HOUSE OF COMMONS
CANADA

PROMOTING INNOVATIVE SOLUTIONS TO HEALTH HUMAN RESOURCES CHALLENGES

Report of the Standing Committee on Health

Joy Smith, MP
Chair

JUNE 2010

40th PARLIAMENT, 3rd SESSION

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THE STANDING COMMITTEE ON HEALTH

has the honour to present its

SIXTH REPORT

Pursuant to its mandate under Standing Order 108(2), the Committee has studied Health Human Resources and has agreed to report the following:

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INTRODUCTION

On February 26, 2009, the House of Commons Standing Committee on Health (hereinafter the Committee) agreed to undertake a study examining Health Human Resources (HHR) in Canada with the following terms of reference: pan-Canadian HHR planning and coordination; research and data collection; inter-professional collaborative practice; internationally educated health professionals; the HHR needs of federal client groups; and recruitment and retention in rural and remote areas. The Committee further agreed that the jurisdictional complexities involved in HHR would be respected during the study, including recognition of the fact that the Province of Quebec considers HHR planning as its exclusive provincial responsibility and therefore does not participate in current pan-Canadian initiatives related to HHR.[1] The study also serves as an in-depth follow-up to the Committee's statutory review of the *10-Year Plan to Strengthen Health Care*, completed in 2008, which included an examination of progress made by federal, provincial and territorial governments (F/P/T) in increasing the supply of health professionals in Canada as a result of commitments made in the 10-Year Plan and the 2003 Health Accord.[2]

Divided into chapters, this report begins by providing relevant background information regarding current HHR challenges in Canada and the federal role in HHR. The report's subsequent chapters examine the topics identified in the aforementioned terms of reference of the study. These chapters summarize the testimony that the Committee heard during the course of its hearings, highlight issues raised by witnesses and identify actions needed to be taken by the federal government in these areas.

In total, the Committee held 12 hearings from April 2009 to May 2010; and undertook a two-day fact-finding mission to Iqaluit and Rankin Inlet from May 24 to 26 May, 2009. During the course of its hearings and site visits, the Committee heard from federal government officials, researchers and academics, professional health organizations, community health delivery organizations, and interested individuals.

1 Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources, A Framework for Collaborative Pan-Canadian Health Human Resources Planning, 2007, http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/hhr/2007-frame-cadre/2007-frame-cadre-eng.pdf, p. 3.

2 House of Commons Standing Committee on Health, "Statutory Parliamentary Review of the 10-Year Plan to Strengthen Health Care", June 2008, 39th Parliament, 2nd Session, http://www2.parl.gc.ca/content/hoc/Committee/392/HESA/Reports/RP3577300/hesarp06/hesarp06-e.pdf.

CHAPTER 1: CHALLENGES FACING HEALTH HUMAN RESOURCES IN CANADA

The Committee recognizes that there are many challenges facing health human resources (HHR) in Canada, which represent the basis for its current study. Statistics Canada defines HHR as paid health care providers within health care systems that are responsible for the delivery of high quality, safe, effective and patient-centred care to Canadians, a definition that is based upon the National Occupational Classification (NOC).[3] It is important to note that HHR refers to a comprehensive range of health professionals, not all of which are directly involve in health care delivery, such as: physicians, nurses, midwives, chiropractors, naturopathic doctors, dentists, pharmacists, laboratory workers, environmental and public health professionals, health statisticians, epidemiologists, health information managers, health economists, and community health workers.[4] The World Health Organization (WHO) utilizes an even broader definition of HHR, considering a health care provider to be anyone engaged in actions whose primary intent is to enhance health, regardless of whether they are paid to do so.[5] This broader definition results in the inclusion of a wider range of persons, such as volunteer and family care givers. This report is based upon the WHO's broader conception of HHR that includes health professionals that are both paid and unpaid.

According to Canadian Institute for Health Information (CIHI, HHR represent the single greatest cost to health care systems: approximately 60 to 80 cents of every health care dollar in Canada is spent on HHR, which does not include the costs of educating those health professionals.[6] This means that of the $160 billion spent in Canada on health care in 2007, $96 to $128 billion went towards HHR.[7]

However, the ability of health care systems to provide Canadians with high quality and safe health care is dependent in part upon having "[…] the right mix of health care providers with the right skills in the right place at the right time.", as well as other determinants of health.[8]

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3 This is based upon Statistics Canada's definition of health care providers, whose National Occupational Classification limits the definition of health care providers to those who are in paid positions. This varies from the World Health Organization's definition, which considers a health care provider to be anyone engaged in actions whose primary intent is to enhance health. CIHI, "Canada's Health Care Providers, 2007," 2007, http://secure.cihi.ca/cihiweb/products/HCProviders_07_EN_final.pdf.

4 Ibid.

5 Ibid.

6 Ibid.

7 Ibid.

8 Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources, "A Framework for Collaborative Pan-Canadian Health Human Resources Planning" 2007, http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/hhr/2007-frame-cadre/2007-frame-cadre-eng.pdf..

Yet Canada has been experiencing HHR shortages in many professions for a number of years. For example, it is estimated that in 2007 there was a shortage of nearly 11,000 full-time equivalent Registered Nurses (RNs) in Canada.[9] The Canadian Medical Association further estimates that between 4 and 5 million Canadians currently do not have access to a family physician.[10]

It is important to note that CIHI has reported that between 2003 and 2007, there have been varied increases in a number of health occupations, including physicians, nurses, occupational therapists, midwives, and pharmacists, among others.[11] However, HHR shortages are still projected to continue due to a variety of factors including the aging of the health workforce population, reduction of working hours by health care providers to support greater work life-balance, and workplace issues that lead to absenteeism and high rates of staff turnover.[12]

In addition, rural and remote areas in Canada face particularly acute HHR shortages. This is due to migration patterns among health care providers, who, like the general population, tend to migrate to centres experiencing greater amounts of economic growth.[13] For example, from 1991 to 2001, physicians, medical laboratory technologists, and dental assistants tended to move away from rural areas.[14] The situation is even more difficult in on reserve First Nations and Inuit communities and the North, where primary care is mainly delivered by RNs and as a result, these population groups must also travel great distances to receive acute and tertiary care.[15]

Though Canada has historically relied on internationally educated health professionals (IEHPs) to address shortages in its workforce, these health professionals are also facing difficulties in having their credentials recognized and experience delays in integrating into the Canadian health care system.[16] For example, 50% of International

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9 Canadian Nurses Association, "Tested Solutions for Eliminating Canada's Registered Nurse Shortage," May 2009, http://www.cna-aiic.ca/CNA/documents/pdf/publications/RN_Highlights_e.pdf.

10 Canadian Medical Association, "More Doctors. More Care: A Promise Yet Unfulfilled," Brief submitted to the House of Commons Standing Committee on Health concerning health human resources," April 28, 2009.

11 CIHI, "Canada's Health Care Providers, 2007," 2007, http://secure.cihi.ca/cihiweb/products/HCProviders_07_EN_final.pdf.

12 Canadian Nurses Association, "Tested Solutions for Eliminating Canada's Registered Nurse Shortage," May 2009, http://www.cna-aiic.ca/CNA/documents/pdf/publications/RN_Highlights_e.pdf and Canadian Medical Association, "More Doctors. More Care: A Promise Yet Unfulfilled," Brief submitted to the House of Commons Standing Committee on Health concerning health human resources," April 28, 2009.

13 CIHI, "Brief to the Standing Committee on Health," April 23, 2009.

14 CIHI, "Canada's Health Care Providers, 2007," 2007, http://secure.cihi.ca/cihiweb/products/HCProviders_07_EN_final.pdf.

15 House of Commons Standing Committee on Health, *Evidence*, No. 41, 2nd Session, 40th Parliament, November 2, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV4198199/HESAEV41-E.PDF and Health Canada, "First Nations, Inuit and Aboriginal Health: Health Care Services," http://www.hc-sc.gc.ca/fniah-spnia/services/index-eng.php.

16 CIHI, Brief to the Standing Committee on Health, April 23, 2009.

Medical Graduates who apply for postgraduate training in Canada each year represent those that are applying to the system for the second time, because they did not receive a position the first time that they applied.[17]

17 House of Commons Standing Committee on Health, *Evidence*, 2nd Session, 40th Parliament, December 9, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV4314977/HESAEV50-E.PDF.

CHAPTER 2: THE FEDERAL ROLE IN HEALTH HUMAN RESOURCES

Under the *Constitution Act, 1867*, health care is not assigned exclusively to one level of government, but rather includes matters that could fall within both federal and provincial jurisdictions.[18] The Constitution grants the provinces primary jurisdiction in the area of HHR. Section 92(13), the power over "property and civil rights in the province", which covers contract, tort and property, is the main provincial power over health care.[19] It authorizes provinces to regulate businesses in the province, including the public and private provision of health care insurance, which determines the payment schemes for services offered by health care providers. More significantly, it also provides for the provincial regulation of health care providers. Section 92(7) grants the provinces authority to establish and regulate hospitals, as well as hospital-based health services, with the exclusion of marine hospitals.[20]

However, section 91 of the *Constitution Act, 1867*, also grants the federal government authority over some classes of people including: military, militia, and naval services; First Nations and Inuit; and federal inmates. Under section 95, the federal government also has jurisdiction over immigrants concurrently with the provinces. It is important to note that how the federal government exercises its jurisdiction over these groups in relation to health care delivery and health human resources varies substantially by federal client group. The federal role in HHR for each of these respective population groups is examined in greater detail in Chapter 7. Furthermore, as the employer of the federal public service, the federal government is responsible for the occupational health and safety of its employees, as well as any employment-related health benefits provided to federal public service workers.[21]

In addition, under the *Canada Health Act*[22], the federal government has used its spending power to establish national standards for the provinces' health care insurance plans as a condition of federal cash contributions to these programs. The federal spending power is not specifically identified in the constitution, but rather is inferred from Parliament's jurisdiction over public debt and property (section 91(1A)) and its general taxing power (section 91(3)), and has been upheld through court decisions.[23] In using its spending power, the federal government may establish conditions for federal grants to the provinces,

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18 Peter W. Hogg, *Constitutional Law of Canada* (5th Edition Supplemented 2007), Vol. 1, Thomson Carswell, Toronto, p. 32-1.

19 Ibid, p. 32-2.

20 Ibid.

21 Ibid.

22 *Canada Health Act*, 1984, c.6, s.1.

23 Marlisa Tiedemann, "The Federal Role in Health and Health Care," PRB 08-58E, October 20, 2008, http://lpintrabp.parl.gc.ca/lopimages2/prbpubs/pdf/bp1000/prb0858-e.pdf.

including conditions that come within provincial jurisdiction and therefore cannot be directly legislated by Parliament.[24]

Under the *Canada Health Act*, the federal government has established the following national standards for provincial and territorial health care insurance plans: (1) public administration; (2) comprehensiveness; (3) universality; (4) portability: and (5) accessibility.[25] With respect to HHR, it is important to note that section 9 of the *Canada Health Act* dealing with comprehensiveness stipulates that the health care insurance plan of a province "must insure all insured health services provided by hospitals, medical practitioners[26] or dentists, and where the law of a province so permits, similar or additional services rendered by other health care practitioners."[27] This means that the *Canada Health Act* requires that physicians services be covered by a provincial health care insurance plan, but does not require that provincial plans cover the costs of services provided by other health professionals that are also the subject of this report, such as: pharmacists, physiotherapists, chiropractors, psychologists, naturopathic doctors, and other non-physicians.[28]

Despite this separation of powers, the federal government has a long history of collaboration with the provinces and territories in both health and health care. This was manifested in the 2003 Accord on Health Care Renewal, where federal, provincial and territorial (F/P/T) governments recognized the need to collaborate across jurisdictions to address HHR challenges across the country. However, they also agreed that this would be done in a fashion that would fully respect each government's jurisdiction.[29] In the Accord, they agreed to collaborate in HHR planning in order "to strengthen the evidence base for national planning, promote inter-disciplinary provider education, improve recruitment and retention, and ensure the supply of needed health providers."[30] To this end, the federal government committed $85 million to HHR renewal, as well as ongoing funding of $20 million per year to develop a pan-Canadian HHR strategy.[31]

These commitments were further elaborated upon in the 2004 F/P/T 10-Year Plan to Strengthen Health Care, which was based upon several principles including, among others: collaboration between all governments, advancement through the sharing of best practices,

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24 Ibid.

25 *Canada Health Act, 1984*, c.6, s.7.

26 The *Canada Health Act* defines a medical practitioner as a person lawfully entitled to practise medicine in the place in which the practice is carried out by that person. *Canada Health Act, 1984,* c.6, s.2.

27 *Canada Health Act, 1984*, c.6, s.9.

28 Peter W. Hogg, *Constitutional Law of Canada* (5th Edition Supplemented 2007), Vol. 1, Thomson Carswell, Toronto, p. 32-5.

29 Health Canada, "Health Care System: 2003 First Ministers' Accord on Health Care Renewal," 2003, http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2003accord/index-eng.php.

30 Ibid.

31 Health Canada, "*Pan-Canadian Health Human Resource Strategy: 2006/07 Report Accomplishments and New Projects"*, 2007, http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/hhr/2007-ar-ra/2006-07-pan_report-eng.pdf.

and jurisdictional flexibility.[32] The agreement also took into account the principle of asymmetric federalism, allowing for the existence of a separate agreement for any province, including the Government of Quebec, which signed a separate Communiqué with the federal government regarding the interpretation and implementation of the 10-Year Plan.[33]

With respect to HHR, governments further agreed to increase the supply of health professionals by establishing action plans that would include targets for training, recruitment and retention of professionals.[34] To achieve these objectives, First Ministers committed an additional $5.5 billion over 10 years to reduce wait times, which would include ongoing collaborative work in HHR.[35] The federal government further committed to:[36]

- Accelerate and expand the assessment and integration of internationally trained health care graduates for participating governments;
- Target efforts in support of Aboriginal communities and official language minority communities to increase the supply of health care professionals for these communities;
- Take measures to reduce the financial burden on students in specific health education programs; and
- Participate in HHR planning with interested jurisdictions.

Specific details regarding the federal government's particular investments and programs and initiatives related to these commitments are the subject of subsequent chapters in this report.

Finally, it is important to note that the House of Commons Standing Committee on Health was also granted authority to review progress towards the implementation of the 10-Year Plan to Strengthen Health Care under section 25.9(1) of the *Federal-Provincial*

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32 Health Canada, "Health Care System: First Minister's Meeting on the Future of Health Care 2004," September 16, 2004, http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php.

33 Ibid.

34 Health Canada, "Health Care System: First Minister's Meeting on the Future of Health Care 2004," September 16, 2004, http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php.

35 Health Canada, "*Pan-Canadian Health Human Resource Strategy: 2006/07 Report Accomplishments and New Projects"*, 2007, http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/hhr/2007-ar-ra/2006-07-pan_report-eng.pdf.

36 Health Canada, "Health Care System: First Minister's Meeting on the Future of Health Care 2004," September 16, 2004, http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php.

Fiscal Arrangements Act, which authorized the transfer of federal funds to the provinces in support of the plan.[37]

37 *Federal-Provincial Fiscal Arrangements Act*, R.S., 1985, c. F-8, s. 1; 1995, c. 17, s. 45.

CHAPTER 3: NEW APPROACHES TO PAN-CANADIAN PLANNING AND COLLABORATION IN HHR

Introduction

While recognizing the fact that each jurisdiction in Canada is responsible for planning and management within its own health care system, the Committee heard that there were numerous benefits for collaboration across jurisdictions in HHR planning. National planning and collaboration in HHR was seen by witnesses as necessary to prevent competition between jurisdictions for the same health professionals, promote inter-provincial mobility for health professionals to address mismatches in supply and demand in different areas across the country, and most significantly, witnesses identified the need to share information regarding best practices in different jurisdictions in addressing HHR challenges.[38]

Current Mechanisms for Pan-Canadian Planning and Collaboration in HHR

The current mechanism for pan-Canadian planning and collaboration in HHR is the F/P/T Advisory Committee on Health Delivery and Human Resources (ACHDHR). Created in 2002 by the F/P/T Conference of Deputy Ministers of Health, the ACHDHR has a mandate to: provide policy and strategic advice to the Deputy Ministers of Health on the planning, organization and delivery of health services, including HHR, as well as provide a national forum for discussion and information sharing.[39] The ACHDHR is made up of representatives from all 14 governments, as well as from the Health Action Lobby; representatives from First Nations communities; the Council of Ministers of Education, Canada; the Canadian Institutes of Health Research (CIHR); the Canadian Institute for Health Information (CIHI); a regional health authority, and Human Resources and Skills Development Canada (HRSDC).

In her appearance before the Committee, the federal Co-Chair of the ACHDHR, outlined the initiatives undertaken by the ACHDHR.[40] In 2007, the ACHDHR released

38 House of Commons Standing Committee on Health, *Evidence*, No. 16, 2nd Session, 40th Parliament, April 23, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV3810879/HESAEV16-E.PDF and House of Commons Standing Committee on Health, *Evidence*, No. 17, 2nd Session, 40th Parliament, April 28, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV3846660/HESAEV17-E.PDF.

39 House of Commons Standing Committee on Health, *Evidence*, No. 41, 2nd Session, 40th Parliament, November 2, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV4198199/HESAEV41-E.PDF.

40 House of Commons Standing Committee on Health, Evidence, No. 14, 2nd Session, 40th Parliament, April 2, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV3806734/HESAEV14-E.PDF and House of Commons Standing Committee on Health, *Evidence*, No. 41, 2nd Session, 40th Parliament, November 2, 2009 http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV4198199/HESAEV41-E.PDF.

A Framework for Collaborative Pan-Canadian Health Human Resources Planning, an action plan with short, medium and long-term objectives in the following areas:[41]

- planning for the optimal number, mix and distribution of health care providers[42];
- working closely with employers and the education system to develop a health workforce that has the skills and competencies to provide safe high quality care, work in innovative environments, and respond to changing health care system and population health needs;
- achieving the appropriate mix of health care providers and deploy them in service delivery models that make full use of their skills; and
- building and maintaining a sustainable workforce in healthy safe work environments.

