House of Commons
CANADA

Standing Committee on Health

HESA • NUMBER 016 • 3rd SESSION • 40th PARLIAMENT

EVIDENCE

Tuesday, May 11, 2010

Chair

Mrs. Joy Smith

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● (0900)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): Good morning, everybody. Welcome to the health committee of Canada.

Today we have a very important meeting, pursuant to Standing Order 108(2), on our study on health human resources.

We have as our witness today, from Correctional Service Canada, Leslie MacLean. Welcome, Leslie. It's nice to see you again.

We also have Fraser Macaulay, the acting assistant commissioner. Welcome, Fraser.

And from the Department of Citizenship and Immigration, we have Lise Scott. Welcome to you. I understand you're the director general of that department.

I think those are all of our witnesses for the first round. The first round is going to go from 9 a.m. to 10 a.m., and the second round is going to go from 10 a.m. to 11. So we will begin with a five-minute presentation, and then we'll go to Q and As after that.

Can we begin with Leslie MacLean, please?

Ms. Leslie MacLean (Assistant Commissioner, Health Services, Correctional Service Canada): I'm going to begin by passing the *parole* to my left, please.

[*Translation*]

C/Supt Fraser Macaulay (Acting Assistant Commissioner, Human Resource Management, Correctional Service Canada): Good morning, Madam Chair and committee members. I would like to thank you for this opportunity to appear before you today. I am also joined by my colleague Leslie MacLean, Assistant Commissioner, Health Services.

The Correctional Service of Canada is a federal agency within the Government of Canada's Public Safety portfolio. CSC contributes to public safety by administering court-imposed sentences of two years or more. This work involves managing institutions of various security levels, preparing inmates for safe and timely release, and supervising offenders under conditional release and long-term supervision orders in the community. CSC has approximately 16,400 employees. It is responsible for some 22,000 offenders, of whom about 13,280 are incarcerated and some 8,720 are supervised in the community.

CSC has a presence across the country, from large urban centres to remote communities across the North. CSC manages 57 institutions of various security levels; 16 community correctional centres; 84 parole offices; and four healing lodges.

[*English*]

As you know, CSC employs a diverse workforce comprised of correctional officers and parole officers, who, for the most part, are exclusive to CSC. The remainder of CSC's workforce reflects the variety of other skills required to operate institutions and community offices, from health professionals—such as from the fields of nursing, psychiatry, pharmacy, and psychology—to electricians and food service staff.

CSC staff routinely deal with high-need and high-risk offenders, whose needs are complex and diverse. These include mental illness, drug and alcohol addiction, and anger and violence issues. While these challenges are faced by a large percentage of CSC's workforce, for health care professionals joining CSC, this institutional work environment is unique and presents challenges not commonly confronted by their profession. Coupled with this unique work environment, when it is recruiting for health care professionals, CSC must respect Government of Canada policy, legislated budget direction, and the collective agreements governing these occupational groups. Together these factors, when combined with the remote location of many work sites, can limit our success in attracting and retaining health professionals.

In keeping with the most recent annual report of the Clerk of the Privy Council, CSC is strengthening its planning, recruitment, and employee development. This will enable human resources to build on its current foundation of sustaining its existing workforce, attracting new people, developing and retaining talent, and finalizing the implementation of our transformation agenda.

As part of public service renewal, CSC's human resource management function will need to increase the efficiency and effectiveness of its services in the organization if the organization is to remain competitive in its search for talent and deliver on its correctional results. In response to this need, the human resources section is committed to improving and simplifying its processes and systems. For example, CSC will be adopting common human resource processes, upgrading our HR management system, leveraging self-serve technology, and increasing the availability and use of strategic information by rolling out a dashboard to all regions and institutions. Together, these initiatives will allow CSC to strengthen its capacity to manage its workforce and to plan more proactively.

My colleague will elaborate on initiatives specific to health care professionals.

Throughout these various initiatives, our union partners have played a key role in identifying and working collaboratively to resolve issues affecting their membership. For example, CSC is working closely with the Professional Institute of the Public Service of Canada to address barriers affecting the mobility of registered psychologists.

● (0905)

[*Translation*]

Meeting the challenges outlined in the Public Service Renewal and our Report on Plans and Priorities will require strong leadership and a sustained commitment. Our renewal must continue to evolve for CSC to sustain the high level of service that Canadians have come to expect.

[*English*]

The Chair: Mr. Macaulay, can you wrap up quickly, because we need to go to the next witness?

[*Translation*]

C/Supt Fraser Macaulay: Yes. I would now like to invite my colleague Leslie to provide more details about the challenges facing health care professionals at CSC.

[*English*]

The Chair: Thank you very much. We usually have one presenter per organization, but we have the time and I understand that you are providing two different looks at the same thing, so I'll give you the full time as well, Ms. MacLean.

Please, go ahead.

[*Translation*]

Ms. Leslie MacLean: Thank you, Madam Chair.

I would also like to thank the committee members. I am pleased to appear here before you to discuss issues related to the recruitment and retention of health care professionals at CSC. As my colleague said, we will brief you today on CSC's Recruitment and Retention Strategy, including key challenges and our work to address them.

[*English*]

The recruitment of health professionals is key to meeting our legislated mandate of providing offenders with essential health services according to professional standards. Members may wish to note that our model of service delivery is principally nurse-based, with physician services principally provided on contract.

We are the largest federal employer of psychologists and nurses. We have a complement of about 750 nurses, or approximately 39% of nurses in the federal government, and about 340 or 71% of psychologists in the federal government. Of course, in addition to nurses and psychologists, we have a wide range of other health professionals: pharmacists, social workers, psychiatrists, occupational therapists, and of course contracted physicians.

It is an ongoing priority and challenge to recruit health professionals to the service. In addition to the challenges my colleague Mr. Macaulay has mentioned, the first is the reality of a very competitive national and international market for health professionals. Provincial and territorial health systems, as well as other federal partners, have the same requirements for health professionals, and in some cases they have more attractive compensation packages.

The second issue is the one of social and demographic trends affecting the pool for all health professionals across Canada. Of course, they apply to the service, so we also face the challenges of an aging workforce and staff who are becoming eligible for retirement.

The third issue was mentioned quickly by my colleague: the challenge of providing health services in a correctional setting. Some of the factors include particular challenges responding to the complex physical and mental health needs of offenders or the occasionally stressful working conditions of a penitentiary environment.

Of course, we're working very actively to recruit and retain these critical health staff. Since 2008 we've had a dedicated recruitment and retention strategy for health professionals. It lays the groundwork for a long-term approach. We are beginning to see some impact. According to our latest vacancy figures, we are beginning to make improvements in vacancy rates for health professionals. For example, last year we would have hired 172 new health professionals, including 125 nurses.

We're also striving to become an employer of choice—everything from having many of our health services staff reporting up through a health organizational structure, new training and development, and working toward the accreditation of all our health care units. We are working, of course, to promote the unique challenges of a career in corrections, with brochures that speak to the challenges and opportunities for psychologists, social workers, and nurses. We've recently had articles promoting our special workplace in the Canadian Psychological Association newsletter and one in the Canadian Nurses Association magazine.

We've also been working with our colleagues in the federal health care partnership, both to find students and to retain them through practicums and internships, which of course produce job opportunities for our staff and provide a collaborative opportunity to recruit to the federal government as an employer of choice.

● (0910)

[*Translation*]

Retention of health care professionals is a key component of the Strategy. To support our efforts in this regard over eight million dollars has been provided annually to support the training and development of nurses both to improve their skills for working in a correctional environment and to keep them current with respect to modern nursing practices.

In addition, psychologists have been provided with dedicated annual funding for their professional development for the last three years.

[*English*]

In summary, we recognize the unique recruitment and retention challenges we have. We're working diligently to reduce our vacancies and of course to retain the excellent health professionals we have. We're committed to focusing our efforts to attract—and retain—qualified employees to careers in the challenging yet rewarding environment of the correctional service.

[*Translation*]

Thank you.

[*English*]

The Chair: Mr. Macaulay and Ms. MacLean, you've given some really very important information this morning. Thank you.

We'll now go on to our next guest from the Department of Citizenship and Immigration, Ms. Scott.

[*Translation*]

Dr. Lise Scott (Director General, Health Management, Department of Citizenship and Immigration): Thank you, Madam Chair.

Good morning. Thank you for inviting me to speak to you today.

I am the Director General of the Health Management Branch of Citizenship and Immigration Canada. My branch holds the responsibility for delivering the Interim Federal Health Program, also referred to as IFH. This is a health coverage plan which reimburses the costs of health services for refugees, individuals who claim asylum in Canada, individuals who are detained under the Immigration and Refugee Protection Act, and victims of human trafficking.

[*English*]

There are approximately 128,000 clients eligible for this program. In terms of numbers and the breakdown by client type, approximately 110,000 are asylum seekers—that's refugee claimants—and approximately 18,000 are convention refugees who were selected abroad and resettled in Canada. There are usually, at maximum, 300 individuals detained at a given time. There are approximately 10 to 15 victims of trafficking throughout the year.

The expenditures of IFH are included in the attached table. For 2008-09, the program expenditures were $65 million, and there were approximately 550,000 claims. The program has seen a significant increase in cost. The program reimburses basic health care services, similar to what's available through provincial plans for Canadian citizens and residents, and supplemental health services, such as medication and dental and vision care, similar to what's offered on provincial social assistance.

