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Chair

Mr. Ben Lobb

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● (1530)

[*English*]

The Chair (Mr. Ben Lobb (Huron—Bruce, CPC)): Good afternoon, ladies and gentlemen. Welcome back and thank you for being here. We're starting our study up again regarding best practices and federal barriers to practice and training of healthcare professionals.

We have two panels this afternoon.

Before we do though, I would ask that at some point in time in the next week or so that the vice-chairs and the chair reconvene. We had agreed on an April 2 date for a meeting and that date will no longer work, so at some point in time if the vice-chairs and the chair could figure out a date that will work, we'll do that. That day is a Thursday, but in the parliamentary calendar, it's a Friday so it's not going to work.

Today, we have the Canadian Chiropractic Association, the Canadian Dental Association, and the Canadian Dental Hygienists Association.

We're going to start on my left and we're going to start with the Canadian Dental Hygienists Association, Ms. Wright and Ms. Leck.

Ms. Ann Wright (Director, Dental Hygiene Practice, Canadian Dental Hygienists Association): Thank you very much.

I am Ann Wright, director of dental hygiene practice at the Canadian Dental Hygienists Association. With me is Victoria Leck, dental hygienist and manager of professional development.

CDHA is the collective national voice of more than 26,000 dental hygienists in Canada, representing over 17,000 individual members. Dental hygiene is the sixth-largest regulated health care profession, and dental hygienists play a vital role in helping to maintain and improve oral and overall health for Canadians.

Dental hygienists are educated at four universities and 33 colleges across Canada, and practise in a variety of settings, including public health agencies, independent dental hygienist practices, traditional dental practices, hospitals, long-term care facilities, educational institutions, and research centres.

Dental hygiene care is not limited to providing preventive services such as scaling, root planing, tooth sealants, and fluoride applications. We aIso examine clients for signs and symptoms of oral cancer, and are committed to facilitating behavioural change through tobacco cessation and nutritional counselling. ln addition, CDHA has participated in Minister Ambrose's family violence and child abuse prevention round table discussions. Because the physical signs of family violence often occur in the head, neck, and face, dental hygienists are in a key position to identify and report on these signs and symptoms.

We are very pleased to have the opportunity to meet with you today and highlight the areas in which the federal government can provide leadership to better meet the health needs of all Canadians.

Poor oral health can cause pain, diminish workplace productivity and general quality of life, and is now recognized as a risk factor for diabetes, and cardiovascular and lung diseases.

ln its report published in 2014, the Canadian Academy of Health Sciences identified the major issues and inequalities in relation to oral health and access to oral health in Canada. Compared to the rest of the Canadian population, vulnerable groups, including seniors, aboriginal people, and the homeless, are more likely to avoid dental care due to cost and have untreated dental decay, gum disease, and pain.

Although health care in Canada is delivered primarily by the provinces, the federal government does have populations for which it is directly responsible for providing health services. Veterans benefit from programs managed by the Department of Veterans Affairs, and first nations and Inuit communities receive health care through non-insured health benefits, NIHB. Insofar as Canada's indigenous populations are concerned, the first nations and Inuit oral health surveys have shown repeatedly that they experience poorer oral health as compared with Canadians as a whole.

Compared with other OECD countries, Canada ranks among the highest in mean per capita spending on dental care, but the majority is funded by private insurance plans, which are not accessible to Canada's neediest. Canada requires leadership from the federal government to ensure that all Canadians have equitable access to appropriate health care professionals who can provide the highest quality care in the right setting and at the right time, based on their personal needs.

A profession's scope of practice encompasses the activities that practitioners can perform based on educational preparation and legislative authority. ln Canada, a profession's scope of practice is shaped by social, legislative, regulatory, and financial forces, which have often hindered the optimization of resources and the overall improvement of care. Currently, dental hygiene scopes of practice vary considerably across Canada, and these differences become apparent when comparing provincial and territorial legislation.

For example, Albertans have direct access to a dental hygienist with the broadest scope of practice in Canada. Dental hygienists in that province hold prescribing authority for schedule 1 drugs, can take and interpret radiographs, and provide local anaesthesia to alleviate oral pain during health procedures. ln contrast, federal programs, such as those offered by Veterans Affairs, prohibit dental hygienists from practising to their full scope by permitting only the most basic level of dental hygiene services for veterans. These services are based on the lowest common denominator of dental hygiene scope of practice.

● (1535)

Moreover, first nations communities often have little and/or infrequent access to oral health providers, yet the non-insured health benefits program for first nations does not recognize dental hygienists as direct oral care providers, even if they live on or near first nations communities, except in the province of Alberta.

We urge the federal government to move quickly to ensure that all NIHB program recipients have the same access to oral health services across the country.

In the north, supervisory provisions require dental hygienists to work under the direction of a dentist exclusively, which severely limits public access to oral health care. This requirement has been removed from almost all other provincial legislation, leaving Canada's northern populations decades behind the rest of the country.

The goal of a successful health care system is to deliver safe, effective, and efficient care. The best use of the health professions' scopes of practice embraces innovative solutions to meet the evolving needs of the public. For example, despite current regulatory barriers in the far north, CDHA has partnered with Health Canada and the Government of Nunavut in an innovative oral health project for children between the ages of zero and seven, living in all 19 Nunavut communities.

The government is funding a project where dental hygienists provide preventive services, which include temporary restorations called interim stabilization therapy, or IST, to prevent pain and preserve tooth structure until the child can be seen by a dentist. This project, launched in 2014, has encouraging preliminary results and is a compelling example of the creative and effective use of health human resources to meet the demands of a specific population. We have enclosed a photo collage from this project.

Dental hygienists advocate for a national dental hygiene standard of practice that maximizes scope of practice to ensure that all Canadians, no matter where they reside, can receive equitable oral health care services.

The alignment of optimal scopes of practice with innovative model of care through educational, legal, regulatory, and economic structures will require time and cooperation from all stakeholders. Education is governed provincially, but with dental hygiene programs offered in eight provinces and 37 institutions, there is a federal role for standardized curriculum and accreditation, as well as opportunities to invest in linking education with scope of practice, regardless of jurisdiction.

In addition, the federal government is ideally positioned to take a leadership role in supporting pan-Canadian health human resource planning and innovations and interprofessional models of care to achieve better health, better care, and better value.

The sustainability of the health care system requires cost-effective models of practice. We recommend that the federal government assume a greater role in health human resource planning and in supporting interprofessional collaboration. The ultimate goal of an equitable and sustainable system is for the transformation of scopes of practice and models of care to best meet the needs of Canadians.

To summarize, CDHA is submitting three recommendations for your consideration.

First, the federal government must recognize dental hygienists as service providers and extend oral health services to populations it serves through its federal health care programs.

Second, in order to ensure that all Canadians have equitable access to the right professional providing the highest quality of care in the right setting and at the right time, the federal government must review and amend outdated legislation related to scope of practice, particularly in the far north.

Third, the federal government must invest in education and training that supports comprehensive scopes of practice and must play a greater role in the pan-Canadian health human resource planning.

While we recognize health care as primarily regulated and delivered at the provincial and territorial levels, the federal government does have a key leadership role to play. With oral health disparities experienced by first nations and Inuit populations, and rising health care costs, it is imperative that we work together to ensure that Canadians have access to oral health services. We still have significant work to do to guarantee that Canada has the right mix of health care providers.

Once again, Mr. Chair, on behalf of the Canadian Dental Hygienists Association, we thank you for allowing us to contribute to this discussion. We look forward to working with the federal government and other stakeholders to implement these identified recommendations.

Thank you.

● (1540)

The Chair: Next up, the Canadian Dental Association, Mr. Soucy and Mr. Desjardins.

Dr. Benoit Soucy (Director, Clinical and Scientific Affairs, Canadian Dental Association): Thank you, Mr. Chair.

Good afternoon, everyone. I'm Benoit Soucy the director of clinical and scientific affairs at the Canadian Dental Association. Kevin Desjardins is the director of government relations.

It's our pleasure as the national representatives of Canada's dental profession to participate in your study of best practices and federal barriers related to the scope of practice and skill training of health professionals. There are more than 18,000 dentists in Canada. All are licensed by a provincial or territorial authority. Thanks to the work done in relation to chapter 7 of the Agreement on Internal Trade, all can move between Canadian jurisdictions without any need to have their professional competencies retested.

The majority of dentists work in private offices, either as solo practitioners or with one partner. The largest practices in the country can involve as many as as 30 to 40 dentists. Independently of their practice setting, all dentists involved in the delivery of oral health care in Canada share an important characteristic. They could not provide services to their patients at the same level of quality and as efficiently without the support of a dental team where each individual has a clearly defined role to fulfill.

Some members of the dental team, such as receptionists and practice managers, are completely unregulated because they are not directly involved in patient care. Others, such as assistants and dental hygienists, are regulated under models that vary from province to province and that in many cases provide for independent self-regulation, placing these occupations outside the purview of dental regulators.

In addition to these members of the dental team, three other occupations are involved in the delivery of oral health care in Canada: dental technicians, who are mainly involved in the fabrication of devices used by dentists in the treatment of their patients; denturists, whose scope of practice is related to the independent delivery of removable prostheses to those who are partially or completely missing teeth; and dental therapists, who are trained to deliver limited restorative and surgical services under the direct supervision of dentists.

