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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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● (1530)

[*English*]

The Chair (Mr. Ed Komarnicki (Souris—Moose Mountain, CPC)): We'll bring the meeting to order and commence.

We have with us the Canadian Dental Association and the Royal College of Physicians and Surgeons of Canada. Each will be presenting, and then we will have a round of questions and answers.

I'm not sure who plans to start, but it looks as though Danielle Fréchette will be starting. Then we'll move to Robert Sutherland.

Go ahead, Ms. Fréchette.

[*Translation*]

Ms. Danielle Fréchette (Director, Health Policy and External Relations, Royal College of Physicians and Surgeons of Canada): Thank you for giving me the privilege today to present certain perspectives of the Royal College of Physicians and Surgeons of Canada.

[*English*]

I will be focusing my comments on the 67 other specialties outside of family medicine. The College of Family Physicians of Canada may present at a separate time.

We all know that training a doctor takes a really long time. If we had a better understanding of the needs of the patients, we could probably better modulate the production of our medical workforce with the actual needs of our population. Needs-based planning is really not sophisticated in Canada, with very different approaches across the country. Is it that we really are short of doctors, or is it a maldistribution of doctors? Some of our research is flagging the point that we may now have a right balance of physicians in certain specialties.

Beyond the needs of the patients, there are system needs as well. Teaching hospitals bring in residents because they're service providers. Are they hired as residents as future doctors because they're really needed for the health care needs of the community, or is it for the immediate institutional needs of the hospital?

We're then in a situation that you might have in British Columbia, for example, according to the Canadian Institute for Health Information, and that is the highest ratio of anesthesiologists in the country but where anesthesiologists from that very province are expressing concerns about very frequent call schedules, and so on, and concerns that they might not be practising in an optimal way, potentially putting patients in harm's reach.

In P.E.I., at the other end of the country, they're taking clinicians away from clinics to staff their hospitals, so they're impairing access to the places patients should be going and redirecting them to hospitals, which are more costly. Again, suboptimal work conditions and suboptimal distribution, whether or not the result of real shortages, are creating bottlenecks of access for patients.

If we could better understand not only the needs of our patients, who are presenting with more complex problems—with comorbidities, and so on—but who also have increasing expectations.... Where do you draw the line in meeting the expectations of patients and that basket of medically necessary services? That is a very broad question that we have failed to grapple with when we're looking at the real needs of populations.

From the providers' point of view, we're seeing a new breed of physicians coming on board. They rank work-life balance as one of the highest things in all the areas of research we're doing. It's not a bad thing: they're good parents; they're not as tired; they're providing better, safer care. There are more women entering medicine, and until you gentlemen can start having babies, women do the child care. They work on average seven hours less a week in that child-rearing phase. We have to factor that in when doing our health care modelling.

With all of the wonderful data that we have to pull these pieces together, to look at the impact.... For example, when you have a new physician assistant coming on board, what is the impact on the need for your medical workforce of the future, recognizing that it takes years to train a doctor?

We were thrilled to see the Senate committee recommending that we pursue the notion of a health workforce observatory. I hope it will be sustained throughout and that the government will view this as a positive way forward, because if we have each province do it within their own resources, we end up with a hodge-podge of workforce approaches.

We're failing to integrate our international medical graduates and to also recognize really scary things. With the U.S.'s new health care reform, they're forecasting right now a shortage by 2020, which is just around the corner when you think how long it takes to train a doctor, of more than 90,000 physicians.

They love the quality of the training of health providers in this country. In the not very distant past, we lost a graduating class from a large teaching centre every year to the United States. We will not be able to keep up with production. We cycle from a boom to a bust, and I anticipate that it will continue.

● (1535)

As to the maldistribution, we could align individuals with jobs more easily if a health workforce agency could help us. We now have evidence of unemployed or underemployed cardiac surgeons as well as centres that are looking for cardiac surgeons. But four out of ten doctors in training have absolutely no career counselling. They don't know where to go, and finding a job in this complex system is a full-time job requiring special skills.

As for how we integrate our international medical graduates, the two national certified colleges have coordinated with the Collège des médecins du Québec, and we're looking at in-practice and various other forms of assessment to ensure that our internationally educated physicians have the right knowledge, skills, and attitudes to provide health care in the Canadian context. We're all doing this with our own resources, recognizing that other provinces have their own systems.

With the agreement on internal trade and the pipeline this gives clinicians, our cities could end up with internationally trained physicians having varying levels of skills, and I don't think that will serve the population well either. So some coordinated efforts in that regard would benefit not only the system but patients as well.

Merci beaucoup.

The Chair: Thank you very much for that presentation.

Now we'll move to Mr. Sutherland and the Canadian Dental Association.

Go ahead.

Dr. Robert Sutherland (President, Canadian Dental Association): Mr. Chair, members of the committee, good afternoon. My name is Robert Sutherland. l'm the president of the Canadian Dental Association and I practise the dental specialty of periodontics in Toronto. With me is Dr. Euan Swan, CDA's manager of dental programs.

Thank you for inviting us to speak to you today about labour market shortages.

l'd first like to emphasize that there is not a shortage of dentists in Canada. Canada is on a par with other OECD countries in terms of the dentist to population ratio. This is supported by a recent Health Canada report, which indicates that a large majority of Canadians have access to and utilize the services of a dentist.

In 2010 Health Canada published an oral health report card based on the results of Statistics Canada's health measures survey. The research indicated that 75% of Canadians saw a dentist at least once a year, and 86% have seen a dentist in the past two years. This ranks Canada fifth out of the 16 OECD countries recently surveyed. According to the same Health Canada report, 84% of Canadians reported their oral health as good or excellent. When compared with other countries, Canada also has a strong dentist to population ratio. In 2007 Canada had 58 dentists per 100,000 population, which compares very favourably to the OECD average of 61.

The perception that the dental profession is experiencing a labour market shortage may arise from the observation that a small minority of Canadians do not have access to regular dental care. The groups within this minority for whom access to care is a known problem include seniors, low-income populations, people with special needs, children, and aboriginal peoples.

Overlaying this access issue is the unique geography of Canada and the challenge that distances pose with respect to the distribution of our population and labour force. The distribution issue of Canadian dentists is supported by research from the Canadian Institute for Health Information, where they point out that although 21% of the population lives in rural areas, only 11% of dentists reside in rural areas.

For these groups, we do not believe that simply increasing the number of dentists will solve the access to care challenge. Doing so will require creative thinking.

Some examples of such creative thinking are already at work. The Canadian and provincial dental associations, in cooperation with governments at all levels, are exploring unique delivery models and systems that address the access to care challenges for specific identified groups.

Successful programs from across the county include the Alberta Dental Association and College's mobile motor home dental clinics, which travel throughout Alberta and provide care; the Ontario Dental Association's remote areas program, where locum dentists are providing care to first nations communities in northwestern Ontario; and Newfoundland and Labrador's income-tested seniors dental plan.

In terms of access to dentists by rural Canadians, a significant consideration is that in some cases the traditional practice model may not be financially viable, as many rural and remote areas do not have a concentrated enough population base to support such an approach. In these areas, simply increasing the number of dentists will not alleviate the distribution issue. Non-traditional practice models such as those I mentioned earlier, as well as satellite, part-time clinic, and public health clinics are required

The final point I would like to leave you with today is that the process to enable someone to practise dentistry in Canada is solely competency-based. In order to ensure practising professionals meet the high standard that Canadians expect, the profession has developed a transparent, fair, and competency-based process. This process is not managed by the Canadian Dental Association but is overseen by the publicly accountable provincial dental regulatory bodies across Canada and the independent National Dental Examining Board of Canada. In addition, the process for admissions to our dental schools is not determined by the Canadian Dental Association. It is primarily a provincial issue. Such a process ensures that licensed Canadian dentists have the knowledge, training, and skills that are required to deliver safe and effective dental care.

In summary, there is not a shortage of dentists in Canada. There is, however, a distribution issue of existing dentists, which we believe can best be addressed through creative thinking and new approaches.

Thank you.

● (1540)

The Chair: Thank you very much for that presentation, highlighting the distribution issue.

We'll now turn to Ms. Charlton. Go ahead.

Ms. Chris Charlton (Hamilton Mountain, NDP): Thank you very much for your presentations.

I know that all of us here on this side have a lot of questions, so I'll just start with one and get the ball rolling. In particular, I'd like to ask Madame Fréchette a couple of questions, if that's all right.

In Hamilton we often say that the best place to have a baby is in the back of a taxicab, because we have so many foreign-trained doctors who, unfortunately, are driving taxis in our city. When we talk to our newcomer community about that, they often say there's a bit of false advertising going on, if you will, by the federal government. You get more points if you're a foreign-trained professional and if you have high education standards and qualifications, so as a result of that it's easier for you to come to Canada. But once you come here...a lot of people are experiencing difficulty actually being able to practise in their profession, and in your case in the medical profession.

I wonder if you could just talk to us a little bit about where the bottleneck is. Certainly the provinces will say it's the federal government, the federal government will say it's the colleges, and you're probably going to say it's both levels of government. For folks for whom we're trying to help navigate the system, it would be really helpful to hear, from your perspective, where you think that bottleneck actually exists.

Ms. Danielle Fréchette: Thank you.

I think if we could match immigration policy with needs, we might create a better sense of expectation among those who are immigrating to Canada and the practice realities.

