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Chair

Mrs. Joy Smith

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● (1530)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): Good afternoon, everyone. I certainly want to welcome our guests to the committee today. We're very excited about having you here. We started a study on human resources and the problems we're facing now with human resources. We started that in the spring, and as a committee we were very anxious to get back to that study. So pursuant to Standing Order 108(2), the study on health human resources, we have our witnesses here.

From the Department of Health we have Kathryn McDade, director general of health care policy. We have Shelagh Jane Woods, director general of the primary health and public health directorate, first nations and Inuit. From the Department of Citizenship and Immigration Canada we have Helga Loechel, director with the Foreign Credentials Referral Office. From the Department of Human Resources and Skills Development we have Jean-François LaRue, director general of labour market integration, and Brendan Walsh, manager of labour mobility and the immigration portal.

We will start with the Department of Health, with Kathryn McDade. You have a 10-minute presentation, and then we'll go to the next witnesses.

Ms. Kathryn McDade (Director General, Health Care Policy, Strategic Policy Directorate, Department of Health): Thank you, Madam Chair.

On behalf of Health Canada, I would like to thank the committee for the opportunity to participate in your study on health human resources. I'd like to focus on two things in my remarks this afternoon. First, I'd like to provide an overview of Health Canada's health human resources, or HHR, initiatives, which I did discuss with you in some detail when we appeared last April.

Second, after our last appearance in April, your clerk indicated that the committee had a specific interest in the work of a federal-provincial-territorial committee, called the Advisory Committee on Health Delivery and Human Resources, or ACHDHR. I'm the federal co-chair of that committee, along with my provincial-territorial co-chair, Dr. Joshua Tepper of the Ontario Ministry of Health and Long-Term Care. Dr. Tepper is not here with us today, but based on the committee's interest, I will try to provide you with a quick overview of the advisory committee's current work.

Health human resources, or HHR for short, has been a priority for Health Canada since 2003, at which time Canada's first ministers made a commitment to work together to secure and maintain a stable and optimal health workforce in Canada. In April, I talked about Health Canada's investments in three key HHR initiatives: first, the pan-Canadian health human resource strategy, which is funded at $20 million per year; second, the internationally educated health professionals initiative, with funding annually of $18 million; and third, the aboriginal health human resources initiative, which is a five-year initiative with total funding of $100 million.

In all three areas, Health Canada's investments are intended to complement the more significant investments that provincial and territorial governments make in the area of HHR, and that's of course in the context of their responsibility for delivery of health care to the vast majority of Canadians.

So just as I said, to take each of the three Health Canada initiatives briefly in turn, beginning with the pan-Canadian health human resource strategy....

[*Translation*]

A significant proportion of the projects funded under the strategy focused on recruitment and retention of health professionals. Health Canada has supported undergraduate medical education programs to adapt their curricula to encourage more medical students to enter family practice. We have noticed a 44% increase between 2003 and 2008 in the number of Canadians exiting post-MD training in family medicine.

We have also invested in several initiatives to promote inter-professional education and a more collaborative approach to the provision of care. This has resulted in a greater number of institutions as well as educators providing mandatory inter-professional education courses, more health professionals trained for collaborative practice, and increased sharing of best practices related to collaborative care.

● (1535)

[*English*]

In 2005-06, Health Canada's second HHR initiative, the internationally educated health professionals initiative, or IEHPI, was launched specifically to reduce barriers to the integration of health professionals trained outside Canada, by promoting access to information and path-finding, competency assessment, training, orientation, and other supports for integration into the workforce.

The bulk of the funding, some 90% of the funding under IEHPI, is directed to provincial and territorial governments that are developing innovative initiatives in the areas of credential assessment, bridge training, career counselling, information services, and orientation.

There are many examples, but just to give you one quick example, there's a new one-stop information, counselling, and path-finding service that was established in Ontario, with Health Canada's support, which is providing service to over 5,200 clients.

In the nursing profession—a second example—there's a new competency assessment program for internationally educated nurses that was developed originally in Alberta but is now implemented in all of the western provinces and also in Nova Scotia.

[*Translation*]

Health Canada's third health human resources initiative, the Aboriginal Health Human Resources Initiative, was announced in 2005 to develop and implement health human resources strategies which respond to the unique needs and diversity among aboriginal peoples. The goal is to address the need for both more aboriginal health practitioners and more non-aboriginal practitioners with some cultural competency in the care of aboriginal patients.

[*English*]

AHHRI, as we refer to it, the aboriginal health human resources initiative, was designed to lay the foundation for longer-term systemic change in the supply, demand, and creation of supportive environments for first nations, Inuit, and Métis health human resources for aboriginal communities with the goal of improving health status, with a particular emphasis on increasing the numbers of aboriginal health professionals.

Currently in its final year, the AHHRI has achieved impressive results. For example, we've increased the number of aboriginal students receiving bursaries and scholarships for health career studies to a total of 1,398 students over the four-year period from 2005-06 to 2008-09. Working with our partners, we've developed a number of tools to be used by Canada's 17 medical schools to help decrease barriers to admission and to increase enrolment of aboriginal medical students.

