HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Standing Committee on Health

HESA • NUMBER 074 • 1st SESSION • 41st PARLIAMENT

EVIDENCE

Thursday, February 14, 2013

Chair

Mrs. Joy Smith

Standing Committee on Health

Thursday, February 14, 2013

● (1535)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): Happy Valentine's Day, everybody.

We have two more guests who are on their way. They are in a meeting right now and they'll be on their way shortly.

We want to start on time so that everyone has the lovely opportunity of asking you questions.

We're going to proceed with you giving a 10-minute presentation. Following that, if they're not here yet, we'll go directly to questions, just so we don't waste any time. I'll make sure everybody has an equal amount of time so that everyone can get everything in. I think that's the most prudent thing to do.

We have with us Madame Gagné, executive director, and Michaël Béland, communications and programs manager for—and you'll have to pronounce this for me.

[*Translation*]

The Clerk of the Committee (Ms. Julie Pelletier): It is the Conseil canadien de la coopération et de la mutualité.

[*English*]

The Chair: You'll be happy to know that I'm taking French lessons. But I don't want to embarrass myself by mispronouncing things.

I welcome you. You have 10 minutes for a presentation. Please begin.

Mrs. Brigitte Gagné (Executive Director, Conseil canadien de la coopération et de la mutualité): Thank you, Madame Chair.

First, we would like to thank you and the members of the committee for your invitation to present on the cooperatives in the health sector. My presentation will be in French, but we also speak English—with a big accent. We can answer in the way you would prefer.

The Chair: We have translation, so we're good.

[*Translation*]

Mrs. Brigitte Gagné: During the International Year of Co-operatives, which just ended, we made a presentation to the Special Committee on Co-operatives on the issues and specific characteristics of the Canadian co-operative movement.

We would like to bring your attention to the following recommendations. First, spur the development of new health care co-operatives by building partnership agreements with local health care networks and by offering start-up financial support. Second, clarify the rules regarding annual contributions made by members of health care co-operatives. Third, acknowledge the investment made by members of health care co-operatives by allowing them to claim their contributions as medical expenses. Fourth, promote the development of new health care co-operatives in order to create new drivers of innovation adapted to the specific needs of communities. And lastly, set up a committee to study the opportunities for complementarity between the heath care co-operative model and the development of health service offerings in Canada.

The following supports our recommendations.

The Canadian health care system has some undeniable strengths, including access to a variety of basic services for all citizens. Some serious dysfunctions must nevertheless be acknowledged. Co-operatives arise out of the desire of a group of individuals to meet a collective social, economic or cultural need. They pool their resources and skills to achieve it. They equip themselves with means and expertise they would not have had access to without the co-operative. They follow the co-operative principles of democracy—one member, one vote—financial participation, autonomy, inter-cooperation and engagement in their community. When we talk about the principle of accessibility, we are referring to the Canada Health Act.

The health care co-operatives concept is both simple and innovative: a community identifies common health care access needs or new health service requirements. Next, it establishes a co-operative offering free or competitively priced facilities, equipment, technological tools and administrative services to health professionals and/or physicians. They tag on complementary services, such as health prevention services, as determined by members.

A health care co-operative can be defined as a collective enterprise which produces services to promote, maintain and improve the health and living conditions of communities, while involving its members in the organization of its services, at the decision-making level. The members define and manage the co-operative's services and investments to suit their needs. This democratic management ensures that services offered match local needs.

Members agree to fund the co-operative's operations through qualifying shares, annual contributions and donations. Most such co-operatives receive absolutely no funding for their operational costs.

It must be noted here that the co-operative does not purport to offer health services, but rather it aims to ensure access to such services on its territory. It considers itself as having a dual role. First, it provides a competitively priced modern professional environment. Next, the co-operative aims to improve access to various health services by becoming actively involved in the hiring of physicians and other professionals, and by offering health prevention or support services to address local health problems.

While rental activities can generate independent revenues, all of the co-operative's other activities—equipment, administrative services and so on—do not generate any revenue at all, and it cannot rely on any public support. That is why members' contributions and donations from the community are requested to fund this portion of its activities. By collectively assuming this structure's operating costs, the community becomes attractive to such professionals.

It is also noteworthy that in 54% of cases, these co-operatives create a new service in the community, while in the remaining 46%, they replace a clinic that has closed or that is at risk of closing.

Doctors who decide to practice in a co-operative are paid by their provincial public system. No part of their salary is borne by members. In return, access to the physician's services is open to the entire population, to both members and non-members alike, without restriction.

Individual and collective empowerment, which are the values underlying the co-operative model, are the core elements of health care co-operatives. Rather than being mere consumers of health services, members of co-operatives are involved in their own health care and take part in the necessary follow-up. They are also asked to get involved in prevention activities.

The co-operative movement also believes in collective health management. It is managed democratically by a board of directors made up of elected members, and all members can vote at the annual general meeting on policy matters. Thus, the community determines not only how it wishes to shape its local health service delivery, but also how members will fund these projects.

We believe that between the private and the public sector, there is room for the co-operative. Health care co-operatives do not represent a privatization of health services. Rather, they are a partner which alleviates the public system's task by improving access to first-line health services and offering supplementary services. They are not-for-profit organizations that allow citizens to invest in local access to publicly funded health services.

Health co-operatives represent a wonderful opportunity for the Canadian health care system. They are an additional collective investment in access and in primary health care coverage. In that respect, this model represents a partnership opportunity for governments and communities to improve the delivery of health services. It gives back to the individual the power to manage his or her health and gives the community better access to health services.

The creation of a health care co-operative requires the involvement of many volunteers, as well as the financial commitment of thousands of members. Add to this challenge that of developing a partnership agreement with local public health authorities.

This exercise is difficult and tedious. We are dealing with small community organizations, a group of volunteers who are working to create their co-operative. Lack of funding at this stage can often discourage volunteers or slow down the project significantly.

We also believe that the government would benefit by acting as a facilitator for such communities looking to manage this crucial phase in the shaping of their local health care services. This support could take various forms, depending on the needs of the co-operative. Health care co-operatives are young, and their activities cost the government nothing. In fact they may lead to savings.

Since health care co-operatives are financially independent, they come at no operational cost to the government. By improving access to health services and by offering prevention services, these co-operatives allow the Canadian health system to better fulfill its mission and to avoid short-, medium- and long-term costs.

We believe it should be acknowledged that by voluntarily deciding to reinvest in our health system, members of health care co-operatives are first and foremost doing something positive for our society. They should be allowed to claim their contributions as medical expenses on their tax return.

The direct relationship between the members and managers of co-operatives requires ongoing innovation. In fact, members are quite demanding of their co-operative. They want to have concrete proof of how their additional contributions to the health care service offerings affect their access to these services.

The following are a few examples: the implementation of a telehealth service in order to give members in remote communities access to a public system doctor in Nova Scotia; the creation of a mobile medical clinic to service remote communities in British Columbia; the integration of a public emergency service and a medical clinic on the same floor in Beauce, Quebec; the creation of adapted services for the Native population—

● (1545)

[*English*]

The Chair: Excuse me. You're out of time now. We're over time.

Can I ask you to quickly sum up?

[*Translation*]

Mrs. Brigitte Gagné: In conclusion, I would say that the co-operative model is first and foremost centred on the individual. We believe this model is one of the innovative solutions that can potentially maximize taxpayers' investment in their public health system.

[*English*]

The Chair: Thank you.

Keep in mind that there will be questions and answers, so you can get anything in that you really want to.

We have Dr. Bradley Dibbie. You're a cardiologist, Dr. Dibbie?

Dr. Bradley Dibble (Cardiologist, As an Individual): It's Dibble.

Yes, I am.

The Chair: I'm blind in one eye and can't see in the other, Doctor, so I'm having challenges up here. Sorry.

Thank you very much.

You have just arrived, and I hope you enjoyed your meeting. It's very nice to have you here.

We also have Dr. Rob Ballagh as an individual. Did I pronounce your name correctly, Doctor?

Dr. Rob Ballagh (Assistant Clinical Professor of Surgery, McMaster University; Adjunct Professor of Otolaryngology, University of Western Ontario, As an Individual): Yes, you did. Thank you.

The Chair: We are very pleased to have you here.

We were so pleased to have our first individuals. Ms. Gagné started with the presentation before you came, so we wouldn't be behind. What we're going to do now is go individually. We're going to start with Dr. Dibble. You'll have ten minutes, Doctor. Then we will finish off with Mr. Ballagh.

Do you have a presentation that you want to put on the screen?

Dr. Rob Ballagh: Yes.

The Chair: We'll hear Dr. Dibble first, and then you'll have the time to do that.

You have ten minutes, Doctor. Welcome.

Dr. Bradley Dibble: Thank you very much.

I apologize for my tardiness, but Valentine's Day is a very important day to a cardiologist, as I'm sure you can appreciate. The last time I checked, I wasn't aware of any other organs that had a special day devoted to them.

The Chair: Because you're here, you're very special and we have something for you, do we not, Tanya?

Happy Valentine's Day.

Voices: Oh, oh!

Dr. Bradley Dibble: Thank you very much.

I don't need to remind anybody sitting around this table that Canada is a vast country, but I wanted to share with you some specific statistics, courtesy of the Society of Rural Physicians of Canada.

One in seven rural physicians plans to leave their community within the next two years, threatening already underserviced areas.

Of Canada's 10 million square kilometres, 99.8% are considered rural by definition.

Nine million Canadians, which amounts to 31.4% of all Canadians, live in those rural areas.

Towns that account for a population under 10,000 are 22% of Canada, but are served by only 10.1% of Canadian physicians, so they have less than half the ratio they should have.

Larger rural and regional centres—that's between 10,000 and 100,000 population—constitute 15.9% of the population but have only 11.9% of Canada's physicians.

So right there, half of all Canadians are underserviced.