Fitting it into practice is really a complex issue. It's not just the technical skills, it's the social acculturation as well. To have a clinician tell me I'm not breathing well because I'm probably a stressed woman I don't think would go over well—and that has actually happened to me.

So the issue is community placements, it's observations and practice, and so on, and these are all very time-consuming perspectives that occupy already very busy clinicians.

I think we're making great strides in trying to integrate our internationally educated health professions into practice, but we have to be realistic. A lot of them will never get the job because they're not good enough.

The experience in Quebec.... When I toured the various medical schools in Quebec, they were saying that a lot of physicians who trained in *la francophonie internationale* are not fit to practise. They really have to start from the start, from medical school. Are we ready to make that investment in these people?

● (1545)

Ms. Chris Charlton: I'd like to follow up. If you're saying that a number of folks who come here expecting to be practising medicine, in your words, aren't "good enough", yet the federal government gives them points for their educational qualification, are you suggesting that we should review the point system? Or are you suggesting we should explore additional government support to make sure that foreign-trained professionals are able to acquire the skills they need to practise here, whether those be actual medical skills or whether they be, frankly, courses with respect to adapting to the culture in their new home country? I'm not sure I understand the recommendation you're making.

Ms. Danielle Fréchette: My observation is really to try to match our immigration policy with our needs, and to understand that whatever extra measures we do apply to provide opportunities for these internationally educated physicians to integrate into Canadian society...that we do not give them greater opportunity than our Canadians who are trying to enter medicine as well. If you tip it too much, you're creating some bottlenecks for Canadians who are trying to enter medicine, which is very competitive in this country. We have a lot of Canadians studying abroad right now who are trying to reintegrate as well, who don't have training slots.

Ms. Chris Charlton: What are you suggesting we do for foreign-trained physicians who have come to Canada in good faith, who want to establish Canada as their new home? Are you suggesting we just write off that entire population of people who are excited to be part of Canada?

Ms. Danielle Fréchette: Absolutely not. We have to be able to identify them, assess their basic skills, but recognize that we have to be able to modulate the intake into our workforce, because they become part of the production of our workforce, to match it with needs. So if you have enough cardiac surgeons in the country and you have cardiac surgeons who want to immigrate, maybe they should know that our needs are not as great right now. It's to be able to match needs with supply and, once they come in, to provide the resources either within practice settings or educational sites so they can be up-skilled or re-skilled.

Ms. Chris Charlton: But matching—

The Chair: Your time is up.

Ms. Chris Charlton: Just for two seconds...?

The Chair: No, we're in a five-minute round and your time is over.

We'll come back to you, if you need, in the next round.

Go ahead, Ms. Leitch.

Ms. Kellie Leitch (Simcoe—Grey, CPC): Thank you very much to all of you for being here today. We greatly appreciate it.

I am a fellow with the Royal College of Physicians and Surgeons, so thank you, Ms. Fréchette, for coming.

There's one thing I want to say before I ask you my question, just so we're clear on the record with regard to jurisdictional issues with respect to physicians. Let's be very clear: the provinces create the spots for residents, whether those are Canadian-trained or physicians from overseas. We as a federal government have no capability to intervene in that. It's a completely provincial jurisdiction.

I'd like to ask a question of all of you, really, to get a sense from your standpoint of the skill shortages we're looking at for the health sector overall. I recognize that, as stated, I don't have any problems getting access to a dentist, but maybe you foresee challenges in the future. Maybe you could address some of those areas you've spoken of, whether it be children, aboriginals, or individuals who are low income, with respect to this question.

What do you see as the top three barriers to making sure we have an adequate supply, whether it be physicians, dentists, or the technical people who your health professionals deal with on a daily and regular basis in order to do their jobs? I know I need a dental hygienist every time I go to a dentist's office. There is significant support staff for health care professionals.

What are those key barriers that you foresee would contribute to those shortages or to the lack of health care professionals being available to Canadians?

● (1550)

Ms. Danielle Fréchette: If you're thinking of redressing maldistribution in our rural communities and recognizing work-life balance as being key, I think a creative use of electronic care, where you could bridge a local clinician with a series of clinicians in some of the larger urban communities, so that they're not the lone practitioner there....

When you're recruiting someone to a rural community, you're not just recruiting the clinician; you're recruiting the family. Recognizing that it does take a while to produce a fellow of the Royal College or the College of Family Physicians of Canada, you're looking at really attracting the whole family. So you're looking for employment for the spouse or their partner, and they want good schools for their children.

These are very locally specific issues that are really outside the realm of the federal government, but those are some of the real barriers.

Ms. Kellie Leitch: Dr. Sutherland.

Dr. Robert Sutherland: There are three things, I would say. One would be the cost to train and the cost to run a practice. The cost to train is expensive and the cost to run a practice is expensive. We run kind of mini-hospitals, if you will, as a dentist. The same procedures are going on and the same sterilization. We have a well-trained and costly workforce. So I think that is one area of barriers.

I think a lack of maybe a common set of guidelines across the country in long-term care facilities would be a second, and a third would be a lack of general education around the need for oral health care. Listed as probably the number one reason why people don't attend a dentist is that they don't feel they have a problem.

Ms. Kellie Leitch: Okay. Very good.

I have a second question, and I'm focusing more on the educational component. We obviously have to create a pipeline for these individuals to be available. What are your recommendations for the federal government on what kind of role we can play in facilitating that type of pipeline?

I'm a product of your system. I know that my colleagues who were educated in northern Canada tended to go home to northern Canada.

Do you have recommendations or suggestions along the lines of what items would be within federal jurisdiction that we could be involved in? One thing we put forward is loan forgiveness, both for medical students as well as for nurse practitioners, so that individuals who are willing to go to remote and rural locations are encouraged to do so by having forgiveness of their Canada student loan.

Do you have suggestions on how we can encourage people to go to those other areas of the country through the educational pipeline so that they end up where we'd like them to be?

Ms. Danielle Fréchette: We'd probably have the solution to world peace if we could answer that question.

Loan forgiveness may be a slight enabler, but it doesn't really inculcate in the future physician the desire to go work in those communities. We do know that exposure to these sites—and we look at the Northern Ontario School of Medicine as a real success story. It's being examined internationally as the way to train some of the doctors of the future.

We are the land of pilot studies, but there's nothing wrong with piloting some of these wonderful ideas, to have some outlets for either faculties of medicine or institutions such as the Royal College to really try to look at new and exciting ways.

We do have, now, a new pipeline for pilots. Any faculty of medicine that wants to pilot a new program, a different way of training doctors, can, but they're doing it on the backs of their own institutional budgets.

You mentioned that education in health care is purely provincial, but what we're missing is this cohesive picture. I know I sound like a broken record, but a health workforce is a science, and we have to get those connecting pieces together. We have so many success stories throughout the country. I just quoted the Northern Ontario School of Medicine as one, but we have other pockets of excellence.

In our institution, we accredit over 700 training programs in the country in our 67 disciplines. We see wonderful things, but there is no outlet where we can put in this wonderful repository these great success stories that might inspire others as well.

● (1555)

The Chair: Thank you for that, and your time is up.

Mr. Sutherland, did you want to make a comment?

Go ahead.

Dr. Robert Sutherland: On the issue of loan forgiveness, we could consider on the provincial end piloting something like tying a financial incentive to having people contract to work in remote areas for certain periods of time, to see if that might be a help. Dr. Swan might be able to speak to the issue that across the faculties of dentistry in Canada, about eight have set aside specific seats within the dental program for special consideration. Those would be the type of people....

Hopefully, they would be aboriginals, they would be people from remote areas who would be given some other consideration, and there would be an incentive to go back to where they were.

I mentioned the Ontario Dental Association's remote areas program. That's where the federal government has contracted the delivery of services for an area in northwestern Ontario that's literally the size of France. The Ontario Dental Association currently has the contract to supply dentists to that area.

That sort of thing might be something to consider as well.

The Chair: Mr. Swan, did you wish to add to that?

Dr. Euan Swan (Manager, Dental Programs, Canadian Dental Association): Only to confirm, Mr. Chair, as Dr. Sutherland has mentioned, that seven of the ten dental faculties in Canada have places set aside for aboriginal students, to encourage the recruitment of aboriginal students from first nations, who would then return to the communities, as Dr. Sutherland said, and have the cultural competency to provide care to the local folks there.

The Chair: Thank you.

Mr. Lapointe, go ahead.

[*Translation*]

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

Ms. Fréchette, I would like to digress for a moment before I address what seems to be the main issue.

[*English*]

The Chair: Are you okay with the translation?

Dr. Robert Sutherland: Yes.

[*Translation*]

Mr. François Lapointe: Ms. Fréchette, your assessment of the situation regarding foreign-trained specialist physicians seems to be rather pessimistic. You said that the situation in francophone countries was rather disappointing.

Does that include people who were trained in Europe, such as French physicians who have to start their education process practically all over again?

Ms. Danielle Fréchette: The quality of international medical graduates varies greatly. A physician may have been trained in India in an excellent institution and may be ready for immediate integration, while someone else may have been trained 40 km from that location and may not have the same skills at all, even in the same area of specialization.

Mr. François Lapointe: When people move from one European country to another, for instance, they don't have the same problem. I assume that the Germans and the French have a more stable system.

