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Chair

Mr. Ben Lobb

Standing Committee on Health

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● (1530)

[*English*]

The Chair (Mr. Ben Lobb (Huron—Bruce, CPC)): Good afternoon, ladies and gentlemen. Thank you for attending our committee.

We're continuing our study.

We have a number of guests today who are appearing by video conference. I think that while the technology is up and running, we better hear your testimony first.

First is the Cline Medical Centre, and John Cline.

Go ahead, sir.

Dr. John C. Cline (Medical Director, Cline Medical Centre): Good afternoon.

Thank you to the chair of the committee and to my MP, Dr. James Lunney, for inviting me to present.

As you know, there's an urgent need for health care reform in Canada. I believe the solution is to introduce and implement functional medicine in health care professions' curricula and practices throughout Canada.

Functional medicine addresses the underlying causes of disease using a systems-oriented approach and engages both patient and practitioner in a therapeutic partnership.

You have the cover page of “21st Century Medicine”, which is a white paper published a couple of years ago on how functional medicine could take our health care forward.

Functional medicine offers a powerful new operating system and clinical model for assessment, treatment, and prevention of chronic disease. It incorporates the latest in genetic science, systems biology, and the understanding of how environmental and lifestyle factors influence the emergence and progression of disease. It enables physicians and other health professionals to practise proactive, predictive, and personalized medicine.

The slide with the picture of the three-legged stool illustrates the importance of the three components of functional medicine: the patient’s complete story, looking at modifiable lifestyle factors, and a systems biology matrix framework.

The next slide goes over the seven organizing systems where core clinical imbalances are developed, such as, assimilation, defence and repair, energy, and biotransformation.

On the next slide the three core tools are the matrix, the timeline, and a GoTo It heuristic. What this provides the practitioner is a way of critical thinking when presented with complex cases.

The next slide is the functional medicine matrix, with a column “The Patient’s Story Retold” on the left, with antecedents, triggering events, and mediators. On the bottom is a section detailing fundamental lifestyle factors. In the centre is the mental, emotional, and spiritual components of the person, surrounded by the core clinical imbalances.

The next slide looks at the timeline from preconception to current concerns.

Then there is the GoTo It heuristic that helps the practitioner gather, organize, retell the story, and initiate a care plan.

The next slide is a picture of a dense jungle. That's how we often feel when we have these complex cases sitting before us and have to sort all of this out.

We know there are many famous detectives in the world, such as Detective Adrian Monk, Inspector Clouseau, Sherlock Holmes, and then the most famous of all, the medical detective, “Dr. Fxn L. MeD”.

I'll end this presentation with a case study of a woman with severe pain and gasping. This is a woman I met a few years ago. She is a 45-year-old businesswoman who had just got her M.B.A. She had a one-year history of episodic vomiting, diarrhea, abdominal pain, non-throbbing headaches, night sweats, red eyes, and severe muscle and joint pain, especially in the wrists and ankles. She also had intermittent shortness of breath with gasping episodes. You can see what I mean about being in a jungle and having to sort all this out. She had had several ER admissions, and most of her symptoms cleared up within several months.

She had evidence of fluid in her lungs at one of those admissions. Her joints were transiently swollen, and her C-reactive protein level was extremely high, at 211. That's the best marker we have for inflammatory disorder.

● (1535)

She had seen five specialists, including a rheumatologist, who thought she had inflammatory arthritis of unknown origin. She'd seen an ophthalmologist, as well as an allergist, and nobody came up with a diagnosis.

When I was taking her history, there was a key question I asked her: Did anything unusual happen to her just before becoming ill each time? She said, “Yes, one to two days before becoming ill, I sprayed my trees and shrubs with malathion”, which is a potent pesticide and herbicide. Examining her, I found her blood pressure was low, her skin was dry, her finger tips were cracked, the membranes of her nose were quite swollen, and her wrists and ankles were warm to touch.

Her lab work showed that she had iron deficiency anaemia, her C-reactive protein inflammatory marker had come down to 38 and it should be under 5, and her vitamin D level was quite low. I also ordered genomic studies to see how she was designed for detoxification and I found that in her phase I detoxification pathways, two of them had genetic mutations. Then in her phase II pathways, she had a complete absence of the most important pathway for getting metals and chemicals out of the system, called glutathione. This is specific to liver and kidneys.

I went on line to the Agency for Toxic Substances and Disease Registry and found the toxicologic profile for malathion and discovered that it is metabolized through the glutathione pathway, the pathway she was missing, and she had every symptom described in that profile.

The therapeutic intervention was to change her diet and put her on a medical food product to support her detox, probiotics, pharmaceutical-grade fish oil, a good dose of vitamin D, high dose of curcumin, which comes from the spice turmeric, the most potent anti-inflammatory compound on earth, and oral glutathione, and I told her to avoid further exposure to chemicals.

The outcomes at the four-week follow-up showed that her wrist and ankle pain and swelling had improved by 95%. Her arm muscles had regained strength. Her night sweats and GI symptoms had all resolved. Her sinuses were clearer than they had been in year. She had only occasional headaches now, and she was back to work.

The second-last page is cost comparisons. We look at the conventional approach and we see she had had numerous trips to the ER, eight days in hospital, five specialist consults, numerous blood tests and imaging studies, numerous medications, and no diagnosis, with prolonged disability. In the functional medicine approach, she had no ER visits, only two office visits, no specialists, and few blood tests. I had ordered the genomic study on detoxification and comprehensive stool study and arrived at the correct diagnosis. She experienced rapid recovery, was back to work in a month, and regained a thriving life.

I do believe that the answer to our health care problem in Canada is the introduction and implementation of functional medicine in the health care profession's curricula and practice throughout Canada.

Thank you very much.

● (1540)

The Chair: Thank you very much.

Next up, from InspireHealth, is Janice Wright, chief medical officer, clinical services. Go ahead.

Dr. Janice Wright (Chief Medical Officer, Clinical Services, InspireHealth): Thank you for this opportunity.

As mentioned, my name is Janice Wright. I'm a medical doctor and the CMO of InspireHealth. We are a non-profit charity in Vancouver, British Columbia.

I'd like to talk today about bringing health into health care by using the example of our cancer care model. For us the most innovative thing that we could introduce into our health care system is the support of health.

I'll give a little bit of background on InspireHealth. We're a not-for profit. We were founded 18 years ago by two medical doctors. We are still to this day physician led. We provide a team approach to cancer care. We are grateful to be partially funded by the B.C. Ministry of Health. We work with local and national cancer foundations and would welcome a stronger opportunity to work with the national cancer strategy. I'd like to move right into talking about our current situation in health care.

We view this health care system as being actually more a disease treatment system, or as some people call it, a sick care system, rather than a health care system. Part of the reason for this is that as physicians, we're trained almost exclusively to diagnose and treat disease. Very little time in medical school is dedicated to learning to support our own or our patients' health.

As we all know, money alone will not save the health care system. The focus of our current system is on how to diagnose and treat disease, and few resources are given to prevention. In fact, as physicians and other allied health care providers, we are left to mop up when patients, who perhaps haven't learned how to take care of themselves properly or optimally, develop significant and chronic diseases.

Have we asked ourselves as physicians, as patients, as decision-makers, how we can work to turn off the tap, how we can work more towards prevention?

Our health care system currently does not effectively teach or model health. Medical students and residents, as I mentioned, don't learn how to support their own health let alone their patients' health. We learn how to diagnose and treat disease. Many doctors, as we know, are stressed and burned out and not in the position to model health for their patients.

Turning to our slides, in the disease treatment model, using cancer as an example from our practice, you'll see the tumour with standard therapy, such as surgery, chemotherapy, and radiation targeting the cancer, targeting the tumour, and the physician is the expert and advises the patient on what to do for their health.

In a fuller health care model, those standard therapies are still important. The surgery and chemo and radiation are still targeting the T—for tumour—in this next slide. However, you'll see all of these other ways that the patient...but also allied health care providers including physicians can support the patient to actually feel well, and perhaps to even have a better outcome than they would have with just standard cancer therapies alone.

I'd like to also point out—on the right-hand side of this slide—that the patient is in the driver's seat here. In fact, sometimes at InspireHealth we call them a participant. The patient is having conversations with their physician, their allied health care providers, and we are all having conversations with one another.

It is absolutely essential that patients become empowered, that they take responsibility, that they become engaged in their own health. Physician engagement in health care is equally important. Again, it's essential that physicians learn how to take care of themselves so that they can model this and support patients along the way, working as guides, as educators, as supporters, in addition to being diagnosticians and people who treat. This leads to a very powerful relationship, the physician-patient partnership, where they work together on shared decision-making and work to support the patient's good health.

You might be surprised to hear that actually many of our cancer patients who are working with a life-threatening illness tell us they've never felt better in their lives.

I'd like to also touch on two health care assumptions that I believe are quite prevalent.

One is that health is simply the absence of a diagnosable disease. Patients are sent the message from our current system that they need to be diagnosably sick before they go in to talk to a health care provider about their health.

There is a commercial on TV right now—I'm sure there have been many in the past, and there will be more in the future—that is quite compelling. I won't mention the name of the company. However, a gentleman who appears to be 20 to 25 pounds overweight runs into his home gleefully to eat foods that are highly processed, high-fat foods spread all across the dining-room table. The important part of this commercial is that he has a pill to take for his heartburn. Now, perhaps he doesn't have a diagnosable illness. He may consider himself to be healthy, and just needs to run to the drugstore for his next dose of a pill that might suppress his reflux. But this gentlemen being 24 pounds overweight, as we all know, is at higher risk for developing diabetes, cardiovascular disease, high blood pressure, and other illnesses.

Health is much, much more than the absence of a diagnosable disease.

