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Chair

Mr. Ben Lobb

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● (0850)

[*English*]

The Chair (Mr. Ben Lobb (Huron—Bruce, CPC)): Good morning, ladies and gentlemen. Thank you to everybody for being here today. We're just commencing our study on best practices in a number of different areas. I appreciate your being here. The way it works is you have 10 minutes to present to the committee. Once all the presentations are complete, we allow each side two rounds of questions with seven minutes and then five minutes.

We'll start off first with Colonel MacKay with the Department of National Defence.

Go ahead, sir.

Colonel Hugh MacKay (Deputy Surgeon General, Canadian Forces, Department of National Defence): Good morning, everybody.

Mr. Chairman and members of the committee, I'm very pleased to have the opportunity to appear before you today to provide an overview of the provision of health services to Canadian Armed Forces' members and respond to your questions pertaining to the scopes of practice of Canadian Forces Health Services Group clinicians.

The Canadian Forces Health Services Group is Canada's 14th health care system, providing high quality care to Canadian Armed Forces personnel wherever they serve. The system comprises an integrated team of military and civilian health professionals, which offers a patient-focused comprehensive spectrum of care in evidence-based health services.

While making use of provincial and territorial health resources within Canada, it is unique among jurisdictions in its integration under a single command of almost all elements of a comprehensive health system, including: education; training; research; occupational health; public health; professional regulation; clinical services, including medical, dental, pharmaceutical, emergency medical services, etc.; and supportive aids and benefits, such as home aids, return to work programs, and peer and family support. It also must uniquely maintain mobile and medical defensive capabilities to deal with hostile and environmental hazards that are generally not encountered in Canada.

The health needs of Canadian Armed Forces personnel is a top priority for the Department of National Defence as they must be employable and deployable at all times. The Canadian Forces Health Services Group is obligated to provide health services in order for Canadian Armed Forces personnel to maintain and improve their health and mental well-being; to prevent disease; to diagnose and treat illness, injury, or disability; and to facilitate return to operational readiness as quickly as possible. With the closure of our static hospitals in the 1990s, we've become far more dependent on the civilian health sector for domestic in-patient care and now access a significant amount of specialist and hospital care through provincial and territorial health systems.

The Canadian Forces Health Services Group comprises approximately 6,300 regular force, reserve force, and civilian personnel. Our mandate is based on three tenets: one, to deliver health services; two, to provide a deployable health services capability for operations; and three, to provide health advice to the chain of command.

The Canadian Forces Health Services Group provides health services to Canadian Armed Forces personnel in two distinct environments: in garrison and on deployment. In Canada, the primary health services system is based on a standardized approach through the primary care clinic model. The nucleus of this system is the care delivery unit, which consists of a primary health care team comprised of a medical administrative clerk, medical technicians, a physician assistant, a primary care nurse, a nurse practitioner, and a family physician, all operating within established scopes of practice. The CDU team works collaboratively with patients to assess their needs and to provide and coordinate their care.

Additionally, physiotherapists, pharmacists, and a variety of mental health professionals provide care in collaboration with the team or through direct intervention. In support of patient care, the Canadian Forces Health Services Group has implemented a pan-Canadian electronic health record system, a robust quality assurance program, a performance measurement platform, and a comprehensive health promotion and public and occupational health protection system.

We must also provide full-spectrum health services anywhere in the world that the Canadian Armed Forces elements deploy, whether on land, in the air, at sea, or under the sea. We must therefore be able to rapidly deploy and sustain medical, surgical, and preventive health capabilities, including tertiary care hospitals, anywhere for humanitarian or military missions without supporting local infrastructure.

In addition to being broadly clinically skilled, our staff must be trained to survive in hostile environments, deal with diseases, exposures, mass trauma, and other health threats that are generally not encountered in Canada. They must also be able to provide superb care with limited resources and intercontinental medical evacuation and supply chains in extremely dangerous and austere conditions.

Such circumstances require that the military health system be structured in a manner that makes the most efficient use of all health resources and occupations. This is facilitated by the military culture's prioritization of mission first, welfare of subordinates second, and personal interest last, as well as by the surgeon general's control of all clinical matters, including scopes of practice, distribution of occupations, health education and training, allocation of clinical resources, etc. During Afghanistan operations, we would not have achieved history's highest war casualty survival rate without the subordination of individual and professional interests to the mission, nor without expanded training and scopes of practice under physician supervision for certain occupations like physician assistants and medical technicians.

The health team in the Canadian Armed Forces is composed of both military and civilian personnel from over 45 occupations and specialties. Many of these occupations are regulated by professional bodies and have mandated scopes of practice, which, when necessitated by unique military operational exigencies, may be modified by the surgeon general. Health professionals are expected to register with their respective regulatory body. For example, in order for a military physician to practise within the Canadian Armed Forces, like their civilian colleagues, they must be registered with a provincial or territorial professional regulatory authority such as the College of Physicians and Surgeons of Ontario.

Given that we span the country we face challenges with respect to scopes of practice for some regulated professionals as they are not consistent across provincial jurisdictions. There may thus be differences for some occupations in some of our clinics. Additionally, we have an internal credentialing process and a practice review board to address issues with respect to registration and clinical practice. Our professional culture is based on a patient-centred philosophy that strives to provide access to the right care at the right time by competent caregivers. This philosophy is supported by a multi-interdisciplinary collaborative care model hinged on a high availability of caregivers and referral of care, as necessary. The clinicians' achievement of optimal professional practice is supported through a robust maintenance of clinical readiness program, coupled with access to a variety of continuing professional education and recertification opportunities.

At one time, the Canadian Armed Forces were the sole national jurisdiction that trained, educated, and employed two unregulated health occupations: medical technicians and physician assistants. With the rising national demand for allied health professionals to extend physician services, civilian physician assistants are now produced by select Canadian universities and employed in several provinces. The Canadian Forces Health Services Group was instrumental in the establishment of the Canadian Association of Physician Assistants, which certifies physician assistants through an examination and ongoing, annual continuing professional education requirements. Our medical technician training includes certification as a primary care paramedic through external civilian programs, community colleges, and internal guidance for ongoing maintenance of clinical readiness. Canadian Armed Forces medical technicians can also obtain registration from a provincial or territorial regulatory authority. They receive more advanced clinical training to have the skills necessary to deal with the urgent needs of deployed Canadian Armed Forces personnel in austere, hostile, and geographically dispersed environments.

In closing, like many other health jurisdictions, the Canadian Armed Forces are very committed to providing the right care to the right person by the right caregiver to optimize care and resource utilization. The Canadian Forces Health Services Group is broadly engaged with national professional authorities and organizations to contribute to the dialogue and to keep abreast of new initiatives that may benefit the Canadian Armed Forces.

Thank you once again for the opportunity to be with you here today.

● (0855)

The Chair: Thank you very much.

Next up from CSC are Michele Brenning and Henry de Souza.

Go ahead for 10 minutes, please.

[*Translation*]

Ms. Michele Brenning (Assistant Commissioner, Health Services, Correctional Service Canada): Good morning, Mr. Chair and members of the committee. My name is Michele Brenning, Assistant Commissioner, Health Services, Correctional Service of Canada. With me is Henry de Souza, Director General of Clinical Services and Public Health.

I would like to thank the committee for the opportunity to comment and provide input on the federal role in the scopes of practice of Canadian healthcare professionals.

● (0900)

[*English*]

The Correctional Service of Canada, or CSC, is mandated under the Corrections and Conditional Release Act to provide every inmate with essential health care and reasonable access to non-essential mental health care. Moreover, the act stipulates that the provision of health care shall conform to professionally accepted standards.

To accomplish our mandate, CSC relies on approximately 1,250 health staff, as well as contractors, who work in interdisciplinary teams and include nurses, psychologists, social workers, occupational therapists, general practice physicians, psychiatrists, and pharmacists. In addition CSC is looking to diversify our staff mix to include nurse practitioners and physician assistants, as well as non-regulated health professionals such as personal support workers.

On a typical day there are 15,000 offenders in federal institutions across Canada. CSC's institutions are divided into five regions: Atlantic, Quebec, Ontario, prairie, and Pacific.

To support professional competencies, CSC provides ongoing training in a variety of areas within the streams of mental health, public health, and primary health care.