The doctor shortage is a severe problem. Many people are working hard to help. Both Dr. Ballagh and I have sat with Barrie's member of Parliament, Patrick Brown, on a physician recruitment task force, trying to attract doctors to Barrie, but the problem isn't going to be solved overnight. Yet in the meantime, things can be done to help these people. A lot of patients do not have family doctors, and as a specialist I'm concerned that they also then don't have access to specialists such as me, because you need the family doctor to access the specialists, especially in these remote areas.

This problem doesn't have to be as severe as it is, however. With the connectivity of the modern world, allowing everyone to be linked by things like e-mail and text messages, Facebook, Linkedin, Twitter, and Skype, there's no reason that these people can't access their specialist and their family physicians remotely. The technology exists today. This isn't something that has to be developed in the future.

I provide a few examples.

There's simulated training whereby primary care physicians working in rural areas don't even need to have the specialist on hand. They can learn the critical skills they need to have remotely by using simulated patients. These patients will breathe, moan, move, and verbalize, they can be intubated, they can be given medications, they can have tubes inserted into the various cavities in their bodies, and they will respond appropriately. So if mistakes are made, the lessons will be learned. This kind of training allows rural physicians in remote areas to learn the kinds of skill sets they need.

There's also remote video resuscitation. You don't always have to have a physician present. Many places don't have physicians on staff there. These resuscitation teams consist of nurses, maintenance staff, health attendants, and even members of the community—anybody who's interested in participating in that kind of a team.

Cameras can be used and are aimed at both the patient and at the equipment, and the physician from a remote area will offer the advice and the direction of where the resuscitation needs to go.

There's also robotic telemedicine, specifically in Nain, Newfoundland and Labrador, which is the most northern community in that province. There are no physicians on site, but there's a robot named Rosie. She's 165 centimetres tall, so just a little taller, I think, than I am. She has a screen for her face, and she has two-way audio and video capabilities so that a physician in a remote area can use a joystick and have her move from patient to patient; interact directly with the patient; see what she needs to see, whether that's looking at the patient or the pill bottle or the chart; and can offer the needed advice.

Doctor in a Box is something that can be carried to various places, such as the EMS teams when a physician will not be at the scene when an ambulance picks them up. It will be able to see not only what's going on, but will be able to receive the telemetry from the heart rhythms picked up and will be able to provide advice to them directly so that the patient is getting expert care right off the bat.

Surgical robotic systems are another thing that can perform surgery remotely using state-of-the-art robotics. Those types of systems tend to be reserved for large academic hospitals, but less impressive systems can still be employed elsewhere in remote regions where surgeons with expertise can simply monitor what's happening with the OR, using two-way audio and video capabilities. So a surgeon with a greater skill set can instruct and advise a surgeon with a lesser skill set who's physically on the scene. They can see the operative field and they can see what's happening with the patient.

Finally, there are telehealth consults. As a cardiologist, I would say 90% of the diagnoses I make are taken from the patient's history. Although performing a physical exam is helpful, it's not always so critical to be able to offer care to these patients. If I had the ability to interact with them remotely and had an echocardiogram whereby I could see the images done by a skilled technologist, I'd be able to help these patients impressively.

● (1550)

You'll see that most of these technologies have two-way audio-video capabilities.

Rosie and Doctor in a Box aren't as widespread as I think they need to be in a country like this. And nothing I've described here uses any technology that doesn't already exist. This would allow people like me to run remote clinics all over the province, all over the country, and I think all these patients deserve this kind of access. In a country as great as Canada is, but as vast as Canada is, I think one goal for our country is to be able to provide everybody, no matter where they live, that kind of access to care, both primary care and specialist care, and with these sorts of technologies, that can be done.

Thank you very much for your time.

The Chair: Thank you very much, Doctor.

I must say, Dr. Dibble, we had a presentation on the robot Rosie, and it was just amazing to see what she could do. Thank you for bringing that to our attention once again.

Now we'll go to our next guest, Dr. Ballagh.

Dr. Rob Ballagh: I am a specialist in otolaryngology, head and neck surgery, in Barrie, Ontario. I also work in Collingwood, Ontario, Orillia, Ontario, and two days a month I travel five hours each way north to work in Kirkland Lake, Ontario. My patients know me as their ear, nose, and throat specialist.

As a surgeon in one of the fastest growing parts of our great country, I was really delighted to be invited by the Standing Committee on Health to address this hearing.

Since my arrival in the community of Barrie almost 20 years ago, I have been involved in innovation in the health care system's delivery model at almost every level. An interest in teaching young doctors led me to volunteer my time to the rural Ontario medical program to bring medical learners, medical students and residents-in-training, to Barrie to be partnered with experienced, hard-working, front-line physicians and surgeons for what for many turn out to be life-changing learning experiences. Many of these young doctors have chosen, upon completion of their training, to return to underserviced communities like Barrie to practise their craft.

I am now an assistant clinical professor of surgery at McMaster University and an adjunct professor of otolaryngology, head and neck surgery, at the University of Western Ontario.

As a continual innovator in medical education, I am most proud of the association I forged in the past decade with the Health Services Training Centre at Canadian Forces Base Borden, where I am a preceptor and lecturer in their physician assistants training program. Working and teaching these highly professional, skilled soldiers has allowed me to indirectly impact the lives and health of many in our military, and indeed many civilians treated by our military doctors and physician assistants around the world.

I completed my medical school and residency training at the University of Western Ontario in 1993. Thereafter, I spent an extra year of training at Cambridge University, in England, where I studied and became an expert in diseases and disorders of the ear, including disorders that cause dizziness and imbalance. In my specialty, and in my community, I am known to the doctors as the “Dizzy Doctor”.

The diagnosis of a patient with a dizziness disorder is one of the toughest jobs in clinical medicine. I remember nights when my father, a small town family doctor, would come home exhausted, telling us how he'd been discussing dizziness problems with only two or three patients that day. The differential diagnosis, the list of possibilities of the causes of dizziness, can seem endless at the beginning of a patient interview.

Vestibular disorders, or disorders of the organ of balance of the inner ear, are some of the most fascinating dizziness conditions, but also some of the most elusive to diagnose. You have all heard, I am sure, of labyrinthitis, a severe dizziness disorder that is caused by a viral infection of the inner ear. You might be surprised, however, to learn that very few doctors have seen and correctly recognized this disorder, which is actually the commonest inner ear disorder causing acute vertigo. Patients with inner ear disorders can be very ill one day and very well the next day. Indeed, some are very dizzy for a few seconds every night when they go to bed and they are symptom-free every other minute of the day.

In medicine, we're taught to take look at the history of a problem and then to do a physical examination of the patient to look for findings. The problem with most inner ear disorders is that when the patient is not dizzy, which is most of the time, they haven't got any findings. When vertiginous, with a disorder like labyrinthitis, a patient will have several findings—they'll get sweaty, their heart will race, they'll complain of nausea—but these are all findings that are non-specific. They're findings that are shared with other disorders. They're findings that I'm feeling right now in this committee room—

Voices: Oh, oh!

Dr. Rob Ballagh: And there are other items on that differential diagnosis list.

But one finding that's very reliable during an inner ear event is nystagmus, a rhythmic, involuntary eye movement in which the eyes dance back and forth in the patient's head. When you see it, as a diagnostician, it seals the diagnosis. Quite often it even tells us which ear the problem is arising in—not always an obvious thing. Treatment, now that the diagnosis is confirmed, can commence immediately.

The problem is the nystagmus is only visible during the event, which can be measured in minutes and sometimes a few hours. So early on in my practice, I found my inability to know what the eyes of my patients were doing during their dizzy attacks to be frustrating. I would write notes to their doctors that they would carry in their wallets and purses, asking them to document the eye movements of the patient if they presented with dizziness. But try getting in to see your family doctor in the next hour, or to see an emergency room doctor within six hours. It's very difficult.

Then one day something very interesting happened to me, and I hope to be able to share a version of it with you today. A lady came to see me for a second visit for her dizziness. I was convinced, having done my comprehensive history and physical examination on her first visit, both of which were normal, that she probably did not have a vestibular inner ear disorder. Two minutes after she sat down on the stretcher in my exam room, she did the most remarkable thing: she had an attack of Ménière's disease. She became very pale and distressed, she started to lean over at a funny angle, and her eyes started to beat very rapidly from right to left for 20 minutes

● (1555)

I learned a great many things in those 20 minutes, but the most important thing I learned was that my initial impression of that lady had been incorrect. Immediately afterwards I started to encourage my patients to shoot video of their eye movements during the height of their dizzy attacks.

I hope to be able to show you a version of this during the hearing.

After nine years of this pioneering work, started in Barrie, Ontario, by me, with my digital camera and now my smart phone, I have shared my observations with dizziness specialists across the country, and indeed with my Cambridge connections around the world. We have made many new medical discoveries in Barrie, Ontario, and we have seen things we could not explain, raising new questions where we did not realize we even had questions before.

If this will work, and if I am not out of time, I want to show you a very short—

● (1600)

The Chair: You have time. Please, go ahead.

Even if you didn't have the time, I would push it somehow.

We really want to see this.

Dr. Rob Ballagh: I want you to have a look at this lady who has Ménière's disease in her right ear. We are treating it very aggressively at the moment. Because she has gotten worse lately, she's convinced she has Ménière's disease developing in her left ear. She has had no objective physical findings in my office, and her hearing test in the left ear is normal. The only way I can know which ear is causing her problems is to look at her eye movements.

There she is. You can see her eyes are beading very briskly in the leftward direction, toward her left eye.

I received that video, and the reason I chose it wasn't that it was the best-quality video—I have a better-quality video I could show, if you are interested—it was because I received it an hour after I received an invitation to join your committee today.