Ms. Danielle Fréchette: That is not really the case. I spend quite a bit of time in France trying to build bridges. People are interested in the Canadian system. Our competency framework interests them. Some medical faculties do not require students to take an exit exam. People complete their studies, find someone who wants to hire them and get the job.

Mr. François Lapointe: Without taking a standardized exam?

Ms. Danielle Fréchette: That's right. There is no standardized exam in the country. Training standards are very, very different. They are now developing a standardized curriculum. There is currently no such thing. In Paris, cardiology training may be different from that provided 30 km away, in the same city.

Mr. François Lapointe: Thank you. That information is useful.

Ms. Fréchette, I want to go back to what seems to be the key issue for you and for Mr. Sutherland. There is no acute shortage of resources, but their distribution is uneven. For instance, there may be too many cardiologists in Winnipeg, and not enough of them in Quebec City. How can we have enough flexibility at all stages of the process? When people are referred to specialized schools, does a certain degree of flexibility exist that helps quickly decide to train fewer people in one discipline and more people in another? In Canada, are there any statistical tools that enable your organization to adjust promptly?

Can you consult your members quickly and tell them that, for instance, there will soon be a shortage of cardiologists in Quebec City, but not in Winnipeg? Are improvements needed when it comes to that? Is there enough flexibility among the provinces so that people can move, if they wish, so that a better balance can be achieved between the regional needs on the ground and the available resources? We have understood that this is where the source of the problem is, but how can that flexibility be achieved?

● (1600)

Ms. Danielle Fréchette: There is currently some flexibility when it comes to that. If a dentist or a physician has full licensure, they can go anywhere in the country, and that is a good thing. However, that does not necessarily solve the distribution problem. If someone wants to practise in the suburbs, they need to have the required resources and know about that way of life—so some of the things I have already described a bit. In addition, needs have to be better adapted to the production. That will continue to be a weakness across the country until we are able to better determine the needs and until each province starts to produce its own labour force, given that physicians move without having a Canada-wide idea of the needs. The provinces are going about it somewhat haphazardly.

Mr. François Lapointe: Is that one of the aspects of the problem?

Ms. Danielle Fréchette: That's the key aspect.

Mr. François Lapointe: You also talked about reconciling work and family. In my generation, that's less and less a matter of gender. I took care of my children from 30% to 60% of the time, depending on the year. My wife is also a professional. At times, I was the one taking care of the children 60% of the time. It all depended on who of the two of us had a better contract in a given year. That's relevant. Around me, I am seeing people in their forties who are professionals. They refuse to work 80 hours a week, as they want to have two or three children and live a quality life.

What kind of measures do you think the government could adopt to facilitate the reconciliation of work and family? How could our work in the House of Commons make the process easier? Should we make sure that the training production increases? That way, not all physicians would necessarily have to work 85 hours a week to meet the needs. What could be done about that?

Ms. Danielle Fréchette: The notion of full-time equivalence does not match up with the number of people. According to CIHI data, there are over 67,000 physicians in Canada, but they don't all work at the same level of intensity. We should not compare ourselves to the OECD countries. We compare ourselves to nations where physicians work at various levels of intensity. In Italy, working 30 hours per week is fine, as there are many more doctors. The number of physicians per 100,000 citizens means nothing.

Mr. François Lapointe: So that's not an essential condition. It depends on whether physicians tend to work 30 hours or 60 hours a week. That makes a huge difference.

Ms. Danielle Fréchette: Exactly. It is really a generation-based notion. Everyone wants to strike a better balance and be a better parent.

Mr. François Lapointe: What can the governments in Canada do to resolve this issue?

[*English*]

The Chair: Thank you, Monsieur Lapointe. Your time is up.

But we'll conclude with the answer, if you could go ahead, Ms. Fréchette.

Ms. Danielle Fréchette: Thank you.

[*Translation*]

I keep coming back to the same solution. It's a matter of gaining a better understanding of what the Canada-wide needs are. We need to stop operating in our provincial and territorial bubbles.

[*English*]

The Chair: Thank you.

Mr. Daniel.

Mr. Joe Daniel (Don Valley East, CPC): Thank you, Mr. Chair. Thank you, witnesses.

My question is skewed a little bit, but I'll ask it anyway.

Obviously, the doctors and nurses, etc., are the heroes of the medical profession. But clearly there are going to be a lot of other support skills and staff needed. Can you talk a little bit about medical technicians? Without them, the doctors cannot complete their work. Or are there any other skills? Really the question is, in your view, what are the foremost issues resulting in skill shortages for the medical sector?

● (1605)

Ms. Danielle Fréchette: One of the studies we're running right now is quite interesting. We're looking at the employability of physicians. It came to light that a number of doctors were either unemployed or underemployed. Looking at the new skill mix and the upscaling of different health professions, it is having an impact on how our physicians should be trained in the future and the numbers we'll actually need.

In a very integrated model in orthopedics, for example, where you could have an occupational therapist, physiotherapists, and so on working together, we're seeing that we need fewer actual orthopedic surgeons. We're also looking at really interesting ways of triaging patients. The hip and knee registries are really paying off now; the patient sees the first available clinician. So those are really neat ideas.

But how are we factoring in all of these new innovations and success stories to align with the needs and the actual production of the future?

There are some disciplines that are in absolute shortage. With an aging population, geriatric medicine is problematic. Family practice has a stream for care of the elderly, but it is a problem as patients are becoming more and more complex. Internists are in high demand as well.

So the disciplines that don't require a lot of infrastructure are having greater ease finding work. At the Royal College we're actually considering what will probably be a vastly different training paradigm, where education will really be more integrated. We have our maintenance of certification program, which is a life-long learning process, but to create some basic entry points so that you can then stream more easily, more nimbly, depending on what the needs are of the country.

Mr. Joe Daniel: So it's really probing to see how essential the medical technicians are who are actually doing all the work on samples and what have you in support of the medical profession.

Ms. Danielle Fréchette: Absolutely. You can't have an open-heart surgery without a properly staffed intensive care unit and cardiac nurses at the ready. So it's an interwoven piece.

When we're doing our workforce studies, we try to get an understanding of those various bits. But we're all trying to do this within our own resources.

We're not investing enough in HRH research. This is the highest-cost centre in the country for health care. It's the people who run it. And yet we're not investing in really understanding it, optimizing it, and implementing our wonderful pilots.

Mr. Joe Daniel: On the dental side—I know you have lots of dentists—what's the situation with regard to hygienists, all your support staff, etc.? Are there enough of them being produced?

Dr. Robert Sutherland: There are actually more hygienists in Canada than there are dentists. So it's really not a skill shortage per se. It's more of a location shortage, where those skills meet the patient.

Dentistry works in a team concept. There's a tremendous respect for each others' skills and the skills of the other team members. You mentioned that dental hygienists are absolutely essential to providing the care that's required. The challenge is less on the numbers and the shortage of skills than in trying to get those skills to where they're needed and have them stay there.

Mr. Joe Daniel: Do you have any ideas of how to incentivize that so that you have the skills in the right place?

Dr. Robert Sutherland: We need to be looking at, as I said earlier, alternate delivery models, looking much more at public health clinics, satellite clinics in these more remote areas. There may not be enough of a population there to have a full-time dentist, so we have to create a situation where a dentist may be there one or two days a week, or two or three days in a month, and still have a viable practice. That's part of it.

You mentioned the incentives. I think they also tie into this. When you can be there only a few days a week.... You have overhead and you have space and employees who are there the rest of the time as well. So there's an overhead aspect to it.

Probably the major thing we need to get at is the prevention end of it. The vast majority of all dental disease—decay and gum problems—is preventable. So we need to get out there in the schools much more. We need to talk prevention. We need to raise awareness. That's more the direction.

● (1610)

Mr. Joe Daniel: Mr. Swan, do you have any further comments on that?

Dr. Euan Swan: No, I have no further comment on that. Thank you.

Mr. Joe Daniel: Should we be doing things like providing the same sorts of tax incentives for medical technicians? This is kind of where I was leading to, in terms of being able to support the medical profession in remote areas. That's where I was kind of going with that. I don't know if you can make any comments on that.

Ms. Danielle Fréchette: Financial incentives are only part of the solution, because we have to have a broader infrastructure within which you could work. The electronic health record is one of those pillars that we often look at, so just throwing more money at it isn't necessarily the solution. I know it's almost heresy to say that, but I don't think—

Mr. Joe Daniel: I don't think I was suggesting throwing more money at it, but more like providing tax incentives for doctors and other medical folks in that....

They really can't do their job unless they have the supporting lab facilities and lab technicians, etc., for whom we're not providing any tax incentives.

The Chair: Thank you, Mr. Daniel. Your time is up, but go ahead to provide some concluding remarks.

Ms. Danielle Fréchette: Investing in infrastructure is definitely a very important solution, and you'll often find that if the physical resources are there, the people will follow.

The Chair: All right.

Mr. Cuzner.

Mr. Rodger Cuzner (Cape Breton—Canso, Lib.): Thank you, Chair, and to our witnesses today.

I think what you're getting at, then, Ms. Fréchette, is that there's an absence of a paying Canadian HR strategy in the health sector, so that the college advocates that one be undertaken and put in place.

I apologize about not knowing more about the observatory you referred to. Could you just take 30 seconds and enlighten the committee?

Ms. Danielle Fréchette: Absolutely.

