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Monday 27 October 2008

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Lundi 27 octobre 2008

Standing Committee on Social Policy

Increasing Access to Qualified Health Professionals for Ontarians Act, 2008

Comité permanent de la politique sociale

Loi de 2008 visant à accroître l'accès des Ontariennes et des Ontariens aux professionnels de la santé qualifiés

Chair: Shafiq Qaadri
Clerk: Katch Koch

Président : Shafiq Qaadri
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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

STANDING COMMITTEE ON SOCIAL POLICY

COMITÉ PERMANENT DE LA POLITIQUE SOCIALE

Monday 27 October 2008

Lundi 27 octobre 2008

The committee met at 1430 in room 1.

SUBCOMMITTEE REPORT

The Chair (Mr. Shafiq Qaadri): Ladies and gentlemen, colleagues both past and current, I'd like to call this meeting of the parliamentary Standing Committee on Social Policy to order. As you know, we're here to discuss and hear from Ontarians about Bill 97, An Act to increase access to qualified health professionals for all Ontarians by amending the Regulated Health Professions Act, 1991.

The first order of business is our subcommittee report, which I would ask Ms. Broten to please enter into the record.

Ms. Laurel C. Broten: This is the report of the subcommittee.

Your subcommittee on committee business met on Wednesday, October 15 and Thursday, October 23, 2008, to consider the method of proceeding on Bill 97, An Act to increase access to qualified health professionals for all Ontarians by amending the Regulated Health Professions Act, 1991, and recommends the following:

(1) That the committee meet for the purpose of holding public hearings in Toronto on Monday, October 27 and Tuesday, October 28, 2008.

(2) That the clerk of the committee, with the authority of the Chair, prepare and implement an advertisement strategy for the major daily newspapers and post the information regarding the hearings on the Ontario parliamentary channel and the Legislative Assembly website.

(3) That interested people who wish to be considered to make an oral presentation on the bill should contact the clerk of the committee by Thursday, October 23, 2008, at 5 p.m.

(4) That the length of presentations for witnesses be 20 minutes for groups and 10 minutes for individuals.

(5) That the deadline for written submissions be Thursday, October 30, 2008, at 5 p.m.

(6) That the clerk of the committee, in consultation with the Chair, be authorized prior to the adoption of the report of the subcommittee to commence making any preliminary arrangements to facilitate the committee's proceedings.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Broten. Are there any discussions or comments before adopting the subcommittee report as read? Seeing none, those in favour? Those opposed? I declare the subcommittee report adopted.

INCREASING ACCESS TO QUALIFIED HEALTH PROFESSIONALS FOR ONTARIANS ACT, 2008

LOI DE 2008 VISANT À ACCROÎTRE L'ACCÈS DES ONTARIENNES ET DES ONTARIENS AUX PROFESSIONNELS DE LA SANTÉ QUALIFIÉS

Consideration of Bill 97, An Act to increase access to qualified health professionals for all Ontarians by amending the Regulated Health Professions Act, 1991 / Projet de loi 97, Loi visant à accroître l'accès des Ontariennes et des Ontariens aux professionnels de la santé qualifiés en modifiant la Loi de 1991 sur les professions de la santé réglementées.

SICKLE CELL ASSOCIATION OF ONTARIO

The Chair (Mr. Shafiq Qaadri): We'll now proceed to our first presenters of the day. I would like to welcome, on behalf of the committee, the Sickle Cell Association of Ontario: first of all, Lillie Johnson, director, as well as Mr. Bob Frankford.

Mr. Frankford, we of course acknowledge you as one of our former colleagues, an MPP of this Legislature some time ago. I'd invite you to please be seated. You'll have 20 minutes in which to make your complete presentation, as you know, and any time remaining after your formal presentation will be divided evenly amongst the parties for questions or comments. I'd invite you to begin.

Dr. Bob Frankford: We're very pleased to be here this afternoon. Lillie and I are directors of the Sickle Cell Association of Ontario. We had hoped that Janet Mulgrave, our president, would be here, but she's too busy working in her day job. But she supports what we're going to say.

Just a few remarks before I introduce Ms. Johnson. The Sickle Cell Association has been in existence for about 26 years, educating, raising issues and providing support for people with sickle cell. As you no doubt know, sickle cell is the commonest genetic blood disorder. It's very much associated with African and Afro-

Caribbean populations, although it certainly occurs in many more groups than that.

I won't say any more. I'll pass this over to Ms. Johnson, who would like to tell you more about us and our position on this bill.

Ms. Lillie Johnson: It is a privilege to be here this afternoon to explain to this group, after 27 years, what we've discovered. One of the most important things is access to the different health care places like hospitals and others, where especially the adults are looked after.

As you are aware, the population in Toronto and the outlying areas has changed considerably, and that means that the highest population for sickle cell and any of the other hemoglobinopathies has extended. We would like also to point out that with newborn screening, there are different things that we have got to look at; that is, we need specialized people, like hematologists, doctors and geneticists, who will be following up with these people. At that end of it, you have the newborn screening; that is, early identification. At the other end of it, we need to be following up with the people or families with traits. So we have, then, that group, plus the others like high schools and different carriers, because since this is an incurable disease, we need to be looking at different aspects where we can reduce the number of people being born with sickle cell disease; that is, we have to find the traits, the carriers.

Added to that, we find that with the different groups in the population, there is a language problem. We have French, we have different people from different parts of Africa, the Caribbean, Somalis and different people who speak different languages. So there also is a problem with how we can get our educational programs out there.

Our mission, really, is to look after the individuals and families with sickle cell after they have been diagnosed. That is, we are looking at a multi-disciplinary program, in which there are not only qualified doctors and nurses, but we are looking too at psychiatrists, social workers and teachers, because these kids spend a lot of time in school. They lose a lot of time and they need follow-up, because our mission is to try and keep them as well as possible so that they can gain as much from their school program and be active members of society.

Dr. Bob Frankford: The Sickle Cell Association is pleased to support this bill for a number of reasons. We certainly share the general concerns about the shortage of doctors and nurses dedicated to this area. As Lillie said, it's a very complex disease, which can affect essentially any organ system. So it's not just a disease for hematologists, although they are certainly important, but people from other specialties like neurology, respiratory medicine and dermatology. So we share in the concerns about the lack of replacement in all of these specialties, and we see this bill as being a useful step towards replacement and retention of skilled specialists.

Lillie has mentioned, as well as the concerns about the shortages of doctors in their retirement, that we are going to be seeing increased populations at risk, some due to the newborn screening program, which is excellent and for which we are very, very grateful, that has been brought in after two years. Perhaps, at this point, I'll just mention, to put in perspective, how common this problem is, understanding that in the first two years of operation of the screening program, about 50 children with the disease are identified in the province out of about 140,000 births. That's a considerable burden on the system when you think about how much hospital time these children are potentially going to need.

1440

We're supportive of the bill and just would like to throw in a few other suggestions. Social workers have been mentioned. Social workers are not under the RHPA so they are not included in this, and we certainly would like to ensure that social workers have a strong medical role, because they're extremely important in relation to the determinants of health, which are particularly relevant in this, in addition to the genetic aspects of sickle cell. We don't see anything that's directly going to affect genetic counselling, which is another very important part of the management of sickle cell, particularly, as was mentioned, in relation to the carriers who are really quite healthy, but the potential of carrying the gene within a family is very critical. We'd like to be sure that public appointments to the college understand the issue, understand the diversity and the diseases associated with diversity.

Finally, we would suggest that there is better and available research in relation to the potential use of foreign-trained physicians and nurses who are not yet licensed but who probably bring considerable experience from their own countries in relation to sickle cell disease.

The Chair (Mr. Shafiq Qaadri): That's great. Have you completed your presentation, or did you want to say something?

Ms. Lillie Johnson: Just one more thing.

The Chair (Mr. Shafiq Qaadri): Please.

Ms. Lillie Johnson: We usually talk about sickle cell, but sickle cell is not the only disorder. This is a red blood cell disorder, and at this point in time we should be emphasizing thalassemia and the other disorders, because they are all red blood cells. What we find now is that many of the individuals out there have sickle cell thalassemia and different disorders like sickle cell C, D, E and whatever. So we would like to approach this as the hemoglobinopathies—that is all of them under one heading. We have to include all of them.

The Chair (Mr. Shafiq Qaadri): I suspect that Dr. Frankford and myself may be the only people who fully understand the word "hemoglobinopathy," but I appreciate your comments. We have probably two and a half minutes—

Interjection.

The Chair (Mr. Shafiq Qaadri): Oh, of course. And Dr. Jaczek; absolutely.

We now have about two and a half minutes per side, beginning with the PC caucus.

Mrs. Elizabeth Witmer: Thank you very much, Dr. Frankford and Ms. Johnson, for your efforts to advocate

on behalf of those with sickle cell and obviously the need to have multidisciplinary teams in place to respond to the needs of those individuals. However, you've indicated that you support the bill.

Now, the bill is one line. The bill says, "It is the duty of the college to work in consultation with the minister to ensure, as a matter of public interest, that the people of Ontario have access to adequate numbers of qualified, skilled and competent regulated health professionals." How do you perceive this bill helping those with sickle cell disease?

Dr. Bob Frankford: Well, I see the words "have access to adequate numbers." I think that's the problem that we're concerned about, the numbers of professionals available currently, let alone what is going to happen in the future, as the need is likely to increase as a result of such things as immigration and a greater identification of cases due to the newborn screening program.

Mrs. Elizabeth Witmer: Right, but how are we—you know, the Premier, five years ago, promised to provide the adequate number of health professionals. That hasn't happened. We now see an attempt by the government to hand off some of this responsibility to the colleges, I guess. How do you think we're magically going to have these numbers?

Ms. Lillie Johnson: Right now, I feel that there is one centre where you have care for adult sickle cell patients, where they can be thoroughly assessed by the specialist hematologist and the other doctors. Outside of Toronto, when you go to Brampton, Mississauga, and the different areas, there are no specialists in the different hospitals who can attend to them, and we feel that this could be addressed at this level, that we do have more trained people specifically. I know you can't do it for every hospital, but I see that there is a problem when they are turned away and not able to get—especially those who have just been discharged from Sick Children's. At 18 years, there is absolutely no care. Most of the physicians are not too up to date with the care of young adult sickle cell patients.

Mrs. Elizabeth Witmer: Part of the problem, then, is the lack of awareness among family doctors about sickle cell?

Ms. Lillie Johnson: Yes, I would say that.

The Chair (Mr. Shafiq Qaadri): I need to respectfully intervene there. We'll now move to the NDP caucus. Ms. DiNovo.

Ms. Cheri DiNovo: Thank you for coming and deputing today. Welcome back, Dr. Frankford.

Picking up where my colleague left off, this is a pretty small little bill with very little to say about a subject for which we in the New Democrats think a lot needs to be said. Certainly, it may be an inch where we need a mile.

I'll just ask you, perhaps, to step out of your own comfort zones a little bit. You had mentioned internationally trained doctors and professionals, social workers among them. Do you have any ideas about what you might want to add to this in terms of how we are going to chip away at—there are a million Ontarians without a family doctor for starters, never mind your particular interest in sickle cell work. What should we do?

Dr. Bob Frankford: That's a nice broad question.