However, it is important to note that the Framework has no hard targets in terms of increasing the supply of health care providers.[43]

In addition to the Framework, the ACHDHR has done a comprehensive update of an inventory of HHR forecasting models, as well as convened workshops to share knowledge and promote collaborative data and modeling activities to support jurisdictional policy and planning requirements. They have further developed a committee to advise governments on whether proposed changes in credentials for the entry-to-practice of health care providers would serve the interests of patients, health care providers and education systems. The ACHDHR has also taken an active role in addressing internationally educated health care professionals (IEHPs) by endorsing a business case for the development and implementation for a standard national assessment for International Medical Graduates entering national postgraduate medical training in Canada. Finally, the ACHDHR is also in the process of developing a strategy to address gaps in the Canadian approach to interprofessional education and collaborative practice.[44]

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41 Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources, A Framework for Collaborative Pan-Canadian Health Human Resources Planning, 2007, http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/hhr/2007-frame-cadre/2007-frame-cadre-eng.pdf.

42 It is important to note that the Framework uses the term health care provider, but does not provide a specific definition.

43 House of Commons Standing Committee on Health, *Evidence*, No. 14, 2nd Session, 40th Parliament, April 2, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV3806734/HESAEV14-E.PDF.

44 This topic is covered in greater depth in the section of the report dealing with innovative solutions to HHR challenges. Interprofessional collaborative practice refers to the provision of comprehensive health services to patients by multiple care givers who work collaboratively to deliver quality care within and across sections. Canadian Physiotherapy Association, "Efficiency & Health Human Resources," A Submission to the House of Commons Standing Committee on Health, November 25, 2009.

Despite the various initiatives undertaken by the ACHDHR, some witnesses appearing before the Committee articulated that it was not providing an effective mechanism for national collaboration in HHR planning. First, they found that the membership of the ACHDHR was not inclusive, as it did not have representatives from the many different health professions involved in collaborative health care.[45] Second, they indicated that implementation of the Pan-Canadian Collaborative Planning Framework was slow and that the ACHDHR had not been successful in ensuring that the Framework was receiving the attention and support it needed from governments to be implemented.[46] Most tellingly, some witnesses appearing before the Committee spoke of the need for a national plan or strategy to address HHR challenges, but seemed unaware of the existence the ACHDHR's Framework.[47]

Consequently, some witnesses called for the expansion of ACHDHR's mandate and membership "to include active participation from stakeholders in order to have realistic and attainable goals" in HHR.[48] However, they also argued in favour of establishing a new national observatory on HHR which "would bring together researchers, governments, employers, health professionals, unions, and international organizations to monitor and analyse trends in health outcomes, health policy and HHR to provide evidence-based advice to policy makers."[49] The national observatory could further serve as a knowledge translation mechanism, in which best practices in addressing HHR challenges would be shared among stakeholders.[50]

Committee Observations

The Committee recognizes that the ACHDHR has undertaken significant efforts in pan-Canadian HHR collaborative planning and knowledge translation. However, it notes that the ACHDHR may need to focus greater effort towards ensuring that A Framework for Collaborative Pan-Canadian Health Human Resources Planning has the support necessary from both governments and stakeholders to be implemented. The Committee also observes that neither Health Canada's *Pan-Canadian Health Human Resource Strategy*, nor the ACHDHR's Framework are linked to hard targets in terms of increasing the supply of health professionals in Canada. The Committee recognizes that the ACHDHR has undertaken steps to ensure that its membership is broad-based by including the Health

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45 House of Commons Standing Committee on Health, *Evidence*, No. 17, 2nd Session, 40th Parliament, April 28, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV3846660/HESAEV17-E.PDF.

46 Ibid.

47 House of Commons Standing Committee on Health, *Evidence*, No. 44, 2nd Session, 40th Parliament, November 18, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV4236244/HESAEV44-E.PDF.

48 House of Commons Standing Committee on Health, *Evidence*, No. 17, 2nd Session, 40th Parliament, April 28, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV3846660/HESAEV17-E.PDF.

49 Ibid.

50 Ibid.

Action Lobby (HEAL), a coalition of national health and consumer associations and organizations dedicated to protecting and strengthening Canada's publicly funded health care system.[51] It also heard that the ACHDHR has recently established working groups devoted to inter-collaborative practice and IEHPs. However, the Committee also acknowledges that there may be a need to consider the creation of an additional mechanism or national observatory on HHR that operates at arm's length from F/P/T governments, as suggested by witnesses. The Committee therefore recommends:

Recommendation 1:

That the F/P/T Advisory Committee on Health Care Delivery and Human Resources to consider the feasibility and appropriateness of either expanding its membership to include a wider range of stakeholders and broadening its mandate to allow for the development of an inventory of data and research on best practices in addressing HHR challenges in Canada; or establishing a new arm's length national observatory on health human resources with a broad-based membership that would promote research and data collection on HHR; serve as an effective knowledge translation mechanism; and identify key priorities for future research.

Recommendation 2:

The ACHDHR report on the implementation of A Framework for Collaborative Pan-Canadian Health Human Resources Planning, including progress towards its short, medium and long-term objectives.

51 House of Commons Standing Committee on Health, *Evidence*, No. 7, 3rd Session, 40th Parliament, May 13, 2010, http://www2.parl.gc.ca/CommitteeBusiness/UrlResolver.aspx?BluesDocumentId=4531758.

CHAPTER 4: HHR RESEARCH AND DATA COLLECTION IN CANADA

Introduction

Research and data collection play a significant role in HHR planning. In order to determine that there will be sufficient health professionals with the right skills to provide high quality health care, policy makers first require sufficient data on the current supply of health professionals.[52] According to CIHI, a minimum data set for measuring the supply of health professionals includes: demographic information; education and training; geographic distribution; migration; non-migration related attrition; employment and practice characteristics; and productivity.[53] Adequate measuring of the current supply of health professionals therefore marks the first step in HHR planning. In addition, policy makers require adequate information on future population health needs in order to determine which types of health professionals are needed.[54] Research on best practices in health care delivery is also essential for determining how health professionals should work together to achieve the best possible outcomes. This chapter examines current initiatives in HHR data collection and research that serve as the basis for HHR planning across Canada.

Data Collection

The Committee learned that CIHI has been collecting detailed demographic and workforce information on a broad range of health professionals, including: physicians, nurses, occupational therapists, pharmacists, physiotherapists, medical laboratory technologists, and medical radiation technologists.[55] CIHI also collects aggregate data for an additional 17 health occupations, including: chiropractors, midwives and psychologists. CIHI further noted that its data collection facilitated national collaborative planning, as it provided a source of interprovincial comparison in regards to workforce supply trends to HHR planners and policy makers across the country. According to CIHI, these data collection projects were made possible by CIHI funding received from Health Canada's *Pan-Canadian Health Human Resource Strategy*.[56]

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52 CIHI, "Canada's Health Care Providers, 2007," 2007, http://secure.cihi.ca/cihiweb/products/HCProviders_07_EN_final.pdf.

53 CIHI, "Guidance Document for the Development of Data Seuts to Support HHR Management in Canada," February 2005, http://secure.cihi.ca/cihiweb/products/Guidance_Document_e.pdf, p. 10.

54 House of Commons Standing Committee on Health, *Evidence*, No. 16, 2nd Session, 40th Parliament, April 23, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV3810879/HESAEV16-E.PDF.

55 House of Commons Standing Committee on Health, *Evidence*, No. 16, 2nd Session, 40th Parliament, April 23, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV3810879/HESAEV16-E.PDF.

56 Further details regarding this strategy will be provided in the sections examining innovative solutions to HHR challenges. Health Canada, "*Pan-Canadian Health Human Resource Strategy: 2007/2008*," 2008, http://www.hc-sc.gc.ca/hcs-sss/alt_formats/pdf/pubs/hhrhs/2008-ar-ra-eng.pdf.

In its report submitted to Committee members, Canada's *Health Care Providers, 2007*, CIHI presented current demographic and workforce trends among different categories of health professionals in Canada. The report further indicated that there were gaps in research regarding some of these trends, for example: the retirement profile of a variety of health professionals; exit rates from health professions and reasons for them; and the percentage of Aboriginal Canadians in specific health professions.[57] Other witnesses appearing before the Committee also reinforced the fact that there was a lack of minimum data available on Aboriginal HHR.[58] Health Canada officials appearing before the Committee indicated that they were working with CIHI to analyse the data available on Aboriginal HHR, as well as work with communities to gather further information at the local level.[59]

Witnesses further identified gaps in data collection that needed to be addressed, including the need for CIHI and Statistics Canada to repeat the national survey of work and health of nurses, which was considered by witnesses to be out of date.[60] They further noted that the survey should be expanded to include other categories of health professionals.[61] Other witnesses stressed the need to focus data collection not only on health professional supply trends, but on future population health needs, such as the management of chronic diseases as a result of the aging population.[62] This was due to the fact that HHR planning was moving away from a model linked to current health service utilization patterns towards the future health needs of the population. Officials from Statistics Canada indicated that such data was available to policy makers and planners on a cost-recovery basis through the Canadian Community Health Survey, which collects data on the determinants of health, health status and the utilization of health services.[63] They indicated that it was possible to produce the data at the regional health level, but faced difficulties in producing the data at the community level due to reliability and confidentiality issues.

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57 CIHI, "Canada's Health Care Providers, 2007," 2007, http://secure.cihi.ca/cihiweb/products/HCProviders_07_EN_final.pdf, p. 73.

58 House of Commons Standing Committee on Health, *Evidence*" No. 5, 3rd Session, 40th Parliament, March 25, 2010, http://www2.parl.gc.ca/content/hoc/Committee/403/HESA/Evidence/EV4378648/HESAEV05-E.PDF.

59 House of Commons Standing Committee on Health, *Evidence*, No. 17, 3rd Session, 40th Parliament, May 13, 2010, http://www2.parl.gc.ca/content/hoc/Committee/403/HESA/Evidence/EV4531758/HESAEV17-E.PDF.

60 House of Commons Standing Committee on Health, *Evidence*, No. 17, 2nd Session, 40th Parliament, April 28, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV3846660/HESAEV17-E.PDF.

61 House of Commons Standing Committee on Health, *Evidence*, No. 17, 2nd Session, 40th Parliament, April 28, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV3846660/HESAEV17-E.PDF.

62 House of Commons Standing Committee on Health, *Evidence*, No. 16, 2nd Session, 40th Parliament, April 23, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV3810879/HESAEV16-E.PDF.

63 House of Commons Standing Committee on Health, Evidence, No. 17, 3rd Session, 40th Parliament, May 13, 2010, http://www2.parl.gc.ca/content/hoc/Committee/403/HESA/Evidence/EV4531758/HESAEV17-E.PDF. .

The Committee acknowledges CIHI's efforts in expanding its data collection initiatives to include a broad range of health professionals. However, the Committee also recognizes that there is a need for CIHI to collect detailed demographic and work information on all categories of health professionals, including information gathered through survey research. Furthermore, they could make efforts to ensure that its data remains current by repeating surveys, such as the national survey on the work and health of nurses. Moreover, CIHI could also work with Health Canada to examine ways of addressing gaps in HHR data collection related to Aboriginal health human resources. Finally, the Committee notes that there is also a need for CIHI to work with other relevant federal government departments and agencies to collect HHR data related to the provision of health care services and benefits to other federal client groups, including: RCMP; immigrants and refugees; members of the Canadian Forces; veterans; and federal inmates. The Committee therefore recommends that:

Recommendation 3:

Health Canada seriously consider providing funding through its Pan-Canadian Health Human Resource Strategy to enable CIHI to:

- **expand its data collection to include demographic and work information on all categories of health professionals;**
- **repeat national HHR surveys as necessary so that they remain up to date.**

Recommendation 4:

Relevant federal government departments and agencies work closely with CIHI to establish a minimum data set for HHR planning for all federal client groups, including: First Nations and Inuit; RCMP; veterans; members of the Canadian Forces; immigrants and refugees; and federal inmates.

Research

The Committee heard from research organizations that a significant amount of research had been conducted, evaluating current HHR challenges, as well as various innovative pilot projects across the country that were demonstrating positive results in addressing the needs of health care providers.[64] For example, the Canadian Health Services Research Foundation (CHSRF) commissioned a report in 2001 entitled *Commitment and Care*, which highlighted successful initiatives undertaken by the British Columbia's Ministry of Health, which launched a program to relieve senior nurses of 20 to 30 % of patient care in return for mentoring new, inexperienced nurses.[65] However, despite

64 Canadian Health Services Research Foundation, "Report to the Standing Committee on Health: Study on Health Human Resources," Brief submitted to the House of Commons Standing Committee on Health, April 23, 2009.

65 Ibid.

the publication of research highlighting positive solutions to HHR challenges, research organizations also emphasized the fact that a mechanism is lacking in Canada to collect and disseminate this information to a broad range of stakeholders.[66]

In addition, witnesses appearing before the Committee raised the issue of health research funding. They articulated that providing sufficient funding for clinical research conducted by health care providers would serve as a means of attracting and retaining health care providers in Canada.[67] Increased funding for clinical research would also serve a dual purpose in providing further opportunities for evaluating and improving the efficiency of Canada's health care systems.[68]

The Committee recognizes that there may be a need to establish additional mechanisms for collecting and sharing research in the area of HHR in order to move forward in promoting innovation in health service delivery across the country, as reflected in earlier sections of this report. The Committee also thinks that sufficient funding should be provided to CIHR to continue supporting the clinical research of health care providers, as a means of ensuring their recruitment and retention, as well as supporting the overall objective of improving health care delivery. The Committee therefore recommends that:

Recommendation 5:

The federal government seriously consider providing CIHR with funding to develop further mechanisms aimed at supporting clinical research in the area of HHR, recognizing it as a means of attracting and retaining health professionals in Canada.

Recommendation 6:

The federal government continue to provide the Health Council of Canada and CIHR with funding to determine the most appropriate mix of health professionals, both paid and unpaid, for different communities and population groups.

66 House of Commons Standing Committee on Health, Evidence, No. 16, 2nd Session, 40th Parliament, April 23, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV3810879/HESAEV16-E.PDF.

67 Ibid.

68 Ibid.

CHAPTER 5: PROMOTING INNOVATIVE SOLUTIONS TO HHR CHALLENGES

Introduction

Many innovative solutions are underway to address some of the HHR challenges facing health care systems in Canada. This chapter highlights the innovations occurring in health care delivery across the country, focussing in particular on interprofessional collaborative practice and health information technology. It also identifies ways in which the federal government could further promote and sustain these changes.

Interprofessional Collaborative Practice (IPC)

It has long been acknowledged in Canada that changing health care delivery models to include a broad range of health professionals is a key strategy in addressing shortages in HHR, as well as improving efficiency in health care delivery. Indeed, in the 2004 10-Year Plan to Strengthen Health Care, First Ministers committed to 50% of Canadians having access to multidisciplinary health care teams by 2011.[69] Interprofessional Collaborative Practice (IPC) refers to the provision of comprehensive health services to patients by multiple care givers who work collaboratively to deliver quality care within and across sections.[70] It recognizes that the skills required to meet health care needs do not reside within one professional or even one profession. Closely linked to the full realization of IPC, is the need to change the way health professionals are educated so that they have the necessary knowledge and skills to work effectively in interprofessional teams, which is referred to as Interprofessional Education and Training.[71]

The Committee learned that Health Canada had invested in more than 32 interprofessional practice projects, as part of its *Pan-Canadian Health Human Resource Strategy*.[72] Health Canada officials told the Committee that these projects had focused on increasing awareness and sharing of best practices related to collaborative care; enabling the provision of mandatory interprofessional education courses by educational institutions;

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69 Health Canada, "Health Care System: First Minister's Meeting on the Future of Health Care 2004," September 16, 2004, http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php.

70 Canadian Physiotherapy Association, "Efficiency & Health Human Resources," A brief to the House of Commons Standing Committee on Health, November 25, 2009.

71 Health Canada, *Pan-Canadian Health Human Resource Strategy: 2006/07 Report Accomplishments and New Projects*, 2007, http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/hhr/2007-ar-ra/2006-07-pan_report-eng.pdf.

72 House of Commons Standing Committee on Health, *Evidence*, No. 14, 2nd Session, 40th Parliament, April 2, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV3806734/HESAEV14-E.PDF.

and increasing both the number of educators who are able to teach interprofessional practice and the number of health professionals trained for collaborative practice.[73]

The Committee also heard from other witnesses that many innovative IPC models had been developed across the country as a result of the funding received through the Health Reform Fund for Primary Care as part of the 2003 Accord on Health Care Renewal[74], as well as funding received from Health Canada. For example, the Committee learned about the Somerset West Community Health Centre (SWCHC) in downtown Ottawa, an interprofessional collaborative practice that included the services of doctors, nurse practitioners, dietitians, social workers, kinesiologists, acupuncturists, chiropodists, social service workers, nurses, health promoters and administrative support staff.[75]

The Committee learned that the SWCHC was governed by a community board of directors and reflected the population health needs of its community, including its desire for the inclusion of traditional Chinese medicine. Witnesses further indicated that the IPC model of practice at the SWCHC had resulted in significant cost savings due to its effective use of nurse practitioners.

The Committee heard that alternative health professionals were also being successfully integrated into intercollaborative practice across the country. For example, the Committee heard that naturopathic doctors were contributing to providing innovative integrated care to cancer patients at InspireHealth, one of four clinics in Vancouver currently conducting research in the area of service delivery for cancer patients as part of the Canadian Partnership Against Cancer.[76] The Committee also heard that chiropractors had been integrated at the Joe Sylvester Anishnawbe Health Toronto clinic, an urban multidisciplinary clinic that offers health care to urban Aboriginal populations.[77] Alternative health professionals appearing before the Committee articulated that their inclusion in the broad range of health care services offered in the context of interprofessional collaborative health care teams served as a means of easing some of the workload of mainstream physicians by providing preventative medicine and complementary treatments for chronic conditions and musculoskeletal disorders.[78]

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73 Ibid.

74 Health Canada, "Health Care System: 2003 First Ministers' Accord on Health Care Renewal," 2003, http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2003accord/index-eng.php.

75 House of Commons Standing Committee on Health, *Evidence*, No. 44, 2nd Session, 40th Parliament, November 18, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV4236244/HESAEV44-E.PDF.

76 Canadian Association of Naturopathic Doctors, "Presentation to the Standing Committee on Health Human Resources," May 7, 2009, p. 5.