A mid-term program review of AHHRI has recently been completed and the results are very positive. The review found that the initiative has made significant inroads in facilitating the conditions for increased aboriginal participation in the health care system in Canada.

Finally, as I said at the outset, I'll say a few words on the advisory committee on health delivery and human resources.

[*Translation*]

The Advisory Committee on Health Delivery and Human Resources, first created in 2002 by the federal/provincial/territorial Conference of Deputy Ministers of Health, has the following mandate. First, to provide policy and strategic advice to the deputy ministers on the planning, organization and delivery of health services, including health human resources, and, second, to provide a national forum for discussion and information-sharing.

In addition to representatives of all 14 governments, the committee includes representatives from the Health Action Lobby, First Nations communities, the Council of Ministers of Education, Canada, the Canadian Institutes of Health Research, the Canadian Institute for Health Information, a regional health authority, and Human Resources and Skills Development Canada.

[*English*]

I'll provide you, just quickly, with a few concrete examples of how this federal-provincial-territorial committee is pursuing its mandate. In the area of HHR planning, the committee recently undertook a comprehensive update of an inventory of health human resource forecasting models and convened a series of workshops to share knowledge related to those models.

ACHDHR recently examined the issue of self-sufficiency in health human resources and has released a discussion paper entitled, “How Many Are Enough? Redefining Self-Sufficiency for the Health Workforce”.

ACHDHR is focused on strengthening collaboration between health and education ministries to better manage requests that are received from professions and educational institutions for changes in entry-to-practice credentials. In that regard, we've established a permanent subcommittee that advises governments on whether specific proposed changes in credentials would serve the interests of patients and the health care system more broadly.

Building on work funded by Health Canada, ACHDHR has recently identified gaps in the Canadian approach to interprofessional education and collaborative practice, which I mentioned earlier, and is in the process of developing a strategy to address these gaps.

As a final example, ACHDHR has made a significant contribution to the integration of internationally educated health professionals, in particular physicians and nurses. For example, ACHDHR recently endorsed a business case for the development and implementation of a new standard national assessment for international medical graduates coming into Canada and hoping to enter the national postgraduate medical education training match.

Finally, ACHDHR in general continues to provide a strong mechanism for communication and collaboration across jurisdictions and within the range of stakeholders who are committed to strengthening Canada's HHR.

I'll stop there, Madam Chair.

● (1540)

The Chair: I thank you for your very insightful comments.

Following the other presentations, we'll go into Q and A.

We'll now go to Helga Loechel of the Foreign Credentials Referral Office.

[*Translation*]

Ms. Helga Loechel (Director, Foreign Credentials Referral Office, Department of Citizenship and Immigration Canada): Thank you, Madam Chair.

My name is Helga Loechel, and I am acting director of the Foreign Credentials Referral Office at Citizenship and Immigration Canada.

I want to thank the committee for this opportunity to provide an update on CIC's role in health human resources. Today, I will focus my remarks primarily on the FCRO's overseas interventions in support of federal, provincial and territorial governments' initiatives on foreign credential recognition.

[*English*]

I think we all recognize that immigration has been and continues to be vital to Canada's growth and economic strength. In recent years, Canada has accepted approximately 250,000 new permanent residents each year.

However, recognizing the foreign credentials of internationally trained individuals continues to be a challenge across the country. In Canada, provinces and territories are responsible for assessing and recognizing credentials. Currently there are more than 440 regulatory bodies across Canada governing approximately 55 professions. There are also more than 200 accredited post-secondary institutions that assess educational credentials for academic placement, as well as five provincially mandated assessment agencies that evaluate education credentials for the purposes of both academic placement and workforce entry.

In fact, more than 53 provincial and territorial ministries are involved since this issue spans immigration, labour market, health, and education ministries. There are literally thousands of players on this file, when you include employers, who are also important assessors of the credentials and work experience in regulated and non-regulated occupations.

[*Translation*]

The Government of Canada has established a relationship of leadership and trust with the provinces, territories and regulatory bodies on priorities such as labour mobility and foreign credential recognition.

Although foreign credential recognition falls within provincial and territorial jurisdiction, the Government of Canada has a responsibility for immigration and its impact on the Canadian labour market and economy. As such, the Government of Canada continues to have a central leadership role in facilitating advancements on foreign credential recognition.

[*English*]

The government established the Foreign Credentials Referral Office, the FCRO, in May 2007 to provide internationally trained individuals with the information, path-finding, and referral services they need to have their credentials assessed as quickly as possible so they can find work faster in the fields for which they have been trained. Additionally, the FCRO provides a coordinated focus at the federal level to work with provinces and territories, regulatory bodies, and employers to coordinate federal, provincial, and territorial efforts; share best practices across the country; and avoid overlap and duplication on an issue that is extremely complex.

