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Chair

Mr. Ed Komarnicki

Standing Committee on Human Resources, Skills and Social Development and the Status of Persons with Disabilities

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● (1535)

[*English*]

The Chair (Mr. Ed Komarnicki (Souris—Moose Mountain, CPC)): I call this meeting to order.

I should mention that we expect you to present for five to seven minutes. I may give you a five-minute warning. We have three groups presenting, so we'll need to be fairly close to the time. But at the same time, we don't want you to be reading too quickly because it's difficult for the interpreters to keep up. We want to have the right balance, if we could.

We'll start first with the presentation from the Canadian Physiotherapy Association.

Michael Brennan, if you wish to proceed, go ahead.

Mr. Michael Brennan (Chief Executive Officer, Canadian Physiotherapy Association): Thank you. *Bonjour, tout le monde.* Good afternoon.

Thank you for the opportunity to present to the committee. The title of this presentation is a somewhat intimidating one—about practical solutions for what is historically an intractable problem—but we'll give it our best shot.

Four years ago, the Canadian Physiotherapy Association and the Alliance of Physiotherapy Regulators co-published a document on foreign credential recognition in Canada for physiotherapists. The research for that document was funded by the foreign credential recognition program at HRSDC. We're grateful for the assistance the government has provided us to examine this problem. We were very keen at the time to tackle those issues, and we continue to be keen to tackle those issues.

Approximately 13% of all physiotherapists currently practising in Canada were trained in another country. Also, 13% of our membership has trained in another country. And we see that trend continuing as the demand for physiotherapy grows.

The study we undertook identified a number of structural barriers I'm sure you're all familiar with—poor pass rates for qualifying exams, the length of time it takes for applicants to be declared eligible for the exam and subsequently to be licensed. Language skills were considered a significant barrier, as well as cultural differences, in understanding the context of Canadian health care vis-à-vis the candidates' countries of origin. The information provided during the immigration process was identified as being a key area or a key shortcoming. Finding employment during and after the integration process was a problem four years ago. And finally, the cost of running the system was prohibitive.

So the physiotherapy community came together and undertook a notable and significant effort to address these issues, which resulted in a physiotherapy language benchmark established in 2009. It helps people identify what the goals or objectives are for their language. We developed an online language test that's available to examine candidates. We developed an online pre-assessment tool to determine how one compared to the Canadian equivalent.

In 2009, only two years after the publication of the study, we ran the first comprehensive bridging program at Ryerson for internationally trained physiotherapists. That program is now at the University of Toronto. Two new programs will be starting up in 2012, and we have profession-specific language training within those three programs.

So we've done a substantial amount of work to address the findings from the 2007 study. However, frankly, we have seen absolutely no impact on the time it takes for a physiotherapist with an overseas credential to be recognized and licensed—mostly because these programs are new. From 2009 to today, we don't really have enough data and enough experience to be able to optimize the programs.

Our problems now are more about running the program and developing an understanding and a reasonable set of expectations, versus the issues of its implementation that we faced a few years ago. Perhaps most substantially, physiotherapy in Canada is significantly different from physiotherapy in most other non-Commonwealth countries, even compared with the competencies of our American counterparts. More often than not, the Canadian standard is significantly above the expectations of overseas-trained candidates. So that continues to be a significant issue. We don't wish to compromise the success story of Canadian physiotherapy, but at the same time we recognize that we must do more to accommodate those candidates.

We're looking at practical solutions now. We recognize that the time it takes for candidates to get through this process is too long. We need more administrative capacity—there's a backlog right now, and we have well-intentioned folks working on credential recognition—but we currently have a nine-month backlog before we even look at a candidate's profile. And by “we”, I'm talking about the physiotherapy community. It's not our association that does it; it's contractors for the Alliance of Physiotherapy Regulators. So the backlog is significant.

Concerning access to practicums, we recognize that it's very important for these candidates to have an opportunity to work in the rehabilitation community. But access to those practicums is extremely difficult.

It's difficult for students in physiotherapy programs. Physiotherapy is delivered 50% in the private sector, so we're asking small business owners to find opportunities to provide these practicums. That's proving to be challenging, as it is for physiotherapy students.

We want better credentials data. We want to get a much better sense of what the equivalents are in other jurisdictions, and we are making some progress with the World Confederation for Physical Therapy. We just launched a program in June, a new database that will allow us to develop a much better understanding of these credentials before the candidates enter the system.

We heard there was a Deloitte study released today about the importance of getting this right. We're keen on doing our part to get it right. We see the most practical solution as doing our homework on behalf of the physiotherapy community and working with Immigration Canada and the various stakeholders.

A good example is a recent negotiation between the Quebec regulators and the French government, which recognizes their equivalent to physiotherapists as what we call a *thérapeute en réadaptation de physiothérapie* in Canada. Perhaps the simplest but least satisfactory solution is a reasonable expectation that somewhere between three to four years is how long it should take to have these credentials recognized and have these workers integrated into our system. It doesn't necessarily solve the problem, but we're not sure we can do better than that. We'd love to talk about how we could do this, but when we look at the difference between Canadian physiotherapists and those who are operating in many of these other countries, we're not sure we can beat that.

Thank you.

● (1540)

The Chair: Thank you.

We'll move to the Health Action Lobby, with Christine Nielsen and Mr. Shields.

Mr. Charles Shields (Member, Health Action Lobby): I was here a couple of weeks ago in another capacity. I am Chuck Shields. With me today are Christine Nielsen and Michael Brennan, who has already presented. We are all three members of the Health Action Lobby, and the leadership asked us to present to you on our experience with the issue.

I am CEO of the Canadian Association of Medical Radiation Technologists, Christine is from the Canadian Society of Laboratory Science, and Michael you have met already.

I'd like to thank the committee for the opportunity to talk on behalf of HEAL, which is a coalition of 35 national organizations. We represent a broad cross-section of associations, institutions, and facilities. Our memberships include about a half a million individuals, providers, and consumers of health care in Canada.

Over the past 20 years, HEAL has had the opportunity to present briefs to standing committees and has released a series of policy papers on a number of issues, including the role of the federal government in funding health care, health human resources, entry to practice, and the Canada Health Act.

Last July, HEAL met with officials at HRSDC to review issues, challenges, and solutions regarding internationally educated health professionals or IEHPs. The concerns that were addressed then continue to be concerns for IEHPs. These include upgrading in techniques and knowledge to meet Canadian practice requirements; preparing to pass licensure exams; obtaining relevant work experience; developing professional contacts or networks; becoming socialized into the Canadian workplace, culture, and context, which requires business information, collegial support, and the soft skills necessary to obtain and manage successful employment; developing or improving communication and language skills; and developing, managing, and meeting career goals.

At this point, I'd like to turn the table over to Christine, who will continue with some other points we want to make.

Thank you.

Ms. Christine Nielsen (Member, Health Action Lobby): The challenges for internationally educated health professionals in the integration and credentialling process include the time and personal resources needed to meet the demands. Quite often, internationally educated health professionals are older than our domestic graduates, and many times they have resource shortages and more responsibilities. The challenge of working and upgrading at the same time can lead to some challenges, with the internationally educated holding survival jobs.

Accessibility and availability of information and supports are necessary for people to understand what courses are available and where they might find colleagues. And relevant work experience is always important. When support and information is available through bridging programs, often an internationally educated health professional might not be aware that a program exists.

There's general consensus among HEAL members that the following supports, which Michael and Charles referred to already, would assist in the assessment and integration component: language training; mentorship; peer support networks; quicker credentialling assessments; preparation for licensure exams; and bridging programs, which in many cases can solve all of these issues.

Many of the barriers have begun to be addressed on a profession by profession basis, and many of the HEAL members have received contribution agreements and grants under HRSDC's FQR programs.

We know from the research we have conducted that bridging programs are a great solution for the internationally educated. Some professions already have these programs in place. They operate on different funding models. Some are fee for service, whereby the tuition is paid by the individual. Some are integrated into the full-time education system, whereby they're eligible for financial support or grants. Others sometimes have low- or no-cost alternatives and can often be subsidized by a return-to-service agreement. We know that the most cost-effective process is to add bridging programs to already existing education programs rather than to create stand-alone programs, because they already have the faculty, curriculum, and equipment.

There are significant challenges finding clinical placements or internships, as Michael mentioned, for the internationally educated. This challenge is not simply for the internationally educated. Our domestic students also face it. The biggest challenge we have is trying to figure out how to add this additional training responsibility to an overburdened health care system and how to compensate the individual and the facility they're training at.

Funding individual internationally educated health professionals through programs such as the Canada student grants program would give them access to bridging programs and would, in turn, help them contribute significantly to the sustainability of these programs.

We understand that a federal loan program for IEHPs has been proposed, and we encourage the government to proceed with this initiative.