Of these occupations, dental therapy is likely the one that has the most relevance to the work of the committee. Outside of Ontario and Quebec, where they are not allowed to practice, dental therapists have been used to improve access to care for children and for remote populations. In many cases they have been employees of the federal government working for the first nations and Inuit branch of Health Canada.

The National School of Dental Therapy, NSDT, was created in 1972 operated with funding from Health Canada until 2011 when the funding was discontinued. This was done because, in spite of its ongoing funding of the NSDT, Health Canada had chronic difficulties filling the positions it had available to serve first nations and Inuit living in remote areas, as the graduates of the program preferred working in urban dental offices in Saskatchewan and Manitoba, the two provinces where they could get licensed to practice.

The failure of the NSDT program to provide access to care in areas where it was intended does not mean that such results cannot be accomplished through actions related to scopes of practice. As mentioned above, dentists rely on the presence of dental assistants and dental hygienists in their offices to deliver quality care efficiently. Changes to provincial regulations, such as the introduction of scaling modules that allow an assistant to provide that service in provinces experiencing a shortage of dental hygienists, continue to improve the dentist’s ability to do so.

The presence of dental therapists in Saskatchewan improved access to care for children while economic evaluations of the federal program have demonstrated that dental therapy is a cost-effective means of providing care to children under specific circumstances. Outside of Canada, the use of dental therapists in New Zealand and Australia has been a success while preliminary evaluation of the impact of their use in Minnesota showed benefits that included direct costs savings, increased dental team productivity and improved patient satisfaction.

To achieve those positive results, these programs had to limit the new providers' ability to perform independently in the private system. Evidence has shown that, in many cases, the availability of additional types of providers will not reduce care prices or improve access to remote regions. They had to find ways to address the fact that dental fees in public programs do not meet the minimum amounts that are required to keep practices solvent, especially in remote locations with low population density. This was done by defining scopes for new providers in a fashion that allowed for reduced training times and reduced cost to the system, and by making the new providers salaried employees restricted to work in certain health settings to ensure they went where they were needed most.

● (1545)

In addition, successful programs provided sufficient, stable funding and managed to maintain the cost savings related to the reduced training time through careful management of the new providers' scope of practice over time.

Based on the experience of the programs discussed above, the Canadian Dental Association sees the following as best practices in relation to the scope of practice and the training of health care providers.

Only regulate occupations where the risk to patients justifies the cost of regulation.

Support regulation at the provincial levels with national systems of accreditation of educational programs and of certification of individuals to promote labour mobility.

Design scopes of practices for each of the involved occupations so they fulfill a real need and contribute to the safe and efficient delivery of care.

Identify all of the factors that could impact the success of new models for the delivery of care before they are implemented and put in place strategies to mitigate them. Such strategies will usually include reducing training time and costs to the system, preventing changes of scopes of practice that erode these savings, limiting the practice settings available to the new provider groups, and hiring them on a salaried basis to ensure they practice where they are needed.

I hope this short review of the experience of oral health care, with attempts to improve access to care through the introduction of new occupations and the broadening of the scopes of practice of others, will be useful to your work.

I thank you for your attention and will gladly answer any questions you may have.

The Chair: Thank you very much.

Next up is the Canadian Chiropractic Association, Mr. David and Mr. MacDonald.

Go ahead, please.

Dr. Ward MacDonald (Member, Canadian Chiropractic Association): Thank you very much, Mr. Chairman, for the invitation to present to the committee.

Good afternoon, honourable members. On behalf of the Canadian Chiropractic Association, or the CCA, the profession and its patients, it is my pleasure to be here today along with my colleague Dr. Robert David, chair of the CCA, and a chiropractor in Montreal, Quebec. My name is Dr. Ward MacDonald, and I'm a chiropractor in beautiful Wolfville, Nova Scotia.

The CCA is the national professional association representing 8,400 trained and regulated doctors of chiropractic. Doctors of chiropractic must complete a minimum of seven years of post-secondary education, including a four-year, full-time program at an accredited chiropractic college. The intensive training prepares chiropractors to serve as Canada's musculoskeletal experts, providing evidence-based, drug-free, and non-surgical conservative care.

As one of three chiropractors in Wolfville, I am often required to practice as a primary contact provider within my full scope of practice. My patients will commonly seek care for a variety of musculoskeletal conditions, and even non-musculoskeletal complaints. Because of my training and the shortage of practitioners in my community, I am asked to evaluate, diagnose, and help patients find appropriate care. I work closely with other health care providers to ensure that my treatment enhances the care that my patients are receiving from their MDs and others. I feel privileged to have this opportunity.

Musculoskeletal conditions are a much bigger pressure on the health care system than most people are aware. Eleven million Canadians each year are affected by back pain and other musculoskeletal issues. lt is the second leading reason for a doctor visit, and the number one cause of disability in overall health costs. This burden has increased by 45% over the past two decades and is expected to continue to grow, in part due to the aging population.

As doctors of chiropractic, we have the clinical skills and expertise to not only assess patients but aIso diagnose musculoskeletal conditions. These conditions are some of the most debilitating and taxing to Canadian society. Our goal is to return patients to their activities of daily living as quickly as possible.

The evidence in support of manual therapy and other chiropractic approaches has made chiropractors an increasingly valuable part of the collaborative care team. This allows teams to use health dollars more effectively in managing patients with musculoskeletal conditions. For example, a number of provinces are using chiropractors and advanced practice physiotherapists to assess and triage patients with chronic low back pain, awaiting referrals to specialists. Among these, 90% are not candidates for surgery, but they can crowd waitlists with unnecessary diagnostic imaging, such as MRIs and CTs. The outcomes include higher patient satisfaction, improved outcomes, and reduced system costs.

Musculoskeletal conditions are not only a provincial problem, but aIso of direct significance to the federal government. As the fifth-largest purchaser and provider of health care in Canada, the federal government has a direct and vital role to play in musculoskeletal health. Federal populations have a significantly higher incidence of back pain and other musculoskeletal conditions compared to the general population.

Most importantly, we need to talk about our Canadian Forces and veterans. Low back pain in the Canadian Forces is double that of the general population. These are young and fit men and women, yet musculoskeletal conditions are the reason for 53% of medical releases. Being a soldier is one of the most physically demanding careers. Without quick access to care, the result of that injury becomes chronic and can lead to medical release.

As musculoskeletal experts, our profession would like to do more. Currently, our soldiers have less access to chiropractic care than other federal employees. These injured soldiers go on to become veterans, and over half of the health claims made by veterans have a relationship to musculoskeletal conditions. Chronic pain from musculoskeletal conditions may not have the same profile as some other health conditions, but for those who suffer the impact can be profound. For example, musculoskeletal conditions can complicate treatments for mental health conditions if opiates are required for pain relief. As well, undue reliance on opiates can create dependency, with many related consequences.

● (1550)

I would now like to turn our presentation over to Dr. Robert David to outline opportunities that exist and the action the federal government can take to improve care of musculoskeletal conditions.

[*Translation*]

Robert David (Chair, Canadian Chiropractic Association): Thank you, Mr. MacDonald.

The federal government has been playing an instrumental role in innovation for many years. Such federal leadership contributed to the creation of St. Michael's Hospital Family Health Team. This hospital's project is an example of a collaborative care model based on nine provider groups, including medical doctors, nurses and chiropractors.

This model has grown and continues to operate successfully to meet the needs of patients and the community at large. As chiropractors, our role in this model has focused on better assessment and treatment of musculoskeletal, or MSK, conditions. St. Michael's Hospital Family Health Team was recognized as one of Canada's four centres of excellence in health.

There are a number of international models where MSK sufferers aIso have direct access to team-based care, including chiropractic care. The U.S. Department of Defense and Veterans Health Administration are two key examples. In Canada, Ontario and Saskatchewan have launched similar initiatives. These models of care can serve as benchmarks in assessing how team-based care could effectively serve federal populations.

ln December 2013, our association made a submission to the Standing Committee on National Defence and suggested the need to invest in the development of a comprehensive MSK strategy, emulating their efforts to develop a Mental Health Strategy.

A robust MSK strategy could address the significant burden of MSK conditions on the operational readiness and well-being of Canadian Forces members. We further recommended that both the Department of National Defence and Veterans Affairs Canada work collaboratively to reduce medical releases for MSK conditions.

Any recommendations from your committee should take into account this issue of need among federal populations and how best to utilize the practitioners already working in communities across Canada. We believe that advancements in the way we care for federal populations could also further benefit Canadians as a whole. Our association recommends that the federal government's approach seek to break down the silos between the various departments and better coordinate delivery of healthcare services by community-based providers.

Fortunately, the Canadian Chiropractic Association, or CCA, has observed first-hand how collaborative partnerships can help implement best practices to better serve federal populations. Notably, the Canadian Forces have taken important steps to better address the burden of MSK conditions for soldiers.

I would like to highlight the Canadian Forces' leadership for the support we have received during preliminary discussions on the merits of partnerships between the Canadian Forces and allied health providers to help support the care of soldiers. The CCA has committed to providing significant funding for a project designed to assess whether our soldiers could also benefit from the kind of access to chiropractic care that is in place for the U.S. military.