On January 16, 2009, first ministers agreed to take concerted action to provide for the timely assessment and recognition of foreign credentials through the development of a pan-Canadian framework for the assessment and recognition of foreign qualifications. CIC, along with HRSDC, and provincial-territorial labour markets and immigration ministries, participated extensively in the development of the framework. As part of this work, the FCRO is taking a leadership role on all matters related to pre-immigration initiatives. To that end, the FCRO received additional funding—$13.7 million over two years—in Budget 2009 to contribute to the development of the framework.

Specifically, the FCRO will support the development of harmonized standards and will clear pathways to foreign credential recognition for targeted occupations, beginning overseas. It will strengthen the scope of the overseas platform and develop a pan-Canadian information centre, a website that will showcase and promote the sharing of foreign credential recognition promising practices across the country.

Prior to the establishment of the FCRO at CIC, HRSDC laid the foundation for consistent foreign credential processes overseas through a pilot with the Association of Canadian Community Colleges, ACCC. In October of 2010, the FCRO will build upon the pilot and expand funding to provide FCRO services not only to federal skilled workers, but also to provincial nominees in China, India, and the Philippines, as well as to support the creation of a fourth location in the U.K., beginning no later than 2011. The U.K. location will serve the British Isles, the Gulf, and Scandinavia. Combined, these offices will cover a larger pool of immigrants and could access close to 75% of federal skilled workers and 44% of provincial nominees.

Our FCRO offices overseas will provide a platform for governments, employers, and licensing bodies to expedite the accreditation process and significantly contribute to quicker success for immigrants entering the labour market. The FCRO is also offering important services to immigrants domestically, including the provision of information on foreign credential recognition processes in Canada. These services are offered in person to clients in Canada through the 329 Service Canada centres and 245 outreach sites, as well as by a toll-free telephone number through Service Canada call centres.

Information on foreign credential recognition is also available on the FCRO website, which includes the “Working in Canada Tool”, which is an online search tool that provides individualized information on specific occupations, communities, and labour market conditions, as well as information targeted to both internationally trained individuals and employers. Between the FCRO launch in May 2007 and September 2009, the FCRO website received over 732,000 visits, mainly from overseas.

Although foreign credential recognition remains a challenge for most immigrants seeking entry into the Canadian labour market, governments are coming together to support initiatives that will play a crucial role in promoting the future growth of the country and in providing immigrants with the tools and services they need to begin the assessment and accreditation process while still in their country of origin.

● (1545)

[*Translation*]

Thank you, Madam Chair. I hope this has provided you with an overview of CIC's role in foreign credential recognition.

[*English*]

The Chair: Thank you very much.

That was certainly a very good presentation. It answered some questions, but I'm sure you'll have many more.

Thank you for your presentation.

We'll now go to the Department of Human Resources with Director General Jean-François LaRue.

[*Translation*]

Mr. Jean-François LaRue (Director General, Labour Market Integration, Department of Human Resources and Skills Development): Thank you, Madam Chair, and distinguished members of this committee.

My name is Jean-François LaRue, and I am the new director general of the Labour Market Integration Directorate within the Skills and Employment Branch at Human Resources and Skills Development Canada. I succeed Ms. Carol White, whom some of you will certainly remember, as she spoke to this committee in April of this year. I have with me my colleague, Brendan Walsh, who was also present at the April 2 meeting of this committee.

Today, I would like to provide the committee with information on HRSDC's investments and activities as they relate to the labour market integration of health human resources. More specifically, I would like to provide an update on what we have done in the areas of labour mobility and foreign credential recognition.

● (1550)

[*English*]

To begin, let me say that we know there are real economic costs for the Canadian economy associated with issues of domestic mobility and the non-recognition of foreign credentials. Beyond the loss to productivity, maintaining barriers to labour mobility and underusing the skills and employment potential of immigrants also results in unnecessary increases in social services costs, the decreased ability of employers to find employees with the required skills, and the loss of potential tax revenue.

Encouraging the recognition of qualifications and certifications across Canada benefits both workers and employers. Workers have a wider range of opportunities, and employers have a broader selection of candidates. By ensuring that we effectively use the skills of immigrants, we can support the creation of a larger, more efficient, more flexible labour market. By ensuring that the qualifications of immigrants are given their due, we are laying the foundation for a more efficient job matching process that responds to the needs of employers. That is why initiatives such as amendments to the Agreement on Internal Trade and the resulting improvements in domestic labour mobility, as well as action on foreign credential recognition, are not just the right things to do for individuals but are also sound economic policy.

Successful labour mobility is vital to ensuring that Canadian workers can enter the labour market quickly, when and where they are needed, which will help strengthen the Canadian economy and will improve the standard of living of all Canadians.

We'll first provide an update on labour mobility and what has been accomplished in the last few months as territorial, provincial, and regulatory leaders have worked collaboratively to take action to ensure that all Canadian workers have the freedom to practise their occupations or trades wherever opportunities may exist.