Respecting provincial and territorial responsibility for its own workforce planning, the observatory could be a hub of research, where we could go to deposit our research, for example. It could also be the place where the various provinces, such as the advisory committee on health delivery and human resources, could go to and get comprehensive data. There would be full-time scientists that would actually be trying to connect the pieces.

I spend a lot of time looking at HR research in the country. We have really neat stuff going on, but nothing to pull it together, so this would become a national resource for the jurisdictions that are trying to make sense of this mess and would potentially better identify needs, better rationalize the production pipeline, including not just, in my case, of physicians, but the cross-impacts of new health professions coming upstream.

One of the next things I'll be looking at are scopes of practice. Within our own specialties...you have an orthopod working on a spine, you have a neurosurgeon working on a spine, but what is the need for spinal surgery in the country, and should my organization be changing its training requirements?

Mr. Rodger Cuzner: Good. I appreciate that.

Mr. Sutherland and Mr. Swan, the studies about skill shortages—I'll inform you that in the next short while you'll discover many skill shortages in your most recent hire.

He's a great young guy.

You're saying now that you're at the sweet spot now with the number of seats and the number of dentists that are being produced in this country. Has that come about over a period of time? Was there a shortage? Was there a strategy to address that? Were additional seats opened, or did it just come about naturally? Could you enlighten us on that?

Dr. Robert Sutherland: Certainly, if you go back after the Second World War, there was—

Mr. Rodger Cuzner: Oh, it's that far back, though?

Dr. Robert Sutherland: It would start.

The demands around the times that we live in would dictate the number of seats that are there. When I graduated, there were nearly 130 people in my class. There are about 90 people in graduating classes now.

The dentist to population ratio is, again, right on par with the OECD, so I think for that reason we're graduating the right numbers of people. Again, it's the distribution of those numbers.

Mr. Rodger Cuzner: You had identified that there were seven institutions out of the ten that are training dentists that have special programs that are allocating seats to first nations people. Is that an institution by institution decision, or is it driven by the provinces for those institutions? Where is the impetus for that coming?

● (1615)

Dr. Robert Sutherland: The seats that are there are available for these groups of people; I wouldn't say they're all dedicated to any particular group. They're available and they would apply for those.

I would suspect that it would be—and I'll ask Dr. Swan—institution by institution.

Dr. Euan Swan: Yes, that's correct. Each faculty of dentistry and their associated university would develop policies regarding places for aboriginal and first nations people.

Mr. Rodger Cuzner: What would be an average application rate for dental training? How many applications get turned down, institution by institution? There's no problem with the application rate, I'm sure.

Dr. Robert Sutherland: It's probably in the order of eight to ten applications per available seat.

Mr. Rodger Cuzner: What about the first nations seats, those you try to identify for first nations?

Dr. Robert Sutherland: I wouldn't have information in terms of the numbers applying versus the number of seats. We could try to get that information.

Mr. Rodger Cuzner: It's been a theme that has come out through the course of the study that if you're able to allow people in rural communities the opportunity to understand that the training opportunities are there, then they go back and serve those communities. That's really when everybody benefits. They're much more comfortable within the community.

I guess the question comes back to how we are educating first nations communities that those opportunities are there. How are we making sure they're aware that those training opportunities exist?

The Chair: We'll conclude with the response to that.

Mr. Swan, did you have a comment?

Dr. Euan Swan: It's a very good question, and I don't have that information right now. This weekend the Canadian Dental Association's committee on the dental admission test is meeting here in Ottawa. That's a question I can take to that committee and get back to you with the information.

Mr. Rodger Cuzner: Thank you.

The Chair: Does anyone else wish to make a comment?

Ms. Fréchette, go ahead.

Ms. Danielle Fréchette: Thank you.

I think a strategic investment in our aboriginal health workforce would help us go a long way. The cultural sensitization is a very, very large job, but to empower aboriginal peoples to care for themselves in their own settings I think is the winning solution for us. It's investing in mentoring programs, financial assistance, and providing extra resources within our educational infrastructure so that we can really integrate them, because they don't come with the benefits that the likes of me present with.

We're actually developing a program at the Royal College right now for our underserviced populations. If we can think of some of the approaches for aboriginal peoples, we could probably then generalize them for other populations as well. We're hoping to go that way.

It's the medical profession trying to be responsive to societal health needs within its own limited resources. I think partnering with some national resources would help the program go a lot further more quickly. Then we could probably apply some of these strategies to help integrate our international medical graduates as well.

The Chair: Thank you.

Mr. Sutherland, did you wish to make a comment?

Dr. Robert Sutherland: To come back to an earlier question on the numbers of students, over the past 20 years there's been a consistent 0.6% increase annually in the number of educational positions. It has steadily increased each and every year over the past 20 years, and it has kept pace with the OECD average as well.

The Chair: Thank you.

Mr. Shory, go ahead.

Mr. Devinder Shory (Calgary Northeast, CPC): Thank you, Mr. Chair, and my thanks to the witnesses for coming here this afternoon.

I want to thank my colleague from across the way, Ms. Charlton, for promoting the story I have been talking about for years and years, about the taxi driver and the doctor. I'm not a doctor by profession, but I have lived through this problem of foreign qualification recognition. It's my passion and one of the reasons I came to politics.

During the study, I found out that the skilled worker point system gives points based upon years of education. Nowhere does it recognize your education as a doctor or an engineer. Basically, it does not qualify you to have the same profession once you come to Canada. That is one fact I found out after doing some study.

When we were having our study on foreign qualification recognition—Ms. Fréchette, this will be for you—the Royal College of Physicians and Surgeons of Canada agreed that there was a shortage of doctors in each province and territory. There was no question about that. They also mentioned that recognizing or training these foreign-qualified doctors would put pressure on provincial and territorial medical regulatory authorities, which would have to register and license these graduates.

We all know there is a shortage. We all know that we do not want to lower our standards. So what do we do? You talked about matching immigration policies with needs. How can we make improvements to foreign qualification recognition without lowering the standard? What is the number one roadblock preventing foreign-trained medical professionals from getting into the system?

● (1620)

Ms. Danielle Fréchette: Documentation is a huge barrier—to have your qualifications recognized. It comes in variable forms, in different languages, and it's not consistent from one jurisdiction to the other. You're trying to estimate the baseline qualifications of an individual. They could have 15 years of training and all the points that go with it, but what kind of training did they have? Training as a general surgeon is really great, but if you've only observed some appendectomies and you might have tried a couple, does that qualify you as a proper general surgeon?

The documentation is probably top of my list, and it has been identified in other research as well. Providing some resources to the physicians abroad so that they could provide standardized documentation would help speed up the process of having credentials recognized.

Mr. Devinder Shory: If we had targeted immigration, say, pre-certification of medical professionals, would that help us?

Ms. Danielle Fréchette: It's a stage process. If the Medical Council of Canada qualifying examination was offered offshore in a number of languages, you could establish certain baselines. You could adjust the expectations of the physicians wishing to immigrate, so they'd know if they were close to being able to practise or if they should be looking at a longer path of training. It could also help the jurisdictions better understand what kind of individual is coming into their community, so that they could provide the proper resources. At the end of the day, the objective is to integrate our internationally educated physicians into meaningful work. Ontario's program for physician assistants allows for the reintegration of physicians who really don't have the appetite for all of the required training but who want to continue to work in medicine.

Mr. Devinder Shory: I understand, but the frustration is that I don't see a clear pathway for so many professionals, and that's where we are seeking some help.

I understand clearly as well that there are jurisdictional issues. Provinces and territories have the jurisdiction on all these things. At the federal level, our government has taken the leadership role by establishing this pan-Canadian framework, which hopefully will help, and it has been helping to an extent.

I'm looking for some suggestions on how we can help with foreign qualification recognition or in addressing the issue of this shortage of skilled workers.

● (1625)

The Chair: Thank you, Mr. Shory. That is your time, but we will allow a response.

Go ahead, Ms. Fréchette.

Ms. Danielle Fréchette: Again, I wouldn't say that we have a shortage of physicians. We have shortages in different locales, so it is a distribution issue. If we could match qualified workers with available positions, I think we would be ahead of the curve ball. This is also predicated on having a longer-term understanding of what the needs are, and we are not there. We are not sophisticated there.

The Chair: Thank you very much for that.

I'm not sure if anyone has any concluding remarks, either from the dental association or from the college. You're welcome to make them now before we conclude.

Mr. Sutherland, I see you do. Go ahead.

Dr. Robert Sutherland: I will just comment from the dental point of view on the same question, if I may.

The profession has taken a number of steps to improve and streamline this sort of processing to get foreign-trained, non-accredited dentists into Canada to practise their skills.

We have a program that has three parts to it that can be completed in a year's time, and at the end of that, on successful completion, they can sit the same examination that a graduate from any dental school in Canada would sit. When they pass that, they can practise in any province in Canada. There is freedom of movement across the country.

If for some reason they're not successful there, there is access to gap training programs and upgrading programs that are offered in essentially all the universities in Canada.

Dentistry is very proud of its track record in this area.

The Chair: Thank you.

Mr. Swan, do you have a comment to make?

Dr. Euan Swan: No, thank you.

The Chair: Ms. Fréchette.

Ms. Danielle Fréchette: Thank you.