● (1545)

The other assumption I'd like to touch on today is that people already know how to take care of their own health. I don't actually think that's true in many cases. In fact, as I mentioned, as physicians we don't necessarily know how to optimally take care of our health, or our patients' health either.

I'd like to show you this chart on the slide that reads “Deaths from Heart Disease”. I'd like to give you the example of cardiovascular disease.

Prior to the 1970s and healthy heart programs becoming *de rigueur*, patients were coming through the emergency room with an acute cardiac event and being told by their physicians that there was nothing that could be done for them. In fact, they were advised not to exercise because it would put them at higher risk for damaging their heart muscle and would lead to another cardiac event or death. Patients were labelled “cardiac cripples”. They were told that diet does not make a difference.

Thanks to some research, mostly that came out of the U.S., there was a change such that now healthy heart programs are recommended to every patient that has a cardiac event. Patients are up and walking and exercising the day after they have either cardiac surgery or an angioplasty. It's very, very powerful medicine. It shows that until that time, we as physicians didn't even know what was best for our patients' health. It's important that we recognize that we don't all necessarily know how to take care of our health and there is much to learn beyond just diagnosing disease.

I'd like to tell you a bit about InspireHealth's model of care. Again, we work exclusively at this time, mandated by the B.C. Ministry of Health, with cancer patients, adults living with cancer and their families. I'll highlight that in a moment.

We believe that we have an innovative program. We are research based. We support the health of cancer patients, but we also support the health of their families. The families come in and learn how to eat healthily through our cooking classes and other programs. They learn how to reduce stress in their lives, not just acutely but long term. They work towards restorative sleep and healthy nutrition. They learn to exercise. They take the programs home with them, or they participate in our exercise or other movement classes. They are provided with emotional and spiritual support.

One of the most important things is that with these group programs, they end up supporting one another. It's in a supportive environment. We provide patient-centred care, a team approach with allied health professionals including nutritionists, counsellors, and exercise therapists. We provide not only in-person programs but also virtual programs that we've now taken across Canada.

I mentioned that we were research based. I want to provide two examples. I won't go into the details, although I'm happy to provide references if you are interested. One shows that physical activity can actually help to prevent cancer in these particular cancers, and the other shows that physical activity can actually help breast cancer patients survive.

Coming to my conclusions, we believe at InspireHealth that the greatest innovation is to bring health into health care. One of the solutions, and a very important one in our eyes, is to actually educate physicians through formal modules on how to take care of their own health and how to support others in their health, so that physicians become educators. They become guides and supports in addition to diagnosticians. They are providing patient-centred care where the patient is in the driver's seat and this powerful relationship between doctor and patient, or other health care provider and patient, is strongly supporting health.

I cannot say enough about group programs. These have been instigated in certain cases across Canada, and I cannot say enough about them. I actually wonder whether we support our patients more greatly or they support one another more greatly. They've been there, and they can support one another in the lifestyle changes they're making that help them feel well and are potentially changing the course of their disease. A team approach is very important, where physicians learn to work not just in a multidisciplinary setting behind closed doors or siloed, but actually alongside one another toward the greatest health for all.

Our model of care is applicable Canada-wide. We've taken it in a virtual way across Canada to date. It is something that we would be happy to be consultants on, to help support the entire spectrum of health across Canada, not only for chronic disease, but for the whole spectrum, including prevention.

Our virtual programs, as I mentioned, have been supporting patients in underserviced areas already, and for patients across the country who don't have access to our services in person. We forge strategic partnerships across Canada with cancer agencies and foundations, and as mentioned, we would welcome the opportunity to work more strongly with the national cancer strategy.

● (1550)

We are very honoured that we are being studied by an international research institute at the moment. It's a four-year study. They have received a sizable research grant to study our model of care. They are doing an observational study, looking at survival outcomes and quality of life. We would also look forward to an economic analysis after that.

I welcome any questions. Thank you.

The Chair: Thank you very much.

Up next is Pure North S'Energy Foundation.

Mr. Allan Markin (Founder, Pure North S'Energy Foundation): Chair, honourable members of the committee, my name is Allan Markin, and my vision is preventive health care for everyone.

I am the founder and chief accountability officer of the Pure North S'Energy Foundation, Canada's largest primary prevention-focused not-for-profit organization. I'm accompanied by Dr. Mark Atkinson, a medical doctor and director of quality assurance, and Dr. Samantha Kimball, research director at the Pure North S'Energy Foundation.

At Pure North we empower Canadians to feel better and live longer through the use of simple and effective prevention-focused clinical interventions. These include vitamin D3 and high-quality multivitamin and mineral supplementation, health education, and the safe removal of mercury amalgam fillings. Our preventive program supports the advancement of modern medicine. Our multidisciplinary team of over 100 people includes medical doctors, naturopathic doctors, nurse practitioners, dentists, pharmacists, nurses, and other health care professionals.

Over an eight-to-ten-year period, 40,000 Canadians, including 25,000 vulnerable seniors, homeless, and first nations, have accessed our preventive health program, and have their blood panel taken regularly. Participants in our program experience a significant increase in quality of life and a 20% improvement in physical and mental health. Forty-eight per cent of those with pre-diabetes have experienced a complete reversal in their disease. Emerging evidence demonstrates there's a 17% reduction in the prevalence of metabolic syndrome for every 25 nanomoles per litre of vitamin D3 increase.

Our request is for the Government of Canada to proactively resolve what we call the four injustices, and for all Canadian physicians, medical students, dentists, and allied health professionals to be educated about these injustices.

Injustice number one is that Health Canada has regulated that no supplement in Canada contain more than 1,000 IUs of vitamin D3. Any amount higher than this requires a doctor's prescription and is regarded a drug. In the U.S.A., a country that has exactly the same recommended daily allowance for vitamin D3 as Canada, people have access to vitamin D3 supplements containing 7,000 IUs of vitamin D3 per tablet. It does not require a prescription, to our knowledge. The FDA has not put a limit on the amount of vitamin D3 in a pill, but Health Canada has. Canadians should have access to vitamin D3 supplements at the same dose as Americans, or higher.

Injustice number two is that the recommended daily allowance for vitamin D3 should be changed to be between 7,000 IUs and 9,000 IUs. Health Canada has been proven to have made a significant mathematical error in their calculation of the RDA for vitamin D3. The Health Canada vitamin D3 RDA for most adults is 600 IUs per day. Using Health Canada data and the correct statistical methodology, Professor Paul Veugelers at the University of Alberta has shown that the IOM vitamin D3 recommendation would have been 9,000 IUs per day if IOM had not made a math error. Another group, led by Dr. Heaney, a vitamin D3 expert from Creighton University in Nebraska, came up with a similar figure of 7,000 IUs based on an analysis of a dataset of 3,600 individuals. Dr. Kimball has published extensively on vitamin D3, including a trial of 14,000 IUs per day in patients with MS. The evidence is clear: vitamin D3 is safe, and the vitamin D3 RDA should be 10 to 15 times higher than the current Health Canada RDA.

Injustice number three is that Canada needs to mandate a complete ban on the use of mercury amalgam fillings in all Canadians, and not just children, pregnant women, and those with impaired kidney function. In Health Canada's report, "The Safety of Dental Amalgam", they acknowledge that amalgams impair kidney function. Pure North research has found that the safe removal of amalgams results in a significant improvement in kidney and liver function and in self-reported physical and mental health symptoms, such as anger, depression, and anxiety. The World Health Organization acknowledges that mercury is poisonous at any level. The use of mercury amalgam fillings has already been completely banned in Norway, Sweden, and soon Brazil, as well as a partial ban in Denmark. Canada needs to follow suit. Amalgam removal needs to be done safely.

Injustice number four is that Canadian emergency departments have unnecessarily long lineups and waiting times. The Wait Time Alliance's annual report card states that 27% of Canadians reported waiting more than four hours in an emergency department, as compared with 1% in the Netherlands, for example.

● (1555)

A recent analysis of the data relating to 6,600 of our program participants by the school of public policy at the University of Calgary found that a preventive health program such as Pure North's keeps people out of hospital. Within one year of being on the program, the Pure North participants had 45% fewer nights in hospital and accessed emergency departments 28% less than controls. This happened in less than one year.

The inconvenient truth is that millions of Canadians experience disease and suffer unnecessarily because our health care system has not yet made primary prevention a priority.

In 1943 the Canadian Medical Association called for preventive medicine to become a federal priority.

The World Health Organization report on the impact of chronic disease in Canada predicted that between 2005 and 2015 over two million Canadians, or 400,000 people a year, on average, will die from chronic disease.

Studies have found that if Canadians optimized their intake of vitamin D3, 37,000 premature deaths would be prevented annually, and the economic burden would be reduced by $20 billion per year.

In summary, integration of a proven preventive health program such as Pure North's prevents premature deaths and saves the government money. An assessment of the economic impact of our program estimated that every dollar invested in the Pure North program provides a return of between 13:1 and 25:1.

The result is that the health care cost curve is bent downwards with real potential cost savings of at least $420 million per year if rolled out to 600,000 Canadians. If Alberta, for example, implemented the Pure North program province-wide, this could free up the equivalent of 1,600 hospital beds every year. This is roughly the same as building two entirely new hospitals.

The provincial governments are also locked into an unfortunate mindset that the health care costs avoided rather than current health care dollars saved are not worth pursuing. Preventing [*Technical Difficulty—Editor*] chronic disease in the future avoids the size of the increase in budget that we are otherwise headed for. To avoid prevention since it does not reduce the size of the health budget today is nothing more than flawed logic with tragic implications, a sicker population and ever-increasing costs of treating them.

It is our hope that the Standing Committee on Health will attach great importance to these issues and take action to resolve them.