For this lady, it was the lynchpin in her diagnosis. What it means is that her Ménière's disease in her right ear is acting up. It is worse. I need to take her treatment of that Ménière's disease in her right ear to the next level, a level that could involve destructive changes in the inner ear. In fact, I could end up having to deafen her inner ear on that side in order to make this better. It's much better, though, to treat that ear than to treat an ear that is actually healthy and that she suspected was abnormal.

The Chair: We've had a very wonderful presentation today.

Now we'll go into our seven-minute Qs and As.

We will begin with Ms. Davies.

Ms. Libby Davies (Vancouver East, NDP): Thank you very much, Madam Chair. And thank you for the Valentine's cookies. I already ate mine. It was very nice.

Thank you to the witnesses for being here today. I feel like we've had quite an unusual diversity of opinions.

I'd like to begin with Madame Gagné.

I have a couple of questions about the health co-ops. I'm very familiar with co-ops, but I have to say I'm not familiar with health co-ops.

I understand there are about 50 of them in Canada. Are they primarily in Quebec?

[*Translation*]

Mr. Michaël Béland (Communications and Programs Manager, Conseil canadien de la coopération et de la mutualité): I will answer for Mrs. Gagné.

In fact, the vast majority of these co-operatives are located in Quebec, especially the new generation co-operatives. But there are also some in British Columbia, Manitoba, Saskatchewan, New Brunswick and Nova Scotia.

[*English*]

Ms. Libby Davies: Thank you. I just wanted to clarify that.

I found your brief very interesting, but I'm not clear on two things. When a co-op operates, it's not necessarily a physical location. It's a co-op that is arranging services for its members that may be in other locations. I want to make sure I'm right on that.

Second, I wasn't clear about the membership fee. I wonder if you would tell us the range of the membership fee. I'm not clear on what you get. I can go to my family doctor now and I don't have to pay anything. I can be referred to a specialist, to the hospital, to a community clinic, and I do not have to pay anything. What is the service that comes from a health co-op? That's my second question.

If there's time, I have a third question. Could you talk a little about the demographics? Are your co-ops providing services to all kinds of Canadians? Do you deal with people who have chronic diseases? You say it's about people having to be vested in their own health. Who is your target in the community? Who are the people who are being served by your co-op?

[*Translation*]

Mr. Michaël Béland: I will try to answer all three questions.

The co-operative model is interesting because the members decide on the type of services they want to offer. Most of the time, it is a physical site, generally understood to be a clinic with a doctor. Other times, it might be a mobile clinic. It could also be telehealth or a clinic that travels within the community. Therefore, the members will determine their needs during their annual general meeting or after speaking with their board of directors, and they will decide whether the service provided will be a telehealth service or whether the town clinic will be kept. It really depends on the community's needs.

In general, as we mentioned in the presentation, it will be a real physical clinic. Basically, if we want there to be a doctor in the community when there isn't one or if we are losing doctors, the community creates a co-op. It is important to understand that the co-op will be a vehicle.

To answer your second question, I would say that the member contributions will be used to fund the vehicle, meaning the building, the additional equipment, additional nurses, additional prevention or other services. The advantage for members is to ensure that these services are available in the community and that people have access, perhaps at a lower cost, to services that are not covered by the government.

Obviously, people always want to know why they would pay an average annual contribution of $60 when members do not have privileged access to doctors over non-members. It is important to point out that annual contributions are not always required. In fact, most of the time, it is really an investment for the community. This sometimes also involves adding services that are not otherwise available. Prevention services under the Japanese model are a good example. We see this often. So additional prevention services not covered by the government are created. In this case, it might be available only to members. But for government paid services, members do not have an advantage over non-members.

To answer your third question about demographics, it is interesting to note that the demographics of members of health care co-ops are similar to that of the general population. You might think that older people need medical services the most and that they would more often be members, but the opposite is true. We have members who are in their twenties and thirties, for example. We have all kinds of members.

● (1605)

[*English*]

Ms. Libby Davies: If you don't mind, perhaps I can interrupt for a minute.

I'm still trying to understand why people would join versus what we have now—recognizing that we need to make a lot of changes. You have 50 co-ops in 50 years, so that's not a lot. For example, if your co-op wanted to engage the services of Dr. Dibble or Dr. Ballagh, why wouldn't those patients be able to directly go to those specialists?

I'm having trouble actually making the connection that you...what the benefit is.

[*Translation*]

Mr. Michaël Béland: Health co-ops are generally found in rural or remote communities. You rarely have specialists there. You usually have general practitioners or other types of health professionals. If there aren't physiotherapists, nutritionists or general practitioners in the community, and if it takes 20 minutes, half an hour or 45 minutes to get to the nearest clinic or to get to another clinic, the people in the community are going to decide to invest in having these doctors closer to them.

[*English*]

Ms. Libby Davies: Are the doctors you engage on a fee for service, or are they on salary? Are you actually hiring the doctors?

[*Translation*]

Mr. Michaël Béland: No, doctors are not paid by the co-operatives. Doctors are paid by the public service. The co-operative pays for the offices, technology, basically everything a doctor needs.

[*English*]

The Chair: Thank you very much.

Thank you, Ms. Davies.

We'll now go on to Mr. Brown.

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

I have a few questions that I want to ask today.

First, to Dr. Ballagh, you mentioned your work at Base Borden. Obviously Canadian Forces are within federal jurisdiction. One of the interesting things about this study is that we are looking at areas where we can actually contribute through the federal government, and with the forces being one, that topic is of particular interest.

What type of technology do you think could be utilized, that isn't being utilized now, to make health care more efficient within the forces? Have you made any observations that might be of interest to this committee?

● (1610)

Dr. Rob Ballagh: I would answer the question in two ways. First of all, innovation is already happening in the Canadian armed forces. In the health services facility that has been built at Base Borden, the training they're doing now, particularly with regard to the physician assistants, is head and shoulders over what they were doing even a decade ago.

Some of the physician assistants I work with in our hospital and in my office are soldiers who have been in military service for 17 or 20 years. They've had the traditional trade medic training and they've gone back to Borden for the subspecialized training program in which they do two extra years of training, one in the classroom and one working in offices and hospitals like ours. It's almost the equivalent of the last two years of my medical training in medical school, in terms of what they get in didactic learning.

So that level of innovation is what they bring to the table. They bring a tremendous amount of experience as well. Physician assistants aren't physicians. They are specifically called physician extenders in the military. The military has had a physician shortage for eons. This is one of the ways they've chosen to fix it. These people come out of the program we have with a skill set that is almost at the level of a family doctor, almost at the level of a nurse practitioner, but they're under the direct supervision of physicians.

My second part of the answer would be that the technology should be for equipping those physician assistants with knowledge when they need it and also with communications skills to get back to the physician they're talking to. Many of them are available by a telephone or satellite telephone connection to those who are supervising them when they're on the very front lines.

Mr. Patrick Brown: Thank you.

Dr. Dibble, you mentioned the use of robotics in technology and the delivery of the services a cardiologist would offer. I remember when the health committee went up to Nunavut a few years back and we were touring health services there. I remember they were using video services to provide some of the health care services up there. I'm sure in cardiology there is a disparity in doctors available in parts of the country. I know you've lectured on cardiology across the country.

What is your knowledge about the challenges that are faced regarding cardiologists in more remote areas, in northern Canada? Are you aware of there being significant shortages? What model would you suggest for servicing those areas?

Dr. Bradley Dibble: I'm definitely aware of the shortage issue. I think the problem is that a cardiologist offers a certain level of expertise that requires a certain catchment area. So the more remote you go, the farther north you go, generally there won't be enough patient population to allow you to continue to function as a cardiologist full time. I am aware of some colleagues who still wanted to choose that lifestyle, so they have gone as cardiologists, but they tend to function more as general internists. They fall back to some of the skill sets they had in other branches of internal medicine, like GI or respirology.

The issue with offering cardiology services remotely is that it has to be done through this sort of remote two-way technology. For example, I could run a clinic one day a week somewhere very remote. I could do stress tests, because there would be a trained technologist there, and I would be there not only in the two-way audio and visual approach, where I can see the patient and I can see what's happening on the treadmill, but also ideally I would see the telemetry on my computer screen as it was being sent to me remotely.

Likewise I could do a consult, in which I would spend maybe 15 minutes discussing with the patient. Then I would be able to have an echocardiogram done, again by a skilled technologist, and I would actually see the images on my screen, because there's no reason that information couldn't be transferred digitally.

I think the biggest hurdle to having cardiac services out there isn't getting cardiologists there, but making sure that the adequate infrastructure is available so that the expertise can be used. I'd say stress tests and echocardiograms provide a lot of what we need to offer.

Mr. Patrick Brown: A general question I've asked each panel so far that we've had on health technological innovation has been about the federal role in the regulation of medical devices and products, because that's another area where there's federal jurisdiction.

Have any of you been involved in a medical device or a product, and what has been your experience? What impressions do you have about how we could become more efficient on medical devices? Is there a lot of red tape in that process? Do you believe we have an atmosphere or an environment that fosters and enhances innovation, or is government a roadblock in that?

● (1615)

Dr. Bradley Dibble: I can certainly address that.

The medical devices we tend to use in cardiology would be pacemakers, and there are complex pacemakers that pump both chambers at the same time. Even beyond that, there are the implantable cardioverter defibrillators.

I think the regulations have worked quite well, from my experience. I don't implant those devices. I'm not particularly involved in that branch of cardiology, but I would say the biggest hurdle there is more likely on the provincial level, whereby the hospitals have a budget to fund so many implants per year. From my experience, those devices have been well regulated, because we tend to have access to them when we need them, at least in my part of Ontario.

Mr. Patrick Brown: Is there any other comment on that?

Dr. Rob Ballagh: I don't think you and I have ever discussed this before, but at one time I was the CEO of a biotech company. When I was a resident in surgery, I made a discovery in the area of radiotherapy. I found something that seemed to make radiotherapy work better for cancer. I had an interesting journey with that company. I call it Canada's least successful biotechnical company, yet I'm still convinced that our product was a working product, a product that would have been helpful.