The IFH program is operated as an insurance plan. Their clients, with the exception of detainees, obtain their services from the provincial-territorial health network and practitioners, and IFH reimburses the cost of such care. This means that IFH is not the actual provider of care. It should be thought of as more of a reimburser. We recognize the importance of fee schedules to help ensure access to services, which is why the program aligns its fee schedule as much as possible with provincial fee schedules. To process a claim, we utilize a third-party claim administrator.

The role of CIC in delivering this program is to define program policy, to define the benefit structure, and to maintain oversight of the claim administrator activity. It should be noted that the detainees are held in Canada Border Services Agency detention centres. Contracts are in place with medical providers, who come to the centre for eight hours a week to deliver health care. The costs are covered by IFH.

● (0915)

[*Translation*]

In conclusion, because the mandate of the program is to reimburse health care services provided by the PIT health care system, we do not deal directly with issues related to access to care, compensation of physicians or other health care professionals or high turnover of health care staff. However, as for the other Federal Healthcare Partnership partners, the considerable increase in program expenditures reflects the fact that the cost to obtain health services has grown significantly

Thank you. I would be pleased to answer any questions Committee members might have.

[*English*]

The Chair: We certainly have some great witnesses today. It's been really good to hear your initial presentations. If there's anything else you want to include as the questions are being asked, feel free to do that, because we rely on your expertise.

We'll now go into seven-minute questions and answers. We will begin with Dr. Bennett.

Hon. Carolyn Bennett (St. Paul's, Lib.): Thanks very much.

My question is for the Correctional Service.

Obviously, mental health is a huge priority I think in terms of your institutions.

You said that your latest vacancy report for health care professionals has improved in most cases. Can you tell me how you ascertain that in terms of the need for doctors, the need for nurses, and the need for social workers? What are your targets, and where are you in each of those? There may be some things that don't need to be done by licensed professionals, but probably lots do. Could you just tell me what your target is for each of those categories and where you are?

Ms. Leslie MacLean: I'd be pleased to respond to the member's question.

To begin, mental health has been a top priority for the Correctional Service for the last several years. We're working within, of course, the various scopes of practice, as regulated by the eight provinces in which we have our 57 institutions.

For example, the institutional mental health initiative, for which we first received funding in 2007, has a complement of about 90 health professionals, and in that we have psychologists, social workers, occupational therapists, and psychiatric or mental health nurses as well. I don't have them broken down by each initiative, Dr. Bennett, but I could, for example, speak to our current complement for psychologists, which is 340 psychologists. That's how many we're funded for across the service, and that's certainly one of our areas where we are struggling with recruitment and retention.

Our current vacancy rate in psychology is 20% of our positions. So when we have vacant positions—of course, we have to ask people to not ever work outside their scope of practice—we look at triaging the work that psychologists do to make sure we're concentrating them on the core areas where we need their valuable expertise, whether it be risk assessment, diagnosis of mental health conditions.... Then we work to provide an interdisciplinary team approach to support the inmates through the provision of mental health services.

For nurses, which is our largest employee group, as I mentioned in my opening remarks, we have a complement of 750 funded nurse positions. Our current vacancy rate is about 6% for nurses in the service.

● (0920)

Hon. Carolyn Bennett: And social workers?

Ms. Leslie MacLean: I'm sorry, I didn't speak to social workers. They're a very important part of our mental health workforce. We have a complement of 55 social worker positions, and six of those are vacant now, for a vacancy rate of 11%.

Hon. Carolyn Bennett: And family doctors?

Ms. Leslie MacLean: For our physician complement, we have six, either physicians or psychiatrists, who work with us. The vast majority of our psychiatry and physician services are provided on contract, so we have over 50 physicians on contract who might come into our institutions for two or three afternoons a week, for a clinic. Similarly, for psychiatrists, we have over 50 psychiatric contracts as well.

Hon. Carolyn Bennett: In terms of addiction, how is that dealt with?

Ms. Leslie MacLean: For addiction, this is a substantive challenge for inmates. About 80% of inmates of the federal correctional system have some sort of substance abuse issue, and we have an extensive suite of substance abuse programming, which is offered in an effort to respond to those issues.

Hon. Carolyn Bennett: What percentage of your health care team would you consider focused on mental health?

Ms. Leslie MacLean: I've never calculated our staff ratios that way. Certainly I could perhaps give you, Dr. Bennett, an overview of the budget. We have about $194 million, which the Correctional Service spends on health services. Of that, about 60% is actually salaries, so the people. Within that envelope we spend about $50 million of that on mental health services, either health services in one of our five psychiatric treatment centres or on our mental health programs that are offered in our other institutions.

I would be glad to give an undertaking, Madam Chair, to come back with more analysis of how that breaks out between physical and mental health services, but that's the overview of the resources.

Hon. Carolyn Bennett: And maybe in terms of how long you've had this kind of shortage, the fact that you've said that some of the vacancy rates are going down.... But are some going up? I mean, 20% for psychologists is huge, because you can't actually see more patients per hour. You can't hurry up in mental health, compared to maybe seeing sore throats.

How do you deal with the fact that you're 20% down in psychology? Does that mean patients aren't being seen or that there are waiting lists?

Ms. Leslie MacLean: There are probably several ways by which each institution is working to respond. One is, of course, triage to ensure we're using our valuable resources on the most important and urgent cases; another one is through contracting for psychology support as and if required; and of course, as your question suggests, trying to get to root causes to really improve the initiative. For example, I think it was in February 2009 our psychology vacancy rate was higher; it was 23%. We brought it down to about 16%, but it's creeping back up. So we'll continue to work diligently on understanding what issues are affecting recruitment and retention for us and of course do our best as a service to respond to those.

Hon. Carolyn Bennett: Do you use unlicensed professionals to fill the gaps?

Ms. Leslie MacLean: We have been working on a regulated, licensed health professional as our model for service, so one of our challenges is making sure we're aligned appropriately with regulated scopes of practice in each of the jurisdictions where we have institutions.

Hon. Carolyn Bennett: In order for them to have a licence, they actually have to abide by the various provincial.... So you don't have a cross-institution approach to who gets to do what?

● (0925)

Ms. Leslie MacLean: In the eight provinces where we have institutions, we work to have people who hold licences in those provinces. As you would know, for some professions, transferring their licence from one jurisdiction to another is much easier, for example, for nurses. For psychologists, that has been presenting a stumbling block for us because the process to transfer the psychology licence from one jurisdiction to another is not as easy. My colleague in human resources and I have been working with the Professional Institute of the Public Service of Canada to try to address those issues.

The Chair: Sorry, I gave you eight minutes, Dr. Bennett.

We'll now go to Monsieur Dufour.

[*Translation*]

Mr. Nicolas Dufour (Repentigny, BQ): Thank you, Madam Chair.

I would also like to thank the witnesses for coming here today.

Continuing in the same vein, I have a question about psychologists. it was said that 50 of them are on contract. You explained briefly what problems that can cause.

As I understand it, you do not have enough psychologists. You say that the vacancy rate is nearly 20%. That must cause serious problems?

Ms. Leslie MacLean: Our challenge is always to ensure continuity of care for inmates. Certainly staff could meet inmates' needs with more thorough knowledge if they were employees of the Correctional Service.

I would like to correct something, though. I mentioned 50 contracts a minute ago; actually it is more than 50 contracts with doctors and more than 50 contracts with psychiatrists. For psychologists, I don't know the exact number of contracts with them. I can provide that information to the committee members later, however.

For the Correctional Service, not having psychologists among its employees presents a challenge, since there is no continuity among members of the interdisciplinary team. We have to provide high quality service to meet inmates' health needs, so psychologists, social workers, nursing staff, staff, correctional officers and case managers all have to work together. They have to work as a team to respond in an integrated manner.

We are happy the ones on contract are there to help us, but we would certainly prefer to have those services provided by employees.

Mr. Nicolas Dufour: Not having permanent, long-term employees must also create a problem because you can't provide follow-up for an inmate from A to Z. Essentially, there is a risk of their case being handled by several people?

Ms. Leslie MacLean: That can happen, certainly. When you have contract employees, you try to provide continuity of care. As well, those employees have to document their work with inmates properly, the things they do, because that is definitely part of the professional discipline.

Mr. Nicolas Dufour: I want to talk specifically about the strategy you have adopted. I have a few questions. How are you going to find new staff? You explained it a little a minute ago, but I would like to have more details.

In concrete terms, how does the process work? How did you develop your strategy and how did you get to the challenges you referred to earlier?

Ms. Leslie MacLean: I would just like to request a clarification. Your question is about our recruitment and retention strategy? Yes, obviously.

We first developed our strategy in 2008, by assessing, based on the knowledge we had at that time, what our main challenges were, and our opportunities, and how to optimize them. We worked with the Federal Healthcare Partnership for the specific purpose of determining the job fairs or exhibitions where we are going to find students this might interest. We would like students to be able to do a placement with us to see what life is like in the penitentiary system, what it's like to work in this kind of interdisciplinary team. Certainly there are areas where you don't have any latitude, because of salary and benefit issues, for example. We are trying to see what aspect of professional development can be used to maximize our employees' strengths, but we are also trying to make the Department be seen as an employer of choice.

● (0930)

Mr. Nicolas Dufour: Can salary be a problem for someone who wants to come into...

Ms. Leslie MacLean: Possibly, it depends on professional qualifications. It also depends on where positions are available in the country. As my colleague Mr. Macaulay said earlier, we have some penitentiaries that are remote, like the one in Port-Cartier, near Sept-îles, where the availability, education and skills required of staff may present challenges.

Mr. Nicolas Dufour: Do you have contacts with other groups or other agencies, for example the Department of Health, not just in developing your strategy, but in the day to day things, to observe how other agencies that deal with health care professionals recruit?