The Chair: Thank you very much.

Our final guest today is here in person. From the Canadian Association of Midwives, we have Emmanuelle Hébert. Go ahead.

[*Translation*]

Ms. Emmanuelle Hébert (President, Canadian Association of Midwives): Thank you, Mr. Chair and committee members, for the opportunity to appear today to contribute to the study of best practices and federal barriers related to scope of practice and skills training of healthcare professionals.

My name is Emmanuelle Hébert, President of the Canadian Association of Midwives, registered midwife and professor at the Université du Québec à Trois-Rivières.

The Canadian Association of Midwives is the national organization representing midwives and the profession of midwifery in Canada. The association's mission is to provide leadership and advocacy for midwifery as a regulated, publicly founded and vital part of the primary maternity care system in all Canadian jurisdictions.

The Canadian Association of Midwives also works to support the interests and objectives of 13 provincial and territorial midwifery associations, as well as the National Aboriginal Council of Midwives. There are currently just over 1,300 practising midwives in Canada.

Registered midwives are health professionals who provide primary care to women and their babies during pregnancy, birth and the post-partum period. They are often the first point of entry to maternity services, and are fully responsible for clinical decisions and the management of care within their scope of practice. Models of care vary across the country, but are based on the principles of continuity of care provider, informed choice, and the choice of birth place which includes hospitals, birth centres and homes.

Midwives regularly interact with a wide variety of health care professionals and social services workers in order to provide optimal care for clients. These include obstetricians and gynecologists, family physicians, pediatricians, nurses, radiologists, psychiatrists, paramedics, social workers, pharmacists, dieticians, and many more.

Collaboration and consultation with other health care providers is integral to the scope and practice of midwifery. Midwives, together with physicians and nurses, are actively exploring collaborative models of care and multidisciplinary practice to help address shortages of care providers and ensure women's access to maternity services, particularly in rural and remote communities.

Let's talk about midwifery training. The midwifery education program is a four-year direct entry baccalaureate program in midwifery. Seven Canadian universities in five provinces offer the midwifery education program. There are also three community-based midwifery education programs located in first nations and Inuit communities that specifically address the needs of aboriginal peoples.

Three bridging programs also exist in Canada, designed to help internationally educated midwives learn how to use their skills in a Canadian context; one in British Columbia, one in Ontario and one in Quebec. All students graduating from the midwifery baccalaureate programs take the Canadian midwifery registration examination which demonstrates that they have the core competencies and meet a common standard for entry level competency in all Canadian jurisdictions. All midwifery education programs are based on the same standards of education to train midwives as autonomous primary health care providers able to practise in all provinces and territories.

In jurisdictions where midwives work to their full scope, midwifery practice includes epidural monitoring, induction for post-term pregnancy and augmentation of labour by pharmacological means, prescription or fitting of contraceptives, well women and well baby care beyond the six-week post-partum period, and other aspects of primary care.

Scopes of practice reviews to amend drug schedules and expand on the authorized acts that midwives may perform have been completed. The objective is to harmonize high standards of midwifery care across Canada, reduce barriers to interprofessional collaboration and keep pace with a changing maternity and newborn care environment.

In every jurisdiction where midwifery is regulated, the provincial and territorial colleges are responsible for registering competent, qualified midwives and establishing, monitoring and upholding standards of practice.

● (1600)

The Canadian Midwifery Regulators Consortium is a body that groups together the provincial and territorial regulatory bodies. It has identified competencies that are common across all jurisdictions, covering antepartum care, care during labour and birth, postpartum care of the woman, care of the newborn and young infant, breast feeding, well woman care, education and counseling, and professional, interprofessional and legal issues.

Regulatory authorities further specify advanced competencies that midwives with the necessary training and certification may perform in certain situations or practice settings. In some rural or remote communities for example, midwives work to an expanded scope and provide a broader range of services to meet the needs of the population. Definitions of advanced—versus entry-level—competencies vary according to the regulatory framework in each province and territory.

In June 2017, Canada will host the world's Triennial Global Midwifery Congress in Toronto. Over 4,000 midwives and maternity care providers from around the globe will be in Canada. This will be a unique opportunity for us to show the world Canada's contributions and to highlight what we do within our own borders to provide fair and equitable maternity care to all of the population.

In order to optimize that visibility in Canada, the Canadian Association of Midwives believes that we should ensure that federal mechanisms are in place to allow communities to hire midwives to deliver maternity and newborn care services. Midwifery is not listed as a recognized profession under the Health Services Occupational Group Structure within the Treasury Board of Canada. This lack of an occupational classification has been identified as a barrier to midwives being hired by communities under federal jurisdiction for service delivery.

Maternal and child health statistics in aboriginal communities fall well below that of the rest of Canada. As the rest of Canada's fertility rates decline, the fertility rates of first nations and Inuit peoples increase. This is in the midst of a severe shortage of maternity and newborn health care providers.

These communities are already underserved and will feel the effects of this crisis disproportionately in the coming years. It is therefore crucial that birth care be brought back to communities and that access to midwifery care services in all aboriginal communities be provided.

Since April 2013, the Government of Canada has been providing student loan forgiveness to eligible family doctors, residents in family medicine, nurse practitioners, and nurses who work in rural or remote communities. Including midwives in this incentive program would increase the outflow of maternity care providers to rural and remote communities.

In New Brunswick, Prince Edward Island, Newfoundland and Labrador and in the Yukon, the profession of midwifery is still not regulated. CAM is working with its provincial and territorial partners and stakeholders to support the regulation of the profession in all jurisdictions.

As stated in the prestigious and well-respected *Lancet* series published in June 2014, midwifery plays an essential and unique role in ensuring safe, quality and cost effective care to women and babies here and around the world.

Thank you for the opportunity to appear before the committee. I look forward to any questions you may have.

Thank you very much.

● (1605)

[*English*]

The Chair: Thank you very much.

We're going to go into our rounds of questions now. Usually I'm quite lenient on time, but to get our rounds in, I'll be cutting off the members at seven minutes sharp.

That being said, Ms. Moore will be asking her questions in French. She'll give you a little practice round just to make sure you can hear it and the interpretation is working. If it is, her time will start.

Go ahead.

● (1610)

[*Translation*]

Ms. Christine Moore (Abitibi—Témiscamingue, NDP): Thank you, Mr. Chair.

When I was a student, there was a focus on clinical assessment. It was said that questions accounted for 70% of that assessment. You had to take the time to assess the patient well and this was done through questions alone. The physical and visual examination, where the patient is touched, made up 20% of the assessment. Additional tests such as blood tests or X-rays made up the remaining 10%.

One often gets the impression now that the opposite happens when you go to a hospital emergency ward to see a doctor. There they ask you questions during one or two minutes, you are examined for a minute or two, and then you are sent for a multiple series of tests, blood tests, lab tests, X-rays, and so on.

Dr. Cline, can you tell me what you think of that? Perhaps the same problem exists in traditional medicine, where physicians take less and less time to question a patient and carry out an in-depth clinical exam. If a physician took the time to question the patient, he or she could have a better idea of what is going on.

[*English*]

Dr. John C. Cline: Thank you for the question.

This is absolutely true. Sir William Osler, the famous Canadian physician, said to his medical students a century ago that if you listen carefully enough to your patient they will tell you what the problem is. For the case I presented, it took me one and a half hours to take that history and to do a careful physical examination.

When I teach residents in functional medicine, I'm surprised at their lack of physical exam skills. A large part of my teaching is on helping residents to sharpen up their history-taking skills and physical exams skills.

The power of the functional medicine matrix is that it forces you to think outside of your comfort zone and it forces you to be thorough in your critical thinking of these complex cases. It also helps us to hone in on what the patient has deemed most important. We teach our functional medicine residents to retell the patient's story back to them, and that's a very powerful therapeutic encounter.

The history and physical exam is still a cornerstone and should be the foundation on which you build other tests.

[*Translation*]

Ms. Christine Moore: Ms. Hébert, my question to you is in the same vein as the previous one.

In your opinion, is the success midwives have in their relationship with patients attributable to the fact that they take much more time to talk to them and assess them properly so as to target their needs? This could be why many patients report preferring their experience with a midwife to the ones they have had with traditional medicine.

Ms. Emmanuelle Hébert: It is certainly true that the time spent with each woman is very important. In fact, the relationship is at the very core of the midwifery profession. In order to support a woman well in her labour and delivery, it is very important that the midwife develop a relationship with her. Also, the woman must be placed at the centre of the decision-making, so there is really a partnership that develops, which is very important.

Ms. Christine Moore: Is the building of such a relationship a part of the training provided to midwives? Is the training limited to teaching midwives the biological aspect of maternal health, or does it also focus on the relationship with the patient and the assessment of her needs? Does the training allow midwives to acquire communication and helping relationship skills, or is it mostly focused on the biological aspect?

Ms. Emmanuelle Hébert: A large part of the training is focused on the relationship, the helping relationship, and communication. The students who do a baccalaureate in midwifery practice have several semesters of practical training and are trained individually by midwives. The midwife becomes a role model for the students. This is an important and integral part of the midwifery practice curriculums. It is really very important to us.

Ms. Christine Moore: My question is addressed to the two witnesses who have not spoken yet.

Do you find that the success of your preventive approach is due to the additional time you devote to patients and to the fact that as compared to more traditional systems, you are much more aware of their needs?

● (1615)

[*English*]

Dr. Mark Atkinson (Director, Quality Assurance, Pure North S'Energy Foundation): I'd welcome the opportunity to speak to that.

There are a number of factors here. The first thing is that when people come into a preventive health program, there are a number of health professionals who are working with them, from the receptionist, to the phlebotomist, to the nurse, to the doctor. We're wrapping around individuals so they know we are here to support them. That can....[*Technical Difficulty—Editor*]

The second thing is the time we spend with them. We are getting to know them, their context, and the way they live their life. That matters.

