a professor at the University of Victoria and I hold a CIHR-funded research chair, so I am funded there in my role at the university.

The Public Health Association has received money from the Public Health Agency of Canada around workforce development and developing the competencies of public health professionals. We have benefited from funding in that regard.

Mr. Colin Carrie: Have they funded you or your members for any type of technological innovation specifically, or just what you said previously?

Dr. Marjorie MacDonald: I can't speak to that. We don't track what all of our individual members may be funded for, so I'm sorry, I can't answer that.

Mr. Colin Carrie: Thank you very much.

I have no other questions right now. Thanks.

The Chair: Thank you.

Now we'll go to Dr. Fry.

Hon. Hedy Fry (Vancouver Centre, Lib.): Thank you very much, Madam Chair.

I want to focus on what both witnesses have been presenting us with today, which is that innovation is not necessarily about using a piece of technology, that innovation is about creative ways of thinking, creative ways of delivering health care, and creative ways for making a more cost-effective and efficient system that provides quality care. I think that's what we're talking about.

You've brought forward ideas for innovation in the delivery of health care.

I must say, Dr. MacDonald, that you made an excellent case for what I think we've all been talking about for the last 50 years, which is the fact that 60% of disease is preventable and that if we moved to a prevention model we would be able to create healthier populations that wouldn't require health care, etc. That was in the past, but currently we are dealing with people who are chronically ill. We have increasing numbers of people with diabetes, as you said, and with heart disease, etc. I just wanted to congratulate you on bringing forward that innovation in terms of looking at the innovative way of dealing with healthy populations, which is looking at prevention, etc.

Dr. Raza, one of the things that interested me was that you talked a lot about the health accord. I know that the delivery of health care is a provincial jurisdiction, in other words, who delivers it, when, and where the health care is delivered, etc., but the accord brought together what is known as a transformative change and an agreement for cooperation between jurisdictions. That was what made the 2004 health care accord remarkable: premiers and the Prime Minister agreed that they were going to look at a flexible delivery of health care, and there were places where the federal government had a huge role to play, such as health human resources, pharmacare, etc.

In that accord, a big chunk of one of the objectives was looking at new ways of delivering health care. The federal government was indeed instrumental in putting money into that in terms of looking at community care clinics. I've been to some in Calgary, and I've been to some across the country, in which, as you said, it was a multidisciplinary model where people were looking at taking care of the chronically ill at the community level and therefore decreasing the amount of hospital admissions, and therefore costs, etc.

I just wanted to ask you about your e-consultation model. How exactly would that work? Would it mean that somebody would have to examine the patient physically, or would it be merely an e-consultation working on simple symptoms, etc.? How exactly would that work to ensure that diagnoses are made based on the examination of patients as well as talking to patients?

● (1610)

Dr. Danyaal Raza: As you know from your own work as a family physician, oftentimes when we make referrals to specialists we may not need the whole meal deal. We may not need a complete workup or assessment from them. It may be a referral just to answer a few questions.

We used to do this through what we called the hallway consult, when a lot of health care was delivered rurally or when family doctors practised more in-patient medicine or in-hospital medicine. Oftentimes we would stop a specialist in the hallway and ask him a few questions about a difficult case we were having, and that would prevent a referral.

That's a process this project is trying to recreate. There are always going to be some patients whose cases are very complex and are going to need more than an electronic version of a hallway consult. This project isn't about reducing those referrals. Think of a Venn diagram: it's more about getting that overlap in the middle. As you can tell, 43% of referrals were avoided, so that's quite a large overlap.

Hon. Hedy Fry: Did that result in bringing down wait times and bringing down laboratory costs?

Dr. Danyaal Raza: It's a decentralized model. If I'm in Ottawa and I'm putting in an e-consultation, it doesn't have to go to the specialist at the Ottawa Hospital, necessarily. It could be someone in London, Ontario, or someone in Windsor. There's not a lot of great data, as far as I understand it, in terms of how much it's bringing down wait times. I can't answer that question for you today.

Hon. Hedy Fry: Okay.

You mentioned the $10,000 cost for joining a clinic in Calgary. I really would like to hear more about that, because the concern here is that the federal government is not supporting the principles of medicare or the Canada Health Act. I remember the last federal minister who actually stopped a clinic from charging people for health care—

The Chair: Could I remind you, Dr. Fry, to keep your questions to technological innovation. I have heard very little about technological innovation.

Hon. Hedy Fry: Actually I'm responding to what the witness spoke about, clearly referring to this clinic in Calgary, and I wanted to comment on it. Is that okay, Madam Chair, if I comment on what the witness said?