Bridging programs solve many of the challenges internationally educated health professionals face and they allow them to integrate into the workforce in their chosen professions much faster. Earlier entrance into the workforce at a high-skill capacity is of financial benefit to the government, as taxation rates are higher with higher wages. Everyone benefits from earlier integration.

We thank HRSDC and the government for their interest and action in the assessment and integration of immigrants to Canada. Investment must continue to be made in this area, as the financial burden for the internationally educated professional, the associations, and the regulators would be insurmountable were it not for the commitment of the Government of Canada.

We thank you for your time today, and we'd be happy to take questions later.

● (1545)

The Chair: Thank you very much for that.

We'll turn to Sandra Murphy, from Centennial College, for the final five to seven minutes.

Dr. Sandra Murphy (Dean, School of Community and Health Studies, Centennial College): The problem with going third is that I'm going to be repeating a lot of information. The one good thing is that we're very consistent in our findings.

One of the reasons I'm here is that in 2008 I finished my doctoral work, and my thesis was on the experiences of internationally educated nurses when they come to work in Canada for the first time, looking at the barriers they face.

As dean of the school at Centennial College, I took on a pilot project in 2009 to 2011 for two bridging programs, which underwent extensive program evaluation. We looked at two bridging programs, one for nursing and one for pharmacists who would complete their diploma as a pharmacy technician. It wasn't a surprise to us that language, by far, is the biggest barrier facing internationally educated professionals. The issue we found is that many of the bridging programs that exist do not have an occupation-specific need, and hence there is a gap there.

There really does need to be pre-arrival language training that should be encouraged and perhaps required. In some professions, like nursing, as an example, internationally educated nurses must demonstrate specific levels in English fluency that relate specifically to meet the needs of the occupation in which they will be practising. Those requirements are very high.

In addition, we found there needs to be improved marketing. Internationally educated health professionals need to have information available about relevant programming for them to initiate the licensing process before they even come to Canada and step off the plane. We need to actually ramp up our current marketing methods above and beyond participating in job fairs for immigrants and disseminating application information at settlement houses or community centres.

Financial assistance for learners remains a barrier, especially for a lot of the bridging programs that are non-diploma bridging programs. What happens there is that students are not eligible for OSAP or for assistance programs. Many of the educated learners, as we have talked about, are mature learners, have families, and are trying to make ends meet while undertaking demanding studies.

What we found is that if you compare it with Canadian stats, 80% of the internationally educated professionals are married and 62% have children, compared to only 54% who are married that are Canadian-born and 47% having children. One of our students in our program stated to us:

> So I think the government should help [students] for funding [beyond OSAP] for those kind of people who are willing to go back because I know a lot of professionals move here and they work in the kitchen because they need money.

Another thing I have found is that there needs to be accurate information regarding professional registration and integration into the Canadian workforce. They are very surprised that we have prerequisites to employment in their professions, and they find this added information very discouraging. They also find that the information is available in a very scattered number of resources and sources, through colleges, regulatory bodies, immigration officials, etc. That information really does need to be consolidated. The lack of a centralized national online information portal that helps these individuals access abroad really does create a significant informational barrier. They need to have this information so that they are able to expedite the licensure process.

The other problem is that with some regulatory bodies there's a very narrow window where they have to prove and demonstrate safe practice. This length of time is decreasing from five to three years, particularly in the nursing area. So when immigrants come over and they have to be landed immigrants, it almost becomes impossible for them to continue on in their profession within that very narrow window of opportunity.

Cultural competence is something that has become very important. A lot of immigrants come from a unique cultural society, and they find that Canadian norms and values, in a very culturally diverse country, are very difficult for them to understand and to be able to practise in their chosen profession. The fact that we have interprofessional teams and a client-centred approach to care is very foreign to them. It's a concept they do not recognize, and they need to have bridging programs to do that.

Examination, preparation, and job searching skills are very important as well.

● (1550)

I will just let you know that the normal pass rate for internationally educated nurses is 70%, compared to 90% for Canadian-educated, first-time writers. In our bridging program the pass rate has been 90%, which is close to 20% higher than for those who do not partake in bridging programs. That shows you the importance of a bridging program to prepare for a profession.

I'm at five minutes, right?

The Chair: You're at five minutes and 40 seconds, but carry on.

Dr. Sandra Murphy: Bridging programs really do provide these individuals with the ability to prepare for exam writing, because they're not used to multiple-choice exams. Once our students leave, they historically have difficulty obtaining jobs because of the barriers they face in the profession. There's a lot of negativity in terms of internationally educated professionals. We find that we need to help them with job search training, preparation of resumés, interview techniques, etc., for them to be able to get positions.

In closing, bridging programs are absolutely instrumental and critical for any health care professional. I cannot imagine how anyone would be able to integrate into the profession without having experience in a bridging program, to get that practical connection and workplace experience.

My suggestion is to continue the funding, and look at funding for students beyond just the bridging program development. Tuition reimbursement would be a great help.

Thank you.

The Chair: Thank you very much for that presentation. We have certainly heard about the need for bridging programs, how well they work, and their success rate.

We'll move on to Ms. Crowder.

Ms. Jean Crowder (Nanaimo—Cowichan, NDP): Thank you.

I want to thank the presenters, and I want to thank Mr. Brennan for highlighting the Deloitte study. I haven't had time to read the whole study because I just got it, but it certainly identifies some continuing challenges with the immigration system. It recommends a number of action items, and I'm going to ask the committee members to address them.

We've been hearing fairly consistently about a couple of things, and I think all of you have touched on one in some way or another.

First of all, there's a real challenge overseas with people having accurate information. I think Ms. Murphy referenced having some language training before people come into the country. There could be some process that starts credential recognition overseas, although other witnesses have identified some challenges with that because of security issues around whether you're actually assessing the person who's coming.

The other three areas appear to be: assessment once they come to Canada; a bridging program that addresses education, work experience, or practicum placement; and finally, the time to an actual job in the profession.

Do I sort of have it in a nutshell there? Okay.

So there are a couple of questions. In your experience, do the regulators, colleges and universities, and associations work closely together to develop a comprehensive action plan? Can I have each of the three groups address that?

● (1555)

Mr. Michael Brennan: The quick answer is yes. Perhaps it's the single best example of collaborative approaches in physiotherapy in the last 30 years. I listed a number of achievements from 2007 to today in the development of those bridging programs: language testing, opportunities for placements, and so on.

The frustration today is that because we have these mechanisms in place, we are more acutely aware than ever of just how much extra work is needed. We have capacity that may improve the problem by 10%, but for every person who gets into a bridging program, six don't. For every person who gets a placement opportunity, 12 don't. So now it's a question of volume. It's been a success for us in the sense that the collaboration is there, but we're more acutely aware than ever of just how big a hill we're trying to climb.

Ms. Jean Crowder: Do those three bodies get some sort of funding to help them work together to develop an action plan, an implementation plan?

Mr. Michael Brennan: We received funding to do the study, but so far everything else has been funded either through our own pockets or through the provincial government. The bridging program at Ryerson, which has now transferred to the University of Toronto, was funded by the Government of Ontario. One of the limitations we've recognized is that they were pretty insistent that the candidates be residents of Ontario, which of course makes sense, and the demand is so much greater than that.

But we've been fortunate in that the Government of British Columbia, the Government of Nova Scotia, and the Government of Ontario are continuing to fund these bridging programs now.

Ms. Jean Crowder: But it's a piecemeal approach, depending on the provincial interest.

Mr. Michael Brennan: That's right.

Ms. Jean Crowder: Mr. Shields and Ms. Nielsen, in your experience do the regulators, the colleges and universities, and the associations work together collaboratively?

Mr. Charles Shields: Again, yes. I can't speak for all of the HEAL members, but I can certainly speak for our own association. We have done that traditionally, but we had been assisted in doing that through the support we had for some of the grants from HRSDC. When we developed guidelines for bridging programs, that included education programs around the country.

Ms. Jean Crowder: I'm sorry, Mr. Shields, may I interrupt? Is that on a project-by-project basis? You don't have an ongoing pot of funding that allows you...? You have to address specific projects?

Mr. Charles Shields: That's right.

Other projects that we've had on creating a national standard for assessment involved regulators and educators and other stakeholders as well. So we've pulled people together. That has been, again, through HRSDC funding.

There are some mechanisms we have so that we pull some of the players together ourselves, just in the course of our own work. But when you get into talking particularly about the internationally educated group, that's been assisted, particularly by the help we've had from HRSDC.

Ms. Jean Crowder: When you're responding to things on a project-by-project basis, how does that help in terms of a long-term plan and strategy? I know other organizations have done it on their own. But a long-term human resource strategy, which requires not dealing with things on a project-by-project basis but actually having the mechanism in place to develop that strategy, looking at labour market information, looking at all the demographic information and trends, and developing that strategy around recruitment, retention, all of those kinds of things that are in an HR strategy....

