HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

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

HUMA • NUMBER 035 • 1st SESSION • 41st PARLIAMENT

EVIDENCE

Wednesday, April 25, 2012

Chair

Mr. Ed Komarnicki

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

Wednesday, April 25, 2012

● (1535)

[*English*]

The Chair (Mr. Ed Komarnicki (Souris—Moose Mountain, CPC)): All right. We'll attempt to bring this meeting to order.

I'll remind the committee that we'll devote the last 15 minutes to committee business. That will be at about 5:15.

We'll hear from the presenters and, of course, we'll be able to ask questions. At about 4:30, we will break for a few moments and then recommence.

We have with us Mr. Arthur Sweetman, who will be presenting. Also, on behalf of the Canadian Institute for Health Information, we have with us Jean-Marie Berthelot, vice-president of programs and executive director of the Quebec office. We have the Canadian Nurses Association with us as well.

With that, we'll start with Mr. Sweetman.

Go ahead.

Dr. Arthur Sweetman (Professor, Department of Economics, McMaster University, As an Individual): Thank you very much.

Since much of what you've been looking at has to do with the private sector, I thought it would be good to start by addressing the need for health human resources, which in the health sector are quite different. Canada's single-payer medicare system is the primary source of divergence between the public and private sectors. While many health service occupations are outside of medicare, its influence remains substantial. As a result, the affected labour markets are not competitive, and what we normally think of as supply and demand do not operate.

Consider the extreme example of physicians. In each province there's only one employer, and fees are bargained collectively. On the supply side, the provinces, with some consultation, set the number of domestic applicants admitted to medical schools, as well as the number of international medical graduates admitted to practise. Provincial governments also legislate the regulatory colleges that provide quality control and oversight.

In determining the number of open slots for new physicians, provinces need to play a balancing game. They need to take into account the health care requirements of their populations. Also, they need to take into account the tax revenue or debt financing needed to fund those positions. This is extremely challenging. In this context, a lot of data and a lot of information and planning are required.

This process has generated a perceived shortage that is slowly being reduced. In fact, in the last decade, many provincial governments have moved very aggressively to increase the number of physicians per capita.

In Ontario, for example, beyond physicians, the Regulated Health Professions Act traditionally covered 24 professions and, at the moment, two or three occupations are in the process of being brought under the act. As well, many health services occupations that are not regulated are primarily employed by provincially funded hospitals or other institutions. None of these occupations operate in the way we traditionally think of labour markets operating.

So what's the federal role? I'd like to raise two issues for you to consider. First, my personal view is that while many of the appropriate institutions are in place, they are frequently not as active as they could or should be. I believe that communication and coordination among the provinces and the federal government are still not sufficient, and there's a need for increased information sharing. Health Canada and CIHI play very important roles, as does Statistics Canada. Also, since it has a lot of capacity in the area, HRSDC also plays a role, though it could play a larger one.

I should note that what I'm talking about is routine. It's what I consider well below the radar screen.

One of the examples that I might think of as a structure for facilitating this is the existing federal-provincial-territorial Advisory Committee on Health Delivery and Human Resources. This is a standing committee of the federal-provincial-territorial Conference of Deputy Ministers of Health. In my ideal world, an invigorated version of this group would, in coordination with CIHI, generate substantial sharing of health human resource data and practical experience between governments and other relevant stakeholders, such as the Canadian Nurses Association and the Canadian Medical Association.

The second issue is a focus on immigration, which plays a very important role in these areas. I believe that immigrant selection for individuals working in health professions, where the provincial governments are the principal payers, should be taken out of the federal skilled worker program and put into the provincial nominee program.

The current points system is very poorly suited to regulated health professions under our single-payer system. A coordination problem arises from having immigrant selection at the federal level while employment and planning occur almost exclusively at the provincial level. This is completely different from private sector markets. I suspect that the most useful approach would be to shift this responsibility to the provinces, since they have the levers to verify credentials in the health area and to implement their health human resource planning.

Thank you very much.

● (1540)

The Chair: Thank you for that presentation and for those comments regarding the skilled worker program and the provincial nominee program. It operates differently from province to province, but it's certainly an area that might be used going forward.

Now we'll let you present, go ahead.

Mr. Jean-Marie Berthelot (Vice-President, Programs and Executive Director, Quebec Office, Canadian Institute for Health Information): Thank you very much.

Good afternoon. On behalf of the Canadian Institute for Health Information, I would like to thank you for inviting us to participate in your study of labour shortages.

I am accompanied by Carole Brulé, who is one of our managers of the HHR databases we collect in CIHI.

[*Translation*]

CIHI is an independent, not-for-profit corporation that provides essential information on Canada's health system and the health of Canadians. Established in 1994, we are funded by federal, provincial and territorial governments. We report to an independent board of directors representing government health departments, regional health authorities, hospitals and health-sector leaders across the country.

CIHI works in partnership with stakeholders to create and maintain a broad range of databases, measurement tools and standards on health information. We produce reports on health care services, population health, health spending and health human resources.

[*English*]

CIHI has been collecting detailed information on physicians and nurses since its inception. More recently, we created new databases that provide demographic and workforce information on pharmacists, occupational therapists, physiotherapists, medical laboratory technologists, and medical radiation technologists. CIHI also collects aggregate data for an additional 17 health professional groups, such as dentists, midwives, and psychologists.

Altogether, more than one million people in Canada, over 6% of the total Canadian workforce, are employed directly in the heath care system. In 2010, approximately 70,000 of these health care professionals were active physicians.

● (1545)

Over the past five years, the growth in the number of these professionals has consistently outpaced population growth. In fact, there were 203 active physicians per 100,000 Canadians in 2010, the greatest proportion there has ever been in this country. Most of the growth in the physician workforce is due to an increase in the number of medical graduates from Canadian faculties of medicine. Since 2003, it has increased by nearly 60% to more than 2,400 graduates in 2010.

The overall number of training seats continues to grow, so the upward trend in the supply of physicians is expected to continue.

[*Translation*]

Regulated nurses, the largest group of regulated health professionals in Canada, are also increasing in number: in 2010, there were close to 35,000 registered nurses, licensed practical nurses and registered psychiatric nurses working in nursing in Canada—an increase of nearly 9% since 2006, about twice the rate of the increase in the Canadian population for the same period.

The nursing representative will no doubt cover nursing care in depth, but still, it is interesting to note that the supply of new nursing graduates was over 14,000 in 2006 and over 16,000 in 2010—a growth rate of 17%—so the increase in workforce numbers is likely to continue.

[*English*]

There are also increases in the supply of other health professionals. For example, the per-population supply of all pharmacists in Canada has increased consistently from 82 per 100,000 in 2006, to 91 per 100,000 in 2010. Supply as a whole grew by 16% in that period, reaching a total of approximately 32,000 physicians in 2010.

CIHI data shows that the number of all regulated health professionals, other than physicians, nurses, and pharmacists, also increased by 16% from 2006 to 2010. In total there were approximately 160,000 in the 18 other professions for which CIHI collects data.

Supply-based trend information for all of these professionals is available through a series of reports called “Canada's Health Care Providers”. They contain a broad variety of other supply and graduate data to support health services management and research.

We also have separate and detailed analyses on doctors, nurses, pharmacists, occupational therapists, physiotherapists, medical radiation technologists, and medical laboratory technologists. All of our reports are available on our website.