Along with adherence to professional standards of practice as articulated by the relevant professional colleges, CSC's national essential health services framework, the national drug formulary, and active quality improvement processes are key tools used to promote consistent, safe, and effective delivery of health services to our clientele.

Health care is costly, and human resources are a significant cost driver. As a provider of health care to a challenging clientele, understanding the scope of practice of various disciplines and finding the right staff mix are critical in our efforts to maximize effective and efficient service delivery.

Although there is no consensus definition, the key element of scope of practice can be identified in the Canadian Nurses Association definition:

> A profession's scope of practice encompasses the activities its practitioners are educated and authorized to perform. The overall scope of practice for the profession sets the outer limits of practice for all practitioners. The actual scope of practice of individual practitioners is influenced by the settings in which they practice, the requirements of the employer and the needs of their patients or clients.

Achieving the optimal staff mix requires leveraging the flexibility within overlapping scopes of practice, while at the same time valuing and strategically utilizing the specialized expertise. For example, in the field of mental health there is overlap within the professions such that the mental health counselling can be carried out by the disciplines of social work, nursing, psychology, general medicine, psychiatry, or occupational therapy.

On the other hand, there are activities where the expertise resides exclusively or primarily within the discipline. For example, a multidisciplinary team will rely on a psychologist to conduct a psychological assessment. Similarly, general practitioners providing primary mental health care may rely on a psychiatrist for more complex or tertiary level psychiatric interventions.

As a federal government department operating within several provincial jurisdictions, and therefore several provincial colleges, there are barriers to optimizing efficient delivery of health care. For example, there is no automatic interprovincial transfer of licensure for professionals. This significantly limits the mobility of registered professional staff across Canada, thereby limiting matching staff availability to the geographic area of need.

Telemedicine and telehealth are recognized as being both effective by providing access to specialists who might not otherwise be possible, and efficient by reducing travel costs and enhancing the ability to see more patients. However, there is still no consensus on liability with respect to providing treatment across provincial jurisdictions.

Although the scope of practice may allow certain activities by a professional, training may be required to ensure competency in unfamiliar areas of practice.

As a result of these observations, we would offer a few recommendations to improve the ability of health care professionals working with CSC to better respond to our evolving needs. These include a national standardization that allows interprovincial mobility, and flexible scopes of practice that allow, in collaboration with the relevant college, the option to train to an accredited standard beyond the scope of practice in order to address needs in rural and remote areas where recruitment is difficult.

● (0905)

[*Translation*]

I believe that CSC is well placed to offer an opinion on the practice and training of healthcare professionals on the federal level in direct relevance to this committee study.

Although considerations for time prevent me from providing more specific details. In my opening remarks, I would be pleased to answer any questions this committee may have.

Thank you once again for the opportunity to appear before you today.

[*English*]

The Chair: Thank you very much.

Next up, from the Department of Health, Debra Gillis.

Go ahead, please.

Ms. Debra Gillis (Acting Director General, Interprofessional Advisory and Program Support, First Nations and Inuit Health Branch, Department of Health): Thank you, Mr. Chair and members of the committee.

I am here this morning to provide you with an overview of Health Canada's role and work on the subject of scope of practice for health professionals. I'd like to begin by stating that scope of practice is defined in many ways by different players in the health care system, both at the national and provincial levels, including ministries of health and education, regulatory bodies, credentialing bodies, national and provincial professional associations, education bodies, and employers.

Broadly speaking, “scope of practice” refers to the roles, functions, tasks and activities, professional competencies, and standards of practice that licensed health care professionals are authorized to perform in a specific field. By this I mean that each regulated health profession has a scope of practice statement that describes in a general way what the profession does and the methods that it uses.

The scope of practice statement is not protected in the sense that it does not prevent others from performing the same activities. Rather, it acknowledges the overlapping scope of practice of the health professions, and therein is the challenge, because health professions often practise as a team. The result is that the scope of practice for each health professional is enacted according to the needs of the patient and the practice environment in which he or she works. Consequently, the actual scope of practice—that is, what happens in day-to-day practice—may vary substantially across health care settings and sectors as well as according to the patient population being served.

The provinces and territories play a major role in scopes of practice. They make the decisions about how best to optimize the scopes of practice of health professionals working within their jurisdictions. They are responsible for health professional legislation and regulation, payment mechanisms, education, and health human resources planning, all of which impact scopes of practice.

The federal government plays a supportive role in this area through research, health human resources programming, related regulatory responsibilities, and working within established scopes of practice for the delivery of care to federal populations. The federal government is committed to ensuring a health system that is responsive to the needs of Canadians and that Canadians have access to the care they need. To this end, we support efforts in health human resources management that allow professions to work to their optimal scopes of practice in a number of ways.

Firstly, the federal government is responsible for national enabling legislation such as the Controlled Drugs and Substances Act, which supports health professions to practice to their full scopes as set out in provincial or territorial legislation. Specifically, Health Canada introduced the new classes of practitioners' regulations that came into force on November 1, 2012. These regulations authorize midwives, nurse practitioners, and podiatrists to prescribe, administer, and provide controlled substances, with some exceptions, provided they are already authorized to do so under provincial or territorial legislation.

Secondly, Health Canada facilitates the advancement of optimal scopes of practice in collaboration with provinces, territories, and key stakeholders in various ways including, for example, by providing $24 million in funding to advance the adoption of team-based care through initiatives such as the Canadian Interprofessional Health Collaborative; by providing $6.5 million in funding to McMaster University to evaluate team-based approaches to health care delivery; by providing advice to deputy ministers of health on the planning, organization, and delivery of health services through the federal-provincial-territorial committee on health workforce; and by partnering with the Canadian Institutes of Health Research to support a best brains exchange on March 14 of this year on optimal scopes of practice.

● (0910)

Thirdly, as a provider of services to federal populations, including to first nations and Inuit, federal inmates, and the Canadian Forces—as you have heard—the federal government has a direct role to play in championing novel approaches to health care delivery, including with respect to scopes of practice. Given this, I will now turn specifically to Health Canada's role in first nation communities.

Working to improve the health outcomes of aboriginal peoples is a shared undertaking among federal, provincial, territorial governments, and aboriginal partners. Health Canada's role involves supplementing and supporting provincial and territorial health services to provide culturally appropriate health programs and services that work to improve the health status of first nations and Inuit communities. To fulfill this role, Health Canada funds or directly provides public health, health promotion and disease prevention, addiction and mental health, and home and community care on all first nation communities, and primary care services in 85 remote and isolated communities.

Regulated health professionals and unregulated health workers make up the almost 10,000 strong workforce. Regulated professionals include registered nurses, nurse practitioners, licensed practical nurses, dentists, dental hygienists, dental therapists, nutritionists, pharmacists, physicians, and environmental health officers. Health Canada requires its health professionals who provide direct services in first nation communities to be licensed in the province or territory in which they work and to maintain good standing with the regulatory body.

However, in remote and isolated first nation communities with limited direct access to physician or even nurse practitioner support, registered nurses delivering direct primary care services often provide a broader range of health services and functions than would be authorized by provincial legislation on scope of practice .

The need to address the legislated scope of practice of registered nurses working in these remote communities, while ensuring safe care and protecting the licences of nurses, is addressed in various ways across Health Canada's regions. For example, the Province of British Columbia has introduced a certified RN designation that defines additional education requirements and broadens the scope of practice for isolated and remote communities, and we require nurses to obtain that certification.

Saskatchewan has introduced new nursing standards specifically addressing primary care service delivery in northern communities that will authorize RNs to take on additional functions.

In Alberta first nation communities, a collaborative and consultative practice model, accessed on site or via telehealth, between nurse practitioners and registered nurses has permitted the safe, timely, and high-quality delivery of primary care services that align with provincial nursing scope of practice legislation.

In Quebec, provincial legislation has been introduced to delegate or transfer authority for RNs to provide primary care. Working with provincial partners, Health Canada has introduced practice directives or *ordonnances collectives* that align with the legislation.

In Manitoba and Ontario, a provincially recognized delegation process permits the alignment of Health Canada's employment functions of RNs with the provincially defined scope of practice.

● (0915)

To mitigate the risk of nurses working outside their scope of practice, Health Canada has recently reviewed its nursing delegation tools, specifically the first nations and Inuit health branch's clinical guidelines for nurses in primary care and the nursing station formulary and drug classification system. This review identified a need to revisit and update these tools to ensure alignment with provincial frameworks, and we are in the process of doing so.