● (1600)

The Chair: There's a lot in that question. Could you maybe shorten the answer?

Mr. Charles Shields: Let me try to take a short go at it and say that when we started, it was really just a project. As we began having our experiences.... The last time I was here with the committee I mentioned that we conceptualize things now in a way that there's a spectrum of activity. We're looking at starting with the internationally educated person back in their home country before they even decide to come to Canada, and carrying all the way through successful completion of the certification exam and beginning to practise. We're aiming our efforts at trying to get at the different areas along that.

So although we're addressing things project by project, we're aware of how they fit together.

The Chair: Thank you.

We'll move to Mr. Daniel.

Mr. Joe Daniel (Don Valley East, CPC): Thank you very much.

Thank you, folks, for coming and allowing us to quiz you.

My first question is to Mr. Brennan. How big is the gap? Why do we need all these foreign-trained people here?

And pushing on the long-term theme, is this gap getting bigger as we go down the years?

Mr. Michael Brennan: Specifically for physiotherapy, the gap is likely to widen. When we consider baby boomers' demand for graceful aging, which includes mobility and so on, the demand for physiotherapy is increasing, and we see a broadening gap. Programs are ramping up in Canada for training in Canada, but we're likely not going to meet the demand over the next 10 years.

So certainly we see the importance of immigration to physiotherapy and rehabilitation. And certainly, just from a population perspective, immigration is key to Canadian growth as a whole, so we support that relationship.

If I can put my HEAL hat on for just a moment, we also recognize that there are some concerns about the appeal of certain health professions, the work-life balance issues that are becoming more prevalent in our conversations, and our concern is that there are not as many Canadians who are now interested in choosing these careers for themselves. That too makes it imperative that we look at immigration as a potential solution to that problem.

So I think there's consensus pretty much in the health profession community that immigration and recognition of foreign credentials is key to making sure our workforce is sustainable.

Mr. Joe Daniel: Is the shortage so acute that we have Canadians training abroad and then would have to face the same requirements when they come back in?

Mr. Michael Brennan: Not in physiotherapy, but I can't speak for the others.

Mr. Joe Daniel: I'll turn to Dr. Murphy.

How do you recruit your students? Do they come directly from other countries to you? Do they come in and you evaluate them? How does that happen? Do you have accelerated programs? I don't know if the bridging program is an accelerated program to help them get through the process.

Dr. Sandra Murphy: First of all, the students come from a variety of means. The regulatory bodies refer students directly to us. In the community, the word of mouth is very strong, so students come directly to us. We actually have to meet with them and refer them back to the regulatory body, because that's how they're assessed.

I would say that our strongest marketing is perhaps our previous students. We've offered bridging programs for internationally educated professionals since the 1970s, so it's just a name out there.

I'm sorry, what was the other question?

Mr. Joe Daniel: I've forgotten, but I'll go on to another question.

You alluded to this sort of scattered or diverse application information process. How do you see it all coming together? Do you work with only Immigration Canada or HRSDC? How do you see the common process coming into place?

Dr. Sandra Murphy: I think as an educational body we would have to work with the government as well as the regulatory body, because it's the regulatory body that governs the licensing process.

The whole reason in starting off the assessment while they're in the country, from what I have learned, is that it's very difficult for the proper documentation...authorization of practice experience is very difficult to obtain once you come to Canada. People rely on their family members to follow their process.

If you want to shorten the licensing process, you have to start overseas. I would say that you would need to have the educational partners, the government, and the regulatory bodies as well.

● (1605)

Mr. Joe Daniel: In addition to that, you would like to see the information available from one site, or one organization, something like that. Would that help to get it together?

Dr. Sandra Murphy: Absolutely.

The Chair: Ms. Nielsen.

Ms. Christine Nielsen: To follow up on that, one of the things that has improved knowledge awareness of many of the members of HEAL is the "going to Canada" portal, which is a requirement in some of the source countries for Canada. Someone going to Canada has to go to a Canadian orientation program.

In my own field of medical laboratory science, we have about 15% of our applicants who apply offshore. You're right, Dr. Murphy, it's absolutely critical for them to get the documents while they're at home. As someone who accepts documents and reviews them, it's a much more robust way.

We have policies in place, and some people have identified barriers. For us, it has been the biggest enabler because there are still things that we can evaluate while they're offshore. They can even fill in some of the gaps for my profession while they're offshore. In my profession, we've taken a holistic approach in acknowledging that Canadian isn't the only way to fill a gap.

The Chair: Thank you.

We'll move to Ms. Crowder.

Ms. Jean Crowder: A number of you have mentioned the whole problem with practical placement. Do you have any suggestions about how that can be improved? It's not only a problem for Canadian-trained people; it's also a problem for foreign-trained people.

Ms. Christine Nielsen: I'd love to take this one.

There was a study funded in Manitoba in the nursing field. It's a terrible name, but it was called the Retention of Older Workers Project. The only group that objected to it was the nurses' union.

It was intended to capture people ready to leave the profession who went from being at the apex of their career to allow them to work a few days a week, or in a limited scope, to help train the next generation. There was funding for that program, so of course it's not sustainable.

The evaluations that came from both the student nurses and the facilities were very positive, because it alleviated the workload for the day-to-day nurses and there was someone who was at the height of their career to help with the knowledge transfer. It hit two different areas. It allowed someone who was a retiring worker to still stay connected to the profession they loved, possibly help pass on knowledge, and alleviate the burden in the workplace. But of course it came with some funding requirements.

Ms. Jean Crowder: You said Manitoba?

Ms. Christine Nielsen: Manitoba, yes.

Ms. Jean Crowder: Mr. Brennan, do you have any comments on that?

Mr. Michael Brennan: We certainly recognize the need and the problem. We've looked at a number of incentives that may make it more palatable for small businesses, clinic owners, and so on to provide opportunities. I'm always a big fan of using taxation as an incentive. So if there's some way to provide incentives to business owners through tax credits, or whatever the case may be, specifically for people with international credentials, that would be something we would support. We've tried two pilot programs, one in Nova Scotia and one in Alberta, essentially to provide funding from the profession to small business, small clinic owners, and the problem was that the amounts were too small to make it worthwhile.

Dr. Sandra Murphy: We are still finding many negative reactions to internationally educated professionals in the clinical areas in the workforce. The research I did for my doctoral studies points out that there still is racism and negative reaction to these health professionals. When we place students into the hospital settings, more of our internationally educated nursing groups are refused than any other of our nursing groups. We've added a manual and some education to our bridging programs for the nurses who work in the health care settings.

I don't know if that transcends other health professionals as well, but that's what we have found. Maybe it's unique to nursing.

Ms. Jean Crowder: Mr. Choquette is going to ask a question to finish this time.

[*Translation*]

Mr. François Choquette (Drummond, NDP): Thank you, Mr. Chair. Ladies and gentlemen, thank you for being here today. I have a few questions for you.

We know that the situation involving foreign-trained professionals is a major issue. In Canada, Quebec and my riding of Drummond, there are many highly educated people who arrive in Canada and then work as labourers rather than in their area of expertise. That's especially the case in healthcare. We could be talking about pharmacists, doctors or nurses. You mentioned that quickly, and it's something worthy of our attention. Physiotherapists are also healthcare workers.

A few solutions have been suggested. Would it not be appropriate to integrate those people in the workplace as soon as possible? We are talking about programs, student loans and internship programs. Would it not be appropriate to have a national internship program?

I see that there is such a program in Manitoba. There are similar programs throughout the country, but there appears to be no Canada-wide initiative.

Would it not be beneficial to have something that would allow professionals to integrate themselves more quickly into the workplace? We know that people need to work in their field to maintain their skills, especially in healthcare.

● (1610)

[*English*]

The Chair: Mr. Choquette, you may want to ask your question because your time is just about up.

[*Translation*]

Mr. François Choquette: Yes, I'm finished.

Mr. Michael Brennan: A federal program would indeed be desirable. I cannot speak for everyone, but I'm convinced that everyone would be willing to agree to that. However, there could be a constitutional debate involved.

In our opinion, Quebec is an ideal example. We have physiotherapists who arrive in Canada, but do not have the qualifications to practice. We could provide them with a limited work permit that may be based on their skills. We could integrate them immediately into a workplace and provide them with some experience or training. Practical experience would be ideal. However, that would require major changes in terms of legislation and work permits. The federal government and the provinces would really need to come to an agreement.

Earlier, we were talking about strategies. If we want to have a comprehensive strategy, that's really where we need to focus our efforts.

[*English*]

The Chair: Thank you, Mr. Brennan.

Maybe you'll get a chance to comment on some of the questions a little later, Mr. Shields.

We'll move to Mr. Mayes.