The other big thing in prevention is our focus on the solution rather than the problem. We are much more interested in not what's wrong, but what's right, what needs to change, and what their goal or aspiration is for their health. That combination is very effective.

Mr. Allan Markin: I would quickly add to that. Thank you for the question.

Our system has a lot of documents to fill out. It gives you a pretty good idea in a very short period of time exactly what their challenge is, in order that we can prevent it from happening in the future.

Do you want to add anything, Samantha?

The Chair: We are out of time. I apologize. We have to keep it to seven minutes here for time's sake.

Mr. Lunney, go ahead, sir.

Mr. James Lunney (Nanaimo—Alberni, CPC): We welcome all of our witnesses to this committee. I want to say to all of you how much we appreciate your testimony today.

Thank you, Dr. Cline, for that interesting case history and the importance of a proper investigation and diagnosis.

Of course, I think you'd be interested to hear that it was Pure North S'Energy that brought up the problem of toxification through mercury amalgam, which is a big concern to many people in the integrated med world.

Allan and Mark, I appreciate that Pure North S'Energy has raised the issue of Vitamin D. I think several of you mentioned Vitamin D, and I hope to hear a little more from all of you on that. I have a motion before this committee to look into two of the four injustices that you mentioned, so I want to come back to that in just a minute.

The first thing I want to mention is that I really appreciated this tile. Not all of you would have seen this, but it's from InspireHealth. Dr. Wright, you have a great cartoon presentation here. You won't be able to see this, but it shows a very busy doctor sweating away and mopping the floor while the sink is overflowing, and no one is paying attention to turning the tap off. I think there is something in common there with the energy that we are spending trying to manage our health care expenses while often missing the root-cause issues.

What I want to suggest is that there is a lot of stress in medicine, and what I've noticed about the groups that are present here is that you are very happy and enthusiastic about what you are engaged in. There is a lot of stress for some of your doctors.

I want to start with InspireHealth and just say that your program seems to take the stress out of cancer therapy for the patients. They can always engage with somebody. We heard from Dr. Cline about the importance of building a relationship with the patient, telling their story back to them, making sure they are understood, but managing stress.

Your results and outcomes in managing the cancer patients, along with the traditional cancer therapy that is targeting the lesions being addressed, have the attention of the B.C. government and the BC Cancer Agency. Your outcomes are sufficiently significant for your patients. B.C. has good statistics and you have received attention.

You do outreach to remote areas. I want you to briefly explain to this group how that works, and the role of Vitamin D in the better outcomes that you're getting. If you would, please start there.

Dr. Janice Wright: Thank you for the question.

With regard to our outreach, we reach out by virtual online programs. We provide group programs but also confidential consultations with any member of our team a patient chooses. Not only are those opportunities available right now throughout the province in rural and remote areas, underserviced areas, but we've also just taken it Canada-wide. There's that piece.

Mr. James Lunney: Do you fly out to the region, meet with the people first, and then follow up through electronic means once you've established a relationship? Is that part of the program? I know you started that way.

Dr. Janice Wright: That is part of the program. We send a multidisciplinary team into a community, and by the way, the community actually helps to fundraise to bring us out there, which is just amazing. They see the value of this and they fundraise to help us come. We arrive there, and we do a one-day program on preventive health and on secondary prevention and supportive health, including mind/body relaxation practices, exercise, nutrition, etc. Then we fly home and support them online and over the phone.

Mr. James Lunney: Someone can always get through to you.

Can you explain the role of vitamin D in your program, along with the other things you do?

● (1620)

Dr. Janice Wright: One of the foundational studies on vitamin D came out of the U.S. in 2007. We've been following the literature on vitamin D for many chronic diseases, but in our case specifically with regard to cancer care over the last seven or eight years. We recommend it not only for the prevention of cancer in a cancer patient's families and friends and community, but also for the cancer patients themselves. We're currently conducting an in-house trial as well on vitamin D and stage 4 colorectal cancer. There's very promising news about vitamin D and its role in cancer prevention and secondary prevention.

Mr. James Lunney: It would also produce better clinical outcomes, I would think.

I don't want to put words in your mouth, but could you confirm that you feel that getting the vitamin D levels up improves clinical outcomes perhaps by reducing the toxicity of their cancer treatments?

Dr. Janice Wright: I was only hesitating because we don't have the results of the study yet. Clinically and anecdotally we absolutely see a difference in folks, not only from the vitamin D but also from all the other ways we support them.

Mr. James Lunney: Thank you.

Allan Markin, your group, Pure North S'Energy, has an amazing story. You've been working with people for eight to ten years, and I think I heard that 40,000 people have come through your program, many of them low-income people in remote areas. By addressing these nutritional deficiencies—I'll let you explain how you do this—the basis of your outreach, you're actually improving the health outcomes significantly and reducing costs to the Alberta health system.

Would you please comment on the improved outcomes you're seeing in your patients and what you attribute those to?

Mr. Allan Markin: I did comment on that a lot. Perhaps you'd like to talk a little bit just about the outreach.

We started this with flying our doctors out to every corner of Alberta, British Columbia and Saskatchewan. We would fly our professionals out there to take the blood and then get back to people on a verbal basis. Eventually, the program evolved to the point where we were giving people close to 10,000 to 20,000 IUs per day because we saw immediately quite an improvement. We try to target people to get up to 150 to 250 nanomoles per litre safely. One of our biggest studies has just come out recently through Dr. Richard Lewanczuk—I just have to mention this—whose title, I think, is chief of chronic disease prevention and senior medical director of primary care, community and rural health for Alberta Health Services, working for the Alberta government. We have a diabetes paper there. We're turning around people, about 48% of them, from pre-diabetic to non-diabetic. We're working with them. Their hearts are getting into a lot better shape because of the vitamin D and other vitamins and minerals we're working with.

I'm not sure if that answered your question.

Mark, would you like to add anything?

Dr. Mark Atkinson: To reiterate that, essentially we provide a personalized combination of high-quality nutritional supplements, vitamin D, which is individualized according to body mass index. Those who are overweight or obese need higher doses of vitamin D. We're finding that physical and mental health improve significantly, and diabetes is being prevented and for people with pre-diabetes, the state before diabetes, that is being reverted to normal just using nutritional supplements alone.

We have a highly cost-effective, simple way to support people's health. The reality is that the vast majority of Canadians have multiple nutritional insufficiencies that drive chronic diseases.

The Chair: Thank you very much.

I'm sorry, but we're over time again.

Ms. Fry, go ahead.

Hon. Hedy Fry (Vancouver Centre, Lib.): Thanks to all of you for some fairly interesting and creative work that you are doing.

I want to ask a question of Pure North.

I notice that you have some very impressive statistical data here in terms of your outcomes, including 25 fewer hospital visits, and for people who stay in the program for four years, 45% fewer hospital visits. This is all good. I think that if you can improve access to hospitals or need for hospitals and acute care, and if you can manage people in the community, this is extremely good.

Do you have anyone else working with you in terms of preventive care other than nutritionists or people who deal with nutritional supplements, etc.? What are the other areas in which you have an integrated approach to care?

● (1625)

Dr. Mark Atkinson: Our core team is built around medical doctors and naturopathic doctors who are educated and informed about nutrition and who work alongside nurses, nurse practitioners, and dentists as well. The dentists actually have become an integral part of our team, because we are starting to realize that the health of your mouth has a profound influence on the health of your body, and vice versa. It's our multidisciplinary team that's the key to the success in this.

Mr. Allan Markin: And pharmacists—

Hon. Hedy Fry: And pharmacists.

Do you get funded on a capitation basis by the Province of Alberta? How are you funded to do this work?

Mr. Allan Markin: One hundred per cent by me, by Allan Markin. I've spent close to $200 million of my own personal money on this, mostly in the last few years. The data that's come out of this has allowed us to get a grant through the Government of Alberta, a minor grant last year for seniors. We got a lot of data out of that for seniors and how to work with seniors, and the quality of life has really improved there.

Hon. Hedy Fry: You don't get any billing at all, and you can't bill the public health care system. You work on your not-for-profit foundation and you use that money to pay the whole team. Is it a salary basis or is it a sessional basis? How do you manage your team?

Mr. Allan Markin: Go ahead, Mark.

Dr. Mark Atkinson: Yes, certainly. Our core nursing team is salary based, and our doctors are there as consultants, but essentially to date, Mr. Markin has personally financed Pure North for the last eight years.

We're now looking to the Government of Alberta to work with us more closely so that we can start to embed the core of our preventive program into Alberta Health Services itself. We are moving towards that.

Hon. Hedy Fry: The reason I'm asking—

Mr. Allan Markin: That's very difficult to do without—

Hon. Hedy Fry: —is that your model might be something that one can emulate, so I really want to know how it actually works in terms of integration, reimbursement, etc. I wanted to find that out, so thanks very much.

I want to ask Dr. Cline some questions.

Dr. Cline, do you have other physicians working in the practice with you? Do you have an integrated system as well? What does your integrated multidisciplinary system look like? Are you paid out of the public administrator in your province?

Dr. John C. Cline: Thank you, Dr. Fry.

I have a small clinic in Nanaimo. I'm the medical doctor. We have two integrated dentists, and I have a nurse practitioner who joined me from Chicago two years ago.

As far as payment goes, we do a blend of payments. We bill the medical services plan for whatever we can and document that in the charts. For uninsured services, which is most of what we do, we bill the patients. Sometimes insurance companies will also pay.

Hon. Hedy Fry: Given that in the 2004 health accord, and prior to that actually, earlier on in 2002, when money was put into primary care models of community care and integrated care, do you not feel that this is an experiment that the provincial government should invest in?