Technology transfer, which is taking something from the eureka on the bench to the marketplace, is a challenging and cumbersome prospect. It cost us $50,000 to patent our project, and we had to do that before I could even utter a word about it in public. I was a resident, and that was my project for that year. I had to patent it before I had the opportunity to present it to my colleagues and pass my residency.

The Chair: Thank you, Doctor. That's very interesting.

Mr. Easter, you're next.

Hon. Wayne Easter (Malpeque, Lib.): Thank you, Madam Chair. Thank you all for coming.

I'll start with Ms. Gagné and Mr. Béland. I'm very familiar with the cooperative structure, but I'm a little like Libby. As opposed to a medical clinic that is funded either provincially or federally or both, I am led to understand that your membership, through their membership fees, uses those resources to buy equipment for telemedicine or whatever it might be. Is the purpose of the cooperative to add moneys to the system for that particular membership base that isn't there under the public health care system?

Is there a possibility of competition between that and medical clinics or the hospital sector?

[*Translation*]

Mr. Michaël Béland: It really is a reinvestment by the communities in their health care system. The public health care system pays the professionals, pays their salaries. When a co-op is created, it really is a reinvestment. The members want to maximize what the government is doing. They will reinvest to ensure they have the equipment, facilities and additional nurses to maximize the doctors' work.

Mrs. Brigitte Gagné: I should point out that 46% of co-ops are created because the clinic is on the verge of closing or has closed. Furthermore, 54% of co-ops are created because people are having a lot of difficulty getting health care services nearby. They have to travel for hours to get access to them.

[*English*]

Hon. Wayne Easter: Thank you.

To the two doctors, I'm quite familiar with the difficulties in rural health care. I sat on a committee 10 years ago, and I expect things haven't improved.

You're saying that one in seven doctors plans to leave their rural communities, so that creates an even greater problem. What is the reason for that? Is it that they don't have the hospital facilities and the equipment to be able to use their expertise to full advantage? Is it that there's less family life for their families or job opportunities for their spouse? What's the real reason they're pulling out of rural areas?

● (1620)

The Chair: Dr. Dibble.

Dr. Bradley Dibble: I'll start, and I'll let Dr. Ballagh add his comments.

I think its multifactorial, just as you referred to. I think part of it is that when you work in a rural community—and I have colleagues who do that; they work very hard. They don't tend to get home in time for supper at five or six o'clock at night because they're the only ones in town. They're on call on a much greater frequency, often one in one.

The other thing is that there are greater demands on them. If they work in a larger community, they have the resources of specialists to fall back on; if something is getting a little out of their territory, they know they can pass it on to someone with greater expertise. When you're in a small, remote community, you don't have that, and it's all on your shoulders. That's a stress that a lot of people don't feel comfortable with.

I also think some people in some communities feel they don't have the infrastructure to support their needs very well medically. They fall to levels of frustration because the dollars aren't there to support something such as setting up better telehealth systems to have specialists work remotely.

I think after a while, unless they're very dedicated, they plan to go. It's a small percentage of these rural physicians, but that's what the Society of Rural Physicians of Canada has documented within the members of its group.

Hon. Wayne Easter: Before Dr. Ballagh responds, I'll get him to respond to both at once, with regard to the question just asked.

What do either of you see that the federal government, or jointly, federal and provincial, could be doing to overcome, one, the rural doctor shortage, and two...?

I was really intrigued by your video, Dr. Ballagh. I know several people who are having huge problems with Ménière's.

What can we do, from the government's perspective, to enhance better health, in terms of rural health care and some of the technologies you're talking about, to be able to access it within an hour when you need to?

Dr. Rob Ballagh: I guess I'm going to frame my answer around medical education. When Brad and I went through medical school, there weren't a lot of options to go into the community and actually have an educational experience. In surgery, I had no option at all to go into any community, outside of Toronto or London or Ottawa, and train with a community surgeon like me.

The rural Ontario medical program that I'm affiliated with, and I also work with the Northern Ontario School of Medicine through my affiliation in Kirkland Lake, have opened up those kinds of opportunities. In the last month, I've had an ear, nose, and throat resident come to work with me in Barrie. I've worked with two family medicine residents in Kirkland Lake.

We have found that in rural educational training and medicine, if you have your formative training, if you have some of those first experiences treating a heart attack or a massive bleed from a laceration in the neck in a small town hospital with very few resources but very experienced and dedicated doctors, those are the experiences that stick with you, and those experiences will often draw you back to that kind of practice.

I was told when I finished my training that I had potential and they wanted me back in the university centre. I'd known nothing else. I was told that if I practised in Barrie, I would be wasting my academic talent. In fact, I would tell you that the opposite is true. I'm able to take the experience I have and hopefully infect some of the doctors who come to work with me with an enthusiasm to work in places like Barrie and Collingwood and Orillia, and even as far north as Kirkland Lake.

The Chair: Thank you so much. Those were very insightful comments.

Dr. Bradley Dibble: Madam Chair, is there time for me to answer that second question?

The Chair: The time is up, and I have to go to Mr. Lizon.

Thank you.

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

Thank you, witnesses, for appearing before the committee.

The first question will go to both Dr. Dibble and Dr. Ballagh.

We are talking about innovation in medicine, but mostly what we've heard is related to treatment.

What is occurring on the prevention side? For example, I know of cases where people have had a heart attack and passed away. They were not expecting it. They were in good shape and never would have expected it.

Is there anything that exists today that a person can have, whether it's an electronic device or some other device, that would indicate the person has a problem and should contact their doctor?

● (1625)

Dr. Bradley Dibble: If I speak specifically to having a heart attack, or a myocardial infarc, as we call it, having a good general assessment—and it doesn't always have to be with a family physician, it could be with a nurse practitioner or a very skilled nurse even—and going through a complete risk profile.... There are nine classic risk factors that contribute to about 95% of all heart attacks.

If somebody knows what their risks are—and sometimes they know they are out of shape, overweight, or they smoke, but sometimes they don't know what their blood pressure and cholesterol are, and you don't need a specialist like me to be able to determine those risks. If people get access to them, they can have their risks calculated, and then they can access the knowledge they need to make those changes, which are very often commonsense things.

I remember *Canada's Food Guide* was very helpful in telling people how to eat healthy. I think there should be a Canada health guide for how to live healthy in general, to make sure people are doing the amount of exercise they should and not smoking. Everybody hears that, and it falls on deaf ears a lot of the time because sometimes lifestyles are hard to modify. I think a basic risk assessment will help predict many heart attacks. The real challenge, I would say, is not finding out what the risk is but making people make the necessary changes so they reduce that risk.

I've been dealing with that for 20 years, and it's a struggle.

Dr. Rob Ballagh: Whenever I answer a question about prevention in my specialty, I always caution everyone to take this message away from a meeting like this. Tell everybody you meet not to put Q-tips in their ears. Prevention is a very big thing in our area, with regard to injury to the ears.

In terms of prevention in our area, in surgery they have to have good quality primary care. That's what's missing in a lot of communities. In our community, 30% of people didn't have a family doctor 10 years ago. If you don't have a family doctor, then you don't have that initial gatepost into the health care system. You don't have that person to tell you to lose weight or to monitor your cholesterol.

That's what I would say to all levels of government. We have to make sure we have a family doctor for every patient in the country, or the equivalent, in terms of nurse practitioners and primary caregivers.

Mr. Wladyslaw Lizon: As a follow-up question, how far away are we from the technology whereby instead of going to see you, Doctor, I can sit in front of a computer, have a device you can tell me to use, and then you can examine me very well?

Dr. Rob Ballagh: I think we have that today in some areas. In Kirkland Lake, some specialists visit via telemedicine. It's hard for me to do so because I have to have somebody with an instrument in the person's ear or a scope in the person's larynx, looking at the vocal cord movement.

Dr. Dibble will answer for his specialty.

Remote access is going on all the time. With the new smart phone technology, I'm able to talk to some of my doctors on my smart phone, and sometimes I can get them to show me the patient. It saves me a run to the emergency department sometimes.

It's not just videotapes and e-mails. It's live patient care, right at the bedside. I see that expanding, particularly with secure video conferencing becoming more and more a staple in technology. We have to have that confidentiality so that those signals can't be abused and used inappropriately.

Dr. Bradley Dibble: I would say the technology within cardiology exists today. We just need the dollars to get it out there in those communities. Again, a well-done risk profile, a history, a stress test, and an echocardiogram done remotely by those technologists so I can see them from wherever I'm located will provide a lot of reassuring information to a lot of patients. I think that's one thing.

The question was asked a short while ago about what the federal government can do, recognizing that health care is provincial. I think we need to have a federal grants program available so that these rural communities can request funds to be able to purchase these sorts of equipment, so they can access specialists remotely.

Mr. Wladyslaw Lizon: Is there any time left?

The Chair: You have about a minute.

Mr. Wladyslaw Lizon: I'm still not clear about the co-ops. Let me ask you a quick question.

In cases like what you described, whereby a clinic you want to keep open is closing somewhere, and instead of a co-op, if a private investor came forward and invested money, bought the equipment, and hired the doctors.... Is this the same idea as a group of people creating a co-op?

● (1630)

Mr. Michaël Béland: There's some common ground with both. Let me give a really clear example.

If a community would like to have the technology Dr. Dibble was just talking about and the public cannot afford it and cannot get grants for the technology, they can come together, form a co-op, acquire the technology, and offer it to the whole community. This is another way to organize and get access to the technology.

Another example is prevention. We use this Japanese Hans Kai model. We hire people to give educational tools so that people are able to check their own health indicators. This is in addition to the service provided to the public. We don't hire a doctor to come to our office.