Ms. Lillie Johnson: This is just a suggestion, from how I see it. Let's say that John is 18 years old, so John is not able to access care. He gets in a crisis and he goes to a hospital. He sees new people he has never seen before. For anyone who has studied sickle cell and the complications, it is not very good when you are in a crisis. They must know how to treat you immediately. So my suggestion would be—and it's easy; we don't have to get into a whole lot of money—we could have different centres. On a Wednesday afternoon, John could go to "B" because they know that that afternoon a trained hematologist or a physician would be there, and this is somebody that they would be seeing each time. In other words, we are saying that we could select different areas and we could say that a half day would be the day when sickle cell and thalassemia patients would be seen. In other words, we could share services.

For the social workers and the nurses, I have been trying to get to the schools of nursing to say that hemoglobinopathy should be taught in a more specific way. Right now, I'm mentoring students, so I do know that they know very little or nothing about sickle cell. The only thing they know is to tell you that it's a black people's disease. It's far from that, because I could bring an array of different people here to show you that it goes right across all the different nationalities. So, we are—

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Johnson. I'll respectfully just intervene there. We'll go to the government side. Ms. Broten.

Ms. Laurel C. Broten: Thank you very much, and thank you both for your advocacy on behalf of a group in our society that perhaps, in the past, has been forgotten somewhat, so thank you very much for that. I also want to thank you for your support of Bill 97. I want to ask you whether you agree that our regulatory colleges should have a duty to consider that it is an important area of public interest that our citizens have access to qualified physicians.

1450

Dr. Bob Frankford: I can't imagine saying no to that.

Ms. Laurel C. Broten: Thank you. Do you think that a qualified physician, now practising in another province, in the United States or other parts of the world, who wants to come to Ontario and set up a practice here would be beneficial for those whom you advocate on behalf of?

Dr. Bob Frankford: I'm sure there are many people who would be very well qualified. Confining ourselves to hemoglobinopathies, there must be people in—we have very good relations and respect for doctors in Jamaica. We would feel that there must be a great deal that we should be able to input from elsewhere. How the licensing and reciprocities are going to work, that's for other people to decide, but I think that there's a whole other—we can benefit. Of course, we don't want to poach too much from countries that need physicians and nurses

every bit as much as we do, but it's a world of widespread travel and sharing information, so I think there's much that is going to be achieved by reciprocal arrangements.

Ms. Laurel C. Broten: Thank you very much, and thank you for attending today.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Broten, and thanks to you as well, Ms. Johnson and Dr. Frankford, for your participation and presentation on behalf of the Sickle Cell Association of Ontario.

OFFICE OF THE FAIRNESS COMMISSIONER

The Chair (Mr. Shafiq Qaadri): I'd now like to welcome a very distinguished colleague from her federal service, as well as now, in the government of Ontario. As you'll know, she's the former federal member of Parliament for the great riding of Etobicoke–Lakeshore, which continues to be very ably led, both at the federal and provincial level. I'd now invite Ms. Augustine to please begin her comments in her capacity as Ontario's Fairness Commissioner and, of course, introducing your colleague.

You have 20 minutes in which to make your presentation. Please begin.

Dr. Jean Augustine: Merci beaucoup et bonjour. Mr. Chairman, I am really grateful to have the opportunity to meet with you and the committee this afternoon. With me are two of the staff of the Office of the Fairness Commissioner: Wilson West, who is a policy adviser, and Beatrice Schriever, who is a communications officer. We have a written submission, but I am pleased about the opportunity to speak to you directly, as you study Bill 97.

As you know, my office was established under the Fair Access to Regulated Professions Act, 2006, or FARPA, as we call it. My office oversees 21 health professions to make sure that their registration practices are transparent, objective, impartial and fair. Bill 97 and FARPA share a common goal: It is our conviction that fair registration in the health professions will mean increased access to qualified health professionals. In the context of the current shortage of health care practitioners in Ontario, it is crucial to ensure better access to the professions for qualified applicants. This will be a major step towards improving access to health care for all Ontarians.

My office undertook a study of registration practices of the 21 health colleges. We learned about some excellent initiatives that have improved applicants' entry into the health professions in Ontario. They include bridging programs, occupation-specific language training, prior learning assessments and examinations that replace work experience requirements.

This afternoon, I will outline briefly some of the findings that are relevant to your consideration of Bill 97.

(1) Some health professions have registration requirements that may create barriers for applicants, especially for those educated in other countries. One significant example is that of the College of Physicians and Surgeons of Ontario. Everyone who wants to become a doctor must perform a medical residency where he or she practises under the supervision of a licensed practitioner, but there may not be enough residency spaces. The allocation of spaces is an extremely complex process involving input from many organizations.

Accordingly, the Office of the Fairness Commissioner recommends that the Standing Committee on Social Policy consider the issues surrounding the process for determining the number of available medical residency spaces and the allotment to domestic and international applicants.

(2) Many of the health colleges commented to us that the process to make changes to their statutes or regulations can be very lengthy. As a result, they're unable to move ahead with new policies and procedures that would reduce barriers to registration.

So we're recommending that amendments to statutes and registration regulations aimed at removing barriers be expedited through the approval process.

(3) We found that some internationally trained individuals turn to programs offered by private educational institutions that advertise an easier path to registration, but these programs may not be accredited.

We recommend that professional programs offered by private educational institutions meet the academic requirements of the regulated professions. In the interim, institutions should inform prospective students whether or not their programs are accredited for registration in the profession.

(4) I'd like to turn again to the subject of international medical graduates. I've noticed that governments have been focusing on new skilled immigrants at the expense of those who've been in Ontario for some time, yet they are an important source of talent with valuable skills. They can contribute to relieving the shortage of doctors in Ontario. The College of Physicians and Surgeons of Ontario recently announced that it would fast-track applicants from the United States, other provinces and eight other countries, and this is good, but it does not address the problems faced by candidates already in Ontario, nor does it help people from countries that are not on the approved list, unless they meet these onerous requirements.

Let's look at what this means in practice. Our study of registration practices revealed that, in 2007, the top five countries from which internationally trained doctors came were in this order: India, Saudi Arabia, the UK, Pakistan and Australia. Only two of these countries, Australia and the UK, are included in the college's proposed list of fast-track countries. In other words, the program doesn't address three of the top five countries—India, Saudi Arabia and Pakistan—from which their own internationally educated applicants come.

I believe that this is called "picking the low-hanging fruit." The college is on the right track, but their own demographics should be telling them what to do next. Consequently, we recommend that this committee

recommend that fair consideration be given to those applicants in the implementation of the fast-tracking initiative.

(5) My office is doing research on registration practices in other jurisdictions. Australia is one place that faces similar challenges to Ontario with respect to medical residency. Currently, Ontario requires all doctors to do at least one year as a resident regardless of the quality of their education or their competence. In Australia, the type of supervised training required of applicants depends on the quality of their education. To assess, governments there use the Australian Medical Council database. This database records the test scores of all applicants, and the database is then used to determine the length of supervised training an applicant is likely to need. The better the quality of an applicant's education, the shorter the period of required supervised training.

1500

The Australian model also takes into account specific schools. For example, the applicants who graduated from the best medical schools in, say, a place like China will not do a full year of residencies. Doctors who graduate from Canada or the United Kingdom and go to Australia will typically need a short period of light supervision.

Our final recommendation is that the committee recommend a study of efficient alternatives in other jurisdictions, and if they are appropriate, these best practices could be tailored to Ontario.

Achieving better access to health care for Ontarians and better entry into the professions for all applicants is a complex endeavour. Ensuring that the people of Ontario have access to adequate numbers of qualified, skilled and competent health professionals requires a serious commitment from all stakeholders. The government plays a key role in improving access to health care. It is not the responsibility of the health colleges alone.

We thank you for your interest this afternoon. I'll be prepared to answer questions from the committee, Mr. Chairman.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Augustine, to you and your colleagues. We'll begin with the NDP side. Ms. DiNovo, about three minutes or so per side.

Ms. Cheri DiNovo: Thank you so much, Ms. Augustine. I found that very informative. You fleshed out what is a very thin bill. It's a bill that we in the New Democratic Party are going to support, but we wish there was a lot more to it, and you've added that lot more.

I just wanted to give you an example from my own constituency—it's not unusual—and wonder how you would change the system that we have to accommodate this person. I have a surgeon who came from Iran. He worked many, many years in Iran. He came over here working as a baker and was told that it would take him 10 years to be accredited. He doesn't have the money; he can't take the time. He would be in his 50s by the time this happened. So what he's doing now is going back to Iran for six months of the year to practise, and then coming back here to spend time with his family. This seems to me outrageous. How would you suggest that we deal with this particular kind of applicant differently?

Dr. Jean Augustine: Thank you very much, Ms. DiNovo. This is not an atypical individual or atypical case. We do hear from individuals. But I want to say to the committee that the Office of the Fairness Commissioner and the mandate I have through the legislation—I have no mandate whatsoever to deal with individual cases. We are arm's length to government; we are arm's length, as it were, to the regulatory bodies.

At the same time, the stories that we do hear, the individuals who provide us with information: This is good intelligence for us as we ask the questions around the fairness, impartiality and length of time. We have been working with regulatory bodies to ask: "How long does it take? What kinds of exams? How many exams? What are your fees? How many fees? How many times can someone write the exam? Do you pay the fee each time you have to do the exam?" We ask again about appeal processes and what kinds of appeal processes there are.

Actually, what we have is a mandate from the legislation really to ensure that the registration practices are fair, impartial, open, transparent, and that answers are given to individuals in that fashion. The regulatory bodies, each and every one of them, are working towards compliance. What we are attempting to do is to create systemic change in the way in which they operate, because many times, when we ask the question or we bring forward an issue, we're told, "This is the way it has always been done." We know that there are several—I call them barriers or hoops. I see my role as commissioner to ensure that those hoops or barriers are not unnecessarily placed. The questions we ask, the probing we do, the questionnaires we send out and the way in which we're working with the regulatory bodies are to ensure that they recognize the systemic things that might be in the system.

I also, in conversations—

The Chair (Mr. Shafiq Qaadri): Ms. Augustine, with respect, I'll need to intervene there. Thank you, Ms DiNovo.

To the government side.

Ms. Laurel C. Broten: Thank you for being here today. I think one of the comments that you opened your statement with is one that we should all pay very close attention to: Fair registration would mean increased access to health professions for qualified applicants. Bill 97, as you know, does not speak to every aspect of breaking down the barriers, but it is one part of our government's plan to do so, in combination with HealthForceOntario, the access centre, the Centre for the Evaluation of Health Professionals, along with the other five points of the action plan that I put forward a number of months ago.

I wanted to just highlight for you and ask for your input as to whether or not a transitional licence that would allow an individual to practise under supervision while they completed some required education, increased

mentorship and bridging programs, hands-on training or perhaps training and bridging to another area of the health profession might speak to the needs of some of the individuals that you referenced in your comments who may not be directly assisted by Bill 97.

Dr. Jean Augustine: I think there is no argument whatsoever about transitional licensing. As we look at other experiences outside our own Ontario jurisdiction, we see those issues like transition, bridging, mentoring and putting individuals in the periphery of the profession so that they could, in turn, be ready, and not be exposed or left to be underemployed, to look for and take other opportunities that frustrate them that they're not a productive member and can't quickly become a productive member of Ontario society.