[*Translation*]

The brief we are presenting to the committee contains further information, including interesting provincial variations, details about the nursing workforce and a list of groups on which we are collecting data.

We know that Canada has more doctors and pharmacists than ever, and that nurses have yet to return to their pre-1990 numbers—but we also know that numbers alone do not tell the whole story.

[*English*]

The demand for services from all health professionals depends on a number of factors. These include population health care needs, the hours professionals spend on patient care, the individual professional's scope of practice, demographic changes to medical and health workforces, and the way care is organized.

The issue of labour supply among health and medical professionals is especially complex. We hope that our data on health human resources help inform discussion on the subject.

We would be pleased to answer any questions you may have in the official language of your choice.

Merci beaucoup.

The Chair: Thank you very much.

Ms. Bard, will you be presenting?

Ms. Rachel Bard (Chief Executive Officer, Canadian Nurses Association): Good afternoon.

On behalf of Canada's quarter of a million registered nurses, I really appreciate the opportunity to speak to you today concerning health labour force issues.

Evidence of a nursing shortage in Canada has long been clear, from frustrating wait times in clinics and hospitals to poorer results for patients. The negative impact of the shortage of registered nurses and other health professionals is something that Canadians face every day.

● (1550)

Current research puts Canada's shortage of registered nurses at approximately 11,000 full-time equivalents. Left unaddressed, that shortage is projected to reach 60,000 full-time equivalent RNs by 2022, a reality that stands to risk future health outcomes. That my colleague said that the numbers are increasing is a good sign. However, there are still some other matters that need to be addressed.

A labour shortage implies an imbalance in both supply and demand. Comprehensive thinking about the supply of registered nurses will help us better meet the health needs of Canadians. We need to go beyond the narrow thinking of strict numbers of nurses and think about their participation in the workforce based on the level of activities—that is, whether they are full time or part time—the rates of absenteeism, and how productive the workforce actually is. The number of services that registered nurses can actually supply in a day is affected by the model of care delivery in place, the composition of health teams, and how efficiently health teams work together. It also includes whether or not barriers exist that prevent health professionals from offering the complete range of care for which they are qualified—that is, working to their full scope of practice.

Productivity gains can be made through facility design, use of technology, and health delivery innovations. We see productivity gains with nurse practitioners in Newfoundland and Labrador, who are supported by teams and telehealth technology while providing care in rural and remote communities. By doing things differently we can enhance the use of the existing supply of nurses already working within the system, all the while providing more patient-centred care. As you can see in our brief, implementing measures to increase RN productivity by 1% per year would have a dramatic and immediate effect on the shortage.

We can also improve our access to and use of labour market information through the Canadian Institute for Health Information. To ensure that we have accurate information on where registered nurses are working, a national unique identifier should be employed. This in essence would be a number assigned to a registered nursing student that would enable us to track when and where they are entering the workforce, and their practice patterns. Implementing this identifier would significantly improve our ability to track the mobility of our nursing workforce both internally between provinces and territories, and externally, for example, when nurses leave Canada to work in the U.S. or other countries.

To better understand the capacity of the nursing workforce, a national study on the health and work of nurses should be repeated. When CIHI conducted a study of this in 2006 it revealed that registered nurses had an absenteeism and sick rate that was double the Canadian average of seven days. These 2006 survey results have led to some innovations in creating healthy workplaces. Repeating the survey now would provide us with current, accurate data, and allow us to evaluate the effectiveness of these innovations.

A third recommendation deals with pan-Canadian health human resources planning and mirrors one of the main recommendations made recently by the Senate Committee on Social Affairs, Science and Technology in its review of the 2004 health accord. The federal government should conduct a feasibility study to determine the benefit of establishing a pan-Canadian health human resource observatory.

Health human resource observatories have been implemented in some European and South American countries to analyze trends and health human resources needs and to identify opportunities to implement best practices, which ultimately lead to more value and better care within our health care system.

● (1555)

The opportunity exists to build this innovation into existing federal agencies to ensure that health human resource planners have coordinated resources and best information at their disposal to better meet the planning challenges of Canada's multi-jurisdictional health care system.

While it is important to explore ways to increase the supply of nurses, it is also critical that we take opportunities to reduce demand for health services, through illness prevention, health promotion, and especially the prevention of chronic diseases like heart disease, diabetes, and cancer.

Canadians benefit from federal programs that encourage smoking cessation or healthier living. CNA is concerned about cuts to these programs, the results of which are as threatening to the supply curve as the shortage of surgical nurses or emergency room doctors.

The stable and sufficient supply and deployment of Canada's health professionals continues to be one of our greatest health care challenges. By looking at these recommendations in concert with a comprehensive view to reducing demand through health promotion and disease prevention, we can take steps to address the nursing shortage and enhance the health of Canadians.

Merci beaucoup.

The Chair: Thank you very much for that presentation. Generally it's good to go beyond our narrow thinking, and being prepared to do things differently is always a good piece of advice, I'm sure.

We're going to have seven-minute-rounds of questioning. We'll try to keep members' questions to around the seven-minute area.

We'll start with Ms. Charlton.

Go ahead.

Ms. Chris Charlton (Hamilton Mountain, NDP): Thank you very much, Chair.

Thanks to all three of you for your excellent presentations.

We'll each be asking questions, so I'm going to focus my questions for the moment to Ms. Bard and deal with the nursing shortage in particular.

I know that the two challenges are both retention and the attraction of new nurses to the field, and I want to explore that a little further. Yesterday we had a witness who said that we needed to change the narrative in attracting people, and I think there is much merit to that with respect to the health field as well.

We've seen a bit of credential creep, if you will, whereby nurses who want to enter the field need to have increasingly higher levels of education. Yet, because of the way salaries are negotiated in the field, these aren't really keeping pace with the cost of that education. It's difficult to attract young people to a field where the tuition fees are unbelievably high.

I wonder if you would comment on whether it might make sense to explore ways to reduce the barriers to that kind of education, whether it's through incentive programs and loan forgiveness perhaps—if nurses were to practise in areas where there are acute shortages.

If you're comfortable with this, I'm going to pose a whole whack of questions and then turn the floor over to you for answers to all of them.

If we're changing the narrative in the nursing profession, I do know that it's one of the professions that has the highest rates of occupational injury and that retaining nurses is incredibly difficult in an environment where sick days are often higher than the national average. You've largely addressed that.

We are now also faced with a policy on the government's part, where we're potentially going to increase the age at which people can collect the OAS from 65 to 67. Nursing is an unbelievably physically demanding occupation. I wonder if you could comment on whether it would be possible for nurses to continue to work until they're 67 and do the jobs they're doing. Again, that speaks to retention, but perhaps from a bit of a different angle.

And lastly, I'm from Ontario, and I remember the Mike Harris years. The premier, I think, infamously compared nurses to hula hoops, that their time had come and gone. At that time we had a huge out-migration of nurses from Ontario to the States in particular—to Florida and Arizona—which then created a shortage at home from which I don't think we've recovered.

If we're looking at retention of nurses, there are work environment morale issues as well. I wonder if you could speak to that and give us some guidance as to what we can do, as federal legislators, to improve the work environment in all three of those respects.

Thank you.

● (1600)

Ms. Rachel Bard: Thank you very much for your question.

I will refer you to our report, *Tested Solutions for Eliminating Canada's Registered Nurses Shortage*, because it addresses some of your questions.