Mr. Wladyslaw Lizon: I understand, but those people who come together have to come up with money. They put money together. What do they get back? Is this an investment? Is this a donation? How does it work? What do they get back?

Mr. Michaël Béland: It's almost a donation to have access to better health services, to have access to better technology, to have access to additional services.

The Chair: Okay, thank you. We've run out of time.

We're now going into the five-minute time slots. You have to be aware of your time because we try to get more questions in, five minutes at a time.

I'll begin with Dr. Sellah, please.

[*Translation*]

Mrs. Djaouida Sellah (Saint-Bruno—Saint-Hubert, NDP): Thank you, Madam Chair.

I will start by admitting that I had never heard of health care co-operatives prior to an unfortunate incident that happened a few years ago. The Quebec Minister of Health asked RAMQ to investigate some allegations. In fact, 75% of health co-ops were making people pay to get access to a doctor, which is illegal. I would like to hear what you have to say about that situation.

I would also like to know what the real difference is between a group of family doctors—a pilot project that was started in Quebec—and health care co-ops.

Mr. Michaël Béland: First of all, I fully agree with you, as does the entire co-op movement: restricting access to a doctor, whether you are a member or not, is an illegal practice. And the Fédération des coopératives de services à domicile et de santé du Québec did a lot of work on that to ensure that it does not happen in the network. There were probably some negative perceptions. This is something we try very hard to avoid.

It is important to understand that members do not have privileged access to a doctor when it comes to a provided service. The member has privileged access to additional services. For example, members might be entitled to certain services at a lower price or might have access to additional free prevention services, things like that. But when it is a guaranteed service, it is very clear to us that there must not be privileged access for members or non-members, because everyone pays taxes, which are used to pay the doctor.

Could you please repeat the second question?

Mrs. Djaouida Sellah: I would like to know what the difference is between a FMG—a family medicine group—and a health care co-operative.

Mr. Michaël Béland: Let me give you a concrete example. In my village, we have a health co-op. The doctors are paid by the government and they also belong to the FMG. The health co-op members create a whole environment for doctors. Perhaps the rent for the health clinic is lower, perhaps there is more equipment and perhaps they have better people around. Doctors get a platform for free or that is significantly cheaper for the health care system. That makes it possible for them to move to the village.

For example, Mr. Ballagh said that people did not want to move to Barrie, Kirkland Lake or other remote places. Co-ops are an attractive workplace for doctors. So they will move to work there. They continue to be paid by our health care system. They continue to be part of an FMG and to work as an FMG.

There is another difference. For instance, a co-operative can decide to hire another nurse, in addition to the one paid by the FMG. The FMG nurse will then be able to take on additional work, which will reduce the doctor’s workload and give him or her time to see more patients.

Basically, people in the community come together to add more services. This creates an environment that will attract doctors.

It really complements the public system. There is no competition. This is especially important for places or areas of activity where the private sector would not benefit from investing in low-priced buildings for doctors, and things like that. Perhaps this answers other questions. When the private sector cannot provide those types of services, the community will decide to do so by creating a co-operative.

The same goes for telehealth. In Nova Scotia, one co-op provides a telehealth service. No private investors were interested in that type of service, because there was no profit to be made. So the people in the community decided to form a co-op in order to have access to the public services they were already paying for as taxpayers. By making an additional investment, they improved their access to health care. They took a real good look at what their needs were in terms of having easier access to public services. They decided to put money on the table, because the private sector found that there was no money in it, basically.

● (1635)

Mrs. Djaouida Sellah: May I ask you another question?

[*English*]

The Chair: No, you really don't have time. You're right on the five minutes. But those were very good questions.

Now we'll go to Mr. Lobb.

Mr. Ben Lobb (Huron—Bruce, CPC): Thank you.

I just want to make a comment on the co-ops. I understand maybe why there's confusion, but I'll give you an example from my community.

In Goderich there was really no clinic. Instead of a co-op, they created basically a not-for-profit organization. Basically people from the community donated money, the municipality donated money, and surrounding municipalities donated money so they would have a clinic.

They had a doctor shortage in Goderich. They built a state-of-the-art facility, because there was nothing there before, really, and now they don't have a doctor shortage. People love going there. A lot fewer people in the area don't have doctors.

So one is a not-for-profit corporation. You guys call it a co-op; it's still the same thing. People who didn't donate money can still go to the clinic and receive service. It's just a way of making things happen in a small community. It's not like there's a clinic on one corner and across the street they put up another thing. There's nothing doing; this is why they have to do it.

This is just so we're all on the same page here.

The Chair: Thank you for that clarity.

Mr. Ben Lobb: Thanks. I'm available for part-time consulting work, too.

Voices: Oh, oh!

Mr. Ben Lobb: Dr. Dibble and Dr. Ballagh, we had a lot of bureaucrats come through here telling us all the things that are happening with electronic medical records. I'd like to hear from you two guys on the state of affairs in Barrie, for example, which is a pretty progressive community. When you see somebody, do you look at a paper file or do you look at electronic medical records? I'd be interested to know.

Dr. Bradley Dibble: I'll speak to that first.

I'm still a dinosaur. As much as I love technology, I still have a non-EMR system in my office. However, one of the reasons I've held out is that I'm going to be relocating my practice to a new building within our community just down the street. It's going to open up next year, and I'm going to make the transition then, because it makes sense to do the transition all at once.

But I will say that I held back a little bit because I heard from lots of my colleagues about lots of bugs that had to be worked out. I'm glad now that I held out, because I think the state of the art is good enough for me to be able to manage it.

It's not the same as a family doctor, where it might be very similar practice to practice; a cardiologist in Barrie is going to be a bit different from a cardiologist in Newmarket, who's going to be different from a cardiologist in Toronto. I needed an EMR that could fit my own personal needs.

Mr. Ben Lobb: Just before Dr. Ballagh answers, does Barrie have kind of a "vendor of choice" for electronic medical records? Have all general practitioners agreed to use one system, or is it a proliferation of systems?

● (1640)

Dr. Bradley Dibble: You know what? I'm—

Dr. Rob Ballagh: I think I can answer that.

Dr. Bradley Dibble: Okay. Yes, go ahead.

Dr. Rob Ballagh: Ours is the largest family health team in the province of Ontario. As such, the family health team went out and kind of led the charge on electronic medical records in our community. They looked at all the vendors and all the products, and they chose one through a very aggressive and big due diligence process.

One of the family doctors is actually their IT lead, their electronic medical records lead, and he's a good friend of mine. When I decided what I was going to get in my practice, I talked to him. I did my own due diligence in an abbreviated fashion, and I ended up using the same one.

In our community, many of the doctors, although not all, use the same system. They all communicate with each other to a greater or lesser extent.

My biggest challenge with electronic medical records is that the patients I see...particularly this lady with dizziness, the complicated case that I presented today. Often the initial consultation request comes with a letter that says "Vertigo?"

By the way, "vertigo" is a symptom, not a diagnosis, so I know, when I get that letter, that I'm really starting from scratch. What I often don't know until the patient is in the office is that they've had two other consultations with other specialists. They have seen a neurologist as well as a cardiologist, and they've had these six tests.

One day I'd like to see an electronic medical record that is available on a memory stick that I can just put in this computer. The patient's electronic medical record can be portable with the patient, and we can actually get that information right in our offices.

Mr. Ben Lobb: Here's the funny thing, I think, about this whole debate about electronics. You're working with McMaster University, right? I will guarantee you that a student who starts off their first year of university will have every single record in electronic format that anybody could look at. It's almost amazing that this somehow hasn't happened yet in the health care system.

There's one other thing I'm curious about. When you make your investment in your electronic medical record, is it subsidized through Infoway, or do you pay the entire amount?

Dr. Rob Ballagh: At the moment, through a program run by the provincial government, through an organization called OntarioMD, there are subsidies and there are some incentives for us to be early adopters. That's one of the reasons I became an early adopter. We are a progressive practice. We're a relatively young group of otolaryngologists. There are four of us and we knew that we were going to go to five. In fact, our fourth guy, who joined us 18 months ago, is all EMR.

The Chair: I'm sorry, Dr. Ballagh, but I'm going to have to interrupt you.

Thank you.

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

[*Translation*]

Mr. Dany Morin (Chicoutimi—Le Fjord, NDP): Thank you, Madam Chair.

My colleague Mr. Lobb had a good question. So I am going to continue along the same lines.

Not too long ago, when I did my chiropractic training, we weren't using the new technologies much, especially when we had to practise in real life. I would say that I am a fan of technology at home and outside work, but at work, I cannot bring myself to use technology such as the video for the nystagmus.

One of the reasons why health professionals in general do not use those technologies in their practice is the confidentiality issue. Just think of X-rays on the computer, for instance. That poses a risk of data leakage and, therefore, a confidentiality problem. I would imagine that the same goes for that video. It is part of the patient's record. So it has to be in a secure place.

Dr. Ballagh, could you tell me what you think about that and give me an example of where you need to use new technologies more and still be very careful about the confidentiality of patients?

[*English*]

Dr. Rob Ballagh: I certainly can, and I should preface this by saying I'm married to a civil litigation lawyer. Confidentiality has been an obsession of mine since the day I met her, and actually since the day I walked into first-year medicine.

To give you an example, I was quite concerned about the confidentiality of the lady in the video that I showed today. I had reassurance from the committee that it would not be archived or shared on the Internet, and in fact that it would be shared only by the people in the room. I also went to the extent of calling her last Sunday afternoon and explaining to her what I was going to be using it for and got her permission to use it. She is an educator as well and she really wanted you to be part of that experience.

In my practice, with regard to these confidential details, they are not archived; they are simply documented. When I see that, I know what it is and I write it down. I don't need to keep that information, but some things do need to be archived and kept. For instance, if someone had a CAT scan five years ago and this year we find a tumour, we often go back and look at the CAT scan to see if that tumour was there. Did we miss it? How small was it? How could we have avoided that error?