77 House of Commons Standing Committee on Health, *Evidence*, No. 17, 2nd Session, 40th Parliament, April 28, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV3846660/HESAEV17-E.PDF, p. 9.

78 Canadian Association of Naturopathic Doctors, "Presentation to the Standing Committee on Health Human Resources," May 7, 2009, p.5. and House of Commons Standing Committee on Health, *Evidence*, No. 17, 2nd Session, 40th Parliament, April 28, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV3846660/HESAEV17-E.PDF, p. 9.

Despite the numerous examples of innovation in health care delivery to incorporate different health professionals, the Committee heard that there had not been widespread change in health care delivery across the country. According to witnesses, funding mechanisms such as the Health Reform Fund for Primary Care had provided a mechanism to promote innovative pilot projects, but it was not sufficient to create sustainable change across the country.[79] They called for the Health Reform Fund to be extended into the next iteration of the Canada Health Transfer due in 2014 in order to promote sustained change in IPC across the country.[80] Other witnesses pointed to systemic barriers to establishing IPC, including provincial legislation governing the scope of practice of professionals, a lack of interprofessional education and training opportunities, payment schemes for health care providers, and liability issues.[81]

While witnesses recognized that these systemic barriers remained under provincial jurisdiction, they articulated that the federal government could address systemic barriers to IPC within its own jurisdiction both in the context of federal client groups and the federal public service. For example, the federal government could address barriers to IPC within the Public Service Heath Care Plan, such as the requirement that physician prescriptions are necessary to access non-physician health care services such as physiotherapy.[82] The Committee also heard that the federal government could include treatments and care offered by alternative health professionals such as chiropractors and naturopathic physicians as part of the services and benefits that it offers to federal client groups.[83]

The Committee fully respects that many of the issues related to the implementation of inter-professional collaborative practice fall under provincial jurisdiction. However, the Committee also recognizes that the federal government could examine ways to eliminate barriers to collaborative practice within its own jurisdiction, including federal client groups and the health benefits provided to its employees through the Federal Public Service Health Care Plan. The Committee also supports witnesses in their view that sustained funding mechanisms need to be dedicated towards the implementation of IPC in provinces and territories. The Committee therefore recommends that:.

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79 House of Commons Standing Committee on Health, *Evidence*, No. 44, 2nd Session, 40th Parliament, November 28, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV4236244/HESAEV44-E.PDF.

80 Canadian Physiotherapy Association, "Efficiency & Health Human Resources," A Submission to the House of Commons Standing Committee on Health, November 25, 2009.

81 House of Commons Standing Committee on Health, *Evidence*, No. 46, 2nd Session, 40th Parliament, November 25, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV4261139/HESAEV46-E.PDF .

82 Ibid.

83 Canadian Association of Naturopathic Doctors, "Presentation to the Standing Committee on Health Human Resources," 7 May, 2009, p.5. and House of Commons Standing Committee on Health, "Evidence," Number 017, 2nd Session, 40th Parliament, 28 April, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV3846660/HESAEV17-E.PDF, p. 9.

Recommendation 7:

The federal government identify and address systemic barriers to the implementation of interprofessional collaborative practice within its jurisdiction, including its responsibilities as the employer of the federal public service and the health benefits and services it offers to federal client groups, including: First Nations and Inuit; RCMP; veterans; immigrants and refugees; federal inmates; and members of the Canadian Forces.

Recommendation 8:

The federal government consider the possibility of establishing sustained funding mechanisms devoted to promoting interprofessional collaborative practice within the provinces and territories..

Health Information Technology

Witnesses appearing before the Committee also emphasized the importance of health information technology in addressing HHR challenges. Health information technology refers to a broad range of integrated data sources that provide timely access to patient health information that can be communicated to different health professionals, as well as the patient and can include: Electronic Health Records for patients, electronic prescription of medications, and telehealth, which is the use of telecommunications technologies, such as the telephone or videoconferencing, to deliver health care services.[84] The Committee heard that current efforts towards development of Electronic Health Records (EHR) in Canada through *Canada Health Infoway Inc*. will promote interprofessional collaborative care by facilitating information sharing between different health professionals.[85] Furthermore, the Committee heard that health information technology was empowering Canadians to take responsibility in their own care, in turn easing some of the workload of health professionals. For example, information technology was enabling Canadians to conduct home monitoring of blood glucose levels, saving trips to the doctor.[86]

Indeed, the Committee was able to witness first-hand during its fact-finding mission to Nunavut the importance of health information technology in addressing HHR challenges in rural and remote areas. While visiting the Qikiqtani General Hospital in Iqaluit, the Committee learned that information technology allowed for the digital transfer of medical imaging, which reduced the need for travel to the south by patients, as well as visits to the

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84 RAND, "Health Information Technology," Research Brief, http://www.rand.org/pubs/research_briefs/RB9136/index1.html.

85 House of Commons Standing Committee on Health, *Evidence*, No. 46, 2nd Session, 40th Parliament, November 25, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV4261139/HESAEV46-E.PDF.

86 House of Commons Standing Committee on Health, *Evidence*, No. 14, 2nd Session, 40th Parliament, April 2, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV3806734/HESAEV14-E.PDF.

North by specialists to assess medical test results. In addition, video conferencing was being used effectively for dermatological and mental health assessments, continuing medical education, visitation with family members and patient follow-ups with specialists. Information technology had resulted in reductions in health transportation costs, which currently represent 18.5% or $50 million of Nunavut's total budget for health and social services. In addition, information technology had further allowed Inuit residents to receive health care within their communities, reducing the cultural burdens and stress associated with travel to urban centres in the south.

The Committee therefore continues to support the federal government's ongoing investments in health information technology, including electronic health records, electronic prescribing and telehealth through *Canada Health Infoway*, as a means of addressing HHR challenges across Canada. To date, the federal government has invested approximately $2.1 billion in *Canada Health Infoway.*[87]

87 Canada Health Infoway, "Annual Report 2008-2009: Building a Health Legacy Together," http://www.infoway-inforoute.ca/flash/ar-bp/en/ar/index.html.

CHAPTER 6: ACCELERATING THE INTEGRATION OF INTERNATIONALLY-EDUCATED HEALTH CARE PROFESSIONALS

Introduction

Historically, Canada has relied on internationally educated health care professionals (IEHPs), and in particular, International Medical Graduates (IMGs) to contribute to its health workforce needs. An International Medical Graduate is defined as a physician who has obtained a degree outside of either a Canadian medical school or a medical school in the United States.[88] An IMG can therefore refer to a Canadian citizen who went abroad to study medicine, as well as those who are permanent residents or citizens of Canada, who were educated abroad before immigrating to Canada.[89]

In 2007, IMGs represented about 23% of the total physician workforce, a decrease from 33% in the late 1970s.[90] According to CIHI, the main source countries for IMGs in Canada are the United Kingdom, South Africa, India, Ireland and Egypt.[91] The Committee also heard that Canadian citizens who pursued their medical degree abroad represent an increasing proportion of IMGs seeking postgraduate medical training and licensure in Canada. In 2008, 24% of the IMGs that applied for postgraduate training in Canada were Canadian citizens who went abroad and this number increased to approximately 40% in 2010.[92] Nurses represent another significant category of internationally educated health care professionals, with internationally educated registered nurses constituting 6.5% of the registered nurse workforce in Canada in 2005.[93]

In order to address the HHR shortages in Canada, the federal government committed to accelerating and expanding the assessment and integration of internationally trained health care graduates, as part of its overall commitments in the 2004 10-Year Plan to Strengthen Health Care.[94] This chapter examines and assesses initiatives undertaken by the federal government, professional health organizations and other stakeholders to

88 Canadian Information Centre for International Medical Graduates, "International Medical Graduate Definition," http://www.img-canada.ca/en/licensure_overview/img-definition.htm.

89 Ibid.

90 CIHI, Brief to the Standing Committee on Health, April 23, 2009.

91 CIHI, "Canada's Health Care Providers, 2007," 2007, http://secure.cihi.ca/cihiweb/products/HCProviders_07_EN_final.pdf.

92 Standing Committee on Health, *Evidence*, No. 50, 2nd Session, 40th Parliament, December 9, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV4314977/HESAEV50-E.PDF, p. 6.

93 CIHI, "Canada's Health Care Providers, 2007," 2007, http://secure.cihi.ca/cihiweb/products/HCProviders_07_EN_final.pdf.

94 Health Canada, "Health Care System: First Minister's Meeting on the Future of Health Care 2004," September 16, 2004, http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index-eng.php.

accelerate the assessment and integration of internationally educated health care professionals into health care systems in Canada, focusing in particular on efforts geared towards the integration of IMGs.

Pathways to Practice for Internationally Educated Health Professionals

The pathway to practice of IEHPs varies widely, depending upon their profession, educational backgrounds and level of training, the requirements of their particular regulatory body, as well as the jurisdiction in which they live. However, the table below outlines the general steps that are required for IEHPs to enter into practice in Canada.

Table 1

Pathways to Practice for IEHPs	
Step 1:	**Preparation and pre-arrival support in home country.**
Step 2:	**Assessment and verification of education credentials and training.**
Step 3:	**Occupation-specific examinations, language testing, and other evaluation activities such as postgraduate training and/or clinical placements through bridging programs.**
Step 4:	**Regulatory authority for a given occupation registers or licences the IEHP.**
Step 5:	**If the IEHP does not succeed in having his or her credentials recognized, alternative pathways are identified, such as skill upgrading programs, provisional licences, or avenues for pursuing other health-related occupations.**

Source: Table prepared using data obtained from the Forum of Labour Market Ministers, A Pan-Canadian Framework for the Assessment and Recognition of Foreign Qualifications, http://www.hrsdc.gc.ca/eng/workplaceskills/publications/fcr/pcf_folder/PDF/pcf.pdf.

Accelerating the Integration of Internationally Educated Health Professionals

The Committee heard from witnesses that the federal government, professional health organizations and other stakeholders were undertaking numerous initiatives to facilitate the entry into practice for IMGs and other IEHPs. First, the Committee heard from officials that the federal government had established the Foreign Credentials Referral Office (FCRO) in 2007 to provide internationally trained individuals with the information, path-finding and referral services necessary to have their credentials assessed quickly.[95] FCRO offices are based both domestically and abroad and serve as an interface between governments, employers, licensure bodies, and immigrants. According to federal

95 House of Commons Standing Committee on Health, *Evidence*, No. 41, 2nd Session, 40th Parliament, November 2, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV4198199/HESAEV41-E.PDF, p. 3.

government officials, it is expected that by October 2010, the FCRO will have offices in China, India, the Philippines, and the United Kingdom.

Second, the Committee heard that the Forum of Labour Market Ministers had agreed to a Pan-Canadian Framework for the Assessment and Recognition of Foreign Qualifications in November, 2009, which commits governments, regulatory authorities and other stakeholders to ensuring that an individual will know within a year whether his/her qualifications will be recognized, or whether additional requirements are needed.[96] The Framework further outlines that this principle of timely service would be implemented by the following health care professions by December 31, 2010: medical laboratory technologists, occupational therapists, pharmacists, physiotherapists and registered nurses.[97] Meanwhile, dentists, licensed practical nurses, medical radiation technologists and physicians would implement this commitment by December 31, 2012.[98]

In its appearance before the Committee, the Federation of Medical Regulatory Authorities of Canada (FMRAC), a national association representing the 13 provincial and territorial organizations responsible for the licensing and regulation of physicians across Canada in their respective jurisdictions, indicated that its member organizations were well on their way to meeting the goals outlined in the Framework.[99] In particular, FMRAC articulated that it had developed a draft agreement on national standards for medical registration in Canada for both Canadian medical graduates and IMGs.[100] The draft national standards have been developed for all dimensions of medical training, including: the recognition of a medical degree, Medical Council of Canada (MCC) qualifying exams, recognition of postgraduate training and/or supervision, and licensing by the regulatory authority. Furthermore, FMRAC indicated that the draft Framework recognizes that IMGs who are not able to initially meet the national standard should be eligible for a provisional licence.[101] Therefore, the Framework also outlines the criteria for provisional licensing for IMGs and the pathway for moving from a provisional licence to a full licence.[102] This agreement would replace the current approach, where IMGs and Canadian-trained physicians alike face different standards and requirements for medical licensure depending upon the jurisdiction in which they are applying. As a result, these national standards will also serve to facilitate labour mobility for physicians across Canada, as required under Chapter 7 on Labour Mobility of the Agreement on Internal Trade, which articulates that any

96 Forum of Labour Market Ministers, "A Pan-Canadian Framework for the Assessment and Recognition of Foreign Qualifications," November 2009, http://www.hrsdc.gc.ca/eng/workplaceskills/publications/fcr/pcf_folder/PDF/pcf.pdf, p. 7.

97 Ibid, p. 12.

98 Ibid.

99 Standing Committee on Health, *Evidence*, No. 50, 2nd Session, 40th Parliament, December 9, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV4314977/HESAEV50-E.PDF, p. 3.

100 Ibid.

101 Ibid, p. 4.

102 Ibid.

worker qualified for an occupation in a province or territory be granted access to employment opportunities in another province or territory that is party to the Agreement.[103]

To further facilitate the process of foreign credential recognition for IMGs, the Committee heard that the federal government has provided the Medical Council of Canada (MCC), an organization created by Parliament to establish national examinations for the practice of medicine in Canada, with funding to improve the credential verification and assessment process for IMGs.[104] Funding provided through Human Resources and Skills Development Canada's (HRSDC) Foreign Credential Recognition Program has enabled the MCC to create a national repository for the medical credentials of IMGs. The repository enables IMGs to have their credentials accessed by multiple organizations in different jurisdictions across Canada simultaneously, rather than having to send multiple copies of their documents to different organizations directly. The Medical Council of Canada has also received funding to develop a computer-based Evaluating Exam (MCCEE), offered in over 70 countries, that is meant to evaluate an IMG's medical knowledge prior to arrival and serve as a means for the Government of Canada to evaluate individuals seeking to immigrate to Canada as skilled workers.[105]

The Committee also heard that stakeholder organizations have made efforts to improve IMG access to postgraduate training. All Canadian medical students must complete postgraduate medical training or "residency" prior to their licensure by a medical regulatory body in Canada.[106] Depending upon their qualifications and prior training, some IMGs may also have to complete partial or complete postgraduate training in Canada.[107] In order to facilitate this process, the MCC has developed a single new nationally recognized clinical examination designed specifically to assess IMGs applying for postgraduate training positions.[108] The Committee also heard that the Canadian Resident Matching Service (CaRMS), the organization responsible for matching medical students with postgraduate training positions in Canada, began opening the matching and selection process fully to IMGs in 2006.[109] CaRMS also began sponsoring an annual symposium for IMGs to provide

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103 Ibid.

104 House of Commons Standing Committee on Health, *Evidence*, No. 50, 2nd Session, 40th Parliament, December 9, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV4314977/HESAEV50-E.PDF, p. 5.

105 Ibid.

106 Standing Committee on Health, *Evidence*, No. 7, 3rd Session, 40th Parliament, April 1, 2010, http://www2.parl.gc.ca/content/hoc/Committee/403/HESA/Evidence/EV4408690/HESAEV07-E.PDF, p. 3.

107 House of Commons Standing Committee on Health, *Evidence*, No. 50, 2nd Session, 40th Parliament, December 9, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV4314977/HESAEV50-E.PDF, p. 9.

108 Standing Committee on Health, *Evidence*, No. 7, 3rd Session, 40th Parliament, April 1, 2010, http://www2.parl.gc.ca/content/hoc/Committee/403/HESA/Evidence/EV4408690/HESAEV07-E.PDF, p. 5.

109 House of Commons Standing Committee on Health, *Evidence*, No. 50, 2nd Session, 40th Parliament, December 9, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV4314977/HESAEV50-E.PDF, p. 6.

them with information to help them understand and negotiate entry into Canada's postgraduate training system.[110]

Finally, the Committee heard from Health Canada that it was providing $75 million in funding for additional support programs to promote the integration of IEHPs in Canadian health care systems through its Internationally Educated Health Professionals Initiative (IEHPI).[111] Launched in 2005, the IEHPI directs approximately 90% of its funding to the provinces and territories to implement innovative support programs for IEHPs, such as bridging programs that are intended to help IEHPs develop the skills, competencies, or formal criteria necessary for the successful completion of their registration exams.[112] Health Canada's IEHPI also provides funding for pan-Canadian initiatives, such as the development of an orientation program to help IEHPs gain knowledge and understanding of the Canadian health care system.[113]

Barriers in the Pathways to Practice for IEHPs

Despite the efforts to accelerate the integration of IEHPs into health care systems in Canada, the Committee heard from witnesses that many continue to face barriers in entering practice in Canada. Witnesses articulated that the costs for IMGs to take all of the required MCC's exams necessary for full licensure, including the Evaluating Exam and the Qualifying Exam Parts I and II, could be prohibitive for recent immigrants, as they range from $1,200 to $3,600 depending upon the exam.[114] Furthermore, the Committee heard that IMGs face particular difficulties in passing these exams, as they are not familiar with multiple choice exams and do not have the same access to test preparation materials, such as question sets, in the same way as their Canadian counterparts do.[115] According to data from the MCC, between 1994 and 2006, approximately only 48% of those who passed the initial IMG Evaluating Exam succeeded in passing Parts I and II of the Qualifying Exams, which are necessary for full licensure in Canada.[116]

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110 Ibid.

111 House of Commons Standing Committee on Health, *Evidence*, No. 41, 2nd Session, 40th Parliament, November 2, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV4198199/HESAEV41-E.PDF, p. 9.

112 Ibid.

113 House of Commons Standing Committee on Health, *Evidence*, No. 14, 2nd Session, 40th Parliament, April 2, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV3806734/HESAEV14-E.PDF, p. 3.

114 House of Commons Standing Committee on Health, *Evidence*, No. 7, 3rd Session, 40th Parliament, April 1, 2010, http://www2.parl.gc.ca/content/hoc/Committee/403/HESA/Evidence/EV4408690/HESAEV07-E.PDF, p.1 and p. 11.

115 House of Commons Standing Committee on Health, *Evidence*, No. 14, 2nd Session, 40th Parliament, April 2, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV3806734/HESAEV14-E.PDF, p. 11.