I think all of the suggestions that you have would certainly make life better for those individuals and also would ensure, through transitional licensing and other things that work in other jurisdictions, that that would make the registration and the quick entry into the profession better for all.

Ms. Laurel C. Broten: Thank you for the work that you're doing, and thank you for helping us make the registration more fair as we move forward, and we'll continue to do that.

Dr. Jean Augustine: Thank you.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Broten. To the PC side.

Mrs. Elizabeth Witmer: Thank you very much. I appreciate the presentation you've made. In fact, there may have been some substance to the bill if some of your recommendations were actually part of what we have here, which is one sentence. Despite what Ms. Broten has said, this bill doesn't speak to breaking down any barriers whatsoever.

I guess that's what so regrettable. There were high expectations, particularly amongst the international medical graduates, that they would see some hope. There isn't any hope here. It's fine to say that the colleges are going to work with the government, but the reality that is the government, as you just said, continues to play a key role in improving access to health care. For example, we need to increase the number of residency spaces, and there are changes to statutes and registration regulations that need to be made.

But I ask you: If there was one change that you would ask the government to make that would create a level playing field and better access for foreign-trained professionals, what would it be?

Ds. Jean Augustine: It's like the good old "make one wish."

Mrs. Elizabeth Witmer: That's right. Well, sometimes that's all you can hope for.

Dr. Jean Augustine: It seems to me that when we look at the systemic issues and we see the individuals who are joining us and the skills that they bring with them, it's important to recognize right off the bat that there are barriers in the way of getting into the profession and that doing things in a timely fashion is essential.

As I said earlier in my presentation, when we look at other jurisdictions, the OECD has done some work with 10 countries, looking at their processes. I was lately at the presentation by the EU: again, there are the languages in the 34 different EU countries and the ability to transition and to have temporary opportunities etc. I think there are practices out there that maybe we can look at and find the best for us, because, again, we want to underscore that we want a quality system, we want individuals who bring with them expertise, and we want to make sure that it fits with what we have set out as quality of care in our province.

At the same time, we want to ensure that in this global village, where there's competition for skills and those individuals can go to other jurisdictions and not necessarily come and sit in a waiting line here in Ontario, frustrated and, as Ms. DiNovo says, underemployed and with difficulties in their lives—I think my one wish would be, let's get going on this.

1510

Mrs. Elizabeth Witmer: So, timeliness.

Dr. Jean Augustine: Timeliness.

The Chair (Mr. Shafiq Qaadri): Thank you, Mrs. Witmer, and thank you as well, Ms. Augustine, to you and your representatives of the Fairness Commissioner's office.

MURRAY RUBIN

The Chair (Mr. Shafiq Qaadri): I would now invite our next presenter, who will be testifying before us in his capacity as a private citizen: Mr. Murray Rubin.

Welcome, Mr. Rubin, and just to remind you, as you've seen, you'll have 10 minutes in which to make your presentation and questions, comments after—

Mr. Murray Rubin: Thank you. I'm well aware that I only have 10 minutes.

The Chair (Mr. Shafiq Qaadri): Please begin.

Mr. Murray Rubin: Personal modesty is not called for when one tries to promote a change that will literally revamp a portion of our health care system. My name is Murray Rubin, and I graduated in pharmacy at the University of Toronto faculty of pharmacy in 1954. I operated a mail-order pharmacy named Vanguard Drug Mart in 1960 in Toronto, from a second-floor location in order to be able to lower prices to my customers by lowering my overhead. I was very successful. When I sold my store, we had over 30 regular pharmacies in operation throughout the province. I have, at present, no financial interest in the health care system.

We were the first retail pharmacy to computerize our prescription records. All pharmacies are now computerized. We were the only pharmacy to regularly phone doctors all over the province, at our expense, to ask to change brand-name drugs to generics in order to save our customers money. Years later, the Ontario government passed a law allowing all pharmacists to do what we regularly did, but without the need to phone doctors for permission.

The players and their prejudices in the health care system: The players in the health care system are the politicians, the public, the health care professions and the companies that provide the ancillary services that allow the system to operate. The companies are beyond the scope of this presentation, but believe me, I have a lot to say about them, too.

The politicians are interested, first and foremost, in getting re-elected. They start every project with the best of intentions, but after they have consulted all the players and have seen that changes will cause a lot of dissension, will take time, and they will probably not be in office when the system works well, they back off and do as little as they can get away with. Sterling Lyon, a former Premier of Manitoba, 1977 to 1981, raised the fee for the Manitoba health plan and was soundly defeated in the next election after only one term—a lesson not lost on the other Premiers. Bill 97 is as little as they can get away with.

The public wants the best health care, wants it free and wants to pay as little in taxes as possible.

The health care professions: The primary interests of the professions are to provide good health care, to protect the privileges accorded them by law—protect their turf—and to make sure the fees they receive from the government are not lowered. Incidentally, they judge who is qualified to practise in the province—a not-so-modest conflict of interest.

The changes we need, as soon as possible: There are many changes necessary in our health care system. Because of time limitations, I intend to discuss the areas around the general practitioner, the nurse practitioner and the pharmacist.

We are headed into a demographic disaster. It is a well-known fact that our older population uses up a disproportionate amount of the health care dollar. Average spending in Canada per person per year on health care in 2004 was $2,630, while spending for those aged 65 to 69 was $5,016 and those between 80 and 84 was around $11,902. The total population grew by 5.4% over the past five years, while the 55-to-64 group increased by 25%. One in every seven Canadians is a senior citizen, according to the 2006 census. Life expectancy is up, while the fertility rate of women is down below the replacement level to maintain our population. In essence, there will be fewer younger people working to pay the taxes to maintain the health care of the elderly.

We do not need more GPs, except in remote areas. We need pharmacists and nurses to do some of the less complicated work done by GPs for less money. We need to save money. Nurse practitioner clinics, such as the one in operation in Sudbury, is one answer, and a good answer. They work on salary. Pharmacists in drugstores can give advice for a fee on minor colds, headaches etc., and if necessary send a patient on to a doctor. Pharmacists should be allowed to repeat a doctor's prescription and save a fee for an office visit.

When I spoke to my GP about the need for more doctors, he laughed and said, "If GPs did less Botox work, they would have more time for regular work."

The pharmacist should be allowed to advise the doctor that a new prescription he just prescribed is not necessary as the drug now in use is fine, at a tenth of the price. A myth propagated by the medical profession is that they are the only people capable of doing these tasks. That is not so. Many mistakes are made by doctors.

Will the government make these changes? You bet your life they will not.

What should be done by the government? Appoint committees of people to go over what each profession does; include members of each profession in all committees; and look for ways to give good service for less money. Professions are not entitled to stay static forever. Conditions change; we have to teach less qualified people to do the less complicated work. Take it out of the hands of the government, and then maybe progress can be made.

I have a blog, http://murrayrubin.blogspot.com. That's it.

The Chair (Mr. Shafiq Qaadri): Thank you, Mr. Rubin. We'll have a minute per side, beginning with the government.

Ms. Laurel C. Broten: Thank you very much, Mr. Rubin, for attending. I would thank you very much for indicating your support for our nurse practitioner clinics. It's certainly something that we're very proud of and we look forward to expanding across the province.

The Chair (Mr. Shafiq Qaadri): Mr. Shurman.

Mr. Peter Shurman: This is a silly-sounding question, but I mean it seriously: I take it you don't support this bill in any way?

Mr. Murray Rubin: This bill is a con. They say that they are trying to get more people into the profession, but the professional colleges could have done that all along if they were really going to do it. You need more push to get them to bring in more people to give them competition for their people. Let's be realistic. I don't not support it. It certainly doesn't do any harm, but it gives an impression that isn't true.

1520

Mr. Peter Shurman: Thank you.

The Chair (Mr. Shafiq Qaadri): Thank you, Mr. Shurman. Ms. DiNovo.

Ms. Cheri DiNovo: Thank you, and thank you for your passion. I would agree that this bill doesn't do much. Certainly, we, the New Democrats, have supported community health centres; they were, in part, one of our inventions, and certainly, nurse practitioners are something that we would support as well. We need more nurses, no doubt.

I'd just correct something for the record, and that is, on behalf of everyone around the table, we're all public servants here and I think, speaking for all of us, we don't just want to get re-elected; we actually do work really hard on behalf of our constituents. I just wanted to correct that. I know it's a popular thing to trounce politicians, but I don't think it's an accurate stance. Thank you otherwise, Mr. Rubin.

Mr. Murray Rubin: I'm entitled to one mistake.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. DiNovo. Thank you, Mr. Rubin, for your presence and your presentation. I'll have the clerk distribute that to all members.

The Chair (Mr. Shafiq Qaadri): We have, I think, one cancellation, but we'll attempt to move forward. The next presenter's actually by teleconference, I understand, in Windsor, but is Mr. Mel Freedman present?

In the absence of Mr. Freedman, we will canvass Windsor—

Interjection.

The Chair (Mr. Shafiq Qaadri): Is Mr. Milling available from the RNAO, the Registered Nurses' Association of Ontario? No. Okay.

Interjection.

WINDSOR WOMEN WORKING WITH IMMIGRANT WOMEN

The Chair (Mr. Shafiq Qaadri): I understand that we do have Sungee John, past president of the Windsor Women Working With Immigrant Women. Is that correct? Ms. John, are you available?

Ms. Sungee John: Hello.

The Chair (Mr. Shafiq Qaadri): Hi. The committee is meeting and anxious to hear you. You have 20 minutes in which to make your presentation, and questions and comments if there's any time following. I'd invite you to please begin now.

Ms. Sungee John: Thank you. My name is Sungee John and I'm with Windsor Women Working with Immigrant Women. Accompanying me for this teleconference is Dr. Ahmer Rasool. He's the president of the Windsor-Essex International Medical Graduates. We do appreciate having—

The Chair (Mr. Shafiq Qaadri): Could I just ask you to speak into your microphone? It's a bit hard to hear you.

Ms. Sungee John: Is that better? I don't know. Can you hear me?

The Chair (Mr. Shafiq Qaadri): Go ahead, please.

Ms. Sungee John: Can you hear us better? Are we coming across a little louder?

The Chair (Mr. Shafiq Qaadri): Yes.

Ms. Sungee John: Okay. Once again, my name is Sungee John and I'm the past president of Windsor Women Working with Immigrant Women. With me for this teleconference is Dr. Ahmer Rasool. He's the president of the Windsor-Essex International Medical Graduates. We do appreciate having this opportunity to submit our comments regarding Bill 97 and the proposed changes to the Regulated Health Professions Act, 1991.

Generally, we are in support of the proposed changes because we think that they will offer more transparency in the decision-making process and allow some government oversight in the process. However, we also feel that it could be improved by including stakeholder input in the consultations, along with the Ministry of Health and the colleges of the related regulatory professions.

We also wanted to raise some points regarding the regulations. Under the proposed changes, it mentions that the government will be working with the college to amend regulations under the Medicine Act. They've detailed five recommendations. By and large, we support most of the recommendations, and Dr. Rasool can expand upon this. However, the first one, the directed practice recommendation, which talks about streamlining the registration process for doctors already practising elsewhere in Canada, the US or other countries with a comparable health and medical education system—for WEIMG, the Windsor-Essex International Medical Graduates, that poses some concerns because, once again, this gives an advantage to people living outside of Ontario. So for IMGs who have been residing in Ontario for at least a year or more, they fear that this process will once again put them on the outside looking in. Perhaps Dr. Rasool can comment on some of these recommendations. Dr. Rasool?