Mr. Colin Mayes (Okanagan—Shuswap, CPC): Thank you, Mr. Chair.

Welcome to the witnesses who are here today.

I will direct this question to Ms. Nielsen.

One of the things I have found in life is that the easiest way to succeed is to copy smart and successful people and ideas. Have you looked at any other models from other countries that are taking professionals in? What is their success, and how do they approach this? Really, our government is trying to address a problem: we need a framework, we have put huge amounts of money forward, but we want something that works and is going to be timely.

Have you had any experience of models elsewhere that we could copy?

Ms. Christine Nielsen: The model I'm most aware of relating to the health professions would be the Australian model. I had an opportunity to go in March with a Canadian delegation of health professionals to look at how they handle their immigration and to share best practices and common challenges. Obviously their immigration policies are a little different from Canada's, so we'll have to acknowledge that, but one of the interesting things they do is pre-assessments before someone is approved for immigration, which possibly helps them select people who have the best chance of being integrated quicker.

They also have had standing bridging programs, I believe since the 1960s, and they are in the federal model. So if you're a physiotherapist who has a really great chance of practising in the field, you know where to land and what program will be accepted. I believe it's subsidized as well by the federal government.

So they do a little more selection pre-immigration. They don't really allow a person to self-declare their occupational code; they verify. They even do offshore competency assessments whereby somebody might do a clinical assessment offshore. They have authorized people in those jurisdictions to do these.

Now, this is from a handful of countries, not from all nations. But they know, just like Canada, what their source countries are, so they've been able to work towards this, and it seems to work for them in the health professions.

Mr. Colin Mayes: Dean Murphy, let me ask you a question. Through technology there's an opportunity to train people online. Is that something that also could be looked at, wherein if somebody applies to come to Canada wanting to be a nurse, we could link them up so that they're aware and could take the training online? Or do you feel that it has to be done in Canada in a work setting?

● (1615)

Dr. Sandra Murphy: I have a couple of comments. First of all, I believe it has to be done in Canada. We have tried to put part of the practical nursing program overseas. In order to be approved by the College of Nurses of Ontario as an educational institution, we have to have Canadian training, so we can only offer one of two years of training overseas.

Online training for an internationally educated professional can only be done, I feel, in adjunct to traditional classroom teaching as well. I think online training is fine, but we are pulling from countries where individuals do not have the technological resources. We have to be very careful with technology. In fact, in the case of internationally educated nurses, as an example, one of their biggest difficulties is the technology.

Mr. Colin Mayes: Okay.

Let me direct a question to Mr. Brennan.

You mentioned that Canada's standards are significantly higher. That was comforting, but is it arbitrary? You look at other professionals working in many other countries and you are saying they're not acceptable. But obviously they're operating and doing the job in those other countries.

Who sets the standards, and are they arbitrary? I want to make sure that people who are helping me with my health are professional and well-trained, but are we setting the bar too high?

Mr. Michael Brennan: That's a fantastic question, and any health profession has to have the courage and honesty to ask itself that on a regular basis.

Our competency standards are equivalent to those of the U.K., Australia, and New Zealand, and that's it. Everywhere else in the world, physiotherapists are not able to do a differential diagnosis, for example, and convey that information to patients, and so on. There are certain distinct advantages; one talks about efficiency in the health human resource labour force.

There are reasons why the situation has evolved this way in Canada that take away the arbitrariness, if you will, because it involves working in collaboration with health professionals. But there are other models. Certainly the Canadian model is not the best —we all recognize that—but it would be very difficult to reverse-engineer where we have wound up. I'm not sure necessarily that we can go backwards to go forward, but maybe that's the solution. It's not practical, though, when we talk about the theme of today's conversation.

But as I said a little bit earlier, part of the solution may be some kind of limited licensure to integrate and get working. It's very much one of the recommendations out of the Deloitte study today: let's use the capacity that's there. If we need to build on top of it, then let's take the time to do it, but let's get them into the workforce right away.

The Chair: Thank you, Mr. Mayes. Your time is well up.

We'll move now to Mr. Cuzner.

Mr. Rodger Cuzner (Cape Breton—Canso, Lib.): Thank you very much, Mr. Chair. I want to congratulate you and Mr. Shields on a great day one of Movember. Both of you are off to a great start. I'm sure Phil and I are going to catch you in the long haul—eh, Phil?—but it will be a big finish.

Ms. Murphy, I had a group of lab techs in from Atlantic Canada this week. They felt that in most of the health service areas, with the number of seats that have been added in institutions in Atlantic Canada, they were going to be able to fill job openings in Atlantic Canada. The areas in which they were having problems were placements and work experience. What they're saying is that in some of the rural hospitals where, let's say, historically they have had three lab techs, they now have one. The additional focus of mentoring somebody and training somebody is putting additional strain on capacity.

First, talk about the number of seats that have been developed to accommodate the demand. Are we turning away people who are applying? Are there enough seats there?

Then also talk about those training opportunities. Is there no financial incentive there, or is there a void in the number of people who are able to provide the training?

● (1620)

Dr. Sandra Murphy: Whether we're talking about pharmacy technicians, pharmacists, or nurses, the preceptors who are in the field are hard to come by. I think there is a lot of burnout, there are a lot of students out there, and we are definitely overtaxing the system. I also think that the people working within some professions are not convinced that this is part of their professional requirement, that it is their obligation to have teaching for the people coming into their profession. I think that's happening.

Part of the answer is that we need to increase the amount of simulation we're using to replace actual clinical hours, but for our accrediting bodies to agree to that, we need to do research showing that it will inform and impact practice.

So I think we need to do simulation, and we need funding for it, and we need to do research on the effectiveness and how it informs practice.

Mr. Rodger Cuzner: If others have a comment, please, by all means, go ahead.

Mr. Charles Shields: I'd concur that simulation is something that is being seen and is used to assist with the clinical preparation in the profession my association has—medical radiation technologists. There are a number of institutions moving in that direction now. Additional funding would be helpful, but I think it's something that is happening. We have been taking steps to see what can be done appropriately through simulation. This is for entry-to-practice education, but it could be applied and transferred over to the internationally educated folks.

We have looked at this to see what sort of simulation makes it sensible to say that clinical competence can be demonstrated through simulation in these instances. So that kind of work is happening, and I think there is something to be said about looking further at it.

Mr. Rodger Cuzner: Thank you.

Mr. Brennan, the two pilot projects you referred to, in Nova Scotia and Alberta, didn't meet with a great deal of success. You indicated that this was because of the amount of incentive that was being offered. Could you explain a little bit more?

And in assessment, did they mention a number that would have been...? Maybe we could have access to some of that information.

Mr. Michael Brennan: Sure. I can certainly provide it.

The answer to question number two is that it wasn't really a numbers question, or at least that wasn't the initial finding. The findings were that in order to make the practicum of value, a drop in patient load was pretty much necessary so that they could have time for teaching and so on, which of course impacts revenue. But I think it was more a cultural issue, not based on any prejudice but more on the challenges of being able to communicate effectively to relay the context of a Canadian health care system and so on, so that both the student and the mentor were having some value in the practicum.

Essentially we tried a Canadian model, with a slight financial incentive to participate, and we got both context and funding wrong in the pilot.

The Chair: Thank you, Mr. Cuzner. Your time is up.

Mr. McColeman, did you wish to use your five minutes?

Mr. Phil McColeman (Brant, CPC): Mr. Chair, I do. Thank you very kindly for allowing me to.

Thank you for being here. The expectation in looking at this might have seemed fairly simple at first blush, that we could boil this down to perhaps people writing an exam and, boom, they're in the occupation. But the more we delve into it, the more complex it is, so I appreciate your input today.

Two of the immigration issues in the forefront of my mind right now are the language issue and having a pre-qualified standard, as Australia does, testing immigrants to meet a certain standard before they come into the country so they can fit into the education system and the protocols of various occupations.

I'd like your comments on how feasible you think that whole pre-entry, pre-certification standard is in a country that's had an immigration policy, as we have in the past.

I'm not asking you to get political, and we're not here to discuss our immigration policies, but that's an issue, as a legislator, that we have to look at. How realistic is it to go to other countries to set up these types of structures that would be required?

Does anyone care to comment on that?

● (1625)

Ms. Christine Nielsen: I think if it were to move that way on a policy basis, it couldn't be all countries, all professions, and all fields, and it probably shouldn't.

Mr. Phil McColeman: Right.

Ms. Christine Nielsen: In my own profession, medical lab science, we know that probably 70% of people come from Canada's top three of the four source countries, with the exception of China. So for us, that would be an obvious place for us to create something.

You've touched on the complexity of it, in that sometimes individual regulators are doing credential evaluation. You've seen the limitation of whether simulation would be accepted by a regulator as being on par with the clinical practicum. It's fraught with political problems, and I don't know how one would go about encouraging the change in immigration policy.