Starting with student retention, we know that a high percentage of students leave in their first year of learning, and it's clear that we do need to have some programs that will help retain students. We know that if we can reduce by even 10% the number of students who leave, that will actually have an impact on the numbers of nurses graduating and who are able to enter the workforce.

So we do need to provide some support. We have students who are starting a second or third career. They have families and therefore they need to have some social programs that will help them, certainly from a financial perspective, or even in terms of better support to help with adjustment and so on.

So I think that has been identified. We've seen this is a policy direction that needs to be addressed.

In relation to absenteeism in the workforce, and certainly the quality of work life of nurses, again I think our report identifies the high percentage involved. If we can address some policy to retaining our nurses and improving the work life and work conditions of nurses, removing barriers for them so that they can practise to their full scope, and providing them with the necessary support, that will have an impact on retention of our nurses and on keeping our nurses in a healthy workplace environment. So definitely, there's a need to address some of that.

CNA has also produced, in collaboration with RNAO, which is within one of our jurisdictions, a report on nurse fatigue. That report identifies some evidence that we need to pay attention to. It requires a collaborative and collective approach between the employers, the nurses, the professional body, such as our association, the Canadian Nurses Association, and the government to create an environment and address some of the barriers and the hindrances in the workplace. It takes a collective effort. It's not just one side: it requires federal intervention as well as provincial intervention.

Retaining nurses over the age of 60 was another policy direction in our *Tested Solutions* report, where we see there are models for doing so. We can retain nurses so that they work beyond the age of 60 and over 65, provided we create a climate that will address their work balance. There are models right now that have been tested, where there's an 80-20 situation. So nurses who are more senior in their practice and more experienced and are older can become mentors for the younger generation and provide other types of services so they're not fully into direct care. Again, you try to retain them as long as you can, but you need to adjust their work conditions.

The Chair: You've got about 30 seconds. I don't know whether you want to ask a short question.

Ms. Chris Charlton: I'll ask a really quick question, because it's really just for clarification.

With respect to reducing international in-migration, there's a note here that says:

> Reducing international in-migration by 50% would result in a larger shortage of RNs; however, the effect of this change is not at all substantial (less than 10%) even in the long term.

I don't understand the bullet. I just need you to explain to me what that actually says.

Ms. Rachel Bard: What it says for us is that if we can address the four policy directions that we've identified for retaining our nurses and improving the conditions in the workplace, we don't necessarily need to rely on international recruitment of nurses, because this is not where it's going to have the greatest impact. It has very minimal impact in addressing the shortfall and that's why we're saying let's not put all our energy there.

● (1605)

The Chair: Thank you for that.

Ms. Leitch, go ahead.

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

Thank you, everyone, for being here today. I greatly appreciate your time and your effort to get here. I have two sets of questions, and I hope we can stay short and succinct.

The first set is about data. I wanted to ask you if you have recommendations for improving the Canadian occupational projection system. Just looking at our notes, I find it interesting that physicians and veterinarians and dentists are all in the same category. It's great to know there's a shortage there, but is there a shortage in all three, or in one or two?

Also, can you identify any additional challenges for the medical sector that are not adequately represented in the data sets that either you currently use—either yourself, Dr. Sweetman, as a professor, or at CIHI—or in the other data sets that you may access for providing information?

Dr. Arthur Sweetman: Let me answer your question in some sense and also come back to the first one a little.

The first question in particular seemed to assume that the labour market for nurses is similar to a private sector labour market, and I would argue that is not a useful way to think about it. I think it's the same in relation to the question you're posing now.

A COPS model does not work very well for physicians and nurses, because there is only one employer for 99% of physicians and nurses, namely the provincial governments; and demand for physicians and nurses can turn on a dime with a provincial budget or a series of provincial budgets. If a province is in deficit, the number of nurses being hired goes down dramatically, and it's the same with physicians. Since the provincial governments have substantial control over the number of places in medical schools, for example, they can reduce the supply very substantially.

Even though right now there's this popular perception of a shortage of nurses, there are actually a substantial number of unemployed nurses.

The problem is that this is not a private sector where you have supply and demand that equilibrate, but a situation where you have in each province a union that negotiates with the province and comes up with a wage or a set of fees for physicians. It's not a market the way you might think about a market, the way the first question posited a private sector market. It's not like that.

I think this is a situation where provincial governments plan and the provincial governments hire, though there are some rare exceptions. They are pretty much the only people who hire. There is a popular perception of shortages because physician and nursing care is for the most part free in Canada, but there is also a perception that taxes are too high, so we don't want to pay for that physician and nursing care that we think we have a shortage of.

Fundamentally, our medicare system makes this a political problem, whereby everybody wants free medicare but doesn't want to pay the taxes to pay for the free medicare.

I don't think there's an easy solution to this. I don't think that the private sector models fit. I think what we need more than anything else is really good provincial planning. This is a provincial responsibility at the end of the day, but that can be facilitated by really good assistance from the federal government in providing planning assistance, information, data, and the like.

As much as CIHI does have great data on some things, it doesn't yet have great data on everything, and not at the detailed level that provinces need for planning.

I think that type of information would be extremely useful to provinces and aid the kind of capacity that HRSDC has for planning. A lot of the provinces could use assistance with that type of detailed planning.

Ms. Kellie Leitch: Mr. Berthelot.

Mr. Jean-Marie Berthelot: In terms of the occupational projections, if you don't mind I'll quote Yogi Berra, who said “It is difficult to make predictions, especially about the future”.

The challenge here is exactly what you mentioned. The number of seats in the faculty of medicine is controlled. The number of jobs available is controlled. Immigration, in some ways, is controlled.

You can make projections at the national level in the short term about how many physicians there will be five years from now, but to make long-term projections is very difficult.

It's the same thing with nurses. It depends how many seats are available. I don't think there's a shortage of people applying for nursing and medicine. There are the issues about how many seats are open.

In terms of data, CIHI has data about the supply. Provinces are working...and each province has its model for doing its health human resources planning. They're trying to focus on needs, but it's very difficult to do. Health human resources need planning because the scope of practice varies, depending on the needs of your population.

Interprovincial migration also plays a role. In Canada, we have observed in the last 30 years that places that have rapid economic growth effectively see an increase in their population and an increase in their health professionals, even though they may not have trained more of them than they have in the past.

In terms of the information, I think CIHI could probably do something regarding health human resources projections, but you have to take into account that those projections can only be short term if you want them to be relatively reliable because they are determined by policy more than natural phenomena or the market.

● (1610)

Ms. Kellie Leitch: I appreciate both of you commenting that this is really provincial jurisdiction from the standpoint of what's driving the numbers. I'm a physician myself, an orthopedic surgeon, and yes, the destiny of my operating room was determined by a provincial budget.

My second set of questions is focused on a different subject matter.

The Chair: You have...[*Inaudible—Editor*].

Ms. Kellie Leitch: I got it. I understand, Mr. Chair. And you just took up 15 of my seconds.

The Chair: Well, we won't hold that against you.

Voices: Oh, oh!

Ms. Kellie Leitch: You won't hold that against me.

I appreciated your comments, Ms. Bard, with respect to workplace conditions—again, a provincial jurisdiction issue. My question is how do we encourage young men to actually enter into nursing? We always talk about women not entering into certain subspecialties, but my understanding is that 80% to 85% of nurses are women. How do we get that 49% of guys who are looking for a profession to consider nursing?

