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Wednesday, May 9, 2012

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)): I call the meeting to order.

As you know, of course, there are bells, so we will suspend after we deal with this motion. Then we'll come back and deal with the presentations. But there are bells ringing, so we'll have to go for the vote.

With respect to the motion, Mr. McColeman, go ahead.

Mr. Phil McColeman (Brant, CPC): I'm happy to present the motion for the committee to consider. The motion reads that the committee examine the main estimates and invite the Minister of Labour and the Minister of Human Resources and Skills Development to appear concurrently on the main estimates, along with departmental officials, during the scheduled meeting of May 30, 2012, from 3:30 to 5:30 p.m.

Just in explanation, I believe we have each minister for one hour of the meeting.

The Chair: Okay.

Do you have a question, Ms. Charlton?

Ms. Chris Charlton (Hamilton Mountain, NDP): Your motion said "concurrently". I assume that both of them would be here from 3:30 to 5:30.

Mr. Phil McColeman: Yes.

A voice: They will both be here.

Mr. Phil McColeman: They will both be here for—

The Chair: Yes, that—

Ms. Chris Charlton: And we can ask questions of either for the two hours, right?

Mr. Phil McColeman: Yes.

The Chair: Yes, that seems to be the way the motion is—

Ms. Chris Charlton: Okay. I'm sorry. I thought when you explained it you said one for an hour, one for the other—

Mr. Phil McColeman: I'm sorry about that.

Ms. Chris Charlton: Okay.

The Chair: It's two ministers for the two hours concurrently. You can ask questions as you see fit during the two hours. It's pretty much along the lines that you and Mr. Cuzner wish to have it. I don't think we need a lot of discussion on that motion. All those in favour?

(Motion agreed to)

The Chair: The motion is carried, so we'll expect those arrangements to be made.

I might just indicate to the witnesses that we would have liked to hear from you, but what we will do is suspend until the vote is taken, and then we'll come back, so if you can remain here, we'd appreciate it.

There's another set of witnesses. We'll probably add them to the witness table and have them presenting as well, and then just do one set of questioning back and forth.

Are there any questions flowing from any of that?

Yes?

Ms. Chris Charlton: I just think we should point out to the witnesses this new spirit of cooperation they're seeing here between the government and opposition members, because it's rare.

I'm really glad you're here to witness it.

Voices: Oh, oh!

The Chair: Indeed, in some respects, it is somewhat different and novel compared to what has been the case in the past.

Ms. Kellie Leitch (Simcoe—Grey, CPC): It's because of our great chair.

The Chair: That's right.

Is there anything further? If not, we'll suspend for probably about 45 minutes. They're 30-minute bells and the vote will take 10 or 15 minutes.

● (1530)

(Pause)

● (1615)

The Chair: Time is short, the witnesses are here, and we may have more votes, so we'll just get right to it and ask you to present. Then we may have to adjourn again.

We will start with Mr. Haggie with the Canadian Medical Association, and then move to the Association of Faculties of Medicine of Canada.

Please go ahead.

Dr. John Haggie (President, Canadian Medical Association): Good afternoon.

Thank you very much for the opportunity to appear before this committee to discuss ways to ensure an adequate supply of physicians in the Canadian health care system.

The reality today is that nearly five million Canadians do not have family physicians, including more than 900,000 here in Ontario. Over one third of all Canadian physicians are over the age of 55. Many will either retire soon or reduce their practice workload.

Many physician practices are at capacity and unable to take on new patients. Canada's supply of new physicians relative to our population is well below the Organisation for Economic Co-operation and Development average. We're the seventh-lowest supplier of physicians per capita amongst OECD nations. Canada ranks below the European Union nations and the United States.

Ensuring Canada has the appropriate number of physicians with the appropriate mix of specialities to meet patients' needs requires planning and leadership at the federal level. Canada must address specific shortages and ensure self-sufficiency in health human resources for this country. Better planning would also help address the issue of wait times and their negative impact on patient care.

The Canadian Medical Association recommends, first, ensuring a needs-based speciality mix; second, targeting health infrastructure investments to optimize the supply of health human resources; and third, addressing the issue of foreign credential recognition.