For the chiropractic profession, we already have a strong national scope of practice that establishes us as doctors delivering primary care for MSK conditions. We would welcome the chance to work with federal departments on developing new approaches that would not just improve health outcomes, but also use federal healthcare dollars more effectively.

We would be happy to further discuss any recommendations made, as well as provide more details on how MSK conditions are affecting Canadians. We can also share examples illustrating how we can use financial and human resources more efficiently.

Thank you very much for your time and attention. We will be happy to take your questions.

● (1555)

[*English*]

The Chair: Thank you very much.

The first round of questions is going to come from Ms. Moore.

[*Translation*]

Ms. Christine Moore (Abitibi—Témiscamingue, NDP): Before asking my questions, I would like to move a motion that we do not need to bring to a vote now. It reads as follows:

> That the Standing Committee on Health include in its study of Best Practices and Federal Barriers: Practice and Training of Healthcare Professionals the witness testimony from Meeting 47 (January 27, 2015) from its consideration of Bill C-608, An Act respecting a National Day of the Midwife.

I will now ask my questions.

In your three respective professions, not everyone has coverage. Often it is private insurers that pay, but people who are not covered by such insurance have to pay out of their own pockets.

In terms of access, it is not the mechanism that interests me. I would like to know what health problems could be prevented if the entire public had access to your health services.

I would also like to know whether you think that your skills are sometimes underutlilized.

In what specific areas could they be better utilized?

If we had better and more efficient access to your services, what would be the benefits to our health systems in terms of costs?

When it comes to affordable care, other ways of doing things sometimes cost more. In regard to chronic conditions and complications of health problems, I would like to know how much costs could be reduced if you could intervene at an earlier stage to help people's health.

I will let each association take a turn to answer this series of questions.

● (1600)

Robert David: There are indeed many of them.

Musculoskeletal problems are very significant and have a serious impact on Canadians' health, quality of life and productivity. These problems account for over a third of missed work days and half of all visits to doctors. This situation has become almost epidemic.

There is indeed a very high need for care. That is also why we are suggesting that a comprehensive MSK strategy be developed. This would first helps us analyze the people's needs and the reasons why there are so many musculoskeletal problems.

Then we should see what can be done to prevent these problems. Naturally, it would be necessary to have access to appropriate care. For example, it may happen that in a military base a person has access to spinal surgery for a problem that can be easily treated by conventional treatments that are not available. In this case, care is accessible, but it is not necessarily the right care in that situation. Accessibility is very important.

That is the first part of my answer.

Ms. Christine Moore: If you do not have some data on hand today, you may send it in writing to the committee chair.

Robert David: That is a good suggestion. We will certainly send you a document with our answers to the other questions.

Dr. Benoit Soucy: In regard to dentistry, over the last five years, Statistics Canada conducted a very thorough study on the needs of Canadians. The study showed that the vast majority of Canadians were receiving the care they needed.

Due to the lack of public coverage for these services, a segment of the population—about 20%—does not have access to the necessary care. We must therefore target this population through public programs. The association certainly recommends programs specifically intended for these people, who are also those with the highest levels of dental disease.

We know that 80% of all cavities are found in the poorest segment of the population, which represents 20% of all Canadians. This is a major problem because it is entirely possible to prevent cavities. There is no problem preventing them, provided the necessary resources are there.

One of these resources is, unfortunately, education, while one of the factors that predict the occurrence of tooth decay and periodontal disease is socioeconomic level. If we were able to provide assistance in these areas, it would be very useful.

Dentists already have a relatively broad scope of practice, which allows them to diagnose, do surgery and use nearly all the approaches needed for the treatment of maxillofacial structures. Dentists can prescribe appropriate medication to treat these conditions. Therefore, we do not really have huge problems in terms of our scope of practice. We are able to deal with whatever problems we have with little difficulty.

When we do nothing and allow problems to go unchecked, we end up facing problems that are much more complicated and much more expensive. For example, it is well known that the main cause of surgery under general anesthesia in children is tooth decay. All these surgeries are easily predictable if the children are properly monitored in care. This is one reason why we propose that children be seen from the age of one at the latest, within six months of the eruption of the first tooth, so that we can intervene, predict and assess the risk of cavities, and act appropriately.

The use of hospital emergency services is another area where there are very high costs. There are not many reasons why a patient with dental problems should have to use a hospital's emergency department. Dentists can provide all the treatments needed. Many dental societies organize emergency services to deliver care around the clock. That is not available everywhere, but it is very common.

Therefore, there is no reason to go to a hospital. In most cases, people who go there do so for financial reasons, and treating them in a dental clinic would be much more efficient and less costly for the system.

● (1605)

[*English*]

The Chair: Okay, Ms. Wright, a brief response, then time is up.

Ms. Ann Wright: Thank you.

I'll ask my colleague Victoria to answer that.

Ms. Victoria Leck (Manager, Professional Development, Canadian Dental Hygienists Association): I agree with much of what has been said by the Canadian Dental Association. There are targeted populations who, even though they have financial access to programs through first nations and Inuit health, still do not have access to the providers who can give them the care that they require.

It's not just a financial need or a need to expand access to programs, it's a need to have the right providers available to the populations that are most at risk. Social and economic situations are definitely impactful in oral health care. As the CDA said, many of the conditions are preventable. Early interventions by a prevention specialist, a dental hygienist, could have a positive impact in providing education to the families and to establishing good oral health care habits early in life.

The Chair: Thank you very much.

Mr. Lunney, sir.

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

Welcome to all of our witnesses today. I wanted to pick up where Ms. Moore was in talking about cost savings. She had directed that at the Canadian Chiropractic Association.

We're all concerned about sustainability of health care services and the accelerating costs. You mentioned a third of absentee-from-work situations involve MSK, musculoskeletal conditions, and half of medical visits, and you mentioned a global strategy for managing the costs of MSK.

I'm going to flip back the calendar a bit to...I think it was 1993. I believe it was the Ontario government that commissioned a report from a health care economist right here in Ottawa, Pran Manga, who studied chiropractic efficiency in managing low back pain alone, I believe, at that time. It was called the Manga report. I think his conclusion was that in Ontario alone they'd save hundreds of millions of dollars by employing an MSK strategy that would have chiropractors be primary contact practitioners that would engage first, just on low back pain.

I wondered if you could comment on the outcomes of that report. Was it a missed opportunity?

Dr. Ward MacDonald: Even just speaking back to earlier interventions and their success, the largest part of the burden represents about 30% of the patients who become chronic with musculoskeletal conditions.

Many models are built right now on getting early access so that conditions can be treated effectively before they become chronic. There are many models that have shown the cost effectiveness of having that early intervention. Many models exist right now where that is the primary focus. Anything that eliminates the barriers for patients to be able to get appropriate care at the right time has shown in many models to be cost effective. We're happy to provide more information with regard to those models.

Mr. James Lunney: You mentioned a couple of examples of integrative care successes. I think it was St. Michael's Hospital. There are some very promising studies. You were talking about the United States model with the military. You said that the U.S. Department of Defense and Veterans Health Administration are two key examples, and that studies demonstrated that integration of chiropractic care to standard medical care improved pain and function without increasing costs, due to a strengthened team.

Could you tell us a little bit more about the U.S. experience with the military?

Robert David: Actually there are models even closer than that. Here in Ontario there have been some projects by the province to integrate the chiropractor as a secondary adviser for musculoskeletal conditions within a medical setting. It was a great success and the patient satisfaction.... The medical doctor appreciated the suggestions made by the chiropractor in order to orient the patient towards the kind of conservative care that he needed.

Again, this is a process of triage. People who desperately needed medical attention from a specialist got it faster. When you look at it from the patient's point of view, who's on a waiting to see an orthopaedic surgeon and knows that the list is two years in front of them, to have somebody come to them, assess them, and say that they really do need medical attention, then they're going to get it sooner because we've cleared the waiting time of a year and a half. It's terrific news. For the patient it's wonderful to have collaborative care like this.

● (1610)

Mr. James Lunney: You can have some long wait times for a specialist, and that's a missed opportunity if your problem is degenerating in the meantime.

Can you give me an idea of the study that you said was here in Ontario? Where did it happen? How long did it run? Was it a pilot program? Is it still ongoing?

Robert David: I don't have that information right here but I'll make sure that it's forwarded to the committee within a few weeks.

Mr. James Lunney: Okay, we thank you for that.

You mentioned practising in Wolfville earlier—I think it was Dr. MacDonald. You mentioned quite a percentage that was musculoskeletal—I've forgotten what percentage—but also another range of conditions that you have to get involved in.

For full disclosure, one of my colleagues suggested that I declare my conflict of interest here as a chiropractor for 24 years. We're called the House of Commons and we represent a lot of different backgrounds here.

I think people are surprised that chiropractors study the wide range of subject matter that we do, including obstetrics and gynecology, the medical doctor at here at the table with us as well. It's not that we're going to be delivering babies, but if you're practising up in Nunavut or in the boondocks somewhere and you're it—we've had the midwives here—and it's up to you to be the primary birth assistant, it's very helpful to know something about the process.