Ms. Rachel Bard: It's an interesting question, because actually we do. The numbers are starting to increase.

I think there is work to be done in the education system through career counselling, so that the profession of nursing can be seen as attractive and men can be directed there. Recently there was an example of a male nurse who said that when he went through career counselling, that's not where he was directed.

So there are some myths that we need to correct, i.e., that it's just for women. But the numbers are actually starting to increase, for sure.

The Chair: Thank you, Ms. Bard.

We'll move on to the next questioner.

I must say, I heard you when you said that it's not a question of a shortage of people who apply but how many seats are available, which is directly related to provincial budgetary measures. So there's that at play.

Mr. Cleary, go ahead.

Mr. Ryan Cleary (St. John's South—Mount Pearl, NDP): Thank you, Mr. Chair.

Thank you to the witnesses.

First, to Mr. Sweetman, going back to your opening statement, did I hear you correctly that the immigration of health professionals should be taken out of federal responsibility and made a provincial responsibility? Are you saying that health-related immigration should be handed over to individual provinces, who know the shortages they have and the weaknesses in their health care systems, and who are better able to plug those holes and address those weaknesses?

Is that what you're saying?

Dr. Arthur Sweetman: Yes, that's exactly what I'm saying. I think especially with IRPA, the current points system under it is particularly poorly suited to health professions, where the provinces are the principal payers. For things in the private sector, IRPA works very well. On many dimensions, IRPA is better than what came before it, but for regulated health professions, IRPA, I would argue, is worse than the legislation that came before.

Under the points system before, there were occupational points. It was virtually impossible for physicians to immigrate in the economic class. They could come as family class, as refugees, as spouses, but it was very, very hard. This was in the days when we thought we had a surplus. There was a so-called perceived surplus of physicians.

Under IRPA, at least before the most recent ministerial instructions, there were no occupational categories. So physicians became prime candidates for the points system and a massive number of them entered Canada and the provinces did not want to hire them. There was a massive surplus of international medical graduates and a large number of people complaining that they couldn't find jobs. They'd been admitted under the point systems, but the points system didn't coordinate at all with provincial needs.

My argument is to take regulated health professionals, who are primarily paid by provincial governments, out of the federal points system—because the coordination problem between the provinces and the federal government is really, really difficult—and put them in the provincial nominee program.

I'm not saying to take this out of the system altogether. We have a stream that works very efficiently. Although there are some problems with the provincial nominee program, it works pretty well. But put the regulated health professionals, who are primarily paid by the provinces, into that stream.

The provinces regulate the regulatory colleges that do credential recognition. They do health human resource planning. They know what's needed. They know the credentials. Let them manage it. They're close to the ground; they can do it better.

● (1615)

Mr. Ryan Cleary: Has there been any appetite by the provinces, or individual provinces, to do just that?

Dr. Arthur Sweetman: Do you mean outside of Quebec?

Mr. Ryan Cleary: Outside of Quebec.

Dr. Arthur Sweetman: Quebec is on board to do that, definitely.

Mr. Ryan Cleary: Of course.

Dr. Arthur Sweetman: I don't know if that question has been posed to any elected politicians, but my informal understanding, from the rumblings I'm aware of from two or three provinces, is that they would be very happy to take that on.

Mr. Ryan Cleary: Can you name those provinces?

Dr. Arthur Sweetman: Well, I hold the Ontario Research Chair in Health Human Resources, so I know a little bit about Ontario. I think Ontario would be very happy to take that on.

I think some of the smaller provinces might face greater challenges. Again, that's where they would need support from an information system like CIHI to help in planning.

I could be wrong, but I suspect that the larger provinces would be more than happy to take that challenge on, because they have the policy levers to do it well.

Mr. Ryan Cleary: My next question is for Ms. Bard, and it's related to the topic of health professional shortages.

You mentioned in your opening statement, Ms. Bard, unique identifiers to be tagged to nursing graduates, so that you can track where they work around Canada and North America, or that sort of thing. Has that been done as a pilot project anywhere?

Ms. Rachel Bard: It's certainly something that we've been highly recommending. Certainly, there has been some work done to start looking at it. We've recommended it. Actually, I know that at the post-secondary level they have also looked at it. It really helps to plan in terms of the supply and dispersal of them, so that you can start to build a pan-Canadian approach to human resource coordination and address some of the shortfall. That's why we believe a pan-Canadian approach is what we need to strive for to retain our people here in Canada.

Mrs. Lisa Little (Consultant, Health Human Resources, Canadian Nurses Association): I'll just add that CIHI, in collaboration with the provinces and territories, conducted a feasibility study for a national unique identifier for nine professions. They identified a start-up cost and a continuing operation cost. I think it was stalled because of the costs. I don't know if CIHI wishes to speak to that more, but certainly there has been a feasibility study done.

Mr. Ryan Cleary: Before you respond to that, what was the cost, and were there any concerns expressed in regard to privacy?

Mrs. Lisa Little: The start-up cost was $17.27 million over three years, and the subsequent annual operating cost was about $5 million.

This has already been done. In some cases, the physician community already has, in essence, a national unique identifier for it. They also did a pilot with the licensed practical nurses at one point. So I think they found ways to get around the privacy issues and use existing provincial numbers already assigned, etc., to create the national number, without large intrusions on people's privacy. But my understanding is that in the end it was the cost, ultimately, that was the barrier.

Mr. Jean-Marie Berthelot: If you have a national unique identifier and associate it with a person when he or she starts going to graduate school, I guess to post-secondary school, it will also allow you to know more about what's happening in the university or the college. You could look at dropout rates, and that's a value-added.

The cost was an issue. But there are also issues regarding the role of the regulatory bodies at the provincial level. There was some discussion about governance, about the institute that would manage a national unique identifier. So what CIHI did was mainly a feasibility study, and it came up with the cost. It wasn't clear that CIHI would be the organization that would run that national unique identifier.

In terms of privacy, we're talking about professionals. They have some obligations. I don't think privacy is a barrier. Things need to be done in a privacy-sensitive manner, but that's not a barrier to creating such a national unique identifier.

● (1620)

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

We appreciate the comments with respect to the provincial nominee program. But the uptake by the provinces has been different from province to province. Some have embraced it, and some haven't. From personal knowledge, I know that Manitoba has, and Alberta, Saskatchewan. Ontario has not, to the same degree. It is an area should perhaps be investigated by this committee in our report as well. So thank you for that.

We'll now move to Mr. Mayes.

Go ahead.

Mr. Colin Mayes (Okanagan—Shuswap, CPC): Thank you, Mr. Chair. And thank you to the witnesses for being here today.

One of the long-term concerns I have, which has also happened in the education sector, is this. We hired a bunch of teachers, built a bunch of new schools, and all of a sudden there were fewer children. People were having fewer children. So now we're closing down schools and all these educated teachers are finding other employment. This is a wave we're dealing with now with the baby boomers. When that wave of baby boomers goes through, we could have a lot of empty hospital rooms and nurses standing around because there are too many of them.

Mr. Sweetman, or either one of you gentlemen, have you looked at any projections in your studies in regard to what we are going to do 20 to 25 years from now? Do you think we're going to see that wave go through and some of the current needs are going to become redundant? Or do you see that need continually growing?