Dr. Ahmer Rasool: Hi. How are you? Can you hear me?

The Chair (Mr. Shafiq Qaadri): Yes. Please go ahead.

Dr. Ahmer Rasool: We support the act, but recommendation number 1 is directed practice: Streamline the registration process for doctors already practising elsewhere in Canada, the US and other countries. As you know, we already have doctors from South Africa, the UK, Australia and the US competing with us. My recommendation would be that at least for PGY-1, 2 and 3 positions—and that does not include the specialties and subspecialties—they should consider those IMGs residing in Ontario for at least one year, just like Alberta and Manitoba. Specialties and subspecialties are different categories, where you can always go and look for other physicians in other countries who are already practising and have postgraduate diplomas. But for those who have PGY-1, 2 and 3 positions, they are still waiting for their chance to get into the system.

The other point I want to make is, those people who are residing in Ontario and have done their MCC examinations and have proven their credentials should be given a three-to-six-month assessment under supervision in a teaching hospital before their fate is decided.

The other thing is, IMGs especially don't have any bridging program for the health care system, and that includes some other health-related professions.

The fourth comment is that there should be an ease on the foreign-trained professions by the universities and colleges so that they could have an expedited program where they can be given special training so that they can be integrated into the system. The government can save a lot of money on those who already have vast experience in their field.

The fifth one, which I think is a concern to everybody, whether they are from outside or inside, is the transparency of the system, the way the interviews are conducted, the way the examinations are conducted, because at the

end, even if they have done everything, they were never told why they were not taken into the system.

That concludes my five points.

The Chair (Mr. Shafiq Qaadri): Thank you very much. Have you both completed your formal presentations?

Ms. Sungee John: More or less.

The Chair (Mr. Shafiq Qaadri): Fine. We'll have considerable time for questions and comments. We'll begin with the Progressive Conservative caucus, and I would invite Ms. Laurie Scott to please begin. You have three and a half minutes or so per side.

Ms. Laurie Scott: Thank you very much. The first speaker who spoke said that she would support the recommendations. The bill is only one page and really almost one line. I just wondered what recommendations she was referring to.

Ms. Sungee John: The consultation between government and the college. The only addition I would make is that the consultations should be opened up for stakeholders to be involved in that process in terms of looking at the needs.

1530

Ms. Laurie Scott: This is something that's not obviously addressed in the bill. Do you think, from your association's presentation, that this bill actually addresses any of the concerns that you've brought forward?

Ms. Sungee John: Well, it's a start. It certainly doesn't address the meat of the concerns. In the years we've had working with IMGs locally and dealing with the various systemic structures in place, we know how difficult it is to even get a foot in the door. If this obliges the college to open up slightly some of their process and allow some modicum of transparency, we are all in support of that.

Ms. Laurie Scott: I appreciate that. You've worked with the college, I take it, in the past, with the IMGs. This bill really is just saying to work in consultation with the ministry, which we would have hoped would have been happening already. The bill doesn't even mention IMGs, really.

Do you feel that the spirit of working in good faith with the college is really going to change that much?

Ms. Sungee John: We're very cynical, but anything on paper that can commit the two parties is a step in the right direction. I guess, as the saying goes, the proof is in the eating of the pudding.

Ms. Laurie Scott: Would you be able to send us the recommendations? I don't know if Hansard has picked them all up, but just for clarification on what changes you'd like to see, some recommendations to actually put some more beef into the bill for us. Do you think you could—

Ms. Sungee John: We can do that, yes. I was just trying to set up my laptop. I'm having glitches right now, but once that's done, we can forward those recommendations.

Ms. Laurie Scott: That would be much appreciated. Thank you very much.

Ms. Sungee John: I agree with your point in terms of your concerns of this legislation being more superficial than actual substance, but it's a start. With the IMGs being, again, on the outside looking in, any start that can help them get somewhere is important.

Ms. Laurie Scott: Okay. We look forward to those recommendations. Thank you.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Scott. This is, of the NDP, Ms. Cheri DiNovo.

Ms. Cheri DiNovo: Hello, and thank you for your deputation. Certainly, we've heard a couple already today. We in the New Democratic Party feel that this is a pretty superficial bill as well—one we're going to support because, how could one not? At the same time, so much more is needed. I'm interested in seeing, as well, the written submission.

I gave an example to the former deputant and I would ask you to answer it as well. I have a constituent who is a surgeon who can't get work here because it would take him 10 years to get accredited. Right now he is working as a baker for about $9 an hour and travels back to his home country of Iran for six months of the year to practise as a surgeon just to keep his family eating and in rent. This is clearly not what we want. How would you address that situation were you to be put in charge of the College of Physicians and Surgeons?

Ms. Sungee John: Certainly, Dr. Rasool made some points earlier in his presentation that the assessment process—at this point, IMGs can pass all the exams, they can score high marks, but the likelihood of even getting an interview or getting a placement in a residency all boils down to connections. Connections are critical. They can be as brilliant and as competent as the next physician, but not having that connection leaves them at a disadvantage.

Oftentimes, as you mentioned, they have other priorities. If they came here as immigrants they have to feed their family. Dr. Rasool would love to practise as a family doctor but has to support his family and work in a factory during the day to ensure that they survive, and he can also live in hope that he will one day be a doctor practising in this province.

Certainly, having a mandatory assessment process, as Dr. Rasool mentioned, forcing the college and various teaching hospitals that offer residencies—to mandate them to have a percentage of their spots that will be given to IMGs based on a combination of merit and other community involvements and not based on who you know and who can get you in because you have to know someone who teaches. That's often the case. In fact, some of the IMGs from Windsor who have succeeded have succeeded thanks to a mentor who is in the system. Without the mentorship, without mandatory assessments, without a fair, transparent and accountable structure, there is no way that there can be some democratization of the process.

Ms. Cheri DiNovo: Thank you very much.

The Chair (Mr. Shafiq Qaadri): We'll now move to the government side. Ms. Broten.

Ms. Laurel C. Broten: Do you, Dr. Rasool, share the public perception that the College of Physicians and Surgeons is not allowing qualified internationally trained doctors to practise medicine in Ontario?

Dr. Ahmer Rasool: Yes, and the reason is—I can just quote you some of the examples. When immigrants come here, especially the physicians, they have to support their families. The immigration law itself says that you have to be in Canada for 1,095 days to get your citizenship, and it's very hard to go back and forth to your country and come back. That's one criterion of the selection, that if you're out of practice for more than three years, then you are not even considered.

Ms. Laurel C. Broten: Right. I have a few more questions for you. Do you think the registration process favours Canadian medical graduates?

Dr. Ahmer Rasool: I have not gone through that personally, but what people tell us is just the selection criteria—when you go for the interviews, even if you scored well in your MCC examinations, your application is not even considered and you are not called for the interview. So all we want is more transparency in the College of Physicians and Surgeons' criteria of selection and the way it is conducted.

Ms. Laurel C. Broten: Have you had a chance, either of you, to read the report that I drafted on removing barriers for international medical doctors?

Dr. Ahmer Rasool: Yes.

Ms. Sungee John: Yes. The group read that back in June, when we met earlier, when the proposed legislation was first announced.

Ms. Laurel C. Broten: Great. So do you feel as I do that assessments being undertaken more efficiently, better hands-on training and some practical experience, individualized bridging support and mentorship are the crux of what is needed specifically to assist those doctors who are already in Ontario but have, to date, been ineligible to practise here?

Dr. Ahmer Rasool: Yes.

Ms. Laurel C. Broten: Thank you very much for your advocacy.

Dr. Ahmer Rasool: You're welcome.

The Chair (Mr. Shafiq Qaadri): Thanks to you, Ms. John and Dr. Rasool, for your presentation on behalf of the IMGs and the Windsor Women Working with Immigrant Women group. Thank you very much.

Dr. Ahmer Rasool: You're welcome.

Ms. Sungee John: Thank you.

The Chair (Mr. Shafiq Qaadri): All right. We'll now move to our next presenter, if present: Mr. Mel Freedman.

Do we have Mr. Robert Milling of the RNAO?

Do we have Dr. Preston Zuliani, chair of the College of Physicians and Surgeons of Ontario?

Fine. We'll recess until 4 p.m., which is 20 minutes from now.

The committee recessed from 1538 to 1553.

MEL FREEDMAN

The Chair (Mr. Shafiq Qaadri): Colleagues, I'd invite you to reconvene just a little bit early, as our next presenter is now present, and I think we have more than quorum.

I now invite Mr. Mel Freedman to please come forward. He'll be presenting to us in his capacity, again, as a private citizen. Mr. Freedman, you have 10 minutes in which to make your presentation. The time remaining for questions and comments will be distributed amongst the parties. I invite you to begin now.

Mr. Mel Freedman: It's a pleasure to have this opportunity to present to the committee. My presentation focuses on the goals of a new international medical graduate mentorship program, IMGMP. The goal of this program is to establish a recognized body to facilitate the assessment and licensure of experienced international medical graduates who now are legally residing in Ontario. Another goal is to create a physician mentorship program for the IMGs that will have strict criteria for IMG mentoring, participation and evaluation, and government funding support. A third goal is to create a balance and a level of equity between two groups of physicians: foreign-government-sponsored physicians who are in this province on visas and have been admitted to residency programs, and non-funded international medical graduates residing in Ontario. A fourth goal is to create equity and balance between foreign doctors who receive an academic licence immediately to practise medicine at an Ontario medical school affiliated with a teaching hospital, and a foreign academic physician from a foreign medical school who is not government-sponsored and is required to pass at least four examinations prior to possible licensure.

Objective of the proposal: This proposal will describe practical ways in which internationally trained physicians residing in Ontario can be instrumental in alleviating the severe physician shortage in Ontario, and utilize a currently wasted human resource of Ontario IMGs. The proposal advocates the establishment of an IMGMP, which will supplement the evaluation and orientation services of the Centre for the Evaluation of Health Professionals, also known as CEHPEA, and the HealthForceOntario Access Centre. CEHPEA is able to provide a practice-ready assessment and post-graduate year-two entry program for post-graduate medical residents as well as a program entitled Orientation to Training and Practice in Canada. The proposed mentorship program will restore new equity and fairness to the existing provisions for licensing foreign-trained physicians.

Background: Although residency spots have increased, a very small number are going to foreign-trained doctors residing in Ontario who are citizens of Ontario. In 2005, 1,082 licences were issued to foreign medical graduates. Visa trainees from foreign countries with government sponsorship numbered 709 post-graduate certificates, 215 physicians received either academic licences or full practice licences, and the balance of 158 were foreign-

trained doctors living in Ontario who received limited-practice licences with acceptance in a residency program at one of the medical schools. This figure of 158 is a very small proportion of the estimated 5,000 foreign physicians residing in Ontario, with a heavy concentration in Toronto, Hamilton, Kitchener-Waterloo and London.

What is needed is a more comprehensive approach to the problem. The diverse composition of the IMGs in Ontario needs to be examined. First of all, there are some physicians whose training is substandard and cannot be considered; I'm not referring to these individuals. Recent graduates of acceptable training programs recognized by the World Health Organization will need to complete the required examinations and residencies to be competent to practise. However, there is a number of physicians who have limited relevant experience of three to four years in their home country but who would need to be enrolled in a highly structured mentorship program or could become academic fellows before getting a full licence.