The Agreement on Internal Trade, also known as the AIT, provides the basis for improving labour mobility for regulated occupations, including the health professions. As a result of the premiers' calls for full labour mobility in Canada, a series of amendments to chapter 7 of the AIT were developed to make it a more effective tool for achieving this goal. These amendments have been ratified and took effect on August 11, 2009. That marked a significant milestone.

The revised labour mobility chapter of the AIT states that any worker certified for an occupation by a regulatory authority of one province or territory is to be certified for that occupation by all others. Any exception must be justified to meet a legitimate objective, such as the protection of public health or safety. There are hundreds of regulated occupations in Canada, and we expect that only a small number of exceptions will be identified.

Maintaining Canada's highly regarded occupational standards continues to be a priority for governments and regulatory bodies. Through contribution agreements between HRSDC and groups of regulated professions, the labour mobility division enables eligible groups representing regulated occupations to develop a better understanding of the Agreement on Internal Trade requirements and to develop tools to enhance labour mobility.

In terms of investment, HRSDC has had a long history of providing leadership, support, and expertise to foster labour mobility. We have worked with regulatory bodies to create common standards, assessment methods, and other pan-Canadian tools and approaches since the Agreement on Internal Trade first came into force in 1995. In the past two years alone we've directed nearly $3 million towards the development of tools and measures to facilitate labour mobility and to promote greater understanding of standards among regulated occupations across Canada. Specifically, HRSDC has directly supported 42 regulated occupations. Of these, 33 were related to health occupations.

With full labour mobility in place, governments have a responsibility to ensure that there are consistent evaluations and entry points into the Canadian labour market. HRSDC's foreign credential recognition program, or FCRP, provides contribution funding and works with provinces and territories, stakeholders, and other partners to facilitate the assessment and recognition of qualifications acquired in other countries.

● (1555)

[*Translation*]

The Foreign Credential Recognition Program, FCRP, began work with regulated professions in three priority occupations, two of which are in the critically important health sector, physicians and nurses. Since 2003, our work has expanded to nine other health occupations for a total direct investment of $12.6 million.

As of October 30, 2009, the FCRP has supported 32 health-related projects, including 8 projects currently under way. Our support to the health sector represents roughly one third of the projects in our portfolio. The FCRP maintains regular dialogue with Citizenship and Immigration Canada, as well as Health Canada and committees of experts in the health sector in order to ensure the strategic investment of FCRP funds and the prevention of funding duplication. Input and feedback from Health Canada officials are solicited on all health-related project proposals received by the FCRP.

The FCRP has made significant progress in strengthening the foreign credential recognition capacity of regulated and non-regulated occupations, and has facilitated strategic foreign credential recognition partnerships and initiatives across Canada and overseas. Many of these investments have directly contributed to the efforts of medical professions to address the recommendations made by the Canadian task force on licensure of international medical graduates in 2004.

[*English*]

Despite the progress of all governments, barriers to effective labour market integration for foreign-trained health professionals remain. Successful labour market integration also requires that Canada has the right systems and processes in place to recognize the knowledge, skills, and experience of immigrants.

As indicated by Helga, in response, on January 16, 2009, first ministers directed labour market ministers to develop a pan-Canadian qualification recognition framework and a plan to put it in place. This process is ongoing.

Over the coming weeks, the Forum of Labour Market Ministers will continue to work towards a consensus framework document. I am confident that the work the Forum of Labour Market Ministers is undertaking will make a significant contribution to reducing barriers faced by internationally trained workers and will lead to the improved integration of immigrants into the labour force.

The FCR program will continue to be a key piece of the Government of Canada response to the issue of foreign credential recognition.

[*Translation*]

In closing, I would like to recognize the department's efforts to create an integrated system of fair and objective assessment processes, and to increase consistency between jurisdictions with respect to recognition and registration processes for internationally-trained professionals, while also improving mobility across Canada.

I would be pleased to provide additional details during the question and answer portion of this afternoon's session, or in writing, as the committee wishes.

Thank you very much.

[*English*]

The Chair: Thank you very much.

Now we will go into our question and answer round. The first round will be seven minutes, Q and A.

Ms. Murray is first.

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

Thanks for your presentations. It's very encouraging to hear of all the progress in foreign credentialing.

As someone who worked in provincial government—five to nine years ago, I guess—I know that was a big issue for our government, so I'm very glad you're making progress. Also, it's such a human issue; people who can't get those credentials can't do the work they want. So it's important.

I'm going to ask some questions along a different line, though, and it comes from a meeting I had with the dean of the College of Health Disciplines at UBC. We were talking about the health human resources study. I was asking her what she sees, from her perspective of trying to integrate various health disciplines—i.e., the training, the curriculum, the objectives, the information—as the gap here.

One of the answers she gave me was that there are many pilot projects for integrating health professionals to be more effective, but they're pilot projects. When they're over, they're sometimes just over. There isn't a rolling out or a systemic adoption of the things we find out that work.