Ms. Leslie MacLean: There are two items worth looking at. First, we work in an integrated manner with our colleagues from other federal departments that also provide health care services, precisely so we present ourselves not as six departments that provide health care services, but as the government of Canada that offers widely varying job opportunities.

Second, the Correctional Service also has a committee of professional health associations that advise the Department in relation to our health care services and how we do things. I have presented our recruitment and retention strategy to that committee on several occasions in the past. This was precisely to see whether those health care professionals or representatives of an association of health care professionals had advice to give us for fine-tuning our strategy, to meet the challenges better.

Mr. Nicolas Dufour: Do I have any time left?

[*English*]

The Chair: You do. I've given you a little extra time, because I gave Dr. Bennett quite a bit, so go ahead.

[*Translation*]

Mr. Nicolas Dufour: Thank you.

I just wanted to ask Ms. Scott about the increase in the budget for the program she is in charge of. What might explain how it rose from nearly $35.9 million in 2000-2001 to nearly $90.8 million in the projections for 2009-2010?

Dr. Lise Scott: Thank you for your question.

The first thing you can see, if you have your table of program expenditures in front of you, is that the number of clients rose quite significantly. It went from 71,000 clients in 2000-2001 to 128,000 clients in 2009-2010.

We don't have the number, but there has also been an increase in the number of claims per client. Then there is the complexity of the services and the increase in the cost of services. So there is a set of factors that mean that costs have risen, by a fairly significant amount in fact.

[*English*]

The Chair: Thank you, Monsieur Dufour.

We'll now go on to Ms. Leslie.

Ms. Megan Leslie (Halifax, NDP): Thank you, Madam Chair.

Good morning, and welcome. My name is Megan Leslie. I'm a member of Parliament for Halifax.

I'd like to pick up on your conversation with Mr. Dufour, specifically with recruitment, not retention. You talked about institutions in remote areas, so that might be an example of why somebody may not want to get involved in working in this environment. Help me understand, because I'm not a health care worker in a federal penitentiary. What are the recruitment problems? Is it remoteness of location? Is it also wages? Is it fear of the population? What are the other key issues?

Ms. Leslie MacLean: For some people it may be all of the above.

Ms. Megan Leslie: Are there others?

Ms. Leslie MacLean: One of the principal issues, from my perspective, would be that our salary package is not as competitive as we would wish it to be in some parts of the country for some professions. Occasionally we're also looking for special skills. If I could take nursing as an example, in Nova Scotia, where we do the reception for the entire Atlantic region, we're often looking for bilingual staff in our Springhill location, but that may be difficult to find in the area. Of course, for psychologists we'd love to find people who've got qualifications not just in clinical but in forensic as a specialty.

There is no question that not all health professionals go to school and think that when they grow up they're going to work in a penitentiary.

My colleague and I were speaking about this, and certainly from front-line staff I've heard enormous understanding of why their work is important, how they contribute to public safety. So it's where for us the placements of students...having nurses come through for a six-week practicum is enormously helpful for them to see what the work practice is like, understand that it's often a very autonomous practice, and for them to get a good understanding of what the pros and cons are.

● (0935)

Ms. Megan Leslie: What are the challenges of retention? I assume they're different. The autonomous practice may come into your answer.

Ms. Leslie MacLean: They can be. I would turn to Mr. Macaulay if he wishes to add.

The work environment can be stressful. I would have spoken about it in my opening remarks. The health workforce is like other parts of the Canadian workforce: it's also aging, and we're having more people eligible to retire. So those are the sorts of things.... I also think there are issues in the workplace around professionalism, putting in place appropriate training and development so that people can be supported and comfortable to respond to an emergency situation if and when it happens. Those are important ways we can reach out to our workforce and make sure we're providing a healthy workplace where our employees are valued.

Mr. Macaulay.

C/Supt Fraser Macaulay: I would just add that nursing is also very much focused on part-time work, the shift work. These things all impact. Professional development is a big one when you start looking at developing part-time staff.

A whole series of things play off each other, inclusive of the environment. We still can't lose the fact of the environment we're working in. It's a difficult environment, and it's the altruistic values that are brought to the employees. That's the key when you talk to them. That's what shines through. The diversity of the work is key, but also their contribution to Canadian public safety.

So it's now a matter of winning the hearts and minds more than anything else. If you look at our retention, our retention is good once we click through that. The actual discussion we had coming down was.... One of the things we've heard is that a lot of managers can tell within five minutes if these people are going to stay. They either love it or it's time to go. It's that clean.

Ms. Megan Leslie: Do you have problems when people might apply for a job in one institution because there's a vacancy or because there are many vacancies—I see you looking down already—and then they try to transfer to other institutions because it's where they'd rather be? Do you have problems with particular institutions?

Ms. Leslie MacLean: There's no question that some parts of some provinces are very difficult for us to recruit to, simply because they're difficult for the hospital across the street from our institution. For example, if we were running a competition in the prairies, we might well get people who apply who are very willing to relocate to one of our big cities. We have institutions in Edmonton, we have institutions in Saskatoon, and one just outside Winnipeg. But getting someone to go a little bit north can be quite a challenge for us. So, yes, that is always a risk for us, that people will see the ad and assume that's next door, that's Edmonton, and they'll apply. But we may be looking for them to go to Grande Cache. You're right, that is a challenge for us in terms of workforce mobility and trying to attract people to some of our more remote sites.

Ms. Megan Leslie: Where are the locations with the most difficult retention rates?

Ms. Leslie MacLean: For nurses, we have two sites in the prairies and one in Quebec where we've had difficulty in recruiting and retaining staff: Grande Cache in Alberta, Prince Albert in Saskatchewan, and Port-Cartier, which I mentioned a bit earlier. Those sites have been more difficult, certainly for nurses and for other health staff as well.

Ms. Megan Leslie: Okay. The numbers you gave us...for example, in psychology there is a 20% vacancy. Is that pretty static? Does it always have that composition, or does it change over time? Has it changed over time?

Ms. Leslie MacLean: In the last couple of years, where we've been tracking it quite closely, we've seen improvement in some regions and deterioration in some regions. It's also important to point out that if you have a small workforce.... We have a smaller number of institutions and inmates in Atlantic Canada, so losing one psychologist or one nurse in Atlantic Canada has a disproportionate effect, of course, for that region.

A year ago, we would have been having recruitment and retention issues for psychologists and nurses in the Pacific region. Our managers there are really to be congratulated. They've really put an enormous amount of effort into recruiting in the last year and have made substantial improvements in vacancy rates for both.

● (0940)

Ms. Megan Leslie: If I have time left....

The Chair: Quickly.

Ms. Megan Leslie: A quick question for Ms. Scott. If I understand this correctly, in your reimbursement program you would reimburse supplemental health services per provincial social assistance. That says to me that the people you represent are receiving different standards of health care per province. For example, in Nova Scotia, they may not get mental health treatment, but in Ontario they may. Am I correct in interpreting it that way?

Dr. Lise Scott: We are trying to align as much as possible to the services offered by the provinces. I wouldn't put it exactly the way you're putting it, though, because the provinces are relatively aligned between themselves too. You wouldn't have a situation where in one province you would receive mental health services and in another you wouldn't. Everybody would receive mental health services.

The Chair: Thank you.

Now we'll go to Mrs. Davidson.

Mrs. Patricia Davidson (Sarnia—Lambton, CPC): Thanks very much, Madam Chair.

And thanks very much to our presenters this morning.

I just want to go to Ms. Scott. We'll just continue along the line that Ms. Leslie has started there. I was interested as well when you said that you offer services similar to what's offered on the provincial social assistance. You said that you try to align them as closely as possible with that. What are the differences? I know there are some differences in what provinces provide. Can you outline what the differences are as they affect your programs?

Dr. Lise Scott: I wouldn't know the differences offhand. If you wish to have that, I would have to do an analysis and provide it to the committee.

The Chair: If you could do that, Ms. Scott, and if you could submit it to the clerk, we'll see that it's distributed to everybody.

Dr. Lise Scott: Okay.

Mrs. Patricia Davidson: Ms. Scott, are you aware that the differences have caused challenges for your organization?

Dr. Lise Scott: I'm not aware that differences in our payments have created challenges for our clients. What I'm aware of is that our clients, as well as other clients, have challenges receiving services and having access to services if they are in an area where there are challenges for other recipients. They are submitted to the same types of challenges as the general population in getting access to care.

Mrs. Patricia Davidson: You said in your opening remarks that you recognize the importance of the fee schedules and that you try to align those fee schedules as much as possible to the provincial schedules. How closely are they aligned? Are they more than the provincial fee schedules in most cases?

Dr. Lise Scott: In most cases, we try to align exactly to the provincial fee schedules. In some cases, we do pay more and in some cases we pay less. It depends on the service. We can provide that in the analysis that we will be providing to you.

Mrs. Patricia Davidson: Okay. Thank you.

So you're not the actual provider of care in any instance. Is that correct?

Dr. Lise Scott: That's correct.

Mrs. Patricia Davidson: But you do have a third-party claims administrator, and your role then is to maintain oversight of that claims administrator's activities.

Dr. Lise Scott: Yes.

Mrs. Patricia Davidson: How do you do that?

Dr. Lise Scott: At this point, I should also say that we have a new contract with a new claims administrator and that we are in a period of transition between the old claims administrator and the new one, who will be starting next January.