For a profession to do it on a profession-by-profession basis, it's probably feasible, but for it to become embedded in policy might be difficult.

Mr. Phil McColeman: Would you agree, though, that one step that might be useful is the integration of Citizenship and Immigration Canada with HRSDC in terms of a one-stop coordinated approach?

Ms. Christine Nielsen: Absolutely.

Mr. Phil McColeman: That would be a step forward, in your mind.

Ms. Christine Nielsen: For sure.

Mr. Phil McColeman: Secondly, take it to another level; take it to the provincial level and the national level. We've been talking about some national standards, and perhaps the proposal would be to create a national standard across the country. But as we all know, there are huge interprovincial barriers.

What do you think the capacity is within the multitude of organizations that would have to be involved province to province to complete that process? Is it realistic to think we could ever do that?

Mr. Charles Shields: I was going to say we are doing that now, in medical radiation technology. It is possible. There is the will. We have the regulators together with the other groups to create that national assessment standard. That's in the process now. It's going to be finished in the next few months.

Mr. Phil McColeman: That is very encouraging. Thank you.

Dr. Murphy, how about in the nursing profession?

Dr. Sandra Murphy: It's the same. They're looking at transferability from one province to another and using the same standards.

Mr. Michael Brennan: With regard to physiotherapy, the standard for the highest level of competence entry into practice for physiotherapists across Canada is recognized, and interprovincial is not a problem.

The trick is that limited licence issue again. We've seen a really elegant solution in Quebec that is not even on the radar anywhere else in Canada. I think it ought to be. If we can engage provincial regulators and legislators to start considering immigration policy and the needs to build the labour force through those mechanisms, we might be on to something.

It took 22 years or so to get interprovincial recognition, and maybe we can cut that in half on these limited licence deals. The potential is there; it's getting the conversation going.

The Chair: Thank you. You're just about up to your time.

This might be a good place for us to suspend and allow the other panel to come on board.

Thank you very much for your presentations and recommendations. We'll certainly take them into consideration.

● (1625)

(Pause)

● (1635)

The Chair: Thank you for your attention.

Just before we get started, as you know, there'll be a vote in the House today. The bells will ring at 5:15, and they're half-hour bells. We're just up the stairwell from the House. I would propose that we go to 5:25 or 5:30, if everyone's agreeable to that. Is anybody opposing that course of action? If not, that's how we'll proceed then by consent.

Having said that, I want to remind the presenters that we'd like you to keep your presentation within the five- to seven-minute range to give everyone an opportunity to ask some questions. We will have three presentations: the Royal College of Physicians and Surgeons of Canada; the Canadian Dental Association; and the Canadian Institute of Health Research.

I believe we'll start with the Royal College of Physicians and Surgeons of Canada.

Go ahead.

Dr. Andrew Padmos (Chief Executive Officer, Royal College of Physicians and Surgeons of Canada): Thank you, Mr. Chair.

Members, my name is Andrew Padmos. I'm the CEO of the Royal College and have been that for five years. I'm accompanied by Paul Tomascik, a senior policy analyst with us. I'm a physician by training, a hematologist. I practised mostly outside Canada, in Saudi Arabia, but since I returned in 1993, I've practised in Kingston, Halifax, and I currently continue a clinic in Windsor, Nova Scotia, the home of hockey.

Thank you Mr. Cuzner.

The Royal College feels there is a simple solution that's within reach to shorten the foreign credentials recognition process and to integrate internationally trained physicians into Canadian practice. However, we feel it's important to pause and reflect on the very high standards for which Canada's health system is very well recognized. It's not that we're an organization with a defined self-interest in the profession. The Royal College was created in 1929 to provide the public with assurance that physician specialists—in those days there were only two specialties, physicians and surgeons—were trained to the highest quality so that public confidence could be maintained.

In fact, our organization welcomes the additional physician manpower that would be available through faster immigration processes, and we're taking steps to improve the integration of internationally trained physicians already in Canada. Approximately 1,500 are practising as specialists in Canada but have not yet achieved Royal College certification, which is acknowledged both inside Canada and outside as the gold standard for recognition and registration of specialists' qualifications.

Our standards are sometimes referred to as CanMEDS, Canadian medical education standards for specialists. They've been adopted in 20 countries and jurisdictions around the world because of their value in setting a framework for medical education and training.

We actually have only four recommendations for consideration here, and I don't think this is the first time they've been presented to standing committees of health and human resources here in Ottawa.

First, we recommend that action be taken to reduce and eliminate confusing standards and information present in various websites, both from the point of view of Canadian immigration and from the registration of the medical regulatory authorities in Canada's ten provinces and three territories. Those who are seeking to enter Canada for a variety of reasons deserve a single source of truth in terms of the information about requirements and the process.

Second, a recommendation is that as much as possible there be harmonization of Canada's immigration requirements and process for those individuals who seek advantage in the immigration process by virtue of their medical qualifications. So if they get additional points because they are a physician, we think they should be subject to additional stipulations. There are only really three. First, language proficiency should be established before the immigration process is completed. Second, their primary qualifications of their medical degrees and other specialist certification should be registered with Canada's physician credentials registry, located and supported by the Medical Council of Canada. It provides a one-stop shop for verification of credentials, and it applies to those in Canada, trained in Canada, as well as those outside. Third, all candidates for immigration who anticipate a medical career should do the evaluating examination of the Medical Council of Canada before their immigration process is completed. This is because that's the base qualification required for all medical graduates practising in Canada.

If members of the federal government would like to turbocharge the process, they should consider an additional recommendation, and that is to provide funding for clinical observation periods for those physicians who are trained outside and have qualifications that might warrant them getting a licence to practise. However, we do not support point-of-time evaluation.

● (1640)

We think that in most cases a period of observation of three to six months is necessary, and it is often required by provincial regulators. However, the funding to make this possible for candidates is often sparse and very difficult to process. So additional funding in this area would greatly speed up dealing with a pool of probably 3,000 physicians who are already landed permanent residents of Canada, and sometimes citizens, who have not yet been able to achieve licensure.

Thank you.

The Chair: Thank you very much for that.

We'll have a presentation from the Canadian Dental Association.

Mr. Soucy or Mr. Lees, go ahead.

Dr. Benoit Soucy (Director, Clinical and Scientific Affairs, Canadian Dental Association): Mr. Chairman, members of the committee, good afternoon. *Bonjour*. My name is Benoit Soucy. Thank you for inviting me to speak to you today about the licensure process used by Canadian dentistry.

On behalf of the Canadian Dental Association, I will present to you the work done by various components of dentistry to ensure the competency of dentists practising in Canada. Joining me is Robert Lees, the manager of registration at the Royal College of Dental Surgeons of Ontario. I look forward to his assistance and perspective during the question and answer period.

Dentistry is well known for its insistence on the importance of prevention and management of oral diseases. The “bias in favour of prevention” approach is reflected in the way we, as a profession, have approached licensure. To ensure the protection of Canadians seeking dental care, we have put in place a solid four-part process of education, accreditation, certification, and licensure, which guarantees that dentists entering practice in Canada have the training and skills that are needed to deliver safe and effective dental care.

Dental education is delivered at ten universities across Canada in a variety of programs that prepare dentists to meet all the needs of the Canadian population. To support their educational missions, all Canadian dental schools operate dental clinics and research centres, thereby combining in one facility what in medicine is delivered through the faculties of medicine and their academic health science centres.

The Commission on Dental Accreditation of Canada, or CDAC, is responsible for accrediting all Canadian dental and dental hygiene education programs, as well as some of the dental assisting programs. Accreditation is a lengthy, involved, and expensive process that requires regular site visits and considerable expertise. Accreditation provides verification of the quality of the education process.

Certification is the confirmation of the competency of individual applicants for licensure. It is done through the National Dental Examining Board of Canada. The NDEB has a system of examination that is fair and effective and that is recognized as one of the best worldwide.

The last step is licensure, which is the responsibility of the provincial and territorial dental regulatory authorities. All the provincial regulatory authorities for dentistry in Canada accept NDEB certification as the basis for licensure without further testing of qualifications. As a result, all Canadian dentists enjoy full interprovincial labour mobility.

One of the most remarkable features of this four-part process is the absence of any patient-based examination in the certification component. In many parts of the world, this type of examination, despite its many shortcomings, is still seen as essential for the verification of clinical competency. Canadian dentistry has been able to do away with this type of examination by requiring candidates for certification to be graduates of accredited programs and by relying on the confirmed quality of the in-curriculum evaluation.

To facilitate licensure of dentistry outside of Canada, the Commission on Dental Accreditation has been asked to establish mutual recognition agreements with counties that have accreditation systems that can be compared to ours. Graduates of dental programs in countries where MOUs exist are eligible to sit the same certification examination as graduates from accredited programs in Canada. Currently, MOUs have been signed with the United States and Australia, and agreements are being negotiated with New Zealand and Ireland.