116 This calculation is based upon data submitted to the Committee by the Medical Council of Canada. It marks the percentage difference between IMGs who passed the Evaluating Exam and then attempted the qualifying exams. Medical Council of Canada, Brief to the House of Commons Standing Committee on Health, February 2010.

Finally, the Committee heard that IMGs are struggling to gain access to the postgraduate training system. While the Committee heard that there had been a substantial increase in the numbers of IMGs receiving residency spots nationally, from 73 in 2003 to 442 in 2009, the Committee also heard that many were still not being accepted.[117] According to CaRMS, 31% of 1,600 IMGs who applied for residency training positions in 2008 were accepted.[118] CaRMS further noted that approximately 50% of IMGs who apply each year are those who are reapplying after failing to be matched in the previous year.[119] CaRMS further indicated that there was a ratio of one residency spot available for every 4 IMGs who applied to the system.[120]

National physicians' organizations, including the Royal College of Physicians and Surgeons of Canada (RCPSC) and the Canadian Medical Association (CMA), explained that there were insufficient residency spots for IMGs because the medical system currently lacked the capacity to mentor and train them.[121] Some witnesses suggested that the medical system lacked the capacity to train IMGs, because postgraduate training spots were being granted to international medical students sponsored by their home government to complete full or specialized medical training in Canada and the return to their country of origin.[122] According to the Association of Faculties of Medicine of Canada, there were 830 visa medical trainees in Canada in 2008; with 120 of them training at the First Residency Level.[123] However, others cautioned that these visa trainees could not be directly compared to IMGs in terms of both their skill level and the training they were receiving in Canada.[124]

The Committee also heard that other internationally educated health professionals were facing similar challenges in foreign credential recognition. For example, the Canadian Society for Medical Laboratory Science also indicated that approximately 90% of

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117 House of Commons Standing Committee on Health, *Evidence*, No. 41, 2nd Session, 40th Parliament, November 2, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV4198199/HESAEV41-E.PDF, p. 9.

118 House of Commons Standing Committee on Health, *Evidence*, No. 50, 2nd Session, 40th Parliament, December 9, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV4314977/HESAEV50-E.PDF, p. 9.

119 Ibid, p.7

120 House of Commons Standing Committee on Health, *Evidence*, No. 41, 2nd Session, 40th Parliament, November 2, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV4198199/HESAEV41-E.PDF, p. 9.

121 House of Commons Standing Committee on Health, *Evidence*, No. 17, 2nd Session, 40th Parliament, April 28, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV3846660/HESAEV17-E.PDF, p. 7.

122 House of Commons, Standing Committee on Health, *Evidence*, No. 46, 2nd Session, 40th Parliament, November 25, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV4261139/HESAEV46-E.PDF, p. 2.

123 Association of Faculties of Medicine of Canada, Presentation to the House of Commons Standing Committee on Health, November 25, 2009, p. 5.

124 House of Commons, Standing Committee on Health, *Evidence*, No. 17, 3rd Session, 40th Parliament, May 13, 2010, http://www2.parl.gc.ca/content/hoc/Committee/403/HESA/Evidence/EV4531758/HESAEV17-E.PDF.

internationally educated medical laboratory technologists did not meet the regulatory standards required in Canada.[125] They further stated that their failure rate on national exams remained well above the Canadian average.

In order to address some of these challenges, witnesses stressed the importance of investing in bridging and adaptation programs that help IEHPs gain the knowledge and the skills necessary to succeed in meeting all the requirements for licensing in Canada. For example, the Committee heard that the Government of Alberta in conjunction with Citizenship and Immigration Canada (CIC) offered a successful Medical Communication Assessment Project, which provides IMGs with language and cultural skills necessary for oral clinical exams.[126] However, others noted that bridging programs also needed to be better integrated into the medical education system. The Committee heard that many IMG bridging programs that focused on supervised clinical experience during a period of several years were not recognized as official training by regulatory authorities, and consequently, many IMGs had to complete residency training after two years of supervised clinical training.[127] They therefore recommended that bridging programs be university-based to ensure that they are recognized in the assessment of an individual's credentials.[128] Finally, witnesses also indicated that bridging programs required sustained funding mechanisms to be successful in the long term.[129]

To address the shortages of residency spots available for IMGs, witnesses recommended that targeted funding in the range of $5 million over five years be provided to medical schools and teaching hospitals to increase their resources and infrastructure in order to be able to provide postgraduate residency positions for IMGs and mentoring programs to IMGs with provisional licenses and/or significant prior clinical experience.[130] Other witnesses suggested that the Government of Canada reduce the number of visa residents it allows into Canada in order to provide capacity within the medical education system for the postgraduate training of IMGs.[131] As positions for visa residents are funded

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125 House of Commons Standing Committee on Health, *Evidence*, No. 16, 3rd Session, 40th Parliament, May 11, 2010, http://www2.parl.gc.ca/content/hoc/Committee/403/HESA/Evidence/EV4515830/HESAEV16-E.PDF.

126 Standing Committee on Health, *Evidence*, No. 7, 3rd Session, 40th Parliament, April 1, 2010, http://www2.parl.gc.ca/content/hoc/Committee/403/HESA/Evidence/EV4408690/HESAEV07-E.PDF, pp. 1-2.

127 House of Commons Standing Committee on Health, *Evidence*, No. 50, 2nd Session, 40th Parliament, December 9, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV4314977/HESAEV50-E.PDF, p. 3.

128 Ibid.

129 House of Commons Standing Committee on Health, *Evidence*, No. 16, 3rd Session, 40th Parliament, May 11, 2010, http://prismweb.parl.gc.ca/IntranetDocuments/CommitteeBusiness/40/3/HESA/Meetings/Evidence/HESAEVBLUES16.HTM.

130 House of Commons Standing Committee on Health, *Evidence*, No. 17, 2nd Session, 40th Parliament, April 28, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV3846660/HESAEV17-E.PDF, p. 7 & 11.

131 House of Commons, Standing Committee on Health, *Evidence*, No. 46, 2nd Session, 40th Parliament, November 25, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV4261139/HESAEV46-E.PDF, p. 2.

by foreign governments, witnesses suggested that the Government of Canada could subsidize the postgraduate training positions that would be offered to IMGs instead.[132]

Other witnesses suggested that a systemic approach could also be taken. As CIC considers physicians to be a priority occupation category for skilled workers immigrating to Canada, the Medical Council of Canada recommended that the Government of Canada require that physicians seeking to immigrate to Canada include the results of the MCC Evaluation Exam as part of their immigration application to Canada so that the Government of Canada could use the exam results as part of their criteria in evaluating the candidate.[133] The MCC indicated that their data showed that if a candidate failed the Evaluation Exam one or more times, he or she had a probability of less than 35% of completing the full licensure process in Canada.[134]

Another alternative suggested by witnesses was the establishment of mutual recognition agreements with professional health associations in top immigration source countries. For example, the Committee heard that the College of Family Physicians of Canada (CFPC) has established reciprocal agreements to certify and welcome board-certified American and Australian-certified family medicine graduates and were working towards reaching similar agreements with other countries.[135] While some witnesses saw reciprocal agreements as a means of recognizing IEHPs prior training and experience, others cautioned that it could raise equity issues whereby immigrants from certain countries with reciprocal agreements could be advantaged over others.[136]

Committee Observations

The Committee recognizes the complexity of the foreign credential recognition process for IEHPs in Canada. In fact, the Committee heard that the system involves over 53 provincial and territorial ministries, five provincial assessment agencies, over 200 post-secondary educational institutions and more than 440 regulatory bodies.[137] While the Committee acknowledges that responsibilities related to the education, accreditation, and licensing of IEHPs rests at the provincial and territorial levels, it believes that the federal government has an important role to play in supporting the roles of the provincial and

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132 Ibid.

133 Medical Council of Canada, Brief to the House of Commons Standing Committee on Health, February 2010.

134 Ibid.

135 House of Commons Standing Committee on Health, *Evidence*, No. 44, 2nd Session, 40th Parliament, November 18, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV4236244/HESAEV44-E.PDF, p. 3.

136 House of Commons Standing Committee on Health, *Evidence*, No. 50, 2nd Session, 40th Parliament, December 9, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV4314977/HESAEV50-E.PDF, p.7 and Standing Committee on Health, *Evidence*, No. 7, 3rd Session, 40th Parliament, April 1, 2010, http://www2.parl.gc.ca/content/hoc/Committee/403/HESA/Evidence/EV4408690/HESAEV07-E.PDF, p. 15.

137 House of Commons Standing Committee on Health, *Evidence*, No. 14, 2nd Session, 40th Parliament, April 2, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV3806734/HESAEV14-E.PDF, p. 3.

territorial governments and other stakeholders in this area. As officials from CIC articulated, the Government of Canada is responsible, in most cases, for the selection of immigrants to Canada and consequently, it is therefore also responsible for ensuring that "newcomers are able to put their talents, skills and resources to work once they arrive in Canada."[138]

The Committee heard that many initiatives were underway to support the acceleration of the integration of IEHPs and IMGs, many of which were the result of federal funding. However, the Committee also heard that many IEHPs and IMGs were facing difficulties in succeeding on exams required for licensure and gaining access to necessary postgraduate training, resulting in delays that significantly affected the maintenance of their skills. The Committee also recognizes the significant cost burden that all medical graduates face in completing their licensure exams. The Committee believes that ongoing support for bridging and adaptation programs, and transitional licences are essential to providing IEHPs the skills, knowledge and experience necessary to meet the requirements necessary to integrate into Canadian health care systems. However, the Committee was also concerned that some witnesses articulated that these programs often became "bridges to nowhere",[139] when the clinical training that they offered were not recognized by regulatory authorities. In addition, the Committee heard that medical schools and teaching hospitals lacked the capacity to integrate IMGs into the health care system, in turn resulting in insufficient residency positions being made available to IMGs and other medical graduates.

The Committee also heard about two emerging issues related to IMGs where further work is needed. First, the Committee learned that Canadian medical schools are providing postgraduate training to foreign medical students who then return to their home country to practice, while many IMGs living in Canada remain unable to gain access to postgraduate training positions. Furthermore, the Committee heard that an increasing proportion of IMGs are Canadian citizens that went to medical school abroad. However, the Committee heard that these IMGs now face the same difficulties in accessing the postgraduate medical training system as other IMGs in Canada. Though CaRMs has received a grant from Health Canada to study this issue in greater depth,[140] the Committee thinks that more work needs to be done in this area. The Committee therefore recommends:

Recommendation 9:

That Health Canada continue to provide sustained funding to bridging, adaptation and transitional licence programs for IEHPs, as well as community-based preceptorship programs in which practicing physicians assess and mentor IMGs.

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138 Ibid.

139 House of Commons Standing Committee on Health, *Evidence*, No. 50, 2nd Session, 40th Parliament, December 9, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV4314977/HESAEV50-E.PDF.

140 Ibid.

Recommendation 10:

That Health Canada work with relevant stakeholders to ensure that the federally funded bridging programs that offer supervised clinical training over an extended period of time be included as part of the assessment of an IEHP's credentials and training.

Recommendation 11:

That the F/P/T Advisory Committee on Health Delivery and Human Resources consider conducting an in-depth study examining IMG access to postgraduate training positions in Canada, including issues such as: capacity and funding within the medical education system for positions, or alternative supervised clinical placements, an evaluation of the residency matching system for IMGs, and the position of visa residents within the system; and that the F/P/T Advisory Committee on Health Delivery and Human Resources report the findings of its study on postgraduate training positions for IMGs.

Recommendation 12:

Recognizing the pre-existing cultural competency of Canadian citizens that went abroad to study medicine, that the F/P/T Advisory Committee on Health Delivery and Human Resources work with relevant stakeholders to identify ways to improve the assessment and integration of these IMGs into postgraduate medical training in Canada.

Recommendation 13:

That the Government of Canada establish an initiative to repatriate Canadian physicians practicing abroad; an initiative that would bring back as many as 300 physicians.

Recommendation 14:

That the Government of Canada consider providing targeted funding to the provinces and territories to increase the capacity of medical schools and teaching hospitals to play a constructive role in integrating IMGs and other medical graduates into the health care system.

Recommendation 15:

That the Government of Canada keep its 2008 commitment to fund 50 new residencies per year over four years at a cost of $40 million.

Recommendation 16:

That the Government of Canada consider a requirement that physicians seeking to immigrate to Canada include the results of the MCC Evaluation Exam as part of their immigration application to Canada so that the

Government of Canada could use the exam results as part of their criteria in evaluating the candidate.

CHAPTER 7: HHR NEEDS AND CHALLENGES FACING FEDERAL CLIENT GROUPS

Introduction

As outlined in Chapter 2, the federal government has jurisdiction over specific population groups, including: First Nations and Inuit; immigrants; Canadian Forces; veterans; the RCMP; and federal inmates. As a result, it offers certain primary and supplementary health care services to approximately 1.3 million Canadians through six departments, including: Health Canada, Citizenship and Immigration Canada (CIC), Veterans Affairs Canada (VAC), Department of National Defence (DND), Correctional Service Canada (CSC) and the RCMP.[141] The overall cost to the federal government for the provision of these health services and related benefits is approximately $2.7 billion annually, making it the fifth largest health care provider in the country.[142]

While the types of health services and benefits that the federal government offers to each of these client groups varies substantially, these federal departments and agencies face common challenges related to HHR, including high vacancy rates in these professions. For example, in 2008, DND had a vacancy rate of 25% in its nursing positions, and CSC had a vacancy rate of 35% in their psychology positions.[143] These high vacancy rates have meant that federal departments and agencies have had to rely on third party contracts that pose significant financial burdens; the cost of DND's third party contract for physicians was $26 million in 2007, while VAC's was $6 million.[144] Moreover, the Committee was told that federal departments and agencies are limited in their ability to offer competitive salaries and benefits to health professionals due to the passing of the *Expenditure Restraint Act*, which limits annual increases in compensation for all professional and administrative personnel within the federal public service to 1.5%.[145]

This chapter examines how federal departments and agencies are addressing both individually and collectively the HHR challenges that they experience in providing services and benefits to meet the health needs of their respective client groups. It begins with an overview of horizontal collaboration in HHR through the Federal Healthcare Partnership (FHP), and then examines in detail the unique needs and challenges facing each of the respective federal client groups.

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141 Government of Canada, "FHP Office of Health Human Resources: Welcome! Working in the Federal Public Service," http://www.fhp-pfss.gc.ca/fhp-pfss/ohhr-brhs/home-accueil.asp?lang=eng.

142 House of Commons Standing Committee on Health, *Evidence*, No. 4, 3rd Session, 40th Parliament, 2010, March 23, 2010, http://www2.parl.gc.ca/content/hoc/Committee/403/HESA/Evidence/EV4370667/HESAEV04-E.PDF, p. 6.

143 Ibid.

144 Ibid.

145 Federal Healthcare Partnership, "FHP & The Office of Health Human Resources," Brief submitted to the House of Commons Standing Committee on Health, March 23, 2010, p. 7.

Horizontal Collaboration in HHR: The Federal Health Care Partnership

The Committee heard that the six departments and agencies responsible for health services and benefits for federal client groups work together to address their common HHR challenges through the FHP, a horizontal initiative that aims to achieve economies of scale in their health care responsibilities across the federal public service and serves as a forum to identify areas for joint collaboration in health care.[146] In response to the shortages in HHR facing federal departments, the FHP established the Office of Health Human Resources in order to coordinate collective recruitment and retention activities and provide leadership and assistance to the FHP member organizations when addressing common issues and challenges in the area of HHR.[147]

The Committee heard that since October 2008, the FHP Office of Health Human Resources has undertaken three strategies to address vacancy rates in health professions within the federal public service. First, the Office is working to address health service occupational classification and compensation issues by supporting the request of federal physicians to be removed from their current occupational classification levels and commissioning a study by Statistics Canada to compare federal physician compensation levels to those received by physicians in private practice.[148] Second, the Office is implementing HHR recruitment initiatives, including offering clinical placements and participating in job fairs and outreach activities, in order to promote the federal government as an employer of choice for health professionals.[149] Finally, the Office aims to promote communities of practice by serving as a functional community hub where federal health professionals can come together to network, share best practices and strengthen their community through training and collaboration.[150]

First Nations and Inuit

(i) Health Canada's Roles and Responsibilities

Aboriginal peoples are defined in section 35 of *Constitution Act*, *1982*, as the "Indian, Inuit and Métis peoples of Canada."[151] Section 91(24) of *Constitution Act, 1867* grants the federal government primary jurisdiction over First Nations and Inuit. The federal government has interpreted this responsibility as being limited to First Nations living on reserve and specific Inuit. Therefore, in accordance with the 1979 Indian Health Policy, the

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146 Ibid.

147 Government of Canada, "FHP: Office of Health Human Resources: About Us", http://www.fhp-pfss.gc.ca/fhp-pfss/ohhr-brhs.asp?lang=eng&cont=501.

148 Federal Healthcare Partnership, "FHP & The Office of Health Human Resources," Brief submitted to the House of Commons Standing Committee on Health, March 23, 2010, p. 8.

149 Ibid, p. 9.

150 House of Commons Standing Committee on Health, *Evidence*, No. 4, 3rd Session, 40th Parliament, March 23, 2010, http://www2.parl.gc.ca/content/hoc/Committee/403/HESA/Evidence/EV4370667/HESAEV04-E.PDF, p. 7.

151 *The Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11, Part II, s.35 (2).

federal government provides certain health services and benefits to these population groups, which are now delivered primarily through Health Canada's First Nations and Inuit Health Branch (FNIHB).[152]

FNIHB employs 800 nurses and home care workers who provide community-based health services to First Nations and Inuit communities across the country.[153] However, some First Nations and Inuit communities are responsible for the administration of these community-based health services through contribution agreements, or Health Service Transfer Agreements with FNIHB.[154] In addition to federal health care programs, on reserve First Nations and Inuit communities access medically necessary acute and primary care through hospital and medical services provided by their home province on the same basis as all other Canadians.[155]

(ii) Current Challenges in the Recruitment and Retention of Aboriginal Health Human Resources

The Committee heard that one of the main HHR challenges facing First Nations and Inuit communities is the recruitment of First Nations and Inuit into the health work force. According to the National Aboriginal Health Organization (NAHO), there is a disproportionate lack of Aboriginal health professionals in Canada.[156] For example, only 3.7% of health care professionals identify as Aboriginal in Saskatchewan, yet Aboriginal peoples represent 8.5% of the employed population in that province.[157] Furthermore, according to the 2006 Census, only 240 people who identified as First Nations had graduated in medicine, veterinary medicine, or dentistry.[158] The Committee heard that increasing the number of Aboriginal health professionals was essential to improve the retention of HHR in on reserve First Nations and Inuit communities, as health professionals of Aboriginal background are more likely to return and remain in their communities due to family ties and kinship networks.[159] Moreover, they are also able to provide on reserve First Nations and Inuit communities with culturally appropriate care.[160]

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152 Health Canada, "About Health Canada: Indian Health Policy 1979," http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/poli_1979-eng.php.

