THE STANDING SENATE COMMITTEE ON SOCIAL AFFAIRS, SCIENCE AND TECHNOLOGY

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UNREVISED EVIDENCE

OTTAWA, Thursday, May 31, 2001
The Standing Senate Committee on Social Affairs, Science and Technology met this day at 11:00 a.m. to examine the state of the health care system in Canada.

Senator Michael Kirby (Chairman) in the Chair.
The Chairman: Senators, I call the meeting to order. In this session we want to try to understand some of the unique problems of providing health care services in rural Canada. Our witnesses today are from the Consortium for Rural Health Research, the Canadian Medical Association, the Society of Rural Physicians of Canada and Health Canada.
We will begin with Dr. Judith Kulig.
Dr. Kulig, may I ask you to just hit the highlights so that we will have time for a discussion. Given the number of hearings we have had, I think you will find that the knowledge base of the committee is pretty good.
Dr. Judith Kulig, Consortium for Rural Health Research: Thank you. It is a challenge to speak of the health of rural Canadians in this country given that we have only recently been able to differentiate more easily between terms such as "rural", "remote" and "isolated". I would also like to caution you about the diversity of our population, given the First Nations and Inuit groups, the multi-cultural groups and the numbers of mainstream Canadian. As well, the adequacy of information on the health status of rural residents is very poor given the number of years that we have had research funding available to us.
In general, we know that in some areas of rural Canada there are shorter life expectancies, higher death rates and higher infant mortality rates. We know that there are high infertility rates in some areas of this country and a disproportionate rate of the young to the old. We also know that the patterns of health of rural Canadians are very much linked to employment within rural Canada. I refer to lung cancer rates, for example, among certain miners and so on.
Environmental health issues are increasingly a concern given practices such as intensive feedlots and their impact on health. I am from the area known as "feedlot alley" within which there is an ongoing study of water quality due to the concerns arising from that.
Unfortunately, reports available to us such as "How Healthy Are Canadians?" and the recent report by CIHI failed consider the health status of rural residents in particular. With regard to the health of rural women, once again reports available to us tend not to analyze health status by gender. However, in Canada, we do have some federally funded centres of excellence in rural health. One of these, the Prairie Women's Health

Centre, has explored health related impacts of the erosion of agriculturally focused support groups in Saskatchewan on farm women. The study confirmed that the farm women support programs have lost funding at both the provincial and federal level. This has meant a decreased opportunity for farm women to voice their concerns and opinions about the stresses of farm life. The women are less able to be involved in policy making, including health policy. In general, they have decreased social support to deal with stressful lives.

The report from the Prairie Women's Health Centre of Excellence emphasized that women are seen as invisible. The centre did a second report analyzing health planning in Manitoba and Saskatchewan to ascertain whether gender was considered in the process. To ensure inclusivity, they looked at health regions that included both northern and southern ends of the provinces, and therefore both urban and rural areas. They found that gender was not considered a variable in developing health plans for those provinces. In fact, there was little sex-segregated data available, in part due to the lack of funds to obtain such databases from Statistics Canada and in part due to provincial health departments not offering to pay for such databases.

In addressing the health of rural residents we have tended not to focus on rural communities as collectives, but this is becoming more interesting to individuals in general. It is certainly theoretically and methodologically difficult to achieve, but there are a number of ongoing projects that do this. The Canadian Federation of Agriculture and the Federation of Canadian Municipalities developed community health for both small and rural communities. The Rural Development Institute at Brandon University is developing rural health indicators that will be used with rural communities to help them assess their communities' health as a collective. Projects such as these add to our understanding of health from a community perspective, but they also raise the expectations of residents that the health system will be able to address health in this new way. Rural residents desire input into the policies and services to ensure that that is the case.

With regard to health service and professionals, we are all aware of the pending shortages of nurses in Canada. We be short approximately 120,000 nurses within the next eight to 10 years. Recruitment and retention of physicians in rural areas has been a longstanding issue. A study by Ng et al looked at the availability of physicians and found that in remote northern communities more than two-thirds of the population lives more than 100 kilometres from a physician. A more recent study done by Pong and Pitblado found that distances to physicians for rural residents are actually increasing. Centralization of health services has led to rural residents driving greater distances to receive care. In Alberta, there is a special program in one of the health authorities called a nurse responder program to deal with this situation. In that program there are four registered nurses -- two each living in two different farming communities -- who received additional emergency preparation to serve in those roles. They also work as nurses at the local public health units. The residents for whom the program was developed are a minimum of 30 minutes away from the nearest ambulance. The home telephone numbers of the nurse responders are provided to the residents. The nurse responders share 24-hour call and are contacted by the families directly for a number of emergencies, including heart attacks. The nurses assess the situation over the phone, advise the caller to call 911 when necessary, go to the home to provide care and wait

for the ambulance to arrive. In this way, the unwell individual gets medical attention sooner and the EMT is assured of knowing which farm to go to.

Recruitment and retention of qualified health professionals continues to be a challenge. We are aware of the medical schools that have responded with the creation of special programs. There is, however, little specific data for registered nurses in similar settings. A recently funded national study will examine the practice of nursing in rural and remote Canada and will provide the most complete information on this topic. This integrated study will include a survey of almost 6,000 rural and remote registered nurses, practice narratives of nurses working in such settings, a secondary analysis of the Registered Nurses Database in terms of rural dimensions and a documentary analysis of reports that impact on the practice of rural and remote nurses. This study will have interim reports available starting this fall.

Tele-health is a very positive part of providing health care to rural residents of our country. One example is the Labrador tele-medicine project which assisted nurses in isolated areas to transmit images to physicians at different locations, thereby decreasing the overall cost to the health system by $20,000 and by $8,000 to patients due to the decreased number of evacuations.

Many gaps remain as research on the topic of rural health and, therefore, information on it are in its infancy. To that end, in 1999 the Rural Health Research Consortium was created to build capacity in research endeavours related to health in rural and remote areas. Some of the activities we have undertaken include developing an inventory of rural health researchers in Canada and identifying the universities in Canada that provide educational preparation for a career in rural health and rural health research. The individuals within the consortium are all involved in research projects that address rural health issues. We are proposing an integrated study entitled "The Canada Rural and Remote Health Study", the ultimate goal of which would be to improve the health of such Canadian. The study would involve researchers who are members of the consortium conducting individual studies in various parts of Canada in order to collect data that would more fully depict the health status, health determinants and health services utilization of rural residents. A second proposed study will also involve the consortium as well as other partners across the country. This study will examine the patterns of health, disease and health service utilization by comparing urban and rural Canada and presenting the information in a user friendly atlas format.