Dr. Arthur Sweetman: The baby boomers are still pretty healthy. In fact, right now is the golden age. If you look at baby boomers, they're still old enough to be paying taxes. The oldest baby boomers are 65. Serious medical costs don't start for another five or ten years.

So the aging population hitting medicare hasn't actually happened yet. When it does happen, most estimates argue that you're talking about an increase in the number of physicians or physician services of something in the order of 0.6% per year. It's not enormous.

Yes, there is going to be a need to change down the road to reduce the number of physicians. You're talking about a time beyond the career of the typical graduate today.

There is a bigger issue. In some sense, you're worried about shortages, but inside most provincial ministries, which are closer to the ground, the concern is about surpluses, not shortages.

Depending on whether they're family practitioners or specialists, there is a six to ten-year training period for physicians. If you go back ten years exactly, there has been a 73% increase in the number of people in medical school, which is dramatically larger than population growth, which has been around 11% in the same period. We're going to need to be pulling back our enrolment in medical school in the near future, or else we're going to have a giant surplus.

The issue of aging is not actually about the number of physicians; it's about the composition of specialities. We really haven't started dealing with that as a society yet. We have the wrong specialities graduating from medical school. If you think someone is going to practice for 30 years, you need to be thinking about what specialities we will need over the next 30 years. We are graduating a lot of pediatricians and not so many geriatricians. We need to think about those things.

Mr. Colin Mayes: I'm going to cut you off so I can hear some comments from Madame Bard.

Ms. Rachel Bard: Thank you.

I would like to add that right now, in nursing, we have three applications for every one entry into the seats available. Our report, *Tested Solutions*, suggested that we should be increasing the number of seats by 1,000 for three years, from the year 2009 when it was launched until 2011. The impact would such that it would take 15 years to actually reduce our projected shortfall of 60,000 FTEs to 45,000 FTEs.

As you can see, we need to keep producing students, because we also have retirements coming. We have demographic realities. Reducing the seats will not be a solution; it will compound the problem.

Mr. Colin Mayes: I appreciate your holistic approach, as far as healthy living and helping ourselves to address the situation are concerned. We've said that it's not necessarily about the number of nurses. You talked about more productivity and resource management.

We just had a new hospital built in my constituency, in Vernon. It has state-of-the-art equipment. No longer is a nurse trying to heave a huge fellow across a bed or something. All of that is automated now.

I noticed in some of the notes here that 40% of the nurses are over 50. Not that 50 is old, but there are some challenges, in that there is physical stress. In one smaller hospital in my area, it costs $500,000 a year for stress leave for nurses. Those costs are hindering service delivery.

Do you see more technology, as far as help for care and better resource management are concerned, as going to help the situation, that it's not just about a labour shortage but about better organization and better use of the facilities?

● (1625)

Ms. Rachel Bard: Absolutely. When we talk about improving productivity, we don't mean doing more with less. We actually say that we should look at our models of care. Let's look at how we can best utilize the technology. How can we remove the barriers to allow nurses to practice to their full scope?

There are some good programs. For instance, the lean methodology, which has been used in Saskatchewan to release time to care, has really removed barriers and has increased the number of hours nurses have around patients. Of course, it also improves the quality of work life.

We also know that we need to make sure that we stabilize our workforce by having full-time positions. Right now, about 58% of positions are full-time positions. We're saying that our standard should be about 70% so that we maximize and ensure that the patient has the right level of care.

Mr. Colin Mayes: But is that the association saying that? I ask because at one of the hospitals I am familiar with, what the nurses say is that because of seniority, they have found that when they phone for a nurse, the person will say no. They have to go through a list, and all of a sudden somebody is working a double shift because they can't get anybody in. To me, that is a management or organizational problem that needs to be addressed, more so than a lack of resources.

There are a lot of people in the profession who do not want to work full time; they want to work part time. It's a career choice. I think some of the challenges we're having in health care have a lot to do with management of resources and technology within the plant.

How am I doing, Mr. Chair?

The Chair: You are right at seven minutes, so that's a good place to stop.

We will adjourn for five or ten minutes and recommence with Mr. Cuzner.

Thank you. We will suspend.

● (1625)

(Pause)

● (1640)

The Chair: Perhaps we could get the members and presenters back to their seats. We certainly appreciate the visiting during the break. I'm sure there were a lot of good questions posed and answers given.

A voice: Better answers.

The Chair: Perhaps they were better questions, but there are good answers always.

That said, on a more formal basis, we'll ask Mr. Cuzner to commence his round.

Mr. Rodger Cuzner (Cape Breton—Canso, Lib.): Speaking of better questions—

Voices: Oh, oh!

The Chair: —with some better questions.

Go ahead.

Mr. Rodger Cuzner: —I have three that I want to ask, but first, Professor Sweetman, you're an economist.

Dr. Arthur Sweetman: That's right.

Mr. Rodger Cuzner: I'll ask you and any of the others to comment on something that we've heard from the corporate sector. I appreciate your comments on the provincial sponsorship, I absolutely do, but what we've heard from a couple of the corporations here is that they still believe there's a federal role. I think your reference to the federal role is a light touch, and I appreciate that.

One thing they floated is something that works really well in Ontario now, a tax credit for co-op opportunities or mentorships, and what have you. Do you see that being a benefit coming from the federal government as well, as far as closing that skills gap domestically is concerned, with our own trained people from Canadian institutions?

Dr. Arthur Sweetman: So are you focusing explicitly on youth—

Mr. Rodger Cuzner: Yes, exactly.

Dr. Arthur Sweetman: —or in general?

In some sense, the federal government already has implemented a program like this. Under EI—

Mr. Rodger Cuzner: A tax credit?

Dr. Arthur Sweetman: Yes. You rebate EI premiums for net new hires to small firms. Expanding that to firms of all sizes, I think, would be a great idea. Focusing it on youth, I think, would be problematic.

If you think back, we used to have a program where we did focus that on youth. In 1998 and 1999, unemployment insurance premiums were rebated for net new hires of youths between the ages of 18 and 24. I think what the research is showing—I've done some of this myself and some of my Ph.D. students have done some of this—is that you saw firms distort the market, preferentially hiring people between the ages of 18 and 24 and not hiring them between the ages of 25 and 26. So I think age—

● (1645)

Mr. Rodger Cuzner: Yes, but this would be for training opportunities as opposed to just new hires.

Dr. Arthur Sweetman: I understand, but ultimately you won't want people trained and dropped. That's fairly useless. I think there's a lot of evidence where new hire programs have been evaluated by HRSDC. They've been tried and they've had mixed results.

I think what you're doing right now works fairly well. It could be beefed up a bit with an EI premium rebate—and you can adjust the size of the rebate—not just to small firms, but to all firms. I think something like that would be very good in stimulating employment growth without paying for a bunch of people who are going to be hired anyway.

Mr. Rodger Cuzner: As opposed to just a tax credit...?

Dr. Arthur Sweetman: It's effectively a tax credit.

Mr. Rodger Cuzner: It is. Yes.

Dr. Arthur Sweetman: you can structure it through EI or you can structure it as a tax credit.

Mr. Rodger Cuzner: Yes.

Dr. Arthur Sweetman: It's six or half a dozen, so I don't care how you structure it.

Mr. Rodger Cuzner: Okay. I appreciate that.

If I could, I'll throw a question at Ms. Bard with regard to Canadian-trained nurses.