We do the oversight through the requirements that we had when we issued our request for proposal for the contract. We asked the provider to provide us with information monthly on the payments they make. We also audit our claims administrator and we reconcile all of the financial aspects of the contract. So we have a series of requirements for the claims administrator that we oversee on a monthly basis.

● (0945)

Mrs. Patricia Davidson: So you have the contract with the claims administrator. Is the claims administrator the group that's responsible for finding the health care professional, or are you responsible for finding them?

Dr. Lise Scott: Nobody is responsible for finding a health care professional. This works as insurance, and it's up to the client to find their own health care provider. Through the claims administrator, we then pay for the care.

Mrs. Patricia Davidson: So if there are shortages of physicians, the clients are directly affected the same as everyone else?

Dr. Lise Scott: That's right. Our role is only to provide payment. We have a mandate to provide payment for the services, not to ensure access.

Mrs. Patricia Davidson: So then access is totally up to the client, and there are no issues with your department as far as language issues, or foreign-trained...or your understanding of different cultural issues are concerned? Are those totally up to the client?

Dr. Lise Scott: Well, our department is quite involved in working with service providers and looking at issues of integration and language. But that doesn't come under my area of responsibility; I am responsible for health.

So if you are interested in issues of integration and the health aspects of integration, then I would have to ask a colleague from our integration branch to talk to you. But, definitely, that is an area where our department is very involved—but not my branch.

Mrs. Patricia Davidson: You have a third-party claims administrator, and you've just said that you're switching administrators in January, but how often do you do an RFP? How often is this evaluated, first of all? And then what is the term of the contract you're normally looking at?

Dr. Lise Scott: The claims administrator we currently have has been working under the same contract for a period of three years, but they also had the contract before that. It wasn't the first time they had the contract.

This new contract is going to be for five years, with the possibility of being renewed twice for two years at a time.

Mrs. Patricia Davidson: When I look at the program expenditures from the chart that you've given us, and I recall your opening remarks where you said there is a considerable increase in program expenditures—reflecting the fact that the cost of obtaining health services has grown significantly from 2001 to 2009, an eight-year period—I see that we're looking at a greater than 50% increase in expenditures, from $42.5 million to $90.8 million. While I know you're looking at more clients, there is no comparison here for the number of claims. Has the cost itself risen that much in the eight-year period?

Dr. Lise Scott: We could provide you with the cost per client also. We have that information. If you wish, we could also provide you with that information. The cost per client has increased. The number of claims has increased. The number of clients has increased. We haven't drilled down into more of an analysis. Our intuition is that the population of clients is in situations where they have a lot more health problems. They come from much more difficult situations and they need more health care. So there are a variety of factors.

● (0950)

The Chair: Thank you, Ms. Scott.

We're now going to go into the second round. It's going to be very, very tight. We will have Ms. Murray and possibly one other question to make sure we get all our questions in.

So it's a five-minute round, Ms. Murray, and I'll be tight on time.

Ms. Murray, do you want to start?

Ms. Joyce Murray (Vancouver Quadra, Lib.): Thank you, Madam Chair.

I'd like to find out from Ms. MacLean, of the psychologists, psychiatrists, social workers, and therapeutic workers, what percentage are working specifically with clients and what percentage are doing policy work?

Ms. Leslie MacLean: The very rough rule of thumb is that most of our health professionals are in our institution. I can give the detailed breakout by profession as an undertaking to the committee, Madam Chair, but, for example, of the nurse component I spoke to earlier, of the 750 nurses—

Ms. Joyce Murray: Sorry, I listed the mental health and drug workers. Do you have a rough rule of thumb on how many are doing policy work? What percentage?

Ms. Leslie MacLean: The complement for psychologists is very small at the national headquarters level. For example, 5 of the 340 psychologists are at our national headquarters. Those would, of course, be our people working principally in the policy area. We don't—

Ms. Joyce Murray: Thank you. Because the time is so tight and I have five questions, I'm going to go through them quite quickly.

Do you do work to assess the care provided in terms of mental health and drug addictions? What's working and what's not working?

Ms. Leslie MacLean: For our addiction programming, we have both formal program evaluation and annual publication of our correctional results in our report on plans and priorities. For the mental health component, some aspects of the funding are quite new. They came in in 2005, 2007, so we're actually going to be doing an evaluation of our mental health strategy over the next year or so.

Ms. Joyce Murray: Can you tell us again—the back of the envelope—how much of the medical and mental health and addiction problems were brought in by the clients and how much is attributed to being incarcerated? How much is either? Do they actually get the hepatitis C from being in the prison? How many of those problems are exacerbated through incarceration as opposed to whether there was a natural state before they came in?

Ms. Leslie MacLean: I'll respond at the high level first. The Correctional Service does not have an electronic health record, so our ability to track detailed health conditions by inmate or to do population health analysis is limited by that. I could give you some of our most recent data on infectious disease, however, because I do have 2008 data. It shows, for example, on HIV/AIDS, in 2008, we had a population of 219 inmates with HIV/AIDS. We also had 87 people admitted that year with HIV/AIDS, 90% of whom already knew they had HIV/AIDS. Similarly, for hepatitis C, where again our most recent data is 2008, of a population of 3,903 people with hepatitis C, 935 were admitted that year with it, 85% of whom already knew.

Ms. Joyce Murray: So can I summarize that some come in with mental health problems, drug addictions, and diseases, and some acquire them while incarcerated?

My last question.... We have been told by the Parliamentary Budget Officer that the potential cost of the government's punishment agenda would be $2 billion over five years, which is 10 times what had been assessed by the government itself. My question is this. Have you been asked to assess what the needs and costs related to this increase in number and time of incarcerated Canadians might be? How do you see the current shortages changing with this punishment agenda that will be increasing the number and length of stay in prisons?

● (0955)

Ms. Leslie MacLean: Our commissioner has been giving testimony before the national security and public safety committee on the impact of the possible change in inmate population, and my understanding is that of the funds budgeted for an increase in offenders, there will be funds for providing health services to inmates as well.

Ms. Joyce Murray: So the short—

The Chair: Thank you, Ms. MacLean.

Now we'll go to Ms. McLeod. Go ahead.

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): Thank you, Madam Chair.

First, I was a little surprised in terms of there being no electronic health record, so I'm just wondering, are there plans? Have you put your application in? Where is that at?

Ms. Leslie MacLean: I'd be happy to speak to our efforts on that. The front-line staff ask me about it every time they see me.

We actually had been going through a formal request for proposal last year. That effort failed, so we are now working to assess, both with other federal partners who deliver health services and provinces and other suppliers, any possible outlets for us to collaborate with others and have a partnership that would enable us to give an electronic health record to our front staff. It's critical to continuity of care and supporting them in excellent health services.

Mrs. Cathy McLeod: Okay, so you have the funding available; you just have not found the product that's going to meet your needs as of yet. Is that accurate?

Ms. Leslie MacLean: The department, some years ago, had succeeded in obtaining funding to buy an electronic health record. Last year our work was not successful, so yes, we have some funds set aside to help us purchase a health record.

Mrs. Cathy McLeod: And you talked about looking at the scopes of practice and of course aligning in the different jurisdictions, and without mentioning any particular province, have you found that there are some provinces that have a scope of practice that allows a much more flexible and appropriate response, or is it pretty well consistent across Canada?

Ms. Leslie MacLean: In the nursing area, we certainly see much more alignment among scopes of practice, with the exception of nurse practitioner, which is not a regulated scope in all jurisdictions. The other area where we would have noticed more difference was actually in the psychology area, where the qualification level seems more variable among the colleges.

Our commitment is to ensure that we have people with licences, or who are eligible for licences, providing our health services.

Mrs. Cathy McLeod: I hope I can get in at least two more questions. Have you been looking at integrating nurse practitioners into the care that's delivered?

Ms. Leslie MacLean: We actually did a very large workload measurement study of all nurses in the service last year, and we will be using that to analyze both opportunities to improve how our staff are working and to make sure we've got good resource indicators, and yes, nurse practitioners would be an area of practice of interest to us in the service.

Our current obstacles in that regard are, one, that it's not recognized, is my understanding, by the classification standards under which we work, managed by the Treasury Board, and secondly, it's not yet a regulated scope of practice in all eight provinces where we have institutions.

Mrs. Cathy McLeod: My last quick question is to Ms. Scott. We've made some adjustments to try to limit bogus refugees from certainly two of our significant countries where we thought they were—

The Chair: I'm sorry, time is running out and I'm just going to have to cut it off here, because we do have other witnesses waiting.

I want to thank you so much for being witnesses at our committee. Your comments were extremely helpful and very insightful. Thank you.

I am going to suspend for two minutes, and if you would do me a huge favour, please do not have conversations with committee members inside this room. If committee members need conversations, please do it outside.

We'll take two minutes to get our other witnesses settled, please.

● _____ (Pause) _____

●

● (1000)

The Chair: I am going to begin now. We do have a lot of witnesses today. We welcome the witnesses. I thank you for being here. Your input is extremely important.

We're going to be very tight on time so we get a chance to listen to all the presenters today. We do have a very long list of people.

We have, from the Association of Canadian Community Colleges, Terry Boyles. You will be presenting from your association, Ms. Boyles?

Ms. Terry Anne Boyles (Vice-President, Public Affairs, Association of Canadian Community Colleges): Yes, with a short presentation from Rae Gropper.

The Chair: You will have five minutes, so if she doesn't have time to do it, I'll have to cut that off. You'll be sharing your time.

From the Canadian Association of Occupational Therapists, Ms. Elizabeth Steggles. You'll be presenting from your association.