So whereas credentialing is more about bringing more professionals in than having a larger volume, I think we also really need to work on the effectiveness of the process we use and having health professionals work together in collaborative ways, with patient-centred processes and so on.

Can you give me any information or ideas about where in your organization there is a focus on taking pilot projects, and the learning we have from them, and implementing them more broadly in Canada?

● (1600)

Ms. Kathryn McDade: Thank you for the question.

I'll give a bit of a response, and if colleagues want to jump in they're welcome to.

One of the pieces that the Advisory Committee on Health Delivery and Human Resources is working on, the federal-provincial-territorial committee that I talked about, is exactly that one that was raised by your colleague in terms of interprofessional education and interprofessional collaborative practice. There have been a number of—you could refer to them as pilot projects—investments in identifying best practices in the years since the health human resource strategy has been in place at Health Canada—the past five, six years. There have been roughly 11 projects, some conducted on a bilateral basis with provincial-territorial governments, some on a national or pan-Canadian basis. And the conclusion is exactly as you've stated it: a lot of good work, a lot of insight into how to make interprofessional education and interprofessional collaborative practice work. But the question now is how well that is being implemented across the country and whether the findings of those pilots have actually been translated into practical knowledge for educators or health care providers.

In this fiscal year, 2009-10, the ACHDHR, the federal-provincial-territorial committee, has set up a health education task force to look back at what we've learned, figure out what the gaps are. For example, is it that some models haven't been tested, or is the gap actually that we know what the models are, we know what the best practices are, but they haven't been implemented in a consistent way across the country? So the gap study is in the current fiscal year, and depending on what that finds, we would take forward proposals to federal-provincial-territorial deputy ministers for the next fiscal year in terms of how to move forward, how to do a better job at knowledge translation, if that's what we find the problem is.

Ms. Joyce Murray: Are there other comments on that question or on the collaborative interdisciplinary approach?

Ms. Kathryn McDade: That one's been largely funded by Health Canada, so colleagues haven't had as much involvement in the work.

Ms. Joyce Murray: Then I have another question. There have been processes to identify ways to be more effective by working in collaborative mechanisms. My guess is that it's money that's missing. When you have a pilot project that does well and then the funding for it is over, it's pretty hard to continue it on an ongoing basis, even though it may save money in the long term and produce better care for people.

Can you give me any commentary on where resourcing is in this absence of progress, or the “slower than we'd like” progress, on something that was really a critical issue half a dozen years ago or more?

Ms. Kathryn McDade: I'm not sure if I can give you the kind of detailed answer that you're looking for. From a Health Canada perspective, we invest in the models, the best practices, the pilots, however you want to describe them.

Just to give you a couple of specific project examples, we did work with the Council of Ontario Universities. That was to look at the interprofessional health sciences education piece. In terms of where that work goes or whether Ontario universities have the full resources that they would like to implement it, we leave that, of course, to the discretion of the provincial government working with the post-secondary education sector in the province.

We provided the support to develop the model, but as to whether the Government of Ontario has done an adequate job, from the perspective of either professionals or health educators, Health Canada steps back from that role.

Ms. Joyce Murray: Thank you. I see that was not a practical question, but here's another.

I know there have been some very successful patient-centred pilots in our health system in British Columbia that are part of the collaborative interdisciplinary patient-centred philosophy. Do you collect data on the effectiveness, in terms of reduced costs and reduced patient bed days and improved outcomes from those pilot projects?

● (1605)

Ms. Kathryn McDade: Yes, we do. Your specific example of British Columbia is probably the best one. We have worked with the University of British Columbia as the host for housing what's called the Canadian Inter-Professional Health Collaborative. We have done a lot of work with them. One of the pieces of work we're funding now is exactly as you described, a concrete cost-benefit analysis—so making it real in terms of the savings associated, whether they're efficiencies or whether they're improvements in patient care or a reduction in incidents of adverse events or patient safety problems. We're working with them now to do that quantifying piece. I can't tell you that we've discovered that for every dollar invested there's an equivalent savings of*x*, but we're trying to do that work now, again, through UBC.

The Chair: Thank you, Ms. McDade.

We'll now go on to Monsieur Malo.

[*Translation*]

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

Thanks to our witnesses for coming here this afternoon.

First of all, Ms. McDade, I would like to go back to the Aboriginal Health Human Resources Initiative. You yourself indicated in your presentation that the program, the initiative, was in its final year. You also told us that the mid-term program review had indicated very positive results.

Can you tell us more about the positive results that you have observed? You told us about significant inroads leading to increased aboriginal participation in the health care system. Can you tell us more about that specifically?

[*English*]

Ms. Kathryn McDade: Thank you, Mr. Malo. I'll pass the question over to my colleague from the first nations and Inuit health branch, Shelagh Jane Woods.

[*Translation*]

Ms. Shelagh Jane Woods (Director General, Primary Health and Public Health Directorate, First Nations and Inuit Health Branch, Department of Health): I am very happy to be here and to have this opportunity to talk about our review, our examination of the initiative.