Dr. John C. Cline: What is usually meant in integrative care is integrating pharmacists, nurses, physicians, social workers, and so on, but what it comes down to is integrating a standard model of care, whereas functional medicine is actually giving, I think, a better operating system for critically thinking the complex cases, such as the one I presented, so that you can actually use history taking and a physical exam with fewer tests to solve these complex problems. Then start with food and nutritional supplements, exercise, and so on, to help move the biochemistry towards a healthier function, but keeping in mind that we have specialists who are there if surgery is required, endocrinology, or gynecology, and so on. We have access to that system.

● (1630)

Hon. Hedy Fry: Do you have any outcomes with regard to your hospitalization rates or fewer hospital bed stays? Do you have any kind of information that would show you are getting better results? This is not a trick question. I just really want to know that you're getting better results than traditional clinical, integrated, multi-disciplinary models.

Dr. John C. Cline: I must say that I rarely have any of my patients go to hospital, except for surgery.

The Institute for Functional Medicine was invited last year by the Cleveland Clinic to set up an institute for functional medicine there as part of the institutes in the Cleveland Clinic, and so there is ongoing research there.

The white paper that I alluded to in my presentation has 245 citations looking at the research in functional medicine that has been published.

Hon. Hedy Fry: Thank you very much.

I think my time is up. I'm getting the flag waved at me.

The Chair: Mr. Lizon, you're next on the list, and again unfortunately, we're tight on time, but we'll give you time for a question.

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

I have a question for Dr. Cline.

I'm not a professional in the medical field; therefore, my question will be quite basic, because I'm trying to understand what exactly you do, Dr. Cline. You're not part of the provincial health care system. Is that correct?

Dr. John C. Cline: Thank you for the question.

Yes, I am part of the provincial system.

Mr. Wladyslaw Lizon: What you're practising, is it conventional medicine or is it not quite conventional?

Dr. John C. Cline: Well, it's a blend of conventional and what we would call alternative. It's blending the two together.

Mr. Wladyslaw Lizon: I don't know whether you are familiar with an Ontario doctor—I think he retired—Dr. Josef Krop.

Dr. John C. Cline: I know him.

Mr. Wladyslaw Lizon: Yes, and you remember he had challenges with the licensing body here in Ontario. Have you had a similar experience where you practise in B.C.?

Dr. John C. Cline: Yes, I have undergone three investigations by the College of Physicians and Surgeons, and just last Friday, I found out that I'm having my practice audited again. One of the barriers to branching out into integrative functional or alternative practice is that you become a target.

Mr. Wladyslaw Lizon: I have just one more question.

I'm very puzzled by the case that you're describing here. I don't know how many cases there are on a daily or monthly basis in this country.

What's the main reason that the person you treated was not able to find the proper treatment in the places where she went for treatment?

Dr. John C. Cline: I think the main reason this woman wasn't able to find treatment is that the underlying disease process was missed. There were many treatments tried, but they didn't work because the underlying process was missed.

Mr. Wladyslaw Lizon: Thank you very much.

Dr. John C. Cline: You're welcome.

Mr. James Lunney: Mr. Chair, may I just make a brief remark for the record about Dr. Cline? This is only because it was mentioned that he is being investigated by the licensing board.

Dr. Cline, like many of the integrated med docs I know has been investigated by his licensing board, but Dr. Cline has been used by the Canadian Medical Protective Association as an expert witness to defend other doctors who are having issues with their licensing boards for doing innovative treatments.

Is that correct, Dr. Cline?

● (1635)

Dr. John C. Cline: That's correct.

Mr. James Lunney: Thank you.

The Chair: Thanks very much.

Mr. Lunney is retiring from politics at the end of this session, so I've showed him lots of leniency in the last few meetings. I hope other members don't mind, but we do enjoy his comments, and we want to make sure he gets as much on the record as he can.

We're going to suspend for a couple of minutes, and we'll come back with our next panel.

Thank you.

● (1635)

(Pause)

● (1640)

The Chair: We're back in session for our second hour of meetings.

We have another witness by video conference, from the UBC Centre for Health Services and Policy Research, Sabrina Wong.

Go ahead, please.

Ms. Sabrina Wong (Interim Director, UBC Centre for Health Services and Policy Research): You asked me to come and talk about your study that you're doing. Is that correct?

The Chair: Yes.

Ms. Sabrina Wong: The Centre for Health Services and Policy Research is a University of British Columbia senate-approved centre. It was established in 1990. The mission of CHSPR is to produce and communicate high-quality health services and policy research relevant to the organization, financing, and delivery of health care.

It also has a mission to train students, as well as in knowledge translation and exchange through its publications, media interactions, and exchanges with local, regional, national, and international health policy and health services decision-makers. It is unique in its focus on broader macrosystem challenges and policies that might normally be relevant to just one or a few regional health authorities.

I'll open by saying there is a changing landscape. The provincially and territorially based health care systems within Canada continue to undergo major reforms in response to new technologies and to demographic changes such as an aging population, advances in health care and disease management strategies, and the recognition of the importance of social determinants of health and ensuring the health of the population.

There has been relatively little attention paid to the impact of system and organizational change on health human resources in comparison to the extent to which such changes have occurred during the past decade. Much of the past literature completed for a scoping review for a report completed for the Health Services and Policy Research Support Network discusses the impact of the major acute care restructuring and downsizing of the acute care sector during the 1990s on health human resources, primarily in urban environments.

Less attention has been paid to innovation in the use of different health professionals' scopes of practice in the non-hospital sector. There is little work on the health human resource implications of the increasing use of multidisciplinary teams and interprofessional collaboration, the use of other types of health professionals working to their full scopes of practice, or the increased use of a wide range of technology.

As a community of academics and clinicians, we know much about how health care services might best be organized and delivered, as well as the different health professions' scopes of practice. We know little about the interaction of these two areas. We know much less about how best to deploy our health human resources for optimal organization and delivery of health care services.

As an example, primary health care delivery across Canada is associated with better and more equitable health outcomes. However, many of the reforms remain incomplete and the potential improvement for patients, communities, and the health system has yet to occur.

A central component of these reforms was the implementation of interprofessional team-based care. Provinces from coast to coast have embraced interprofessional primary health care teams resulting in many diverse models of teams now serving Canadian communities. Despite rising demands and expectations, the primary health care system remains ill-prepared to deliver the expected benefits of interprofessional primary health care.

A major obstacle to improving primary health care through interprofessional teams is the lack of understanding team members have of the scopes of practice and potential roles of other team members. Many of the professions that are part of these interprofessional primary health care teams such as pharmacists and psychologists, and even ones which have long been a part of these teams such as nurses, have only recently developed frameworks delineating the competencies of these professionals delivering primary health care services.

As the primary health care system faces growing demands for efficient and effective patient-centred care for increasingly complex patients, it is essential that these interprofessional primary health care teams develop better approaches to assessing and deploying their team skills to improve the care they deliver and better meet their patients' needs.

To answer your specific questions, I've drawn on our expertise at CHSPR as well as our colleagues from across the country, namely the Canadian Academy of Health Sciences, which recently re-released a report on scopes of practice.

● (1645)

Your first question was what the federal role is in the scope of practice of Canadian health care professionals. There are a couple of things that I have decided to come up with in terms of this.

One would be to invest in an infrastructure to measure and monitor scopes of practice of Canadian health care professionals linked to appropriate dimensions of care. A federal role is needed to implement systematic monitoring and evaluation, with a specific focus on inputs and outputs, to estimate costs incurred for introducing change and the long-term return on investments. A federal role is needed to enable a broader application of collaborative performance measures and an overall quality assurance framework through involvement of accrediting bodies.

As an example, in community-based primary health care most agree that we need responsive first contact care for emerging problems, capacity to resolve common health problems, ongoing care for most chronic conditions, routine delivery of preventive and health promotion services, timely coordination with other actors concerning specific diseases, and action on the social determinants of health. However, performance reporting in community-based primary health care is challenging because of the dearth of concise and synthesized information and because many clinicians prefer to be accountable only to their individual role and do not view themselves as elements or actors within a larger system.

That would be the first recommendation.

The second one would be to earmark research funds to address gaps in the literature and our knowledge in a number of areas. We know that payment models do not support changes in scopes of practice, so one area of research is to look at alternative funding, such as bundled or mixed-payment schemes, to include all health care professionals and to be aligned with desired outcomes. We also know that care is moving into the communities and multiple-care settings, so we need to understand the implementation and upkeep of electronic medical records, since it is essential for all health care professionals and patients to have timely and up-to-date information on treatment and status. We know there's a lot of professional protectionism that goes on, so we need to do work to understand how there could be better representation of interests of professions in the context of collaborative care arrangements and interprofessional standards and overlapping scopes of practice.

Another area is to earmark funds for educating professionals and courts on changes to legislation that recognize the principles of shared-care models. Right now health care professionals are worried about their accountability and liability. There is a federal role in addressing currently rigid legislation and regulations. If we could expand adoption of more flexible legislative frameworks that could be interpreted at local settings, that would greatly help. As well, there is a need to support the development and ongoing implementation of umbrella health professional regulatory legislation across provinces and territories.

The second area that you asked me to address was to highlight best practices on the use of scopes of practice, both in Canada and internationally.

Did you want me to continue, or do you want to ask questions now?

The Chair: Do you have a little more left in your presentation, or are you done?

Ms. Sabrina Wong: Yes, I have a bit more.

The Chair: Okay, you can have about a minute, and then we'll be at 10 minutes.

Ms. Sabrina Wong: Yes, okay.