Further, Health Canada provides education and training to all nurses working in primary care to ensure they have the skills and necessary certifications to provide safe care. All nurses are required to take, within a period of time after joining the federal government, a primary skills training course covering the expanded care needs. Health Canada also makes sure that nursing staff in remote and isolated locations have direct phone or video access to a physician at all times to discuss diagnosis and treatment, and to authorize treatment such as prescription medications.

We are also implementing the recommendations from an internal study on health service delivery models in remote and isolated first nation communities, which will further support an alignment with the provincial scope of practice legislation for health care providers in primary care services. The measures being implemented include the introduction of collaborative and interdisciplinary teams; the introduction of providers not currently included in primary teams, such as X-ray technicians and pharmacy technicians; the increased presence of nurse practitioners; and the increased use of e-health services.

In closing, Health Canada will continue to undertake activities to address scope of practice issues to support improved health care in first nation communities. In terms of Health Canada's broader role, I would emphasize that we will continue to collaborate with the provinces and territories and to facilitate the sharing of knowledge and best practices in support of their efforts to optimize the scopes of practice of health care professionals.

Thank you very much.

The Chair: Thank you very much, Ms. Gillis. That's good, we know you're committed because you're the first witness that's got choked up doing their presentation. We know you're definitely passionate about what you're talking about there. Thank you. You got through it.

First up, Ms. Davies, you have seven minutes. Go ahead, please.

Ms. Libby Davies (Vancouver East, NDP): Thank you very much, Chairperson, and welcome to our presenters today.

As you've heard, we're just beginning our study about best practices, scopes of practice, health human resources, and so on. It's a bit of a mouthful, and we're just beginning to get familiar with the topic and how we need to address it. So maybe our questions will be a bit general today.

Listening to what you each had to say, I have two questions. First of all, I have to say I was a bit surprised that none of you mentioned Health Canada's pan-Canadian health human resources strategy, which we understand from the background work that we had prepared is sort of the document or strategy that's overseeing a commitment that was made—I think it was made in 2005. That strategy outlines five areas, one of which is health human resource planning and forecasting, so that takes us directly into the issue of where there are shortages, how they're regionally based or within remote communities.

I guess my question is this. Who's doing that? Who's overseeing the planning and the forecasting? I can tell you that when we, and I assume this is for all members of the committee, meet with various professional associations, whether it's the nurses, or psychologists, or occupational therapists, or whoever it might be, this issue of disparity and shortages, depending on where you are, but particularly in remote communities, northern communities, comes up again and again. It certainly was a major issue identified in the 2004 health accord. My first question is whether the various departments that you work in federally are aware of this strategy. Does your department collaborate with other departments? It's meant to also be a provincial and territorial thing, not just a federal role. I'd just like to know, do you know who's responsible for it? Do you work with those people? That's one question that you could all address.

The second question, if I could just be quick about it, is this. Ms. Brenning, I really appreciated your presentation. There was one paragraph that you actually didn't read out, and I don't know whether you skipped over it or whether you didn't want to say it, but I thought it was good. It said health care needs to exist on a broad continuum ranging from addressing activities of daily living and emotional support to more complex medical interventions. It's at the top of page 6. We've heard previously that 80% of inmates have substance use issues. That's obviously a major concern. I wanted to ask you whether or not Corrections Canada uses a harm reduction approach—for example, needle exchanges, methadone—in looking at the issue of substance use from a multidisciplinary perspective and actually reducing the risk and the harm of inmates who may be involved, particularly with drug use. If you could address that, it would be very helpful.

Those are my two questions. Sorry to take so long.

● (0920)

Ms. Debra Gillis: Mr. Chair, I'd like to address perhaps the first question on the pan-Canadian health human resources strategy. Yes, Health Canada is very aware of this strategy and very proud of the work that we have done with the provinces and territories over the years on the development of this strategy.

Perhaps it was garbled in the time that I was having a choking attack and getting over my cold, but one of the pieces of work that Health Canada leads, and in fact we are the co-chair with the Province of Manitoba, is with the federal-provincial-territorial advisory committee on health delivery and human resources. That is a committee that reports directly to the conference of deputy ministers of health. Their work is guided by the health human resources strategy. The provinces work very closely together with the federal government in areas such as planning, identifying health service needs, sharing information.

Ms. Libby Davies: Ms. Gillis, is there a report that we could look at? This has been going on since 2005. Are there any sort of monitoring reports, evaluation reports, that we could get our hands on? It would really help us address what has happened or where the gaps still are. If you could point us to anything....

Ms. Debra Gillis: Absolutely. I'd be happy to ensure that any reports the group has provided, public reports and things like that, are provided to the committee.

You also talked about planning. As part of the work of this committee, they do a lot of work in modelling in health care, such as the number of nurses. The other piece is that a lot of work is also done in terms of health planning, workforce planning, and looking at the distribution of the health workforce across Canada. The Canadian Institute for Health Information produces reports on a regular basis around health workforce planning. It released a report a couple of years ago that I think you will find very interesting.

Ms. Libby Davies: Ms. Brenning.

Ms. Michele Brenning: I'll start with your first question, which Health Canada also answered. Certainly we rely on the leadership of Health Canada, but from a very operational perspective, we're a fairly small employer of about 2,400 health professionals.

We do very detailed operational planning. Each of our five regions has an operational plan for where the hiring needs to happen. We know that we have a continuous need for intake of nurses in the prairie region. We have an open process where we're always evaluating nurses who would be willing to come and work for Correctional Service of Canada. The prairies is one area where we do see a shortage of nurses.

We do have some needs, depending on how remote some of our institutions are. For example, Grande Cache is an area where we typically have challenges recruiting health professionals. There are some gaps with psychologists, but overall we have fairly good success in recruiting health professionals.

To answer your second question, yes, thank you for pointing that out. That really was a paragraph that talked about the overlapping scopes of practice. We did address that earlier, but to answer your question very specifically, we do have harm reduction programs. It includes the use of bleach kits and other types of measures such as that. We do not do needle exchange.

With regard to a methadone program, we have a very rigorous methadone program. It's an interdisciplinary team approach. Essentially you have an aspect where the physician, the nurse, and counselling will be provided, and there's ongoing, very regular routine monitoring of that particular program.

So yes, we do have that program in place.

● (0925)

Ms. Libby Davies: Is it...?

Okay, Mr. Chair. Thank you.

The Chair: Thank you very much.

Next up is Mr. Lunney for seven minutes, please.

Mr. James Lunney (Nanaimo—Alberni, CPC): Thank you, Mr. Chair.

Thanks to the witnesses for being here today as we get started on this important study on scope of practice. We're wanting to get an update on where Health Canada is at in terms of managing the processes in evaluating human health resources for federal institutions and so on.

Colonel MacKay, you described the primary care model that DND uses. You described the primary health care team as being regulated and non-regulated persons, and others at the table here described a very comprehensive list of professionals. It strikes me a little odd, if I come back to the military first, that our third-largest primary contact profession is not represented in any of your teams that you discussed today. I'm curious about that.

We have about 75,000 medical doctors in Canada. There are about 19,000 dentists who are primary contact. There are 8,400 chiropractors in Canada; that's a very large and regulated profession across the country. It strikes me odd, when we're talking about human resource shortages, that the third-largest primary contact profession is not represented.

Colonel MacKay, I know that chiropractors made a presentation not too long ago to the Standing Committee on National Defence about representation in the military. We know that amongst their areas of expertise for low back pain it's well established that chiropractors give far more cost-effective and effective care delivery. Chiropractors are working with the U.S. on 51 bases as part of the integrated health care team.

Is there a barrier to chiropractors participating in the primary care delivery, at least as part of the integrated team, to manage musculoskeletal issues on bases? I understand that 53% of your medical releases are actually related to musculoskeletal problems.

Could you respond to that?

Col Hugh MacKay: Thank you very much for the question.

We didn't mention a chiropractor specifically as part of our team within our clinic model, but we do access chiropractic care through the civilian community on a regular basis for personnel suffering from musculoskeletal pain.

You're absolutely right about the issue with respect to low back pain, and we actually, recently, just held a week-long task group to look at development of a clinical pathway for low back pain, because it is such an important issue to us. We did invite the Canadian Chiropractic Association to participate in that week-long working group with us. As a result of that meeting, we are right now pursuing opportunities for a clinical trial to integrate chiropractic care more fulsomely into our clinic model. I don't believe there are specific barriers to doing this right now. We're in the process of looking at building in an evidence base in order to be able to continue to support further work with chiropractors.