From the Canadian Public Health Association, Dr. Neudorf, and from the Canadian Society for Medical Laboratory Science, Ms. Nielsen.

From the Association of Canadian Academic Healthcare Organizations, Glenn Brimacombe. You'll be the person presenting, Mr. Brimacombe? Great.

Pursuant to Standing Order 108(2), let's begin, starting with Terry Boyles, please.

Ms. Terry Anne Boyles: Thank you.

The Association of Canadian Community Colleges represents Canada's colleges, specialized institutes such as the Michener Institute, polytechnics, CEGEPs, university colleges, and colleges with university mandates. Our membership is very broad. We have 150 member institutions and we have campuses in over 1,000 Canadian communities.

There is a crisis in advanced skills in the country. Even with the recession and the downturn in the economy, industry sectors across the board have been coming to the association saying they're very concerned about this.

Twenty national industry associations, including the Canadian Healthcare Association, led by Pamela Fralick, are meeting. They're concerned that they're raiding each other's staff, particularly when you're looking at people with backgrounds in maths and sciences. Moving forward, they're really concerned about the capacity of Canada's colleges and institutes. Pamela Fralick is actually one of the leaders when we appear before the finance committee speaking about that concern and crisis.

On the aboriginal front, first nations institutions are members, but certainly our colleges serve aboriginal peoples. We share with the Assembly of First Nations the real concern about the cap on the post-secondary education program for status Indians and Inuit. There were over 10,500 students on the wait lists in 2006. Our estimate with the AFN is that they're growing at 3,000 per year.

In the math and science areas in particular, we're really concerned. I was a college president. We're seeing the people de-skill, and we're seeing them becoming almost discouraged and not going on to post-secondary, or it's discouraging to other people from their communities about going into post-secondary education.

On the immigration front, I just want to draw the committee's attention to materials in our kit. Our association ran the pilots for the Government of Canada for immigrants between when they're accepted and when they come to Canada, to introduce them to the regulatory frameworks, to the region of the country they're moving into, to the bridges and ladders in terms of accreditation processes. We've just been awarded the contract to expand that to 25 countries overall, so we'll be opening up a new office in London and one in the Middle East shortly.

In our recommendations—and those are on the last page of the document—they really talk about the capacity issue and that the system programs are full; the aging infrastructure; the cost of technology; and recruitment of our faculty out into the health sector and into other countries—a major concern. There's a dearth of data on health human resources.

I'd like to have Rae Gropper just speak to one of our big national projects.

● (1005)

Ms. Rae Gropper (Consultant, Association of Canadian Community Colleges): It's a challenge to speak so quickly on an issue of such importance, but I'll do my best.

I'm involved in a project called “Sustaining an Allied Health Workforce”. It's a constituency that gets very little attention because the attention focuses more on physician and nursing education. But the diagnostic and therapeutic activity within the system is critical in this workforce.

What we're looking at is demand and supply and trying to get a handle on the issues that are involved here. This is an area in the country that we don't have a good handle on in terms of numbers. We're hoping to promote a pan-Canadian approach to sustain supply, to identify and promote innovative practices. We're going to do this by developing a blueprint and policy statement in consultation with all stakeholders: provincial, professional, and educational.

Our working group consists of 14 to 16 members, uniquely representing educators, professions, regulators, employers, and creditors. Our blueprint activity will be beginning shortly. The innovative activity will focus on six regions in the country and will try to address and evaluate innovations that can be of use to the colleges that are doing about 70%-plus of the training.

The colleges I represent participate both in the collaborative forum, which involves educators, professions, and regulators, as well as the allied health programs and the deans of allied health.

The Chair: Thank you very much.

I know the constraints are restrictive for all of us. We have to live within the rules, but when the questions and answers come, if there's a point you really want to make, sneak it in there. That's what some people do, and it's helpful to you.

Ms. Rae Gropper: Thank you.

The Chair: Oh, you're very welcome.

Now we'll go to Ms. Steggles from the Canadian Association of Occupational Therapists.

Mrs. Elizabeth Steggles (Assistant Professor, Project Coordinator, School of Rehabilitation Science, McMaster University, Insititute for Applied Health Sciences, Canadian Association of Occupational Therapists): Good morning, and thank you for this opportunity to contribute to your committee's study on human health resources.

My name is Elizabeth Steggles, and I'm an assistant professor at McMaster University. Today I'm here to represent my profession and my association, which is the Canadian Association of Occupational Therapists. I'd like to share my thoughts—our thoughts—with you about the challenges and opportunities being dealt with by occupational therapists.

Occupational therapy is an essential health service that enables Canadians to maximize their productivity, reduce lifestyle restrictions, and avoid unnecessary dependency. A sense of well-being and meaning in one's daily occupations is an important determinant of health and is an effective means of reducing health care costs for the public purse.

Occupational therapists are faced with human resource challenges similar to those faced by other health care professionals. We must deal with workforce shortages, a lack of seats in universities, exclusion from service delivery, and the inclusion of internationally educated professionals.

Labour market information and workforce studies indicate that there is a strong and persistent demand for occupational therapy services across Canada to address the challenges of aging; mental health issues, such as post-traumatic stress disorder; workforce management; and chronic disease management.

Yet to us as a health profession, whose use is limited when compared with countries with similar health systems, underutilization is primarily due to a shortage of therapists and to limited use or the exclusion of occupational therapy in appropriate health care settings.

The Canadian Association of Occupational Therapists believes that the answer to human resource concerns for their profession lies in effective health human resource planning, including enhancing the integration of foreign-trained occupational therapists into the Canadian workforce.

Workforce shortages are resulting in negative impacts on occupational therapy service delivery. Occupational therapists are concerned about the impact of organizational and workplace demands on the quality of services they deliver to their clients. They report that workplaces demand higher productivity, while they provide fewer resources to support service delivery and limited opportunities for professional development. On a personal note, I'd like to note that I hear that from my colleagues on a daily basis. Professional requirements for an evidence-based service are frequently placed in conflict with employer demands to assume high caseloads while reducing the costs associated with service delivery.

Ensuring an adequate supply of occupational therapists will require a greater current commitment to increasing seats in occupational therapy programs in Canadian universities as part of any health human resource modelling plan. Increasing the number in our profession is also being addressed through our program that assists international graduates who immigrate to Canada fully qualified to work as occupational therapists. Internationally educated occupational therapists play an important and growing role in meeting service demands for occupational therapy in Canada. Many employers are actively recruiting occupational therapists educated outside the country to meet staffing needs and the needs of our clients, who themselves come from diverse and multicultural backgrounds.

● (1010)

International occupational therapy graduates often find it difficult to practise in Canada and face barriers to entering the occupational therapy workforce.

The Canadian Association of Occupational Therapists has undertaken a number of initiatives to work with occupational therapy partners to address barriers experienced by international graduates. For example, the occupational therapy examination and practice preparation program assists internationally educated occupational therapists as they prepare to write the Canadian exam and transition into practice.

The Chair: Thank you, Ms. Steggles.

Now we'll go to Dr. Neudorf, please.

Dr. Cordell Neudorf (Chair, Board of Directors, Canadian Public Health Association): Thank you for this opportunity to appear before you, both as chair of CPHA and as informed by my practice as a public health leader in Saskatchewan.

This committee has heard CPHA say on prior occasions that the vast majority of our health dollars within the country go to fund the treatment side of the system at ever-expanding cost, without a commensurate increase in people's health status. Public health, that part of the system that focuses on keeping people healthy and preventing disease, is relatively underresourced—less than 2% of the health budget in many jurisdictions.

In times of crisis, the public rightly expects a robust public health system, but between crises it seems less top of mind than waiting lists for surgery or other treatment or diagnostic services and often becomes vulnerable to budget cuts. As a result, we have in the country a patchwork of approaches to and variable investments in public health. We need strong federal leadership to bring forward the implementation of a coherent, coordinated, and consistent approach across the country to deal with issues such as immunization coverage, inspection rates, chronic disease prevention, injury prevention, etc.

The people on the front lines, my staff, the public health workforce, are the key element to building and maintaining public trust and confidence in the public health system. But this workforce isn't expanding at a rate that matches increased demand for service from the public, and it doesn't have sufficient surge capacity to respond in an effective and timely fashion to simultaneous public health emergencies and outbreaks. We need a pan-Canadian public health infrastructure action plan that includes as a key element the expansion and enhancement of the country's public health workforce.

CPHA has advocated for many years for increased investment in public health in the implementation of a population health-based approach to health sector human resource planning and allocation, and certainly some progress has been made of late; for example, the 2005 “Pan-Canadian Framework for Public Health Human Resources Planning”, the Pringle and Emerson report, and the Public Health Agency of Canada's April 2008 online resource *Core Competencies for Public Health in Canada* , and also the recent emergence of several schools of public health in Canada. But there hasn't been sufficient response to achieve the necessary improvements to public health capacity at the front line.

Although health care is a provincial responsibility, ensuring that a strong and unified public health system is in place across the country certainly should be a federal concern. We feel that the best way to guarantee public health capacity in times of crisis is to ensure that the public health system has a strengthened baseline capacity, working on enhanced disease and injury prevention, health promotion, and protection activities between crises.

CPHA's brief to the Standing Committee on Health, “Enhancing the Public Health Human Resource Infrastructure in Canada”, presents several recommendations that we encourage the committee to consider in its deliberations and final report to Parliament.

The pan-Canadian framework for the planning of public health resources exists. The challenge before us is to implement it now, with well-defined timelines and the achievement of key milestones and the definition of roles and responsibilities of key players.