In order to address your second point, my suggestion would be again to fund research to assess the impacts of selected key health system innovations on health human resources in both urban and rural settings; to develop a national framework for guidelines and quality standards for optimal, expanded, and overlapping scopes of practice; and then to promote best practices and facilitate subsequent scale-up and sustainability of initiatives across the country.

Your third point was to understand what the federal role is in supporting skills training curriculum development. As I have already noted, there is a federal role in addressing the current legislative frameworks to support the ongoing development and implementation of umbrella health professional regulatory legislation. Second is having a standard that allows people to work to their full and optimal scopes of practice by helping to establish standards for practicums and residencies that foster interprofessional competencies. Another is to have post-licensure credentialing. The last is to work with the regulatory and accrediting bodies to require continued professional education to cultivate team thinking and develop levels of trust around relative competencies.

● (1650)

The Chair: That's great. Thanks very much. We have two guests here who are going to present. Then we'll open it up to questions. Stay tuned, if you can.

First, we're going to have, from the Canadian Federation of Medical Students, Bryce Durafourt.

Go ahead.

Mr. Bryce Durafourt (President, Canadian Federation of Medical Students): Good afternoon.

Thank you, Mr Chair and members of the committee, for inviting me to speak to you today as you explore the role of the federal government in the practice and training of health care professionals.

Before speaking to the topic at hand, as the representative of the Canadian Federation of Medical Students, I would like to take a few moments to introduce our organization.

The CFMS represents more than 8,000 medical students from 14 Canadian medical schools coast to coast. We represent medical students to the public, to the federal government, and to national and international medical organizations. As the national voice of medical students, we connect, support, and represent our membership as they learn to serve patients and society.

I am here today in my capacity as president of the CFMS. I'm also a fourth year medical student at McGill University in Montreal.

I would like to start by reviewing the current process by which physicians in Canada are trained.

A potential doctor in most provinces in Canada is required to complete an undergraduate degree prior to being accepted into medical school. Medical students usually then complete four years of studies before graduating as doctors. They then complete additional training, referred to as residency, in their specific field of interest. Residency in family medicine is an additional two years, whereas specialty training is usually five years. Additional sub-specialty training is often required for a physician to be hired in an academic centre.

The implication of this system is that medical students can study in one province, complete their residency training in another province, and ultimately be hired as staff physicians in yet another province. As a result, there is an opportunity for federal leadership in the development of a robust supply-and-demand model for health care professionals.

The CFMS would like to commend the federal government for its ongoing support of the Physician Resource Planning Task Force, PRPTF. Through the work of this group, the government is helping to address an imbalance of unemployed or underemployed specialist physicians against a continued shortage of family physicians, especially in rural, remote, and northern communities. The CFMS believes there is a need for ongoing modelling of physician supply-and-demand projections in order for medical students to make informed career choices that best serve the Canadian population.

We support the recommendation of the PRPTF for the establishment of a pan-Canadian physician resources planning committee for continued collaboration on this issue. The CFMS also commends the Government of Canada for its support of the transformation of medical education through the Future of Medical Education in Canada projects. These programs, if realized to their full potential, will result in better physicians who are more responsive to the health needs of Canadian society and better equipped to improve health, enhance quality of care, and secure a sustainable health system.

While there has been progress towards a more equal distribution of physicians across Canada, there are still significant challenges. In 2012, the Canadian Institute for Health Information reported that 18% of Canadians live in rural and remote areas, while only 8.5% of physicians work within these regions. These distribution issues underlie the 2014 Commonwealth Fund finding that placed Canada last in terms of timely access to care when compared with 10 other OECD nations.

The Government of Canada has made positive steps towards correcting the maldistribution of physicians across the country. An example of this progress is the Canada student loan forgiveness for family doctors and nurses program. This initiative allows family doctors or family medicine residents in a rural or remote community to benefit from up to $8,000 of federal loan forgiveness per year to a maximum of $40,000. As of November 2013, this program had enabled more than 1,150 family doctors and nurses to receive some loan forgiveness.

While this program represents a positive step towards providing rural Canadians with better access to care, the CFMS believes that this program is not operating at its full potential. The barrier to maximizing the number of new family doctors taking advantage of the program lies in ensuring that they have outstanding federal government loans when they are in a position to take advantage of the program. That means that you still need to have Canada student loans at the end of your medical training.

● (1655)

It is helpful to know that medical trainees are required to begin payment of principal and interest on federal loans during their residency. The interest rate charged on loans through the Canada student loan program is significantly higher than that charged by major financial institutions for other professional student lines of credit. For instance, the interest rate on Canada student loans is currently set at prime plus 2.5%, whereas a medical student line of credit would be set at prime.

As a result of this difference in interest rates, most medical residents choose at the start of their residency training to consolidate their Canada student loans to a line of credit from their financial institution. This shift of debt significantly reduces the incentive that has been created to draw new doctors to rural and remote communities. Simply put, residents and family physicians who no longer have outstanding debt on a Canada student loan are no longer eligible for the debt relief program.

The program would be significantly improved if the federal government were to delay repayment of principal and defer interest accrual on Canada student loans until after the end of residency. As a result, many more physicians would be able to participate in the Canada student loan forgiveness for family doctors and nurses program, and Canadians in rural, remote, and northern communities might enjoy better access to care. Furthermore, this proposal would better align federal and provincial policies, as several provinces already offer loan forgiveness for residents who remain within the region.

The CFMS appreciates Ottawa's important role in supporting skills development of health professionals. Two areas in which the Government of Canada can tackle physician maldistribution are long-term projections of physician supply and demand, and improvements to the Canada student loan program. These solutions have the potential to be important levers to improve the federal role in skills training of health professionals.

Thank you for your time and your attention. I look forward to our discussion.

The Chair: Thank you very much.

Next up is HealthCareCAN, and we have Raj Bhatla and William Tholl.

William Tholl will be first.

Carry on.

Mr. William Tholl (President and Chief Executive Officer, HealthCareCAN): Thank you, Mr. Chairman, and good afternoon, everybody.

[*Translation*]

My name is Bill Tholl. I am the President and Chief Executive Officer of HealthCareCAN, which is the national voice of hospitals and other health care organizations in Canada.

[*English*]

We foster informed, continuous, results-based discovery and innovation across the continuum of health care. We act with others to enhance the health of the people of Canada, build capability for high-quality care, and help to ensure value for money in publicly financed health care programs.

You would better know us historically as the Canadian Hospital Association and the Association of Canadian Academic Healthcare Organizations. About a year ago, the two organizations merged.

This afternoon I'm joined by Dr. Raj Bhatla, chief of staff and chief of psychiatry at the Royal Ottawa Health Care Group here in Ottawa, one of our 40 member organizations. I've asked Raj to illustrate for you in some practical ways some of the issues around scope of practice and the area you're studying here today.

Before doing that, though, we're pleased to be here to contribute to your study of best practices and federal barriers related to scope of practice and skills training of health care professionals.

As one of the last groups to present to your study, we're certain you have heard a number of critical issues from individual professions. We would like to think that we bring a collage of those perspectives to this table. Many of the professions you've heard from work in our hospitals, in our academic health care institutions, and the perspective you get from that multi-professional perspective is somewhat different again. We'll try to explain just how that looks from our perspective.

The issue of scopes of practice is one of legislation and involves more innovative approaches to teaching. It is an issue requiring legislators not to look just at eliminating barriers but also at creating bridges, so my remarks today will be split into the two categories of looking at some of the barriers, but also looking at one of the things that the federal government can do. Given this is an area that's principally the responsibility of the provinces and territories—they are the ones that determine scopes of practice, that develop disciplinary legislation, that regulate—there are things the federal government can do to aid and abet, help, or hinder, so I'm going to break my remarks into two categories.

Generally speaking in this context, looking at scopes of practice is a function of time and place. This isn't the first time I've been before this committee talking about scopes of practice, wearing at least four different hats, but it's a different time. The fiscal environment is much different from that of the last 10 or 15 years, so it's not a simple task in the current policy environment of getting it right in terms of scope of practice.

I chair the finance and audit committee at the Royal Ottawa Hospital. We're now into the fourth year of zero means zero in terms of annual budget increases, and it has now become absolutely necessary to look at how we get it right in terms of scope of practice. Dr. Bhatla will share with you some of the things we have been doing at the Royal Ottawa Hospital.

As numerous professional groups have stated already, and I would echo, we need leadership and better leadership at all levels within institutions, within governments or across governments, and in fact, right down to patients. We need leadership such as that being demonstrated, we believe, by Minister Ambrose with the establishment of the Naylor advisory panel on health care innovation.

Health care organizations and personnel seeking innovative solutions find ways to work around things. I don't know whether folks have recommended to you the “From Innovation to Action” report that was prepared for the premiers and released in July 2012, but it identified nine very specific examples of integrated, full scope of practice exemplars across Canada.

One that I remember is the Brier Island, west of Halifax, where they had trouble keeping emergency physicians. They would go in and they would leave. They would shut down the ER department and they would have to open it up again. They came up with a marvellous innovation, which was to have souped-up paramedics to work in the actual community with direct on-call access to emergency physicians as and when necessary. That's the kind of innovation we think we need to have in Canada.

● (1700)

What's missing? What's missing is an ongoing source of support for that innovation. There is no ongoing innovation secretariat. The health care innovation working group doesn't support that. That's an area where we think the federal government has a role to play in establishing an innovation fund that would help promote the Brier Island kinds of innovations in Canada's health care system.

Another potential barrier is the new legislation on temporary foreign workers. You have heard, I think, from others that it has the potential for unintended consequences in terms of impeding our academic health care institutions from going out and recruiting post-residency training professionals or health researchers who are in their fellowship or post-fellowship training programs to spend a couple of years here in Canada. The current law potentially—potentially—creates barriers to our doing that.