● (0930)

Mr. James Lunney: I appreciate that. Probably it's the integrated model and working together that you'd be having trouble with, because the clinical effectiveness of chiropractic in low back pain is well established. I could point you all the way back to the Manga report here in 1993 in this province. That report was done by an economist here at the University of Ottawa. He studied the issue and at that time recommended that Ontario could save $100 million in this province alone by selectively making use of chiropractic, because the evidence was there from the Cochrane Collaboration and others.

I appreciate that you're willing to experiment with those models. I notice that a chiropractor who made a presentation to DND offered to provide services on five bases. They'd make them available for those studies to go on on to see how they could integrate these services. I'm glad you're looking at that.

I might apply the same question to Corrections Canada. For full disclosure, I practised as a chiropractor for 24 years in two provinces, and one of our other colleagues across the aisle is also a chiropractor. Obviously we carry a bias in that regard, but having delivered those services for 24 years, I have no doubt in my mind of their clinical effectiveness, and it surprises me that others haven't benefited from or expanded on that opportunity in the north. In Corrections Canada, I made a house call to one of our local prisons, a provincially regulated one, and there were lots of people who would have liked my service beyond the patient of mine who happened to be spending some time there.

I just wonder, Corrections Canada, when you have all kinds of regulated professions and Health Canada is sending unregulated professions and even training medical technicians and physician assistants, why you wouldn't take someone from an area that is highly regulated, someone who is well educated—it takes up to seven years of post-secondary education—and look at using those resources for Corrections Canada. Do you have any models you've been working with there?

Ms. Michele Brenning: I'll just go back to what our mandate is under the Corrections and Conditional Release Act, and that is to provide every inmate with essential health care. Our essential health care framework defines what essential health services are for federal inmates. We work on a referral system. In other words, if a medical doctor determines that there's a need, for example, for speech therapy or physiotherapy, we would bring in the appropriate specialized expertise. I didn't mention speech therapy or physiotherapy, but I do know that we do referrals as needed.

Mr. James Lunney: I noticed one of your recommendations was for flexible scopes of practice that allow the option to train to an accredited standard beyond the scope of practice. Again, when you're dealing with northern communities, where you have trouble getting people up there and you take a nurse practitioner, that's very good, but if you had a nurse up there, along with a chiropractor who has a broad range of experience to help with those issues.... First nation communities, by and large, are a little bit less oriented towards medications, and they handle them, perhaps, less well than do other populations. Would it be possible to make use of these resources in remote and northern communities where it's hard to get physicians to go?

Ms. Debra Gillis: That's an interesting question, Mr. Chair.

Right now, I think as you can imagine, staffing remote and isolated communities is very complex and very difficult. Although, as I described, in the first nation communities for the most part throughout Canada our mandate is public community health care, first nations people who live on reserve or in Inuit communities access the provincial health system for physician, dental, and even chiropractic care.

It is through our non-insured health benefits program that we either provide medical transportation to these services or pay for the services, such as dental services specifically. In the remote communities, occasionally we are able to have and find physicians and other health professions beyond nursing who are willing to come into the communities on a rotating basis based on the need of a community. I can't speak to the fact if ever a chiropractor has been brought in, but I know physicians come in on an occasional basis. We pay for their travel in and they bill the provincial health system because of the universal nature of physician services in the health system.

If there are other more specialty services or dental services, sometimes they're brought in, but more specifically people are transported out of their communities to the provincial health system. Sometimes we've also used the mid-level dental technician, dental therapist, to provide some services in the remote communities under the guidance of a dentist. There are a variety of different ways to do that.

● (0935)

The Chair: Thank you, Ms. Gillis.

Next up is Mr. Scarpaleggia. Go ahead, sir.

Mr. Francis Scarpaleggia (Lac-Saint-Louis, Lib.): Thank you, Chair. It's a pleasure to be back here, if only on a one-off basis.

I find this to be a very interesting discussion.

Colonel MacKay, I'm trying to understand how your health system, which is essentially internal to National Defence, is laid out. You would have doctors on bases or around military bases. In an emergency, or if we're talking about a complicated case, the military personnel would be transferred to a provincial hospital. There are no national defence hospitals or even veterans hospitals left, so you're working in close collaboration, but you might have a doctor who would see the officer or the military person first, and then basically refer them—or even maybe you have to airlift them if the base is far from a hospital. Is that correct?

Col Hugh MacKay: Yes.

The situation is that we don't have any static hospitals in Canada at this point in time. If a patient becomes emergently ill they may be seen by one of our clinicians, initially on the base. That could be a physician, a nurse practitioner, or a physician assistant, who would assess the patient and make a determination as to whether or not a higher level of care is required, in which case they may be referred to a local civilian hospital. We work very closely on the local level with those health care facilities in order to make sure that we have all of the transfer smoothed out and that it can happen as easily as possible. There may also be occasions, though, where a military member is at home on a weekend, has an accident, and may call 911, and a civilian ambulance service may come and pick them up and transfer them automatically to a civilian hospital.

Mr. Francis Scarpaleggia: That was actually my follow-up question, what happens if the individual worked at DND headquarters but did not live in Ottawa or around DND; they could live in Montreal, for example, or wherever.

In terms of PTSD, in the case of personnel suffering from PTSD, how is that situation managed? I know in my riding we have the Ste. Anne's Hospital and there is a PTSD unit. I don't imagine it's only for veterans. It could be for DND personnel who have not left the forces yet. Is that correct?

Col Hugh MacKay: I'm not aware of our actually using that facility for our PTSD patients. Normally, for post-traumatic stress disorder, because of the nature of the illness, we would try to have people in care as close to home as possible and as close to their family support system as possible.

Mr. Francis Scarpaleggia: They're working with the provincial health care system for the most part.

Col Hugh MacKay: If there's a requirement for in-patient care, then we would be organizing that through the local civilian hospitals in the province where the individual resides.

Mr. Francis Scarpaleggia: But if we're talking about consultations with a psychiatrist, for example, would we have a military psychiatrist, or would you send that person to the provincial health care system as well?

Col Hugh MacKay: At the present time we have both uniformed and civilian psychiatrists who work in our mental health clinics or who work in our operational trauma support centres. We have seven centres that are specifically set up to help with operational stress injuries like post-traumatic stress disorder, and in those facilities we have military and civilian psychiatrists.

Mr. Francis Scarpaleggia: But it's all within the purview of National Defence. So you're not going to the provincial health care system unless they're an in-patient, in which case they would be in the provincial system.

● (0940)

Col Hugh MacKay: That's the situation. We look after them in our clinics; however, occasionally there may be somebody who requires some in-patient care, in which case we would arrange for them to be seen in a civilian hospital.

Mr. Francis Scarpaleggia: Thank you so much.

Ms. Brenning, I used to sit on the public security committee, and of course we looked at mental health issues in penitentiaries, and the answer we always got—and of course you laid out the same information today—was yes, in the system we have psychologists and we have social workers. But how do we really know that what's being done is enough? For example, it's one thing to say we have all these professionals, but do we have enough professionals? Is demand being met? Is someone who should be getting treatment from a psychiatrist being treated by a social worker? They would show up in the statistics as someone whose problem is being dealt with, but maybe not in the optimal fashion and the stat wouldn't show that it's not optimal. How do we know?

I guess the same would apply to any of you representing your particular department. We know there are staff available, but how do we know if there is a shortfall, if we need to do more, if we need to invest more? How do we know if we need to spend more so that the level of care is optimal? Are there reports or measurements? I can't imagine the government wanting to publish a report saying that we have mental health professionals in the prison system, but it's really insufficient. Where are we going to get this information?

Maybe we'll start with you, Ms. Brenning.

Ms. Michele Brenning: Yes.

Maybe I can sketch out a little about what we do for our clientele. Upon intake we do a 24-hour nursing assessment that looks at both physical health needs as well as the mental health needs. That's followed up by a 14-day nursing assessment during which you look at the same measures, and we do a more comprehensive screening. That's followed up by referrals to the appropriate team members, whether it's a psychologist or whether it's a member of an interdisciplinary team.

For men, about 47% of our population gets a mental health service, and for women about 75% of our population gets a mental health service. So the numbers are quite high for those who are accessing the services.