There is another group of many very proficient and highly experienced physicians with over 15 to 20 years' experience, who have worked in sophisticated health care systems. This group, as well, would only require a period of structured mentorship or probation prior to licensure for independent practice. One of the common features of this group is that many of these highly trained specialists periodically leave Ontario for about two or three months, go back to their home country and practise, and then come back again. So they are keeping up their skills, although in their home country.

1600

The intent of the IMGMP will be to take a second and more comprehensive approach to gaining licensure in Ontario and utilizing existing avenues in creating a new mentorship program for qualified IMGs. This second path would include four elements.

First, the path to gaining an academic licence should be broadened to include foreign physicians who are actually resident in Ontario, are citizens of Ontario and have academic credentials in their home country.

Secondly, the same residency positions available to foreign graduates and funded by foreign governments—examples of foreign governments would be Saudi Arabia and Libya—would be open to applications from Ontario residents and citizens.

Thirdly, a sophisticated mentorship or preceptorship program would be created. Such a program would enable qualified IMGs of variable experience who are not in the health care system an opportunity to be mentored by a community family physician or specialist and have a restricted licence. This program could target physicians who have many years of experience in health care systems similar to the Canadian system—the United Kingdom, France, Italy, Ireland, Israel and, I'm sure, other countries. It would be anticipated that the mentorship for this group of physicians be one to two years, followed by a period of limited licensure and probation.

Fourthly, all IMGs who have been successful in any of the three paths noted above will have to participate in some form of compulsory continuing medical education designed for foreign-trained physicians and developed by the six Ontario medical schools in association with the College of Physicians and Surgeons of Ontario, the College of Family Physicians of Canada and the Royal College of Physicians and Surgeons of Canada.

Structure of the mentorship: A senior community physician will sponsor and supervise the IMG—some form of payment needs to be given to physicians who sign up as supervisors and mentors, as they are now being paid in the province of Alberta today. A uniform training program will be designed and made available for the community supervisors. A liaison person will be assigned to the supervisors. The mentorship program would consist of graduated areas of responsibilities, as determined by CEHPEA and HealthForceOntario.

Methods of evaluation of the mentorship: The Ontario medical schools will be asked to share their protocols for assessment of residents. The assessment will include aspects of character, competency and medical knowledge.

Personnel required: The new body would need the usual administration and personnel office support to be able to keep track of all mentored IMGs. Possibly, the entire program for mentorship would be supported by CEHPEA and integrated as a total support program.

Finally, the role of the Association of International Physicians and Surgeons of Ontario: This is a group of 5,000 foreign-trained doctors who are not practising in Ontario. AIPSO would be a constructive voice in implementation of the project and could have a representative on the board of the IMGMP and be able to liaise with the CEHPEA. Possible roles include being a resource database for both IMGs and their supervisors; being a single voice to bring forward issues related to the program; being the avenue for initiating, organizing and evaluating CME; and disseminating information on the program to interested parties. Thank you.

The Chair (Mr. Shafiq Qaadri): On behalf of the committee, I thank you for your written presentation as well as for coming forward with your points today.

REGISTERED NURSES' ASSOCIATION OF ONTARIO

The Chair (Mr. Shafiq Qaadri): I now invite Mr. Robert Milling, health and policy director of the RNAO, if he is available, to please come forward.

You have 20 minutes to make your presentation, with time remaining distributed among the parties.

Ms. Catherine Mayers: Good afternoon. My name is Catherine Mayers. I am a board member of the Registered Nurses' Association of Ontario. To my left is Kim Jarvi, and to my right is Rob Milling.

The RNAO is the professional organization for registered nurses who practise in all roles and sectors across this province. Our mandate is to advocate for healthy public policy and for the role of registered nurses in enhancing the health of Ontarians. We welcome this

opportunity to present to the Standing Committee on Social Policy our recommendations on Bill 97.

RNAO applauds any measure that acknowledges or addresses the need for access to an adequate number of heath care professionals. We believe that Bill 97 does this and is a helpful step forward.

Registered nurses have a lot at stake here because many of us have been working under difficult circumstances for many years. This is not sustainable. The root cause of the difficult circumstances was prolonged system neglect of nursing issues. In particular, employment opportunities in nursing lagged far behind population growth. Combined with an aging population with growing and complex needs, nurses started experiencing workloads that many found unbearable. Compounding the stress were mass layoffs of nurses in the later 1990s, which further increased the burden on the remaining nurses. Thousands of nurses left the province for work elsewhere or left the profession entirely, and enrolment in nursing schools plummeted. With a large number of nursing retirements on the horizon, the profession was facing a dangerous time in Ontario.

Halting this dangerous trend called for a massive effort, as pointed out in the Nursing Task Force report of 1999. The government of the day reversed its policy with respect to nurses and started rehiring them. It made a number of commitments to nurses, including the creation of 10,000 new positions. When the current government came to power in 2003, it committed to create 8,000 nursing positions in its first mandate. It promised 9,000 additional positions in its second mandate. Because nurses comprise the bulk of Ontario's health care professionals, this is a very crucial but massive undertaking, and it must be dealt with urgently. According to figures from the College of Nurses of Ontario, some progress is being made. Over the first three years of the government's first mandate, the nursing workforce rose by 6,501 and the share of RN employment that was full-time rose from 59% to 63%. However, we were alarmed to hear in the Minister of Finance's statement this past October 22 that the government was postponing its commitment to create the 9,000 nursing positions as well as 50 health care teams by one year. I find it quite ironic that a bill seeking to ensure access to health professionals is going to committee at the same time that much-needed nursing positions are being delayed.

Bill 97 acknowledges that it is in the public interest that Ontarians have access to adequate numbers of qualified, skilled and competent regulated health professionals. The bill would make it an obligation of the regulatory bodies to work with the government to ensure that access. Below, we discuss what that obligation should entail.

As I mentioned earlier, Bill 97 is a step forward, but it is not in itself a solution to the nursing shortage, which requires a comprehensive nursing strategy with recruitment and retention components. Such a strategy would include the following: creating enough nursing positions to meet population needs; supporting interdisciplinary practice; allowing RNs to work to their full scope of practice; supporting healthy work environments; funding enough seats in nursing programs; and ensuring that there are sufficient faculty, facilities and preceptors to educate the nursing students who will renew the nursing workforce. Implementation of this strategy is the responsibility of the government and not of the colleges, which do not have the capacity to educate the needed nurses or to create the positions for them.

The government has committed to some key elements of a nursing strategy, and we will work with the government to ensure timely implementation of those commitments. With respect to internationally educated nurses, IENs, the RNAO has been a strong advocate in support of those who exercise their human right to migrate and choose to make Ontario their home. There must not be any systemic barriers to internationally educated nurses with permanent status in Canada from practising their profession and serving the public.

1610

The IENs comprise an increasing share of the nursing workforce in Ontario. In 2005, the IENs accounted for 34.1% of all new RNs. Research shows that IENs face challenges at all stages of the process of moving into practice in Ontario. These include: difficulties and delays completing the application process to become licensed; required investments in upgrading and further education to become eligible to take the RN exams; difficulty writing the exam due to a lack of familiarity with Ontario nursing culture and with exam formats; and integrating into the nursing workforce. As a result, the pass rates for the IENs were much lower than for nurses educated in Ontario.

There are several existing programs that facilitate registrations of IENs in Ontario. The CARE Centre for Internationally Educated Nurses has had success in assisting internationally trained nurses to prepare for qualifying exams once they have met their academic requirements. A number of Ontario nursing schools offer bridging programs for IENs. For example, York University offers a 20-month program that enables internationally trained RNs to meet the current academic entry-to-practice requirements more quickly. The first class graduated with a bachelor of science and nursing degree in December 2006. The program also offers an extensive ESL component created for health professionals. The government must continue to support programs of this sort to ensure that we do not waste the skills of internationally educated health professionals.

While the RNAO's commitment to facilitating the practice of IENs in this province is clear, we are just as convinced that a nursing strategy must not resort to the international recruitment of nurses. We must not contribute to global health inequities and the human and economic costs of stripping vulnerable populations of access to health care professionals.

RNAO supports the World Health Organization, the International Council of Nurses and the Canadian Policy Research Networks in calling for ethical international

recruitment guidelines within the context of a responsible national and provincial health human resource strategy. International recruitment is not an acceptable substitute for greater investments in nursing education, improved interdisciplinary work and a focus on workplace health that must be key components of a made-in-Ontario nursing strategy.

The role of the colleges: The colleges' first duty is to ensure that regulated health professionals meet practice standards. In response to the bill, they would work with the government to quantify shortages and advise on strategies to address those shortages. They may be in a position to streamline procedures for internationally educated health professionals and remove unnecessary obstacles while still maintaining standards. They may also be able to advise the government on developing programs that would make it easier for internationally educated health professionals to meet requirements for registration in Ontario. But to repeat, relying on the recruitment of internationally educated health professionals is not a solution to the shortages of health professionals.

How many more RNs are needed in Ontario? There are different methods that could be used to determine the number of additional RN positions required. However, it is safe to say that most would not want Ontario's RN population ratio to fall below that of the rest of Canada, particularly given that Canada's ratio is considerably worse than it has been in the past. Based on the latest available data, Ontario would require more than 10,000 RNs to catch up with the rest of the country. At the very least, the 9,000 promised RN positions should be delivered as quickly as possible to enhance access to health care.

In conclusion, Bill 97 is a step forward in providing a mechanism for identifying the magnitude of the shortage or surplus in each health profession. However, the bill must not be interpreted as an obligation on colleges to water down standards to meet health human resource objectives, nor is it a substitute for a health human resource strategy, which remains the responsibility of the government to implement.

In closing, RNAO welcomes Bill 97 but remains deeply concerned about the contradictory message sent last week with the delay in the government's commitment to hire 9,000 nurses and deliver 50 more family health teams. We would urge the government to rethink its position and keep its original promise on track. Thank you very much.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Mayers. We'll have about three minutes per side, beginning with the NDP.

Ms. Cheri DiNovo: Thank you, and thank you very much for all your hard work and for deputing before us. I'd like you to speak just a little bit about community health centres and nurse practitioners, because one of the motivators behind this bill—such as it is, in its one page, one line; it doesn't do much, but it's a tiny step forward—is the outrageous shortage that we have, for example, of GPs. One of the deputants has raised the issue that in a sense more GPs are part of the solution, but also part of the solution are more CHCs and nurse practitioners. If you could just address that.

Ms. Catherine Mayers: Absolutely. The need for more RN- or more nurse practitioner-led clinics is vital. Nurses work very well with physicians, as they work well on their own. Actually, I would say that it's a combination of both: To increase the number of nurse-run NP clinics, which has been promised, although I'm not quite sure how soon this is going to happen, especially now with the economic downturn; and the 50 family network clinics, and utilizing RNs to the best of their scope, also utilizing physicians and other health professionals at the best of their scope, will certainly increase access to the Ontarian population.

Ms. Cheri DiNovo: Certainly we in the New Democratic Party are fully committed to making sure that those 9,000 nurses do come down the pike—to the best of our ability, at any rate. Thank you very much for deputing.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. DiNovo. To Ms. Broten.