We also need some minimum level of public health workforce investment across the country. CPHA also suggests a targeted investment approach through transfer payments that require a percentage of matching dollars from the provinces in order to ensure a stable level of funding for a public health system across the country. This mechanism has been used successfully before. The national immunization strategy is one example in which federal funds were targeted to certain immunizations deemed core for all Canadians, which in turn helped leverage provincial funding in support of this public health priority area.

We don't expect the federal government to do everything; it's a joint effort. But it does need leadership, championing, and stewardship, and it needs political commitment to get the job done. I can assure you that CPHA will do its part to support the enhancement, expansion, and further development of our country's public health workforce.

Thank you.

● (1015)

The Chair: Thank you very much, Dr. Neudorf.

We'll now go to the Canadian Society for Medical Laboratory Science.

Ms. Nielsen, please.

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

Good morning, and thank you for giving me the opportunity to comment on the committee's study on HHR.

The Canadian Society for Medical Laboratory Science, or CSMLS, is the national certifying body for medical laboratory technologists and medical laboratory assistants. It is also a voluntary, not-for-profit society that represents 14,000 medical laboratory professionals who work in Canada and around the globe. You may be surprised to hear that our profession is the third-largest health care profession in Canada, and approximately 85% of physician decisions are based on medical laboratory test results.

Canada is presently facing a nationwide shortage of medical laboratory technologists. Our organization predicts that by 2016, half of our MLTs will be eligible to retire. Since 1998, we have been alerting decision-makers that the number of seats in medical laboratory technology education programs is not sufficient to produce enough new graduates to replace those who are leaving the workforce. The domestic supply is simply too low.

Since 2000, governments have taken great steps to address the shortages by opening new MLT education programs and increasing capacity in others. This is a positive development; however, we are still more than 120 seats short annually.

But there is a bigger problem. Funding for programs has been provided for the classroom portion, but not for the clinical training piece. As with most health professions, clinical training is a vital component of medical laboratory science education. Completion of a clinical placement is mandated by the accreditation body, and students cannot graduate from their programs without completing a clinical placement.

In 2004, in partnership with Health Canada, we completed a research study, *Clinical Placements for Canadian Medical Laboratory Technologists: Costs, Benefits, and Alternatives*. The report revealed several issues that if not addressed will compromise the ability of education institutions to deliver the clinical component of their programs in the future. Most importantly, there is inadequate funding for the clinical education, staffing shortages at the clinical sites negatively impact their ability to allocate resources to student training, and there is very little research on best practices in clinical education.

But we're not alone. Other health care professions are facing exactly the same problem. The pan-Canadian HHR plan explicitly recognizes the importance of clinical education and sets a specific goal of increasing access to clinical training and clinical education.

So where are we today? We're in a situation now where clinical sites, primarily hospital labs, are refusing to accept students because of staffing shortages. It's becoming a very vicious cycle: they can't take students because they're too busy due to staffing shortages, and they're short of staff because there are not enough students supplying the labour market. We have to break this cycle soon.

This brings me to the issue of the internationally educated medical laboratory technologists. We recognize and applaud the federal government for its continued work to accelerate and expand the assessment of internationally trained health professionals, but more needs to be done. As the shortage continues to grow, we are consistently receiving about 600 self-identified technologists through immigration annually. But practice varies significantly across the globe, and it is a requirement that all practitioners in Canada meet the rigorous entry-to-practice standards to provide excellent patient safety. A system that allows for additional training and practice in the Canadian context that is accessible, affordable, and reliable is imperative.

“Bridging programs for internationally educated medical laboratory technologists: a business case” is a project that we recently completed study on. It concludes that bridging programs significantly shorten the time in which internationally trained technologists become certified and start working in the Canadian workplace. They also decrease their financial hardships.

We conduct prior learning assessment and credential evaluation every year for about 300 medical technologists, and about 90% of them do not meet the standards required in Canada. Furthermore, the failure rate on the national exam is well below the Canadian average. So it is absolutely imperative that the government invest in bridging programs for the internationally trained and make some provisions to fund clinical training spots.

In conclusion, we strongly recommend long-term, sustainable investments be made to support on-site clinical education. We need dedicated full-time preceptors in our labs who can devote the necessary time and attention to students and the internationally trained. We further recommend long-term and sustainable funding for bridging programs to facilitate quicker entry into the workplace. Strong investments today will help ease the future impact of the shortages.

Thank you for your time and attention.

● (1020)

The Chair: Thank you, Ms. Nielsen.

We'll now go on to the Association of Canadian Academic Healthcare Organizations, with Mr. Glenn Brimacombe.

Mr. Glenn Brimacombe (President and Chief Executive Officer, Association of Canadian Academic Healthcare Organizations): Thank you, Madam Chair.

I'm Glenn Brimacombe. I'm president and CEO of the Association of Canadian Academic Healthcare Organizations. I'm joined today by Dr. Jack Kitts, who is the ACAHO board chair, and he's also president and CEO of the Ottawa Hospital.

ACAHO represents Canada's teaching and research hospitals, academic, provincial, and regional health authorities, and their research institutes. Our members are uniquely defined in terms of their publicly stated, integrated, tripartite missions of patient care, education and training, and research and innovation. This morning our remarks are focused on the issue of the supply mix and distribution of health providers and the role of the federal government in the context of the standing committee's study on health human resources.

Of the estimated 18,000 new graduates each year from medicine, nursing, and other professions and disciplines, most will have had at least one practicum in an ACAHO member organization. For students across all years of a multi-year clinical training program, ACAHO members provide 55,000 clinical placement and residency opportunities per year. These placements enable the transition from textbooks to the reality of human life and the provision of care. In many cases, these experiences shape the foundational practices and career decisions that will influence these individuals for a lifetime and the care their patients will receive.

In addition to sheer volume, however, these placements are also occurring in environments in which the research and innovation mandate allows world-class training experiences. With the co-location of research, ACAHO member organizations are more likely to be early adopters of innovation, resulting in the ability to take on complex health issues. For example, some ACAHO members have mandates to improve aboriginal health, the health of the vulnerable, complex, and aging populations, and to lead in the use of innovative health and information technologies to achieve efficiencies and improve system sustainability, while improving the quality of care, enhanced patient safety, and better health outcomes.

By virtue of the capacity resulting from the integration of patient care education and training and research innovation, ACAHO members provide a national resource by consolidating rare, expensive, and complex procedures to optimize outcomes and efficiencies, but also to minimize competition for scarce human resources and sub-specialty resources; by providing clinical mentorship to trainees who may become employees of other organizations, often in other provinces or parts of the country; and generate research and innovations that have no geographic boundary, which can be applied across the system and have a global impact.

While the policy issues related to health human resources and their supply mix and distribution are largely addressed at the provincial and territorial levels, ACAHO is of the view that there is a strong complementary and catalytic role for the federal government to play, given their constitutional responsibilities. To address the sustainability of the clinical training experience, the pre-budget submission of the 38 national associations that form the Health Action Lobby, which is known as HEAL, recommended that the federal government establish a five-year, time-limited, issue-specific, and strategically targeted national health human resource infrastructure fund. Such a fund would allow organizations to sustain and engage experienced clinicians in the training and mentorship of new trainees by providing funding for special initiatives to offset the direct cost of training providers and developing leaders, such as the cost of recruiting and supporting more community-based teachers and mentors, funding for the indirect or infrastructure costs associated with the educational enterprise, support for departments' education offices, and the materials and equipment necessary for clinical practice and practical training. The fund would also focus on the need for an overall data management system for specifying, tracking, forecasting, and costing of health human resource requirements in the face of evolving population health needs.

We would also recommend that it be complemented by the creation of a body, which some have termed an observatory, that would enable providers and policy makers to exchange, learn, and pilot widely implementable leading practices.

In closing, ACAHO believes that the federal government has a role in contributing in a complementary pan-Canadian fashion. It can do so by leveraging national resources to optimize the integration of patient care, education and training, and research and innovation, and by providing the infrastructure needed for evidence-informed management of the many health systems across our country.

Thank you.

● (1025)

The Chair: Thank you very much.

Now we'll go into our first round of questions, which is a seven-minute Q and A. We'll begin with Dr. Bennett.

Hon. Carolyn Bennett: Thanks very much.

First I want to congratulate Ms. Nielsen on what you've been able to do with the bridging program. It shows what can happen, and your success could happen in lots of other areas. And I hope we can make sure that some examination of bridging programs and preceptors can help in terms of incorporating our foreign-trained health grads.

We have such great people here that I want to take a slightly different approach. Separate from what you've told us, if we're going to focus on quality and cost-effectiveness over the future of health and health care and evidence-based policy and practice and practice-based evidence...I want to just think about Cuba, where now every polyclinic has a statistician and an epidemiologist measuring what they're doing all the time and feeding back. The fact that they've now beat us on infant mortality speaks to actually measuring and adapting, and measuring again.

Dr. Neudorf, you have led the country, pretty well, in using health informatics and GIS mapping on the social determinants of health. And obviously the academic health facilities are worried about patient safety and measuring and adapting, whether it's hospital-acquired infections or.... It seems appropriate, in this week of National Nursing Week and World Health Week, that we are celebrating Florence Nightingale, who was a statistician more than she was the compassionate lady with the lamp.

How do we make sure that our health human resources include the people who can measure, make assessments, and manage not only in health promotion and disease prevention but also in the care we give?

● (1030)

The Chair: Dr. Neudorf, do you want to start with that?

Dr. Cordell Neudorf: Sure.