Just to scope out—and you might have covered this in your previous work—we have five regional treatment centres that are in-patient hospital beds, and those are designated under the provincial mental health acts, except for Quebec where the provincial system is slightly different, but they are designated hospitals. They're also accredited by Accreditation Canada. We have five regional physical health hospitals as well that are accredited by Accreditation Canada. So we have a number of processes in place that assess, that provide the treatment to the patients, and that also have the infrastructure in order to take care of the needs of patients.

Mr. Francis Scarpaleggia: We keep hearing that there aren't enough psychologists in the system, but thank you for your answer to that question.

The Chair: You're over time.

Mr. Young, go ahead, sir.

Mr. Francis Scarpaleggia: Thank you.

Mr. Terence Young (Oakville, CPC): Thank you, Chair.

Thank you all for being here today.

Colonel MacKay, I wanted to ask you about the medical services you provide. I'm sure you know that antidepressants are recognized as one of the largest group of drugs given to armed services personnel; certainly they are in the U.S. One out of four soldiers in Iraq in the U.S. Army is on antidepressants, and they can cause a whole range of adverse effects, including suicide and bizarre acts of violence.

I look at your list of medical practitioners, and it doesn't include naturopaths. I personally have had a positive experience. I've seen a naturopath for three years with measurable, really good, positive results, but non-drug therapy so there's no risk of adverse effects. Do you ever support services in the military for naturopaths to be part of the solution for armed services personnel?

Col Hugh MacKay: At the present time we do not use naturopaths in the care of Canadian Forces personnel.

The Canadian Forces follows a program of evidence-based care. We are certainly in a position where we will review any evidence that is available and make determinations as to whether or not the evidence would support certain types of care being provided.

● (0945)

Mr. Terence Young: Would you consider a pilot project?

Col Hugh MacKay: I wouldn't be prepared to make a commitment at this point in time to a pilot project.

The Canadian Institute for Military and Veteran Health Research is investigating the evidence-based treatments for mental health at this point in time—

Mr. Terence Young: Well, I'm thinking of physical health as well.

Col Hugh MacKay: Pardon me?

Mr. Terence Young: Not just mental health but physical health as well.

I understand you're not prepared to consider something just on the suggestion by a member of this committee. But if there was evidence, would there be a time that you might consider it?

Col Hugh MacKay: As evidence develops for any particular treatment methodology, we are prepared to investigate whether or not those treatment methodologies may be applicable to Canadian Forces members if it's for their well-being.

Mr. Terence Young: I was particularly intrigued by a comment you made that the Canadian Forces Health Services Group has implemented a pan-Canadian electronic health records system. This is really exciting news for me because I live in Ontario and in Ontario the McGuinty-Wynne government wasted $1 billion trying to develop a system like this. That's $1 billion down the tube with very little to show for it.

Have provincial authorities ever come to you and asked you to look at your electronic records system? Has anybody ever said, “Look, you've got something that works, can we look at that? Maybe that'll work in the province of Ontario”?

Col Hugh MacKay: We haven't specifically been approached by a province. But certainly, we participate with the Treasury Board CIO on a committee that is looking at, from a federal government perspective, where we should be going with electronic health records. They do look at our health records and try to capture the lessons that we have learned as we've implemented these health records.

Mr. Terence Young: Will these health records follow the personnel as they move from town to town if they change assignments?

Col Hugh MacKay: We can access any soldier's record from anywhere that we have a base, including overseas.

Mr. Terence Young: Any medical personnel who are authorized can access those records.

Col Hugh MacKay: We have some very strict access rules as to who can access which parts of the health records. But yes, somebody that has the access authorities on a base can access a member's record.

Mr. Terence Young: That sounds fantastic.

Debra Gillis, thank you for coming today.

Do you authorize or support naturopathic medicine, in first nations or in any of your areas of authority?

Ms. Debra Gillis: At this time through our non-insured health benefits program, naturopathic medicine is not included as an approved—

Mr. Terence Young: And why is that?

Ms. Debra Gillis: We have a pharmacy and therapeutics committee, and as my colleague says, we are looking.... As evidence comes forward, we put forward...so it's the same situation.

Mr. Terence Young: Who is on the therapeutics committee? Is it medical doctors?

Ms. Debra Gillis: It's a variety of people, medical doctors, scientists, pharmacists, a wide variety like that.

Mr. Terence Young: On a reserve, I noticed that the role of nurse practitioners has increased in remote communities, which I think is a great idea. What can a doctor do in medical practice that a nurse practitioner can't do in remote communities?

Ms. Debra Gillis: Oh dear. That's a very broad question because it's more like what can a nurse practitioner do as opposed to a doctor.

I honestly don't have the details with me. But there are more invasive procedures that a physician can do that, of course, a nurse practitioner can't do. The nurse practitioner is limited to diagnostics and prescribing within a certain range that is not as broad as what a physician can do.

Mr. Terence Young: Can a nurse practitioner prescribe addictive opioids?

Ms. Debra Gillis: A nurse practitioner, according to the Controlled Drugs and Substances Act, can prescribe controlled drugs if it is allowed on-reserve, if the nurse practitioner is working on-reserve or for the federal government, and if it is allowed by the province.

So, for example, in Ontario, while the Controlled Drugs and Substances Act allows nurse practitioners, potentially, to prescribe controlled drugs, at this point in time the Province of Ontario has not allowed that. A nurse practitioner working for Health Canada cannot prescribe controlled drugs in Ontario. But it's allowed in B.C., so they can prescribe in B.C.

● (0950)

Mr. Terence Young: You talked about the best brains exchange on optimal scopes of practice, which sounds very interesting. Could you tell us a little about that?

Ms. Debra Gillis: Generally a best brains exchange brings together in a comfortable setting a variety of people who are free to speak their minds on a topic. They may have a lot of information. It's to draw out more details, more opinions, more thoughts. This is a way that has been developed, through the Canadian Institutes of Health Research, to try to combat some of those tricky questions we need to look at.

The Chair: Your time is up. Thank you.

Mr. Terence Young: Thank you.

The Chair: Now we're going to Mr. Morin for his questions. Mr. Morin, I understand you're going to share your time with Ms. Morin.

Go ahead, sir.

[*Translation*]

Mr. Dany Morin (Chicoutimi—Le Fjord, NDP): Thank you very much.

My question goes to Ms. Gillis.

This morning, *Le Devoir* published an article with a headline saying that Quebec wants to repatriate its health care dollars from Ottawa. The Minister for Canadian Intergovernmental Affairs, Alexandre Cloutier, must often talk to you about those claims. Personally, as I read the article, I learned things that I did not know. I would like you to comment on the subject.

According to the article, the federal government spends $210 million per year in health care in Quebec. I assume that most of that money comes from Health Canada. In their 120-page report, Mr. Lalumière and Mr. Malouin point out that the federal government spends that money for promotion and prevention activities and for funding treatment and rehabilitation services.

If that $210 million that Quebec is claiming really does come from your department, what consequences would repatriating the amount have? Your department's mission is to promote health all across the country. What consequences would it have on your Canada-wide prevention campaigns?

[*English*]

Ms. Debra Gillis: You've asked a number of different questions in a number of different topic areas that are beyond issues related to the study here today. If you wouldn't mind, I would prefer if we could respond to those questions more specifically in writing, if you wish, so we fully understand their scope.

Mr. Dany Morin: It's not a problem. It was not a trick question. It was just something I saw in the paper this morning that is linked to Health Canada spending across Canada. I want to make sure that my colleague has plenty of time to ask her questions. Isabelle.

[*Translation*]

Ms. Isabelle Morin (Notre-Dame-de-Grâce—Lachine, NDP): Thank you very much.

Mr. MacKay, in your presentation, you say: "Given that we span the country, we face challenges with respect to scopes of practice for some regulated professionals as they are not consistent across provincial jurisdictions."

Can you suggest any solutions? Is there a way of getting around that difficulty, or can nothing be done?

● (0955)

[*English*]

Col Hugh MacKay: I think we've had discussions certainly around the health human resource table for some time about trying to standardize scopes of practice and licensure to permit mobility across provincial and territorial lines. Although that does present some challenges I believe it is very much worth pursuing as a possible solution to the difficulties or frictions that might arise as a result of different scopes of practice as people try to move from province to province or territory.