In terms of recommendations, rural health is certainly a complicated issue and I applaud the Honourable Allan Rock for creating the Office of Rural Health. However, not enough rural health professionals and rural residents are aware of its existence. My first recommendation is, therefore, to invest time and effort in rectifying this situation. The Rural and Remote Health Innovations Initiative at both the federal and provincial levels provided funding for a number of interesting rural health projects. My second recommendation is to continue such funding opportunities on a regular basis. Throughout my presentation I noted that there are significant gaps in our understanding of rural health status in Canada. My third recommendation is to further our understanding of the health status of rural women, men and communities through strategic calls for research.

A notation was made of the efforts of the Rural Health Research Consortium and our attempts to seek funding for studies on the health of rural and remote residents. My

fourth recommendation is to further reinforce to the CIHR the importance of funding projects that also address the health of rural residents.

At this time the political will is very strong to address the health needs of rural residents. Given that I do research with rural residents on a regular basis, their renewed interest and hope in rural life means that they are more than willing to act as partners with you.

Mr. William Tholl, Secretary General and Chief Executive Officer, Canadian Medical Association: I will get immediately to the heart of our brief and focus on essentially two elements. The Canadian Medical Association has done two studies about physicians who have worked or are working in rural and remote areas and in particular what factors influenced their decisions to locate in rural and remote areas and their decisions to stay or leave. The first study was done about 10 years ago. It was headed by a physician from Newfoundland and former Associate Dean of Memorial University, Dr. Harry Edstrom. I will summarize some of the early findings from that first survey and then supplement that with a survey that the CMA did in 2000.

We will then be en route to the second focus, which is a set of five specific recommendations that we have for the consideration of this committee. After that, I would be happy to answer any questions.

With that as the objective, I will begin by making observations according to the 1991 survey. I believe, Mr. Chairman, that that is attached to the more detailed brief if committee members wish to follow the bar charts there. We essentially took 500 doctors whom between 1986 and 1990 left rural and remote areas, defined to be populations centres of 10,000 or less. We randomly digitized them, did not hurt a bit, to determine some of the factors and characteristic that might have been important in terms of decisions to leave. We also interviewed 500 physicians who stayed in those areas between 1986 and 1990.

We asked both groups a series of questions about what was important in terms of their initial decision to locate in the rural and remote parts of Canada. The answers were fairly interesting. They are summarized for you in the first of the bar charts. Committee members will be interested to know it was personal factors. A desire to locate their practice in a rural or remote area was factor number one, 53 per cent. Spousal considerations, children, recreation, community size were popular reasons. Notice where financial incentives are in terms of initial decisions to locate in rural and remote locations. IT ranks seventh down the list.

If you flip over to the next chart, when asked about importance of selected professional considerations and decision to move, work hours, professional back-up, additional training, speciality support services, are listed. Again, earning potential ranked well down the list in terms of decisions of a professional nature in terms of why one would want to locate in a rural and remote practice.

Moving to the third item, if you asked those 500 doctors who chose to move from a rural or remote area to a more urban area, the factors that were considered most important were children's education, recreation, spouse's job opportunities, cultural opportunities and decision to retire. Interestingly, if ask those 500 physicians who left rural or remote areas what factors or things would have been prompted them to maybe stay, the list includes additional colleagues, parenthetically professional burnout, and locus tenets, parenthetically professional burn out were amongst the most common factors.

Opportunities for group practice, not wanting to work on their own, and, access to speciality services are aspects that seem to run throughout. I think that other witnesses will get into those items. There are some interests new ways one might address some of that in a virtual sense through telemedicine and other means.
Alternative compensation, notice that is not level of compensation, but alternatives to compensation was a factor for leaving rural or remote areas. I will come back to that as well.
There are some interesting lessons Mr. Chairman, to learn from asking physicians why they left and why they stayed. In summary, many of the instrumentations that have been used provincially are largely to do with financial sticks and carrots. They do not have much to do with some these other major aspects of the decision to leave or to stay.
The more recent survey, which we can make available in detail to committee members, the 2000 survey did not get into the detail and did not do the kind of stratification that I am describing. It is my intent, the CMA's intent, to do that again because it would be useful. The survey that we did most recently used this series of questions to track over time. We found that, basically in a nutshell, personal factors, those things that were important for physicians in terms of moving to rural and remote areas have not changed much and remain relatively high as personal decision factors over time.
Professional burnout, limited access to collegial support and feelings of concern with respect to access to speciality care and services have become profoundly less satisfactory over the last 10 years. Again, driving home this point, I think, that we need to look well beyond the financial instrumentation to find how to address some of these problems.
That leads me to the second to last set of comments I would like to make. There is an interesting study to which I am sure the committee has already been referred in terms. It is the Baer, Wood and Snider study of May 1999 from Centre for Health Services and Policy Research by someone who seems to have an omnipresent role to play in matters related to physician planning and management, Dr. Morris Baer. He is now the scientific director for the Institute for Health Services and Policy Research within the CIHR complex. Dr. Baer seems to be a part of this continuum about which we are talking.
I would like to quote from the report that he and his colleagues did. The quote is from page 40. It helps to provide the context for our five recommendations. It states:
While all regions of the country have some policies in place intended to improve access to medical services in rural and remote areas, there appears to be virtually nothing of a pan-Canadian nature in place. This is undoubtedly in large measure due to the fact that health is constitutionally a provincial-territorial matter. As a result, there are relatively few policies levers held at the federal level.
I will shortly articulate five of those areas, including immigration policy.
Less immediately explicable is the vacuum in national, in contra-distinction to federal policy. There are some processes in place, and some have been in place for decades. From my time at Health Canada, I can tell you that they have been around for many decades. All jurisdictions share approaches and policy ideas through forums such as the federal-provincial/territorial advisory committee on human health resources and the NCCPMT, that is the National Coordinating Committee on Post MD Training. Sadly,

any cross-national ideas emerging from these deliberations must return home to face the realities of limited policy levers, the local political music or both. More often than not, they get drowned out. Despite best efforts and despite the existence of all these tables, the reality is that the decisions are taken at different places.

We may want to discuss the challenges of post MD training, as it is important to the whole matter of rural and remote practice. The NCCPMT, with which I have been involved in the past, has been a singular failure precisely because the decisions are taken at a different table.

In sum, Baer and colleagues are attempting to say that we have a vacuum with respect to national planning. That vacuum needs to be filled. CMA does not think that we can continue to look simply to the provinces to solve the problem independently.

That leads me to five areas that we would like to suggest deserve further consideration in terms of the federal leadership role in this arena. I begin by commending, as did my colleague, the efforts of the all and Minister Rock in establishing the office of rural and remote services. However, we think that that is necessary but not sufficient. We need to go beyond that. We would like to see more dedicated resources. We would like more access within and the be taken more seriously by the bureaucracy of Health Canada relating to the initiatives on the human resources development areas in terms of sector studies.