Could you just comment on chiropractors as primary care practitioners—I think you mentioned 8,400—and integration? You gave a couple of examples, but I see examples across the country of integrative care that includes dieticians, physiotherapists, and psychologists sometimes, but there is no chiropractor on that health care team. Are there missed opportunities in integration? Is there an opportunity to better integrate chiropractic services?

Robert David: You are right, for sure. St. Michael's again is a great example of where chiropractic is integrated. It's a multi-disciplinary setting with nine professions within a hospital in downtown Toronto addressing the needs of musculoskeletal conditions for a low socio-economic community. It has had wonderful results. This is a program that has been going on for at least 10 years, but I'm not sure about the length of time. It's also giving care to the patient who couldn't afford it in this particular instance. It's a total success.

We would be happy to forward you some more information on that one.

Mr. James Lunney: You mentioned a study on advanced diagnostics like MRI and a $25-million saving. Could you tell us more about that study? Where did that take place?

Dr. Ward MacDonald: There's one model in Alberta which is the spinal health centre. It was an idea that started, like with many great ideas, over a beer.

A chiropractor and his two neurosurgeons were sitting around complaining about their workload. The neurosurgeons said they had a stack of faxes on their desk this thick of referrals from medical doctors for patients that have back pain and leg pain, and they knew most of them did not need surgery, but they still had to see them.

They set up a triage system where patients could be assessed prior to coming in to see the surgeon so they wouldn't have to wait two years to be told they don't need surgery and they needed to go somewhere else. The doctors were able to turn things around within weeks of seeing the patient, getting them the care they needed properly.

The patients are happy because they are getting care quickly and getting relief quickly. The doctors are happy because the patients they are seeing are high-yield patients that give them good outcomes as well. The cost of this more conservative approach was enjoyed by all.

As chiropractors we are trained as primary care practitioners, and while 95% of aches and pains that come into my office are mechanical in nature, we are still trained to pick up on the other 5% that are not, that are more serious and need a proper referral. This is where our training to be able to recognize these things and work with other providers within the community is important.

Patients trust us as well. We build a relationship with them so they will come to us with their health questions. If we don't have the answer, to have the network of supporting professionals around us allows us to serve them better.

● (1615)

Mr. James Lunney: Mr. Chair, can I ask a question that they could send us some information on very quickly?

The Chair: Briefly....

Mr. James Lunney: You mentioned about triage with chiropractors and advanced practice physiotherapists doing triage ahead of time in several provinces. Could you at least send us some information on where that's happening, and which provinces, and whatever information you have on that?

The Chair: Thank you, Mr. Lunney.

It's little bonus round today for you with the chiropractors in town.

Ms. Fry.

Hon. Hedy Fry (Vancouver Centre, Lib.): Thank you very much, Mr. Chair. I want to thank the witnesses for coming today.

We're talking about scope of practice here, and as you all know the big question today is: is medicare sustainable? But it shouldn't be "is medicare sustainable?" It should be: is the delivery of health care going to be sustainable under a public system?

I think we're looking at how we shift the system, change it completely, so that chronic care and chronic management is done by community groups in a multidisciplinary integrated system.

I heard the chiropractor saying they could work in that system, and the thing is that they should be able to work in that system as we look at how we do a lot of prevention and promotion, and then move into care when somebody is sick, and then chronic management of care as they get older.

The question I have is not for you because I know you are capable of being integrated into that. My question is to the dentists and the dental hygienists because currently one of the things we know is that poor oral health leads to heart disease, etc. It's now been found to have that strong link between oral health and illness, chronic disease, etc.

I know that dentists and hygienists, although in certain sectors you are capable of working within the system, are in a private system mostly, except in certain areas like the north. Do you see a role for dentists and for dental hygienists to play within their scopes of practice, working within this multidisciplinary system? How do you see that happening?

It would mean the dentist in many places would have to move out of private practice—well, not private practice because many practitioners provide private practice out of the public system, but out of the private system you currently work in and into a publicly administered system of care.

How do you see that happening? Do you think that's feasible? We could then be able to work on getting to young children earlier, getting to dentureless seniors earlier. How do you see that working? How do you see that integrating itself into a system that would mean a huge systemic change here for the way you practise?

Dr. Benoit Soucy: There's no doubt dentistry is practised in isolation from the rest of the health system, but there are some very significant interfaces where dentistry is practised within the health care system.

This area is mostly in two specialties, and the two specialties need surgical facilities to do their work. Oral maxillofacial surgeons and pediatric dentists practise largely in hospital settings. Depending on the province, some of their services are covered by provincial medicare programs.

There's a lot of variability at that level, and there are some contradictions. If you go to the hospital in Quebec to have your wisdom teeth taken out, it will be covered by RAMQ. If you get that in a private office, it won't be. The same service, different setting, different coverage.... That is something we've learned to deal with and to manage to the best of our ability.

Hon. Hedy Fry: Sorry, Dr. Soucy, you're talking about acute care hospital care, and I think the thing is that it's moving out of the acute care hospital care system into chronic management and early intervention or early prevention.

Do you see your scope of practice broadening to fit into that area through a public administrative model?

Dr. Benoit Soucy: You talked about the correlation between a lot of periodontal disease and general health, systemic health, and that is forcing us into those areas. The model of care is changing within dental offices so that instead of treating only acute problems, we're treating chronic problems. We're following patients. A lot of times patients will come twice a year to dental offices. In one visit they will see the dentist to get a diagnosis. The second time they won't even see the dentist. They will work with the hygienist and receive the care they need at that level to maintain the situation that has been diagnosed. Those things are happening.

The only thing that is problematic, that is difficult, is how you move that into a public setting. The private part works extremely well for a large number of Canadians, so you don't want to disturb that. You just want to make sure that those who do not have access get access appropriately through targeted programs that look at their needs specifically and try to improve them and help them to receive the care they need at the time they need it.

● (1620)

Hon. Hedy Fry: I would like to see if we could explore that as we move through this, because, as you well know, physicians and chiropractors and a lot of health care providers actually run private practices even within...because the system is public administration, not public delivery. The thing is that if you wanted to move dentists into an integrated system, obviously there would be professional push-back. Come on—that's just reality. But how would you see that happening if, say, we started by saying that all children up to the age of seven could be moved into the public system? How would that work? How would dentists react? As we look at seniors care, would dentists see themselves automatically moving into an integrated system for seniors care?

Dr. Benoit Soucy: We actually used to have that for children. When I grew up in Quebec, children under the age of 18 were all covered by RAMQ, and we got very good care. Saskatchewan was the pioneer in that area. It was also the first to cut back on its program. One of the impacts we see is that we're going back to levels of cavities in children that were seen before those programs existed.

I don't think you would get too much push-back with regard to programs targeted at children, because we have experience with those and we know they work.

Seniors are more problematic, and the reason they're more problematic is that we are too successful in our work. We're keeping teeth in the mouths of those seniors for a long time, and when they retire and lose their employment benefits, they end up with a lot of teeth that require a lot of care and they have no coverage of any kind. We haven't found a good way to address that problem.

Hon. Hedy Fry: Can I get a quick one-two from the hygienist? I know I talked to you about this, but go ahead.

Ms. Ann Wright: We have a little bit of a different perspective on this. Certainly it's not a human health resources numbers issue with dental hygiene. As I said, there are 26,000 dental hygienists in Canada, so there are a lot of dental hygienists who wish to practise in all different areas.

The issue for dental hygiene has been awareness of what we do and what we can do, and with the rise of self-regulation, meaning dental hygienists are self-regulated, we have the opportunity now to work interprofessionally, and we want to work interprofessionally in public health, in hospitals, and in interprofessional groups.

The issue is informing the people who are the decision-makers that we are a great group to include in these programs. What I outlined in my oral presentation had to do with family violence, because 50% of injuries associated with family violence occur in the head, neck, and face. Who better to recognize something than your trusted dental hygienist, who you see on a friendly basis in more cases than not?

As I said, we are very proud to have been invited to the minister's round table.

The Chair: Thanks very much.

Ms. McLeod.

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): Thank you. I too would like to thank all the speakers for coming here today.

I'm actually going to pick up on some of the discussion around dental care and the dental hygienists.

Dr. Soucy, you said the dental therapist program is not being funded anymore. Is it still in place, and how long is that program?

Dr. Benoit Soucy: There are about 200 dental therapists who are still practising in Canada. The majority of them are practising within dental offices in Saskatchewan and Manitoba, and they're providing care to children.

There is no longer a training program for new therapists, so we expect that number will go down over the next few years.

● (1625)

Mrs. Cathy McLeod: What my question is, and this is where I perhaps can talk to the hygienists because we know up north we have the significant issue that dental therapists used to provide some good support in a northern community. What was within the scope of a dental therapist? You have a great scope of practice. Are there things in the scope of a dental therapist that are not in your current scope that could be easily attained? Is this where we should be doing a bit of thinking about a shift? I'll let both of you respond.

Ms. Victoria Leck: That's a great question.

Actually, the federal government released a great report in 1971, the ad hoc report on dental auxiliaries. You may want to dig that out of the archives and take a look at it. They talked about this very same issue, about access to care for vulnerable populations and making equitable access for all Canadians. The recommendation from the committee at that time was that dental hygienists' scope of practice could be expanded to include some further opportunities for them to intervene.