The Chair: Be very careful that we centre on our study if you could.

Hon. Hedy Fry: I am careful. I'm trying to follow the witness's questioning and the witness's train of thought, Madam Chair.

The Chair: Yes.

Hon. Hedy Fry: I think that's what we're supposed to do at committee.

I just wanted to say that the ability to break the Canada Health Act is going to deter any kind of innovation being able to provide a public health care system that is following certain rules. Is that what you were trying to say with regard to the clinics that are now charging people to join, breaking the Canada Health Act?

Dr. Danyaal Raza: I was commenting on how spreading innovation, including technological innovation, is something that we feel the federal government should take strong leadership in, and as part of the federal leadership and the health accord, that includes the spread of technological innovation. It should also include the Canada Health Act. When its principles begin to be violated and we have more for-profit clinics, it makes it much more difficult to appropriately plan and to coordinate because there just becomes too many cooks in the kitchen. And we know that for-profit medicine is both more expensive and leads to poor health outcomes. It's not something the federal government should be allowing to continue. Enforcing the Canada Health Act is a way to stop the spread—

The Chair: Time is up now.

Is there any way we could get back to our topic of technological innovation? It seems to me what's happening here is we're trying to do a study on technological innovation to bring up new ideas, nobody's particular political platforms. What we're trying to do is get these new innovative ideas out there. So let's go on to Mr. Wilks.

Ms. Libby Davies: I have a point of order.

Madam Chair, I wouldn't have said anything but because you've made such a point of it, I would like to point out that from day one we were very clear that when we spoke about technological innovation we were also speaking broadly about practice and delivery. That was very much a part of our discussion on how this study would be undertaken. So I don't think anything has been out of order. I do find it very curious that only these witnesses are being kind of pegged with that.

● (1615)

The Chair: Now if we could add some technological innovation....

Ms. Libby Davies: They both spoke about things that are taking place.

The Chair: Maybe I'm missing it then. I just wanted to make a reminder.

Ms. Libby Davies: Then maybe we can go back on the record and look at it, but it was very clear.

Mr. Wladyslaw Lizon (Mississauga East—Cooksville, CPC): On that point, Madam Chair, I think we have a topic that said very clearly, technological innovation. Sometimes people are going off the topic that you allowed, but I wish you'd stay on the topic. This is the topic and it's very clear. Maybe the witnesses were not informed what the topic of the study is.

The Chair: Let's go to Dr. Morin.

[*Translation*]

Mr. Dany Morin (Chicoutimi—Le Fjord, NDP): Madam Chair, correct me if I am wrong, but it seems to me that, since the beginning of this study, we have been talking about new technological advancements and innovations in the health sector, and not just technological innovations. So the two can be viewed separately. Correct me if I am wrong.

[*English*]

The Chair: In February 2012 we adopted the following motion:

> That the Committee undertake a study of technological innovation, including best practices, in health care in Canada....

Are you interpreting this as best practices?

A voice: Yes.

The Chair: Okay let's carry on, thank you.

Mr. Wilks.

Mr. David Wilks (Kootenay—Columbia, CPC): Thank you, Ms. Chair, and thanks to the witnesses for being here today.

I'm from the southeast corner of British Columbia in the IHA region. You can feel sorry for me if you like. I was a member of the board of directors of the East Kootenay Foundation for Health as part of the regional district of East Kootenay, so I'm somewhat familiar with IHA and its delivery of primary health care in the Elk Valley, specifically to Sparwood, which lost its hospital in 2005 and went to a primary health care model.

Doctors have been in and out of that system throughout those years. It's been very hard to continue to retain them. Whether it be through the increase of taxation locally and a number of innovations that we did to try to keep them there, nothing worked. Once the incentive was gone, they were gone.

So I'm not one to think that taxation works because, as the mayor of that community for six years, I personally have seen it not work. What I did see work was once the primary health care model went to an opportunity to provide patients with things they could do to improve their health to avoid such problems as diabetes or obesity. A lot of those programs are provided within the primary health care model in Sparwood, anyway.

A lot of those things are found through electronic technology that we have that wasn't available even 10 years ago for that matter. What type of technology do you see in the future that is going to aid rural Canada with limited opportunities for physicians and/or nurses, for those clients who need to have access to the medical facilities they can't readily get to?