So I think it's important that the information be available, but it has to be available only through the most secure firewalls. Getting through those firewalls, particularly if you're not in the hospital and in the facility inside, can be very difficult. From my office, it can be very difficult. Even though I share an electronic medical record with 85% of the doctors in my community, I can sometimes have a hard time getting that neurology consult, that CAT scan from last year.

● (1645)

Mr. Dany Morin: Thank you very much.

[*Translation*]

My next question is for the representatives from the Conseil canadien de la coopération et de la mutualité.

I know that health co-ops are well established in Quebec and that there are some in Ontario. Perhaps I missed what you said about this in your presentation, but could you provide us with an overview of how health co-ops have developed? I think this model has been very promising for a number of years, despite possible management abuses. Those are little details. Actually, I think that, when a community takes action to invest in resources, we are talking about a winning model, especially in a context where we have to deal with failing health care systems across Canada.

Mr. Michaël Béland: Just like with any innovation, there is nothing new under the sun.

Let's look at the evolution. Quebec now has about 50 health co-ops. The first one of this new generation was founded in 1996. In 10 years, 50 or so were created.

There are also 46 home care co-ops in Quebec. In those cases, health care professionals go to people's houses.

Let me just add that co-ops have a significant international presence. In Japan, millions of people are co-op members. The same goes for Brazil. In Canada, this started with the Coopérative de services de santé de Québec, among others. There were also some in Saskatchewan when Tommy Douglas was around. Saskatchewan has four health co-ops. In Winnipeg, Manitoba, in Ontario, in Nova Scotia and in New Brunswick, there is one telehealth co-op. In total, Canada currently has 120 primary health care co-ops.

[*English*]

The Chair: Thank you so much.

Now we'll go to Ms. Block.

Mrs. Kelly Block (Saskatoon—Rosetown—Biggar, CPC): Thank you very much, Madam Chair.

And I want to thank all of you for being here today.

I have a number of questions that I'd like to ask. Some are at a real macro level and then some are at a micro level.

I used to be the mayor of a very small community. I wouldn't call it remote, but it was definitely rural. We had a medical clinic. We provided the space, and then we contracted with the different folks to come in and provide a service.

In Saskatchewan we have health regions. I am wondering if you could describe for me what relationship a co-op may have, if in fact they do, to a health region or to the province or what have you.

[*Translation*]

Mr. Michaël Béland: I will talk about the situation in general. Each co-op is autonomous and, as a result, has its own features, but the fact remains that the first partners are usually the municipalities. We make sure to maintain or to create services in municipalities. Generally, people in municipalities are board members and members of health centres. So public servants are board members and partners. The two are always working together.

Here is a very concrete example. In Beauce, Quebec, a co-operative set up shop on the same floor as the emergency room to be able to provide that service at the clinic when the emergency room is not open. In this case as well, the municipalities were the first to invest. There is a very strong partnership between all those players. That is really the key to the success of co-operatives.

But that is not the same thing you were talking about in terms of the co-op being open to the whole community. It is not the municipality that is in charge of the clinic. We invite everyone to become a member. There are about 3,000 to 4,000 members on average. All those who become members make their contribution and participate in a democratic process. They identify the types of services they want and how they want them to be organized. So we work very closely with the constituents. We determine what services people want in the community and whether additional services need to be provided, and we check to see if the people are ready to pay the bill that comes with those services.

● (1650)

[*English*]

Mrs. Kelly Block: Thank you.

My second question would be for you, Dr. Ballagh.

You talked about how you wished your patients would come in with all of their information on a memory stick. I don't understand all of the regulations around the sharing of information. I know that we are protected through privacy legislation. But you say that the first question that comes to your mind is, who owns what? When that person has a memory stick with all of their information, does it include your records and everything that you might have notated when you're treating them, and then, of course, that gets put on the memory stick, and then the next doctor and the next doctor? I have a hard time understanding the protection of the information.

Do you own some of the records, or do the patients own the records? Does it all go on the memory stick and you don't mind that whatever you've notated is going somewhere else?

Dr. Rob Ballagh: It's a complicated question because it is the patient's information.

First of all, this is a dream, the memory stick; this is not a reality yet. And it's a dream that we can collectively, hopefully, have together this afternoon. There needs to be a comprehensive medical record on that medical stick, and it should include, very quickly after the patient sees me, the record of my visit with them that day, and it should be contiguous with all the records, hopefully dating back right to their birth.

In terms of who can access it and to what depth they can access it, and can the patient access it, these are very difficult questions that have to be hashed out. Patients, when they read their own records, can sometimes misinterpret things or be offended. We're very careful in our language, but sometimes they can come back in with concerns about the way things were documented and things like that.

At the same time, not having that information, and particularly if I can't get that information during that very short patient visit—our patient visits are not long, and in my specialty they're 20 minutes—sometimes that guarantees another visit. Many of my patients come from miles and miles away to see me for that critical first visit, so we try to get as much done as can. But if we had that extra information, it would just be so much easier to get more done in a single visit.

The Chair: Thank you so much, Dr. Ballagh.

We'll now go to Mr. Kellway.

Mr. Matthew Kellway (Beaches—East York, NDP): Thank you very much, Madam Chair.

Thank you, folks, for coming to see us today.

There has been lots of talk today about access to doctors in rural and remote communities. I never actually thought of Barrie as being particularly rural. Since I come from Toronto, it's just kind of up the road, with lots of suburbs in between.

Setting that aside for the moment, I was watching *The National* last night and there was a story about paramedics in Toronto being rerouted seven times in the course of three hours and a woman eventually dying over that period of time.

If I may, I'll share my own personal experiences with trying to access a doctor. I've had the same doctor for almost 20 years in Toronto. I thought I could book an appointment for a checkup with two months' notice, but apparently that's not correct. It required six months' notice. Then I had to miss that one, so that set me back another five or six months. By the time I got my annual physical booked, a whole year had gone around. In my family, my son and I —the boys in the family—have stuck with this particular doctor. Once my girls grew up, they decided to go to a female doctor in our neighbourhood, and it's really just this constant rotation of doctors through a clinic where you never see the same doctor twice.

With all of that, I accept the issues of remote and rural communities, but in our cities we have a huge problem with accessing health care and doctors on a consistent basis as well.

I should add that even in downtown Toronto, because of this condo boom we've experienced, even though there are a whole bunch of hospitals up and down University Avenue, as you know, they have simply been overwhelmed with the population in downtown Toronto.

My first question, after that lengthy introduction, is to the cooperative folks. You talked about pretty much all rural cooperatives. Is there any application of this model in an urban context?

● (1655)

[*Translation*]

Mr. Michaël Béland: Yes, of course.

[*English*]

Certainly there are some in Saskatoon, Regina, Winnipeg, and Vancouver, so there are some in the urban areas for sure. There is one currently being formed in Montreal.

Mr. Matthew Kellway: All right.

To Dr. Dibble and Dr. Ballagh, regarding the application of innovation and technologies that you guys are using out in rural communities, is there any reason this doesn't apply to urban health care as well?

Dr. Bradley Dibble: No, I would say there is no reason, especially if there are difficulties, as you describe, of having to wait six months despite being in Canada's largest metropolis. Anybody should be able to access this.

I think where the biggest problem is and what those statistics I revealed from the Society of Rural Physicians speak to is that Toronto still has a greater percentage of doctors per capita than the rural areas do. That's why I focused on that. But truthfully, that's right; anybody should be able to access this if they need it.

Dr. Rob Ballagh: I would just say, on the doctor shortage front, that our community grew at a terrible time. We grew at a time when we had cut the number of medical school slots in our province. We were just starting to see the effects of those cuts when we actually started to have our massive growth. So at our worst, 35% of our population didn't have access to a family doctor, and as a consequence they were all getting their total medical care—their annual checkups, and Pap tests for ladies—through the walk-in clinics and the urgent care facilities.

Ours is the second-busiest emergency room in the province of Ontario. It's not in downtown Toronto or downtown London. So there are urban places where these kinds of crises are happening, and we're in the middle of one of them in Barrie. That's part of the reason that's our passion with regard to the doctor shortage.

I was previously the chair of our physician recruitment task force, and when I first moved to Barrie it was not something I would ever have imagined us needing. I can say to you that we have really had to innovate to get our doctors on board.

In terms of technology, I can see the emergency room of our hospital from my office, but there are three traffic lights between there and my office, and I have to get parked. For me to run to emergency to see a patient versus having the technology to show me what the patient looks like can save me that dash and can sometimes save the patient's life. There is no difference between rural and urban when it comes to that kind of technology and that kind of communication.

Mr. Matthew Kellway: Thank you very much.

The Chair: We now go to Mr. Wilks.

Mr. David Wilks (Kootenay—Columbia, CPC): Thanks, Chair, and I thank you people for showing up here today.

Dr. Ballagh, it was interesting to hear you talk about the armed forces and the physician extender. My son was over in Afghanistan for the last combat mission. He's a combat engineer, so he deals with all the IEDs. He likes to find things and blow them up, and hopefully not get blown up himself.

With regard to that, I'm curious about your type of service when it comes to the remoteness. Is that something, with your specialty in the inner ear, you could deal with? That could be a problem for a combat engineer if he or she gets their bell rung. Is there remote technology available where you could, for instance, be in Barrie and deal with something in Afghanistan? If someone were able to contact you through that remoteness, could you deal with it and guide them through it?

Dr. Rob Ballagh: First of all, can you thank your son for his service to our country? I try to do that every time I meet a new military person I work with.

● (1700)

Mr. David Wilks: He's all right.

Dr. Rob Ballagh: In terms of remote access and that kind of transfer of information, I can say that we, as preceptors for these physician assistants and for some of the physicians in the military, are often asked via e-mail, months or years after, questions about patient care and that sort of thing.