In particular, speaking to the second of our five points, we would like to see an important clearinghouse role for all this information. All of the studies that will hear about today should be in one place and someone should be looking at them in a sensible way and transmit key learning.

The federal government has a constitutional responsibility in the area of rural and remote service. It is there; it has been there since forever. It is particularly germane with respect to Aboriginal peoples. There are some valuable lessons again from an evaluation points of view to be learned. For example, there is important work that is done between physicians and outpost nurses that deserves ongoing and closer examination in our view.

There is the entire are of immigration. In order to meet the short term health care needs of Canadians, through C-11, the federal government is moving to develop an immigration policy that is friendly towards qualified international medical graduates. It is important as we look to meet short-term needs in places like my home province, Saskatchewan, that we ensure that the immigration policies as they unfold in the wake Bill C-11 do not throw the baby out with the bath water.

We need to continue to ensure that the accreditation standards for people who wish to apply to come into Canada and want to be physicians that, on the one hand, we do not give them false expectations. They may be accredited in some other country but may have difficulty meeting our accreditation standards. That is the one side of the equation. The flip side is to ensure that when folks come to practise in rural and remote Saskatchewan that, again, they are not led to false hopes about easy access or entry to other parts of Canada. I believe that is all in the context of the regulatory provisions pursuant to Bill C-11. All of that is in the context of an overall policy of self-sufficiency for Canada.

In relation to planning, there is no question that Canada needs a national health human resources plan. I have spoken to the issue about what stands in the way. I would

advise that you look strictly at federal-provincial advisory committee structure to do that. We believe that there needs to be an overarching approach and we believe that rural and remote health has an important role to play as part of that overall national planning effort.

Again, we think that the Office of Rural Health needs to be given the adequate support and funding to carry out a comprehensive workforce needs assessment for rural and remote services. We see that being done, in part, through the sector studies that are currently being funded through Human Health Resources Development Canada. Parenthetically, Mr. Chairman, it is interesting to observe that much of this planning activity is being funded through human resources -- the HRDV side of the equation -- in a very interesting juxtaposition relative to the Minister of Health, who is responsible for such things. That is to say there are many challenges in terms of creating a bridge between HRDC and Health Canada.

Finally, there is the subject of funding. We believe that there are at least two precedents that this committee might want to take into account as one looks prospectively into what to do in this arena. The first is the 1966 Health Resources Fund Act. When we introduced Medicare there was a similar concern about getting physicians in the right places doing the right things with the right tools. The response back then was to create a $500 million, five-year program to create four new medical schools, create training programs, increase capacity and increase the capacity to learn. We believe we are at that same point now in our history and we need to take a strong look at what can be done along a similar line to address the large and growing issues relating to rural and remote practice in this country.

The second precedent is, if it is true to say that there is a federal role to realize national policy objectives with respect to bilingual access available on uniform terms and conditions pursuant to the Canada Health Act, with respect to the two official languages of this country, therefore, the federal role in supporting the University of Ottawa as the only bilingual university in this country. We believe there is a similar strong federal role to play with respect to the achieving the objective of uniform terms and conditions of access throughout Canada, and that there are a variety of means that might be used to achieve that. However, in the context of the whole discussion in Ontario about what yesterday was referred to affectionately as the seventeenth university, “Thunder-Barrie Medical School,” what can we learn in the context of the whole deliberations there. We just met yesterday with the deans of this country to look at how that could transcend Ontario and be instructive nationally. The idea that came out of that discussion was a challenge role for the federal government, where we go 50-50 funding with provincial governments through medical schools to encourage some kind of improved standards of training and retraining in all 16 of Canada's medical schools by building on the experience in Ontario.

I trust that was useful to the committee. I would be pleased to answer your questions.

Dr. Peter Hutten-Czapski, President, Society of Rural Physicians of Canada: Honourable senators, I would like to thank you for asking the Society of Rural Physicians of Canada to present on the state of rural health care. I will start with the principle of fundamental justice expressed by Emmet Hall.

Every citizen in Canada should have equal access to health care regardless of where they live.

This is quite a monumental challenge. Rural Canada is 9 million people and growing, scattered over 10 million square kilometres. The number of physicians serving this population is proportionately under half of that serving those in the cities. When you allow for the additional 348 medical school seats announced subsequent to 1999, including the rural medical school in Northern Ontario, absolute urban doctor numbers are predicted to increase but rural doctor numbers will continue to drop, so the gap between urban and rural grows.

One of the reasons, even with an adequate number of doctor trainees there will be a decreased access to rural doctors, is that the current educational system produces rural doctors by accident and not by design. Barer and Stoddart pointed out, regarding educational strategies, only a fraction of that which could be done in this area is currently being done, and why should we expect it to change by itself.

Another systemic trend is the increasing centralization of hospital services. People must understand that if rural people are forced to travel for care, some will not travel. If they do not travel, they cannot achieve the health outcomes of people who are able or willing to travel. Some will travel, but the delay caused by the travelling or the need to travel will cost them. Others will be subject to the hazards of transport or inclement weather. Collectively forcing people to travel long distances for health care, even to a centre of the highest standards, will adversely affect health outcomes.

This is particularly concerning for women's health. Studies show that women do poorly if they must travel long distance to birth. In Saskatchewan, it should be noted that the 1993 closure of 53 rural hospitals was followed by an increase in its parinatal mortality rate. We cannot say that these things are causal, but it is certainly concerning.

The Quebec Health Survey found that there is a trend towards a progressive deterioration in health as one moves from an area bordering urban centres into the very remote hinterland. As in the brief before you, geographically based variation of life expectancy in Canada is quite apparent. This illustrates the principle of inverted pyramids of care. Doctors are concentrated where the most healthy people in this country live, and the sickest populations have the least access to health care, so the gap between urban and rural grows.

You can be tempted to supplement physicians with technology, and there is potential here for sure, particularly in those disciplines where the physician does not need to touch the patient: Tele-radiology, tele-psychiatry and tele-dermatology. While there is a huge potential here, we must avoid these cyber snake oil salesmen selling to rural Canada what we do not want or we cannot use.

The table in my brief shows a number and variety of provincial rural incentive programs that were probably inaugurated with the Ontario Underserviced Areas Program of 1969. This does not describe the actual programs, it just mentions the date of introduction of the first program in each particular category. You will see the vast majority of dates in this table are in the last five years. To be fair, many doctors do come to rural communities as a result of these incentive programs. The problem is that doctors are not staying. In the smaller communities, doctor turnover is so fast that most cancer patients outlive the tenure of their physician. The gap between urban and rural grows.