[*Translation*]

Ms. Isabelle Morin: Are professional associations open to that at the moment? Do you have good dialogue going on or is it kind of a tough situation?

[*English*]

Col Hugh MacKay: From what I understand it's not an issue of the professional associations. I believe the professional associations may be open to that, but it's the regulatory bodies from province to province that set the standards. It's a matter of having those regulatory bodies all come to some agreement with respect to what practitioners are permitted to do or not to do.

[*Translation*]

Ms. Isabelle Morin: That's fine, I will wait for the next round. Thank you.

[*English*]

The Chair: Thank you.

Mr. Wilks, you have five minutes, sir.

Mr. David Wilks (Kootenay—Columbia, CPC): Thanks, Chair. Thanks to the witnesses for coming today.

I think I'll take a little different light at it.

Colonel, my son's in the military, and was deployed over to Afghanistan and has come back. I'm retired from the RCMP so you will have to mind my answer to him when he came back. He came back and complained of some lower back pain. I basically told him to "suck it up, buttercup", but I recognize it's more than that from the perspective that I don't think we recognize from time to time what our soldiers are doing overseas and the heavy load they do carry.

I wanted to carry on with the questions from Dr. Lunney who had been speaking about the chiropractic care, and it seems like it would be of benefit to the forces to look down that road. It certainly has helped many people.

From the perspective of that, and because you had mentioned in your opening remarks that you follow the primary care clinic model, that would mean to me anyway, coming from a community that follows the primary care model, that there is the potential to enlist those types of medicines that are not normally found within what we'll call the traditional model.

In terms of my question—and I know you can't answer it here today—but I believe there's some opportunity for the armed forces to consider such roles that are not normally found within the health care model. Could you speak to it a little more, especially certainly to those injuries that are not normally looked at from the perspective of chronic pain. When we look at back pain, we look at it from the perspective of a temporary issue as opposed to a long-term issue.

I know that's a difficult way of looking at it, but I guess the way I'm looking at it is from the perspective of primary health care. In my community all of the medical services are provided through one roof, through one funnel, and one of those is chiropractic. If that is the case is there the potential for the armed forces to do that as well?

Col Hugh MacKay: As I had indicated earlier, I would like to say there are no barriers to chiropractic care really. We do access chiropractic care. When I was a physician in Shilo, Manitoba, I had a great chiropractor in Brandon I would refer to regularly for low back pain because it worked and I was trying to do what was best for my soldiers. So I know physicians across the country are accessing chiropractic care.

When I spoke about the study, I think it's looking at changing the model somewhat. Right now the model is that we have our CDU, which I had described earlier, and we refer out to chiropractic care. In terms of whether or not there is some better way to integrate the chiropractor into that team, and whether or not that would produce other benefits other than the way we currently access chiropractic care, we are constantly reviewing the medical literature to find out what is the best way to provide care to our soldiers.

We are open to care that is evidence based when that evidence arises. We are engaged in research ourselves to try to develop evidence, in particular through the Canadian Institute for Military and Veteran Health Research, which we helped to set up in order to look at the things that are specific to Canadian armed forces personnel and veterans.

● (1000)

Mr. David Wilks: Thank you.

Further down in your opening comments you mentioned a performance measurement platform. Could you speak to that a little bit? I'd just like to understand what that is in the context of what we're talking about today.

Col Hugh MacKay: The health services group has a small cell that looks at performance measurement across our organization. It is an evolving program that we currently have. Certainly we are looking at things like wait times, next available appointment, and process-type things right now to evaluate where we are with the provision of health care. We're also doing things like satisfaction surveys to see how our care is being perceived by members of the Canadian Armed Forces.

As we evolve with this performance measurement, we need to start to do more in the way of outcomes measurement. Somebody raised the point here of how you know when you're doing enough. That's part of looking at outcomes. This is where we're trying to evolve our performance measurement platform at this point in time.

Mr. David Wilks: Okay. Thank you.

The Chair: Thank you, Mr. Wilks.

[*Translation*]

Ms. Morin, you have five minutes.

Ms. Isabelle Morin: Thank you very much.

I am going to change the subject.

Ms. Gillis, I have some questions for you. Just as my colleague Mr. Young asked you some questions about naturopaths, I am going to ask you some about midwives.

I recently met with representatives from the Canadian Association of Midwives and the National Aboriginal Council of Midwives. They told me about the difficulties they are having in practicing with First Nations. We know that the practice of midwifery somewhat matches what First Nations are looking for: it is more natural, there is a lot of supportive care. The profession is more and more popular. A number of Canadian universities offer courses in it. But they told me that they were having difficulty in obtaining the classification they need in order to practice with First Nations.

Have you made recommendations to Treasury Board for new classifications for midwives so that they can practice their profession with First Nations?

[*English*]

Ms. Debra Gillis: I think midwifery is becoming more and more recognized. In fact Health Canada has been working quite closely, at the first nations and Inuit health branch specifically, with the National Aboriginal Council of Midwives. We have provided them with funding over the years to promote their profession and to start looking at their overall work, which we've been doing.

We've also been working with a variety of different midwifery associations. In fact in the province of Ontario, through some of the work that we've been doing and with the midwives, the role of the traditional midwife is being recognized in first nation communities.

With respect to your last question, the creation of a new classification is one that is quite a complex subject and takes many years of work with Treasury Board. Frankly, we have been focusing much more on a classification for nurse practitioners, more so because there is not a federal classification for nurse practitioners. Although there is a CHIN community health NP, it really doesn't outline a nurse practitioner. So right now our focus is really on nurse practitioners.

● (1005)

[*Translation*]

Ms. Isabelle Morin: Has the work begun, given that it needs so much time?

In April 2013, the federal government officially launched—

[*English*]

the student loan forgiveness program.

[*Translation*]

Since my document is in English, I am going to speak in English. Please forgive my accent.

[*English*]

This permits nurses and nurse practitioners to address the shortage of health professionals working in more than 4,200 rural and remote communities in Canada. Seven universities in Canada offer a four-year health sciences baccalaureate degree in midwifery, and yet midwives have been excluded from this initiative.

Is there any reason for this, and is there any way in which we can include midwives in this program?

Ms. Debra Gillis: The program is actually managed through Employment and Social Development Canada and not through Health Canada. We would have to check with them to see the scope of health professions that are eligible.

[*Translation*]

Ms. Isabelle Morin: Could you make a recommendation to Employment and Social Development Canada to include midwives in that program? Do you support the idea?

[*English*]

Ms. Debra Gillis: I think right now we would need to take a look to see if they are eligible to begin with. Right now I'm not quite sure if midwives are eligible or not.

[*Translation*]

Ms. Isabelle Morin: How can we find out if they are eligible? What is the process? How could I help that group to become eligible?

[*English*]

Ms. Debra Gillis: What we could do is provide, Mr. Chair, the name of the area within Employment and Social Development Canada that manages this program. That perhaps would then allow someone to get in touch with them.

The Chair: Very good.

[*Translation*]

Ms. Isabelle Morin: I would appreciate that very much.

[*English*]

The Chair: Those are good questions, Ms. Morin. I think for all the committee's benefit, a lot of the questions we've heard today are really getting at the whole point of what we're trying to accomplish here, to take that extra step to figure out why these are the barriers and who we have to talk to in order to get it straightened around.

Mr. Allen, you're up. I would normally give you five minutes, but last night you wouldn't let me skate around you and score a goal, so how about four minutes and 45 seconds, sir?

Mr. Mike Allen (Tobique—Mactaquac, CPC): At least you didn't go to negative two. Thank you, Mr. Chair. I appreciate that.

Thank you to our witnesses for being here.

Not being a regular member of the health committee and subbing in today, I want to ask a few questions that tweaked me as you were giving your testimony.

Colonel MacKay, you talked about, given the span of the country and the challenges with respect to scopes of practice across, each one of you have regional differences, provincial differences. Which regions and which provinces give you the most flexibility with respect to the capabilities and scopes of practice, and which ones the least?

From all of you, please....

Col Hugh MacKay: I'm not sure we've assessed them from a flexibility perspective necessarily. I will say, though, that generally the Province of Ontario provides a fairly well-defined scope of practice that often we're able to look at and use to help formulate where we believe we need to be with our scopes of practice. But that's not to say we don't look at all the other provinces, when necessary, to see whether or not there's something we can learn from with what they've had to say.

Mr. Mike Allen: Ms. Brenning.