There was a program where dental hygienists in the military, after a certain number of years, were eligible to go back and receive additional training and become a dental therapist. This model is also being used in other jurisdictions around the world where they have dual designation as a dental hygienist and a dental therapist, similarly to a nurse practitioner going back, after becoming a nurse, for additional training to become a nurse practitioner. A similar model has been used elsewhere for dental hygienists to become dental therapists, to have the dual designation.

But there are some things that are in our current scope of practice that we can do to intervene and to provide temporary relief of situations where there is no dentist available. An expanded scope of practice for dental hygienists could be considered.

Mrs. Cathy McLeod: I understand the dental association—

Dr. Benoit Soucy: The scope of practice of an oral health care provider is essentially divided into three tiers.

Dental assistants and dental hygienists can provide care that is reversible. Any act that is reversible can be done at that level according to the regulations. Obviously, assistants have a very restricted scope of what they can provide directly on patients. Hygienists have a much broader scope, but the services they are providing are essentially reversible.

Dental therapists are intermediate mid-level providers because they can do irreversible services. They can do simple extractions. They can do restorations. They can remove dental material to do restorations.

The thing that none of these groups can do outside of Alberta—Alberta is a bit of a special situation—is diagnosis. Only the dentist can provide the whole meal deal providing the restoration, doing the irreversible acts, and base the care on a diagnosis that has been done of the patient.

That's really where you have the difficulty moving from one scope to the other.

In order to be able to do reversible acts you have to have a certain type of training. In order to do the diagnostic you have a certain type of training that is based on a lot of fundamental basic science courses that are not necessarily provided to the other occupations. That's where the transfer becomes difficult. There is no doubt that the hygienist who goes back to dental school, gets a lot of credits, and can go through dental school easily because they have some of the work that was done before, but they still need to learn all of those additional skills.

Mrs. Cathy McLeod: I think we talked about our northern populations and how there is a lack of care. We talked about a pretty big pool of practitioners who could do great work in those settings. What would it take to move to that therapist level? I would think it would be a much simpler program than the dental therapy program as it did exist.

Ms. Ann Wright: We've just completed a bachelor of competencies for degree-entry practice for dental hygiene across Canada. That's something that we feel very strongly about with changes in technology, changing with what dental hygienists do.

I'm glad you mentioned dental therapy because that's the primary reason that we are now working with the Nunavut program, because there are no dental therapists who work in Nunavut and there were almost no dental hygienists working up there. This was, again, a very innovative program to bring dental hygiene up to Nunavut. As I said, we only have a year under our belt but the preliminary results are very encouraging for what we do.

Just to correct Dr. Soucy a little bit, dental hygienists do communicate a dental hygiene diagnosis, they don't complete a complete oral diagnosis.

● (1630)

The Chair: Thanks very much.

We're going to suspend for a minute or two. We're going to excuse our guests and bring in our next panel.

● (1630)

(Pause)

● (1635)

The Chair: Welcome back, ladies and gentlemen. We're back in session. We have three more guests to present this afternoon.

We have the Canadian Association of Occupational Therapists, Canadian Physiotherapy Association, and the Paramedic Association of Canada.

First up is going to be the Canadian Association of Occupational Therapists.

Ms. Guitard, you have 10 minutes.

Dr. Paulette Guitard (Professor and Former President, Canadian Association of Occupational Therapists): Thank you.

My name is Paulette Guitard and I am an occupational therapist. I am an associate professor at the University of Ottawa and also the director of the occupational therapy program there. I've just finished my term as president of the Canadian Association of Occupational Therapists that I am representing today, and we thank you all for your invitation.

Before I delve into the subject, I would like to give you a brief overview of our profession and our association.

Occupational therapy came into existence around 1915, just after the First World War when the soldiers were coming back with their injuries and trying to transition to their daily lives. Occupational therapists helped them restore, through meaningful occupation, their physical issues, mental health issues, and their social capabilities.

Today our CAOT, which was founded in 1926, has about 9,000 members, and we represent 15,000 occupational therapists within the country with a master's level entry to practice. We also have post-graduate degrees in areas of specialization.

As occupational therapists we help people do the occupations that are meaningful to them in their everyday lives, and by occupation I mean everything the person does from the time they get up in the morning to the time they go to bed at night, whether it is paid work, going to the bank, driving to the bank, playing with your child, or watching a hockey game with friends.

As occupational therapists we ensure that the person has the skills to meet their occupation and we also look at the environment in which the occupation is being done to ensure there is a perfect fit between all of them.

Just to let you know, we work with people of all ages and we work mostly in hospitals, schools, homes, everywhere where people have occupations.

Coming back to the subject, there are four things we would like to talk to you about, where in the federal arena, the occupational therapist scope of practice could be better used: better representation in first nations and Inuit communities; veterans communities; correctional services; and also general health and community care, especially for the aging population.

Starting with the first nations and Inuit communities, the first problem is access. There is very limited occupational therapy service able to serve that population. In B.C., for example, less than 5% of the occupational therapists are employed in remote first nations communities, so access for those people is very limited.

There are several things we can do to increase that. One of the things we've noticed in education is that when people are trained, they go back to where they came from. If we can get youth from the first nations and Inuit communities into specific programs, they could go back to serve their communities, and that would be helpful.

We might also look at foreign trained professionals. More and more there are demands for foreign trained people to come to Canada. It's my understanding that occupational therapy is no longer a part of the national occupational classification, so that foreign-trained occupational therapists can take advantage of the express entry system under the federal skilled worker program.

That would be something we could look at because there are roughly 175 foreign-trained occupational therapists who take the national certification examination every year. As of May 2015 it will cost a foreign-trained OT about $4,000 to qualify to practise in Canada, so if there could be some funding available, that would be helpful. Maybe in return, they could have a period of time that they could devote to this community, which would also help.

The second thing is that the non-insured health benefits program is causing a lot of frustration. When you have an occupational therapist who is meeting with a client who needs a wheelchair, for example, the occupational therapist completes his or her assessment, talks to the supplier, the supplier might even be in another territory or another province, and then that person needs to go back to the program. Then the program comes back to the supplier, who then goes back to the OT, and it takes months before the person actually gets the wheelchair, so they are limited within their occupation during all that time. If there were a clearer process, we believe these people would be better served by our skilled people.

I mentioned that occupational therapy started after World War I. It's very interesting to see that today there is very limited occupational therapy within veterans' services.

● (1640)

We've tried over the last few years to make some headway. We have, but there's still very limited occupational therapy involvement for these people who are coming back from outside of the country. Occupational therapists are employed as policy analysts and case managers, which is not necessarily a bad thing, but it prevents the client from having direct access to an occupational therapist who will be able to help them return to the occupation that is meaningful to them.

Where OTs are employed, it's often on a contractual basis. They're relegated to the periphery and not included in the decision-making for their client. This also limits our scope of practice. Privately contracted OTs are sometimes also used to review reports, and this is not an effective use of OT scopes of practice, education, training, or competency and skill sets. We can also help not only with the injuries but with the transition from military to civilian life.

The other sector is correctional services. This is another federal arena where there are very few OTs who are involved, and as we all know, this population has a lot of mental health issues. This is one of the arenas where occupational therapists can have an impact. These people are going back to their communities without having developed any better coping skills than they had before they went into prison. It's a perpetual circle. We would be hoping to make headway into the correctional services to have better service for that population.

With regard to health care in community and the aging population, we would like to talk briefly about some of the initiatives our association has done to help older adults live more independently and as actively as possible.

We've worked a lot on the older driver blueprint. The goal is to help older adults maintain their licences for as long as possible, but to be safe because we're all sharing the road. We believe there are a lot of things that we can do. As part of that, we are hosting the CarFit educational program. That's another initiative where we have partnered with CAA. We've noticed, and there are statistics from Transport Canada, that a lot of older adults or seniors are driving and there are a lot of fatalities. We also know that a lot of times these happen because the cars are not properly adapted to the person. There are a lot of adjustments that can be done, but older adults do not know about these and don't know how to do them. For about $500, we can host an event where we can show people how to be better suited in their own cars and make sure that the car is best suited to them.

Another project would be elder abuse. This project came into effect because a lot of our members were working in homes and asking us what to do when they suspect elder abuse. We got some funding to look at this issue, and now we're hosting train the trainer programs to train people to prevent, detect, and intervene appropriately when elder abuse is taking place. This is not just for occupational therapists, but we're broadening this to physiotherapists, speech language pathologists, nurses, social workers, anybody who's working with the elderly population.

I would like to conclude by saying that one of the things that would be helpful would be to look at OT as a return on investment. When you look at costs, a day in a hospital is about $1,000 very minimally, and it's $130 for a long-term care facility. One day at a supportive housing or home in community care costs about $55. Occupational therapists are looking at helping people to stay in their homes longer and safer, so we're keeping people out of the hospitals and saving the system a lot of money.

Lastly, one of the things we would like is that occupational therapy be included in the extended health benefits for federal workers; that is not always the case. There's a limited amount of money, so people who require our services are not able to get them.