Ms. Laurel C. Broten: Thanks very much, and thank you for your thoughtful presentation and your advocacy on behalf of Ontario's nurses. Through you, back to those nurses, please thank them for the important role that they play in our health care profession and in our health care system.

I don't know whether you yourselves have had an opportunity to read the Report on Removing Barriers for International Medical Doctors that I drafted and we released some months ago, but I did want to acknowledge in your presence that the CARE Centre for Internationally Educated Nurses was acknowledged in the report as providing a wonderful example of the type of work that can be done when our colleges take a look at how you can prepare internationally-trained professionals to be practice-ready in Ontario. It's my understanding that the CARE Centre has about a 75% success rate on licensure exams, and I'm wondering if you can comment on how critical that really specific program of mentorship and training is to taking those who might not otherwise pass an exam, getting them ready and then getting that level of success rate. It's quite incredible.

Ms. Catherine Mayers: I think I'll ask Kim to answer that.

Mr. Kim Jarvi: I haven't seen the most recent figures for CARE for Ontario, but we're very grateful that it was acknowledged in your report. We did read it very closely, I assure you.

For the first year in the program, the success rate went from in the 40s to in the 80s. I don't know about subsequent years, but that's a tremendous improvement. It obviously was fixing a problem that was readily fixed. That's really great bang for the buck, so we're glad for the support.

Ms. Laurel C. Broten: Thank you very much.

The Chair (Mr. Shafiq Qaadri): Ms. Mayers, I'd just ask to identify your colleagues for us for the purposes of recording for Hansard.

Mr. Kim Jarvi: It's Kim Jarvi, senior economist.

The Chair (Mr. Shafiq Qaadri): Thank you, and thank you, Ms. Broten. To the PC side.

Mrs. Elizabeth Witmer: Thank you very much. I had the distinct pleasure of working with the RNAO and setting up a task force which identified some of the needs and saw the creation, I think, of almost 12,000 new nursing positions which were badly needed. I guess I shared the shock of many people last week, if my phone and e-mail are any indication, at the government now breaking its promise and giving no date whatsoever for moving forward with the 9,000 new positions that were promised.

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What I would like to hear from you, because this bill says nothing other than that the government will work with the colleges—end of statement. I've heard from nurses. I have to tell you, nurses are frightened. They have been in contact with me because they know that many people are nearing retirement and there's a message communicated here when the government says, "We're not going to hire these 9,000 people," people who are the backbone of the health care system. The public identifies nurses with health care. So I want you to share with me what you perceive the impact to be, because I think that whatever we can do to motivate this government to get this back on track needs to happen ASAP.

Ms. Catherine Mayers: Absolutely. Thank you for all of your work. We really appreciate you at RNAO.

I would say that more than the nurses are upset. The actual public is upset. There has been a public outcry at these 9,000 nursing positions that aren't being filled. These are not extra positions; these are positions that we need now, today. We were giving the government a little while to get them going, but we actually need them today. Our worry is: In a year from now, what is the economic situation going to be like? Is it going to be postponed yet another year? So I don't quite buy postponing it now.

What is the implication of these positions not being filled? It's decreased access to health care, increased wait times for surgeries because the nurses—it's not that there are no beds; there are no nurses to man the beds. So it is a very serious situation, and the RNAO is very displeased with the present government on their announcement last week.

Mrs. Elizabeth Witmer: Is there anything that you would plan to do in order to ensure—because I think you pointed out here somewhere that we're actually 10,000 nurses short as of 2006.

Ms. Catherine Mayers: Right.

Mrs. Elizabeth Witmer: Is there anything? I have been hearing about surgeries being postponed. Obviously, the new family health teams, nurse practitioners, emergency rooms—long-term care is having trouble right now hiring nurses, and we've got a growing and aging population. Is there anything that can be done in order to make sure the government realizes that this is critical, this hiring of nurses, if we're going to provide access to health care?

Ms. Catherine Mayers: Right now, we have a campaign going to write your MPP to discuss displeasure with the announcement of last week, and we'll see if we can get forward—and just continuing. I was in the media last week promoting the 9,000 nurses and showing our displeasure. So just more of what we do, what RNAO does, and—

Mrs. Elizabeth Witmer: We're certainly there with you, and I know the public is there too, because we've heard from them too.

Mr. Catherine Mayers: Yes, we have.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Witmer, and thank you as well, Ms. Mayers and your colleagues on behalf of RNAO.

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

The Chair (Mr. Shafiq Qaadri): I would now invite our next presenter to please come forward: Dr. Preston Zuliani, the chair of the council of the College of Physicians and Surgeons of Ontario, and colleagues.

As you've seen, Dr. Zuliani, you have 20 minutes in which to make your presentation. Questions and comments will be distributed amongst the parties afterward. I'll just have you introduce yourself and perhaps identify your colleagues for the purposes of Hansard recording. I would invite you to begin now.

Dr. Preston Zuliani: Thank you very much. My name is Preston Zuliani and I'm a family doctor practising full-time in general practice in St. Catharines. I'm president of the College of Physicians and Surgeons of Ontario. With me today to my right is Louise Verity. She is the college's director of policy and communications.

We are pleased to be here to present on behalf of the college on Bill 97, Increasing Access to Qualified Health Professionals for Ontarians Act.

At the outset, I would like to emphasize that the college is a body with a public-interest focus. It is important to note that the college's mandate is not to train or supply doctors for the province but to ensure that those who are practising medicine in Ontario are competent. As the self-regulating body for the medical profession, the college ensures that all doctors who practise in Ontario meet the standards for training and experience.

While the college is committed to ensuring that there are no unnecessary barriers to registration for those seeking to practise medicine, our first and foremost priority is to protect the public interest and to ensure patient safety.

In our presentation, we will first outline the college's interpretation of Bill 97, our concerns regarding its current wording, and a proposed amendment which we believe reflects the intent of the legislation.

We will also outline the progress the college has made in registering ever-increasing numbers of doctors to serve the people of Ontario, including international medical graduates, and also our work with other stakeholders to register even more doctors; some recent changes in our

registration policies that will simplify registration of doctors trained in other Canadian provinces and the US; as well as our ongoing efforts to facilitate the registration of more international medical graduates while preserving a high professional standard.

The college supports the registration of all qualified IMGs. However, we would like to emphasize that there are two components to Bill 97. The first is to increase the number of health care professionals; the second—and central to the mandate and role of the regulatory colleges—is to ensure that these health care professionals are qualified. The pursuit of one cannot come at the cost of the other.

The college's first priority is, and must remain, the safety of the public. Ontarians want more doctors. They also want the comfort of knowing that they're being cared for by qualified doctors who meet Ontario's standards of practice.

We understand that the bill was developed to convey the government's objective of increasing the access of Ontarians to qualified health professionals. We support the spirit and intent behind the proposed legislation. However, the legal implications of the legislation on health colleges are of significant concern. It appears to impose a new duty on health colleges to ensure that the people of Ontario have access to adequate numbers of qualified, skilled and competent regulated health professionals.

As noted earlier, the college is not in the business of making or training doctors. We cannot simply open up the tap and increase the supply of doctors. When it comes to physicians, others—like the government of Ontario, medical schools, as well as many other stakeholders—all play a critical and arguably more central role in ensuring an adequate supply of physicians than the college.

For instance, it is the medical schools that provide education to future doctors, set the curriculum, determine the number of students who will be admitted etc. The number of medical schools in Ontario depends, to a large degree, on provincial government funding. The availability of residency positions is determined by the medical schools, government funding, and the availability of hospital-based educators. The examinations to secure specialist titles are set by the Royal College of Physicians and Surgeons of Canada. The credentials evaluation and assessment of international graduates are undertaken by the Medical Council of Canada and the Centre for the Evaluation of Health Professionals Educated Abroad. These are just a few of the organizations that are involved in training physicians. It is inappropriate and impractical to impose a duty or an obligation on health colleges to achieve outcomes that are outside their control.

We believe that the government could achieve its objectives through a slightly different approach. We suggest that instead of imposing a new duty on health colleges, Bill 97 should amend the Regulated Health Professions Act to add an additional object for each college. Specifically, we recommend that instead of amending section 2 of schedule 2 under the RHPA, the bill should amend section 3 as follows:

"3(1) The college has the following objects: ....

"12. To work in consultation with the minister towards ensuring, as a matter of public interest, that the people of Ontario have access to adequate numbers of qualified, skilled and competent regulated health professionals."

Increasing access to physicians has been a college priority for many years. For many years, the college has been a leader in working with our partners—the government of Ontario, medical schools, national education bodies etc.—to find new ways of enhancing patient access to physicians. We have initiated a number of task forces, involving multiple stakeholders, to look at ways of enhancing the number of doctors without compromising standards.

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Many of our recommendations have been implemented and have resulted in an increase in the number of residency positions available and ever-greater numbers of international graduates being registered in Ontario. In fact, over the past 10 years, we have consistently registered more new doctors each and every year, and a growing proportion of these are international medical graduates. Let me provide you some examples from our 2007 registration report:

Last year, the college issued 3,279 certificates of registration. Never before have we even approached 3,000.

For the fourth straight year, more certificates were issued to international medical graduates than to our own Ontario graduates.

Twenty-five per cent of independent medical certificates, or one out of every four, went to international medical graduates. The number of independent practice certificates issued to IMGs was the highest in more than 20 years and marked the seventh straight year of increasing issuance of these certificates to international graduates.

As a direct result of new college policies and programs developed in collaboration with many stakeholders, and in some cases funded by government, well over 1,000 applicants have been issued a practice certificate who would not have been licensed previously.

The college has been diligently seeking to, and succeeding in, registering more doctors for the people of Ontario. We are also continually seeking new ways to streamline our registration process to facilitate the registration of international medical graduates. As demonstrated by our most recent registration results, we have also had success in this area.

The college continues to look for additional ways to register even more doctors, including IMGs. However, we cannot do this alone. The training and registration of physicians and surgeons involves a variety of organizations, and these include government, medical schools, hospitals, credentials assessment organizations, the College of Family Physicians of Canada, the Royal College of Physicians and Surgeons of Canada, the Canadian Medical Protective Association—and I could go on and

on. To increase Ontario's supply of doctors, all the agencies must pull together.

The college has taken on a number of initiatives to work collaboratively with our partners. Amongst other things, the college has led a multi-stakeholder group called the physician resources task force. This task force has been meeting over the summer months, and our work has already borne fruit. Just in September, the college approved four new pathways to registration. These new policies, which will come into effect on December 1, make it possible for doctors fully licensed and practising in the United States or other parts of Canada to become registered in Ontario without further training or examinations. Our colleagues at HealthForceOntario believe that these new policies will make it much easier for Ontario to attract physicians from other provinces and especially from the United States.

The college is also in the process of consulting on two additional routes to the registration of foreign graduates trained outside of Canada and the United States. I won't go into the details, but could do so if you choose.

The college is consulting broadly on these proposals and will continue to work to refine our registration process, as well as find additional ways of enhancing routes to licensure. Our consultation includes a number of stakeholders, including MPPs as well as provincial bodies like the Human Rights Commission and the Fairness Commissioner.

Increasing the number of health care professionals is an important but long-term and complicated goal. As there are many professions working in the health care system and many players within each profession, the college renews its recommendation that the government establish an independent health human resources planning body. We feel this is particularly critical given the direction of this legislation.