Certainly what we've found in public health, with the new regionalization of health services occurring in much of the country... we see these skill sets not only as a service provision within the service of public health but as a support for the rest of the health system and health system planning. And you've heard ACAHO talk about observatories. And similarly, within the population health initiative, the perspectives that we feel can be brought to the table in an observatory manner for population health data to inform health system planning, as well as quality improvement, are something we're experimenting with at the local level in various areas across Canada where those types of skill sets—measurement, epidemiology, surveillance, quality assurance—are being merged together.

What we're not seeing are the kinds of support to hire these types of people to help us manage the system better.

The Chair: Dr. Kitts.

Dr. Jack Kitts (Chair of the Board, President and Chief Executive Officer of the Ottawa Hospital, Association of Canadian Academic Healthcare Organizations): I think you've hit the nail right on the head.

In health, change is very difficult. We're completely risk averse, and if that's the way we've been doing it for 20 years, it must be good. I think the only way to achieve effective change is that this health human resources plan for the next 10 to 20 years has to be based on a different service delivery model. We cannot continue to provide the same service delivery and add more of the same to the status quo.

So change is essential. It should be collaborative, with a full scope of practice and health care professionals working in a team. The biggest factor to effect that is to be able to measure quality outcomes and base those decisions on evidence, which we don't have today.

Hon. Carolyn Bennett: So if you were going to write recommendations for pushing "reset" on all of this and how we would do things differently, does it mean that community colleges have to be training people who can do these things? What extra set of statisticians, epidemiologists, applied research do we need?

Dr. Jack Kitts: I would suggest that the health service delivery model begin with taking every one of the professionals—some of whom are represented here today—beyond doctors and nurses and use them to the full scope of practice based on the needs of the patient, working in a team. I suggest we'd find we have lots of health human resources in that respect.

I do believe that if we do it right...the future has yet to be defined; health care providers will require close work between hospitals and colleges to create the course that will develop those health care providers based on the patient need, working in a team.

Ms. Rae Gropper: From our perspective, you're absolutely right, and I think the first primordial step is for us to get a handle on what's going on in allied health. We can't seem to get a really good analysis around the country, and that's part of what I would recommend to you, that you move onto in recommendations. The other, of course, is to integrate very strongly the whole idea of interprofessional education as a core component of every curriculum regardless of the profession. I think Dr. Kitts, Christine, and I agree on that wholeheartedly.

Hon. Carolyn Bennett: At the health infostructure we can't really be measuring unless we can get into this century on not only measuring patients but with health human resources at the same time, in terms of instantaneous....

The occupational therapists...you obviously feel you are being underutilized in terms of teams as well.

Mrs. Elizabeth Steggles: Certainly, yes. There are beginning to be small breakthroughs. In Ontario now we've just been included on family health teams, which is a big breakthrough. We know from experience and research that by introducing occupational therapy into interdisciplinary teams, as has been pointed out by other members here, you can produce a more satisfactory service in a more cost-effective manner.

● (1035)

Ms. Terry Anne Boyles: I have a point on the data. I sit on the chief statistician's advisory committee on post-secondary education and statistics, and one of the biggest concerns—obviously there is lack of data on the colleges altogether—is that there is a wealth of information in the census reports that would be extremely useful to the work of all of us as we look at health human resources. But you actually have to buy that data, and most of the partners can't buy the data.

The Chair: Thank you, Ms. Boyles.

We will now go to Mr. Malo.

[*Translation*]

Mr. Luc Malo (Verchères—Les Patriotes, BQ): Thank you, Madam Chair.

I would also like to thank our witnesses for being with us today.

My question is for Ms. Boyles.

You said that your organization is responsible for the Canadian Immigration Integration Project. Could you tell me how that project works and how you implement it around the world?

[*English*]

Ms. Terry Anne Boyles: Certainly. Excuse me if I speak in English. It's my Saskatchewanian background.

Once an immigrant in the three pilot countries—we have an office in Manila, in Guangzhou, and in Delhi—is accepted for immigration to Canada, they are referred to the staff in those offices. The staff work with them, and they do workshops on the area of the country they might be moving to, their particular field or discipline, linking to the regulatory groups, the accreditation groups—medical lab technologists, for example—trying to fast-forward the ability of the immigrant to enter the employment field once they get to Canada. We've identified the bridge areas that need to be moved into, and depending on where they are being located to in Canada, we then link primarily to Canada's colleges that do the bridging programs, in partnership, in this case, with the various health professions. That's now being expanded to the other 20-plus countries.

[*Translation*]

Mr. Luc Malo: Does it work? Are there a lot of people who use it? Are there employers interested in it?

[*English*]

Ms. Terry Anne Boyles: Yes, the pilot was about three years in length. We now have 8,000 people who have gone through the program. In your packages—it's only in English, I'm sorry—there are four examples of health care workers who've moved into employment in hospitals, in home care settings, in technology lab settings in Canada. That's the reason why the Government of Canada has moved from the pilot to expanding it to the other 20-plus countries.

[*Translation*]

Mr. Luc Malo: Do you have something to add, Ms. Nielsen?

[*English*]

Ms. Christine Nielsen: Just to add to that, being a national professional association that receives immigrants globally, ever since the program started we have been receiving incremental increases of applications offshore. In terms of the success for someone who has applied and figures out where they will fit into the Canadian context, it's much better for them to do that while they are in their source country. So the three source countries they are working in, with the expansion into the U.K., will definitely help our profession. As I said, 90% of our people are not equivalent, and they can fill those gaps while they are still in their home country. We are not limited to just using domestic resources. Our PLA program allows for the philosophy that education can be obtained anywhere as long as it meets the competency requirements. So for our association it has been a very successful program by allowing people to have better answers on a much timelier basis while they are still at home.

[*Translation*]

Mr. Luc Malo: Ms. Boyles, do the usual consular staff manage this project or has a new team been set up to do that? If so, how many additional people have to be deployed to carry out the project?

[*English*]

Ms. Terry Anne Boyles: The managers of each of the centres are employees of our association, working in partnership with the consular staff, so the consular staff refer to the team. It's a combination of Canadians who are posted into those communities and locally hired people working on the program. We posted, actually this week, the management positions for the new centres as well. We are hiring now for the office in London and then the office in the Middle East.

● (1040)

Mrs. Elizabeth Steggles: I want to add that we have realized, through the services we've been offering to internationally educated occupational therapists, that to try to talk to people offshore before they come here is in fact a great advantage.

A lot of people are coming here. It's taking them far longer than they ever anticipated to transition into practice. We've developed some online resources to assist people in countries before they come here. We are in the early stages of this, but we're beginning to realize that this is going to be a big advantage, because people often don't have a good idea of the health care system here. To get some of that knowledge before they come is really going to help in the transition. Also, they don't end up in low-paying jobs as soon as they get here and get trapped into that position.

[*Translation*]

Mr. Luc Malo: Thank you, Madam Chair.

[*English*]

The Chair: Thank you very much.

Now we'll go to Ms. Leslie, please.

Ms. Megan Leslie: Thank you, Madam Chair.

Hi, there. My name is Megan Leslie. I am the member of Parliament for Halifax. Welcome.

Mr. Neudorf, you said “strong federal leadership is needed in some areas”, and I really very much agree. Maybe we can figure out a way to increase the number of seats at universities and colleges; maybe we can figure out a way to help internationally trained grads get certified here. But I look at your pan-Canadian framework for public health human resources planning project and I think it's tremendous.

I am wondering if the two of you can talk to us about some of the lessons learned from that. When we're thinking about doing a national health strategy that includes, as one of its key components, health human resources, what are some of the lessons learned that we can transfer to the health strategy?

Dr. Cordell Neudorf: I can certainly start on that.

The challenge we have with many of the allied health professionals, I think, is that we don't have sufficient capacity in many of the provinces to be self-sufficient in training some of these professionals, so we require more of a pan-Canadian approach to generate the number of professionals we need. Health inspection is a very good example; within Canada, there are only two or three places where they're trained. To take my own specialty as a public health physician, not all colleges of medicine have training programs in that area as well. So an approach that looks at what the need is overall has been necessary, and I guess that's what has driven the project.

But also what we have seen is a large change in the way the health system is delivered and organized, whereby there's a lot more emphasis on integration. We have heard about interdisciplinary teams, but also trying to use professionals for a better scope of practice, not just within their area of service but for the rest of the system. That has changed the way in which people need to be trained and the kinds of experiences they get in their training as they start to transition into the workforce.

Similarly, are the right positions in place for them, once they graduate, to continue practising in that environment? We've seen a bit of a disconnect between the field and the training program in that area, such that in some cases the field is a little ahead of the training program, and in other cases the training program is setting up an ideal interdisciplinary environment, but the students graduate and find it difficult to discover the same type of practice out there.

What we've been trying to do is get those two groups together in the health human resource planning—the training institutions and the field working a little more closely together, as one plans to provide the needs for the other.

Ms. Megan Leslie: That's a piece of the progress. What is the progress on implementation right now?

Dr. Cordell Neudorf: With the schools of public health being invested in by multiple universities, for example, you're starting to see some investment from the universities coming in. The core competencies models that have come out to list both common and unique core competencies in various disciplines in public health have been a huge benefit. They have translated into accreditation standards in our area as well.

The area in which we're starting to fall short, though, is the ability of people who are already in the field to take advantage of some of the retraining and continuing education to meet these core competencies. In some cases, there is not the requisite investment in the new types of positions that are required at the field level, so the students come out and the jobs aren't available for them, because those investments haven't been created yet.

● (1045)

Ms. Megan Leslie: My next question will be for all of you. If there isn't time, don't worry, because I would like to ask that you follow up with a written response if you haven't had a chance to speak here.