● (1645)

I would stop there, if you would have any questions.

The Chair: Thank you very much.

Next up is the Canadian Physiotherapy Association.

Ms. O'Connor, go ahead.

Ms. Kate O'Connor (Director, Policy and Research, Canadian Physiotherapy Association): Thank you very much. It's a pleasure to be here this afternoon.

On behalf of the Canadian Physiotherapy Association, I'd like to thank you for this opportunity to speak to best practices and federal barriers related to the scope of practice of Canadian health care professionals. I think this is an extremely important topic, as there are many different health professionals looking to work through interprofessional collaboration, and it's not always possible. There are a lot of local innovations that aren't necessarily spread throughout the system.

One of the most important changes to improve efficiency in health care today is the integration of this interprofessional collaboration in a variety of different primary health care settings. The benefits of interdisciplinary team-based care have been clearly demonstrated in research, with very positive outcomes, including better access to services, shorter wait times, better coordination of care, and more comprehensive care than from a single health care provider alone.

Physiotherapists are among health professionals who have the qualifications and skills to share responsibility for the provision of care with the family physician and with other health care providers. They have advanced knowledge in the assessment and diagnosis of conditions and injuries, and it's all within their scope of practice.

Today I'd like to focus my comments on three specific areas where the federal government can play more of a leadership role: first, to align federal health programs and permit health professionals to work to their maximum scope of practice; second, to support best practice through collaboration and communication with health professionals in areas of federal health programs; and third, to support skills training for physiotherapists and other health professionals who are working in rural and remote areas.

To begin, aligning federal health programs with recognized scope of practice is a bit of a challenge, and we do recognize this, because many health professionals are regulated by provincial bodies. It's a bit of a patchwork quilt to be able to match the provincial regulatory bodies and regulations and the scope of practice with what is happening federally. However, we do see that there's an opportunity where there can be better alignment with provinces and regions, particularly because within federal programs there are a lot of regional offices that do oversee the health provisions under the programs.

I'll use the NIHB program, the non-insured health benefits program, as an example of where there are barriers to working to full scope of practice. I'd like to reiterate Dr. Guitard's comments around the challenges of access to care. Really, the barriers to appropriate care in this program do include these gaps in access to the right professionals, who can deliver the right care at the right time to improve health outcomes and quality of life. Evidence shows that there are significant opportunities for cost savings when there is a focus on prevention and promotion of health, but more important, there's an immediate need to curb epidemics of obesity, diabetes, and asthma, and to focus on injury prevention and ending addictions.

When Minister Ambrose announced the review of the non-insured health benefits program in 2014, we took that opportunity to reach out to our members to find out what their challenges are with the NIHB program. We really wanted to better understand what physiotherapists are doing and how they're working within the program and to possibly help inform a better direction for the future.

What we learned is that while there are regional variations in the program and the regulation of physiotherapy, the federal program is not consistent and does not recognize or support current scopes of practice of physiotherapists. One of the biggest challenges we see as physiotherapists is not just that they're not quite aligned with the scope of practice, but that their scope within the federal program is actually quite minimal, where they're only allowed to prescribe or order assisted devices and supports for individuals, for example, rather than actually working to fully use their knowledge and competencies to improve the health and well-being of the individual.

In practice, what this really means is that physiotherapists are regulated, so if you're working in northern Alberta, you're regulated within the Province of Alberta to work to your full scope of practice, but as soon as you step onto a reserve to provide care or services, that scope is no longer recognized. There's a great variation in the ability—and the inability—to really work to full capacity under the NIHB program.

The recommendation for this is really to look at the evidence. There's strong evidence in favour of positive patient outcomes at a lower price if governments are willing to invest in interdisciplinary models of care to maximize health outcomes.

● (1650)

We call on the federal government to actually look at how to maximize scopes of practice within federal programs, such as the NIHB program, and invest in interdisciplinary models of care that truly reflect these models.

To go back to one of Dr. Guitard's points, if a physiotherapist, for example, were to work under the NIHB program, they would not only have to look at suppliers but call the doctor to ask for the doctor to sign off on what they would be prescribing as an appropriate device, when the doctor has never seen this patient. The physiotherapist actually does have the scope to order it on their own, but under the program, they aren't able to actually follow through with their full scope of competencies.

The second point I'll make is around supporting best practice through collaboration and communication with health professionals. Evidence has shown that direct access to physiotherapy services decreases total health care costs. This is because patients require fewer visits with their general practitioners and they require fewer prescriptions. Patients require less referrals for radiographs, less referrals for secondary care, and a decreased need for invasive treatments. An example of cost treatment per episode is with patients with musculoskeletal conditions. It is much less when patients are treated by physiotherapists, making additional health care dollars available for other more critical medical services.

To fully achieve these interprofessional models of care within the federal health programs, we have to look at examples of communication and collaboration at the systems level rather than looking at the local level for how to improve care. Without this change, we'll continue to have local-level efficiencies but with very little system-wide change. If we reverse it so that there's better communication at the systems level, we can actually improve the efficiency at all levels under the larger umbrella.

Our second recommendation is to reinstate the federal health care partnership program. The federal health care partnership program, if you're not aware, was created to achieve economies of scale while enhancing the provision of care. Under the program, federal departments responsible for the delivery of health services would meet regularly with health professional groups to identify gaps and concerns and provide strategic leadership. While there are still some ongoing agreements between various departments and associations, the program on the whole has been disbanded. CPA would like to see this program reinstated, as we see it as a best practice model. We believe if it were to be reinstated, it could facilitate strategic partnerships with key stakeholders in support of better programs, interdisciplinary care, and evidence-based policy development.

The third area I'll focus on is federal support for skills training. Physiotherapists are health care professionals who have demonstrated advanced knowledge and scope of practice and a unique value to solve problems within Canada's health systems. However, there's a disconnect between physiotherapy education programs that provide this advanced skills education and training for health professionals and the recruitment and retention of physiotherapists in rural and remote areas. I know that physiotherapists aren't alone in this challenge. It's across the board. Rural and remote areas struggle to recruit and retain the best of the best, because they're often going to urban areas. However, of significant concern to CPA is the challenge of filling vacancies or getting access to physiotherapy in many regions across Canada.

For example, in 2014 the Physiotherapy Association of British Columbia reported that vacancies across B.C. reached 267 positions, which was last audited at the end of 2013. These 267 vacancies represented a substantial gap between the nearly 3,000 practising physiotherapists in the province and the need for a least 10% more physical therapists to fill the immediate need, not to mention the need in the future. At this time the physical therapy community of B. C. has urged the Ministry of Advanced Education to immediately expand the UBC physical therapy department to 132 seats through a distributive model that would better address challenges for Fraser Health in northern B.C.

● (1655)

Now, I understand that this a provincial issue, but it does reflect on federal responsibility as well, because we do see evidence to suggest that models of distributive education across the country actually do enhance recruitment and retention in rural areas. We would like to see this opportunity extended to physiotherapy programs and other programs that would allow for a more stable health care workforce that will meet the urgent need in various regions.

B.C. is not alone in its challenge in filling vacancies in rural and remote regions. We also see, through the Manitoba Physiotherapy Association, that there's a top priority to improve access to physiotherapy in rural and remote parts of the province because there's only a handful of publicly funded physiotherapists outside of the Winnipeg region. Nova Scotia is also fearful of the impact of vacancies. because what happens in Nova Scotia is that if a vacancy is left open for too long, the vacancy disappears rather than having it filled.

We see that the solution is more about health human resource planning as opposed to provincial jurisdiction over education.

So the third recommendation is about expanding the—

The Chair: We are over time, so I wonder if you'd be able to sum it up in the next 30 seconds or so.

Ms. Kate O'Connor: Yes.

So, the third recommendation is about expanding the CanLearn program to rehabilitation professionals working in rural and remote areas.

In conclusion, I'll just say that I don't think it's news that many Canadians don't have access to the right care or the right professional. We would like to see better coordination of care and services through different levers from the federal government.

Thank you.

The Chair: Okay. Thank you very much.

From the Paramedic Association of Canada, Mr. Poirier. Go ahead, sir.

[*Translation*]

Mr. Pierre Poirier (Executive Director, Paramedic Association of Canada): Thank you, Mr. Chair.

My name is Pierre Poirier, and I am the executive director for the Paramedic Association of Canada.

[*English*]

Thank you for the opportunity to speak today.

I have a few notes, and hopefully I'll be brief, in recognizing the time of day.

In some ways the short answer to the question regarding the best practices and the federal barriers is that the federal government continue to be engaged in the development of professional scopes of practice. The paramedic best practice probably already does exist in many locations within Canada, and that's also international recognition, and the federal government should continue to support curriculum development in alignment with those scopes of practice.

Just a bit of history, there are about 40,000 paramedics in the country. We're arguably the third-largest health care group in the country, following nurses and physicians. Our nomenclature is related to three classes of paramedics: primary care, advanced care, and critical care. The education related to that is at the diploma level. It's two years to be at primary care, probably a third year to be at advanced care, and subsequent training to that for critical care.