While MOUs work well, the number of countries with whom they can be signed is relatively small, and alternative approaches are required to assess the competency of the majority of international applicants. While other occupations use credential assessment services for that purpose, the reality is that for dentistry this avenue is less than promising. Test cases were sent to credential assessment organizations with very disappointing results. Graduates of all test cases were deemed to be equivalent to Canadian grads, despite an enormous variation in the quality of their education. In fact, even graduates from schools with no clinical training at all were given passing marks.

To provide a working alternative, NDEB has been asked by the Canadian Dental Regulatory Authorities Federation to develop, with funding from the federal government, a process to verify the equivalence of dentists trained outside of Canada to graduates from accredited programs. The NDEB equivalency process is brand new and was used for the first time this year. It starts with a voluntary web-based self-assessment designed to allow potential immigrants to gauge their ability to become licensed in Canada before they are committed to moving here. Candidates who choose to seek licensure are assessed on their fundamental knowledge, clinical skills, and clinical judgment in a process that can be completed in less than a year.

● (1645)

Those who successfully complete the three assessments are judged equivalent to graduates from an accredited program and can get licensed in the same fashion. Candidates who fail to complete the equivalency program successfully can apply to a qualifying degree or degree completion program to become eligible to take the certification examination as graduates of an accredited program.

These two-year programs are offered in eight Canadian universities. From 2000 to 2010, they were the only avenue available to dentists from non-accredited programs who wanted to license in Canada. They are our best source of information on the level of preparedness of dentists moving to Canada and showed an immense variation, not only from country to country but in many cases from school to school within the country. Some foreign-trained dentists are essentially at the same level as their Canadian colleagues, while others simply do not even come close to making the grade, even missing some of the prerequisites to enter dental schools in Canada.

The variability is our biggest challenge and the reason a dental degree on its own cannot be taken as confirmation of competency. We either have to have formal knowledge of the educational process through accreditation or we need to test individual candidates in some way.

To wrap up, I would like to thank you again for listening to my remarks. This is a huge policy area and one that has clearly become a priority for this government. I applaud you for consulting with the many groups you will hear from during your hearings, and I encourage you to continue to consult with the Canadian Dental Association on a move forward basis.

We're available to answer any questions you may have.

The Chair: Thank you very much for that presentation. We will move to the Canadian Institutes of Health Research.

Ms. Bourgeault, is that you?

Dr. Ivy Lynn Bourgeault (Advisory Board Member, Health Services and Policy Research Institute, Canadian Institutes of Health Research): Thank you.

Like the other panellists, I would like to thank you for inviting me to make this presentation to this panel. This is a very important issue.

I want to highlight, however, that I do not represent the Canadian Institutes of Health Research at this table. I am here as a CIHR- and Health Canada-funded research chair in health human resource policy. So I'm here more as an individual.

I have with me my colleague, Anne Brasset-Latulippe, who is the coordinator of the Pan-Canadian Health Human Resources Research Network.

You all have a copy of the presentation I will make today.

I come here as a research chair in health human resources, having worked for the past 10 years on this topic, not only in Canada, but also in the United States, the U.K., and Australia, focusing on the professions of medicine, nursing, and midwifery.

There are two main points I want to make about the recruitment of internationally educated health professionals and their integration into the Canadian health care system.

Just as a backdrop, if we look at this question historically, the role of internationally educated health professionals has for some time been intricately connected with health human resource policy in Canada. We rely heavily on them, particularly during periods of shortages, when we recruit from outside the country and integrate those who have come here through our immigration process. Their integration process becomes much more difficult when there are periods of perceived surpluses or periods of health care cutbacks. Canadians have benefited from this flow, receiving greater access to health care and reduced public costs for health professional training. There are costs, of course, for their integration.

The context I want to put this issue within is a series of ethical codes, the most recent one being the World Health Organization global code of practice on the international recruitment of health personnel. What is interesting, however, in the research that I and my research team have undertaken is that there's very little recognition of these codes. There's a Commonwealth code from 2004. The code in hand was developed in 2010, and there's a requirement to report back to the World Health Assembly on the commitment to this code. Some of the key principles of the code have been recrafted into a Canadian document.

It's beyond the recruitment issue; it's really about the sustainability of health human resources. Some of the key principles include creating a self-sufficient health workforce, however that becomes defined; an aim for transparency, fairness, and mutuality of benefits, not only for the internationally educated health professional, but also for the country where they have had their training and the country they come from; and ensuring that all aspects of the employment of international health personnel are without discrimination of any kind.

There are two aspects of the integration of internationally educated health professionals. The one that you're primarily dealing with is integration into licensed practice, into the profession in this country. This includes national policies and processes surrounding the recognition of their qualifications and licensure at the provincial and territorial levels. So there's the complexity between federal and provincial jurisdictions.

The second issue is the integration into the culture of practice. This matter of cultural competency is often neglected but forms an essential part of the integration process. In all four countries in which I've been doing research, this has been highlighted as a particularly important issue. In research that we've done in Canada, we have seen a variety of barriers that internationally educated health professionals face when they're trying to become integrated into the Canadian workforce. There is English or French language competency, but it's beyond passing the standard language test—they want profession-specific language competency. That's quite important.

There are a variety of different financial difficulties related to the requirements for licensure that are compounded by the time-consuming and sometimes bureaucrat nature of the process. I can speak personally as a Canadian-educated researcher that it has become difficult even for me to understand what the process is to become licensed as a physician, as a nurse, or as a midwife in Canada. I can imagine how difficult it must be for someone coming to this country.

● (1650)

The challenges posed by the lack of opportunity to gain Canadian experience while they're here, trying to become integrated, means they don't gain that much-needed cultural competency. Particularly in the area of health care, which is dealing with issues of privacy, very sensitive issues, this is a very important issue.

The consequence of those barriers includes downward professional mobility, the lack of recognition of qualifications. And the numbers are quite large. The most recent estimate we had in Ontario is that there are approximately 5,000 physicians who are in Ontario and not able to practise. These are quite important numbers to look at.

Canada has developed a variety of different bridging programs. In fact, Canada, among the four countries I've looked at—Canada, the U.S., the U.K., and Australia—has been a leader in those bridging programs. They are quite variable. They vary in length, they vary in purpose, and they vary in effectiveness. Some programs focus on assessment of the existing education and skills to identify needs to train up; some focus on preparation for licensure exams; and some provide some clinical or work experience. Very few provide some familiarity with the social and cultural context of the Canadian health care system.

One particular promising practice that I would like to highlight for the committee is the Access Centre for Internationally Educated Health Professionals here in Ontario, where they take a case management approach, very personalized, and they do career reorientation. It is actually through access to their data set that we know they have a clientele of 5,000 physicians in the province who are trying to make their way into regulated practice.

● (1655)

The Chair: Ms. Bourgeault, if you could wrap up, that would be good.

Dr. Ivy Lynn Bourgeault: Yes. I will go to my concluding facts.

In highlighting how to make the integration process easier, we have to also note that it may have the unintended consequence of drawing more people here from other countries, which contravenes one of the principles here.

Another challenge is that of reducing discrimination against internationally educated health professionals while diminishing the negative effects of their migration on their home countries.

I would also like to stress that a coordinated approach is very much warranted, particularly offered through a pan-Canadian health human resources observatory, which has been recommended by the Standing Committee on Health. I'm just back from Australia where they have an organization called Health Workforce Australia, which provides this coordinated approach. They have a model for us to look at in terms of a coordinated approach to integrating internationally educated health professionals.

Thank you very much.

The Chair: Thank you very much.

We'll start with Ms. Crowder.

Ms. Jean Crowder: Thank you.

I want to thank the panellists for your presentations, and particularly the specific recommendations for things the committee might want to undertake. Although this sort of relates to cultural competency, one of the previous panellists raised the issue of racism and discrimination. The Deloitte report actually raises that issue as well. I'll read one brief quote from it:

> Some immigrants say that they've been advised to change their name on their resumé or refrain from bringing 'different' or 'smelly' foods for lunch to fit in.

It goes on to talk about one particular employer who had a series of layoffs happening, and 85% of the people on a list of layoffs were highly educated, competent, and ambitious professionals, and all were foreign-born workers.

On the one hand, we're actively pursuing people to come to this country and work, and yet on the other hand it seems there are some real challenges towards integrating people into the workforce, once their credentials are even recognized. Are you aware of any programs that work with employers in Canada around increasing cultural sensitivity, so that when we do have people who are accredited they can then work?

Ms. Bourgeault, I'll start with you.

Dr. Ivy Lynn Bourgeault: Yes. I'm not aware of any specific programs, but I do know that through the Access Centre for Internationally Educated Health Professionals here in Ontario, through their case management approach they do provide some support for the employers who hire the particular internationally educated health professionals with whom they are working.