The fundamental issue was expressed by David Fletcher, Inaugural President of the Society of Rural Physicians of Canada, when he said, "We have to make rural health care a job doctors want to do." Lucre alone, without dealing with working conditions, will

not be enough. The question arises: what does work? There are some things that do work.

Australia is a country that is roughly two-thirds the size of Canada and has the same kind of high urbanization with a small population scattered literally across millions of square kilometres of land that they are having difficulty servicing. I am not saying that they have it right; they have a rural / urban gap, but it is shrinking.

This is probably by virtue of a couple of things. One, they have a rural infrastructure driven by the federal government that has placed into every medical school in the country a rural medical curricular reform. They have thrown in a judicious number of incentives for the field, but it is a combination of educational reform and incentive.

In rural Canada, there are some models scattered throughout the country, where things seem to work. In Newfoundland, most rural doctors are salaried or on contract. In fact, most contract and salaried physicians are in rural Canada. Is this important? Am I advocating for salaries? I am not really as much advocating for salaries, as I am pointing out that when you write a contract, you make an explicit agreement as to the working conditions. This is rather attractive. As mentioned in the CMA talk, working conditions are among the first six most important issue on the doctor's mind when considering whether to locate in one community or another. Furthermore, contract or salaried positions aid in integrating allied health professionals into the existing health care teams.

That brings us to the question of what the feds can do. The short answer is: nothing; that is easy. The problem is not new, and the proposed solutions are not new, either. The challenge is to move forward from point A to point B. There is no mechanism in place within the federal government to achieve the desired state from the present state. Hence, the gap between urban and rural grows.

I am not here to ask for something simple like money and a program, although both will be needed. That is not the first step. The first step includes changes to empower the bureaucracy to allow the federal government to help the growth from the present state to the desired state.

To make the government responsive, we need to build structures that focus on rural -- structures that have rural as their only mission, and nothing else to detract them from that mission. Those structures will work with the ministers and the rural and health constituencies to make things happen. Provinces cannot do it alone.

This is an opportunity for a novel, non-coercive federal-provincial approach, in which a cooperative synergy will be available to make things work. Right now, we have provinces that are spending a great deal of time and money to bribe one physician into moving from one province to another. That is currently being done, and it is not working.

We recommend that the federal government, in cooperation with the provinces, reduce the structural barriers to a national rural health policy advancement, and that they form a national rural health strategy, NRHS, that can be implemented. We recommend that this NRHS be empowered by an advisory committee on rural health, by ministerial counsel and by a rural medical forum. The initial priorities should be to aid the provinces in accelerating the expansion of existing, successful, rural collaborative models, including those that rely on non-physician health professionals to provide care. The initial priorities should also include the facility to support initiatives that promote the

retention of health professionals. They should ensure appropriate work conditions, education of an adequate workforce for rural health care and funding to universities to develop plans to become more rural-oriented in admissions policy. They should support initiatives to develop empowering rural health professional training curricula. Furthermore, there should be incentive planning funding for the universities, as they implement these plans. The initiatives should facilitate Canadian medical licensing standard and training bodies to develop and implement rural-friendly policies.

We suggest that federal funding for telehealth be contingent on tailoring programs by local rural analysis of health care needs, amenable to telehealth support, and that rural health delivery research be adequately funded.

The Chairman: Our next witness is Dr. John Wootton.

Dr. John Wootton, Special Advisor on Rural Health, Population and Public Health Branch, Health Canada: Thank you. For the last two and one half years I have been the First Executive Director of the Office of Rural Health in Health Canada. I have had a certain amount of time to consider these issues and to consider where the issues come from. I know that many of them come from a background that I share -- Dr. Hutten-Czapski and others -- in providing service in rural Canada.

As I fulfilled the functions of the office of rural health, I had opportunities to travel across the country. I learned that in many areas, although we can neatly summarize the statistics about the rural population as 30 per cent of the population, underneath the statistics is the reality that there are many different kinds of rural communities. They are as different as night and day -- remote and peri-urban. The solutions that are appropriate to those different kinds of environments must come from those environments. The first lesson that I learned from this statistic was that one of the roles of the office of rural health had to be that of a conduit between those different environments and the various levels at which decisions and ideas could be implemented. There was not an opportunity, from the top down, to provide a solution that was satisfactory everywhere.

As I travelled, I was also able to reflect back on the people that I met at many different levels. As Dr. Hutten-Czapski mentioned, the reality is that these are not new issues. When I began my practice 20 years ago in Ocean Falls, on the coast of British Columbia, I quickly realized what it meant to deliver services a long distance from "the mother ship."

It is only in recent times that those stories and those messages have, in fact been, been able to find a broad audience. It is particularly important that a number of different committees of the Senate are interested enough in this issue to invite witnesses on rural health services and rural health issues.

One of the things that has allowed that is, obviously, the improved communications between communities, providers and planners. To some extent, the "genie is out of the bottle." If I jump ahead to some of the recommendations, the issue really is about what to do with the genie now that we have recognized that, across the country, there is this common issue.

At the same time that communications are improving, technologies are also improving. Technologies are a double-edged sword: on the one hand they allow you to do things differently, and on the other hand they put an increased load on local systems. Both of those are probably good things, but they have to be planned for.

In the room with me is my colleague from the CHIP program at Health Canada, which has funded many of these technological solutions. Many of those technologies allow the avoidance of the geographical reality that necessitates travel for people to access health care. Those individuals and the health care workers who provide the service are able to remain in the local community and many things happen that do not have a technological solution. In some sense, they actually increase the level of resources required and the level of expertise required. That must be planned for, because it is an issue of quality of care as opposed to substitution of care.

That is occurring at the same time as communications are improving. People look at other communities of similar size and wonder why one community is organized in such a way and another community is organized in a different way.

Two years in government is a relatively short time, I learned. Nonetheless, I think that Health Canada did take a lead in establishing an office of rural health, in recognizing the need to apply a rural lens to its programs, and in recognizing that functioning in a horizontal manner, whether it be with HRDC or with Agriculture Canada, was a valuable and valid way to bring a number of perspectives into the search for a solution.

As I mentioned in the brief and in my presentation, the first go around included $11 million in grants and contributions, from which many of the projects that you will hear about, and that are mentioned in the brief, have been funded. One of the things that I heard clearly from rural communities, as I travelled during my time in the office, was that one-off solutions did not work, no matter how good the project was. Rural communities were looking for a long-term commitment to their issues, and they recognized that it would take time to move things in the right direction.

The office of rural health is not the only area where some of this activity is working. It has been found that some completed programs, particularly the health transition fund, that, when their activity is analyzed, a tremendous amount of rural programming is emerging. Some of the lessons learned from that program will be useful in designing future ones. That simply speaks to the fact that these issues have been present and, clearly, if you are to consider transition within the system, the rural issue bubbles to the surface.