I'd be glad to elaborate on any of these.

The last one I'll mention in terms of barriers is kind of a cultural barrier. The recently published report of the Canadian Academy of Health Sciences entitled “Optimizing Scopes of Practice: New Models of Care for a New Health Care System” notes, “Determining the optimal scopes of practice of these health care providers will be an essential element in leading health care transformation for the future.” I remind you that 80% of our health care costs in our hospitals are about people—health human resources—so we have to get that right in terms of striking the right balance. The report goes on to say, “Unfortunately, the systems in place for determining and regulating scopes of practice have done more to preserve the status quo than promote change.” We have to get past that. That's looking to the past to try to create a better future, and that won't work.

Let's get to the more positive stuff. What are the examples of building better bridges that would involve, or could involve, the federal government in a leadership capacity? This is all in support, by the way, of what I've already heard here today, which is the recurrent theme that we need better approaches to needs-based health human resources planning, the emphasis being on needs-based. When all is said and done, we've been more saying things than doing things when it comes to needs-based planning in this country.

I'll give four or five examples. One, the Government of Canada, working with the provinces, could convene a national symposium to bring all stakeholders together to talk about what you're talking about. Health Canada could fill the void left by the health care innovation working group, and in particular the health human resources working group which, to be frank, floundered as the third of the three working groups, and pick up where they left off.

For a very long time we've talked about creating an observatory where we'd look at health human resource needs through the lens of the patient and evaluate those on an ongoing basis, and yet we have not done anything. The closest thing we have come to it, by the way, is to fund a health human resources network on the basis of a CIHR funding grant. Dr. Ivy Bourgeault here at the University of Ottawa is heading that up. Their funding ends at the end of this month. I think that's a tragedy.

Health Canada could continue to work with HealthCareCAN and others to harmonize legislation and regulations across the country. I would put this under the general rubric of aiding, abetting, and supporting the overall intent of the Agreement on Internal Trade. We still have a lot of work to do in terms of harmonizing accreditation and licensing programs across the country.

● (1705)

The Chair: Mr. Tholl—

Mr. William Tholl: Do I have to wrap up?

The Chair: You're doing quite well. I just wanted to interject for a second, because you mentioned that Mr. Bhatla would have some time to present.

Mr. William Tholl: Yes, right. How about right now?

The Chair: That's fine. I just wanted to make sure he didn't miss out.

Mr. William Tholl: Mr. Chair, I've asked Raj to give you some illustrations from one of our local hospitals on some of the challenges.

The Chair: You have a couple of minutes, Mr. Bhatla.

Dr. Raj Bhatla (Member, Royal Ottawa Mental Health Centre, HealthCareCAN): Thanks, Mr. Chair. I will keep my comments very brief and it will be mainly a view from the front line.

I'm the chief of psychiatry at the Royal Ottawa, one of the academic health science centres in Ontario and part of HealthCareCAN across Canada.

My work on the ground is in large part telemedicine-based. I work in the operational stress injury clinic, giving support to veterans, RCMP, and members in the forces who are transitioning. What we found at our place is that the field is really ready to adopt some of the newer technologies.

I'll speak specifically about telemedicine where we've been able to get out of our hospital per se and get into all areas of eastern Ontario, providing clinics to people to have access to psychiatry. Not only is there access to psychiatry, but there is also access to nurses, psychologists, social workers, and addictions specialists. I think in many ways the field is really ready to adopt some of the technologies to outreach to patients and families in a collaborative and interdisciplinary way. We have a variety of things we can do not only one-on-one care but group care. Aftercare can be done in groups via telemedicine, a fascinating approach and very well liked by patients. They appreciate the access.

What will be coming, and we're experimenting with it now, is outreaching straight into the patient's home. We know that's happening for other chronic diseases, but mental health will surely follow. I think that will be a huge convenience to patients in the home. We know cardiology can be done pretty much in the home with data transmitted to health science centres and cardiologists. It's the same thing for dermatology. Wait times have decreased substantially.

Last, as a final example, we even do mental health review boards up to Yukon and Nunavut, providing access for people with mental health issues to the care and appropriate judicial safeties that they need, right from Ottawa, as opposed to flying people to the farther reaches of the north.

I think we have a lot of potential and I look forward to any discussion on it.

Thank you.

● (1710)

The Chair: Thank you very much, and thank you for the work that you do with our veterans and Canadian Forces and RCMP, for sure, and other Canadians.

Ms. Moore, you're up.

Again, I will advise all members that we are up against the clock. We will try to keep it very close, if we can, to seven minutes.

[*Translation*]

Ms. Christine Moore: Thank you, Mr. Chair.

My questions are for the President of the Canadian Federation of Medical Students.

During the previous hour, I spoke with a physician. I told him that when I did my schooling, the emphasis was placed on the clinical assessment of patients, and we were told that questions made up 70% of the assessment, the physical and visual examination made up 20%, and the remaining 10% was made up of additional tests such as blood tests and X-rays. Dr. Cline replied that he had noted among many young doctors a lack of skill or competence in physical examination. This comment was also echoed by other experienced physicians who said that they had often observed this shortcoming among young physicians.

On the other hand, it is difficult to fill positions in remote areas. Young physicians and nurses are asked to go and work in remote areas, where practitioners should have excellent skills in clinical and physical assessment and questioning patients, because there are fewer possibilities to get complementary tests done.

According to you, does medical training focus sufficiently on the fundamentals, that is to say skill in asking questions, relationship skills and the physical examination, so that that training is adapted to work in remote areas—for instance in aboriginal communities or areas under federal jurisdiction—where young physicians often have to practise when they finish their training?

Mr. Bryce Durafourt: Thank you for your question.

[*English*]

When we're talking about the physical exam, it still remains the basis of our training, I would say almost certainly. Of course our curricula do keep up with the times.

The curriculum at McGill, for example, has recently changed. The new curriculum does include ultrasound, which was not even included in my curriculum. There has been a lot of talk that these technological advances will replace instruments like the stethoscope, and we'll be more reliant on ultrasound.

I think training will always continue to have the basis of the physical exam, and we'll always learn to use the traditional ways, but we need to keep up with the times, for sure.

I think what we could do better is to promote campaigns such as Choosing Wisely Canada, which is a program that aims to reduce physicians' prescribing or requesting unnecessary tests. It saves money by reducing these tests. It also leads to better outcomes for patients if we don't have incidental findings that we need to investigate if there was no indication to do such a test.

By promoting these initiatives, we'll continue to focus on the important basics of the physical exam and the history taking, which has been and I think will remain the focus of our training.

[*Translation*]

Ms. Christine Moore: If I understand correctly, even if new technological elements are being integrated into the training of doctors or nurses, it is essential that this never be done to the detriment of the fundamentals, such as the physical examination and the health questions designed to gather the patient's history.

Mr. Bryce Durafourt: That is correct.

Ms. Christine Moore: Thank you very much.

Are young medical students made aware of the importance of prescribing fewer tests that are not necessarily useful and slow down the functioning of the health care system?

● (1715)

Mr. Bryce Durafourt: Not enough, and I think more should be done to raise their awareness.

Ms. Christine Moore: Fine.

Sometimes, one has the impression that physicians order tests to protect themselves from being accused of not having done the test. Sometimes, they order tests just for reassurance, when they are already 99% sure of the diagnosis. But the test is done anyway, just in case.

Mr. Bryce Durafourt: That is certain. Ordering tests for self-protection is a part of the legal aspect of things.

Ms. Christine Moore: Fine.

So this is a barrier in the way of good health care practices.

Mr. Bryce Durafourt: Yes.

Ms. Christine Moore: Very well.

Mr. Bhatla and Mr. Tholl, do you have anything to add?

[*English*]

Dr. Raj Bhatla: Being a psychiatrist, obviously I think talking to people is really important. Tests will only tell you so much. You won't even know what to test if people don't actually come forward with some comfort in telling you what's troubling them and don't have the confidence that you will do things the right way.

The other thing is that health care is turning into a team game, so even if you talk about physicians, it's how physicians interact with nurses, psychologists, an others to make sure we bring out the qualities in other professions and work as a team to help an individual. I think we'll have much less one-on-one care, but understanding and caring about patients and speaking to them, I hope, is going to remain front and centre in the art of health care.

[*Translation*]

Ms. Christine Moore: As a psychiatrist, do you often see that people have not received optimal treatment, simply because the examination was done too quickly? Do you sometimes hear patients say that they consulted a physician who saw them for two minutes and prescribed something that did not help?

[*English*]

Dr. Raj Bhatla: That happens a fair amount, and I wouldn't fault anyone other than the system on that one. In psychiatry we're blessed —or unlucky, depending—that we're time-based in terms of the remuneration to psychiatrists in a fee-for-service system. You get paid for the amount of time you spend, and we don't overspend because of a lot of demand. In family medicine at times—and not in all the models, but it's fee-for-service—you really have to get through a lot of people, so I really feel bad for the primary care physicians who sometimes cannot spend the time they would like. That's where you can get into very good shared care models that could help both sides.

The Chair: Well done. We're right at seven minutes, maybe just five seconds over.

Ms. McLeod, you're up.

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): I too would like thank all the witnesses as we bring a very interesting study to a close.

First of all, I'd perhaps want to start with Sabrina Wong from the UBC Centre for Health Services and Policy Research.

I want to pick up on two of your recommendations or comments. You talked about researching around payment models and how that facilitates or doesn't facilitate collaborative care.

Certainly, one of the perhaps most creative examples I ever saw in terms of a funding model within B.C. was the adjusted clinical group payments based on that Johns Hopkins modelling, where they tried to pay a team based on the numbers and the acuity of the patients. It seemed to flounder and flop. I always thought that it was actually quite a good way to compensate for a model of care.