There are also some good models through the Office of the Fairness Commissioner in Ontario to provide some support in that regard.

Ms. Jean Crowder: That's a provincial government program. It's fine once somebody is hired, to work with the employer to help with cultural sensitivity and integration, but how do we even get employers to the place where they're willing to consider foreign-trained professionals?

Dr. Ivy Lynn Bourgeault: There are some municipalities—here it's Hire Immigrants Ottawa. It's a particular program from the City of Ottawa that provides incentives and training and support for employers to hire immigrants. It's not specifically focused on health professionals or professionals in general, but that is another program that I'm aware of.

Ms. Jean Crowder: It sounds like a one-off.

Dr. Ivy Lynn Bourgeault: Yes, and that is why there's very much a lack of a coordinated approach in this area.

Ms. Jean Crowder: Mr. Soucy or Mr. Lees.

Dr. Benoit Soucy: The immense majority of dentists are self-employed and the need to work with employers is not there, but there is a big need to work with the internationally trained dentists to be able to function on their own in the Canadian market,and that is something we haven't been very successful in doing.

We know Canadian dentists have some cultural sensitivity training to know how to deal with patients of different origins and be more efficient at that level, but as far as having national programs to support international dentists, not much is done.

Some local efforts are made. The Royal College of Dental Surgeons of Ontario has an ethics course that is mandatory for any new licensee. It is not necessarily focused on internationally trained dentists. It is for any new dentist who wants to practise in Ontario. That is required, and that might be helpful.

Mr. Robert Lees (Representative, Canadian Dental Association, and Registration Manager, Royal College of Dental Surgeons of Ontario): The module that Benoit is speaking to recently moved online. It is also free, so although it's a requirement for licensure in Ontario, anyone around the world can take it. The National Dental Examining Board, NDEB, does have a self-assessment tool as part of its armamentarium, but anyone, anywhere in the world, can take our ethics course, which does speak to how dentistry works in this province, ethically, culturally, and legislatively.

● (1700)

Dr. Andrew Padmos: Thank you.

The Royal College represents an educational certifying college for approximately half the medical profession in Canada. The other half is represented by the College of Family Physicians of Canada, who are primarily in primary care.

We're in the same situation as our colleagues in dentistry. Most of our members are self-employed, autonomous physicians who have privileges to practise in medical institutions, so they don't have employers, nor is there any organization that sets out a program of orientation or mentoring.

Some of the provincial colleges that are the regulators of medicine have a buddy system as part of their enforced clinical observation period, which provides that orientation, mentorship, and supervision that are very necessary components.

The Chair: Thank you. Your time is up.

We'll move to Ms. Leitch. Go ahead.

Ms. Kellie Leitch (Simcoe—Grey, CPC): Thank you very much, everyone, for presenting today.

Maybe I could get your comments on a couple of questions.

To go back to what Dr. Padmos was already commenting on, what are your thoughts on how we, as the federal government, can facilitate your specific professions achieving this integration of our provincial colleagues to be able to have the opportunity for the single, national approach for credentialling in your fields? If it be a single source, who should be developing this, and how should they be going about doing that? It would be good to have your input since we seem to be struggling with these professions to be able to achieve that.

Dr. Andrew Padmos: The Federation of Medical Regulatory Authorities of Canada, FMRAC, as we know it, has already taken considerable action provoked by the Agreement on Internal Trade. It has established that certification by the Royal College or the College of Family Physicians would be accepted as the gold standard for unrestricted, independent medical licensure. They are rationalizing a vast number of provisional or limited licences to make sure that the qualifications are appropriate and that the progress to full and independent licensure is clear.

They have done quite a bit of work on this objective.

Dr. Benoit Soucy: The majority of the work in dentistry is done as a consequence of the Agreement on Internal Trade. We have a one-point facility for the assessment of credentials and testing afterwards, which is the National Dental Examining Board. They have been doing that for the last 10 years in a model that had a qualifying exam for foreign-trained dentists that led to the qualifying program, as I mentioned. Thanks to some federal funding they were able to come up with a model that can lead straight into practice, mostly through the addition of some simulation practices.

Ms. Kellie Leitch: I also wanted to ask what your thoughts are with respect to processes for pre-credentialling foreign sites so that students who are graduating from those sites—individuals who would come to Canada and train on Canadian soil and then be accepted into the process—could more freely and expediently enter into the Canadian workforce.

Dr. Andrew Padmos: Again, for the physicians, the Medical Council of Canada's evaluating examination is available online at several hundred sites around the country. I believe the language proficiency testing is also available. The Physician Credentials Registry of Canada could be accessed from outside the country. All of those stipulations could be met.

Ms. Kellie Leitch: What I mean by “site” is a physical site providing for the clinical capabilities of those individuals, not just a website. I apologize, I should have been more specific.

Dr. Andrew Padmos: That would be extraordinarily difficult, because we're requiring the evaluation, experience, and acumen of Canadian-trained or Canadian-placed individuals. Some might want to be exported to those faraway sites like Australia or New Zealand to conduct such work, but it would be out of context and probably inadmissible.

● (1705)

The Chair: I think Ms. Bourgeault had a brief comment, if you could.

Dr. Ivy Lynn Bourgeault: There were a couple of comments in regard to where you establish such sites and whether or not they're examining sites, whether it's a written exam or a clinical exam. There are resource implications for those. There are also 50 countries that have been identified on the WHO list where you should not be recruiting from. There are additional countries where you should probably not recruit from as well, even though they're not on the list.

For this notion of mutuality of benefits, this creates an easier way for people to become integrated before they come to Canada, but it's a double-edged sword, because it does create a draw of people outside of countries that need their human resources as much if not more than we do.

The Chair: Go ahead, Ms. Leitch. Do you have any further questions?

Ms. Kellie Leitch: I don't know if Mr. Soucy wanted to comment on that as well.

Dr. Benoit Soucy: As I mentioned, the approach we have chosen in dentistry is the mutual recognition agreement of accreditation systems in other counties. Setting up a specific process that would be operated from offshore is extremely difficult because of resource issues. What we have committed to is to make the equivalency assessment of the national board available to any international site where more than 50 candidates are willing to write the exam. For example, we have a site set up in London for next year where we have 70 candidates registered already.

The Chair: Your time is up.

We will move to Ms. Hughes.

Mrs. Carol Hughes (Algoma—Manitoulin—Kapuskasing, NDP): Thank you.

This is for Mr. Padmos.

International medical graduates need to complete an accredited residency program in family medicine or another medical or surgical specialty before obtaining certification. Are IMGs able to find residency placements rapidly after they arrive in Canada?

Dr. Andrew Padmos: That's a good question. In fact, the premise is not currently operative. We have a practice eligibility route to certification for people to whom medical regulator authorities have already given licences and who are practising in Canada. Those individuals are able to access the Royal College certification without doing a formal residency training program by going through a multi-step assessment, a multi-dimensional evaluation process leading to a portfolio evaluation of the type of work they are doing, rather than a full examination of the full spectrum of their specialty.

Also, the family physicians of Canada, as far as I know, do have alternate pathways that do not involve residency or examination, depending on the country and accreditation system that has been employed in those cases. For those individuals who are deemed by a medical regulatory authority—not by the colleges—to require a residency program, there are severe constraints on the availability.

Canada has approximately 2,800 residency positions for intake into the first year of training after medical school. That number is closely related to the output of medical schools so that they guarantee each Canadian graduate the chance at a residency program. There are few extras set aside specifically for international graduates. Most are in Ontario. Taken altogether, about 250 residency positions are available. This is, however, insufficient to deal with the several thousand permanent residents and citizens of Canada who are international medical graduates.

The system has limited capacity to expand further. We now have residents-in-training outside major hospitals and urban centres all over. If funding were made available—deans of medicine are known to respond to the provision of hard cold cash—perhaps further residency slots could be made available.

Mrs. Carol Hughes: I appreciate that. That's what we heard last week—that there is a big shortage of placements for international professionals.

The Government of Canada allocated $75 million over five years for the international educated health professionals initiative to support projects aimed at facilitating the assessment and recognition of foreign credentials, as well as the integration of medical graduates into the health care system.

Have you participated in any of the funded programs under this initiative?

● (1710)

Dr. Andrew Padmos: Yes, we have. We're members of working groups, particularly the national assessment collaboration, which is headed up by the Medical Council of Canada. It has developed what's called an objective structured clinical examination for international medical graduates to ascertain their suitability for residency positions. That examination has now been rolled out in several provinces and soon will be available in all provinces. We participate in programs of that nature on invitation. We're not funded to conduct any of them.

Mrs. Carol Hughes: Mr. Soucy, do you want to comment on this—or anybody else?