153 Health Canada, "First Nations and Inuit Health: Health Care Services," http://www.hc-sc.gc.ca/fniah-spnia/services/index-eng.php.

154 Ibid.

155 Commission on the Future of Health Care in Canada, "Building on Values: the Future of Health Care in Canada," November 2002, http://www.healthcoalition.ca/romanow-report.pdf, p. 217.

156 House of Commons Standing Committee on Health, *Evidence*, No. 5, 3rd Session, 40th Parliament, March 25, 2010, http://www2.parl.gc.ca/content/hoc/Committee/403/HESA/Evidence/EV4378648/HESAEV05-E.PDF, p. 5.

157 Ibid.

158 Ibid.

159 House of Commons Standing Committee on Health, *Evidence*, No. 5, 3rd Session, 40th Parliament, March 25, 2010, http://www2.parl.gc.ca/content/hoc/Committee/403/HESA/Evidence/EV4378648/HESAEV05-E.PDF, p. 11.

160 Ibid.

However, witnesses explained that there were numerous barriers to recruiting First Nations and Inuit into the health workforce. Primarily, many First Nations and Inuit lacked the education necessary to pursue health careers, as high school completion rates for these population groups are disproportionately lower than the rest of the Canadian population.[161] According to the 2001 Census, 16% of Canadians aged 20 to 24 had not completed high school. However, among Aboriginal Canadians in the same age group, 43% did not have a high school certificate.[162] The Committee heard that in Quebec, only 3% of First Nations meet the requirements to access post-secondary education.[163] For those who succeeded in accessing post-secondary education, many further lacked the necessary background in mathematics and sciences to pursue health careers.[164]

In addition, the Committee heard that First Nations and Inuit often face funding barriers in pursuing post-secondary education in the health sciences. Though scholarships and bursaries are available, witnesses articulated that funding arrangements often do not take into account the unique needs of First Nations and Inuit students, including: lengthier and interrupted educational careers due to factors such as family obligations and participation in transitional programs.[165]

Finally, the Committee heard that First Nations and Inuit students experience cultural, social and geographic barriers in pursuing the post-secondary education in the health sciences. Some First Nations and Inuit students have difficulties gaining proficiency in the language of instruction.[166] They also continue to be educated in environments, where many health professionals do not have knowledge of their cultural practices, or respect for the contributions that traditional medicine has made to health care.[167] Many First Nations and Inuit students must pursue their post-secondary education in locations where they are distant from their own communities and social support systems for extended periods of time, leading to further isolation.[168]

According to witnesses, on reserve First Nations and Inuit communities also encounter challenges related to the retention of HHR due to a lack of funding. The Committee heard that on reserve First Nations and Inuit communities had difficulty retaining health professionals, because the pay scales offered by the federal government could not

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161 Ibid. p. 4.

162 Michael Mendelson, "Improving Primary and Secondary Education on Reserves in Canada," *Caledon Institute of Social Policy*, October 2006, http://www.caledoninst.org/Publications/PDF/608ENG%2Epdf, p. 1

163 House of Commons Standing Committee on Health, *Evidence*, No. 5, 3rd Session, 40th Parliament, March 25, 2010, http://www2.parl.gc.ca/content/hoc/Committee/403/HESA/Evidence/EV4378648/HESAEV05-E.PDF, p. 4.

164 Ibid.

165 Ibid, p. 9.

166 Ibid, p. 4.

167 Ibid, p. 5.

168 Ibid, p. 4.

compete with those offered by other health service providers.[169] In particular, the Committee heard that Aboriginal physicians carry high debt loads from their education and training and therefore are reluctant to return to their home communities to practice for lower salaries.[170] Similarly, the Committee heard that on reserve First Nations and Inuit communities face HHR shortages because they are not provided with sufficient base funding from Health Canada to hire the health human resources necessary to meet their growing population needs.[171] The Committee heard that despite their increasing population, Health Canada had only provided on reserve First Nations and Inuit communities with one additional nurse, as part of their nursing transformation strategy in 2004.[172]

Difficult social conditions in on reserve First Nations and Inuit communities are another factor affecting the retention of health professionals in these communities, as one witness told the Committee:

> We were talking about the experience of one of my students in the nursing program. She's from Onion Lake on the Alberta-Saskatchewan border, and I asked her if she was going back when she said she'd done nursing school. She said ideally she'd love to, but the reality is she's going to stay in an urban centre until her kids are done school, because she doesn't want them to struggle the way she is struggling in the maths and sciences.[173]

The Committee also heard that Aboriginal physicians experience higher levels of burnout due to the stressful nature of the work in rural and remote locations and the multiple roles that they play as advocates for their communities.[174]

(iii) Strategies to Improve the Recruitment and Retention of Aboriginal Health Human Resources in First Nations and Inuit Communities

The Committee heard that Health Canada had introduced the Aboriginal Health Human Resources Initiative (AHHRI) in 2005 with the overall goals of increasing the number of Aboriginal health professionals, as well as provide non-Aboriginal health professionals with the cultural knowledge and skills to provide appropriate care to Aboriginal population groups.[175] Provided with $100 million in funding over five years, Health Canada officials told the Committee that the AHHRI had succeeded in increasing

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169 Ibid, p. 10.

170 Ibid.

171 Ibid, p. 7.

172 Ibid.

173 Ibid, p. 18.

174 Ibid, p. 20.

175 House of Commons Standing Committee on Health, Evidence, No. 41, 2nd Session, 40th Parliament, November 2, 2009, http://www2.parl.gc.ca/content/hoc/Committee/402/HESA/Evidence/EV4198199/HESAEV41-E.PDF, p. 2.

the number of aboriginal students receiving bursaries and scholarships for health career studies to a total of 1,398 students over a four-year period from 2005 to 2009.[176]

In addition, the AHHRI has provided funding for the development of curriculum frameworks for medical and nursing schools to provide their students with the cultural knowledge and skills necessary to make them effective practitioners in treating Aboriginal peoples, as well as working in on reserve First Nations and Inuit communities.[177] These cultural curriculum frameworks are also necessary to provide Aboriginal students with a health science education that is relevant to their life experiences.

The AHHRI has also provided colleges and universities with funding to develop bridging programs that help Aboriginal students qualify for entry into health studies.[178] The Committee heard that bridging programs helped those who were unable to complete high school gain the knowledge and skills necessary to enter post-secondary education. These programs, in part, serve to address the low high school completion rates in on reserve First Nations and Inuit communities. The Committee heard that AHHRI was also supporting initiatives to raise awareness of the educational requirements necessary, in particular in mathematics and sciences, to pursue careers in the health sciences.

In terms of the retention of health professionals in on reserve First Nations and Inuit communities, the Committee heard that Health Canada, in its renewal of its AHHRI Initiative, will focus on providing increased training to community-based paraprofessionals and allied health professionals such as addictions workers, mental health, diabetes, maternal and child health workers, and home community care workers, in order to enhance their capacity to provide health services and support to health professionals working with those communities.[179] The Committee also heard that Health Canada was working with the Assembly of First Nations to determine the necessary funding required to address the lower pay scales offered to HHR in on reserve First Nations and Inuit communities.[180]

Witnesses appearing before the Committee articulated that AHHRI is providing welcome support to programs and organizations working towards increasing the number of Aboriginal HHR in Canada. They stressed the importance of funding bridging programs for Aboriginal students, which include support such as counseling, mentoring and dedicated places where Aboriginal students can interact with each other, problem solve and maintain a sense of community throughout their education.[181]

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176 Ibid.

177 Ibid, p. 7.

178 Ibid.

179 House of Commons Standing Committee on Health, *Evidence*, No. 17, 3rd Session, 40th Parliament, May 13, 2010, http://www2.parl.gc.ca/content/hoc/Committee/403/HESA/Evidence/EV4531758/HESAEV17-E.PDF.

180 Ibid.

181 House of Commons Standing Committee on Health, *Evidence*, No. 5, 3rd Session, 40th Parliament, March 25, 2010, http://www2.parl.gc.ca/content/hoc/Committee/403/HESA/Evidence/EV4378648/HESAEV05-E.PDF, p. 13.

Witnesses also highlighted the importance of community outreach activities to encourage the pursuit of health careers among Aboriginal youth. For example, the Committee heard about a program in Quebec, funded jointly by the federal and provincial governments, where representatives from the First Nations of Quebec and Labrador Health and Social Services Commission visit First Nations and Inuit high school students in their communities to educate them about the prerequisites and the procedures to attend university in the health sciences.[182] The students are then able to visit the university campuses and meet with university students to learn about university life.

While witnesses were supportive of Health Canada's AHHRI, they expressed concerns about funding. First, witnesses articulated that although AHHRI's funding had been extended for another two years until 2012, this was not a reasonable period of time to make significant improvements in increasing the number of Aboriginal health professionals. As they noted, "it takes a minimum of nine years to train a physician."[183]

Second, witnesses articulated that AHHRI did not provide funding to organizations in a manner that would enable them to sustain their activities.[184] The Committee heard that organizations, which play leadership roles in promoting health careers among Aboriginal peoples through the establishment of outreach and mentorship programs, conferences, and the development of curriculum in cultural competence and safety, such as the Indigenous Physicians Association of Canada, the Aboriginal Nurses Association of Canada and the National Aboriginal Health Organization, only receive project based funding rather than core operations funding through the AHHRI. As these organizations do not have other major sources of funds, they have difficulty maintaining their operations beyond the project for which they have received funding. They therefore recommended that Health Canada move towards funding core operations rather than a project-based funding model.

Finally, witnesses stressed the need for more scholarships and bursaries to be made available to First Nations and Inuit students pursuing health careers, with some funding targeted towards skills upgrading.[185] Some suggested that this could be done by increasing the funding provided through Indian and Northern Affairs Canada (INAC)'s Post-Secondary Support Program, which provides funding for tuition for eligible Status Indians[186] and Inuit.[187]

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182 Ibid, p .14.

183 Ibid, p. 2.

184 Ibid, p. 8.

185 Ibid, p. 17.

186 Registered (Status) Indian: those people who are registered or entitled to be registered as Indians in accordance with the provisions of the *Indian Act*. Tonina Simeone, "Federal-Provincial Jurisdiction and Aboriginal Peoples" February 1, 2001, Library of Parliament Publication TIPS-88E, http://lpintrabp.parl.gc.ca/apps/tips/tips-cont-e.asp?Heading=14&TIP=95.

187 House of Commons Standing Committee on Health, *Evidence*, No. 16, 3rd Session, 40th Parliament, May 11, 2010, http://www2.parl.gc.ca/content/hoc/Committee/403/HESA/Evidence/EV4515830/HESAEV16-E.PDF.

(iv) Committee Observations

The Committee recognizes the importance of increasing the number of Aboriginal HHR as part of the Government of Canada's overall efforts to improve health outcomes for on reserve First Nations and Inuit communities. The Committee learned that many of the barriers to increasing the number of Aboriginal health professionals were deeply rooted in socio-economic factors, including: low levels of educational attainment and the inability to afford post-secondary education. However, the Committee heard that there were many successful initiatives funded through Health Canada's AHHRI that helped mitigate some of these challenges, including: scholarship and bursaries, as well as bridging, outreach and mentoring programs. The Committee also heard that these programs require secure and sustained funding in order to succeed. The Committee is also aware that on reserve First Nations and Inuit communities face numerous challenges related to HHR retention, including: shortages, burnout and a lack of funds to pay market rates for health professionals. The Committee heard that some of these challenges could be addressed through the utilization of a broad range of health professionals, such as midwives, traditional healers, community health representatives and health promotion experts. However, the Committee recognizes that it is important to encourage Aboriginal health human resources to work in all areas of the health care system, including: teaching indigenous heath in university faculties, providing health care to Aboriginal populations living in urban centers, providing tertiary care, and developing Aboriginal health policy.[188] The Committee therefore recommends:

Recommendation 17:

That Health Canada provide secure and stable funding for Aboriginal Health Human Resources, including support for programs and initiatives such as: bridging, mentoring and outreach programs; scholarships; organizations providing leadership in this area; and initiatives supporting the recruitment and retention of a broad range of health professionals including: midwives, community health representatives, traditional healers, health promotion experts, and addiction counsellors.

Recommendation 18:

That Health Canada review its project-based funding model under the Aboriginal Health Human Resources Initiative to determine whether it is meeting the needs of stakeholders and on reserve First Nations and Inuit communities;

Recommendation 19:

That Health Canada continue to increase its focus on retention of health professionals in on reserve First Nations and Inuit communities, while respecting the institutions and initiatives already in place; and in

188 Ibid, p. 18.

particular, addressing issues related to cultural concerns and the pay scale of health professionals in those communities.

Recommendation 20:

That Health Canada consider enhancing its collaboration with Indian and Northern Affairs Canada, other relevant departments, and organizations such as: Indigenous Physicians Association of Canada, the Aboriginal Nurses Association of Canada and the National Aboriginal Health Organization, to promote careers in health sciences at all education levels, including: primary, secondary and post-secondary education.

Other Federal Government Client Groups

(i) Royal Canadian Mounted Police (RCMP)

The RCMP is responsible for the health care of its members under the authority of the *Royal Canadian Mounted Police Act*.[189] As such, members of the RCMP are excluded from the *Canada Health Act*. The Committee heard that there are two dimensions to the health care benefits and services that the RCMP offers to its members. First, comprehensive health care is provided to members through health insurance benefit and entitlement programs offered by the RCMP, where members receive health care from health care professionals in the community, which are chosen by the individual, but paid for by the RCMP.[190] If necessary, the RCMP will arrange for travel or relocation in order for a member to receive adequate health services when they are not available in the community. As such, the RCMP does not provide direct health care or treatment to its members.[191]

Second, the RCMP is also responsible for the occupational health and safety of its members.[192] In support of this mandate, the RCMP's occupational health and safety branch establishes policies and programs aimed at promoting a healthy and safe work environment, which includes developing national medical and psychological health standards. The occupational health and safety branch is responsible for monitoring the health of regular members throughout their career through its regional divisions. This is done through a mandatory periodic health assessment, which is completed by a division physician, who evaluates the member's physical and mental well-being every one to three years. In order to further promote health and wellness among its members, the Committee heard that the RCMP had established the position of director general of workplace

189 House of Commons Standing Committee on Health, *Evidence*, No. 4, 3rd Session, 40th Parliament, March 23, 2010, http://www2.parl.gc.ca/content/hoc/Committee/403/HESA/Evidence/EV4370667/HESAEV04-E.PDF, p. 3.

190 Ibid.

191 Ibid.

192 Ibid.

development and wellness on April 1, 2010, who is tasked to develop a wellness strategy for the RCMP.[193]

The Committee heard that the HHR challenges facing the RCMP were related to occupational health and safety. Witnesses appearing before the Committee spoke to the enormous physical, emotional and psychological difficulties that members of the RCMP face as result of their work, as "they are regularly exposed to traumatic events, tragedies, atrocities, natural disasters and deep human suffering."[194] As a result, many develop operational stress injuries (OSI), which can be defined as any persistent psychological difficulty resulting from operational service and can include diagnosed medical conditions such as anxiety, depression and post-traumatic stress disorder (PTSD).[195] The Committee heard that OSIs, when left undiagnosed, can have a significant impact on functioning and well-being of an individual, which could include behavioural changes, depression and suicide.[196]

According to witnesses appearing before the Committee, the RCMP lacked the health human resources necessary to address OSIs among its members. The Committee heard that the physicians that conducted physical and mental assessments of the members of the RCMP were often employed on contract seven days per month and had little knowledge of the police profession or tools to diagnose symptoms of OSIs.[197] The Committee heard that the RCMP employed 14 psychologists, but they were employed to work with special police units rather than to provide counselling for members of the RCMP.[198] Finally, the Committee heard that there was insufficient follow-up and case management of those diagnosed with OSIs and were receiving treatment within the community, including data collection.

In order to address this situation, witnesses articulated that the occupational health and safety branch required a stable budget that took into account the increasing need to diagnose OSIs among members of the RCMP.[199] Health professionals needed specific training in the culture and experiences of members of the RCMP, as well as tools to recognize the symptoms of OSIs.[200] They further articulated that the RCMP could hire clinical psychologists with expertise in dealing with victims of trauma.[201] They also suggested that members of the RCMP have access to the same benefits and services as some of the other members of the Federal Healthcare Partnership (FHP), such as Veterans

193 Ibid, p. 4.

194 Ibid, p. 3.

195 Ibid.

196 Ibid. p. 3-5.

197 Ibid, p. 2.

198 Ibid, p. 16.

199 Ibid, p. 12.

200 Ibid, p. 4.

201 Ibid, p. 9.

Affairs Canada's (VAC) Veteran's Independence Program (VIP), which provides home care services to veterans and their families.[202] Finally, witnesses also stressed the need for a cultural change within the RCMP that would encourage members to come forward when dealing with mental health issues.[203]

(ii) Canadian Forces

The *National Defence Act* grants the Minister of Defence authority over the management and direction of the Canadian Forces.[204] The Minister, in turn, has given the Canadian Forces Health Services (CFHS) responsibility for the management and direction of health care delivery to the Canadian Forces.[205] As members of the Canadian Forces receive health care from the federal government, they are also excluded from the *Canada Health Act*.