Within the current structure of Health Canada, the office of health and the information highway, and the excellent report that their advisory committee produced, also made the point that if technology were not at the service of rural and remote regions, Health Canada would be missing the boat. With the CHIP funding that was announced, a large number of rural projects have been supported.

I support the other witnesses in respect of some of the recommendations that I would like to present. We find that there are jurisdictional challenges in Canada when we review the health care system, as a whole. That is the deck that we have been dealt. It is not, in fact, an insurmountable barrier. It has more to do with learning how to be helpful, than it has to do with wresting jurisdiction from one group to another.

I am hopeful that Health Canada will consider the continuation of cycles of support for rural initiatives and that it does so in a collaborative manner, recognizing that some of the answers will not be found within the department. Rather, the answers will be found by reaching out broadly to the communities, to the professionals who work in the communities and to the associations that represent them. In that way, they will take hold of the hand of experience that will give validity to the choices that they make.

Within the structures that Health Canada deals with more directly, particularly in the health information and research areas, it is important that we recognize what we do not know so that we are able to pursue answers to those questions in an organized way. There are technological tools that should be applied to rural problems. Health Canada has an important role in continuing to support these.

The Chairman: Thank you.

Senator LeBreton: Mr. Tholl, figure 4 of your presentation shows the survey of physicians moving from rural to urban areas between 1986 and 1990. You talked about alternative compensation and I believe that you said you would come back to it. I circled it because I would like to know what it means. Of the people who reported, 35 per cent talked about alternative compensation. What is the definition of that, Mr. Tholl?

Mr. Tholl: I apologize for not coming back to it. It was mentioned that the majority, to the degree that we have salaried physicians in Canada, is still about 30 per cent. However, it is growing and most of those are in rural and remote practices. In Newfoundland it is well over 50 per cent now.

Regarding alternative compensation mechanisms, we have more details of that in the brief, which contains a complete policy statement, that should answer your question. Essentially, it means that we can look at what physicians are expected to perform in the system and then look at customizing the methods of payment, through combinations of salary capitation and fee for service. Too often we see those as alternatives to one another, rather than see them as ways in which a basic salary could be topped up as work loads increase, for example.

Alternative compensation mechanisms refer to salary capitation, where you pay physicians on a per-patient basis, usually adjusted for age and sex. The CMA would suggest, and I would also suggest, that the form of payment should follow the functions that you identify for the physician in the system. Clearly, physicians and other health professionals working in rural and remote areas have a different functions in the system as compared to those that work in downtown Toronto.

Senator LeBreton: I will read the brief in more detail.

Dr. Kulig, with regard to the office of rural health that Dr. Wootton represents, what is your experience? Are there areas in the mandate of this organization that you find particularly strong? Conversely, are there areas where you would like to see improvement vis-à-vis your relationship with Health Canada?

Dr. Kulig: I came to know Dr. Wootton when he became the Executive Director. He came up to the University of Lethbridge as a guest where we hosted meetings with community and agency individuals about rural health. I have known him through the Rural Health Research Consortium. I am currently on a sabbatical, and I have spent time at the Office of Nursing Policy, as well as the Office of Rural Health. That has been my involvement.

Senator LeBreton: Would you like the mandate to be expanded? What are the strengths and areas where you would like to see improvements?

Dr. Kulig: I would like to see the mandate expanded. Certainly workforce issues have absorbed a great deal of the time and effort of the office, which is appropriate.

They are involved in the variety of other committees, and they also supported us in terms of trying to advocate for more dollars at the federal level for rural health research, but I would see a greater expansion federally and then to have equivalence, perhaps

even provincially, to look at these issues.

Dr. Hutten-Czapski: I have seen Dr. Wootton. He usually comes to large conferences or gatherings that have the words rural and health in their name at the same time. This is one of them, and I am not surprised to see him at the table.

He has been playing a very important role. He has been personifying the office -- it is not just him, of course -- and raising the stature of rural, letting people increase their awareness, or as the minister would prefer to put it, putting a rural lens to the issues. He and the office have been particularly successful at making the bureaucrats and the politicians rurally aware. Certainly, my meetings with Minister Rock have indicated that he is well aware of the issues and the lay of the land and is sensitive to that. That sensitivity is now available and present in Ottawa partly because of his willingness to become more aware by setting up the Office of Rural Health and also through the Office of Rural Health. Unfortunately, the limitation of the office is that it cannot do any policy work. It is not designed to do policy work. They do not want the office to do policy work, and if it tries, I am sure it is told. We have an awareness building system that has worked quite well, but now what happens? This issue could stand to be addressed if the government so chooses, but how to get from the present state to the desired state? They cannot do it.

For those reasons I would suggest that a ministerial council be set up with community and rural health professional input. The office of rural health could serve in some ways as a secretariat without having a policy role, but it would be able to help implement and develop policy by giving the feedback and support necessary for the committee.

Senator LeBreton: I was struck by your brief, Dr. Kulig, in particular when you described one health authority in Alberta developing a nurse responder program, and then you gave details about how they interact. That would be an outstanding program to expand. When you have a program like that and you see it is working, where does it go from here? Do you do it through Health Canada? What is the success rate of it? Is it only in one jurisdiction, or is Alberta looking at expanding it to other jurisdictions? How do you get it into the rest of the country?

Dr. Kulig: It began in an area that had hospital closures. When we think about isolation, we often think of the north. We forget about the farming areas of southern Alberta that are a long way from hospitals. Therefore, this health authority developed it on their own. The person who was going to get back to me about it was not able to. I know the people who run the program are the nurse responders, and from their perspective it has been very successful.

My understanding is in Alberta the CEOs for the health authorities all get together and discuss it, so if it went provincial, it would happen in that way. It would be discussed at the CEO level. Then health authorities would adopt it. It has real potential for doing an evaluation, through funding from the Alberta Heritage Foundation, to look at how it is working there. One could even do a comparison as we did in parts of Saskatchewan, because there are similarities and differences between the two provinces, to see if it would work there.

It also is on the border of looking at this notion of nurse practitioners. That is one phrase that has not been mentioned by the other witnesses thus far, but I think our study on national nursing will also look at this notion of nurse practitioners and the meaningfulness of that potential role for rural areas. The reality is some rural

communities are not going to be able to maintain physicians. As much as we want to do recruitment and retention, it will not work. These alternative programs are there, and, again, we want to make sure they are working provincially in different provinces. Then we can begin to look at them from the federal level, or, at least, look at them in terms of choosing certain areas across the country that have the same kind of distance issues of Alberta and see how they work out.