Ms. Michele Brenning: Thank you for the question.

I'm not sure we would have looked at it that way because my sense of it is that it also depends somewhat on the various professions that you're talking about.

One thing we have noticed is that often the regime in the province of Quebec requires us to understand it a little bit more than in other parts of Canada. The example I'll use is that our psychiatric hospital there does not have what you would call listed schedule I beds, so it's slightly different. Their process for certification of inmates under the mental health act is slightly different. All that to say it takes more effort from our part to understand.

I will add that one of the things we do is use generic job descriptions to a fairly large degree. For example, we have generic nurse job descriptions, generic OT job descriptions, generic social work job descriptions. So while the scope of practice across Canada may vary, the work that we require our professionals to do is standardized across, as are our policies that they operate under, our programs, and our processes. That's how we bring standardization across Canada.

● (1010)

Ms. Debra Gillis: With respect to the work we are doing, like my colleagues, there isn't any one province we can point to. It's with respect to the nurses who are working in an advanced scope of practice that we've been working with provinces. I've been working with first nations and Inuit health branch for many years. We have been working with provinces for many years. Many of them run into exactly the same situation whereby they have to provide services to their remote communities. That's why, for example, in the province of British Columbia, through the work that we've been doing with British Columbia and working with the regulatory bodies and the health professions, they now have a new, advanced certificate that recognizes a broader scope of practice.

Saskatchewan is going there. Each of the provinces are working to ensure means are in place for the broader scope of practice for registered nurses primarily to be recognized. We are not asking nurses to work significantly beyond their scope of practice and putting anything in jeopardy. There isn't one place. We've been working continuously. Each province is dealing and looking at it within their specific area and we're working with them to find a good solution that works for all.

Mr. Mike Allen: I have a quick follow-up.

They talk about attracting and retaining people. In New Brunswick we see some of our nurses choosing to work in Maine. It's not necessarily because of the money but because of the flexibility in training.

What are the key elements that you see as attracting and retaining these people. What specifically is your resource challenge?

Ms. Debra Gillis: Our primary principal challenge is recruiting nurses in our remote areas. It's not as much of a challenge for nurses who are working in public health. The majority of nurses working in public health are working directly for the first nations. In remote areas the isolation is definitely a factor in recruiting and retaining nurses. The lack of amenities in many of these communities is often an issue. It also offers a lot of other things that attract people in working with a different culture. Working in that expanded role often attracts many nurses. Because of the professional isolation we're trying to look at broadening the interdisciplinary team and having nurse practitioners going in. We have, on average, around a 30% vacancy rate of nurses in remote and isolated communities and then we have to rely on contract agencies to ensure we have the full support of staff.

The Chair: Thank you very much.

Ms. Davies.

Ms. Libby Davies: Thank you very much.

I'm very glad that my colleague raised the question of midwifery and what's going on there. I'd like to come back to that question, Ms. Gillis, and question it a little more closely, given that we have some additional time for questions.

First, there's no question that primary health services to first nations, Inuit, and Métis communities is a federal responsibility, constitutionally. There's a lot of evidence to show that midwifery does improve the health outcomes in aboriginal communities. To be quite honest I don't feel very satisfied by the answer you gave. To me, this is a key example of scope of practice where we could be doing something that is practical, effective, cost-effective, and has good health outcomes.

There's an association that's ready to go. They want to do this. As you say, it's a profession that's being more and more recognized. For you to tell us, you're focusing on nurse practitioners...by the way, I understand how important that is as well. Surely the federal government has the capacity to advance two job classification requests to Treasury Board. Are we waiting until the nurse practitioners are done and then maybe the midwives will come forward? There has to be a better answer to that. There's a lot of interest on this committee because it is so basic. It's something that would really qualitatively change health outcomes in northern and remote communities.

Please tell us if Health Canada has recommended to Treasury Board to look at this classification. Are you monitoring it? How long will it take? When do you expect to see a resolution?

● (1015)

Ms. Debra Gillis: As I mentioned earlier, we have not put forward through the first nations and Inuit health branch a recommendation around midwifery, at this point; however, what we are doing is.... Because of the recognition that midwifery services or services for birthing closer to home are really quite important, because rather than—

Ms. Libby Davies: Can I just interrupt you?

I want to get to the timing question here. I know you know how important it is, so when you say you haven't made the recommendation, does that mean that Health Canada does not contemplate doing that in the foreseeable future? Is it something that's on your work agenda? Could you give us a sense of timing, or is this just not on the radar right now?

Ms. Debra Gillis: I really can't provide you with the timing around that.

Ms. Libby Davies: Who can?

Ms. Debra Gillis: Right now we are looking at our options to provide birthing services closer to home.

Ms. Libby Davies: Surely that must require some sort of classification change. My understanding is that they can't operate unless they get that classification. I just don't understand what the obstacle here is, given the importance of this particular measure. Is it something that Health Canada is going to advance at some point?

Ms. Debra Gillis: That's why we're looking at our options around birthing closer to home. Some of the first nation communities, especially in the remote areas, are very small. In many cases, we operate, for example, a two-nurse nursing station. Given our ability —or lack of ability sometimes—to attract staff, we have to look at the scope and we have to look at the number of staff we can have. So we're looking at the different options available to us in the variety of communities in which we provide services.

Ms. Libby Davies: It seems to me that would be something that would come about as a result of getting a classification, because then you know what capacity you have and what resources need to go where. If you don't have the classification to begin with, then midwifery isn't even part of the review and the consideration. So really, I'm just not getting it. It seems inexplicable why this wouldn't be advancing. According to all the information we've seen, midwives would actually be assisting nurse practitioners. They would actually be extending the scope of practice. Maybe there wouldn't be one in every remote community, but they would be one of the choices there if you could get over the technical barrier of having the classification. I'm sure we'll take this up in the study, but I really wish Health Canada would advance this and see it as something that is a priority.

The Chair: Okay.

Mr. Lizon.

Mr. Wladyslaw Lizon (Mississauga East—Cooksville, CPC): Thank you, Mr. Chair.

Welcome to all the witnesses here.

The first question I have is to Colonel MacKay.

As you're probably aware, the committee just completed a study on prescription drug abuse. My question to you is how serious prescription drug abuse is in the military. What is used, generally speaking, for pain maintenance? What we found out here was that there's a huge problem with opioids being over-prescribed and abused. Can you inform the committee what the scope of practice is in that field?

Col Hugh MacKay: I'm sorry. Could you clarify what link you see to the scope of practice in that field?

● (1020)

Mr. Wladyslaw Lizon: The witnesses who came before the committee indicated that there is not enough knowledge among doctors, and there's no clear guidance on prescribing drugs. Some witnesses told us that one of the reasons for over-prescribing opioids is the very aggressive advertising campaigns by drug companies, which was quite shocking. What do you use for pain maintenance for our troops?

Col Hugh MacKay: Within the spectrum of care for the Canadian Forces health services, we have a full suite of medications available which would include narcotics and non-narcotic pain medications. We also have modalities like physiotherapy, referral to chiropractors, and those types of modalities to help with pain management. Occasionally, we need to refer folks to specialty pain management clinics in order to assist members with their pain management.

In the forces you've expressed concern about problems with misuse of prescription medications. We have a survey that we do every four years called the health and lifestyle inventory survey in which we do have personnel reports on drug usage. That study would suggest to us that there is a very small percentage of personnel who are reporting anonymously whether or not they have used prescription medications inappropriately. I don't have the specific number in my head, but it was a very small percentage of personnel that reported that.

As part of our treatment suite, we also have addiction counsellors available to us, who work in our mental health clinics and who are certainly available to help anybody who is starting to have any issues with respect to substance abuse, whichever type of substance that may be, whether it's prescription or non-prescription medications.

Mr. Wladyslaw Lizon: My colleague asked you about chiropractors, and we know that in many cases instead of using chiropractors, doctors would prescribe a pain medication to treat lower back pain or other pains. That's also something that perhaps should be considered for the treatment of our troops. The statistics that were mentioned here indicate that about 50% of releases are due to that problem. Is that correct?

Col Hugh MacKay: I believe the highest percentage of medical releases are a result of musculoskeletal injury, yes.

Mr. Wladyslaw Lizon: Is this something new or has it always been that way?