The Committee heard that CFHS operates as its own health jurisdiction, providing members with health services that include: primary and tertiary care, its own health training, dental service, public and occupational health, pharmaceutical supply systems, health research, and specific health teams to support military operations. These health services are provided by military members of the Canadian Forces, as well as civilian health professionals.[206]

According to officials appearing before the Committee, the CFHS began experiencing severe health personnel shortages in the 1990s.[207] This led to the development of the Rx2000 project in 2000, which aimed to improve recruitment and retention of health professionals in the military through the provision of competitive recruitment incentives, compensation scales, continuing medical education opportunities, and employment opportunities in other work environments.[208]

In addition, Rx2000 introduced primary health care reform into the military, focusing on the development of patient-centered practice, collaborative practice, and continuity in care. The Committee heard that the Canadian Forces' collaborative health care model includes a broad range of health professionals, including: physicians, nurse practitioners, physician assistants, physiotherapists, and clinical and population health specialists. This collaborative health model has also been extended to mental health, where psychologists, psychiatrists, mental health nurses, social workers and pastoral counsellors all work

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202 Ibid, p. 9.

203 Ibid, p. 15.

204 DND, "Canadian Forces Health Services," http://www.forces.gc.ca/health-sante/default-eng.asp.

205 Ibid.

206 House of Commons Standing Committee on Health, *Evidence*, No. 4, 3rd Session, 40th Parliament, March 23, 2010, http://www2.parl.gc.ca/content/hoc/Committee/403/HESA/Evidence/EV4370667/HESAEV04-E.PDF, p. 5.

207 Ibid, p. 5.

208 Ibid.

together to treat the patient.[209] Officials also noted that this health care reform was further facilitated by the development of a health information system, including electronic health records for members of the Canadian Forces.[210]

Despite the success of the Rx2000 initiative, which has resulted in the CFHS meeting most of its health human resource needs, some gaps remain. The Committee heard that the CFHS has difficulty recruiting pharmacists, as there are general shortages in this profession and they demand high salaries. Furthermore, the recruitment of civilian health professionals remains challenging because of the disparities in salaries offered by the public service in comparison with private practice. Consequently, the CFHS is still forced to rely on contracted services, which are able to charge fees that are between 130% and 200% higher than those paid under provincial health care insurance plans.

(iii) Veterans Affairs Canada

In recognition of the service and contributions of former members of the Canadian Forces, the VAC offers certain health insurance benefits and rehabilitation services to veterans to ease their transition into civilian life. These health benefits and services are legislated through the *Canadian Forces Members and Veterans Re-establishment and Compensation Act*, *2005*, which is commonly referred to as "The New Veterans Charter" and regulations under the *Department of Veterans Affairs Act*.[211]

VAC employs various health professionals in different capacities in support of its health insurance benefits and rehabilitation programs.[212] First of all, VAC employs health professionals in order to administer its health benefits and service programs, rather than provide direct health care to its clients. In addition, it employs a broad range of health professionals to provide direct health care delivery to clients receiving treatment and rehabilitation services through the department's operational stress injury clinics and Ste. Anne's Hospital, which it also manages. These health professionals are responsible for providing a wide range of health services, including: addressing veterans' physical, psychological and social needs, providing both palliative care and treatment for dementia, pain management and operational stress injuries.[213] In total, the Department's full complement of health professionals includes 377 nurses, 51 medical officers, and 57 contract occupational therapists.[214] The Department has also established an extensive network of clinical care managers, occupational therapists, psychoeducators, psychiatrists,

209 Ibid, p. 12.

210 Ibid, p. 6.

211 Veterans Affairs Canada, "The New Veterans Charter," http://www.vac-acc.gc.ca/clients/sub.cfm?source=Forces.

212 Veterans Affairs Canada, "Report to the House of Commons Standing Committee on Health," Brief Submitted to the Committee, May 17, 2010.

213 Ibid.

214 Ibid.

psychologists and social workers to provide support and treatment to clients with complex mental health needs.[215]

Though officials from VAC were unable to appear before the Committee, they submitted a written brief outlining their HHR challenges. VAC's statement articulated that the department was facing projected vacancy rates of 25% for nurses and 55% for medical officers by 2014 due to retirements and shortages in the overall health work force across the country.[216] Their brief further outlined HHR challenges specific to the department, including:

- a complicated and protracted staffing process that discourages candidates from applying;
- the perception among physicians that compensation in the federal public service is not on a par with that of the private fee for service structures;
- difficulties finding bilingual health professionals to provide clients with services in their language of choice; and
- the need for stable funding for professional development opportunities.

They further outlined their efforts in addressing these issues. In order to improve their hiring processes, they now contact candidates upon receipt of their applications and as follow up to interviews. They have changed the interview approach and invested in marketing strategies to make health professionals more aware of employment opportunities at VAC. They also offer research opportunities to employees in partnerships with universities, international bodies and the Canadian Institutes of Health Research (CIHR), in the area of military trauma and mental health issues.

(iv) Federal Inmates

In accordance with the *Corrections and Conditional Release Act,* Correctional Service Canada (CSC) is responsible for providing federal inmates with essential health care and reasonable access to non-essential mental health care that will contribute to the inmate's rehabilitation and successful reintegration into the community.[217] As such, federal inmates are also excluded from the *Canada Health Act*, while serving their sentences within federal penitentiaries. CSC aims to provide essential health services that are comparable to provincial and community standards. Health services are provided to federal inmates

215 Ibid.

216 Ibid.

217 CSC, "The Standards for Health Care," www.csc-scc.gc.ca/text/prgrm/fsw/hlthstds/healthstds5-eng.shtml.

through 52 health centres across Canada and four regional hospitals that are managed by CSC's Health Services Sector.[218]

The Sector employs approximately 800 staff in a wide range of health professions, including: nurses, physicians, pharmacists, psychologists, epidemiologists and social workers.[219] However, health service delivery is carried out primarily by nurses with physician services provided on contract.[220] Furthermore, CSC's Health Services Sector represents the largest federal employer of both nurses and psychologists.[221] These health professionals are responsible for providing health care to high risk offenders with complex and diverse health needs that include: mental illness, drug and alcohol addition, anger and violence.[222]

Officials appearing before the Committee indicated that CSC faced numerous HHR challenges, including shortages in particular health professions. The Committee heard that CSC has vacancy rates of 20% in psychology positions, 6% in nursing positions and 11% in social work positions.[223] In addition to the common HHR challenges faced by other federal departments, including the aging workforce and compensation issues, officials indicated that many health professionals were unwilling to work in their health centres in rural and remote areas.[224] Furthermore, as health professionals are regulated provincially, officials indicated that they had difficulties transferring staff between institutions located in different provinces.[225] This represented a particular challenge for the department in relation to nurses and psychologists. Finally, officials articulated that the stress of providing health care to federal offenders with complex physical and mental health care needs also served as a deterrent for the recruitment and retention of health professionals.[226]

The Committee heard that CSC implemented a recruitment and retention strategy in 2008 to address its HHR issues. As a result of this strategy, CSC has produced a series of materials aimed to promote health careers in CSC, as well as published articles in professional journals highlighting the work of their psychologists.[227] In addition, CSC has developed internship and practicum opportunities for physicians, psychologists and other health professionals, which have resulted in positions for some of these individuals.[228]

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218 CSC, "Health Services Sector: Quick Facts," August 2008, http://www.csc-scc.gc.ca/text/pblct/qf/15-eng.pdf.

219 Ibid.

220 House of Commons Standing Committee on Health, *Evidence*, No. 16, 3rd Session, 40th Parliament, May 11, 2010, http://www2.parl.gc.ca/content/hoc/Committee/403/HESA/Evidence/EV4515830/HESAEV16-E.PDF.

221 House of Commons Standing Committee on Health, *Evidence*, No. 16, 3rd Session, 40th Parliament, May 11, 2010, http://www2.parl.gc.ca/content/hoc/Committee/403/HESA/Evidence/EV4515830/HESAEV16-E.PDF.

222 Ibid.

223 Ibid.

224 Ibid.

225 Ibid.

226 Ibid.

227 Ibid.

228 Ibid.

Finally, CSC has also focussed on retention issues by investing $8 million to support the training and development of nurses and providing psychologists with dedicated annual funding for professional development.[229]

(v) Immigrants and Refugees

Citizenship and Immigration Canada (CIC) through its Health Management Branch is responsible for the health aspects of immigration, including the health assessments of those seeking to immigrate to Canada, and the provision of certain health services and benefits to refugee protection claimants. Under section 38(1) of the *Immigration and Refugee Protection Act*, CIC is mandated to assess applicants for permanent and temporary residency according to three grounds for health inadmissibility: danger to public health, danger to public safety and excessive demand on health or social services.[230] It does so by selecting and training medical practitioners, who are based worldwide, to perform international medical examinations, which evaluate the health of potential permanent and temporary residents.[231]

In addition, the Health Management Branch provides health benefits and services to refugee protection claimants, Convention refugees, persons detained for immigration purposes, victims of trafficking in persons and dependents of these groups. This is done on humanitarian grounds through its Interim Federal Health (IFH) Program, which is a health insurance program managed by a third party insurance company.[232] Based upon a 1957 Order in Council, the IFH Program is intended to provide urgent and essential health services to the aforementioned groups, who are unable to pay for such services on their own.[233] IFH benefits include basic health services similar to what is provided to other Canadian citizens and residents through provincial health plans, as well as supplemental health services that are offered to persons on social assistance in varying provinces such as dental care; essential prescription medications; and vision care.[234]

Officials appearing before the Committee articulated that as CIC provided its health services through the IFH Program, its roles and responsibilities were related to the management of this insurance program rather than to health care delivery. As such, they do not have a direct role in issues related to the recruitment and retention of health human resources. However, they indicated that many of the increases in costs associated with the

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229 Ibid.

230 Public Health Agency of Canada, Canadian Lung Association, Canadian Thoracic Society, "Canadian Tuberculosis Standards, 6th Edition," http://www.phac-aspc.gc.ca/tbpc-latb/pubs/pdf/tbstand07_e.pdf, p. 312.

231 Ibid, p. 314.

232 House of Commons Standing Committee on Health, Evidence, No. 16, 3rd Session, 40th Parliament, May 11, 2010, http://www2.parl.gc.ca/content/hoc/Committee/403/HESA/Evidence/EV4515830/HESAEV16-E.PDF.

233 Public Health Agency of Canada, Canadian Lung Association, Canadian Thoracic Society, "Canadian Tuberculosis Standards, 6th Edition," http://www.phac-aspc.gc.ca/tbpc-latb/pubs/pdf/tbstand07_e.pdf, p. 314.

234 Ibid.

IFH Program were related to challenges in health care delivery in provincial and territorial health care systems, including gaining access to health care providers.[235]

(vi) Committee Observations

The Committee believes that the federal government has a leadership role to play in addressing key HHR challenges facing the population groups for which it has direct responsibility. However, the Committee also recognizes that federal government departments and agencies face unique challenges in delivering health care to these population groups, as many have complex health needs particularly in the area of mental health. While the Canadian Forces and Veterans Affairs Canada have established innovative strategies to provide the HHR necessary to treat mental health problems, the Committee also heard that in deployment situations members of the Canadian Forces did not have access to clinical psychologists, only psychiatrists due to the size constraints of deployment forces.[236] In addition, the RCMP has only just begun to develop its own wellness strategy to address the mental health needs of their members. Meanwhile, Correctional Service Canada continues to face difficulties in reducing the vacancy rates for its psychology positions.

The Committee heard that these federal departments and agencies were cooperating in the context of the Federal Health Care Partnership to address common problems related HHR, including: compensation issues and recruitment and retention. The Committee believes that the members of the Federal Health Care Partnership could also work together in this forum to address common HHR issues and share best practices related to the provision of mental health care treatment and supports, including: case management, data collection, the recruitment and retention of mental health professionals, and tools for mental assessment.[237] The Committee therefore recommends:

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235 Ibid.

236 House of Commons Standing Committee on Health, *Evidence*, No. 4, 3rd Session, 40th Parliament, March 23, 2010 2010, http://www2.parl.gc.ca/content/hoc/Committee/403/HESA/Evidence/EV4370667/HESAEV04-E.PDF, p.13

237 In its annual report that was submitted to the Committee, the Federal Healthcare Partnership indicated that it had established a mental health working group to provide a forum for inter-organizational dialogue and information-sharing concerning mental health services, programs and policies. While the mental health working group held several meetings, the report articulated that the working group did not receive enough funding to undertake all of its planned activities. Government of Canada, Federal Healthcare Partnership, "FHS-PFSS Annual Report 2008-2009," p. 18.

Recommendation 21:

That the Federal Health Care Partnership ensure that its Mental Health Working Group has sufficient funds to undertake collaboration in addressing common health human resource issues related to the provision of mental health care treatment and support, including: case management, the recruitment and retention of mental health professionals, and tools for mental health assessment.

Recommendation 22:

That the RCMP continue to enhance the following components of its workplace development and wellness strategy: case management and data collection, training of health care professionals in the experiences of members of the RCMP, development of mental health assessment tools, the recruitment and retention of mental health professionals with expertise in trauma.

CHAPTER 8: HIGHLIGHTING BEST PRACTICES IN RECRUITMENT AND RETENTION IN RURAL AREAS

Introduction

According to 2006 Census data, 20% of the Canadian population lives in rural areas, which are defined by Statistics Canada as including towns and communities with a population of 1,000 or greater that are also outside of areas with more than 400 persons per square kilometer.[238] Studies by CIHI have indicated that populations in rural areas experience on average poorer health outcomes than the rest of the Canadian population, as both women and men living in these areas have lower life expectancy rates and face overall higher mortality risks related to circulatory diseases, injuries and suicide.[239] Researchers link these health outcomes to the fact that rural residents of Canada are more likely to face poorer socio-economic conditions, to have lower educational attainment and exhibit less healthy behaviours related in particular to smoking and eating.[240] In addition, access to health care in rural areas remains a persistent problem, which is due in part to insufficient health professionals located in those areas.[241] In 2004, approximately 16% of family physicians and 2.4% of specialists were located in rural areas and small towns in Canada, while 21.1% of the Canadian population resided in those same areas.[242]

This chapter highlights innovative initiatives currently underway that are aimed at increasing the number of health professionals providing care to Canada's rural populations. It also identifies potential avenues for federal leadership in addressing health human resource issues in rural areas.

Best Practices in the Recruitment and Retention of HHR in Rural Areas

According to witnesses appearing before the Committee, there are three main factors that are most strongly associated with students entering rural practice after education and training: having a rural upbringing; positive clinical and educational experiences at the undergraduate level; and targeted training for rural practice at the

238 Statistics Canada, "Population urban and rural, by province and territory", http://www40.statcan.gc.ca/cbin/fl/cstprintflag.cgi.

239 CIHI, "Canada's Rural Communities: Understanding Rural Health and Its Determinants", 2006, http://secure.cihi.ca/cihiweb/products/rural_canadians_2006_report_e.pdf, p. ii.

240 Ibid. p. v.

241 CIHI, "Geographic Distribution of Physicians in Canada: Beyond How Many and Where", 2005, http://secure.cihi.ca/cihiweb/products/Geographic_Distribution_of_Physicians_FINAL_e.pdf, p.1.

242 Ibid, p. viii.

postgraduate level, including residency programs that prepare medical students to practice in rural areas.[243]

The Committee heard that these three factors were being addressed in Canada through the establishment of medical schools dedicated to practice in rural and remote areas. For example, the Committee heard that the Northern Ontario School of Medicine (NOSM) has developed a model of medical education and health research that aims to prepare graduates to have the knowledge and skills necessary to pursue a medical career in northern Ontario or a similar northern rural, remote, Aboriginal or francophone environment.[244] It does so by focusing on selecting students that have a particular interest in rural medicine, as well as reflect the populations that they will eventually serve. Approximately 90% of the students have grown up in northern Ontario, while between 40 to 50% are from rural and remote areas and 6 to 11% are from Aboriginal communities.[245] The NOSM also offers a curriculum that focuses on rural medicine, interprofessional education, and Aboriginal health. The Committee also heard that the Rural Ontario Medical Program offers targeted training programs in family medicine that are located in rural communities, these programs often result in trainees pursuing their residencies in those same areas in 85% of cases.[246]

In addition to developing innovative education models for rural medicine, witnesses also outlined strategies that would improve the retention of physicians in rural areas. This included providing health professionals with the opportunity to undertake clinical teaching through rural medical schools that keep them engaged in the community.[247] Furthermore, witnesses stressed the need for continuing education and training for rural health professionals either through distance learning programs or facilitating the provision of supports such as locums that enable physicians to travel in order to upgrade their skills.[248]

Finally, witnesses discussed the importance of financial incentives in the recruitment and retention of health professionals in rural areas. Witnesses articulated that financial incentives need to focus on providing higher levels of compensation to rural health professionals because of their broader scopes of practice and higher levels of responsibility, rather than perceptions regarding the possible constraints associated with living in rural and remote areas.[249] Moreover, witnesses articulated that financial incentives should be distributed throughout the careers of health professionals living in those areas, as the provision of large sums at the beginning do not encourage retention over the long

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243 House of Commons Standing Committee on Health, *Evidence*, No. 6, 3rd Session, 40th Parliament, March 30, 2010, http://www2.parl.gc.ca/content/hoc/Committee/403/HESA/Evidence/EV4393630/HESAEV06-E.PDF, p. 1.

244 Ibid.

245 Ibid, p. 2.

246 Ibid, p. 4.

247 Ibid, p. 4.

248 Ibid, p. 7.

249 Ibid, p. 8.

term and create divisions, when established health professionals in the same community do not receive the same levels of financial compensation.[250]

Witnesses highlighted the need for stakeholders to collaborate to promote best practices in the recruitment and retention of health professionals in rural and remote areas, including examining the rural health education models across the country and best practices in other jurisdictions.[251] They articulated that this could best be done through a national conference on rural health funded by the federal government.[252] They further suggested that the findings and recommendations emerging from this conference could then serve as the basis for a pan-Canadian rural health strategy.[253]

Committee Observations

The Committee recognizes that the federal government does not play a direct role in health care delivery in rural and remote areas, except in the case of on reserve First Nations and Inuit communities. However, the Committee supports witnesses in their view that the federal government could support collaboration with interested jurisdictions in the area of rural health and health human resources. The Committee's study revealed that there are excellent health education models that are promoting rural medicine across the country. The Committee also learned that these types of rural health education models serve as concrete examples of some of the recommendations and guidelines on recruitment and retention of rural health professionals that will be presented to the upcoming World Health Assembly held in May, 2010.[254] The Committee therefore recommends:

Recommendation 23:

That Health Canada host a national conference on rural health to bring together stakeholders to discuss best practices and develop recommendations in rural health, education and the recruitment of health human resources.