Can you talk a little more about what research has been done and what research hasn't been done? I'm very curious.

Ms. Sabrina Wong: That's a really good question. Pay attention to the Naylor report that Dr. Tholl also mentioned. That's going to be released soon. I think they're still working on that committee.

There is some work that's coming out, mostly from the U.S., the U.K., and the Netherlands. I believe they have thought about using bundled payments. Bundled payments and mixed payments pay for episodes of care. You wrap the bundle of payments around the episode of care. I think this works really well for defined cases, such as a hip replacement, where you know what some of the costs are going to be. What you do is that the payment pays for all the providers who would take care of that patient for that episode of care.

What it does is it helps people to collaborate across the different sectors, the acute care sector and the community sector, and there are agreements that are worked out that can then.... There is the risk-sharing across the places of care. As well, there could be gains if the care goes well for the patient. That's one thing. Bundled payments may not work as well in terms of episodes of care in a place like primary care, but they could work well in terms of thinking about paying for a year-long bundled payment to primary care, extending the time out 60 or 90 days.

● (1720)

Mrs. Cathy McLeod: Again, that was a model that I thought showed great promise but floundered. Maybe there wasn't a readiness at that time. Maybe the readiness is further along.

For my next question, I know that one of your other recommendations was around electronic medical records. It's interesting, because the federal government has provided significant funding over the years in terms of what we're doing and where we're going. We've seen some physicians go on their own and some of them go through support, and there are provincial programs. I guess my bigger thought is, are we getting integrated in terms of what needs to be readily available?

I'll use an example. Today there are comments about different provinces and different immunization rates. Public health nurses may be doing immunizations in one location and family doctors.... Half the time, even the family doctor doesn't know what immunization has been done, because we don't have good system connectivity. Are we getting anywhere with that? What is your perspective? You did highlight that as a recommendation.

Ms. Sabrina Wong: In terms of interoperability across different sectors in public health, acute care, and primary care laboratory data, we need to work towards that. I think we're starting to think about integrating our systems. There's going to be some work done in the Vancouver Island Health Authority to try to do it so that they get to electronic health records.

In terms of electronic medical records, there is the Canadian Primary Care Sentinel Surveillance Network, the CPCSS network, where we do extract data from different electronic medical records across the country and can then start to tell you about things such as immunization rates or who has been immunized, those kids who have a primary care physician.... There is some movement in terms of being able to utilize the electronic medical records not only at the point of care, but for surveillance as well.

Mrs. Cathy McLeod: Of course if the public health system does it rather than the primary care physician, there is that whole connectivity.

There is not enough time for many questions that I'd like to ask.

Mr. Durafourt, you talked about loan forgiveness. I thought your comments were interesting in terms of the on-the-ground practicality of what happens. I have actually talked to some other physicians, some resident doctors. There is your practical aspect, but my question to them was whether they thought that loan forgiveness was helping to drive behaviour. That's part of the purpose of the changes we've made representing a number of rural communities, which are very desperately shy of physician services. That little carrot out there for a debt-ridden student, which I always thought sounded pretty good, is it your sense that it makes a difference for the choices that students make, or would the ones who were going to go rural, the 1,150, have gone rural anyway?

Mr. Bryce Durafourt: It's a great question.

We don't have data to know whether this program is encouraging more family physicians or nurses to move to these areas. What we do think is that if we want to get physicians to rural areas, we need to do it by having incentive programs rather than mandatory return of service agreements, or disincentive programs, or limiting the ability of physicians to practise in urban areas. We want people to go to areas where they will want to stay and practise. That could mean also doing a better job of recruiting medical students from rural areas, because we know that they are twice as likely to return to practise in rural areas than their urban counterparts. The bottom line is we don't have that data, but we certainly think that it helps.

● (1725)

Mrs. Cathy McLeod: Great. Thank you.

The Chair: Ms. Fry.

Hon. Hedy Fry: I want to thank everybody again for coming and presenting some very interesting stuff.

Cathy just stole most of my questions, so I won't be redundant and go over them, but I want to ask Ms. Wong about some interesting concepts that she brought up.

One of them is to look at how you monitor the standards for competencies when you have a multidisciplinary team. Given that the competencies are going to be very different, how do you see that happening? Are there models we can look at?

You talked a little bit about looking at best practices. Who do you think is best placed, in fact, what level of government is best placed, to actually put forward these best practices? How do you encourage people to take on best practices? What are the incentives you would use to get people to take on best practices so we don't keep reinventing the wheel all the time?

Ms. Sabrina Wong: Those are really good questions.

In terms of the competency-based question, we actually have a grant in to the Canadian Institutes of Health Research to try to study this some more. What we want to try to do is map the dimensions of care and the indicators particularly in primary care to competencies, because we know that nurses and even medical office assistants can help to move towards timely access to care. That should not all be an accountability attributable only to physicians. It's really a team-based approach that we need.

What we're trying to do is to move towards performance measurement and monitoring to have a system whereby we can actually look at creating information systems for the indicators and then to also map the competencies on. That would take working with the different regulatory bodies.

In terms of your other question, I think William Tholl talked about the fact that Dr. Ivy Bourgeault, is heading up the Pan-Canadian Health Human Resources Network. They are actually collecting best practices across the country. To be able to then take that a step further would be to try to really assess those that could be scaled up.

We have to get away from thinking that each province is so different and each context is so different and try to figure out how we can learn from each other. I think the initiative, the strategy for patient-oriented research and the primary and integrated health care innovations networks, should try to do some of that where we can try to create a continuous learning environment whereby we learn from each other and scale up those innovations that work and actually get rid of the ones that don't work early on; so turf them sooner rather than later, rather than let years and years go by.

Hon. Hedy Fry: That's absolutely true. The question is who is going to bell the cat? Who's going to decide how you turf and what are the incentives and the disincentives? What are the incentives to adopt best practices, to measure outcomes, and to look at indicators for measurement, or to keep an old practice because it's simply easier to do even though it doesn't give the right outcomes?

What are the incentives and disincentives that one would put into place? No matter what a research body finds, it doesn't have the ability to do incentives and disincentives.

How do you see that coming about, the practicality of that?

Ms. Sabrina Wong: I think you report it to the public and allow the public to have some input. These are things the public isn't necessarily aware of. There ought to be some public reporting of their dollars going into the health care system. If we can report it to them in a way that's meaningful, I think you would get a lot of traction.

This has been done in Australia, where they did a national immunization report. What the National Health Performance Authority showed was that in one state that is largely middle class they were the ones who had the lowest immunization rates. What happened was the state government, as a public protection, legislated that they had to have their kids immunized before they went into the school system.

That was kind of a thought-out thing. There's obviously consequences to that as well, but I do think public reporting would be helpful.

● (1730)

Hon. Hedy Fry: Okay, thank you.

Dr. Bhatla, I want to ask you a question about this scope of practice, i.e., virtual, going to the patient instead of the patient coming to you, which could save a ton of money especially in remote and rural care.

How do you see this gaining traction? Is there enough money to make this become a national initiative or at least a provincial north-south initiative? Do you think this could happen? How long do you think it would take to get a system like that up and running, and optimizing the system to help with, for example, the demographics of some provinces that have extreme distance between cohorts of people living in small communities?

How can we get that to happen? How long will it take to move that? Is there enough work done on it?

Dr. Raj Bhatla: I'm tempted to say it's a money issue, but I don't think it is. It's a situation where you want to create systems that do connect with each other. We've talked about interoperability.

I'll give you an example out of dermatology that's interprofessional, can save tons of money, and has done great with wait times. It's a simple solution where you start using technology to take pictures of a dermatological lesion. You send them electronically safely to a centre where dermatologists can look at them and decide which ones need further review. Some do and will need to see a dermatologist, but there will be a large percentage that can be looked at and treatment recommendations given right away to family doctors to execute.

That requires the technology to potentially go between provinces, or even between institutions, depending on your province. It requires someone at the other end who can take a picture, usually a health care provider, but not a physician necessarily, and a way to store the data and transmit the information safely and securely.

It doesn't cost a lot of money, but you have to have those systems working.

Hon. Hedy Fry: Can the Canada Health Infoway pull that together?

Dr. Raj Bhatla: I think they can do an even better job doing that. I wouldn't be an expert on Canada Health Infoway, but I think that could be one of the facilitators to allow this to happen and has a huge potential.

Hon. Hedy Fry: I'm looking at you.

The Chair: Do you have another question?

Hon. Hedy Fry: It was not so much a question, as to get Mr. Tholl to elaborate on his determining optimal scope of practice, and that the current system does more to hinder that than to help it to happen.

Can you expand on that statement?

Mr. William Tholl: Sure, in the limited time available, I have a couple of points.

To pick up on the earlier discussion around SPOR, I agree fully with Sabrina when she says we have a lot to learn from one jurisdiction to another, but right now there's no clearing house.

I'm on the SPOR review panels, and there are 10 separate SPOR business plans, but there is no provision for the sharing of that information that's built into the SPOR. I say we need the super-SPOR, something that sits above the individual SPORs and the support unit executive directors. That would be one example.

A second example is, as I mentioned, what I think is a great report, “From Innovation To Action”, prepared by premiers Ghiz and Wall. The initiative stopped in July 2012 because of a lack of ongoing secretariat support.

Those would be two examples of learning what works in terms of optimal scope of practice. The Taber, Alberta, example was also given in that report. There's no reason that we can't generalize the key learnings from the Taber, Alberta, primary care network, as another example.

There's no clearing house at present. Ivy has one place where we were tracking these data, but its funding is being terminated at the end of March.

The Chair: We've had a great discussion.

That'll do it for today, and we'll see everybody back in a week's time.

The meeting is adjourned.