I don't have any figures, but I'm sure you do, on how many nurses we bleed, how many we lose, especially to the United States, nurses who are trained here and leave the country. Do we have any indication of how many that would be annually?

Ms. Rachel Bard: I don't have specific numbers here, but we know that if we had a unique identifier we would be able to start tracking that. We had an assumption and know that they are—

Mr. Rodger Cuzner: Is that information out there? We don't have that?

Ms. Rachel Bard: I don't have it with me right here, but we know that we do need to track better. Certainly with some of the changes that are happening in the United States, we are very concerned, and we would not want to see us losing more of our resources. But we do need to have some strategy to retain our Canadian nurses.

Mr. Rodger Cuzner: Are we getting any kind of indication why we're losing those Canadian-trained nurses?

Ms. Rachel Bard: Well, again, if we look at the 1990s, with the reductions that occurred, we lost a high percentage of our workforce at that time. We want to avoid having a similar situation happen, which is why we want a pan-Canadian approach in coordinating our human resources to make sure that we address where some the shortfalls are. We also want to have programs that better support the movement and mobility of nurses so that we can make sure that we use all of our resources, with full capacity, and they don't have to look across the border to secure full-time employment.

Mr. Rodger Cuzner: Yes, and that goes back to what Mr. Sweetman said earlier about the provinces being able to calibrate that a little more.

What is the average retirement age of a nurse in Canada?

Ms. Rachel Bard: It's 57, which is why our policy is recommending that we see how we can retain our nurses longer. They bring a breadth of knowledge and experience, and we need to look at models so that we can try to retain them much longer.

Mr. Rodger Cuzner: As Mr. Mayes said, nursing is a stressful vocation. It's also stressful physically, and a person begins to show wear and tear from lugging and moving. Would that play into early retirement?

Ms. Rachel Bard: It certainly does.

Mr. Rodger Cuzner: Or is it because they're all independently wealthy?

Voices: Oh, oh!

Ms. Rachel Bard: We have nurses who want to work full-time much longer, but the working conditions at times do not necessarily encourage them to stay longer in the workforce. Looking at improving the working conditions certainly is an area to be addressed.

Mr. Jean-Marie Berthelot: There is clearly the issue of the challenging nature of the work, the fact that it's hard work. But we also need to acknowledge that most of the nurses in the country are unionized. Many in the current cohort of retiring nurses have diploma degrees. They started working relatively young and have probably acquired 35 years of experience, with a pension. One social phenomenon is that their husbands would be a bit older. Such social phenomena play a big role in the age of retirement of nurses. Most of the provinces, except Quebec, I think, are now requiring a bachelor's degree to be a nurse, so you would expect in the future that they would retire a bit later. But after 35 years of service and a full pension, why would you continue to work?

● (1650)

Mr. Rodger Cuzner: I still have a little bit of time.

The Chair: Your time is up.

Mr. Rodger Cuzner: I was saving the big one for the end.

The Chair: We'll give you an opportunity after all is said and done.

Mr. Shory, go ahead.

Mr. Devinder Shory (Calgary Northeast, CPC): Thank you, Mr. Chair.

Thank you, witnesses, for being here.

Dr. Sweetman, we all know that education is within provincial jurisdiction. You talked about immigration. I'd like you to comment on whether foreign qualification recognition can play any role in addressing the issue of shortages, because we have a lot of professionals in the medical profession who have qualifications from other countries.

Dr. Arthur Sweetman: If I understand, you're asking if credential recognition is the issue. Is that really what you're focusing on?

Mr. Devinder Shory: Correct.

Dr. Arthur Sweetman: There is a variety of issues. For the most part there is an excess of immigrants with credentials in most health professions relative to the number of spots available in provincially funded professions. In professions like dentistry, where it's more in the private sector, it's a slightly different issue.

Credential recognition is an issue. It's a manageable issue in the long run, but it's much more complicated. Don't forget that in almost every single health profession—nursing being a notable exception—the percentage of immigrants working is higher than the percentage of immigrants in the adult population.

In Canada, the percentage of immigrants in the population between the prime working ages of 25 and 64 is roughly 23% or 24%, and 33% of physicians are immigrants, and 29% of pharmacists are immigrants. I may be off by 1%, but it's more or less that. If you look at optometrists it's a similar thing. That applies to every group except nurses, which are close to the national average. So in almost every single regulated health profession, the percentage of immigrants is well above the national average.

There is a credential recognition issue for some people, but it hasn't stopped a very substantial number of immigrants from entering regulated health professions.

Mr. Devinder Shory: Thank you for your comment.

When I was talking about foreign credential recognition, I was not only talking about immigrants but also about all of those who are foreign qualified, whether Canadians or new immigrants.

Ms. Bard, I have a question for you. You mentioned the shortage of 11,000 full-time equivalent nurses, which will potentially be 60,000 in 2022.

I was looking at the report, which looked at the impact of six policies in areas designed to reduce the current and projected shortages. I wonder if you can describe which measures will be the most effective, in your estimation, at addressing the issue of shortages today or in the future.

Ms. Rachel Bard: We've certainly looked at the six policy areas, and the first five are where we want to invest our energy. Evidently we know that by increasing productivity and removing some of the barriers and allowing full scope of practice is where we can reduce the shortage. Just increasing it by 1% would reduce the shortage to close to half of what the projection is right now. When you look at the absenteeism, if you reduce that from 14 day to 7 days then you would start to see an addition of about 7,000 FTEs. So you see each of them really provides some clear evidence. The first five are really showing the best investment.

● (1655)

Mr. Devinder Shory: Are these projected shortages updated after the report?

Ms. Rachel Bard: Yes, we will continue to monitor these, and evidently the information CIHI is producing is helping us to try to take a range. We try to do an assessment about every four years to try to understand where some of the changes are and what they are.

Mr. Devinder Shory: Another issue is that we have a huge aboriginal population in Canada and a large portion of that population is at an age where they can be a great workforce. How can we encourage young aboriginals to enter nursing studies and what are the biggest obstacles? Has any action been taken by your organization to encourage that group?

Ms. Rachel Bard: The Canadian Nurses Association certainly works with the Canadian Aboriginal Nurses Association to try to see how we can address that. There are some programs that dedicate some seats for aboriginal students, because we also believe that we need to encourage and train aboriginal nurses who can go and work in first nation communities. So there are some seats reserved and better support, and we've even developed some cultural diversity guidelines to better prepare nurses, even when they are entering nursing programs, so they are able to go and work among aboriginals and first nations, because evidently we want both. We want to train aboriginal students to become nurses, but we also want Canadian nurses who can work as well with aboriginal communities.

Mr. Devinder Shory: Do I have a minute?

The Chair: You have about 30 seconds.

Mr. Devinder Shory: Could anybody quickly give me an idea of any steps you would suggest that the federal government take to address the future shortage of these skills? We all know that we are and will be facing it. Are there any suggested steps to be taken by the federal government?

Dr. Arthur Sweetman: Can I maybe return to your aboriginal question, which is a massive future need? I think of local examples. The First Nations Technical Institute is the type of partnership that traditional medical schools and nursing schools need to bring people through. These are first nations educational institutions that partner with more traditional mainstream educational institutions.