It would be encouraging to see the certifying bodies working together, with some federal resources to ramp up our assessment capabilities and technology. We know that simulation is huge, and to really capitalize on the potential of simulation, to give our foreign-trained physicians a quicker diagnostic of where they're at, would help pave the way for their integration as well.

Thank you.

The Chair: Thank you very much for that presentation.

We will suspend now for our next panel.

Thank you very much for coming before this committee.

● (1625)

(Pause)

● (1635)

The Chair: I call the meeting to order.

We have a good group of witnesses here with us today, and we're waiting to hear each of your presentations, and there'll be some questions and answers.

We'll start with the dieticians, I understand. Please go ahead.

Ms. Pat Vanderkooy (Manager, Public Affairs, Dietitians of Canada): Good afternoon. I'm Pat Vanderkooy, representing Dietitians of Canada, with public affairs. My colleague is Marlene Wyatt, with professional affairs in our association.

You have before you an outline, and we will shortly be following up with a brief that we will submit.

Dietitians of Canada is our only national professional association of dietitians in Canada. We're already on record calling for cross-sector collaboration, national leadership, and coordinated action to address key issues.

Today I'll address access to dietitians' services in all sectors with a sufficient dietitian workforce. In Canada, dieticians are the only regulated health professionals with accredited education and training in food and human nutrition. Becoming a registered dietician requires five years of post-secondary training, four years at an accredited four-year university program, and an additional year of practicum training.

Of the 9,500 dieticians in Canada today, most are employed in our publicly funded health system. As well, dieticians work in academic settings, in the food industry, and as private consultants and counsellors.

With growing interest in healthy lifestyles and the urgent need to prevent and better manage chronic diseases and obesity, dieticians are in high demand. Dieticians participate in collaborative care as members of interprofessional health teams. In Canada, however, access to dieticians is limited by a shortage of dieticians. Today I'll address three aspects of that shortage.

First is our labour shortage and essentially the bottleneck in our practical training component. Last year Dieticians of Canada produced a snapshot of the dietetic workforce in Canada. We found, one, that all provinces and territories have vacancies that are difficult to fill, especially in the rural, remote, and northern communities, and almost half of the dietician workforce currently is planning to retire within the next ten years. Dietician vacancies are already impacting the quality of health services. Some employers, to fill gaps, have hired non-professional educators or health professionals with different scopes of practice. In our health care systems there is limited funding to support practicum training. There are gaps in training opportunities as well in smaller communities and among aboriginal populations. Based on our projections, there is an urgent need to increase the practical training capacity for dietician candidates in Canada.

Second, as with other professions, we also have a growing number of internationally educated colleagues who wish to practise in Canada. We require bridging programs for qualification to practise. We believe it's only fair and equitable that these internationally educated dieticians have the opportunity to be employed here in their chosen profession. Currently, we have only one such program for dietician bridging supported by government funding. In the past five years, this program at Ryerson University in Toronto has graduated over 100 internationally educated dieticians. Before this program was established, very few internationally educated dieticians were able to gain registration for practise in Ontario. Today, almost all the graduates of this bridging program have succeeded in passing the national certification exam and are employed as registered dieticians. Demand for this program remains high, with applicants from across Canada.

My third point today is that, as you may know, the Canadian Institute for Health Information tracks workforce data for six other health professions. We dieticians are not one of these professions. We don't have continuous, up-to-date, accurate information about our workforce trends and the projected needs in Canada. We support the continuation of the work of the Canadian Health Human Resources Research Network. We really need access to information for innovation in development, training, regulation, recruitment, and retention.

What is it that we need? We need a comprehensive health human resources strategy so that Canadians will have access to the right care at the right time.

We recommend, as dietitians of Canada, improved and increased training capacity in accredited universities and practicum programs. Our profession needs more spots for practicum training to increase the number of practice-ready dietitians. We need support to coordinate this practicum training and an efficient system that addresses the newer competency standards that we have developed.

● (1640)

We also require improved workforce mobility, and specifically here we ask for sufficient support for bridging programs for internationally educated dietitians. This would require sustained government funding to ensure the continuation of our one current dietitian bridging program in Canada, and of course it would be great if there were assistance to develop and implement bridging programs for dietitians in other parts of Canada.

Last, we do need improved labour market information. Our profession requires support from the research network. We would like to have assistance from CIHI and Stats Canada to initiate data collection for dietitians, and some support from the provincial and territorial models for supply and demand responses.

I thank you for this opportunity to address you on behalf of health human resources challenges in our profession. We look forward to your questions, and also to your report and recommendations in the near future.

The Chair: Thank you, Ms. Vanderkooy. We appreciate your presentation.

I know the next presenters, the Canadian Federation of Medical Students. We've had the great privilege of having met many of them on the Hill, lobbying many of us from year to year, and we appreciate that very much. It's good to have you involved in our study. We're looking forward to hearing from you.

I understand you're going to split your presentation, so we'll commence with either Ms. Hassan or Ms. Ward. Go ahead.

Ms. Noura Hassan (President, Canadian Federation of Medical Students): Good afternoon. Thank you for having us. I am Noura Hassan. I am president of the Canadian Federation of Medical Students. I am here with Chloé Ward, who is our vice-president of advocacy.

[*Translation*]

I would be happy to answer your questions in English or in French.

[*English*]

The Canadian Federation of Medical Students represents over 7,800 medical students attending 14 medical schools in Canada. Thank you for having us to discuss the issue of labour shortages in Canada.

Today we wanted to address three key issues in health human resources from our perspective. First, we wanted to bring to your attention a pending oversupply of physicians. We had a presentation from the Royal College earlier, so we're going to build on that, providing a little more of the student perspective.

Second, we'd like to address some labour shortages in key medical specialties. Last, we're going to discuss the geographic maldistribution of health human resources in Canada.

As you all know, more than 20 years ago, in 1990, Canada was faced with a significant physician undersupply. This issue was addressed by a number of medical stakeholders, including the Canadian Medical Association and the Canadian Medical Forum, and that led to an increase in admissions at medical schools across the country. At this point, we are training more physicians than ever in Canada. Essentially this is good news because it limits the likelihood of physician undersupply as it stands right now. However, as you also know, it takes from six to eleven years to train a physician who is ready to practise in Canada. For that reason, it's clear that we only see the impact of any changes in policy with respect to medical school admissions five or ten years down the road. It's not an immediate result.

At this point we're starting to see a change in paradigm. In the not-too-distant future, some graduating medical students will not be finding jobs upon completion of their specialty training. When I say “specialty training”, I'm not only speaking about Royal College specialties, I'm also talking about family medicine. We have information from CIHI suggesting a net influx of 1,600 physicians in 2010. This is important to note because this does not reflect the biggest medical classes that have graduated. Bigger cohorts have yet to pass through the system. So we're going to keep seeing a more important net influx of physicians as the years go on.

As it stands right now, we need a mechanism that will help us match the residency training positions to Canadian health care needs from one end of Canada to the other. So essentially what we need is a joint mechanism. Ideally, it would be a federal-provincial effort that will help us ensure that we're not training too many physicians in Canada.

We have to stop this reactive yo-yo trend that we've been experiencing in Canada with respect to human health resource training. We have to be proactive to make sure we're serving the interests of students, medical schools, and our taxpayers.

● (1645)

Ms. Chloé Ward (Vice-President, Advocacy, Canadian Federation of Medical Students): One of the more pressing problems we're seeing is that many specialists are unable to find work in their specific field. Essentially, we are reaching a point, as Noura indicated, where there soon will be enough doctors, but these doctors will not be aligned with the specialties in demand.

Training spots in the various medical specialties simply do not match the population needs of Canadians. There are over 60 medical specialties that medical students can choose from. We're currently doing a very poor job of identifying current and future medical doctor labour shortages with respect to specialty and by geographic location.

For example, many specialists in cardiac surgery, radiation oncology, and orthopedic surgery currently have difficulties finding jobs in their fields. Because these specialists are highly trained, whenever they're unable to find work, they're often forced to leave the country.

The lack of a national level of cooperation is a large impediment. For instance, Ontario projects that before 2017 there will be labour shortages in almost every medical specialty in Ontario. Quebec is expecting an oversupply of physicians by 2016.

We're seeing similar trends across the country. When medical students apply to specialty spots after medical school, they apply through the CaRMS portal, which is essentially a national portal redistributing medical students across the country, not necessarily within their home province.

As of right now, there is no national health human resources database that tracks this kind of information. “The Future of Medical Education in Canada Postgraduate Project”, which is funded by Health Canada, actually calls for HHR planning on a national level, with government involvement.

Basically, we have demographic data on our population and on disease prevalence, and we know what the burdens are for our health care system. All we need now is a national database to collate this information and make it available so that we can use this information in the future to make projections and essentially align the residency and training spots in different specialties with the needs of Canadians.

According to the Society of Rural Physicians of Canada, 21% of Canadians are rural, but only 9% of Canadian physicians practise in rural areas. One of the main reasons that we have some underserved rural and remote areas in Canada—we're echoing previous messages from today—is that we're training few students from these rural and remote communities.

It is estimated that over 90% of medical students come from wealthy urban areas—essentially areas where there are no physician shortages. We know that medical students from rural or remote communities are far more likely to return to their communities to practise after medical school.