Recommendation 24:

That Health Canada provide targeted funding to support initiatives aimed at increasing the number of students pursuing careers in rural health, such as: scholarships and bursaries for students of rural background that would like to pursue health careers in rural areas.

250 Ibid.

251 Ibid, p. 4.

252 Ibid.

253 Ibid, p. 13.

254 Ibid, p.6

Recommendation 25:

That the F/P/T Advisory Committee on Health Delivery and Human Resources consider establishing a working group dedicated to examining and responding to best practices in the recruitment and retention of HHR in rural and remote areas, including: the guidelines and recommendations presented by the WHO's expert panel at the World Health Assembly in May 2010.

CHAPTER 9: AN EXAMINATION OF THE UNIQUE HHR NEEDS, CHALLENGES AND INNOVATIONS IN THE NORTH

Introduction

The Committee sought to examine firsthand the unique HHR needs, challenges and innovations in Canada's northern territories through a fact-finding mission to Iqaluit and Rankin Inlet in Nunavut from May 24 to 26, 2009. During the course of its visit, the Committee met with the Government of Nunavut's Health and Social Services (HSS) Department officials, as well as local health professionals during its site visits of local hospitals and community health centers. This chapter highlights the unique HHR challenges related to health care delivery in the North, as well as local solutions developed to meet the health and cultural needs of northern populations.

Health Care Delivery in the North

During its visit to Nunavut, the Committee learned that health care delivery in the North was substantially different than in the rest of Canada. According to Department officials, Nunavut has one full service hospital with surgical facilities, Qikiqtani General Hospital located in Iqaluit and two regional health centers with expanded services and full time family physician coverage located in both Rankin Inlet and Cambridge Bay. Other communities have community health centers that are staffed by nurses who have 24/7 access to physician back-up in Iqaluit. The Committee also heard that two continuing care facilities with 20 beds will also be opening in Nunavut.

The Committee learned that primary care is very different for family physicians and nurses in Nunavut than it is for other regions in Canada. The Committee heard that there are 24 full-time equivalent family physicians or general practitioners in Nunavut, with 14 located in Iqaluit and the others travelling to communities across the territory. Department officials indicated that many of these physicians were working in Nunavut temporarily on locums. Meanwhile, the Committee heard that specialists also come to Nunavut on a short term rotational basis. As a result, primary care in Nunavut is primarily delivered by nurses, while family physicians frequently act as consultants to the nurses. Physicians only take over primary care in difficult cases and provide other services, including obstetrics, anaesthesia and managing patient care.

As a secondary or tertiary care is only available in certain communities in Nunavut, the Committee heard that many people must leave their home communities to receive these services. Consequently, the HSS Department has established three main North-South transportation routes for patients needing secondary or tertiary care outside of Nunavut's three main regions: Qikiqtani Baffin Region (East), Kivalliq Region (Centre) and Kitikmeot Region (West). The Committee heard that Kitikmeot Region sends patients to Yellowknife or Edmonton; patients from the central region travel to Winnipeg; and patients from the Baffin region travel either to Iqaluit or Ottawa for treatment. As a result, medical

travel constitutes a significant portion of the HSS Department's budget: approximately $50 million annually or about 18.5% of the total budget. However, department officials indicated that they expected travel costs to decline with the increased use of telehealth.

HHR Challenges in the North

The Committee heard that Nunavut faced unique challenges in the recruitment and retention of health professionals. During their site visit of the Qikiqtani General Hospital, the Committee learned that the hospital had difficulties recruiting and retaining staff because there was a lack of housing in Iqaluit. The hospital administrator pointed out that with the short building season of approximately four months and the high demand for housing in Iqaluit, very few housing units are available to offer to potential nurses and physicians. The Committee also heard that despite an aggressive recruitment strategy, Nunavut was unable to offer sufficient bonuses and incentives to recruit health professionals to the region. In particular, the hospital administrator indicated that Nunavut was unable to offer sufficient vacation travel allowances, which enable physicians and nurses to travel outside of Nunavut for vacation and continuing education. The Committee also heard that the Qikiqtani General Hospital is currently facing staffing shortages of 40%, while only 54% of nursing positions in Nunavut remain filled.

With respect to the recruitment of physicians, HHS Department officials indicated that licensure requirements were a barrier to practice for physicians from other regions in Canada. However, they noted that the Agreement on Internal Trade was a positive step in harmonizing licensing requirements for physicians across the country. Furthermore, they saw the Mutual Recognition Agreement signed by Ontario and Quebec, allowing for the mutual recognition of physician credentials in both provinces, as a possible solution for Nunavut.

In terms of the recruitment and retention of local populations into the health workforce in Nunavut, the Committee heard that many Inuit students face barriers in pursuing health careers at Nunavut Arctic College. Administrators of Nunavut Arctic College pointed out that very few Inuit students are able to attain their high school diploma, a pre-requisite for entering the nursing program. Moreover, many students face the challenge of studying nursing in their second language of English, rather than their native tongue. Many students at the College are also mature students with competing family obligations. The Committee heard that though the Arctic College was successful in training many nurses despite these barriers, approximately 30% did not remain in Nunavut, but rather sought positions in other parts of Canada.

Administrators at the Qikiqtani General Hospital indicated that the employment of local staff also presented its unique challenges. They articulated that many Inuit staff were reluctant to take on management roles in the hospital because it would venture beyond the scope of practice in which they were trained. Furthermore, they indicated that many were uncomfortable in taking on a role that could require them to reprimand other staff for poor work performance, who could also be fellow community, and possibly family, members.

Finally, Department officials spoke against the recruitment of IEHPs as a possible solution to HHR shortages in the North. The officials indicated that though they had signed a contract for 100 nurses from the Philippines, very few of them passed the exam enabling them to practice in Canada. Moreover, the cultural challenges IEHPs face are significant as they would have to adapt to health care delivery in the North to a very specific population group. Further, the scope of practice required in Nunavut far exceeds the training and capacity of many foreign-trained nurses. Departmental officials emphasized however that those nurses who had overcome these challenges were some of the best nurses in the territory. Department officials therefore recommended that IEHPs should undergo at least one year of training or practice in southern Canada before entering practice in Nunavut.

In order to address some of these challenges, Department officials recommended that federal funding though the Territorial Health System Sustainability Initiative and the Medical Travel Fund be sustained. They further recommended that federal funding to Nunavut take into account the differences between the challenges faced by the Inuit living in the North and First Nations population groups living in the South.

HHR Innovations in the North

Through its various site visits, the Committee learned of various programs and initiatives that have been developed to meet the local population health and cultural needs. The Committee learned about Nunavut Arctic College's mental health councillor program aimed at training students to address the mental health needs of the local population, including addictions, suicide and legacies from residential schools. Students in the program were also mentored by traditional healers to help better integrate them into the community. In addition, Nunavut Arctic College had also developed laddering programs where students learned how to transfer and build upon the health related skills that they had developed in one health profession and apply them to a more advanced health related career. For example, students trained as home care workers were able to build upon their existing training as a launching pad for entering into nursing. The Committee also visited the Rankin Inlet Birthing Program located at the Kivalliq Wellness Centre, which provides family-centered care to pregnant women in the community. The Birthing Program is an initiative of local Inuit women, who wanted to enable women to give birth in their communities with traditional birthing practices. At the Wellness Centre, midwives provide comprehensive pre- and post-natal care along with counselling to women with low risk pregnancies. Delivery is then performed at the Kivalliq Health Centre[255] with the help of the midwives. Staffed by two permanent registered midwives, one casual registered midwife, and one maternity care worker, the Committee was pleased to learn that the program strives to incorporate traditional customs into the birthing practices, including involving fathers and traditional non-registered midwives.

255 The local hospital in Rankin Inlet.

Committee Observations

Through its fact-finding mission, the Committee gained insight into the particular HHR challenges facing Canada's northern populations in the areas of recruitment and retention and health care delivery. The Committee also learned that many of the health challenges in the North, including rising rates of diabetes, obesity, sexually transmitted infections (STIs) were linked to the broad determinants of health, such as poverty, access to healthy food, and loss of identity and culture related issues. These comments suggest that a broad approach towards addressing HHR challenges in the North is necessary, including focusing on health professionals that use preventative approaches and promote mental health and overall wellness, as well as addressing other determinants of health such as poverty. The Committee learned that the health challenges faced by northern populations also needed to be understood as distinct from those of First Nations living in south, as well as other Canadians. This is due in part to geography, which limits access to low cost healthy foods that can lead to poor health outcomes such as diabetes, dental problems and obesity, as well as hinders access to care and treatment for populations living in remote communities. The Committee therefore recommends:

Recommendation 26:

That Health Canada, Indian and Northern Affairs Canada, and the Public Health Agency of Canada utilize health professionals and program officers with expertise in food security and recreation as part of their programming in Nunavut..

Recommendation 27:

That the Government of Canada consider sustaining its funding of the Territorial Health System Sustainability Initiative and the Medical Travel Fund beyond 2012.

Recommendation 28:

That the Government of Canada continue to take into account the differences between the challenges faced by the Inuit living in the North and First nations populations living in the South in its funding decisions.

Recommendation 29:

Over the course of its fact-finding mission in Nunavut, the Committee heard of the difficulties faced by Inuit living in Nunavut in gaining access to spots in provincial faculties of medicine, the Committee therefore would like to bring this to attention of the Association of Faculties of Medicine Canada and requests their feedback on this issue.

CONCLUSION

The Committee learned that many innovative initiatives are underway to address HHR challenges in Canada, including in the areas of interprofessional collaborative practice, health information technology, health education models for rural medicine, and bridging programs for Aboriginal students and IEHPs. It is clear from the Committee's study that thinking boldly and broadly about HHR is necessary to develop local and unique solutions that involve a wide range of health professionals from midwives to health information managers. The Committee learned that these innovative solutions have been made possible by continued collaboration and financial investments made by the federal government and the provincial and territorial governments, which began with the 2003 and 2004 agreements on health care reform. However, it remains clear that sustained results in addressing HHR challenges in Canada requires on-going collaboration between different levels of government, as well as leadership from the federal government in providing sustained and secure funding mechanisms geared towards: primary care reform, increasing the capacity of the health education system to train and integrate internationally educated health professionals, and increasing the number of Aboriginal health human resources. The federal government needs to be more effective in its promotion of collaborative planning in HHR with interested jurisdictions, either through existing mechanisms or the establishment of new ones. Its collaborative planning efforts and funding initiatives furthermore need to be linked with specific targets in order to be able to measure progress. Finally, the federal government also has a role to play in promoting the cultural shift towards IPC by addressing barriers to inter-professional care within its own jurisdiction. Moreover, it must continue to work hard to ensure that the population groups for which it has direct responsibility have access to the health professionals that they need. Without these changes, health care reform in Canada could remain merely a pilot project.

LIST OF RECOMMENDATIONS

Recommendation 1:

That the F/P/T Advisory Committee on Health Care Delivery and Human Resources to consider the feasibility and appropriateness of either expanding its membership to include a wider range of stakeholders and broadening its mandate to allow for the development of an inventory of data and research on best practices in addressing HHR challenges in Canada; or establishing a new arm's length national observatory on health human resources with a broad-based membership that would promote research and data collection on HHR; serve as an effective knowledge translation mechanism; and identify key priorities for future research.

Recommendation 2:

The ACHDHR report on the implementation of A Framework for Collaborative Pan-Canadian Health Human Resources Planning, including progress towards its short, medium and long-term objectives.

Recommendation 3:

Health Canada seriously consider providing funding through its Pan-Canadian Health Human Resource Strategy to enable CIHI to:

- **expand its data collection to include demographic and work information on all categories of health professionals;**
- **repeat national HHR surveys as necessary so that they remain up to date.**

Recommendation 4:

Relevant federal government departments and agencies work closely with CIHI to establish a minimum data set for HHR planning for all federal client groups, including: First Nations and Inuit; RCMP; veterans; members of the Canadian Forces; immigrants and refugees; and federal inmates.

Recommendation 5:

The federal government seriously consider providing CIHR with funding to develop further mechanisms aimed at supporting clinical

research in the area of HHR, recognizing it as a means of attracting and retaining health professionals in Canada.

Recommendation 6:

The federal government continue to provide the Health Council of Canada and CIHR with funding to determine the most appropriate mix of health professionals, both paid and unpaid, for different communities and population groups.

Recommendation 7:

The federal government identify and address systemic barriers to the implementation of interprofessional collaborative practice within its jurisdiction, including its responsibilities as the employer of the federal public service and the health benefits and services it offers to federal client groups, including: First Nations and Inuit; RCMP; veterans; immigrants and refugees; federal inmates; and members of the Canadian Forces.

Recommendation 8:

The federal government consider the possibility of establishing sustained funding mechanisms devoted to promoting interprofessional collaborative practice within the provinces and territories.

Recommendation 9:

That Health Canada continue to provide sustained funding to bridging, adaptation and transitional licence programs for IEHPs, as well as community-based preceptorship programs in which practicing physicians assess and mentor IMGs.

Recommendation 10:

That Health Canada work with relevant stakeholders to ensure that the federally funded bridging programs that offer supervised clinical training over an extended period of time be included as part of the assessment of an IEHP's credentials and training.

Recommendation 11:

That the F/P/T Advisory Committee on Health Delivery and Human Resources consider conducting an in-depth study examining IMG access to postgraduate training positions in Canada, including issues such as: capacity and funding within the medical education system for positions, or alternative supervised clinical placements,

an evaluation of the residency matching system for IMGs, and the position of visa residents within the system; and that the F/P/T Advisory Committee on Health Delivery and Human Resources report the findings of its study on postgraduate training positions for IMGs.

Recommendation 12:

Recognizing the pre-existing cultural competency of Canadian citizens that went abroad to study medicine, that the F/P/T Advisory Committee on Health Delivery and Human Resources work with relevant stakeholders to identify ways to improve the assessment and integration of these IMGs into postgraduate medical training in Canada.

Recommendation 13:

That the Government of Canada establish an initiative to repatriate Canadian physicians practicing abroad; an initiative that would bring back as many as 300 physicians.

Recommendation 14:

That the Government of Canada consider providing targeted funding to the provinces and territories to increase the capacity of medical schools and teaching hospitals to play a constructive role in integrating IMGs and other medical graduates into the health care system.

Recommendation 15:

That the Government of Canada keep its 2008 commitment to fund 50 new residencies per year over four years at a cost of $40 million.

Recommendation 16:

That the Government of Canada consider a requirement that physicians seeking to immigrate to Canada include the results of the MCC Evaluation Exam as part of their immigration application to Canada so that the Government of Canada could use the exam results as part of their criteria in evaluating the candidate.

Recommendation 17:

That Health Canada provide secure and stable funding for Aboriginal Health Human Resources, including support for programs and initiatives such as: bridging, mentoring and outreach programs; scholarships; organizations providing leadership in this area; and

initiatives supporting the recruitment and retention of a broad range of health professionals including: midwives, community health representatives, traditional healers, health promotion experts, and addiction counsellors.

Recommendation 18:

That Health Canada review its project-based funding model under the Aboriginal Health Human Resources Initiative to determine whether it is meeting the needs of stakeholders and on reserve First Nations and Inuit communities.

Recommendation 19:

That Health Canada continue to increase its focus on retention of health professionals in on reserve First Nations and Inuit communities, while respecting the institutions and initiatives already in place; and in particular, addressing issues related to cultural concerns and the pay scale of health professionals in those communities.

Recommendation 20:

That Health Canada consider enhancing its collaboration with Indian and Northern Affairs Canada, other relevant departments, and organizations such as: Indigenous Physicians Association of Canada, the Aboriginal Nurses Association of Canada and the National Aboriginal Health Organization, to promote careers in health sciences at all education levels, including: primary, secondary and post-secondary education.

Recommendation 21:

That the Federal Health Care Partnership ensure that its Mental Health Working Group has sufficient funds to undertake collaboration in addressing common health human resource issues related to the provision of mental health care treatment and support, including: case management, the recruitment and retention of mental health professionals, and tools for mental health assessment.

Recommendation 22:

That the RCMP continue to enhance the following components of its workplace development and wellness strategy: case management and data collection, training of health care professionals in the experiences of members of the RCMP, development of mental health assessment tools, the recruitment and retention of mental health professionals with expertise in trauma.

Recommendation 23:

That Health Canada host a national conference on rural health to bring together stakeholders to discuss best practices and develop recommendations in rural health, education and the recruitment of health human resources.

Recommendation 24:

That Health Canada provide targeted funding to support initiatives aimed at increasing the number of students pursuing careers in rural health, such as: scholarships and bursaries for students of rural background that would like to pursue health careers in rural areas.

Recommendation 25:

That the F/P/T Advisory Committee on Health Delivery and Human Resources consider establishing a working group dedicated to examining and responding to best practices in the recruitment and retention of HHR in rural and remote areas, including: the guidelines and recommendations presented by the WHO's expert panel at the World Health Assembly in May 2010.

Recommendation 26:

That Health Canada, Indian and Northern Affairs Canada, and the Public Health Agency of Canada utilize health professionals and program officers with expertise in food security and recreation as part of their programming in Nunavut.

Recommendation 27:

That the Government of Canada consider sustaining its funding of the Territorial Health System Sustainability Initiative and the Medical Travel Fund beyond 2012.

Recommendation 28:

That the Government of Canada continue to take into account the differences between the challenges faced by the Inuit living in the North and First nations populations living in the South in its funding decisions.

Recommendation 29:

Over the course of its fact-finding mission in Nunavut, the Committee heard of the difficulties faced by Inuit living in Nunavut in gaining access to spots in provincial faculties of medicine, the

Committee therefore would like to bring this to attention of the Association of Faculties of Medicine Canada and requests their feedback on this issue.