Senator LeBreton: When you have a program like that and the potential for connecting into tele-health, one of the frustrations is hearing about these isolated programs and wondering how they will be pulled together for the benefit of the whole country.

Dr. Kulig: I mentioned it because I came across it while doing one of my studies in rural areas. I spent much of my time driving through southern Alberta and came across these nurse responders. It is not my health authority. It is another one. However, I was not aware of the program, and I am a nursing instructor, so I was quite surprised that I did not even know it existed.

Senator Fairbairn: I certainly thank you all for coming, and a special welcome to Dr. Kulig, who is associated with my favourite institution, the university.

All these presentations are incredibly gripping and useful. I would ask you all to comment on this question, and I go back to a quotation that I picked up in one of our documents. Presumably, it was from Dr. Wootton, who stated at one point that if there is two-tiered medicine in Canada, it is not rich and poor. It is urban and rural. Senator LeBreton is on the Agriculture Committee with me, and we have just had two and a half hours this morning on a study of the whole system of rural Canada and agriculture. One of the issues that struck me from that particular perspective is the depressing decline in rural Canada. It is something which the rest of Canada is not really aware of. Therefore, it can be assumed, certainly by people in rural Canada, that the rest of the country does not care a lot about it. If we are in a crisis, as some would call it, with respect to the sustainability of rural communities, and then consider the issue of health care in rural communities, it is an incredible challenge to even contemplate how services and people are going to be encouraged. It is admirable to see in these graphs that the financial aspect is at the bottom, at the beginning, when physicians are thinking about it.

However, when you get to the more recent ones, are those physicians and people who are working on the ground in rural communities becoming discouraged by the notion that these communities are at risk, and that the whole effort through the education system and other incentives is to bring people into the rural communities whose sustainability is considered, across the West, at least, at risk? Is that situation impeding the ability to develop the health services that you are talking about? To what degree, then, does a ferocious, cooperative communications strategy become necessary to persuade the rest of Canada that this is not only a huge geographical part of the country, but is also, historically and almost in our soul, still a foundation for what Canada is all about?

It is sitting there being either misunderstood or ignored. How does one persuade physicians and nurse practitioners -- the whole bunch -- to turn in that direction when the signals coming out of that direction are somewhat negative, if not confused?

Dr. Kulig: One of the studies I am now doing is about the creation of hope in rural

communities with health professionals and community members working together. Despite the decline in the issues of sustainability in rural communities, what I have been struck by is the grassroots movement, certainly in southern Alberta, of people who want rural communities to survive. As an example, I have met the women who stopped the hog plant operation that was to be moved to Foremost. Two women stopped a $98 million company from moving in.

When you meet those kind of individuals, you know that the potential is very much there to create sustainability in rural communities. Studies have shown that we need investment in local leadership and in rural youth to create those leadership opportunities. We need to look at a diverse economic base and other ways of farming. I know that in Saskatchewan, for example, there are some farmers who have given up their own individual equipment. They have bought equipment with other farms to farm much larger tracts of land together. They share the profits and the risks together as a way of surviving.

Those are all the issues we need address, simultaneously with looking at health services. There are certain issues that are important to all Canadians no matter where they live. One is water quality.

Senator, you are well aware of what is happening in southern Alberta in terms of feedlots. I live in a province that has agreed to triple corporate farming by 2003. However, there are communities that are developing bylaws to prevent intensive livestock from moving into their area. They do this to prevent the health issues about which we are aware.

You are right. There are many challenges ahead. In some ways people feel like we are beating the wrong drum as they ask if it will survive anyway. I think there are ways of creating local leadership, dealing with issues for rural youth and addressing women's health. I mentioned already the erosion of farm support programs for women in Saskatchewan. There is notion of having that kind of support available to them is important, as well as looking at nurse responder programs and everything simultaneously. It is important that we look not just at health but at rural sustainability at the same time. Honestly, I have seen a great deal of hope in people despite the issues they are dealing with.

Dr. Hutten-Czapski: First, there is a myth that rural Canada is dying. It is most definitely not dying. It is increasing in population, although not as fast as the urban population. Certain areas, in particular the farming sector, is subject to decay at this point in time, not to mention corporatization, monoculture and so on that you have eloquently described.

This is not a hopeless issue. Rural Canada is alive and well and thriving. There is much self-potential, as you mentioned. Rural citizens are happy to live in rural Canada and do not want to have to go to the city to get a job.

The two-tiered quote is from Allan Rock and it is probably because of John Wootton.

The Chairman: Having worked around ministers, as Senator Fairbairn and I have, the truth is John Wootton probably wrote it.

Dr. Hutten-Czapski: I am sure being in government even for two years he realizes that he cannot answer that question.

I will be accused of piping my own horn, so to speak, when I say this. However, if you cannot have health care, how will you get a community to recruit technical support for

the mill and town when the families ask where they will send their children to school and where will they go if they get sick. That in itself is part of the important infrastructure that we consider the Canadian social contract. When you come to a community, you expect to have education and health care. If the answer is that these things are available, but only 100 kilometres away, then suddenly it becomes difficult to sustain that mill.

Mr. Tholl: The Canada Health Act says something like all Canadians as a right of citizenship are entitled to reasonable access on uniform terms and conditions. What does that mean to the 99.89 per cent of our land mass that is rural? I think it means that we must be watchful. It is said in medicine, do no harm. In the area of public policy, I think it is do no obvious harm. In this case, I think there has been some obvious harm done in response to the economic imperatives. I will just use Saskatchewan, my own province, as the example. It is the home of medicare. There have been formal studies and there have been case studies. I will encourage you to think about Melfort, Saskatchewan. Why? Because Melfort, Saskatchewan, which is about 120 miles outside Saskatoon, had a horrendous problem of trying to get and keep a group of physicians, including some general specialists to move and to stay in Melfort. This was a project that took well over seven years. They finally established a group of a dozen that worked well together. All of a sudden regionalization came on to the scene. Regionalization was billed as bringing responsibility and accountability down to the people. For the people in Melfort, Saskatchewan, it was not decentralization; it was centralization. The control over the things that mattered much to physicians in Melfort suddenly were no longer in Melfort. They were regionalized to one of these 30 or 32 regional health centres.

One of Senator Fairbairn's basic points was communication. I would put it differently. I would put it in the context of awareness raising. When we take decisions, albeit necessary ones, and I am a health economist by training, that are in response to economic imperatives, we understand that, in certain cases, you cannot make a business case for providing reasonable access to people living in rural and remote area. However, you may actually have to say that it may not be cost effective, but it is the right thing to do in the context of these waves of reform that sweep us.