Dr. Marjorie MacDonald: That is a tough question. I think that e-health and telemedicine hold a lot of promise. Some of that has been piloted and tested in British Columbia and other parts of the country. I don't know much about that, not having been involved in it myself, but I do think that is one thing that will make a difference. In the Interior Health Authority in British Columbia, I think there's been some very interesting innovation in primary care with the integration of nurse practitioners into fee-for-service family practice. That has had some very powerful effects in reducing ER visits and hospitalizations, improving chronic disease management, and providing opportunities for people to have access to a primary care provider that they previously hadn't had. Those were all in rural settings. That isn't technological innovation in the sense of e-health and telemedicine, but it is innovation in service delivery. I think Interior has provided some leadership in that, and the rest of the country could learn from it.

● (1620)

Dr. Danyaal Raza: Thank you for the question, Mr. Wilks.

I've had some experience working in isolated communities. As a resident I spent a few months in Moose Factory, a community on James Bay. The technological tools that we used to access some specialist input were telehealth and telemedicine.

I also want to get back to your initial concern because I think it's a valid one. That's the shortage of health care professionals in rural communities. Telehealth is one of the best practices we can use to meet this demand. Studies have also been done, and I'm happy to connect you to them afterwards. To increase the health of the workforce in rural populations we need to also start recruiting medical students and future physicians who are from those communities. I think those are certainly other best practices we can share among our medical education systems across the country.

Mr. David Wilks: If I could interject on that, Madam Chair, that sounds good in theory, but if you have a doctor who has just come out of school, it's highly unlikely that they want to practise in a rural setting, where they cannot under any circumstances practise their trade. I mean, they want to be able to have hands on, and I can assure you, at least in my area, that is not the case.

As we move forward, in 20 years from now, Dr. Raza, as we all age and we live longer—and I'm sure that everyone in this room would agree that we are living longer—what are some of the innovations that you see will assist us in having that population stay out of the hospital setting and stay in home care, that would lessen the burden on the entire system by home care?

Dr. Danyaal Raza: One of the ones that I spoke about in my remarks, I think, is one that's moving in that direction. That's around providing better collaborative support for patients who have been recently admitted to hospital and who are frail, often elderly, who are at high risk for being readmitted to hospital. By setting up and putting more of an emphasis on community-based care, it helps keep them in the community as opposed to being readmitted to hospitals. That's important because it will save money, because acute care can be expensive, and it's also better care for the patients.

Mr. David Wilks: What is the patient doing at home in this setting? How are they interacting with those—

The Chair: I'm sorry, Mr. Wilks, your time is up.

We have about five more minutes until we go to our business meeting, so we'll go into the five-minute round with Dr. Sellah.

[*Translation*]

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

Before I get to my question, I'd like to make a comment, if I may. With all due respect to my colleague, Mr. Carrie, I found his questions about whether the witnesses were receiving money or not inappropriate. I just wanted to make that point, Madam Chair. Now, back to the topic in hand.

My question is for Dr. Raza.

I want to start by commending the two witnesses who are with us today. Their comments have been quite specific and relevant regarding the state of our health care system, a situation we are all very familiar with. They reconfirmed my impression of the health care system.

I know your organization considers the progress in primary health care reform less than significant. The issue was a key feature of the 2003-04 First Ministers' Accord on Health Care Renewal. Why do you think we haven't made much progress in reforming Canada's primary health care? What are the major barriers to that reform?

● (1625)

[*English*]

Dr. Danyaal Raza: I can speak from my experience working in primary care in Ontario.

In Ontario there have been some moves towards new funding models in order to improve access to primary care physicians. Traditionally, family doctors and doctors in general are paid fee for service, so there's been a move to capitate it, which means that doctors are paid for the size of roster they have per patient, and then they're also paid a percentage on fee for service to see those patients.

Then there's another model, which is the model that I work in. I work in a community health centre. It's a model that Ms. Davies alluded to earlier. Here we're salaried, and we have a slightly different goal. Our goal is to work with a more high-needs population, patients who don't speak English or French as their first language, immigrants or refugees, the homeless population. We're encouraged to spend more time per patient, because they tend to be much more complex, and we have a higher complexity as a result.

It's recognizing that there's not a one-size-fits-all solution for marginalized populations. The community health centre is a great model. For other communities it may be something else. It's a willingness to have funding to try these new reforms in order to address primary care.

[*Translation*]

Mrs. Djaouida Sellah: I have one last question.

Thanks to the input of all the witnesses who have appeared before us, we have learned that Canada is unfortunately a land rife with pilot projects. You may not know the answer to this. But what I'd like to know is how the government could take the lead in spreading these best practices to make sure that every Canadian, no matter where they live or how much they make, is able to benefit from those practices.

[*English*]

The Chair: Go ahead, either one of you.

Dr. Marjorie MacDonald: I think that is a difficult question. Why have we not made progress? I think it's a very complex issue. There are many reasons why I do not think we have made a lot of progress.