On our first area of focus, ensuring a needs-based specialty mix, a CMA survey this year of provincial and territorial medical associations on physician resources underscores the pressing need for a pan-Canadian approach to health human resource planning. All jurisdictions in Canada are experiencing challenges, although shortages by type of practice vary from province to province.

Ensuring an appropriate specialty mix requires planning. At present there is no pan-Canadian system to monitor or manage the specialty mix. Our survey found only three jurisdictions that have a long-term physician resource plan in place, while, until today, only one jurisdiction had employed a supply- and needs-based projection model—Nova Scotia just released a second one of these today.

The consequences of this lack of planning are evident. From 1988 to 2010, the number of post-graduate trainee positions in geriatric medicine—care of the elderly—was essentially constant at only 18 physicians, while the number of trainees in pediatric medicine—childhood illnesses—increased by 58%, in clear contradiction to the demographic trends.

The last time the federal government prepared a needs-based projection of physician requirements in Canada was 1975.

The second issue I wish to address is health infrastructure. Recruitment of specialists and subspecialists is affected by the limitations of existing hospital infrastructure, such as operating rooms. Ensuring that infrastructure is in place to allow the doctors that we do have to carry out their work would no doubt help address Canada's persistent problems with wait times.

The CMA recognizes the federal government's commitment to address the issue of foreign credential recognition and recognizes that physicians are in the target group for 2012. The medical profession is well positioned to support the federal government's objective.

Under the auspices of the National Assessment Collaboration—a group of federal, provincial, and other stakeholders—the medical profession is working to streamline the evaluation process for international medical graduates for their licensure in Canada.

The pan-Canadian portable eligibility for licensure is another important issue for physicians. In 2009, the Federation of Medical Regulatory Authorities adopted an agreement on national standards for medical registration in Canada that reflects the revised labour mobility chapter of the Agreement on Internal Trade. The federation and the Medical Council of Canada are working on a one-stop process for IMGs to apply for licensure in Canada.

Close to one-quarter of all physicians in Canada are IMGs. I'm one of them. While the CMA fully supports bringing into practise qualified IMGs already in Canada, actively recruiting doctors from abroad cannot be the only solution to our physician shortage. Canada must strive for greater self-sufficiency in the education and training of physicians.

● (1620)

To conclude, for several years now, the CMA has advocated health care transformation. With the Canadian Nurses Association, it has developed six principles to guide transformation. These principles have been endorsed by over 100 medical, health, and patient organizations.

One of these principles is sustainability. Addressing health human resource shortages is critical to ensuring a sustainable system that's also accessible and patient-centred.

Despite progress, our country continues to experience a persistent shortage of physicians. This is hardly surprising given that few jurisdictions engage in any health human resource planning and that the federal government has not examined physician supply in almost 40 years.

Canada requires a pan-Canadian approach to ensure adequate health human resources in support of a sustainable health care system.

Thank you very much for your attention. I'll be pleased, if the opportunity presents itself, to answer any questions.

Merci beaucoup.

The Chair: Thank you for that presentation.

We have another presentation to hear. I hear the bells going again, so we will need unanimous consent to continue.

Is there a will to hear the next presentation? Do we have unanimous consent? It will take probably seven or eight minutes.

Some hon. members: Agreed.

The Chair: We will hear from the next set of witnesses.

After that, you'll be excused. You can stay if you want to because we'll come back after the next vote, but there won't be a whole lot of time.

So go ahead and present, and we'll suspend after that.

Dr. Nick Busing (President and Chief Executive Officer, Association of Faculties of Medicine of Canada): Thank you very much, Mr. Chair.

I appreciate the opportunity to present on behalf of the Association of Faculties of Medicine of Canada. I would suggest that you pick up the document I have here. There is some data that I'll be referring to and referencing in some of the slides.

I would say right up front that you will find some of my comments —and in fact some of my information—very complementary to that which you've heard from the CMA. Notwithstanding the fact that we did not plan it that way, I am very appreciative of how clearly we represent similar views.

As you know, physicians are a highly skilled part of our workforce, and the care they provide is in high demand. At the same time, we continue to struggle with some shortages, particularly in rural and other underserviced areas. It is clear that if we're to meet the needs of Canadians, we need to achieve the right number, mix, and distribution of physicians. This is precisely what's being recommended through the future of medical education in Canada postgraduate project—FMEC PG.