However, only three years ago, the federal government cut funding to almost all of those institutions. In Ontario, the provincial government stepped in and replaced some of the funding. But this is a real issue: If we want first nations doing those types of activities, we do need to fund first nations education. In fact we've been going the other way in recent years. So I think that's a real issue that we need to address.

I think it's an extremely important issue. I'll mention, for example, that there are four positions set aside in the medical school at Queen's for first nations students, and these are almost always not filled. They are almost always empty. So it's not a matter of there not being positions; it's a matter of having people who are prepared and who have the appropriate background to take up these positions.

The Chair: Thank you, Mr. Sweetman.

Your time is up, Mr. Shory.

Does anyone else have a comment they want to make?

Please go ahead, Ms. Bard.

Ms. Rachel Bard: I think what is critical, as well, is that we need to invest in promotion and prevention programs. We need to reduce the demand. We need to help our first nation communities on the one hand to have better living conditions and try to help them on the other hand to maintain a healthier lifestyle. That is applicable to all Canadians, but certainly we do need to pay special attention because we still have cases in first nation communities where they don't have potable water. The social determinants of health are critical.

So we do need to have some programs that will help restore and also better support the youth to enter into education, and certainly a nursing program.

The Chair: Mr. Berthelot, did you want to make a comment?

Mr. Jean-Marie Berthelot: When we look at physicians, there is a perceived shortage. But when you read a bit in the media, you will see there's a perceived surplus coming our way. You already have a surplus of cardiac surgeons and some other specialties, so I think you need to keep this in mind.

In terms of health expenditures, among the three largest expenditure categories, physician expenditures is the one that has been increasing the fastest in the last six years. That may raise some concerns with provincial government.

In terms of the long term, the aging of the population is not a tsunami, because a tsunami wipes out everything very quickly. It's a glacier. What is the issue with a glacier? You know that it will come your way, but you have time to move away from it. We need to think about reforming the way health care is being provided to Canadians for an aging population that needs a lot more primary care and a lot more home care services, which may require a different group of professionals. By focusing on the current professionals who provide the services, we may partially miss the boat regarding the needs of an aging population. We have a lot of time to react because the oldest baby boomers are 65 and will only start to be really demanding of the health-care system when they are 80 or 85. So there is a lot of time to adjust.

● (1700)

The Chair: Thank you for that.

We will now go to Mr. Lapointe. Go ahead.

[*Translation*]

Mr. François Lapointe (Montmagny—L'Islet—Kamouraska—Rivière-du-Loup, NDP): Thank you, Mr. Chair.

[*English*]

Mr. Sweetman, I don't know if your French is good, but I will do mine in French.

[*Translation*]

As an elected official in Quebec, we are always walking a bit on eggshells when we come to issues related to health care because, in Quebec, this is a fully provincial jurisdiction.

Still, I would like to take advantage of your experience because you are very interesting witnesses. I would like to take advantage of your knowledge to determine whether certain administrative solutions or ways of doing things could help us. We are talking about the lack of human resources. Sometimes the solution is to have more human resources, but it may also mean doing things more efficiently. So I would like to appeal to your pan-Canadian experience on the matter.

I am from a rural region where there is no major city and no city larger than 30,000 people. There are a lot of small towns of 500 or 600 people, and there is a crucial need for doctors who want to stay in the regions. I think the same problem exists in Saint-Pamphile and in Moose Jaw. I don't think it is specific to eastern Quebec.

One of the solutions we've recently heard about involves offering incentives so that trained doctors go and live in the regions. I know that, in Australia, they have addressed the problem from the opposite end, meaning that the Australians choose successful students in the regions and encourage them to become doctors. So when they become doctors, returning to live on the mountain, near the river or the ocean in a small community is something they want to do. It isn't necessary to offer them bonuses to go back to a way of life they enjoy. The Australians have been very successful with this approach.

Would this solution be plausible in Canada to help the regions finally have doctors? What do you think, Mr. Berthelot?

Mr. Jean-Marie Berthelot: I seem to think there is a university in northern Ontario where the goal is basically to train doctors who will go to the regions.

The allocation of health human resources is a very complex thing. It varies greatly from province to province and depends on how the health care system is organized.

Compared to several other provinces, I think Quebec's doctors are relatively well distributed in the regions.

Mr. François Lapointe: In my region, we've been closing emergency rooms for two years now.

Mr. Jean-Marie Berthelot: They are also being closed from time to time in urban centres on the other side of the river.

Clearly, there is an issue when it comes to allocating resources. If we take Quebec as an example, it's the province that has the most doctors per capita in Canada. Given the way the health care system is organized, people make more use of the local community service centres and walk-in clinics. As a result, that population has the lowest percentage of people who say they have a family doctor.

The issue is still ensuring that there are health care professionals in the regions. There are the experiences of places like Australia and Ontario that, in my opinion, do not resolve the problem entirely, but that may be part of the solution.

Mr. François Lapointe: Do you think we could use this as inspiration in several Canadian territories?

Mr. Jean-Marie Berthelot: Yes, I think so.

[*English*]

Dr. Arthur Sweetman: Thank you. It's a very good question.

I agree, actually. Quebec is probably doing the best of the provinces in Canada on this front. So as poor as things look to you, they look worse in other provinces, and we're certainly in the area of provincial jurisdiction right now, not federal jurisdiction.

I think that a large number of policy proposals, or more than a few, could be put forward, but would need intestinal fortitude if they were to be pursued. You could do what Quebec does but even more strongly. That is to say, let primary care physicians or primary care practitioners, not just in medicine but more broadly, be hired by regional health authorities rather by provinces. So if there's a need in a certain area, they hire, and if there's no need on the island of Montreal, they don't hire. That would distribute people.

You could also change the way you recruit into medical school. It's exactly what you're saying. But you could put even a bit more bite into it. You could have people, as part of the admissions process to medical school, make a commitment to where they want to practice, and the admissions committee could take that into account in adjudicating admissions. If the admissions committee had two people who looked the same, and one wanted to practice in northern Quebec and the other one wanted to practice in Montreal, whom would they admit if they looked otherwise comparable?

I think there are a number of policies we could pursue.

● (1705)

Mr. François Lapointe: Those are interesting solutions.

Dr. Arthur Sweetman: There are solutions. They would take intestinal fortitude.

Mr. François Lapointe: Do I have a few more minutes?

[*Translation*]

Since I still have a bit of time left, I would like to mention some other very interesting initiatives. In Holland, for example, the proportion between the long-term care provided at home and in health care institutions is completely the opposite of what we have here. There, the proportion is 80% and 20%, whereas here, it is 20% and 80%. When long-term care can be provided at home, the Dutch hire personnel instead of spending billions of dollars on infrastructures.

Do you think we could consider this as a real long-term solution?

Ms. Rachel Bard: Certainly, the association puts forward models such as primary health care and at-home services so that people can stay in their homes. It's very good. I think that we should also consider offering incentives to encourage professionals to go and work in the rural areas or to stay there. Currently, about 10% of nurses work in rural areas, while 30% of the population live in rural areas

The World Health Organization made recommendations that dealt with four major sectors. In education, we are talking about study incentive programs to encourage people who live in rural areas and who are more likely to return there. We can also improve the working conditions and remove obstacles, among other things, to ensure that nurses can work in the full scope of their practice.

We could also use nurse practitioners to respond to some shortages within the professional team. We could also consider incentives to better support people who want to study health sciences as a nurse and better support them once they are on the labour market. Incentives could be offered to help them pay back the cost of studying, and so on. We could also look at providing support and a framework for professionals who work in rural regions.