[*English*]

We have just completed our mid-term program review, and it's a very detailed one. It gives us insights into how effective our allocation of resources and implementation projects have been. My colleague gave you some, but I'll give you a little bit more detail.

We know that the review tells us that the initiative has made inroads in creating conditions that enable aboriginal people not only to enter health career studies, but to succeed at them. We know from the review and some of the work we've done ourselves that many more aboriginal people have a much greater awareness of the educational requirements that are necessary if they're going to pursue health careers. This was a concern of ours when we went in, because we found many young aboriginal students approaching the end of high school and not realizing how important it was to do well in or even to study mathematics and sciences. We have done some outreach and we think that generation has a better understanding of what's required.

In addition, they're much more aware of the full range of health careers that are available to them, and they are more interested. Initially, the aboriginal students tended to gravitate towards nursing because it was nurses they saw in their communities, which is great, but now we have a much larger cohort of aboriginal students studying medicine, occupational therapy, x-ray technology, etc.

We've also started a number of bridging programs. We've helped universities and colleges develop bridging programs that help aboriginal students to qualify for entry into health studies. As you know, with some of the not so good rates of high school completion, particularly in the reserve communities, many of them are not able to qualify. We found that the bridging program model is a very good one.

I think one of the most important things we have funded, through the Indigenous Physicians Association of Canada, the Royal College of Physicians, and the Association of Faculties of Medicine, is the development of core competencies in a curriculum framework for undergraduate medical education. We think this has worked very well and will be implemented. We will continue to support it for this last year. This is to do two things. It's aimed at producing non-aboriginal practitioners who are more sensitive to and aware of cultural considerations to make them effective practitioners in those settings and with those patients, but also to provide a kind of curriculum that is relevant to aboriginal students. We think this is actually of benefit to the entire health system. Those are just a few of the things.

Another piece of work that we've done is to survey best practices for recruiting mature aboriginal students to medicine. It's a fact of life that in many cases you're not going to get these people before they are in fact mature and they have a lot of responsibilities. We've looked at what kinds of things appeal to them and what supports they need.

● (1610)

[*Translation*]

Mr. Luc Malo: I have two supplementary questions.

In the light of those numbers, do you feel that the initiative should be renewed? Will it be? Perhaps you already know the answer for next year.

And about the groups of students that you followed, once they were trained, did they tend to go back to their communities to practice their professions?

Ms. Shelagh Jane Woods: Thank you, Madam Chair.

If I understood you correctly, the first question deals with what will happen next year?

Mr. Luc Malo: Yes, exactly.

Ms. Shelagh Jane Woods: When the initiative comes to an end, we can but hope. But as public servants...

[*English*]

I will say we are hopeful. We would like to see this renewed, and we think we have some good evidence for that. We've begun to talk to our partners, so that if the opportunity for a renewal should come, we will be ready with an improved initiative. But it's not for me to say whether it will or won't be renewed.

The Chair: Are you finished, Ms. Woods?

[*Translation*]

Ms. Shelagh Jane Woods: Can I answer the second question?

[*English*]

The Chair: Very quickly.

Ms. Shelagh Jane Woods: It's our hope that many of the students who are trained will return to their communities, but it is not a condition. The initiative is designed to help make improvements in the whole workforce. We have a lot of evidence that if training takes place in a culturally appropriate way and in a culturally appropriate setting, many students will choose to remain in their own or other aboriginal communities. That would be a good result, in our view.

The Chair: Thank you very much, Ms. Woods.

Now we'll go to Ms. Hughes.

Mrs. Carol Hughes (Algoma—Manitoulin—Kapuskasing, NDP): I have a variety of questions; I'm just trying to figure out where I want to start.

First of all, I should welcome you to the committee and thank you very much for your reports. We can see that there has been some headway and that we still have a long way to go.

With respect to the internal agreements, when the internal agreement was negotiated, there were concerns expressed that cross-jurisdictional qualifications for health professions might exacerbate shortages in some provinces and territories as it became easier to move to major centres out of province. The advantages of free movement are evident, but I'm wondering what has been done to ensure the added mobility doesn't shortchange regions that are already suffering from health care shortages.

● (1615)

Mr. Brendan Walsh (Manager, Labour Mobility and Immigration Portal, Department of Human Resources and Skills Development): Thank you for the question.

The decision by individuals to relocate, particularly to another jurisdiction, is influenced by many factors, not just whether their certifications can be recognized. What we're looking at under the revised chapter 7 is more of an enabling agreement. It enables workers who are certified to have their qualifications recognized, so it removes a barrier that used to be there. The chapter is neutral on whether workers are actually going to be encouraged to move, so I think that's important to remember.