In the following short presentation, I will outline why AFMC feels it is critically important to address certain physician shortages and also offer some specific strategies.

As you will note if you look at the second slide, our first recommendation from our report is to ensure the right number, mix, and distribution of physicians to meet societal needs. We've structured our report with what we consider to be key transformative actions. The transformative action to make that happen reads as follows: “create a national approach, founded on robust data, to establish and adjust the number and type of speciality positions needed in Canadian residency programs in order to meet societal needs”.

As you will see from that same slide, there are two other FMEC recommendations quoted, plus seven more recommendations that are in the report I have circulated. I encourage you to look at that report. I'd be pleased to answer any questions with regard to it.

The next slide, slide 3, talks about the growth in our trainees. The first and foremost way to achieve the right number of physicians is through our medical education system. In recent years, enrolment in undergraduate medical education has grown to levels that we have never seen before. What's shown in our chart is the flow of much larger medical classes through to postgraduate residency training.

The number of incoming medical residences has doubled over the decade, from 1,547 in 2000 to 2,912 in 2011. Residency programs are also an important entry point for international medical graduates, and that will be taken up in our next slide on the right numbers. As shown by the green line on that slide, since 2000 there has been a 400%-plus increase in the number of international medical graduates entering MD training. At all levels—not only at the entry level, but throughout the system—there are 2,139 IMGs enrolled in Canada's post-MD training programs. This represents approximately 17% of all residents training in medicine in Canada.

Slide 5 shows you a map of our country. The map shows where medical education currently happens in Canada. We have 18 main medical campuses situated in relatively large cities, spanning the country from St. John's, Newfoundland, to Vancouver, British Columbia. In addition, we have 13 satellite campuses situated in communities like Moncton, New Brunswick, Windsor, Ontario, and Prince George, British Columbia.

Finally, we have about 900 small clinical teaching facilities, many of which are in doctors' offices and clinics in rural communities. These teaching sites are situated in communities that are frequently most in need of physicians. Apart from aiming for the right number of physicians, we also need to train an appropriate number of family doctors, other specialists, and scientists.

I'll say a word about shifting demographics. Our next slide shows that, in 2001, 13% of Canadians were aged 65 or older. It is estimated that by 2036 one in four Canadians will be 65 or older. This demographic shift will create and in fact is creating new demands on our health care system. We may ask ourselves if the mix of physicians we're training today will be poised to care for tomorrow's elderly.

● (1625)

That takes us to the next slide and the comment made by Dr. Haggie. Enrolment increases in pediatric residency programs look very much like the overall increase in our postgraduate programs; however, the picture is dramatically different for geriatric medicine and programs for care of the elderly. Over the past decade, relatively few doctors have taken the opportunity to train in geriatric medicine and care of the elderly. You will see the numbers, as highlighted by Dr. Haggie, in the next graph.

It is imperative, in our view, that a multi-stakeholder forum be established to identify, prioritize, and address areas where the training of future health care providers can be brought into greater alignment with future health care needs. AFMC would like to take this opportunity to repeat its call for such a forum. I would also like to remind you that in the report of the House of Commons Standing Committee on Health, “Promoting Innovative Solutions to Health Human Resources Challenges”, the committee made this its number one recommendation.

We propose that a national health human resources data and analysis centre be established to provide a formal structure for the collection and analysis of Canada's disparate data sets, the collection of data where needed, and to serve as a resource to governments, federal and provincial, in matters of policy planning for health human resources. The centre would bring together caregivers, patients, federal, provincial, and territorial governments, managers, researchers, and other stakeholders to analyze data, make evidence-based recommendations, and build consensus around forward-looking strategies.

As a first step, AFMC is proposing that it form a secretariat for this initiative and hold a series of national, regional, and provincial consultations that would culminate in an actionable business plan, including a budget for such a centre. The anticipated cost for this work is $600,000. The work could be completed within two years.

Thank you for your time.

If there is any time, I'd be pleased to answer any questions.

● (1630)

The Chair: Thank you for that presentation.