We are talking about every province except Ontario, which is affectionately called the control group for regionalization in Canada. We need to raise awareness about the need to look at meeting that commitment even when health economists might say that it is not cost effective to do it that way.

Senator Cook: Thank you very much for another overload of information. I should tell you I am a Newfoundlander. I have been listening and have been trying to get outside the loop because I think that is where we all have to go. What I am hearing this morning is outside of the loop is the norm in the delivery of health care services for people. Everyone has a right, so they believe, to live in a safe community, where they choose, to earn a living and to be cared for. That is your basics.

I see from my limited knowledge, and having served on a board of trustees on the health board in Newfoundland for nine years, a problem in how we manage change. How do we look after people? How do we look after an ageing population whose desire is to live at home? How do we create an environment for the extended family to find a job, live and have children educated there. That, I suspect is where many of support

systems come from as you age and need care.
I cannot shake from my mind that the road to that piece is through population health. I would like you to respond to that. To me population health encompasses all the ingredients from the safe water to the social to the whatever. There is then the medical field, like your nurse practitioner.
When I was a child, there were nurses in the outports. I forget the name of their order now. After we built the roads, we did not think we needed those nurses. Instead anyone who is sick is put into one of those tinny ambulances and driven over a couple of hundred miles of highway to the nearest hospital. In my isolated part of the coast, there used to be a hospital boat. In the 1940s, that boat even had an X-ray machine. Again, we built roads and centralized everything.
The challenge of getting the right professional people to go into these areas and to give care in a holistic way is an awesome task. There are some core clusters of population with a clinic at the centre. I do not even want to think about the lives of the professionals and their families in those communities; that is a whole other issue. We are bussing children 30 or 40 miles down the road to schools. There are no hockey rinks. The quality of life will the real challenge. If they love to ski, there are lots of mountains. It depends on the social skills and the desires of those professions.
Dr. Wootton: I will just leave your comments. As you probably know, Health Canada has adopted a population health approach. When I arrived in Health Canada, coming from a provider background which is individually focused, it took some time to integrate the two approaches to the health of a population. Clearly there are some efficiencies when looking at groups as a whole. Their characteristics come out. One can plan prevention more effectively if one is looking at similar people in similar circumstances and one can design something that particularly fits.
In the literature, there is an increasing body of evidence that supports the population health approach and planning and prevention along those lines. The difficulty in rural areas is that there is no university in each area to manage that process. There is no parallel population health manager in most places. I brought to Health Canada my intent to integrate our knowledge from a population health approach into the workforce in all the places where it works.
Health care is only one of the determinants of health. We must look at poverty and the particular situations of women and children and different populations groups. In rural areas, medical workers must do a mental switch from one oversight frame of mind, over to dealing with an acute emergency on the highway whenever that is the appropriate thing to do.
In my approach to redesigning rural health care, I say we must use that information but we do not live in a world where we can expect to prevent everything. We cannot. We also cannot ignore the root causes of illness because then we just retreat illnesses that could have been prevented. We need to integrate those two lines of scientific inquiry. Rural areas are a good laboratory in which to integrate the two approaches because the populations are better defined. It is a little easier to see the factors that affect health. If a one-resource town sees its industry close down, the health effects are immediately noticed. The information is not obscured nor hidden as it can be in some large, complex, urban environments. We must take an integrating approach. Hopefully, some of the reforms will bring together different kinds of providers in teams and bring together

those different perspectives.

Dr. Hutten-Czapski: In looking at health, I like using the analogy of a cliff. At the very top of the cliff, population health people build fences. Patients who drink or smoke climb over those fences and then fall to the bottom, where physicians and nurses are working at the bottom of the cliff to look after the broken bones.

There are two issues. Obviously we need to build fences at the top of the cliff, but we must also look after the mangled remains of people when they end up at the bottom of the hill. Both sets of work are important.

I include here a graph showing a four-year range in women's life expectancy across the various regions of Canada. Four years is a huge range in population health terms. That range is not because there are no rural doctors. If we could cure all types of cancer with one pill and without side effects, the life expectancy would still only improve by 2.3 years.

This disparity in life expectancies is a population health issue. Questions like aboriginal health and socio-economic status would be included here. Just because these people are dying off more quickly does not mean that they do not need physicians and nurses. We must deal with both problems. That is clear.

The other issue that Senator Cook mentioned was the lack of things like hockey rinks and the problem of attracting professionals to rural areas. One important research finding about rural medical education is that although many medical practitioners end up in the city, a greater proportion of rural trainees will return to rural areas because they are already comfortable with the rural culture. Apples do not grow in the tropics and, similarly, banana trees do not grow on Fogo Island. It just does not happen. So one approach is to train people from rural areas with the technical skills to provide health services. They will be easier to keep.

Mr. Tholl: To reinforce what you have already heard, up until 42 days ago I was the CEO of the Heart & Stroke Foundation of Canada. I do not think you can find an organization more committed to population health and health promotion and illness provision. Now I am CEO of the CMA. I would simply make the observation that all too often health and health care are put in opposition with one another. Even the architects of population health -- Evans, Bearer and Stoddard -- would argue that you must not do that. The economic problem is usually that there is not enough money to go around and choices must be made on where to spend the limited dollars.

I would use a different analogy. It is called the Leeds Declaration. It is one of the earliest documents that helps me to understand this, and I will share it with you. There is upstream thinking and downstream thinking. Some are jumping in the river or off the cliff or being pushed off the cliff for one reason or the other. Others are downstream on the river trying to pluck people out and save them from drowning.

In reality, a CVT surgeon cannot move from downstream to upstream. In the short term, we must see the two issues not in opposition to each other but as existing upstream and downstream at the same time. Let us save those people who smoked their brains out -- because it is a Canadian right to do so -- once they get down river but, at the same time, let us get some new resources upstream to help kids resist the urge to take up smoking at age 13. I know another senator is working on that.

Senator Cook: I know that currently in the system there are, from a human perspective, human resources of all stripes, shapes and whatever to deliver this health care in a very

complex environment, if I might say so. How do you get that which is available, like tele-medicine, like all the nurse practitioners that could be available to address the concerns of women's health, things which I think are not being addressed as fully as they could be, into a rural setting?

We could set up a futuristic clinic, but people will not use it if it is not a first class clinic, and stocked. Then we are into economics and capital expenses with a mammography machine or tele-medicine or anything to do with distance. I am only seeing this from my own province. Have you any evidence-based information or anything in your research that would help get those barriers down?