There is, though, an acknowledgement that in having easier mobility and easier certification qualifications, as people move across jurisdictions there is a risk it could lead to some skills shortages. We've heard those concerns. One of the things that ministers did when they agreed to the new agreement is that, as part of the annual report, we're going to be monitoring that situation specifically. There's a specific commitment that governments, in addition to assessing the overall effectiveness of the chapter, will have a particular focus on whether there are any unintended negative consequences that could be attributed to the chapter, for example, shortages of health service providers in regions.

I think it's a bit early to say that anything has been happening in that regard yet. Governments are aware of the risk, and we're committed to monitoring it as part of our annual review of the chapter.

Mrs. Carol Hughes: Thank you.

I have a couple of questions for Ms. Woods. On the aboriginal front, you mentioned how things seem to be improving. However, I'm concerned. I think it's good that we can provide more doctors who are more culturally aware of what is happening in those areas and who will maybe service those areas, but given that there's been a 2% funding cap for so long within aboriginal communities, I think we're actually restraining some of these future professionals from coming forward.

I'm wondering where you see the challenges with that. With respect to educating them a bit earlier in life, you mentioned they would be better served if it's one of their own. What are the challenges there, as you see them? I know that funding is a big one.

Ms. Shelagh Jane Woods: That is a complex question. There are a lot of challenges in the whole area. We do still see that, in basic education, high school completion rates lag behind those of other Canadians. And there has been really a lot of effort put towards that over the past 30 or 40 years.

But to be fair, it's a wide world with a lot more choices now. So it's not as if the choices of aboriginal kids who can go out and get a good education are really limited to the things we would have seen traditionally, like nurses, school teachers, etc.

So I would say that one of the basic challenges we face both on the side of the aboriginal students and in terms of our own recruiting is that there is a tremendous shortage of health care professionals. It's a big world out there. There are a lot of things people can do, and you can't compel people to take the courses.

What I find hopeful is that we've begun to put more and more emphasis on training the aboriginal people themselves in ways that accommodate their needs. The fact is that many of them are mature students who have family responsibilities, and the ones who are based in the communities may not be readily able to leave their communities for two years, three years, four years, or five years. So if you can make a lot of the training available to them on site, spread out over time so they can keep their jobs and work on their academic qualifications, we find that works very well.

More than the money, that's really the kind of challenge we face.

● (1620)

Mrs. Carol Hughes: But at the end of the day, there are still challenges with respect to having that funding cut in place.

Ms. Shelagh Jane Woods: I'm not sure of the funding cut you're referring to.

Mrs. Carol Hughes: Sorry, I meant the funding cap, not the funding cut.

Ms. Shelagh Jane Woods: It's not a cap on our money. I think you might be talking about Indian Affairs' post-secondary education.

Mrs. Carol Hughes: That's right, but that is hindering them moving forward. Don't you believe so?

Ms. Shelagh Jane Woods: I don't think so necessarily. We've provided a lot of bursary and scholarship money to aboriginal students—as my colleague, Kathryn, mentioned—to about 1,400 students, and that doesn't include this year's students. There is good take-up, and there is a little more demand than there is supply, but I don't see it as being a major hindrance so far.

Mrs. Carol Hughes: Thank you.

Attracting physicians trained outside of Canada is complicated by the placement opportunities for residency programs. How are you working to address this?

Ms. Kathryn McDade: I did bring along some numbers on the residency issue because there has been quite remarkable progress in the past few years actually. Just to put it into context, before we talk about the specific issue of internationally educated doctors and their capacity to come in as residents, in terms of medical school enrollments generally—all undergraduate seats, not just foreign-trained—first-year undergraduate seats increased by 31% from 2002 until 2008. So that was a six-year period with a pretty dramatic increase in undergrad seats. If you assume there's a very low attrition rate—there has historically been a pretty low attrition rate out of undergraduate medicine, and most of those students do, of course, take on residencies, either in family medicine or specialties—down the road that will represent quite a significant new flow of professionals.

The Chair: Ms. McDade, could we wrap up as quickly as possible?

Ms. Kathryn McDade: Yes.

Just to give you a number on internationally trained medical graduates, in 2003 there were 75 students from outside the country, foreign-trained, who were successful in getting residency seats in Canada. In the current year, in 2009, that number is up to 442. So from 2003 to 2009, that's basically a quadrupling of the numbers. It is quite dramatic.

The Chair: Thank you.

Mr. Uppal.

Mr. Tim Uppal (Edmonton—Sherwood Park, CPC): Thank you, Madam Chair.

And thank you for contributing to this important study.

There are always regular reports of shortages of doctors, nurses, and other health professionals. Can you tell us what the actual shortages are in the country right now?

Ms. Kathryn McDade: The most recent data we have are from the Health Council of Canada, a study published at the beginning of 2008, based on 2007 data. This is survey data. It's a survey of Canadians. It found that 14% of Canadians don't have access to a regular family physician. If you translate that into raw numbers, that's 4.6 million Canadians. And this number was widely reported.