Are there any improvements that need to be done to that?

Dr. Benoit Soucy: The biggest problem we have in dentistry is that, unlike medicine, we don't have a public system of care delivery. All the care is provided privately. The only place we could send a resident is to a dental school.

As we were told, the deans seem to respond to cold hard cash. We haven't been able to get ongoing funding in order to set up this type of program. We are definitely lacking in opportunities to train certain categories of dentists when they come here. We even have the same problems for dentists who are practising in Canada and require remedial education because they ran afoul of the regulator in their province.

Mrs. Carol Hughes: Where are the shortages of dentists in Canada, or is there a shortage?

Dr. Benoit Soucy: There is no shortage of dentists in Canada in numbers. There is a problem with distribution. When you get into a sparsely populated area, there simply isn't the population required to maintain a viable business. That's a huge problem in the areas that do not have dense populations.

The Chair: Thank you, Ms. Hughes.

We'll now turn to Mr. Butt. Go ahead.

Mr. Brad Butt (Mississauga—Streetsville, CPC): Thank you very much, Mr. Chair.

Thank you all for being here today. I think I'll start with Dr. Padmos.

Is there a physician shortage in Canada right now?

Dr. Andrew Padmos: That depends on whether you're a patient or a member of the public. But I think there is a physician shortage. Part of it is maldistribution. A lot of it is because physicians are doing things they probably shouldn't do that others could do just as well or perhaps even better.

In some respects there are specific shortages. Primary care is an area where, if we accept the proposed model of a medical home, a large number of Canadians do not have access to a comprehensive, continuous family practice environment, which is the ideal model for delivering primary care.

There are some specialties in medicine. There are 65 specialties and subspecialties within our purview that are considered to be short. There are others where the supply is probably at least temporarily more than we need. Some physician specialists and surgical specialists are currently looking for positions or continuing their training in more and more arcane and erudite areas of medical practice in order to wait or to train themselves for a specific practice opportunity.

Mr. Brad Butt: I think you mentioned that 2,800 per year are going through residency and eventually becoming physicians or surgeons in some way, shape, or form. Is that number sustainable each year? Are we going to fall further and further behind because there aren't enough graduating to replace those who are retiring or ceasing to practise in some way?

On the second part of that question, is that number sustainable only with Canadian graduates, or will we require, as we move along, more and more doctors in Canada who have been trained internationally?

Dr. Andrew Padmos: If the stock market improves I think there will be a sudden shortage of physicians, because many of them are still practising beyond normal retirement age. That is a significant current issue.

The number of 2,800 is not enough to have national self-sufficiency in our supply of physicians. Of Canada's medical workforce, 25% trained outside of Canada, and that has been the case for a long time. So if we want national self-sufficiency, we probably need to have an intake or at least a medical school output of well over 3,000 per year, and a suitable number of residency positions to fully train and certify those individuals.

● (1715)

Mr. Brad Butt: I was going to ask Dr. Bourgeault a question. You said you studied four countries, their systems and what they're doing. Who is doing it better than we are? Who is getting their international medical graduates recognized quicker, practising quicker, whether it's Australia or whatever other country? Who is doing a better job, and why is it better?

Dr. Ivy Lynn Bourgeault: I think all four countries fail in terms of health human resources. I think that the tool three of those four countries, not Canada, have put in place has been a coordinated observatory, Health Workforce Australia, Health Workforce New Zealand, Centre for Workforce Intelligence in England. They are trying to coordinate this.

To answer the question you were talking about before, do we have enough doctors, I think the better way to answer that, or a different way to ask that, is what should doctors be doing? Where should they be practising? Should they be working at the top of their skill level, as well as the nurses, nurse practitioners, working at the top of their skill level?

We have written in legislation scopes of practice, and often these health care professionals are not working to their full scope of practice. If we did that through a variety of different incentives and coordinated policies, then I think we would have less of a shortage.

I also do want to caution that there has been a ramping up of the numbers in medical schools. If we looked at some of the other countries, like Australia and the U.K., they ramped up medical education. They will have quite a few of their graduates. They're looking at—and they were talking about it last week—unemployment amongst physicians in the U.K. and a possible situation of unemployment in Australia. They've ramped up much greater than we have.

I think you have to think about the health human resources as a system. It isn't just physicians and it isn't just nurses; it's the whole system together. Who should be doing what? They're doing fascinating things in New Zealand, having pharmacists manage certain prescriptions—because we're moving into a system of managing chronic diseases. Who is the best person to do what? I think that's the kind of question we need to ask, rather than do we have enough numbers. We seem to always be focused on numbers rather than on what they should be doing, where, and how.

The Chair: Thank you, Ms. Bourgeault. That concludes your time.

Ms. Crowder.

Ms. Jean Crowder: I do have a question. I just saw that Mr. Padmos had his hand up. I wonder if he wanted to add to that.

Dr. Andrew Padmos: I was just going to say that half of the patients I see in a general hematology clinic would not need to come to a general hematology clinic but could be seen in a family physician's office. The reason they don't is either uncertainty on the part of the physician or because our payment system, where you pay people to be pushed through a primary care system, encourages referral of anything that's out of the ordinary or at all difficult.

Rather than taking the time, they flip them off, and they wait three, six or nine months often to see someone like me in a specialist clinic.

Ms. Jean Crowder: Ms. Bourgeault and Dr. Padmos, you have both addressed a very critical issue in terms of the whole planning for health human resources in Canada. Again, in my view, we need a national strategy around the human resources. We're not talking about health care delivery, because that's clearly a provincial responsibility, but in terms of national leadership about health human resources....

Both of you have identified a couple of problems. Dr. Padmos, I heard you say that doctors are doing things they shouldn't be doing. We've got this problem with medical school graduates and whether there are placements for them, and we've got Canadians who are foreign-trained physicians coming back to Canada and they can't get residencies. These are people working in the highest and best practice.

If you were going to make one key recommendation to this committee around a health human resources strategy, what would it be?

Dr. Andrew Padmos: I think we should fund the observatory or research unit that Dr. Bourgeault has described.

Dr. Ivy Lynn Bourgeault: I would echo that.

Ms. Jean Crowder: Along with the funding, what are one or two key first steps that need to happen with this?

Dr. Ivy Lynn Bourgeault: You have so many different organizations in the health human resources field. You have an organization, the Canadian Institute of Health Information. It's an absolutely fantastic, internationally recognized organization collecting statistics, but those statistics aren't feeding into an advisory process.

You have the Advisory Committee on Health Delivery and Human Resources, which doesn't as a rule consult with the kinds of stakeholder organizations that you're consulting with on a regular basis.

The thing you have to realize is that the system of health human resources, the health care division of labour, is a complex adaptive system. You pull one policy lever and something will happen here. You have to have an organization whose full-time job is to watch that and to monitor it, and to have policies that respond when things are starting to go awry.

Sometimes you may have this amazing technological change that will mean, oh, we don't need any more of this kind, or we need less, or we need them over here. So having an organization like the pan-Canadian health human resources observatory allows you to do that. Again, it's not rocket science. It's being done with incredibly good results in Australia, New Zealand, and England.

● (1720)

Ms. Jean Crowder: So there are three good examples of where it's working.

Dr. Ivy Lynn Bourgeault: Health Workforce Australia, Health Workforce New Zealand, the Centre for Workforce Intelligence in the U.K., and there's also an organization that's much smaller in the United States. But I think those other three organizations are much more applicable because of our public health care system.

Ms. Jean Crowder: Dr. Padmos, did you want to add something to that?

Dr. Andrew Padmos: No.

Ms. Jean Crowder: What gets in the way? I was the health critic for the NDP back in 2004-05. This is not a new conversation, and there are many, many, many people out there who have written books and studies and whatnot to talk about what we need to do with health human resources in Canada. Yet we don't seem to be able to come to grips with it.

Dr. Bourgeault.

Dr. Ivy Lynn Bourgeault: We have some of the best researchers in health human resources here in Canada, and that's recognized in those other countries. But they have created an organization that really capitalizes on their research expertise and their knowledge. The research expertise is not just in the universities; it's in the stakeholder organizations as well.

The thing is that there's this allergic reaction to doing any centralized planning around health care delivery, because yes, it is a provincial jurisdiction.

But just getting back to the comment before about the $75 million that was provided to instigate some initiatives around internationally educated health professionals, the provincial stakeholders said without that money we would not have been able to do these things that we're doing.

I think there is an appetite to have a better coordinated response, because you have one province stealing from another province. So there's interprovincial jurisdiction or competition as much as there is international recruitment. I think someone just has to take the bull by the horns and do this.

The Chair: Thank you for that point and suggestion.

Your time is obviously up, and given that the bells are ringing, it may be a good time for us to adjourn.

Thank you for your presentation and for your recommendations.

The meeting is adjourned.

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