I want to open it up to each group for comments specifically about...well, it doesn't specifically have to be this plan, but....

Mr. Kitts, I see you want to jump in.

Dr. Jack Kitts: I think strong leadership means setting a goal or vision. The federal government could say: we're interested in investing in collaborative teams, working at the full scope of practice, to ensure that all Canadians have access to quality care in the most appropriate setting as close to home as possible.

I think those three things define a whole different thing. For example, the Ottawa Hospital has a relationship with Nunavut. In the case of providing quality care in the most appropriate setting as close to home as possible, clearly we can't set up a heart transplant program or a major complex surgery program in Nunavut, so the investment in health human resources would be more in transportation and transport workers, to get them to the most appropriate place as close to home as possible.

At the secondary care level, with generalists and consultants, we send providers up there, which I think is more appropriate than trying to staff a rural or northern area that can support one-half or one full-time equivalent. It won't work in those groups, so send providers of care. And on the primary side, use more technology and full scopes of practice to provide primary care.

If you took that model across Canada and looked at urban-rural relationships and urban-northern relationships, the health human resource plan would be very different from what it is today. It takes several years—14 or 15 years—to create a physician. We're talking about providing enough people for a service delivery model that I hope is not based on the status quo 15 years from now.

Putting a stake in the ground saying that we're only supporting collaboration and collaborative teams, that whether remote, urban, or local, we have to start working in teams, is the only way to sustain it. That's what health human resources should be based on.

Ms. Megan Leslie: Before I turn it over for you to answer the question, you touched on something I forgot to put in my question, which is that making a line between the quick and dirty "this is what we need now" versus.... Yes, we do need long-term planning, and that is probably the most useful way of moving forward, but there are also some things that urgently need to be addressed now.

Dr. Jack Kitts: In many respects, at the front-line level the providers are finding ways to provide the service. I think somebody said you're getting a lot of local pockets of innovation and teams and collaboration being forced because of the demands and the shortage. What I'm saying is that it's better to lead it and create it than to respond to it.

Ms. Megan Leslie: Thank you.

The Chair: Would anybody else like to comment? Ms. Gropper?

Ms. Rae Gropper: Thank you. I can only echo the sentiments that Dr. Kitts has just expressed and tell you that the project I described under the auspices of Health Canada is looking for those pockets of innovation and searching out where they are viable and workable. We will do everything possible to promote them and to share that information for other centres across the system to look at.

The whole issue of education and training, understanding the numbers we need and developing a curriculum that matches it, and most critically, having the graduates go into a system that fits this curriculum.... If we have these integrated teams and we raise expectations for people who choose health as a career, we want the system to be able to adopt them and accept them, instead of hearing from them that it doesn't quite fit. I think I hear an echo around the table of the very same issue.

● (1050)

The Chair: Thank you so much.

Now we'll go to Mr. Brown.

Mr. Patrick Brown (Barrie, CPC): Thank you, Madam Chair.

Those were interesting comments by Mr. Kitts. You talked about a collaborative health team. I know that in my riding the most successful units we have are the family health networks. I find that they're able to deal with many more patients. It would be great to have more.

What is included in your definition of a collaborative health team? Is it similar to what the Province of Ontario has set up with these family health...?

Dr. Jack Kitts: I think the family health teams are a step in the right direction. But I don't think they're based on sitting down and truly looking at the needs of the patient and creating the team around that patient. I think it's more a mixture of family doctors with other health providers. I think I heard that occupational therapists are only now becoming part of the team.

If you actually sat down at every level and looked at the patients you serve and what they need, we would go much further in terms of scopes of practice and collaboration than we do now. But it's not easy. I think health care professionals in general are hard-wired to be independent, autonomous practitioners. We're not oriented around a team, so this goes against our very culture.

So there needs to be a very clear focus. I would argue that most if not all of the associations fiercely defend the turf their professionals work on, and I don't think we're ready to wipe the slate clean and use all of us to the full scope.

Mr. Patrick Brown: I hesitate to ask, but what else should be added to the family health teams?

Dr. Jack Kitts: I think they're a step towards working as teams, but I suspect that in many cases there could be fewer primary care physicians and more dieticians and nutritionists and others along the prevention line. Physicians are created to diagnose and treat; the prevention comes from all of the others.

I don't know every team in detail, but I suspect that if we were to look at them based on the needs of the patients, the mix would be different.

Mr. Patrick Brown: In terms of the academic health care organizations, do you also deal with the teaching hospitals you talk about, with the residency spots available through those teaching hospitals?

Dr. Jack Kitts: Yes, the residency spots are dictated by the universities, and we accept the residents.

Mr. Patrick Brown: Is there a capacity to have more residency spots in existing infrastructure, if there were the funding?

Dr. Jack Kitts: I think in some, but it's getting very tight. Medical school enrollments have more than doubled in the last several years, so I think they're getting tight.

Mr. Patrick Brown: I find, when we look at the physician side of the equation, that one of the greatest challenges is the lack of residency spots. Fingers are pointed in different directions, but from what I've heard from foreign-trained doctors and from people looking to be integrated into the health care system, that seems to be the greatest hurdle: finding a residency spot at a teaching university. What steps can we take to open those doors more?

Dr. Jack Kitts: I think there are enough residency positions for all Canadian graduates from medical schools. What you're probably hearing is that there aren't enough neurology positions or enough dermatology, so someone may have to graduate medical school and take a specialty that wasn't their first choice; that may be what you're hearing. But there are enough spots for all of the students who graduate.

Mr. Patrick Brown: But there aren't for foreign-trained graduates?

Dr. Jack Kitts: No, they're created differently. I think the provincial colleges determine how many spots are opened up, and then they deal with specific hospitals. That's getting tighter. At the Ottawa Hospital we have 120 residents from the Middle East, and I think the spots are getting very tight.

But we do not bring in a foreign graduate as a resident at the expense of a Canadian position. The Canadian positions are funded and filled, and the foreign residents are over and above.

Mr. Patrick Brown: Are there any additional comments, perhaps from your colleague, about what would be required to open up more residency spots, if we wanted to allot spots for foreign trained graduates as well?

Mr. Glenn Brimacombe: One of the issues is the issue of funding, both at the undergraduate and the postgraduate level. They go hand in glove. So as much as you're looking at spots within medical schools at the undergraduate level, if you're going to move them into the postgraduate round, it's making sure you have the infrastructure within facilities such as the Ottawa Hospital or the Vancouver General Hospital—pick your institution across the country. There's the notion of twinning the two, as they move from the classroom into the clinical practice environment.

● (1055)

Mr. Patrick Brown: In terms of occupational therapists, do you find that there are some areas of the country that have much more acute shortages?

Mrs. Elizabeth Steggles: I can't tell you specifically, but I know that in remote communities there are more shortages of occupational therapists.

If I may also address the field work issues, that is a big problem for us. There are not enough field work placements. Where there are field work placements, there are often difficulties with affiliation agreements or with insurance issues. It is something that we, the Canadian Association of Occupational Therapists, are beginning to look at and do a scan of across the country to try to find out what the issues are related to this. We know that with all the different regulatory bodies there are different requirements, and that becomes a big issue in trying to find placements.

Mr. Patrick Brown: What are the consequences for patient care if a hospital or lab or practice doesn't have an occupational therapist? What is the secondary loss because of that? Are there other procedures that can't be done? Does it inhibit patient care?

Mrs. Elizabeth Steggles: We work in so many different areas that it's difficult to answer that question quickly. Basically occupational therapists help to enhance an ability to take part in daily activities of life. They help people be more independent in their self-care, in the way they look after themselves in the work they need to do or in leisure. As a result of anything that is not addressed in that field, they may be a less productive person, and a person who we know is less productive or who is deprived of occupation is usually a less healthy person.

Dr. Jack Kitts: Can I add to that?

In our hospital I think occupational therapy is one of the underutilized and undervalued professions that could add more value. In our hospital patients stay longer, and when they go home they can't cope, so they either are re-admitted or go to another facility. I think occupational therapy is essential as part of a team.

Mr. Patrick Brown: This is a question for the community colleges. We have an excellent community college in Barrie, Ontario —Georgian College—that has a focus on health and wellness. One thing they pride themselves on is the fact that most people who graduate go right into a job.

Do you find that typical everywhere in the health and wellness field, that there's an instant take-up?

The Chair: Mr. Brown, you are very close to your time.

So maybe respond quickly, so that we'll have one more question.

Who wants to comment on Mr. Brown's question?

Ms. Terry Anne Boyles: There is about a 94% placement rate across the country as a whole. If the community wants more grads, we don't have the capacity to provide them.

The Chair: Ms. Murray, take just one quick question, please.

Ms. Joyce Murray: Thank you.

We heard that change is needed and that data is essential to the right kind of change. Would the panellists recommend to this committee that Stats Canada, or any other federal body that collects data linked to population changes or social or environmental determinants of health, make that data available free to the organizations that are doing this kind of analysis? Is that a recommendation you would support?

Ms. Rae Gropper: I would support it most emphatically and strongly.

Ms. Joyce Murray: And would you have it available to the communities for their planning as well?

Ms. Rae Gropper: Absolutely.

The Chair: Thank you.

This is the culmination of our presentation.

Hon. Carolyn Bennett: Dr. Neudorf was nodding. Did you see that?

The Chair: Good.

This is the end of our presentations today. I want to thank you so much for coming and giving your insightful comments. It's been very useful to our committee.

We will adjourn this committee to go into the subcommittee on neurological disorders shortly.

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