I'm wondering if everyone's okay to hear yet one more witness. Is everybody okay with that? I'll need unanimous consent. If we don't have it, then what we'll do is we'll—

Ms. Chris Charlton: What time is the vote? Do we know?

The Chair: It's a 30-minute bell, so we have probably another 15 or 20 minutes.

Ms. Chris Charlton: I don't think we can....

The Chair: Okay.... We have 22 minutes. I think we could squeeze Mr. Brennan in and have him present.

Then, with respect to the other two organizations, you're free to go after we suspend, because we're probably not going to be back again for another 40 minutes.

But we will come back, because we do have one other witness who is to appear. She is here now, so we will have to hear her too.

Go ahead, Mr. Brennan, with your presentation.

Mr. Michael Brennan (Chief Executive Officer, Canadian Physiotherapy Association): Thank you very much. I will be brief.

[*Translation*]

Good afternoon, everyone. I am very pleased to appear before you once again.

[*English*]

I was a little unsure of what to tell you since I was here a few months ago delivering a lot of data and information about physiotherapy's efforts to integrate foreign-trained and -skilled physiotherapy workers. I thought I'd take a slightly different tack this time and talk to you about our perception of new discussions around policy targeting skilled workers—skilled immigrants who can actually integrate immediately into the workforce.

One of the realities is that we in Canada are among the most highly trained physiotherapists in the world. There are only a few countries that can put physiotherapists directly into practise here in Canada—Ireland, the U.K, Australia, and New Zealand. Not even our American counterparts could get licensed right away. That difference between those countries and the rest of the world is not about language or culture. It has more to do with the acceptance of interprofessional collaborative models of health care.

Having foreign-trained physiotherapists coming to Canada from other countries requires big investments in evaluation, education, and language training. The physiotherapy community has made these investments over the last several years. We now have three integration programs: one at the University of Toronto, one at the University of Alberta, and one at UBC. The last two came online in the last few weeks.

Despite this new capacity, it's still at least two years from arrival in Canada to licensure for physiotherapists. That's not good enough, and we are doing what we can to improve.

One solution may be graduated licensing, but I believe that trades one bureaucratic headache for another. How do you integrate the workforce quickly? We could look to Ireland as a source of skilled immigration. They have a tremendous surplus of physiotherapists right now, but that surplus is based more on their inability to pay than on population demand.

My concern would be that if physiotherapy were to target the U. K., Ireland, and Australia, inputs would not necessarily be permanent. The boom-bust cycle in Ireland has a high amplitude, and I would suspect that when the boom comes back, expatriates may be quite willing to leave Canada. We may be trading one problem for another by drawing on those resources.

Unlike engineering and other industries where skilled workers can come to Canada and the growth of the economy mirrors their immediate contribution, growth in the health sector mirrors the population and its ability to pay. The risks resulting from miscalculation of human resources demand in the health field are extremely high. The question we must ask is, will a skilled immigrant strategy that's right for our resource, manufacturing, and service sectors be the right one for our health sector? I don't have the answer today to that question, but it does give one pause.

Thank you, everyone. I promised to keep it brief. I would be happy to take questions—maybe some other time at the parliamentary restaurant.

Voices: Oh, oh!

● (1635)

The Chair: Thank you for that.

I think we'll try to go ahead with Ms. von Zweck.

Go ahead.

Dr. Claudia von Zweck (Executive Director, Canadian Association of Occupational Therapists): Thank you very much.

Thank you, Mr. Chair and honourable members of this committee.

I am honoured today to speak on behalf of the Canadian Association of Occupational Therapists. I am Dr. Claudia von Zweck, and I am the executive director of the Canadian Association of Occupational Therapists.

I want to speak to you today about three primary areas in need of national coordination and commitment: modelling and measurement of health human resources, retention of occupational therapists, and workforce integration of internationally educated occupational therapists.

First is the modelling and measurement of health human resources. At this point in time, the measure of the needs for occupational therapists is flawed. Shortages in occupational therapy occur in Canada because the current models used to predict health human resource needs are insufficient. They insufficiently predict the demand for occupational therapy services. We are aware, for example, that in some areas of the country, the number of education seats for occupational therapy programs is not sufficient to meet the current workforce demands, because of inaccurate human resource projections.