We're throughout the country. A bit of our history includes the contemporary history, probably transitioning in the 1970s in Calgary away from ambulance drivers, where enhanced training started to be provided. In Toronto there were advanced care paramedics starting in the 1980s. In the 1990s you saw many other provinces come on board with recognition of education. The key element to the transition for paramedics in this country, and our contribution to health care delivery, was the support in 1997 from Human Resources and Skills Development Canada—I'm not sure what the title was at that time—of the development of a national profile for paramedics. That was a key contribution from the federal government that helped create a national view of what a paramedic was. There were over 50-odd different titles for what we did at the time. Right now we recognize that there are essentially three for the profession. Different jurisdictions across the country have different titles, but essentially they are all trained to be three specific titles.

Our scope of practice is varied across the country, and that's a result of our health care framework in recognition of the province's authority over health care to a large degree. Paramedics, in terms of their scope, do incredible things in terms of the ability to save a life. All of the interventions are about that. What we're seeing today is the development of a community paramedic and our ability to, I wouldn't say intervene, but contribute to health care in many different ways that are not necessarily in the critical or the emergency situations.

I was thinking about this in a broader context, and my apologies for that. In some respects the Canada Health Act doesn't recognize paramedics. It doesn't recognize us in terms of our environment. When you talk about ensured health services, that limits us to hospitals and physician services and doesn't include what we do outside of that. I think there's an opportunity there to look at the broader scope of how we view the health act and how the federal government could be engaged in what paramedics do.

I think we're at a transition time where, when we look at health care delivery models, another dollar added isn't necessarily of equal value in terms of what it was previously. To look at it in a different sense, I think there should be a recognition of interprofessional collaboration and unexclusive scopes of practice, particularly opening up scopes of practice and reducing the ability to have exclusivity in areas of treatment. A good example of that recently is in Alberta with the Health Professions Act, where it was recognized that colleges would apply for the ability to make use of restricted activities. Everything that wasn't a restricted activity was open to the health care system and for different colleges to provide that service. Colleges could, by themselves, build the argument to access these restricted activities. That's really opened up the realm of how health care can be delivered. That's an important piece for us to look at. I think there's an opportunity for national leadership from the federal government on this issue of looking at scopes of practice in a much more open way.

Recently there was documentation with respect to the “Optimizing Scopes of Practice” document, which talks specifically about not having exclusive scopes and not having siloed regulation or siloed concepts at how we look at health care.

● (1700)

Another area where the federal government could take a leadership role would be looking at how we combine what is current practice or how professions practise, how paramedics practise, and how we can integrate that into the system and recognize those as different skills, and all those skills and abilities are attributed to a specific area, and that there's a way of accrediting that outside of the college realm in terms of delivery of service. I think Dr. Turnbull in that document “Optimizing Scopes of Practice” has a very good point about how we should look at health care in a very different way.

I mentioned that in many respects Canada has demonstrated a leadership role with respect to alternate service delivery. The development of community care paramedicine over the last five to 10 years or so has really contributed to a positive delivery and access for patients. I can list a few of those initiatives.

I think this committee may have heard previously about the aging at home strategy in Deep River, Ontario, whereby paramedics are providing blood glucose checks; teaching prevention education with respect to slips, trips, and falls; and doing blood pressures. These are not restrictive activities in terms of medically delegated acts. It's basically helping or assisting people to age at home and keeping them healthy in that environment. That's one of the areas.

Paramedics were also very much engaged in H1N1, providing vaccines. There's a long-term case study that's been going on in Brier Island in Nova Scotia with respect to paramedics providing service to the local community. It's not always emergency care. It's oftentimes the more basic levels of care and I think those are very important.

Recently, the Ontario government provided $6 million to community paramedicine, which is a great investment. I think what we're starting to see is the return on investment for the communities and also for different levels of government on how this is a very positive thing.

Another important note, and I come back to the Canada Health Act, was in terms of cost being restrictive or preventing access. Recently, CBC's *Marketplace* talked about the cost of—and I hate to say it—an ambulance ride in terms of the care that a paramedic provides as being, I would say, outrageous, but also preventing or restricting access. Across this country you'll pay around $50 in Ontario, $140 in New Brunswick, and upwards of $250 to $300 easily in Saskatchewan or Manitoba for an ambulance, and this is a problem. I think there should be some leadership that could be demonstrated from the federal government in assisting with the concept of it being something that restricts access for patients.

In all, I'd like to thank the group for your time and for the ability to present before you today.

● (1705)

The Chair: Thank you very much.

For the members, first up is Ms. Moore.

[*Translation*]

Ms. Christine Moore: Mr. Poirier, I would like to ask you a few questions about current disparities between the provinces.

In Quebec, there has been a longstanding fight to recognize certain medical acts. Ontario paramedics are allowed to perform certain medical procedures, while those in Quebec are not entitled to do so. There is a rather significant difference between the provinces in terms of the medical procedures that may be performed by paramedics.

I would also like you to talk about that kind of independence regarding assessment. I am a nurse and I was still working until January, before my pregnancy. Paramedics would regularly arrive at the hospital with patients and say that although these people did not need to go to emergency, they had no choice but to take them there.

Is there a way for you to assess patients and provide guidance by telling them that they do not need to go to the hospital's emergency department as their condition does not warrant it, while providing some advice? Would it be possible to make this part of your practice?

I have a technical question. Medical assistants in the Regular Force take the same study program at Collège Ahuntsic as civilian paramedics do, but not medical assistants in the Reserves. Would it be a good idea to find a way to incorporate them into your profession after they have completed their military careers?

Those are all the questions I have for you, Mr. Poirier.

I will now turn to Ms. Guitard.

I would like to talk about access to occupational therapy. Often in the health system, a medical referral is required for access to occupational therapy services. We need to have something happen and then go to a doctor, who will give us a referral. We are then put on a waiting list and eventually see an occupational therapist.

Would not it make more sense to make it possible for a person to directly ask to be assessed by an occupational therapist or other health care professional, such as a nurse, and enable these professionals to give a referral and determine whether it would be appropriate for this person to be assessed by an occupational therapist, thus preventing injury?

● (1710)

Mr. Pierre Poirier: Thank you.

I will start by answering the first question about non-emergency care, outpatient care.

[*English*]

It's important to note that there have been a number of initiatives. Probably the most recent one—it's been going on for several years in Toronto—is called the community referrals by emergency medical services.

[*Translation*]

That is exactly what they do. Instead of sending people to the hospital, they put them in touch with the social services available. I wish this could be done across the country, in every city.

[*English*]

It's really an important piece of the care, and it's not in terms of acute care. It's not even health care in many respects. It's a referral service to the appropriate social service that may be available in the community. Toronto is a good example. It's being done in other communities across the country, but they're the first ones to have done that.

[*Translation*]

For some time now, Collège Ahuntsic has offered a program related to the national profile. It works quite well. There are also ways for health professionals leaving the Canadian Forces to be recognized as civilian professionals.

[*English*]

I would compliment the federal government. Over the last 10 years, actually, they've taken the initiative on that, with respect to integrating military, post-service, into the profession of paramedics. There's been a link. They've adopted the terminology from the national profile.

Merci.

[*Translation*]

Dr. Paulette Guitard: A medical referral is not required for access to occupational therapy services. Some occupational therapists see clients without requiring them to submit a medical referral. The problem is that insurance companies ask their customers for a medical referral before they reimburse them for the services received. If people want to be reimbursed for their expenses by their insurance company, then they must provide a medical reference. We then get caught in a vicious circle where a referral from a physician is required to obtain a refund from the insurance company. That aside, the referral is not necessary.

Ms. Christine Moore: Seeing an occupational therapist who works in a health centre absolutely requires a referral. You cannot just show up at the hospital and say you want an appointment with an occupational therapist.

Dr. Paulette Guitard: It is true, and that is becoming increasingly the case. I, for one, am from the old school. I have been an occupational therapist for a long time. When I started practising this profession, many of the occupational therapists available worked with outpatients. We rarely see that today. Occupational therapists who work in hospitals are strictly assigned to in-hospital patients.

Indirectly, a medical referral is necessary in a hospital. However, things are different in such settings as schools, where occupational therapists have a private practice. Only hospitals, internally, require a medical referral.

Ms. Christine Moore: Ms. O'Connor, do physiotherapists have the same problem in terms of the requirement for medical referrals?

[*English*]

Ms. Kate O'Connor: Yes, in every province and territory in Canada there is direct access to physiotherapists. You do not need a physician's referral. It comes down to a question of insurance coverage.

We recently conducted a study of access to extended health benefits. A couple of the things that we learned are that insurance companies use that doctor's note, the referral or the prescription for physiotherapy, occupational therapy, and other services as a cost containment measure. It's simply to try to defer patients from seeking other treatment, but what it does in essence is double bill the system.

One of the reasons why we would be in support of the federal health partnerships program is to look at how to streamline the system for direct access under federal health programs, including Sun Life for coverage of public servants through their extended health benefits. There are a lot of things within the program that actually don't make sense because they are delaying the access to treatment and access to professionals who are within the scope of practice of the professionals.

● (1715)

The Chair: Thank you very much. We're over time.

Mr. Wilks.

Mr. David Wilks (Kootenay—Columbia, CPC): Thanks to those who came here today.