In Budget 2011, as you know, there was money allocated to forgive the loans of physicians and health care providers who begin to work in underserved rural and remote communities in Canada. This program aims to improve access to primary health care in underserved regions. We applaud this initiative; however, this program is inherently flawed as it currently stands.

Essentially, the loan forgiveness incentive begins only after residency, meaning that medical residents make payments on the federal portion of their Canada student loan during residency years. This greatly diminishes the incentive of loan forgiveness to attract physicians to underserved rural and remote areas. We need to defer the interest on and payment of the federal portion of the Canada student loan during residency in order to render this program effective.

● (1650)

Ms. Noura Hassan: Briefly, in conclusion, we really want to make it clear that as the doctors of tomorrow and the representatives of the Canadian Federation of Medical Students, we want to ensure that we're training not only the right number but the right mix of physicians in Canada, in order to be able to serve the health care needs of Canadian taxpayers.

What does that mean? It implies that we need to attract and also retain physicians in the rural and remote areas in Canada that need and deserve adequate health care. As it stands right now, we don't necessarily need to train more physicians; we just need to make sure they're distributed more efficiently across the country.

As we outlined earlier, there is a problem in physician maldistribution by geographic location and specialty, and that needs to be addressed. The way we need to see this addressed on a national level is to have a national human health resource database that will help us deliver adequate health care to all Canadians.

Finally, as Chloé highlighted earlier, there is a need to adjust the repayment schedule for the Canada student loans program in order to ensure that people can take advantage of these great resources that are being presented to residents who are interested in practising in rural and remote areas.

We look forward to answering your questions. Thank you for your attention.

The Chair: Thank you for your presentation. I'm sure everyone here is familiar with the yo-yo and the effect. The point was well made.

We will now turn to Christine Nielsen, who I think appeared before this committee in our study of foreign credentials.

It's good to see you again to present on this issue as well. Please go ahead.

Ms. Christine Nielsen (Executive Director, Canadian Society for Medical Laboratory Science): Thank you for having me back.

I would like to thank the committee for inviting the Canadian Society for Medical Laboratory Science to appear once again today. My name is Christine Nielsen. I am the executive director for the society, which is located in Hamilton, Ontario.

The CSMLS is the national certifying body and professional association for over 14,000 medical laboratory professionals in Canada. Medical laboratory technologists, or MLTs, conduct complex laboratory tests on blood, body fluids, and body tissues, and they also interpret results. These tests provide critical information about your health.

As a group, our profession is the fourth-largest health care profession in Canada, which is incredible, considering we know that relatively few Canadians know who medical laboratory professionals are or know about the important work that we do.

Medical laboratory professionals play an extremely vital role in the Canadian health care system, generating over 440 million lab test results every year.

Doctors depend on these laboratory test results to accurately diagnose and treat illness and to monitor patient health. Canada is presently facing a nationwide shortage of medical laboratory technologists. Our current supply of new graduates will not be sufficient to address the shortages. Our organization predicts that, alarmingly, nearly half of Canada's medical laboratory technologists will be eligible to retire in the next ten years. This shortage will undoubtedly directly affect patient safety.

For over a decade, we have been alerting decision-makers that the number of seats in medical laboratory technology programs is simply not sufficient to produce enough new graduates to replace those who will leave the workforce. The domestic supply is simply too low.

Since 2000, governments have taken steps to address the shortage by opening new education programs and increasing capacity in others. This is a positive development, but the retirements coming simply will not equal the number of new graduates. In addition, funding for programs has been provided for the classroom portion only, with little thought or interest in funding clinical placement education.

As with all health professionals, clinical training is a vital component of medical laboratory science education. Completion of a clinical placement is mandated by the accreditation body, and our students cannot graduate from their programs without completing a clinical placement.

This brings me to the issue of internationally educated medical laboratory technologists, or IEMLTs. As the shortage continues to grow, Canada receives hundreds of self-identified IEMLTs through immigration every year. About 200 apply for evaluation with the Canadian Society for Medical Laboratory science.

Practice varies significantly across the globe, and it is a requirement that all practitioners in Canada meet the rigorous entry-to-practice requirement, putting patient safety first at all times. A system that allows for additional training or practise in the Canadian context that is accessible, affordable, and reliable is imperative. We recognize and applaud the federal government for its continued work to accelerate and expand the assessment of internationally educated health professionals, and we look forward to continuing the momentum.

We're excited to hear about proposed changes to the immigration system that may require credential assessments pre-arrival. This step will allow newcomers to better understand the process and be matched to Canada before they get here. We were very pleased to see the recent announcement of the launch of the foreign credential recognition program loans pilot, and we hope that through this initiative, medical lab professionals will benefit as well.

We recently released key research findings on barriers faced by internationally educated health professionals in fulfilling their entry-to-practice standards in Canada. This project was funded by the Government of Canada's foreign credential recognition program and involved four other professions. The research highlighted that without a doubt the integration of internationally educated health professionals has benefited from recent attention and investment in the past several years, but it is also clear that internationally educated health professionals will benefit from further initiatives that will help to ease the future impact of our health human resource problems.

In addition to greater opportunities for clinical placements, it was clearly indicated by internationally educated health practitioners that a number of supports would definitely expedite the integration process. The majority of survey respondents were not able to participate in formal bridging or mentorship programs. Instead, they have to develop their own ad hoc system in Canada to help navigate the tenuous first few years of their careers in Canada.

Another report we released concluded that bridging programs shorten the time for internationally educated medical technologists to become certified in Canada, decrease their financial hardships, increase their taxation contributions, and expedite their integration into the Canadian workplace.

Targeted long-term sustainable investments are needed for the bridging programs. Success rates on the national exam are clearly higher for those who complete bridging programs.

● (1655)

Currently there is but one bridging program in Canada that serves 11 students a year with clinical placements, and it's located in Hamilton. With targeted investment, qualified professionals can enter the workforce more quickly to provide laboratory testing to Canadians.

In conclusion, I would like to highlight three broad categories of action as recommendations. First, develop additional training and support suited to the needs of internationally educated health professionals before and after licensure. Second, investigate how to improve the overall access and availability of clinical placements. Third, conduct future research into the reasons why a number of applicants do not complete the assessment process and ultimately fail to become licensed and work in their professions.

Strong investments today will help to ease the future impact of the shortage of medical laboratory technologists tomorrow.

Thank you.

The Chair: Thank you very much for that.

We'll start the first round with Madame Boutin-Sweet.

[*Translation*]

Ms. Marjolaine Boutin-Sweet (Hochelaga, NDP): Thank you, Mr. Chair. Thank you, ladies.

I think that, when they choose health sciences, most young people want to become physicians or nurses. Those professions are more popular. They don't really think about becoming dieticians or working in a laboratory.

Based on what you have told us, there is risk of having a surplus of physicians in the future, but also of having a shortage of people in other medical professions that are less recognized. What kind of methods can the federal government use to promote some of those professions, so that the young people who choose the health care field can learn more about them? That's an important question I ask everyone. I will add other points to it.

Loan forgiveness has been discussed. Could similar measures be implemented to encourage young people to choose certain careers over others?

The same goes, locally speaking, for first nations. Would it be possible to promote certain professions over others—which may take less time to learn—since you were saying that the consequences will be seen only in 5 to 10 years?

I would like to know what you think about that.

● (1700)

[*English*]

Ms. Chloé Ward: If we have a national database that looks at what the heath care needs of Canadians are, not just for medical physicians but also for nurses, dietitians, and other allied health care providers, we can identify what the needs are in different specialties. We can then align our medical doctor training spots, along with our other allied health care provider training spots, to meet those needs. If we have a continuous database from which to make long-term projections, we can appropriately incentivize and target high school students, medical students, and different groups during their training processes so they enter the fields we need them to go into.

[*Translation*]

Ms. Noura Hassan: I would like to add something.

Mentorship is very important, and it begins as soon as students start their studies. It is known that people studying in medicine often have mentors from that profession. We all know that's why medicine students often come from wealthy families or have parents who are doctors.

So it is important to have mechanisms for attracting young people from disadvantaged communities, or young people from rural areas who are not necessarily underprivileged. In fact, it is known that people from remote rural areas tend to practise in those areas more than urbanites. Therefore, such a strategy should be adopted.

When it comes to the federal government, it would need to fund organizations that already do that. We know that some faculties of medicine have invested a lot of money into mentorship programs. They meet with young people from remote rural regions and high school students to educate them about medicine. Those mechanisms are already in place, but they are not well-funded. It's a matter of encouraging the development and promotion of those programs.

[*English*]

The Chair: Ms. Vanderkooy, did you have a comment?

Ms. Pat Vanderkooy: Yes, I did. I entirely agree with what our other two respondents have said. They have essentially highlighted that we need to pull together the information that is out there but that we haven't ever really looked at really. What are the true needs to serve the health of Canadians? Where do we have to specialize? Just like physicians, dietitians specialize as well. Do we need more dietitians in public health? Do we need more of them in the pediatric wards? Do we need them in palliative care? We don't know.

The mentoring and the geographic area—we also experience that. As dietitians, and I believe the medical laboratory technologists are in a similar situation, we don't really need to recruit more people to our education programs. There are lots of students wanting to get into university-accredited dietetics and nutrition programs. The problem is that among these keen students, who fought to get into these competitive programs, who needed high marks to get in and then did their four years, only about half of them get practicum training.