In closing, I'd like to reiterate the college's support for the goal of Bill 97, that of increasing the number of health professionals who are qualified to serve the people of Ontario. However, we believe that this goal could be better achieved by amending the bill so that it emphasizes that working collaboratively with the health minister on this is an object of each health college under the Regulated Health Professions Act.

The college has and continues to stand ready to work with all of our partners to help ensure that Ontarians have access to qualified regulated health professionals.

Thank you for the opportunity to present to the committee. We would be pleased to answer any questions you have.

The Chair (Mr. Shafiq Qaadri): Thank you. We have about two minutes or so per side. Ms. Broten.

Ms. Laurel C. Broten: Just to clarify, you're prepared to work in consultation with the minister toward ensuring, as a matter of public interest—and the sentence continues—but you're not in agreement that a positive duty be imposed upon the College of Physicians and Surgeons to work with the minister?

Dr. Preston Zuliani: No. We definitely want to work with the minister on this; it's very important. We have concerns that if it becomes our duty to make sure that there are enough doctors and we don't the ability to do so, we could be challenged legally in some of the things we're doing.

Ms. Laurel C. Broten: The phraseology of the bill is, "It is the duty of the college to work in consultation with the minister to ensure, as a matter of public interest, that the people of Ontario have access to adequate numbers of qualified, skilled and competent regulated health professionals." And you are in agreement with working with the minister?

Dr. Preston Zuliani: Definitely in agreement with working—

Ms. Laurel C. Broten: And we have successfully undertaken that work over the summer, to introduce new pathways following the introduction of Bill 97. Correct?

Dr. Preston Zuliani: Absolutely.

Ms. Laurel C. Broten: Do you agree that the current registration process for doctors is rooted in a process established to favour Canadian medical graduates and that ultimately it is substantially unfair when it comes to assessing the qualifications and experience of internationally trained doctors?

Dr. Preston Zuliani: No, I wouldn't agree with that. The centres of medical training in different parts of the world are radically different. For us to be able to assess each medical program in 100 countries is very, very difficult. We have come up with some innovative ways to try to get around that.

Ms. Laurel C. Broten: Do you agree that internationally trained doctors face a number of barriers, including challenges with respect to credential recognition, misinformation regarding certification and registration?

Dr. Preston Zuliani: As I said, we've licensed more international graduates than Ontario graduates for four years in a row. We are doing our very best to break down barriers, and you can see, from the new proposals that will come into effect on December 1 and our suggestion for new pathways for other graduates, that we'll be going much further.

Ms. Laurel C. Broten: Do you agree that international medical graduates face different barriers than our Canadian medical graduates?

Dr. Preston Zuliani: They definitely have different barriers, yes—language, culture, training etc.

Ms. Laurel C. Broten: But not with respect to credential recognition or certification?

The Chair (Mr. Shafiq Qaadri): With respect, I will need to intervene there and offer the floor to the PC side. Mrs. Witmer.

Mrs. Elizabeth Witmer: I appreciate the presentation that you've made. I think sometimes we lose sight of—and I guess I say this based on having been a health minister—what the priority of the colleges was intended to be, and that is to protect the public interest and to ensure patient safety. I consider that to be a very, very significant responsibility. Certainly, I would share some of the concern about imposing this additional duty because I do

believe the colleges are not capable of making or training doctors. I think it has been well pointed out here that it's dependent upon a lot of other people, including the government; the number of medical spaces we have in the province of Ontario; and certainly some of the other partners. So, I think in working co-operatively, we have a responsibility to co-operate, one with the other. But I think as the nurses pointed out, it's not something for any one college or one group, so to impose this type of an obligation to achieve outcomes outside somebody's control is really quite unrealistic.

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Having said that, what more do you think you could do as a college—and I understand that you have made some progress in recent months, and we're going to be seeing some different pathways—over the short term? I hear from IMGs, but I also hear, increasingly, concern from people who have been educated in Ontario and then go away to medical school and try to come back. How can we accommodate those two groups of people that are having difficulty?

Dr. Preston Zuliani: One of the pathways we're working on is to simplify registration requirements for physicians who have trained in certain jurisdictions recognized by the royal college of Canada; for example, Australia, Hong Kong, the Republic of Ireland, New Zealand, Singapore, Switzerland, South Africa and the UK, so that a pathway, which is in development now and is open for consultation—we're waiting for feedback—will allow us to bring these doctors into the country very easily. There's another pathway we're working on for doctors who are trained in countries where we don't have as good a confidence in the medical systems, and we're trying to find creative ways of bringing them up to speed and bringing them here as well.

The Chair (Mr. Shafiq Qaadri): Thank you, Mrs. Witmer and Dr. Zuliani. Now to the NDP. Ms. DiNovo.

Ms. Cheri DiNovo: Thank you, Dr. Zuliani, and thank you for the clarification of what your role is. We heard a deputant earlier who talked about another organization, the Association of International Physicians and Surgeons of Ontario. Apparently there are 5,000 medical doctors, which was news to me, who are trained but cannot practise, and who are residents and citizens of Ontario. Clearly, we have a GP shortage in Ontario, among other issues with our health care system. So I guess I'm going to lead off where my colleague began, and that is to say: What suggestions do you have, then, for ways in which we can bring the two parties together?

Dr. Preston Zuliani: The difficulty there is, someone who's been out of practice for 10 years, five years, 20 years, someone who's trained in a totally different system, would probably flounder in our system. What they need is further training and more residency positions. So if you could open up more residency spots, take those doctors and send them back to school for a couple of years to bring them up to speed, I think that would be wonderful.

Ms. Cheri DiNovo: How would we get more residency spots?

Dr. Preston Zuliani: That would be a government initiative to open more residency spots so that these doctors could go back and be updated.

Ms. Cheri DiNovo: So it comes full circle back to the Ministry of Health, then?

Ms. Louise Verity: There's another option as well that we're exploring, and that is looking at other—the reality is that not every internationally trained physician who is currently in Canada is ever going to be able to practise, and that's simply a reality. So some of the other initiatives that we are considering, together with government, are looking at—we have the physician assistant program, which is certainly under way now, and there are some others as well. There is some discussion about a physician associate position as well, and so that's certainly the direction that we also need to go in. But it does become increasingly difficult to license physicians who have not practised for a significant amount of time.

I think another big part of this as well is, we do, as a provincial college, rely on the national education bodies to do the assessment of which jurisdictions where the training is appropriate to what occurs here in Ontario and in Canada. The royal college, which is the body that certifies what we would describe as specialists, has actually not been doing this—they have not been keeping up in this particular area for some time.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. DiNovo, and thank you to you, Ms. Verity and Dr. Zuliani, for your presentation and written submission on behalf of the College of Physicians and Surgeons of Ontario.

MUKARRAM ALI ZAIDI

The Chair (Mr. Shafiq Qaadri): We'll now proceed directly to our final presenter of the day, Dr. Mukarram Ali Zaidi, who I understand is on teleconference. Dr. Zaidi, are you there?

Dr. Mukarram Ali Zaidi: Yes, I am here.

The Chair (Mr. Shafiq Qaadri): That's great. And if I might just ask that everyone increase their volume so we can proceed.

You will have 10 minutes, Dr. Zaidi, in which to make your presentation, and any time remaining will be offered to the parties for questions. I invite you to begin now.

Dr. Mukarram Ali Zaidi: First of all, thank you very much for giving me the opportunity to present my ideas. I am an international medical graduate. I did my MD in 1996 and then I came to Canada and did my master's in epidemiology at the University of Toronto. There, I extensively studied population health, risk assessment and management at U of T. My areas of interest were the Canadian family health care system and the integration of international medical doctors into the health care system. I have provided three documents to everyone. One is a reference document, which is my final submission for a course; one is a three-page document, Pathways to Medical Practice for International Medical Graduates and A

Model to Effectively and Efficiently Deliver Health Care to Canadian Citizens. Do you all have that?

The Chair (Mr. Shafiq Qaadri): Yes, it has been distributed. Thank you for your, I think, more than 50 pages of submissions.

Dr. Mukarram Ali Zaidi: Perfect. I would like you to focus on just the three pages and the one that says, "Pathways to Medical Practice." I would like to start on the second page, where it says, "Problem Identification."

At this point, we have severely insufficient human health resources. Currently, we have a shortage of 2,200 physicians in Ontario, and two million patients are without family health care physicians. The irony of the matter is that we have 4,000 international medical graduates in Ontario, and just recently, 946 eligible international medical graduates who had applied to the Canadian Residency Matching Service were not matched. On top of it, which is really sad, 121 residency spots that were paid for by the government and available were left empty. From the previous year, there were 154 spots left empty, and so it just goes on and on.

The myth is that international medical graduates are not passing the exam and are not eligible to work in the health care system, whereas the current stats from the Canadian Residency Matching Service show that 946 eligible candidates who had passed all the exams, TSE and TOEFL—they can speak English properly—were not matched and the spots were left.

Point C: Only 27% of the international graduates—353 out of 1,300 international medical graduates—were matched in the system, and I was one of them. But 72% of international medical graduates—that's 946 graduates—were not matched. What I am advocating on behalf of all the other international medical graduates is that an international medical graduate who passes MCCEE, QE1 and QE2 and the CE, which is the clinical exam, should be given at least a clerkship, a residency, a practice reassessment or some kind of system that can adopted into the health care system.

Second, all the 946 medical graduates who applied never received a letter saying why they were not eligible for residency; they just get a letter that they did not match. There's no system of feedback saying that if you want to do internal medicine, you need to go back and practise medicine for six months so that we can see that you have sharp skills, or something like that. There's no system that feeds back with the thought of making them more eligible candidates.

Third, there are spots, but we need to increase the spots for clerkship, for residency—PGY-1, 2 and 3—and then practice-ready assessment spots.

Fourth, in 2004, the Ontario government was giving preference to international medical graduates living in Canada and not to international medical graduates coming from outside Canada. We need to go back to that.

The next page is my solution, which is a program action logic model that is used by the federal government as well for all their projects. I had made up the "Pathways to Medical Practice" figure in different colours, but I understand you have a black-and-white copy.

I have developed that model in a way that is cost-effective. Money that is invested in the program would be a loan, like OSAP to students. The input is international medical graduates who have their degrees with them and have passed all these exams. What we need to provide is funding, in the form of a loan to them.

I have separated MDs and specialists. These are those who come in and don't have a fellowship. They may have practised for one to 15 years, but with no fellowship exam passed.

We start the program, which I will talk about, and expand existing seats. The immediate output would be that we would get allied health professionals. As you know, a doctor who has not passed all those exams can get into a nursing program and do the final year and become an RN, and, in the same way, become a lab technician in different programs.

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The second stream is physician and surgical assistant. There were 35 taken last year. That was encouraging, so this time, they took in 150 more. This way, we can take international medical doctors into the system and help the system as well. They're not paid at the level of doctors, so again, it's cost-effective, and then these doctors are getting back into the system.

The third option is like what we do in dental school. What happens is that if an international dentist comes to Canada, they have to write the exams. Once they complete all those exams, they are taken into the third and fourth year of dental school. We can also apply the same model to medical school to increase the clerkship quota, which we started a few years ago, but Ontario stopped it.