Not so widely reported, but included in the same Health Council report, was the following fact: of that 14%, 10% had access to a regular place of care. These are people who are using clinics, community-based health services. They don't consider themselves to have a regular physician, but they may have a team of physicians who serve them. When you look at it that way, the number goes up to 96% of Canadians with access to either a regular physician or a regular place of care. So it's a much smaller number than was reported.

There are a considerable number of students in the pipeline now. We would expect that as these students graduate from undergrad medical education and take their residencies, we would have the prospect of significantly addressing the shortages that remain.

Mr. Tim Uppal: Would you say the situation is improving? Do you have data to show that it's improving?

Ms. Kathryn McDade: Yes, I think it's definitely improving—it has been improving since 2002-03. The investments are quite dramatic in undergrad, in residencies, and in graduating physicians.

● (1625)

Mr. Tim Uppal: Beyond increasing the supply of health care professionals, what is being done to reduce recruitment and retention challenges?

Ms. Kathryn McDade: Health Canada, in partnership with the federal-provincial-territorial committee, has been working on the shortages issue, the numbers recruited into the profession. We have also invested in a number of projects directed at getting people to remain in the profession once they're in. This has been especially relevant in nursing. There is a relatively high attrition rate. I don't have the number at my fingertips, but the attrition rate in nursing is quite significant.

We did work on something called the healthy workplace initiative. It wasn't limited to nursing, but it provided $5 million over several years for 11 provincial projects. For national projects, it considered how to strengthen workplaces to increase retention. In the last few months, our minister announced a new initiative with the Canadian Federation of Nurses Unions. It provides more than $4 million over a period of three years. It will look specifically at nursing and develop innovative projects in nine centres across the country to try to increase the retention rate.

Mr. Tim Uppal: I was fortunate, in Edmonton, to be able to go to a centre—it was funded partially by the federal government—that had foreign-trained doctors. Some of them even had surgery experience, but for various reasons they weren't able to become licensed doctors here. However, through this program they were able to be trained as paramedics. And these people were grateful to be back in the health field, to be working directly with patients and helping out in Canadian society.

Are there other creative programs like this across the country?

Ms. Kathryn McDade: Actually, that's been one of the major areas of investment under the internationally educated health professionals initiative. Most of the money goes to provincial-territorial governments, about 90% of the program funds. So investment is at the discretion of the provincial-territorial governments. Many of them have invested in bridging programs for foreign-trained doctors and nurses.There's a new bridging program in physiotherapy in the province of British Columbia. So that is one of the major areas of investment.

Right now we're coming to the end of the first five years of that program funding. We're starting to talk to the provinces about where they haven't been able to do bridging, whether there are emerging professions. You gave the example of paramedics. Physician's assistant is an emerging profession in some jurisdictions. We want to talk to provinces about whether this might be a stream for doctors who don't have the credentials to practise as fully licensed physicians in Canada.

Mr. Tim Uppal: Very good.

The Chair: Thank you.

You have time for another quick question, Mr. Uppal.

Mr. Tim Uppal: Great.

It's a little bit opposite of what we were talking about. I mean, it's important to get our foreign-trained doctors licensed and established, but on the other hand, in Canada we expect to have the best doctors, the best medical care. What checks and balances are in place to make sure that the doctors we are bringing in from overseas are qualified to Canadian standards?

Ms. Kathryn McDade: Health Canada does not have direct responsibility for the regulatory function in medicine, of course. That's with provincial and territorial governments, and they've delegated that responsibility, in most cases, to their own regulatory agencies. All of the work we've done on new initiatives to integrate foreign-trained professionals, we do with a steering committee of the regulators and the leading national organizations.

For example, the work we've done on a common assessment for international medical graduates was led by the Medical Council of Canada. It included regulatory agencies from across the country. It included provincial-territorial governments. We don't try to substitute. We don't have the expertise. We depend on the expertise of those partners to make sure that the balance is right, that we're not working so quickly to integrate that we've kind of lost sight of the health and safety considerations that are primary for the regulators.

● (1630)

Mr. Tim Uppal: Thank you.

The Chair: Thank you very much, Ms. McDade. That brings us to a close.

Before we close this meeting, I would like to bring to the attention of my colleagues that I have two constituents in the audience. I know Doris Quinn is just coming through the door. Doris, welcome to my committee.

Some hon. members: Hear, hear!

The Chair: And Jack Armstrong, welcome.

Some hon. members: Hear, hear!

The Chair: I have to thank Ms. Wasylycia-Leis, who has been showing them around and being such a gracious hostess. I would invite you to drop into my office, Room 434, Confederation, if you're here tomorrow, and we'll certainly treat you like kings and queens. Ms. Wasylycia-Leis has made me aware you're here, so thank you very much.

Let's give Ms. Wasylycia-Leis a hand.

Some hon. members: Hear, hear!

The Chair: Having said that, we will suspend the meeting for two minutes because we're now going into our business meeting. I thank you for being here, and I would graciously ask anybody who is not staff or not a part of the committee to withdraw. This is an in camera meeting.

We will reconvene in three minutes.

[*Proceedings continue in camera*]

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