So in fact there are plenty of people out there who want to be dietitians, and after four years of university, unfortunately, there are quite a few people out there who are disappointed that they can't become dietitians. That, bizarrely, occurs in the face of vacancies, and in ten years' time there will be lots of vacancies.

So what are we going to do? There is no funding. If you're a dietitian who is really busy going out to your patients and then you are asked to do training, but there's no coordination and there's no extra budget for people to do the training, your accountability and your productivity statistics will look horrible if you spend time with students, and yet you're expected to train students.

● (1705)

The Chair: Thank you.

Ms. Nielsen, you had a comment you wanted to make.

Ms. Christine Nielsen: I have just a final comment that can't be underestimated. The entry-level salary for a medical laboratory technologist is probably a tenth of what an entry-level physician will make. So to take the same group and suggest that they become medical lab technologists, when they're expecting six-figure salaries...it's not going to happen.

I've been told by a dear friend who's a lawyer that if you ask any law school class, it's full of people who failed GMATs, because a lot of people have decided they want a professional career and there are very few of them in Canada; doctors and lawyers are the two professions people naturally gravitate towards. I have a better understanding when you tell me that people going into medical school come from affluent areas primarily, because 6 to 12 years of school is a long haul for someone who comes from a working-class background. It may not be possible for such a person.

So I think it's not quite as easy as saying you can redirect a family physician down to the lab or over to dietetics, when our salary scales don't hit six figures, unless you're in senior management.

The Chair: Your time is up, but we used a lot of that just for commentary.

Ms. Marjolaine Boutin-Sweet: It's fine.

The Chair: All right.

Mr. McColeman.

Mr. Phil McColeman (Brant, CPC): Thank you for being here and providing some very useful information.

Ms. Vanderkooy, I'd like to pick up where you left off on the practicum side, but before I get there, I would like one clarification in terms of your comments. You talked about the internationally educated individuals and the bridging program at Ryerson, saying it graduates about a hundred graduates. You're saying that bridging program is funded.

Is it funded federally or provincially?

Ms. Pat Vanderkooy: I'll let Marlene answer.

Ms. Marlene Wyatt (Director, Professional Affairs, Dietitians of Canada): I'm involved with the program at Ryerson. It's currently funded; it has been on funding from the Ontario Ministry of Citizenship and Immigration for the past five years, and it graduates, on average, 20 students per year, so a hundred over the course of the five years.

The success rate, as Pat mentioned, on the national certification exam is almost at the same level as graduates of our accredited programs. With that program we do apply, every couple of years, for extended funding. Bridging programs by nature are extremely expensive to operate because you're figuring out what skills and knowledge people have and then equating them to the Canadian system, helping people to develop different skills than they had in their country of origin. And there is a practicum component, so we get back into getting clinical placements.

The average bridging program is probably in the neighbourhood of 16 months, but people who graduate from those bridging programs are fully employed. They pass the exam and they're fully employed, whereas prior to that, I think Christine mentioned, almost no one got through, and they were in low-paying, alcohol and food service-related jobs. The people who get through bridging programs are now getting fair Canadian wages for their work.

Mr. Phil McColeman: Maybe I'll switch to Ms. Nielsen.

Is your experience with bridging programs similar to this?

Ms. Christine Nielsen: Absolutely. They do really well during the pilot funding phase. The most expensive thing to do is create curriculum.

There have been several pilot programs that have started and have ceased to exist. British Columbia had one and the Northern Alberta Institute of Technology had one. The Michener Institute in Toronto had one, but when it had to move out of its pilot funding, it actually floundered for a few more years. They have a bit more kick-in funding for now.

But the biggest challenge is the sustainable funding. Something like the foreign credential recognition loans pilot project might actually help a student be able to pay the $14,000 or $20,000 tuition that it actually costs, and they can pay that back the first year if they move from a food services industry job that pays about $25,000 a year to being a lab technologist, which pays $50,000 the first year. They can even almost pay it back the first year out.

We think the success of those loans pilots is a really good opportunity for bridging programs to find their sustainable piece.

● (1710)

Mr. Phil McColeman: Okay.

I will just make a comment on the earlier comments made by Ms. Vanderkooy, which was that because the practicum portion of their education—getting the final certification to practise, I would think—is being somewhat rejected by people who are already in the field because it cuts into their income, primarily....

It doesn't cut into their income?

Ms. Marlene Wyatt: It cuts into their productivity at work and people judge them by their productivity.

Mr. Phil McColeman: Okay, so they're being judged. They're losing some status because of their productivity.

Ms. Marlene Wyatt: Well, because the students take the extra time, they're not able to see as many clients, etc.—

Mr. Phil McColeman: Could I make my comment?

I owned a business and had apprentices working for my company. I welcomed every one of them, and my carpenters took the time to make sure they were apprenticed properly.

I have a hard time understanding that lack of social responsibility.

Ms. Pat Vanderkooy: I understand how you might have misconstrued that piece of it. It's not about not wanting to be a preceptor. In fact, the majority of our dieticians in the workforce survey said that, yes, they had been preceptors at some point. All of us really do enjoy having students, but we know that the system within which we work—this publicly funded health system—judges our profession and funds our work by productivity output statistics.

We are simply caught between a rock and a hard place, in that our departments—our professional contribution in the systems—have to keep up certain productivity statistics while we are preceptoring. That doesn't even account for the coordination of these students within a little system. So there might be six students running around in the hospital or a community program. Who is coordinating them? Who is directing where their placements are going? All of this takes time.

So, in essence, the problem is that there is no funded time to do the preceptoring that the professional people very much enjoy doing. You don't enjoy it when your work is piling up and you essentially have to stay for unpaid overtime. It's a real problem that way.

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

Mr. Phil McColeman: Is that right? Ah, you're mean.

Voices: Oh, oh!

The Chair: Mr. Stewart, go ahead.

Mr. Kennedy Stewart (Burnaby—Douglas, NDP): Thank you, Chair. It's a pleasure visiting today.

Thank you to the witnesses.

I'd like to start with Ms. Vanderkooy, if I may. I just have to say that I've seen the value of dieticians firsthand. I have a lot of interaction with the local urban first nation reserve, and the changes it makes in people's lives when they start eating properly just.... It stops folks going further up the medical chain, that's for sure. So thank you for your work.

You said you have a problem with the supply of dieticians: there are not enough dieticians. I just wonder about the distribution. We've heard from surgeons and from dentists who say there is a distribution problem. How about your distribution?

Ms. Pat Vanderkooy: We did refer to it.

Ms. Marlene Wyatt: Yes, we do have a distribution problem. I think we referred to it very briefly when we said rural, remote, northern, and aboriginal communities. Those are the areas that are hurting the most.

We have tried to put some targeted programs, especially at the clinical placement level, in those areas, and it helps. But one of the issues with providing clinical placements in rural/remote areas is travel, etc. It's kind of a double-edged sword.

That would be where we are with the shortage of dietitians, and it did come out in our workforce survey.

I think the point made by the medical folks was that if we had a better handle on this, and they quoted some statistics, we'd be able to better address the issue. We did a point-in-time survey, which is the only data we have to measure that.

I'm not sure where you're from. In Newfoundland, for instance—I'm doing some work in Newfoundland currently—there are a lot of areas that are rural/remote, and all of our training is centred in one area. We're trying to move the training out, but again, the students have limited funds to travel to rural or remote placements.

● (1715)

Mr. Kennedy Stewart: Thanks. Maybe we can come back to that.

Ms. Pat Vanderkooy: We also have some shortages in public health. This profession we belong to, the dietitians, is one of the few health professions directly employed in public health units. Typically, public health units would be nurses and dietitians. That is another area where the distribution has become quite skewed, and it's problematic for our workforce.

Mr. Kennedy Stewart: Thanks. Maybe we can come back to that in a second.

I'll move to Mrs. Hassan.

I think a database is a great suggestion from both of you, actually. I think the more data we have, the better. And if it were a regularized thing, I'm sure it would help with placements and would help stop the yo-yoing.

I'm just wondering if you surveyed students. In particular, you talked about an oversupply of students. What I'd be worried about is that some intend to leave Canada anyway, no matter what the incentives are. Have you surveyed the students and asked them what their intentions are? I guess there's being forced to leave and there's wanting to leave. I'm just wondering if you have any information on that.

Ms. Noura Hassan: We haven't formally surveyed our students recently to see whether they intend to stay. But if we simply look at the data we can collect from the Canadian resident matching service, CaRMS, which is the way we apply to residency or specialty training positions, the vast majority of students graduating from Canadian medical schools stay in Canada for residency training. The reason we do that is because we want to practise in Canada. It's much easier to practise where you've trained, so the vast majority of people do want to stay in Canada.

It's unfortunate that the Royal College is not here anymore, because they'd be able to give you a better idea of where their graduates go.

In general, there is a vast appetite to stay in the country.

Ms. Chloé Ward: I have one thing to add to that.

CIHI has actually released some data indicating that in recent years there has not been an increase in the number of physicians trained in Canada who are leaving the country. It appears that most are staying.

Mr. Kennedy Stewart: We've heard a lot about student loan forgiveness. I'm on the industry committee. It's a global world now. Everybody moves around.

I'm just wondering if that's the best way to direct government moneys. Wouldn't it be better to just pay somebody, as other countries do? They just pay people more to work in rural and remote communities. Do you think a more broadly placed plan, rather than something attached to loans, might be a better way to go? Maybe I'll leave that open to you all.