I have three questions for you, Mr. Poirier, and one for Madam Guitard. If I have any time, left Dr. Lunney has a question and I have no idea how to say it, so I'll let him do it.

Pierre, first, what role could paramedics play beyond emergencies if they were to maximize their scope of practice? Second, could you provide more information on community paramedicine and examples of their scope of practice? Third, how would inclusion in the federal health workforce strategy benefit paramedics and Canadians?

Ms. Guitard, you brought up quite an interesting topic that intrigues me, and that is with regard to Corrections Canada and the release through federal penitentiary—not provincial jail but federal penitentiary—and the need for better coping skills for those who are being released. I think it's something that is sorely missed because they have things that trigger them very quickly when they're released, and I wanted to hear your thoughts on that part of it.

Mr. Poirier is first and Madam Guitard second.

Mr. Pierre Poirier: Thank you.

With respect to paramedics and their role, and expanding that, I think there's very much an opportunity with respect to rural and remote areas. You've probably heard from different professions that the rural and remote communities are oftentimes the least served by our health care system. I'll use Alberta as an example. Right now, many of the rural hospitals don't have physicians overnight or in specific periods of time. Paramedics provide those services, and paramedics oftentimes provide the emergency care service in the overnight period. That's one place where I think there is opportunity.

I think it's a good use of resources from a value perspective as well. I'm not saying that paramedics are underutilized or that they have great capacity. I just think it makes sense, in terms of their skills and ability, to be able to provide that service. It's a good use, and it works for the community. I heard Kate or Paulette mention before that if you can train individuals from a community, they are more likely to stay in that community. I think there is great opportunity with respect to that.

I'll go to the third question and then come back, because that leads into the whole concept of health workforce planning, which is an important piece, and I think this could be a good opportunity for the federal government. Paramedics are not listed in that plan of where we're going. If you look at pharmacists—and I've reviewed the pharmacy—there is information about their number, age, education, and career prospects. There is a whole understanding of who they are, so you can plan in the future.

When I said there are approximately 40,000 paramedics, I absolutely don't know the exact number. We could go to all provincial regulators, and we still wouldn't know the number. I think there is a real disconnect, and there is a missed opportunity in terms of planning. I think that's a very important linkage, so thank you for that question.

The last part is with respect to scope of practice. Hopefully this is not too abstract, but the Royal College of Physicians and Surgeons has adopted the CanMEDS model of looking at how they define the profession. We've adopted that model as well, because it takes your knowledge, skills, and abilities or competencies and takes it up one step to look at what your role is. I've always been fascinated by their presentation on it. They went to the community and said, “What do you want physicians to be?” Physicians themselves thought they wanted to be clinicians, and that's how they viewed the world. When they asked the community, the community wanted physicians to be collaborators, educators, leaders, all these other things.

That's how they started to develop their new competency profile. That's what we are choosing to do with respect to the paramedics. We are engaged in that exact process, to look at all the roles that we can undertake. How does the community view the way we should be engaged? What are those roles? That will then lead to what the knowledge, skills, and abilities or competencies are that support that.

Again, I think there is a role for the federal government to support that kind of thinking about how we look at health care. Hopefully I've answered your question.

● (1720)

Dr. Paulette Guitard: I'll go back to your question about people who are in these settings who have mental health issues. You were talking about triggers. As occupational therapists, we can help these people recognize what their trigger points are to help them know the signs, and then get them to express their emotions in a socially acceptable manner. That's one of the coping skills that we can give to people: helping them learn to say “I'm upset“ when they are upset, rather than take a punch at somebody.

Those are the types of things in day-to-day life that we can work on, having a routine and a sense of purpose and meaning through occupations. These people usually don't have skills. I'm talking about job-readiness skills. We can help them with that. Then we can help them look at having a meaningful occupation. We can work toward that, helping them build some of the coping strategies that they need to deal with the everyday stressors that they are going to be facing.

The Chair: Mr. Lunney, sir.

Mr. James Lunney: Thanks very much.

That's three underutilized professionals here, and I appreciate your contributions, all of you.

I have a quick question for the physiotherapist. In British Columbia, we had 12 visits when I was practising. I did a lot of things with overlap, obviously. In my office, I had a lot of adjunctive therapy, lasers, microcurrent, interferential current, and so on. Twelve visit is what they allowed. For low-income people, often you can't fix them or adequately rehabilitate them in 12 visits, so I would refer them to a physiotherapist, and he'd follow up. He had the same issues I did with low-income people; he'd refer them over my way to follow up.

I just wanted to ask you to contribute. What is the coverage for physiotherapy across the country? Have you been more or less defunded, as chiropractors have across the country in order to feed the monster overall, the health budgets? Where are you at?

Ms. Kate O'Connor: Physiotherapists across the country have largely been delisted from provincial health insurance programs. There are exceptions. For example, in Ontario, if you're under the age of 18 or over the age of 65, often there are exceptions if there's an overnight stay in hospital that requires rehabilitation. Unfortunately, the circumstances are such that low-income people often don't have access. Even if there is the potential for coverage under provincial programs, the wait-lists are so long for the publicly funded physiotherapist that it is inaccessible, because if you have a fractured ankle and have to wait six to eight months for a physiotherapist, you will have chronic pain and problems that often cannot be resolved at that point.

The balance, for the profession, is to look at the opportunities to try to promote better access to care, to look at the competency issues and how we can overlap in areas where there is access to care with the public system, and then also to look at the private system and opportunities to help support access.

The Chair: Okay, thanks very much.

Ms. Fry.

Hon. Hedy Fry: Thank you very much.

Actually, I think that segues into something that is.... We're talking about scope of practice here. The point is that there is a lot of overlap in scope, so the big question is as you look at appropriate HHR strategies, how do you fit...? I know what occupational therapists do. I think it's really a crying shame that occupational therapists are no longer involved in veterans' care and diagnosis, because occupational therapists were the actual advocates for veterans. I think that's why they're no longer involved in veterans' care.

I want to suggest that if we were to look at integrated models of care, community care—let's just leave aside the hospital and acute care model, which is part of that new integrated model—where does a physiotherapist, an occupational therapist, or a chiropractor fit in the scope of practice in that model? If you look at the paramedic, the nurse practitioner, the home care nurse, the family physician, how do those four people fit into the scope of practice when you have overlapping?

How do we build effective scopes of practice that are necessary and needed? How do we integrate them into a system without duplication, overlap, and turf wars? How do we ensure that the most effective care is given to the patient in the most cost-effective manner, so that we can see the savings and the quality of life and all those other indicators for measuring a system that are working well? How do we do that when there are so many people that overlap? That for me is the beginning of how we have to start looking at scope of practice when some people are doing the same things in so many ways. I just wonder how we do that. That is something that I am struggling with. I think integrative, comprehensive care, etc., is important. But how do we decide who is the best person, let us say, in rehabilitative care?

That's what I'm struggling with. How do we decide?

● (1725)

Dr. Paulette Guitard: Well, when Ms. O'Connor was talking about interprofessional models, that is exactly what interprofessional models are trying to do, and that's what we're trying to teach our students as well. So there's no need to be in a turf setting, saying, “This is needed, and this needs to be done by this person and this person”. If you really have a truly interprofessional concept, then the person will come in, will be evaluated, and then it will be identified who is the best person to meet that person's need. The assessment might not be from an occupational therapist but a physiotherapist knows exactly what an OT can do, and in a particular setting, the physiotherapist might say, “This is the problem with this person and I believe that she needs OT, and she needs speech language pathology”.

I think there's a lot of duplication going around because we're set in our ways, and we also have rules and regulations from our colleges. But there's nothing preventing us from being truly interprofessional and doing one assessment, instead of doing an assessment in OT, one in physiotherapy, one nursing, etc. We could have somebody there who does one assessment. We'd work as a team, and then would decide on the best professional to meet this person's needs. There are some models like this working really well right now, but it's a shift. So you're constantly debating with a model like that and trying to fit it into a model that it's not. It's difficult.

Ms. Kate O'Connor: I might add that we may want to consider changing the language that we use rather than just simply focusing on scopes of practice, looking at complementary skills, complementary scopes of practice. Because of this overlap, it is about working together.

Through primary health care models, for example, if there's enough flexibility at the systems level there is a possibility to have many different professions working within a primary health care team. Then the local level decision-maker, who knows the demographic being looked at and the types of clients being seen on a very regular basis, can make the decisions around resource allocation and the inclusion of specific skill sets or specific professionals.

It goes beyond just working within the rehabilitation community, looking at physiotherapists, occupational therapists, and so on. We could integrate physiotherapy assistants and other rehab assistants into programs. For example, in rural and remote areas, it may be the physiotherapist who goes in on an intermittent basis to provide overall programs, but there could be assistants who are trained to be able to deliver the day-to-day programming.

That's a way of looking at the resources within a community and within a team, and allocating those resources most efficiently by using assistants rather than always looking to the physiotherapist as the go-to person.

Hon. Hedy Fry: So you're looking at having the communities themselves decide what their needs are.

Ms. Kate O'Connor: Yes.

Hon. Hedy Fry: Thank you.

The Chair: Thank you very much. I appreciate everybody's time here today.

We'll see everybody back on Thursday.

The meeting is adjourned.