In terms of direct contact at this point in time, those things are evolving, but they're not happening right now. They're not happening as quickly as they could be. For that physician extender who's on the front line in Afghanistan who has a patient with a neck wound that is bleeding, right now it's very difficult for them to show that to me back in Barrie.

Mr. David Wilks: It would seem to me that through the federal government there may be an opportunity to do some R and D on that. Certainly for our men and women in the armed forces, when they're in harm's way thousands of miles away and something bad does happen, those minutes and seconds count.

Dr. Rob Ballagh: The learning goes two ways. I had one of our elite soldiers who's also a medic come and work with me on a Saturday. I don't normally oblige them to come in on a Saturday, so I thought I'd give him a cup of coffee and teach him something.

I gave him the scenario that an IED had gone off, his Buffalo had turned upside down—that's their ambulance—and he had to do a cricothyrotomy because the patient had an emergency airway obstruction. I asked him to tell me what steps he would go through. He said, “Dr. Ballagh, in the three that I've done, this is what I did.” I don't mind telling you that as a certified specialist in ear, nose, and throat, I've not done one. I actually learned from him that day, so the transfer of information goes back and forth.

Mr. David Wilks: That's cool.

Dr. Dibble, I'm intrigued with this Doctor in a Box, and Rosie is another thing that is pretty cool, especially for rural living.

The defibrillators that we've been able to put in every recreational facility across Canada, more or less, have probably saved tens of hundreds of lives since their emergence. It would seem to me as though the Doctor in a Box concept in emergency vehicles, whether it be in ambulances and/or police vehicles, may be of assistance to those who are first responders when they get into a situation where they're in trouble and they need help very quickly. Do you see that as an emerging opportunity for first responders in ambulances and/or police officers who have very little capacity when it comes to medical understanding but could be talked through something?

Dr. Bradley Dibble: Yes, absolutely. I think it could be used by any kind of first responder who has the ability to deal with a crisis situation but may not have that medical expertise to deal with it.

The automatic external defibrillators you talked about that are across the country are great for anybody who has succumbed suddenly to a cardiac abnormality, but that's not what everybody needs emergency access for. The AED will not provide any help to somebody who does not have one of those rhythms that needs to be shocked, whereas the Doctor in a Box will be able to help assess the situation and provide guidance.

An ER physician with trauma expertise could help by talking to the people who have the ability to be guided remotely on how to deal with the crisis at hand. I'm not sure it would work as well as an AED on the wall, and the public may not have the ability to respond to talk from a doctor like that, but police, fire, and EMS services for sure would be able to benefit from that.

Mr. David Wilks: In my 20 years as a policeman I came across a lot of interesting things. I just see this as a huge opportunity.

The Chair: Mr. Wilks, I'm going to take this huge opportunity to tell you that you're out of time.

I'm sorry about that because I love your questions.

Mr. David Wilks: I'm going to take this huge opportunity to thank you.

The Chair: Mr. Wilks is a true gentleman. He carried all my bags on the way to committee today. He not only does that for me, he does it for other ladies too—just when they have heavy bags.

It's hard to cut off a gentleman like that, but there you go. I'm a hard-hearted person, Mr. Wilks.

Dr. Carrie, you're up next.

Mr. Colin Carrie (Oshawa, CPC): Thank you very much, Madam Chair, for the opportunity to ask a question.

I do want to thank my colleague Mr. Lobb.

I think you do have a future in consulting.

You know, when I look at the co-op model, I can see how the model would give control to local communities. In Canada we have such diverse communities.

We've heard about first nations communities. Different communities, like first nations, for example, might want aboriginal healers. They might want chiropractors, more natural healers. They may have issues with respite care, home care.

Could you maybe give an example to the committee of how a cooperative model might be very innovative, if these communities decide this is a way they could attract physicians, attract human health resources?

One of the things we hear over and over again is how difficult it is to attract human health resources to these communities. Could you give us an example of how the co-op model would work in a situation like that?

● (1705)

[*Translation*]

Mr. Michaël Béland: I am going to try to be as clear as Mr. Lobb.

Let's take Saskatoon as an example. There is a health cooperative there that has decided to offer additional service to aboriginal persons, service that is adapted to their needs, because no public service was doing that. They decided to do so using the resources of the cooperative.

I will give you another example. In northern Quebec, there is a project to serve the needs of the Inuit using cooperatives. The local cooperatives have decided to offer health prevention services that include health education, because this is a considerable challenge among the Inuit. This is being done according to the cooperative model. The public service was not offering such services, and so they used the cooperative model in order to provide these targeted services.

I find your comment about involving citizens very interesting. To express things in the simplest way, the health cooperative model implies that citizens decide to provide additional funding in order to have additional services, or to have greater access to services. Those citizens decide how they will do that. So this is a vector for innovation. Citizens decide to look at the innovations needed to meet their own needs, since the public services alone are not managing to do that. They reinvest and go and get what they need to target the public service to the needs of the community, and they foot the bill.

[*English*]

Mr. Colin Carrie: Thank you very much.

I have another question.

One of my colleagues brought up the Canada Health Act. I am curious. Do some provinces not recognize co-ops? Are there any challenges as to how this model is interpreted under the Canada Health Act?

[*Translation*]

Mr. Michaël Béland: All of the provinces recognize cooperatives in general and they recognize health cooperatives. How is accessibility interpreted? Does the contribution of one member influence that? I will give you a very concrete example.

In Nova Scotia, there is a telemedicine service. Members are asked to pay $10 to cover the costs of the technology. The province accepts this without any problem, whereas other provinces might interpret the situation differently. It is difficult, because cooperatives are managed by volunteers. They have to be able to interpret what is acceptable and what is not properly. There is indeed a grey zone.

In Quebec, as I mentioned, the cooperative movement has led to very specific guidelines, in order to ensure that things are well understood.

[*English*]

Mr. Colin Carrie: How am I doing?

The Chair: You have half a minute.

Mr. Colin Carrie: I have a real quick one.

I was curious about working with physician assistants. I've heard a lot about them and how they can really be helpful. You said they don't have the autonomy; they do have to work under supervision.

Is there a way they are remunerated, or do they have to be remunerated through the family physician? Are they able to bill provincial programs?

Dr. Rob Ballagh: Very briefly, the forces remunerate our Canadian Forces physician assistants. It's a model that has slowly started to percolate into the civilian sector. Manitoba, in rural medicine, is using physician assistants. In Ontario, they're getting contracts through separate contracts with the Ministry of Health.

In Kirkland Lake, in the emergency room, we have one of the physician assistants I trained from Borden, who now works in the civilian sector. He provides a model of practice for the other civilian physician assistants. There's a program at McMaster University in civilian physician assistants, so he provides a model for young physician assistants.

The Chair: Thank you very much.

Now we go to Mr. Easter.

Hon. Wayne Easter: Thank you, Madam Chair.

Mr. Dibble, before I get to another question, I'll give you the opportunity to respond to the question I asked you previously about what the federal or provincial governments could do, from either a policy or a financial perspective, to get us further down this road.

Dr. Bradley Dibble: Thank you. I did actually try to sneak that answer into another answer.

I think one thing that would be very helpful, since these technologies cost money, is that rather than necessarily relying on communities and co-ops trying to pay for them, perhaps there could be federal grants or programs through which these rural communities could apply for the funds to bring those sorts of technologies into their communities. Obviously, health care is a provincial issue, but a federal grant program could certainly offer people a Rosie, or a Doctor in a Box, or adequate telehealth, so that someone like me could do a stress test and an echocardiogram and see a patient all in one fell swoop.

● (1710)

Hon. Wayne Easter: Both doctors have mentioned how you can use telemedicine and other technologies to use nurses in a remote area, or just three blocks down the street in Toronto, for that matter. In terms of your own time as specialists, you already are extremely busy, so when there is an opportunity to help in a situation that's further afield, how do you manage to schedule that in? That has to be a problem.

You have your own patients in your local practice for sure, but when you're doing remote medicine, whether it's in Nain, Labrador, or wherever it might be, how do you manage that? Also, is there a way of creating greater efficiencies in that area?

I think Mr. Dibble said earlier that one of the problems for a rural doctor is that they're the only one there, they're on call 24/7, and they eventually wear out. I've seen that happen with my own doctor. So how do you not put yourself in the same position, as a doctor, when you're doing your stuff in your own practice and this remote stuff? How do you see creating some efficiencies so that we don't end up burning out the specialist too?

Dr. Bradley Dibble: I'll speak briefly to that. I think one thing is trying to make sure that doctors don't have to spend as much time on the road actually travelling to rural areas. For example, right now Dr. Ballagh drives to Kirkland Lake to provide services there. The time he spends driving could be spent seeing patients. I think making sure that the technologies are there, so that you don't have to physically be in the room, will create some time there.

Obviously, any community that is using doctors for remote areas has to have enough doctors, so that you're not taking away from that community. For example, right now I am the only cardiologist in my hospital. It would be tough to spend one day a week in a rural community. But we're working hard on recruitment, and I am very confident that by the end of next year we'll have plenty of cardiologists in my community. We're already talking about outreach programs. Rather than driving an hour in this direction or that direction, I'd rather just spend the time, if I could, remotely, so that we could save the time in the car.

Hon. Wayne Easter: Dr. Ballagh.

Dr. Rob Ballagh: Very briefly, we need more bodies. It's interesting that in the public eye, the physician shortage is all about the family doctor shortage, because of the problems we've talked about, but we have a shortage of doctors in specialties as well, or maybe we don't have a shortage of those doctors now, but we have a shortage of resources to actually put those doctors to work. You've read about orthopedic surgeons, who are graduates, who can't find operating room time. Some of these guys are doing calls at our hospital on weekends to get in with our group, so that when operating room time becomes available they can actually have a job.