To transform health care into a system that is efficient and effective, we have to look at what is possible. Occupational therapists aren't being used to their full scope of practice but could offer many solutions—more than what our current utilization allows. However, if occupational therapists were to work to their full scope of practice, current shortages would intensify. The current human resource planning measures do not and cannot predict the demand or the subsequent supply required to fill the demand.

For this reason, our first recommendation is to improve the health human resources modelling tools to create a more accurate measure of the supply and demand of professionals across jurisdictions. Those planning tools must consider the use of occupational therapists within their full scope of practice and with appropriate productivity expectations.

In the last few years, our organization has worked with the Canadian Physiotherapy Association and the Canadian Association of Speech-Language Pathologists and Audiologists in a project that was funded by Health Canada to develop an interprofessional case management tool. The utilization of these types of tools will help to provide a better understanding of appropriate productivity expectations for health professionals.

I would now like to address critical factors for retention. Similar to what we have heard from the physiotherapist community, occupational therapists are highly educated. We are experts in identifying meaningful interventions to support everything that people do during the course of everyday life, such as self care, play, work, study, and leisure.

However, one of the biggest challenges to the retention of OTs is the recognition of the importance of the profession in the delivery of health services and the acknowledgement of the profession in delivering comprehensive and quality care. Occupational therapists want to feel valued, and they want their profession to be recognized and understood by health professionals and the health system decision-makers.

Occupational therapists want their expertise to be recognized as a valuable part of the interdisciplinary team. They want occupational therapy to be recognized as an autonomous health profession that provides expertise in interventions to support daily living.

In addition, there are concerns within the profession related to health, well-being, and safety. Occupational therapists frequently have workplace injuries because they often work in isolated settings. They travel extensively to offer community-based services and encounter both threats and physical acts of violence. Community-based services and home care are increasingly recognized as a part of health care delivery, but the delivery of these services cannot come at the expense of the health and safety of professionals.

Therefore, our second recommendation focuses on improving work environments and the well-being of the professionals as a whole. We recommend that retention efforts focus on adoption of a national interdisciplinary health services model that promotes satisfaction of occupational therapists and other health providers through the recognition of the importance of their skills and expertise, while developing appropriate staffing plans based on the needs of clients, demands of the population, and safety and well-being of the OT professional.

Lastly, I'd like to address the issue of internationally educated health professionals.

Internationally educated occupational therapists play an important and growing role in meeting demands for occupational therapy in Canada. In order to meet staffing needs, many employers actively recruit occupational therapists who are educated outside the country.

● (1640)

With the support of the Government of Canada, CAOT has very actively worked on a number of initiatives with occupational therapy partners to address barriers that have been experienced by international graduates. We've had tremendous success with them. We recently partnered with McMaster University to develop a national curriculum to assist internationally educated occupational therapists to meet the entry-to-practice requirements of occupational therapy regulators.

However, despite the success of the curriculum in meeting the needs of internationally educated occupational therapists, we fear the program will end with the completion of our pilot funding in 2013. Therefore, we see opportunities for the federal government to continue to build on the successes we have been able to achieve to support successful and valued bridging programs that facilitate entry into the workforce.

Therefore, our last recommendation is for mechanisms for long-term funding for bridging programs that are aimed at assisting international graduates to successfully work as occupational therapists in Canada.

In closing, I'd like to thank you once again for your time and for your recognition of the important role occupational therapy plays in a comprehensive and coordinated health system.

Thank you.

The Chair: Thank you very much. My apologies for rushing things along, but I think we've come to the place where we'll have to leave for the House.

I am just going to have a quick straw poll here on how many feel we should simply adjourn and how many feel we should come back for 15 or 20 minutes.

How many feel we should adjourn?

Ms. Chris Charlton: May I ask a question first?

The Chair: Sure.

Ms. Chris Charlton: I assume the witnesses would prefer not to be sitting around waiting for us. If that's the case, I think we should adjourn.

A voice: There are cookies.

Voices: Oh, oh!

Ms. Chris Charlton: Do we want to ask questions or do we want to adjourn?

The Chair: In fairness to everyone, I think we'll simply adjourn the meeting.

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