Change is difficult. You have a system that's been developed and has benefited people for many years, both patients and providers. It's difficult to shift from what we know, from what has worked, to try new things. The mechanisms and structures have not necessarily been supportive of making those changes. There are vested interests in the system, and some of those vested interests are very powerful.

I know there is a shift in the demographics in the health care provider population. More and more women are getting into medicine. There is an increasing desire among some in that group to look at alternative funding models because they don't want to practise medicine or health care in the way that it has been practised in the past. But that is very difficult for them to do for all kinds of reasons. Again, it's vested interests in the system.

I think everybody has the interests of the population in the communities and their patients' best interests at heart, but I just think it's very difficult to make those changes.

Again, I think it's the role of the federal government to take leadership in convening provincial and territorial governments to come to some agreements. That may be difficult, but I think it is important for the federal government to take some leadership in that.

● (1630)

The Chair: Thank you so much to both witnesses.

Just for your knowledge, one of the reasons we have done the innovative technology study is that we're trying to get a big report out that will show best practices across the country. We're also trying, all of this committee, to think outside the box. It is a very complex issue, as you say.

As you say, Dr. Raza, one size doesn't fit all. It depends on whether it's remote, whether it's urban; it also depends on the populations. Many variables come into play.

I think we all agree that this is a difficult, complex situation that we're looking at together. We appreciate your coming today.

Ms. Libby Davies: Madam Chair, I'd like to make a point of order.

I know that you're thinking the time for witnesses is coming to a close, but we haven't had a full round of everybody asking questions. Conversely, we don't usually have an hour for committee business.

I'd like to suggest that in order for more questions to be put to the witnesses who have come here today, including Dr. MacDonald, who has come all the way from B.C., we go for maybe another 20 minutes. We'll still have time for committee business. I don't think the bells will start until 5:15 p.m.

It's unusual that we wouldn't have a full round of questioning. We've done that for all other panels, so I'd like to suggest that we continue on. I'm sure we'll have adequate time for committee business as well.

The Chair: In actual fact, we haven't done that for every witness. We haven't had two full rounds. We're—

Ms. Libby Davies: No, I'm talking about one full round, not two.

The Chair: No, I know.

Ms. Libby Davies: We've only done half a round.

The Chair: Excuse me, but could I finish, please, Ms. Davis.

We haven't done the full-full round. We've made sure that everybody from all sides has had questions. What we need is to have the committee business, which we have started in other meetings and we have not finished. Today was more conducive to doing that, because we only had two witnesses.

But I'll take it to committee. Let's just see what everybody thinks.

Mr. Brown.

Mr. Patrick Brown (Barrie, CPC): We have early bells today too with votes at 5:45 p.m., so I note that we would not have an hour; we'd barely get half an hour to have committee business.

The Chair: What time are votes today, Mr. Brown?

Mr. Patrick Brown: At 5:45 p.m., so bells will start at 5:15 p.m.

The Chair: Ms. Davies.

Ms. Libby Davies: Recognizing that the bells are going to ring at 5:15 p.m., which is kind of weird because committee doesn't technically finish until 5:30, but that's a matter for whips, my suggestion is that we go to 4:40 p.m. and that way we'll still have 25 minutes for committee business. Sometimes we've done committee business in five minutes. Very rarely have we done an hour of committee business. What I'm aware of in terms of committee business I can't imagine that it's going to take 45 minutes or an hour. It just doesn't seem fair that we don't have at least one full round of questioning for the witnesses who are here which we normally would do.

The Chair: Ms. Block.

Mrs. Kelly Block (Saskatoon—Rosetown—Biggar, CPC): Madam Chair, I'm going to suggest that we stick with the agenda that was circulated to us. It was clearly defined that we would hear the two witnesses from 3:30 p.m. to 4:30 p.m. and then have our business portion of the meeting from 4:30 p.m. to 5:30 p.m. I would think that we should stick with our agenda.

The Chair: I think the majority of the people do want to continue to stick to our agenda.

Ms. Libby Davies: I would like to put a motion that we continue for another 15 minutes to hear the witnesses. I'd like to move that.

The Chair: Is there a seconder for that motion?

● (1635)

Mr. Dany Morin: I'd like a recorded vote please.

The Chair: We will have a recorded vote.

(Amendment negatived: nays 6; yeas 4)

The Chair: I want to thank the witnesses so much, but we do have to get on to committee business. Thank you so much for being with us.

I'm going to suspend for only two minutes because we are going to be short of time. The bells are going to ring very shortly.

[*Proceedings continue in camera*]

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