I sit on the national council for my specialty. We received a report last year that currently we're training 30% more ear, nose, and throat doctors than we're going to have resources for when they graduate. In other words, there aren't going to be enough resources like operating room time, clinic time, nurses, or hospital resources for those doctors to actually have surgical work. But you're right; we get overwhelmed. I'm working in four different communities.

To answer your question, we just have to manage our time very, very carefully.

Hon. Wayne Easter: It's certainly something for the committee to ponder, Madam Chair.

I'll let somebody else have a turn.

The Chair: I think we'll stop the pondering right now, but that's a very good comment, absolutely.

Since we have a few more minutes, we'll go back to the seven-minute round and begin with Dr. Morin.

Mr. Dany Morin: Thank you so much.

My next question is for Dr. Dibble. Earlier you mentioned that it would be a good idea to have a federal grant program for medical infrastructure and for new technology. I'm not against it, but when we talk about asking for more money, one question comes to mind: what kind of number do you think would be enough for that federal grant program, and where should we take the money from?

In terms of our current economic situation in Canada, money doesn't grow on trees. So we need to either cut something else.... If you have a suggestion as to where the federal government should move money around, I want to hear it.

● (1715)

Dr. Bradley Dibble: It's difficult for me because I can't say I understand all the financial workings of the federal government.

Voices: Oh, oh!

Dr. Bradley Dibble: The closest experience I have to this is I sit on the AED committee for the Heart and Stroke Foundation of Ontario. On an annual basis we read all the requests for AEDs to be put into communities, and we made the decisions as to where they went.

One thing that can be done.... It may not necessarily be a request for funds, because you don't necessarily know how those funds are going to be used once they go into a global budget of a community's facility. Perhaps it could be a request for a Rosie or a Doctor in a Box.

It's difficult to know where that money will come from. I often ask what you would rather live without, your heart or your lungs. You need both. You can't do without either, although you can live deaf, I like to point out to my colleague Dr. Ballagh. It's not necessarily a nice life, but....

The Chair: It's Valentine's Day. We need to be kind to Dr. Ballagh.

Mr. Dany Morin: No bickering, please.

Dr. Bradley Dibble: I think I'd give cardiologists' the first right to be able to say something like that.

Anyway, the funds have to be there. Most people feel that health care and education are two supremely important things. We just have to make sure we use the funds we have available for those things as wisely as possible.

Just because some people chose to live north of the French River, for example, they shouldn't have access to health care. They're Canadians, after all. We need to make it as feasible as possible.

We don't want to mandate doctors like me to go up there who won't be able to function as a cardiologist full time, but maybe they could make it so that I work from my own community back home.

If these communities can appeal for those sorts of technologies, that's great. That's money very well spent. I'd have to see the whole budget to know what else you should cut, though.

Mr. Dany Morin: Thank you very much.

[*Translation*]

My next question is for Mr. Béland.

A lot of people are indeed becoming more familiar with the health cooperatives concept. In English, we hear more about community health centres. These are quite similar health care models. They may even overlap. Since you are a pan-Canadian organization, I would like you to tell us more about this system, and especially about the community health centres.

Mr. Michaël Béland: In some provinces, the community health centres are equivalent to some degree to the CLSCs, the local community service centres. They are really a public system. It is interesting to note that Alberta is considering the creation of family care clinics and is studying the possibility of adopting the cooperative model.

Also interesting, the four Saskatchewan cooperatives are a part of the community health centres network and of the public network. The democratic process is what differentiates a cooperative model organization from one that is not built around that model. In the first case, the population, the members, are involved. Often they make a financial contribution, small or large. The fact is that members become the owners, to a certain extent, of their health development tool, in their community. And so, there is more involvement on the part of those members.

Members of cooperatives believe in the collective responsibility for health, but also believe in personal responsibility. The principle is that people should be involved in fostering their own health, and learn to manage it themselves. You can see the difference. Generally speaking, the additional services involve prevention, essentially because people want to help each other out. Rather than using a program or a standard approach that allocates funds to a specific purpose, the model trusts the communities and allows them to determine their own needs themselves. In a lot of cases, their solutions really meet their needs, since they are the ones who know what they are. That is the difference we have observed.

Mr. Dany Morin: Thank you.

My next question...

Is my time up?

● (1720)

[*English*]

The Chair: No, you've got one minute.

Mr. Dany Morin: Okay, I'll be quick.

[*Translation*]

I think that a lot of people are afraid of cooperatives because they are under the impression that they provide medical care that should be free. Can you reassure those people so that they really understand the usefulness and complementarity of cooperatives?

Mrs. Brigitte Gagné: I am a member of the Aylmer cooperative. It has 9,000 members. Every year I attend the annual general meeting.

I asked one physician why he worked at the cooperative. He replied that it was because the services he receives from the cooperative allow him to put the emphasis on his medical practice, rather than having to deal with administration, reports, and all of the red tape that involves. He added that he really wanted to practice medicine. So they try to give people the opportunity of putting the emphasis on what they do best: practice medicine.

Mr. Dany Morin: Thank you.

[*English*]

The Chair: Thank you so very much.

Now we'll go to Mr. Brown.

Mr. Patrick Brown: Thank you.

One question I wanted to get in, and I didn't get a chance in my initial round, is with regard to international collaboration on research. I know one of the vehicles for innovation is certainly health research, and we do a lot of that with the federal government through the various federal agencies, like the CIHR. I want to know if you think there are adequate levels of collaboration in the research community. I can think of one example, and I've mentioned this before to a different panel. It's the artificial pancreas project, which the Juvenile Diabetes Research Foundation did in Hamilton and Waterloo, and there was a similar research effort in Australia. I'm sure research is being done across the board in each country on similar topics.

Is it your experience that an adequate level of collaboration exists in research in the medical communities?

Dr. Bradley Dibble: In my experience within cardiovascular medicine, I think there's very good collaboration. In one way we're unique because more people die from our diseases than anything else, so we get to do a lot of studies on these patients. Clinical trials are always coming out. As a result, for example, I'm connected to CIHR, and I'm invited sometimes to participate in clinical trials if I would like.

It's very easy to be connected internationally because we're constantly getting information, usually by Internet or e-mail from all our organizations, the Canadian Cardiovascular Society, and then, in the U.S., where we tend to be members, the American Heart Association and the American College of Cardiology. We're told exactly what's going on with these clinical trials, when they're starting, when they're going to finish, and if we want to get involved, we know whom to contact.

Within cardiovascular medicine, I would say the global community has a lot of collaboration. Most good trials that answer the questions I have about how to better serve my patients tend to be multinational trials. Very few trials are done now in one community or even one country, because the question across the pond will be whether or not it applies to their patients. So these tend to be multinational, and they tend to have many thousands of patients. You can't do that without that level of collaboration.

Dr. Rob Ballagh: I'll take it to a micro level, and that is because I've just finished being the president of medical staff at my hospital. As such, I sat on the board of the hospital, and I also sat on the medical advisory committee, where we have to look at all the research proposals that come across the desk. You might not realize that a hospital the size of ours would do a lot of research, but we do a whole lot of research, and we do a lot of multi-centre research, particularly in our oncology area, our cancer treatment area, that comes out of the city, that comes out of Sunnybrook Hospital or Princess Margaret Hospital.

One interesting thing is that when a research study is proposed, it has to go through our research ethics board, and it's gone through the research ethics board of Sunnybrook. Of course, these are very important steps, because we want to make sure that all research is ethical, but you can imagine that if there are 20 hospitals, it would have to go through 20 boards before that research gets off the ground. Sometimes we can streamline these things with technology. I think there should be some way we can streamline these things so that they can go through boards in hospitals, not just in our country, but perhaps elsewhere. Multi-centres should not just be in small places like Ontario, but in the whole world.

Mr. Patrick Brown: Another thing that came to mind with health innovation is the role it plays as a job creator as well, especially with technology. Obviously, better access to health care is the major benefit to our citizens, but there is a huge job component to this too, and I'd be interested to get your input on that.

I think of the example in Barrie, where the company Southmedic had a novel medical device that is produced in Canada; previously it was produced in China. They were able to make a superior product that is being used across North America. Southmedic is just one company.

You mentioned your experience as a resident, where it was challenging. What types of opportunities do you think we're missing in having a regulatory process that, as you described it, is burdensome? What opportunities would exist for Canada if we were to create an environment that would make medical devices easier to get to market?

● (1725)

Dr. Rob Ballagh: It's such a huge topic and my experience is longer than a one-minute or two-minute question.

What I would say is that to take an idea from the bench to the marketplace, to a drug with a label on the counter at your pharmacy, costs $1 billion today; it costs between $750 million and $1 billion. My product, had it come to fruition, would have seen that kind of an investment. At each step of the line there are regulatory processes. Some of them are easier to get over than others. It's a very important process to go through. There are similar processes in every other country that has patents. For me and for my company, our stumbling block was at the third or fourth step, when we were doing some proof of principle. We had to get a partner. We had to partner up with a company. That's where our stumbling block occurred; it was in that process.

Having help with those technology transfer issues, and certainly in the patent area, is where we could have great improvements in this country.

Mr. Patrick Brown: You don't think Canada is behind other industrialized countries in terms of the regulatory process that exists? It's a lengthy process in all these countries today?

Dr. Rob Ballagh: I don't think we're behind, but I think we could be leading. We have some of the best doctors and some of the best scientists in the world in our country. That's one thing where I think we could, as a committee of innovators, be leading.

Mr. Patrick Brown: Thank you.

The Chair: My goodness, I have to say it's been an extraordinary afternoon. What strikes me is your humble attitude, and that's everybody, the two doctors especially. I'm quite amazed. I can see why you're leaders in this field. What you say is very important.

We're putting a report together, and all the good work and good ideas from all our witnesses will be part of that report. We have a long way to go yet because this has been a technological innovation. It's been an extremely important study that we've done.

Have a great Valentine's Day. Don't forget your spouses.

Have a good evening.

Thank you.