The Chair: I see that a number of people want to comment.

Go ahead, Chloé, and then we'll move on to Ms. Nielsen and Ms. Vanderkooy.

Ms. Chloé Ward: There are definitely a number of ways you can incentivize medical trainees to go into different professions. We have been focusing on that, because it is a new program the government announced in Budget 2011. They have indicated in Budget 2012 that they will continue to implement this program, which will begin in 2012 and 2013. Since this is an existing program that is going to come into effect very shortly, and since it is inherently flawed in what its main goal is, which is basically to attract physicians to these underserved rural and remote communities, we've been focusing on just this.

This is something very tangible that will not cost the government very much to change. It will greatly improve the efficacy of this program that is going to come into place in the next few months.

The Chair: Mr. Stewart, your time is up, but we will hear from Ms. Nielsen and then Ms. Vanderkooy.

Go ahead.

Ms. Christine Nielsen: In my profession, medical laboratory science, right now about 80% of the students go to university first. They have their B.Sc. and think they're destined for medical school and find out that's not happening. There are very few jobs you can do without getting your next professional certification or licence, or without moving into the master's realm. My students today are graduating at about 25 to 27 years of age with six to eight years of student loans behind them. Even though my profession is not included in the loans relief program, I do believe it would be an incentive to move to rural and remote locations.

The other bonus behind that employment is they don't offer, as the large urban areas do, a job that's a point to or casual employment; they offer a real full-time job. We think that a real full-time job along with a loan forgiveness program that would help them pay back years of loans would definitely help. I do know there are some programs where there are things such as workforce relocation bonuses, but what we find is sometimes other employers will buy out the contract or the return to service agreement.

I'm not too sure what the perfect solution is, but we'd like to be included in the pilot, if we could.

● (1720)

The Chair: Okay, a short response if you could, Ms. Vanderkooy.

Ms. Pat Vanderkooy: There's also the matter of a differential in wages for those who are employed in hospitals versus those who are employed in community settings, like community health centres and family health teams. There is the rural versus the urban pay differentials, as well as benefits, such as having access to a pension plan. There are other incentives that possibly would attract people to the different sectors.

The Chair: Thank you for that.

Mr. Mayes, go ahead.

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

You've all made statements about the shortages in certain disciplines. You've all said that we need more data. On what do you base those statements if you don't have data? It seems strange to me that you're making knowledgeable statements of the shortages and everything else, and then you say you need more data.

Could all three of you answer that?

Ms. Chloé Ward: I'll take the first stab at it.

We actually do have some studies that have been done. They're just done in points of time. For example, in Ontario there was a study in 2010 that looked at one year and made projections for upcoming years. This is happening only in Ontario. However, whenever you apply for medical residency positions, you apply across the country. This is a nationwide problem. We need a central or national database so that we can work in collaboration with the provinces and territories to collate all the information from the localized studies that are happening in short periods of time. Basically, you would have longitudinal studies in a central location so that we could make that data available and use that data effectively.

Mr. Colin Mayes: You're saying that the data is fragmented.

Ms. Chloé Ward: Exactly. Pretty much.

Ms. Noura Hassan: I want to add to that.

We do have data, but we don't have enough data. The Royal College addressed this issue. Human health resource planning is complex. We can't just look at a snapshot every now and then and say that we're producing a surplus, or that the output this year was positive with 1,600 positions. That's not enough. We have to have a better idea globally of what's going on. We need to know who is graduating, how many hours they're going to be working, where they're going to be working, what infrastructure they're going to need. We need a lot more information than just the net numbers that we have now. It's multifactoral.

It wouldn't be an easy task to develop this kind of database, but there are a lot of stakeholders who are interested in this. A lot of stakeholders would be interested in contributing to the knowledge behind what we need. I think Health Canada would be a good partner.

Certainly, we agree there is information, but we just don't have all the pieces.

The Chair: I think there are some other responses.

Ms. Vanderkooy.

Ms. Pat Vanderkooy: I think it's much the same response. The data is fragmented. We took on the survey simply because there wasn't data. Point in time data is as good as it gets, and it's certainly flawed. The data exists. The data is being collected differently at the provincial level. There are different definitions. We're not part of the CIHI database, so what we're getting from one jurisdiction might be different. That's why to plan properly we need some consistent data.

The Chair: Ms. Nielsen.

Ms. Christine Nielsen: Regarding the complexity of being a service that provides testing for physicians, none of us can predict what tests will be coming on line in the next five years and what certain jurisdictions will be willing to fund. OMA has to agree to fund certain things. For us to do health human resource planning involves a large conversation with health care providers and health payees to see where the challenges lie.

What we do know is that no one's ordering fewer lab tests than before. Patients now walk in and tell their doctors what they want ordered, and when they want it done, and if the doctors can't do it, the patients offer to pay. I think the complexity of lab testing and what funders are willing to pay for it change the conversation for my professionals.

● (1725)

Mr. Colin Mayes: I saw a presentation on a machine that helped physicians practise. It was a simulation machine you could use to practise surgery. It shortened the time that a surgeon would have to stand beside a doctor to learn to do a surgery.

I guess the question I'm getting to is technologies. Do you think technologies like this are going to help, especially for medicine but also in the lab? Will technology improve productivity so that we won't need as many people?

Ms. Chloé Ward: This is something we see in different medical specialties. As technology evolves, it affects the needs we have in different specialties. In cardiology, for example, as technology and surgical procedures evolve, there's less demand for cardiac surgeons. We need to make long-term projections and identify needs based on a number of factors, including developments in the field and technology. We have to make sure we're training professionals to meet our needs so we don't have these labour problems.

The Chair: Thank you.

We'll conclude with Mr. Cuzner. Go ahead, please.

Mr. Rodger Cuzner: Mr. Chairman, I'd like to get two quick questions in here.

The Chair: Sure.

Mr. Rodger Cuzner: Mr. McColeman had an interesting line of questioning going there, and I'd like to give him the back end of my time.

The Chair: Sure.

Mr. Rodger Cuzner: Most of the medical students coming out now would carry about how much in debt? Is there an average amount?

Ms. Chloé Ward: There are average amounts. Figures that I commonly see are $150,000 to $200,000 when they finish medical school. Then, when you go into residency, the salary is quite limited for the first two to five years, depending on the residency.

Mr. Rodger Cuzner: Your residency is two years?

Ms. Chloé Ward: It's two years for a family practice and five to six years for some of the more specialized areas.

Mr. Rodger Cuzner: Is there a costing on your request about the deferral of interest or payments? Have you guys costed that out? It sounds like an absolutely legitimate and modest ask. It's easy for me to say that on the opposition side, I guess, but have you costed it out?

Ms. Chloé Ward: Yes, and I can share with you a document afterwards that looks at that. We've met with senior policy analysts with the Minister of Finance, and they've essentially said that this is like a rounding error in the federal budget and that it's almost negligible.

Mr. Rodger Cuzner: Thank you very much.

I have a question on the practicum before I turn it over. Are they paid positions?

Ms. Christine Nielsen: No.

Ms. Pat Vanderkooy: That's the other thing.

Ms. Marlene Wyatt: They are not paid.

Ms. Pat Vanderkooy: There was a time when dietetic interns made a modest stipend, but now they are not paid and they are still carrying their loans from university.

Mr. Rodger Cuzner: Are they having to pay the loans while they're working their practicum?

Ms. Pat Vanderkooy: Sometimes—it varies according to province.

Mr. Rodger Cuzner: Phil.

Mr. Phil McColeman: Thank you, Roger, for your generosity.

You're going down the same avenue that I wanted to with the medical students—what the residency is all about and whether they receive income while in residence.

I have a question for the person representing the students. You mentioned that in the future graduates will not find jobs. When is the future? Is it today? Are they not finding jobs today? Is it a year from now, two years, when?

● (1730)

Ms. Noura Hassan: It depends on who you're talking to and which province you're in. So far we don't have a lot of information at the national level. We have a lot of anecdotal evidence. For example, one of the specialties that's faced with the most job shortages in Canada is orthopedic surgery. So there are many reports of orthopedic surgeons who graduate and can't find jobs. They sub-sub-specialize and become specialists on the tiniest bones in the hands and feet. That makes them less and less employable.

It's certainly happening now. The Ontario Medical Association, in collaboration with the Ontario Ministry of Health and Long-Term Care, made a projection model that was published in 2010. They showed that even in family medicine—these are generalists in Ontario—in 2017 they project an oversupply of family doctors. That is not very far from now.

Speaking for myself, I'm going to start my training in obstetrics and gynecology. In 2012, if I want to work in Ontario, I may not find a job.

Mr. Phil McColeman: I appreciate that.

The Chair: You have 45 seconds.

Mr. Phil McColeman: It's really a good news story that we're graduating enough doctors. In my community just five years ago we were short 21 family physicians in a city of 100,000 people. I think we're still short a couple, but it's good that we're doing this.

So in some ways it's a good news story, and I agree that we have to somehow figure out a way to get better data to correct the distribution situation.

By the way, orthopedic surgeons become politicians on our side of the table.

Voices: Oh, oh!

The Chair: We've come to the end of our time.

Thank you very much for appearing before us and sharing your thoughts and comments. We will certainly take them into regard.

With that, we're adjourned.

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