Col Hugh MacKay: As long as I've been in, and that's for 30 years, our statistic has been that musculoskeletal injuries or problems, have been the number one reason for release. Our soldiers are asked to work in very difficult environments and do very difficult work. Unfortunately, occasionally, that has an effect when you do it over a career. So that is the case.

Our clinics have the benefit of a remuneration system that is different than some clinicians have across the country in that we have salaried physicians who are able to take the time to spend with patients and have discussions with patients. We have a multi-disciplinary team that is involved with helping patients.

I believe that perhaps provides us a little bit of protection from what you may have heard from some of the other presenters to you regarding prescription drug misuse. Our model allows us to have time to work with those patients, and hopefully not see the same types of rates that are seen in other populations.

● (1025)

The Chair: Mr. Scarpaleggia.

Mr. Francis Scarpaleggia: Thank you, Mr. Chair.

My understanding is that what we're trying to do with this study is to see how the federal government, through its foothold in health care.... We always assume that it's entirely a provincial matter, but in fact the federal government has an important role to play by virtue of its work and its jurisdiction over aboriginal communities, the military, and the penitentiary system. So we're trying to see how we can be the leaders in terms of breaking down barriers in the medical professions in such a way that someone could practise anywhere in the country really. That seems to be my understanding of what we're aiming for here.

I'm just wondering, for example, what the Department of National Defence is doing in the area of telehealth. Are you doing that in complete isolation, the digitization of health records, and so on, for easy access? Are there any bridges with, for example, Quebec? Are they looking at your example? Are you looking at what they're doing? Because I know they're quite active in the area of telehealth. Is there some synergy here? That's the one question.

The other is this. Do you find—maybe Ms. Gillis would want to answer this—that through the examples and the standards that your department is setting, provinces that might not have the same standards and necessarily all the occupations are bringing their standards up? For example, just by way of analogy, in terms of drinking water quality, the idea is to set federal standards so that provinces that maybe don't meet those standards then have something to aim for. Do you find that you're accomplishing that?

Also, we know that through the immigration system we're trying to make it easier for newcomers to Canada to integrate into the medical profession. Are you interfacing with Citizenship and Immigration on issues of certification?

Maybe we can start with Colonel MacKay.

Col Hugh MacKay: Maybe I can answer the first question.

As a small health care provider, we're not actually engaged with all of the provinces in discussing what we're doing with electronic health records. We are, however, engaged certainly within the federal government. As I explained earlier, we sit on a committee chaired by the chief information officer of the Treasury Board, where we discuss where the federal government's going with electronic health records and trying to standardize applications across the federal government. That is where we have involvement with sharing the lessons that we have learned in the implementation of an electronic health record.

Mr. Francis Scarpaleggia: Thank you.

Ms. Gillis.

Ms. Debra Gillis: Let me try to answer the three questions that—

Mr. Francis Scarpaleggia: Try the best you can. I know there was a big mouthful there.

Ms. Debra Gillis: Absolutely.

We have been working very closely with, in particular, provinces in which first nations live, and are finding significant success in working very closely with them in a number of different areas and breaking down some of those barriers between the first nation communities and the provincial health system. In fact, the more recent and very successful example is that last year in October, through many years of work with the Province of British Columbia, the first nations in British Columbia, Health Canada, and the federal government of Canada, we have transferred all health services to the First Nations Health Authority in British Columbia, which is working very closely with the province. But you see lots of examples of that happening right now in many different ways.

In terms of standards, and you mentioned specifically water, there are Canadian drinking water quality standards, absolutely, but they are developed in a collaborative manner with the provinces and territories. So while they are Canadian drinking water standards, they are...so for the most part provinces adopt these but they may make some minor modifications depending upon their situation.

In terms of work with foreign-trained physicians and nurses, this is some work that Health Canada has been involved in for quite some years, working with Citizenship and Immigration Canada, with Employment and Social Development Canada, with the medical and nursing colleges, and education boards. We have been working very closely over a number of years to break down some of those barriers, but ensuring that foreign-trained health workers are meeting the same standards that all physicians or nurses or others in Canada must meet.

● (1030)

The Chair: We're over time.

Mr. Lunney, please.

Mr. James Lunney: Thank you, Chair.

Thanks to all of our witnesses for your participation in this study. It is, of course, one of the purposes of this study to examine barriers to effective teamwork and collaboration.

The challenge I want to throw out to each one of you is, when you hear those packages put together of collaborative interdisciplinary approaches, and the third-largest primary care provider in Canada—that would be chiropractors—is not included, there is a gap there. When you're talking about bringing in and training other people to fill gaps as medical technicians, it's past time for that to be remedied. You're going to find that there are tremendous opportunities for more cost-effective care.

Colonel and Dr. MacKay, it was 1985 when a medical champion—if you will—in Saskatoon, Dr. Kirkaldy-Willis, published the first study on spinal manipulation and low back pain along with a chiropractor. It was the first time a chiropractor's credentials were recognized in a Canadian medical journal. The evidence has been there for 30 years, so it's time that we find better ways of collaborating.

I put that on the table as a challenge to everyone at the table here, not just for chiropractors but for naturopaths, because there are more promising avenues and more effective opportunities there that are being missed.

Now back to Ms. Gillis.

You're talking about the north here. “Health Canada funds or directly provides public health, health promotion and disease prevention, addiction and mental health, and home and community care on all first nation communities, and primary care services in 85 remote and isolated communities.”

I wonder if you have heard of a program based in Alberta called Pure North S'Energy. Pure North S'Energy started with an oil company executive's own foundation treating his oil workers with EDTA chelation therapy to take the heavy metals they're exposed to in that environment out of their systems. They also provide vitamins and minerals. They have maybe 100 health professionals working with them: doctors, nurses, and naturopaths. They'll do an analysis to determine what nutrients they're short of, he will provide the nutrients to these people in that remote northern environment—he's working with Inuit communities—and they will send the nutrients to them for life as long as they agree to a blood test a couple of times a year to monitor their progress.

It's been going on for almost 10 years now and they're accumulating—last time I talked to them—17,000 people on the program with amazing results. One of their primary strategies is to get vitamin D levels up. They're not getting vitamin D in the north; they're clothed all the time. Naked at noon is the buzzword for vitamin D, 20 minutes when the sun's high in the sky. It's not happening for most Canadians, especially in the north. Anyway, stay tuned; we hope to have them here as witnesses in this committee.

There are opportunities, and one last one would be preventing fetal alcohol spectrum disorder; it's a huge issue in the north. There's compelling evidence now that trace amounts of methanol in alcohol is what crosses the placenta and does this devastation to the developing nervous system. A simple folic acid supplement—a penny a day for the average person at risk—would mitigate that risk. Isn't it time we looked at measures like those that could be implemented in the north? There are promising models out there, and that's a challenge for all of us to move ahead.

Ms. Debra Gillis: First of all, I've never heard of the Pure North S'Energy, so we will look into it.

In terms of folic acid, we encourage all pregnant women in first nation communities to take folic acid. This is something that we have been doing for many, many years, and we continue to do that.

Mr. James Lunney: Well, good.

I suspect that a pregnant woman's taking 400 micrograms might help with spina bifida, but frankly you need.... A milligram is a penny a day, and we could probably make sure they get at least a couple of milligrams a day to help mitigate the risk of fetal alcohol syndrome while we're encouraging them not to engage in alcohol. But of course before they know they're pregnant is when they're most at risk, in the early stages.

Thank you for that.

Thank you all of you for showing up here today. We have an interesting challenge ahead of us and great opportunities, so we're hoping to develop those together.

Thank you.

● (1035)

The Chair: Thank you very much, Mr. Lunney.

We're going to head in camera for a few minutes to discuss some committee business. The only thing I would ask witnesses today is—we've had a great discussion—if there's anything else that you think of that comes to mind or your staff's minds, please put it forward to the clerk and the analysts so that we can have it for our report. I think you hear passion and concern from all MPs here for this scope of practice study. Thank you very much.

We're going to suspend.

Yes?

Mr. Dany Morin: I just want to make sure that I will have a written answer to my question.

The Chair: Oh, yes.

Ms. Debra Gillis: Yes. If you could please send the specific question to Health Canada, we would be happy to provide a written answer.

The Chair: You'll have that by the end of the day.

Ms. Debra Gillis: The question?

The Chair: The answer.

Voices: Oh, oh!

The Chair: No, no, I'm just....

We'll now suspend the meeting and move in camera.

[*Proceedings continue in camera*]