APPENDIX A
LIST OF WITNESSES

40th PARLIAMENT, 3rd SESSION

Organizations and Individuals	Date	Meeting
As an individual	2010/03/23	4
Paulette Smith		
Department of National Defence		
H.W. Jung, Director General of Health Services, Commander of the Canadian Forces Health Services Group, Surgeon General and Queens Honorary Physician		
Department of Veterans Affairs		
Janet Bax, Executive Director, Federal Healthcare Partnership Secretariat		
Hilary Flett, Manager, Office of Health Human Resources, Federal Healthcare Partnership Secretariat		
Royal Canadian Mounted Police		
Rich Boughen, Acting Director General, Occupational Health and Safety Branch		
Murray Brown, Staff Relations Representative, Occupational Health & Safety		
Alain Tousignant, Acting Assistant Chief, Human Resources Officer and Chief Learning Officer		
Aboriginal Nurses Association of Canada	2010/03/25	5
Rhonda Goodtrack, Director of Education, Secretary-Treasurer		
Audrey-Claire Lawrence, Executive Director		
First Nations of Quebec and Labrador Health and Social Services Commission		
Michel Deschênes, Policy Analyst		
Isabelle Verret, Program Officer, Aboriginal Health and Human Resources Initiatives		
Indigenous Physicians Association of Canada		
Marcia Anderson, Past President		
National Aboriginal Health Organization		
Valorie Whetung, Director, First Nations Centre		
National Indian & Inuit Community Health Representatives Organization		
Debbie Dedam-Montour, Executive Director		

Organizations and Individuals	Date	Meeting
Northern Ontario School of Medicine	2010/03/30	6
Roger Strasser, Doctor		
Rural Ontario Medical Program		
Michelle Hunter, Manager		
Peter Wells, Executive Director		
Society of Rural Physicians of Canada		
Lee Teperman, Administrative Officer		
John Wootton, President-elect		
Alberta International Medical Graduates Association	2010/04/01	7
Chander Hariramani, Treasurer, Alberta		
Ali Varastehpour, Vice-President, Edmonton		
Canadian Resident Matching Service		
Jim Boone, General Manager and Chief Executive Officer		
Federation of Medical Regulatory Authorities of Canada		
Fleur-Ange Lefebvre, Executive Director and Chief Executive Officer		
J.A. Hildes Northern Medical Unit		
Bruce Martin, Doctor, Faculty of Medicine, University of Manitoba		
Medical Council of Canada		
Ian Bowmer, Executive Director and Chief Executive Officer		
Association of Canadian Academic Healthcare Organizations	2010/05/11	16
Glenn Brimacombe, President and Chief Executive Officer		
Jack Kitts, Chair of the Board, President and Chief Executive Officer of the Ottawa Hospital		
Association of Canadian Community Colleges		
Terry Anne Boyles, Vice-President, Public Affairs		
Rae Gropper, Consultant		
Canadian Association of Occupational Therapists		
Elizabeth Steggles, Assistant Professor, Project Coordinator, School of Rehabilitation Science, McMaster University, Insititute for Applied Health Sciences		

Organizations and Individuals	Date	Meeting
Canadian Public Health Association	2010/05/11	16
Cordell Neudorf, Chair, Board of Directors		
Canadian Society for Medical Laboratory Science		
Christine Nielsen, Executive Director		
Correctional Service Canada		
Fraser Macaulay, Acting Assistant Commissioner, Human Resource Management		
Leslie MacLean, Assistant Commissioner, Health Services		
Department of Citizenship and Immigration		
Lise Scott, Director General, Health Management		
Advisory Committee on Health Delivery and Human Resources	2010/05/13	17
Margo Craig Garrison, Federal Co-Chair		
Joshua Tepper, Provincial Co-Chair		
Department of Health		
Debra Gillis, Director, Primary Health Care, Primary Health Care and Public Health Directorate, First Nations and Inuit Health Branch		
Abby Hoffman, Associate Assistant Deputy Minister, Strategic Policy Branch		
Shelagh Jane Woods, Director General, Primary Health Care and Public Health Directorate, First Nations and Inuit Health Branch		
Statistics Canada		
Gary Catlin, Director General, Health, Justice and Special Surveys Branch		
Jeff Latimer, Director, Health Statistics Division		
Sylvain Tremblay, Senior Analyst, Chief, Canadian Community Health Survey, Health Statistics Division		

APPENDIX B
LIST OF WITNESSES

40th PARLIAMENT, 2nd SESSION

Organizations and Individuals	Date	Meeting
As an individual	2009/04/02	14
Mary Fernando, Physician		
Merrilee Fullerton, Physician		
Peter Kuling, Physician		
Department of Citizenship and Immigration		
Corinne Prince St-Amand, Executive Director, Foreign Credentials Referral Office		
Department of Health		
Kathryn McDade, Director General, Health Care Policy Directorate, Strategic Policy Branch, Advisory Committee on Health Delivery and Human Resources		
Shelagh Jane Woods, Director General, Primary Health Care and Public Health Directorate, First Nations and Inuit Health Branch		
Department of Human Resources and Skills Development		
Brendan Walsh, Manager, Labour Mobility and Immigration Portal		
Carol White, Director General, Labour Market Integration		
Canadian Health Services Research Foundation	2009/04/23	16
Maureen O'Neil, President and Chief Executive Officer		
Canadian Institute for Health Information		
Jean-Marie Berthelot, Vice-President, Programs and Executive Director, Quebec Office		
Francine Anne Roy, Director, Health Resources Information		
Canadian Institutes of Health Research		
Alain Beaudet, President		
Health Council of Canada		
JohnG. Abbott, Chief Executive Officer		
Jeanne Besner, Chair		
Canadian Chiropractic Association	2009/04/28	17
Deborah Kopansky-Giles, Associate Professor, Canadian Memorial Chiropractic College		

Organizations and Individuals	Date	Meeting
Richard Valade, President		
Canadian Federation of Nurses Unions	2009/04/28	17
Linda Silas, President		
Canadian Medical Association		
Owen Adams, Assistant Secretary General, Research, Policy and Ethics Directorate		
Robert Ouellet, President		
Canadian Nurses Association		
Lisa Little, Director, Public Policy		
Kaaren Neufeld, President		
Royal College of Physicians and Surgeons of Canada		
Danielle Fréchette, Director, Health Policy and Governance Support		
Andrew Padmos, Chief Executive Officer		
Department of Citizenship and Immigration Canada	2009/11/02	41
Helga Loechel, Director, Foreign Credentials Referral Office		
Department of Health		
Kathryn McDade, Director General, Health Care Policy, Strategic Policy Directorate		
Department of Human Resources and Skills Development		
Jean-François LaRue, Director General, Labour Market Integration		
Canadian Alliance of Community Health Centre Associations	2009/11/18	44
Jack McCarthy, Chairperson		
College of Family Physicians of Canada		
John Maxted, Associate Executive Director, Health and Public Policy		
Local Health Integration Network		
Gary Switzer, Chief Executive Officer, Erie St.Clair		
Association of Faculties of Medicine of Canada	2009/11/25	46
Nick Busing, President and Chief Executive Officer		
Steve Slade, Vice-President, Research and Analysis		

Organizations and Individuals	Date	Meeting
Canadian Association of Naturopathic Doctors	2009/11/25	46
David Lescheid, Scientific Advisor, Goverment Relations Committee		
Paul Saunders, Vice-Chair, Government Relations Committee		
Canadian Pharmacists Association		
Jeff Poston, Executive Director		
Canadian Physiotherapy Association		
Michael Brennan, Chief Executive Officer		
BIOTECanada	2009/12/07	49
Peter Brenders, President and Chief Executive Officer		
Alberta International Medical Graduates Association	2009/12/09	50
Nicodeme Mugisho-Demu, Vice-President, Calgary		
Canadian Resident Matching Service		
Sandra Banner, Executive Director and Chief Executive Officer		
Federation of Medical Regulatory Authorities of Canada		
Fleur-Ange Lefebvre, Executive Director and Chief Executive Officer		
Medical Council of Canada		
Ian Bowmer, Executive Director and Chief Executive Officer		

APPENDIX C
LIST OF BRIEFS

40th PARLIAMENT, 3rd SESSION

Organizations and Individuals
Aboriginal Nurses Association of Canada
Association for Access to Health Care Services
Canadian Public Health Association
Department of Veterans Affairs
National Indian & Inuit Community Health Representatives Organization
Rural Ontario Medical Program
Society of Rural Physicians of Canada

APPENDIX D
LIST OF BRIEFS

40th PARLIAMENT, 2nd SESSION

Organizations and Individuals
Association of Faculties of Medicine of Canada
Canadian Association of Naturopathic Doctors
Canadian Association of Occupational Therapists
Canadian Chiropractic Association
Canadian Federation of Nurses Unions
Canadian Health Services Research Foundation
Canadian Institute for Health Information
Canadian Medical Association
Canadian Nurses Association
Canadian Pharmacists Association
Canadian Physiotherapy Association
Fernando, Mary
Health Action Lobby (HEAL)
Royal College of Physicians and Surgeons of Canada

REQUEST FOR GOVERNMENT RESPONSE

Pursuant to Standing Order 109, the Committee requests that the government table a comprehensive response to this Report.

A copy of the relevant Minutes of Proceedings for the 40th Parliament, 2nd session (Meetings Nos. 14, 16, 17, 41, 44, 46, 49 and 50) is tabled.

A copy of the relevant Minutes of Proceedings for the 40th Parliament, 3rd session (Meetings Nos. 4, 5, 6, 7, 16, 17, 19, 21 and 25) is tabled.

Respectfully submitted,

Joy Smith, MP

Chair

Ottawa's Incurable Disease: Interference

The Bloc Québécois would like first of all to thank all those individuals and groups from Quebec and Canada who appeared before the Committee with regard to Health Human Resources (HHR). Naturally, the Bloc Québécois questions why such a topic should be considered by the House of Commons.

In its report, the Standing Committee on Health "agreed that the jurisdictional complexities involved in HHR would be respected during the study, including recognition of the fact that the Province of Quebec considers HHR planning as its exclusive provincial responsibility and therefore does not participate in current pan-Canadian initiatives related to HHR." The logical choice would have been to explicitly exclude Quebec from the report's recommendations. Despite all the evidence presented, the federalist parties flatly refused the Bloc Québécois's request to do so.

We must conclude that once again Ottawa is suffering from an incurable disease: interference. There is no denying that the divide between Quebec and the rest of Canada is growing steadily. These two irreconcilable visions are constantly clashing, with Canada seeking to interfere in matters over which it does not have jurisdiction and Quebec having to constantly defend itself against these attacks on its sovereignty. Let us be clear though that health services have always been and remain under Quebec's exclusive jurisdiction, regardless of the specific issue in question.

1. Health human resources: a huge challenge

The members of the Bloc Québécois do of course recognize the challenge posed by the shortage of health human resources (HHR) in Quebec and in Canada. In 2009, in Quebec alone, there were some 5,000 vacancies to be filled[1] in health services, and the needs in this field are growing steadily, especially with the ageing population.

In its report, the Standing Committee on Health suggests measures that the federal government could take with regard to HHR. Apparently the Bloc Québécois has not repeated it often enough that HHR planning falls under Quebec's exclusive jurisdiction. Appearing before the Committee, Joshua Tepper, Provincial Co-chair, Advisory Committee on Health Delivery and Human Resources, noted that Quebec is a "leader[s] in numerous ways in health human resources."[2] Not only has

1 http://www.ledevoir.com/societe/sante/248460/penurie-de-main-d-oeuvre-le-pire-est-a-venir

2 http://www2.parl.gc.ca/HousePublications/Publication.aspx?DocId=4531758&Mode=1&Parl=40&Ses=3&Language=E

Quebec always been excluded from HHR agreements, it has already taken various measures to address the shortage of qualified health workers within its borders.

2. A question of jurisdiction

Let us recall that, in the 2003 First Ministers' Accord on Health Care Renewal, Quebec decided not to participate in developing the Framework for Collaborative Pan-Canadian Health Human Resources Planning, the purpose of which was to determine provincial HHR requirements and to establish the Pan-Canadian Health Human Resource Strategy. This accord led to the adoption of the 10 Year Plan to Strengthen Health Care by federal, provincial and territorial first ministers in September 2004.

For its part, Quebec signed a separate agreement with Canada under this accord to enable it to "exercise its own responsibilities with respect to planning, organizing and managing health services within its territory."[3] Quebec is already meeting its commitments in this regard since a number of cooperation mechanisms are in place, including FPT issue tables, formal and specific agreements and regular and ongoing contact with the provincial governments and the federal government.

In short, it is up to Quebec to establish its own human resources strategies in order to address such issues as wait times and the shortage of qualified health care workers. Quebec is nonetheless open to sharing information and best practices in this regard with other governments, including the Canadian Institute for Health Information.

3. Acting within its jurisdiction

The report of the Standing Committee on Health recognizes the complexity of managing HHR issues in Canada given that Quebec "does not participate in current pan-Canadian initiatives related to HHR." Yet despite the Bloc Québécois's best efforts to reach a compromise, the Committee categorically refused to exclude Quebec from the report, whether with the intent of undermining it or for lack of understanding of the issues. The Bloc Québécois accordingly feels compelled to contest the vast majority of the recommendations that directly interfere in matters under Quebec's jurisdiction.

The Bloc Québécois does of course acknowledge and appreciate the fact that the Committee has given serious considerations to matters under its jurisdiction. Yet it deplores that the Committee has once again deviated from its original mandate for health care, which involves services to such groups as

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3 "Asymetrical Federalism that respects Quebec's Jurisdiction," Health Canada, 15 September 2004, http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/bg-fi_quebec-eng.php

Aboriginal communities, veterans, the military, federally sentenced offenders and the RCMP.

Instead of trying to extend its jurisdiction into matters in which it has no expertise, the federal government should have focused on its own clients such as the First Nations and Inuit, where the HHR shortage is much more acute than in the general population in Canada. The federal government faces major challenges in this regard, as it has a constitutional responsibility for providing health care to these groups.

4. Spending power

The report also refers to the federal government's supposed "spending power" in the section on the federal government's role. The report notes that the federal government may take action with respect to health care by virtue of its constitutional spending power. Yet Quebec has always maintained that this "spending power" does simply not exist and that federal initiatives in areas under Quebec's jurisdiction are unconstitutional. Quebec has always contested this view of federalism. In short, the Bloc Québécois could not leave this reference in the report unchallenged.

5. Process well underway in Quebec

Quebec is already taking its own initiatives and must receive its fair share of the funding earmarked for federal HHR initiatives, in accordance with its constitutional areas of jurisdiction and the 2004 ten-year plan. Here are three examples of measures taken in Quebec in this regard.

i) Recognition of foreign credentials

Appearing before the Committee, Corinne Prince St-Amand, Director General, Foreign Credential Referral Office, Department of Citizenship and Immigration, recalled that "In Canada, the provinces and territories are responsible for assessing and recognizing credentials."[4]

In Quebec, the recognition of physicians' credentials is the exclusive responsibility of the *Collège des médecins du Québec* (CMQ), which applies specific criteria, including competency in French. The federal government simply does not have the authority to overstep Quebec's exclusive jurisdiction in order to change the process for the recognition of the foreign credentials of physicians wishing to practice in Quebec.

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4 http://www2.parl.gc.ca/HousePublications/Publication.aspx?DocId=3806734&Mode=1&Parl=40&Ses=2&Language=E

As to the shortage of physicians, Quebec is in negotiations with Ontario and other provinces and with France regarding workforce mobility. On 17 October 2008, Quebec signed the Quebec-France Understanding on the Mutual Recognition of Professional Qualifications, the first such agreement between Europe and America. Professional bodies in Quebec, in other provinces and in France will have to agree on the recognition of their qualifications, including the requisite postsecondary education and the additional training required for that recognition. These negotiations have so far led to the signing of mutual recognition arrangements (MRAs) for 54 occupations and trades in France and Quebec.[5] These arrangements fall under provincial jurisdiction and the federal government may not interfere in them.

ii) Recruitment for rural and remote areas

The underrepresentation of socioeconomically disadvantaged and rural groups at medical schools is a threat to accessible and quality health care for all Canadians, especially in the regions. The situation is somewhat different in Quebec however, which has frozen tuition fees and taken initiatives to increase the skilled workforce in the regions.

In 2003, for example, the Government of Quebec established a tax credit to recruit young graduates to work in the regions as a way of countering the exodus of young people and the shortage of skilled workers. This tax credit is equivalent to 40% of the salary an eligible young graduate would earn during the first year, up to a maximum of $8,000. This program has been very popular, with some 10,000 people taking advantage of it every year since its inception, the vast majority of whom might not have taken their first job after graduation in the regions had it not been for this Quebec tax incentive.

To continue to attract young workers to the regions, the Bloc Québécois has twice introduced a bill to establish a tax credit for young graduates who work in the regions, based on the model developed in Quebec. Bill C-288 is currently before the Senate. Moreover, to keep medical school accessible to all Quebeckers, the Bloc Québécois reiterates its demand that the federal government transfer to Quebec the $800 million shortfall under the Canada Social Transfer.

iii) Clinical research

Quebec and the provinces of course also have jurisdiction over basic and clinical health research. The Bloc Québécois considers research to be one of the most promising avenues and that it must be supported. It is therefore calling on the federal government to substantially increase research budgets and to transfer them

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5 "Mobilité de la main-d'oeuvre - Le premier *ministre* du Québec et la consule générale de France annoncent la signature de 26 nouveaux ARM entre le Québec et la France," Canada Newswire, 3 June 2010.

to Quebec so it can in turn allocate the funding in accordance with its own policies and terms and conditions.

Appearing before the Committee, even the President of the Canadian Institute for Health Information, Alain Beaudet, maintained that the jurisdiction of Quebec and the provinces must be respected. “If we want to conduct effective clinical research in health services, epidemiology in particular, we have no choice but to work closely with the provinces. […] In Quebec, this would be the Fonds de la recherche en santé du Québec.”6 The Bloc Québécois considers this to be the absolute minimum; the funding invested in research must be transferred to Quebec, with no conditions attached.

In short there are many ways of demonstrating the federal government’s constant interference in an area that is clearly under the jurisdiction of Quebec and the provinces. The Bloc Québécois concludes therefore that the federal government is truly suffering from the incurable disease of interference.

The Bloc Québécois therefore recommends:

- **That if the federal government takes action to address the HHR shortage these actions shall not be binding on Quebec;**

- **That the federal government’s HHR initiatives must give Quebec the right to opt out with full compensation, and without conditions.**

6 http://www2.parl.gc.ca/HousePublications/Publication.aspx?DocId=3810879&Mode=1&Parl=40&Ses=2&Language=E