Dr. Kulig: There is a project in Taber, Alberta, funded by the Canadian Health Services Research Fund, and they have salaried the physicians. It is an integrated approach, so the patient can see a public health nurse, a nurse practitioner and a physician all in the same day and get it all over with at the same time. That has been a three-year project, and it is in its final year. It has had many other wonderful spin-offs from it. The nurse practicioner that they hired was an out-force nurse in the Yukon for many years. She is principally focussing on women's health. She has also very much dealt with the multicultural issue, because in that area we have a great number of Mennonites returning from Mexico and Belize and Paraguay, and that is a very challenging group to work with. I have worked with them for the past six years. She has addressed their health needs. If you can address their health needs, you are doing a lot, because that is a very conservative religious group. That might be another project that this committee would want to look at in terms of outcomes. They have felt that, through all their struggles, they have been able to address health in a new way for rural residents and address some of those issues.

You could also probably look at some of the areas of northern Canada with nursing outposts and how they have had addressed them. I am a former outpost nurse myself, and they have been able to create programs that would be applicable to other parts of your province. I know someone from your province who is on our national study for nursing, and she is also very diverse in terms of understanding those issues like tele-health and women's health and nurse practitioners.

Senator Robertson: Will these people be back in the fall?

The Chairman: Yes, either individually or collectively.

Senator Robertson: It is impossible to digest all this material in a short time, but I do have two or three quick questions.

I note that a ministerial council on rural health has been announced but seems stalled, according to the Society of Rural Physicians. Would someone care to comment on that? Will that be a driving force?

Dr. Wootton: I can tell you what I know most recently about it. I think that some of the stalling had to do with the federal election that got in the way in the fall and some issues related to that. The minister did announce it in Chesterville last June. The planning has gone ahead to set it up, and the funding is in place. I believe it will happen in relatively short order.

Senator Robertson: That is good news.

Dr. Tholl talked about immigrant health professionals and what to do with them, how to bring health professionals in or how to use them when they came. Would you enlarge on that? You skipped over that rather neatly.

Mr. Tholl: I can assure you I did not intend to skip over it. In fact, it is a fairly significant part of the puzzle. We met earlier this morning with Minister Caplan to review some of the issues pertaining to immigration.

Roughly speaking, each year Canadian medical schools put out between 1600 to 1800 doctors. That is increasing in the wake of announcements lately. We still have about 400 physicians per annum who come into Canada either on a requested basis or not, and many of them wind up practicing in rural and remote communities.

The concern I was trying to relate to the committee was that if you are looking at an overall national plan, you need to look at how many doctors are leaving each year and how many are coming in each year and ensuring that particularly those that are coming in are trained to a certain level and do not come here with false expectations about either readily getting accredited to do this kind of practice or this specialty practice, or that they simply see a request to practise in Saskatchewan as an one-year layover en route to Toronto. In that context, the particular issue that is on the table with respect to implementation of Bill C-11 is the issue of what we mean by a temporary licence to practise medicine in this country. Is it restricted to one province, or is it in fact applicable, once you get landed immigrant status, to practice anywhere in Canada? That is the particular issue that I was referring to there, and it has particular application to what I would emphasize is the short term fix. We cannot continue to, for one reason or another, rely on doctors from South Africa or other parts of the world to meet our short term needs. We need to develop a self-sustaining physician national plan.

Senator Robertson: What would you do with them after they have served their time, as you are identifying?

The Chairman: We will find a better way to phrase that in the report.

Mr. Tholl: Certainly those who could qualify and pass their requisite exams would then be entitled to practice as provided for by mobility rights. As residents of Canada, they would be allowed to practise wherever they found themselves. However, in that period of time that they have a restrictive licence, they would be required to stay in that province.

Senator Robertson: That makes good sense. Thank you.

In this report, the state of rural health in Canada, one word jumps off the page. The fifth priority of the NRHS is funding to let universities develop, et cetera. What is your definition of "let" used in that regard?

Dr. Hutten-Czapski: As I was saying, the rural physician currently is produced by accident and not by design. In fact, the largest source medical school that is most pertinent to rural Canada is the University of Johannesburg. We have 1,500 physicians from South Africa in Canada. Over half of rural doctors in Saskatchewan are foreign trained.

The Chairman: Fifty per cent?

Dr. Hutten-Czapski: Over 50 per cent in Saskatchewan.

The Chairman: You understand I am dumfounded by the number because it seems so astronomically high.

Dr. Hutten-Czapski: I should point out that for Canadian schools, the one school that is shining and stellar is University Laval.

Senator Morin: Best university in the country.

Dr. Hutten-Czapski: I wonder why you think so.

The Chairman: For those who do not know, Senator Morin was Dean of the medical school there prior to coming to the Senate.

Dr. Hutten-Czapski: They have a rural friendly program, and that is exactly what we need. We need a university which actually takes this on. Universities are very amenable to money because they do not have any. If you give them money and say, "Develop a rural friendly program," they will develop a rural friendly program for you. They will do it in short order. The catch is whether they buy into it. To do that, you either have to be visionary like the University of Laval or you have to give them incentive. One way to give them incentive is to say, "Work out the program on how to do it, and then we will give you more money to implement it, but we will only pay you as you implement it. If you have a five-point plan and you give us one point, we will give you this much money. If you give us two points, we will give you this much money." That is how we can move them in rather short order into rural friendly stances, for both recruitment of people from rural regions, which will be important, and also in terms of having a curriculum that trains people so they do not need to have a CT scanner in the basement to be able to practise medicine.

Senator Robertson: Encourage might be a better word.

The Chairman: We will call it an incentive rather than a bribe.

Mr. Tholl: Laval is certainly a lesson worth noting. I would observe for the committee that when you start to look at success in going to and staying in rural remote areas, there is some interesting data that you can trace back to school of graduation. For example, McMaster University has three times the success rate, because of their training program, in placing and retaining physicians in rural remote areas relative to the University of Toronto.

The University of Calgary has also been quite successful in providing undergraduate training programs that enable physicians to more successfully deal with some of the professional issues of practising in rural remote areas. We have data that can support the school of graduation as being fairly instrumental to success in moving to and staying in rural remote areas.

Senator Callbeck: The areas I wanted to question have been covered, but certainly I want to thank the witnesses. Being from rural Prince Edward Island, I am very much aware of most of the challenges that you presented here this morning.

The Chairman: I have a request for further information from Dr. Hutten-Czapski. In your first recommendation you talk about reducing the structural barriers. It would help us if you could identify precisely those structural barriers rather than generically. I know you know what they are, and I understand why you did it generally here, but if you could say in a bullet point form the three or four key points and send them that to us it would be great.

Dr. Hutten-Czapski: I would be happy to, but briefly, the structural barriers could be overcome by the three committees. I am by no means an expert on government, so I fear to tread with any specifics on how to overcome inertia.

The Chairman: I thank you all for coming. This has been a terrific session and we will be doing a cross-country series of hearings in the fall so we will see you much closer to your home bases.

The committee adjourned.