The intermediate result would be, which is my fourth program, that we increase the residency spots of PGY-1, PGY-2 and PGY-3. We have the residency spots, but what happens is that we give them to international doctors coming from other countries. Their countries provide the funding, so they come to practise on Canadian patients and then they go back to their own countries. So we lose in all ways. If the government funds those positions, the doctors will be willing to take loans and do their residency, and once they become a doctor, they pay the government back. In this way, we have the residency spots—it's not that we have to create those spots; the spots are there. It's a cost-effective method that we are not throwing a lot of money into; we're giving loans to international doctors and they're going to pay us back.

Someone who has practised more than five years should not be taken at the PGY-1 level; they should be at PGY-3 or PGY-4. The Ottawa Hospital just got a few more PGY-2s and PGY-3s.

The last one is that an international medical doctor who has passed the fellowship exam and has experience should be dropped into the practice-ready assessment pool, which is my last stream. That model has been really successful in community hospitals, and doctors in the community can really help out. These models are really

working well in the west side of the country, where a doctor takes an international medical graduate and practises with them for three years. Once they're satisfied, they give them a licence to practise.

All the five outcomes are not really expensive; they're cost-effective, and what we get are more doctors. Just practically, we have 900 doctors who are eligible to get into residency and become doctors. Instead of delivering pizza, they can deliver babies.

That's the end of my presentation.

The Chair (Mr. Shafiq Qaadri): Thank you, Dr. Zaidi. We have 20 seconds each. With the PC side, Mrs. Witmer.

Mrs. Elizabeth Witmer: I would like to congratulate the doctor. That was an outstanding presentation, and I look forward to reading your paper. You can be assured that we'll certainly try to incorporate some of these recommendations; they're outstanding.

The Chair (Mr. Shafiq Qaadri): Thank you, Ms. Witmer. Ms. DiNovo.

Ms. Cheri DiNovo: I just wonder—I would agree—what the response has been from the Ontario College of Physicians and Surgeons and the Royal College of Physicians and Surgeons of Canada. Quickly.

Dr. Mukarram Ali Zaidi: Sorry?

Ms. Cheri DiNovo: Have you run your plan past the College of Physicians and—

The Chair (Mr. Shafiq Qaadri): Ms. DiNovo, we probably have to intervene somehow. To the government side.

Ms. Laurel C. Broten: I will just thank you very much for your presentation.

The Chair (Mr. Shafiq Qaadri): Dr. Zaidi, on behalf of the committee, we thank you for your deputation, as well as your very elaborate written submission. Thank you very much.

Dr. Mukarram Ali Zaidi: Can I have one more minute, please?

The Chair (Mr. Shafiq Qaadri): Yes.

Dr. Mukarram Ali Zaidi: I would just like to say that I can work with this committee or someone else to emphasize my program and give a practical blueprint—

The Chair (Mr. Shafiq Qaadri): Thank you very much, Dr. Zaidi.

Ms. Laurel C. Broten: Just before everyone runs off, I want to raise an issue that we have not landed at, with respect to subcommittee. We said that we would deal with it at the termination of today's conclusions, and that's with respect to our instructions to research about what we might like to see back from them and a determination of the date for clause-by-clause hearing of this bill.

I would propose, on behalf of the government, that what we ask research to provide us with is quite limited in that it would be limited to a list of amendments proposed by the deputants today rather than a holistic analysis of the submissions made, and that we have clause-by-clause hearings of this bill set at the next day that the committee meets, which would either be November 3 or 4.

Mrs. Elizabeth Witmer: We've had this discussion before. I'm not sure why the government isn't prepared to carefully analyze the written submissions that are not going to be received by us until end of day on Thursday. I think one of the concerns I have is that this bill is one sentence. I think it's the only opportunity that people have had for some time to take a look at this issue. For example, I'm quite impressed by this last presentation. I think there's a lot of information there that I'd like to carefully take a look at. There was a paper submitted. I'd like to make sure that the research people go through each one of the written submissions and identify for us what the recommendations for changes that are made, but more importantly—I think it's really important—it would be helpful to the government to also identify the current obstacles that there are in this system to health professionals having an opportunity to practise in the province of Ontario.

If you put both of those together, it would help the government of the day to move forward, because perhaps there are things that could be done in a relatively efficient and quick manner. But I would propose that we set aside—and obviously we don't need any longer than one day—November 17 for this committee to meet, and in the one day complete the clause-by-clause and send it forward.

The Chair (Mr. Shafiq Qaadri): Fine. Just to, first of all, remind the committee, the deadline for external written submissions is Thursday, October 30 at 5 p.m., as you've agreed to in our subcommittee.

I would invite the committee to reach a consensus; otherwise it will be put to a vote. Ms. DiNovo, if you have any comments.

Ms. Cheri DiNovo: I would defer to our health critic, France Gélinas, but certainly Mrs. Witmer's comments made some sense to me. I would like to see that report as well.

Ms. Laurel C. Broten: Certainly, it is the view of the government that it is imperative, and we absolutely will examine all of the thoughtful submissions that have come forward. The examination of many of the submissions, including that of the last presenter, will be facilitated upon the execution and the passing of this bill, if it does pass in the Legislature, and the imposition of a duty of the college to work with the province. So I would encourage us to move with respect to a report whereby we would identify those amendments that have been suggested to the bill itself and that we can do that on receipt of written comments on October 30, and that the bill could be returned to clause-by-clause on November 4.

The Chair (Mr. Shafiq Qaadri): The volley continues. Mrs. Witmer, if you have any suggestions or comments.

Mrs. Elizabeth Witmer: Do you know what? For a government that talks about democracy and input from the public, I find it unbelievable that they are not prepared to allow for people to present written submissions

which we actually would hopefully have an opportunity to read.

I guess one of the things that concerns me the most is that when I come in here for clause-by-clause, I have dumped on my plate submissions that have come in and I never have an opportunity to read them in their entirety. I'm not sure what the hurry is. As I say, we can get it done on Monday, November 17. It would give us ample opportunity to review whatever submissions we receive up until next Thursday.

It will take one day. Certainly, when we go into third reading, I don't think it's going to take much more time than that either. This bill isn't going to take too much longer once it does come back. We don't have any plans to hold it up.

1700

The Chair (Mr. Shafiq Qaadri): Thank you, Mrs. Witmer.

I need two dates to agree to today, and one is, based on the final date for submissions of October 30, when would committee members like the research report? Then, of course, there's the official date for clause-by-clause consideration.

Ms. Laurel C. Broten: I would propose that following today's committee, it would be appropriate that the submissions today with respect to proposed amendments be provided to committee members by October 30, at the same time as any written submissions be provided directly to members, and that a summary of written submissions be provided to the committee on Monday, November 3, if there are proposed amendments, and that we deal with clause-by-clause on November 4—four business days.

We are anxious to get moving and to continue our work with the college in this regard.

The Chair (Mr. Shafiq Qaadri): Questions and comments?

Ms. Cheri DiNovo: I would just ask Ms. Broten if perhaps she could give an explanation for why the hurry. I haven't really heard that explanation in detail. It seems that for a government that is quite ready to take its time on other matters, this is being rushed. So I'm just interested in why.

Ms. Laurel C. Broten: I certainly would not suggest that a bill that was introduced in June and has been out for consultation for many months—to date in our submissions, today, we had one proposed amendment come forward. As many have said, the bill is one page long. It is a foundational structure to work that the government wishes to do, wants to build upon, and I think it is imperative that those individuals who have waited for access for many, many years be seen to have this Legislature standing behind them. Bill 97 is an important foundational step to that work.

The Chair (Mr. Shafiq Qaadri): Mrs. Witmer, then Ms. DiNovo.

Mrs. Elizabeth Witmer: Regardless of when the bill was introduced, there was no notification or request for people to come forward and attend hearings or make submissions until late last week. There has been little in the way of opportunity, and we all know that sometimes groups of people come together to make presentations. So you're not giving people a lot of time to prepare submissions and then give them the time and the consideration.

It was last week that you first asked for submissions, with a very short timeline given to people to respond. Although it was introduced in June, we didn't invite submissions until late last week, when it was placed in the newspaper ads. I'm not sure why we're now hurrying, because the reality is—you know what?—people haven't had a lot of time and haven't received a lot of notification. It seems as though somebody's trying to push this through—maybe it's the foreign-trained professionals—before they understand that there is an opportunity for them to exercise their voices and to get their views on the table.

I would further add that for many of these people—I know from personal experience; my parents were immigrants—it takes them a long time to put their concerns in writing. So I'm not sure why, if this bill is intended to help facilitate the entry into practice of foreign-trained professionals, we are not prepared to give them the opportunity to put their views on paper and respectfully, I would say to you, read their submissions and actually hear what it is they're telling us. There are a lot of people out there who have stories to tell, and I think we have an obligation to listen. I don't know what the haste is right now.

The Chair (Mr. Shafiq Qaadri): Are there any further questions or comments?

Ms. Laurel C. Broten: I'd like to make one final comment, and then I will call for a vote on this matter. Mrs. Witmer's comments are speculative in nature. We ran ads in major daily papers all across the province, we have had our committee hearings, and our government has worked closely with those individuals—

Mrs. Elizabeth Witmer: When did you do the ads? Last week.

Ms. Laurel C. Broten: —and individuals have sought to come forward to tell us their stories. They have been telling these stories for decades, and it is time for action.

The Chair (Mr. Shafiq Qaadri): If I'm detecting non-consensus, I will require the committee to vote on both these issues. The first is the summary of report due on October 30, which I just remind the committee is also the same deadline for written submissions. Is that correct, Ms. Broten?

Ms. Laurel C. Broten: That we would have a summary with respect to those statements and depositions made today by October 30, be provided written comments in their extensive form, should they arrive from those individuals, and a summary of those written submissions by November 2.

Mrs. Elizabeth Witmer: Recorded vote.

The Chair (Mr. Shafiq Qaadri): We'll proceed to the vote unless there are any questions or comments.

Ms. Laurel C. Broten: Oh, sorry, Chair. Monday, November 3.

The Chair (Mr. Shafiq Qaadri): Monday, November 3; fair enough.

Ayes

Broten, Dhillon, Jaczek, Ramal, Rinaldi.

Nays

DiNovo, Witmer.

The Chair (Mr. Shafiq Qaadri): I declare that proposal carried.

We'll now proceed to the vote on the clause-by-clause date as of Tuesday, November 4.

Again, a recorded vote.

Ayes

Broten, Dhillon, Jaczek, Ramal, Rinaldi.

Nays

DiNovo, Witmer.

The Chair (Mr. Shafiq Qaadri): Are there any further questions or comments from committee members? Seeing none, we are adjourned till Tuesday, November 4, for clause-by-clause consideration.

The committee adjourned at 1709.

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Mr. Vic Dhillon (Brampton West / Brampton-Ouest L)

Ms. Laurel C. Broten (Etobicoke–Lakeshore L)
Mr. Vic Dhillon (Brampton West / Brampton-Ouest L)
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M^me^ France Gélinas (Nickel Belt ND)
Mr. Lou Rinaldi (Northumberland–Quinte West L)
Mrs. Elizabeth Witmer (Kitchener–Waterloo PC)

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Ms. Laurie Scott (Haliburton–Kawartha Lakes–Brock PC)

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Mr. Katch Koch

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