Mr. François Lapointe: Is the big initiative, which might mean going so far as to reverse this proportion, changing the definition of the duties carried out by nurses, discussing with all the unions and reviewing the way all the provinces do things, feasible or even desirable?

If it is feasible, how long would it take? Are we talking five years, 10 years? Are the majority of the provinces interested in doing this? Do you understand basically what I'm asking?

Ms. Rachel Bard: Yes.

[*English*]

The Chair: Please give a very short answer, if you could.

[*Translation*]

Ms. Rachel Bard: If we really want to put in place primary health care, we should initially act on prevention and promotion. We should also consider the entire continuum of care within an interprofessional practice to maximize the capacity of all the professionals to avoid enormous shortages in one sector. It's really important to look at that.

[*English*]

The Chair: Mr. Berthelot, just give a short response, if you could.

[*Translation*]

Mr. Jean-Marie Berthelot: Each of the provincial governments wants to reform its health care system to be able to meet the needs of an aging population. We are looking at what is going on in Denmark, the Netherlands and elsewhere.

With respect to the idea of implementing a pan-Canadian system that everyone should conform to, I think it is unrealistic and not necessarily desirable. Within diversity, we can learn from the experience of others, from their successes and their failures. Regardless, it is clear that the provincial governments want to reform their health care system. They are actively working on it, but changing all the services provided takes time.

[*English*]

The Chair: Thank you. Your time is up.

We'll conclude with Ms. Leitch.

Ms. Kellie Leitch: Thank you very much.

I want to go back a little bit to our skills gap question. I know we talked a bit about how the average age of retiring nurses is 57, but I think the average age of most nurses in the workforce is older. The average age of a physician, at least in the province of Ontario, is 53.

There are some substantial challenges. With this aging of the health care professionals across the country, I am wondering what your thoughts are on how we can increase the participation rate of those groups who don't traditionally enter into health care professional roles. I'm thinking of aboriginal Canadians—and there Dr. Sweetman talked about spots for them going vacant at Queen's—or individuals with disabilities, for whom maybe there are things we should be doing to allow them to take on these roles, albeit some of them are quite physical, or older workers who want to transition into health care professional roles.

Do you have some thoughts on what we can do to help deal with our looming skills gap by focusing on those three groups of individuals: aboriginal Canadians, persons with disabilities, or older workers transitioning into filling that gap?

● (1710)

Ms. Rachel Bard: I would definitely say that if there are some programs that would actually better support student entering into.... For instance, going through the university years, if you have an older student who has children, you need to have some programs that will allow them not to have to worry as they're trying to study. You could also have a student with an aging parent.

Again, if you really want to bring people back into some of those professions, you need to start looking at programs. We need to look at social programs. We also need to look at how we provide incentives when they are graduating so that we assist them with the burden of the student loans and to make it more appealing, for instance, to bring them to a rural community.

Ms. Kellie Leitch: With respect to the student loan issue, just so you are aware, this government has made a commitment to physicians, as well as to nurses and nurse practitioners, for specific reductions in their loans upon graduation if they go to a rural or remote area.

Are there any other comments on this?

Mr. Jean-Marie Berthelot: I think that when we talk about involving specific groups, we need to talk about the culture of these groups. I think they're probably the best ones to answer your questions.

Dr. Arthur Sweetman: In terms of aboriginals, there's clearly an enormous amount of work that could be done. As I said earlier, funding aboriginal organizations to assist them and starting with education at a much lower, or K to 12 more generally, I think is where we need to form a foundation. I say that because that foundation is the issue; it's not about access to post-secondary education. From the institutions' point of view, it's about preparation for post-secondary education that's the key issue.

In terms of the retirement issue, there are dramatic differences across professions. As you know, physicians never retire. The number of physicians over 80 who are still practising is very substantial. Nurses retire much, much younger. There's no one solution; there are a lot of occupation-specific issues that need to be addressed.

For people with disabilities, I know less about that, but my impression in general is that this is becoming less and less of a barrier in many health professions.

Ms. Kellie Leitch: Thank you very much.

Is there time left?

The Chair: Yes, you still have time, if you wish to use it.

Ms. Kellie Leitch: I still have time. I'm very excited.

I'll ask one last question. With respect to the current federal programs that are available, what are your thoughts about what the federal government can do to deal with the labour pool size and meeting future demands? We have a certain suite of programs right now, but what are the ones you believe are working that should be our focal point?

If you have some thoughts on that, I would greatly appreciate it, just so that we're aware of what you're hearing from your professional colleagues. You mentioned the student loans, but are there others?

Ms. Rachel Bard: We would hope that the federal government consider looking at a more pan-Canadian approach. There is a committee on human resources, the CCHRA, but it could do more by looking at and creating an observatory so that we really start looking at some of the trends and demands and the population's needs, and how we deploy our resources. So I think there are good programs in place. We need to try to maximize them.

CIHI is another good program, but we've been recommending that there be a unique identifier to be able to better track our resources, to know about their mobility and where they are moving. I think there's a good foundation. We need to continue to supplement it so that we are able to take decisions based on evidence.

A Voice: [*Inaudible—Editor*]

● (1715)

Ms. Kellie Leitch: You don't have to comment. It's okay. You're allowed to take a pass.

The Chair: Is there anyone else wishing to comment?

Dr. Arthur Sweetman: I think that the Canada student loan program is working reasonably well. I think we should in some sense be quite pleased about that.

In terms of training, HRSDC's information programs are good. They're perhaps not excellent yet, but I know there's a lot of work under way to provide labour market information, and I think there are some real moves being made. I think the changes that have been and are under way on the immigration side are quite positive. I think there are some real solutions there to some real problems.

So I think there are a number of good things, either in progress or operating, at the moment.

Ms. Kellie Leitch: Thank you.

The Chair: Thank you very much for taking the time to appear before us and for sharing your insight and suggestions with respect to the matters we're considering. We certainly want you to know that we appreciate that. Thank you for coming.

We'll suspend for a few moments. We have some matters of committee business to deal with, so I would ask the members to hold back for a couple of minutes.

Thank you.

[*Proceedings continue in camera*]

Published under the authority of the Speaker of the House of Commons

SPEAKER'S PERMISSION

Additional copies may be obtained from: Publishing and Depository Services
Public Works and Government Services Canada
Ottawa, Ontario K1A 0S5
Telephone: 613-941-5995 or 1-800-635-7943
Fax: 613-954-5779 or 1-800-565-7757
publications@tpsgc-pwgsc.gc.ca
http://publications.gc.ca

Also available on the Parliament of Canada Web Site at the following address: http://www.parl.gc.ca

Publié en conformité de l'autorité du Président de la Chambre des communes

PERMISSION DU PRÉSIDENT

On peut obtenir des copies supplémentaires en écrivant à : Les Éditions et Services de dépôt
Travaux publics et Services gouvernementaux Canada
Ottawa (Ontario) K1A 0S5
Téléphone : 613-941-5995 ou 1-800-635-7943
Télécopieur : 613-954-5779 ou 1-800-565-7757
publications@tpsgc-pwgsc.gc.ca
http://publications.gc.ca

Aussi disponible sur le site Web du Parlement du Canada à l'adresse suivante : http://www.parl.gc.ca