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Mr. Massimo Pacetti

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● (0935)

[*English*]

The Chair (Mr. Massimo Pacetti (Saint-Léonard—Saint-Michel, Lib.)): Good morning, everyone.

I'd like to get started, if possible, because we have six groups and I know you all have opening statements to make. The members will stroll in eventually.

I want to thank the groups, the witnesses, for coming. The way we work usually is I give you about five minutes for your opening statements and then we'll have the members ask questions after. So all the groups will go one after the other.

I have a list here. The Canadian Medical Association will go first. Dr. Albert Schumacher.

Dr. Albert Schumacher (President, Canadian Medical Association): Thank you, Mr. Chair.

Good morning. Bonjour.

It's a pleasure to address the Standing Committee on Finance today as part of your pre-budget consultations. For the past several years the Canadian Medical Association has stressed two overall messages to this committee. First, we must act to sustain the health care system, and second, fiscal policy must be better used to support health policy objectives.

Over the last year the federal government has set its sights on ensuring sustainability of the health care system. The creation of the Health Council of Canada, the Public Health Agency and the Chief Public Health Officer, and most recently the first ministers health agreement represent major steps forward. Now we must focus on putting the wheels under these vehicles, many of which were recommended by this very committee, to ensure they result in concrete benefits for Canadians. The CMA's brief today contains a number of important recommendations essential to the future of health care and our entire system.

In the interests of time, however, I'll focus on two specific issues under this committee's purview: the accountability framework for the 2004 first ministers agreement, and the alignment of economic and health policy.

The first ministers health agreement is a significant achievement and finally addresses the issue of timely access to quality health care and a funding escalator to encourage financial sustainability. However, without an appropriate accountability framework, its vision of providing a ten-year plan to strengthen health care will not be achieved.

We've been down this road before. Past health care agreements, such as the 2003 health accord, failed to deliver change primarily because they failed the accountability test. Specifically, these deals lacked the appropriate accompanying accountability legislation to ensure funding allocated to buy change actually achieved that result. We cannot afford to allow this to happen again.

We ask this committee to recommend legislation to provide an accountability framework for the agreement; that the wait times reduction fund be subject to contribution agreements, to specify how the provinces and territories will use their share of this fund to reduce waiting times; and finally, that health care stakeholders be actively involved with all facets of the agreement, particularly in developing the clinically derived wait times benchmarks.

In addition to taking the specific actions, this committee must recognize how the first ministers health agreement falls short in at least two critical areas: health human resources and public health.

The recent national physician survey, appended to our brief, identifies the perfect storm now brewing in terms of physician shortages. Currently, Canada ranks 24 out of 30 OECD countries in terms of access to a family physician. International comparisons are one thing, but harsh domestic realities are another. Twenty-five per cent of Quebec residences, almost 2 million people, don't have access to a family physician. This is but one example of the physician shortage facing Canadians throughout the country. Unless we take immediate action, as proposed in the CMA's pan-Canadian health human resource strategy, our health care system will fail.

In terms of public health, Canada once again is at the back of the pack. While recent investments were significant, they fall well short of basic requirements. This shortfall, which we refer to as the Naylor gap, must be addressed, because as SARS taught us, there is a tremendous human and economic cost of inaction.

The CMA has highlighted a number of economic and tax policies that are out of step with the national health policy goals in previous presentations to this committee. While examples of such issues abound, three continue to demand immediate attention by this committee: first, the Canada Pension Plan Investment Board's investment in tobacco; second, the application of GST on health care; and finally, the lack of flexibility in the Canada student loans program for health professionals.

Despite the fact that tobacco continues to kill about 45,000 Canadians a year and cost Canadian society about $11 billion per year in net cost, the Canada Pension Plan continues to invest millions—in fact $94 million at last count—in the tobacco industry. This is a hypocrisy, it's unethical, and, according to public opinion research released today, contrary to the views of the majority of Canadians.

If the Government of Canada is going to talk the talk in tobacco, it must listen to Canada's doctors and walk the walk. Accordingly, we call on this committee and the Standing Committee on Health to join and jointly review the CPPIB's investment policy and recommend that the CPPIB be prohibited from investing in the tobacco industry and instructed to divest itself of its current tobacco holdings.

● (0940)

Most Canadians would be surprised to learn that Canada's hospitals pay a significant portion of their limited budgets to the federal government in taxes. This adds up to over $90 million a year, the equivalent of purchasing 40 MRI machines. The GST applied to physicians adds another $75 million to this total. This committee has twice recommended that the government look at the removal of this health tax and both times the government has not heeded this direction.

We once again ask for the support of this committee to stand up for health and health care providers by recommending first that the GST rebate for publicly funded health care institutions and clinics be 100%, and second, the zero rating of GST on publicly funded health care services provided by health care providers.

On student loans, as I mentioned earlier, the shortage of physicians is a critical issue. Once again, another fiscal policy of the government stands as a barrier, in this case the Canada student loans program. By the time medical students get their degree and begin their post-graduate training, many of them are doing so with a debt of more than $120,000. Although still in training, medical residents and other health professionals are required to begin paying back these loans. This policy affects both the kind of specialty that physicians in training choose and ultimately where they decide to practise.

In recognition of the health human resource crisis, and to address the fairness in application to the Canada student loans program on health professionals, we request that this committee recommend that the federal government work with relevant stakeholders to extend interest-free status on Canada student loans for all eligible health professional students pursuing post-graduate training.

To conclude, as we embark on this new post-first-ministers health agreement era, the fact remains that there is work to be done. As I've said, that work must centre on filling in the gaps we have. First, we have to build the true accountability framework that will help us deliver the change necessary to secure a sustainable health care system. Second, we must finally align our economic policy with our health policy to end the ongoing cycle of undermining our best health care policy efforts with our tax and economic policy. Canada's doctors are prepared to do their part to make the first ministers health agreement work, but governments also need to do their part. The fact that the health ministers seemed to have parked benchmarks is not a good early indicator.

The CMA appreciates and values the opportunity to discuss this with the committee. These issues are important to the health of our patients and the sustainability of our system. We look forward to answering any questions you may have.

Thank you. Merci.

[*Translation*]

The Chair: We will now hear from the Canadian Public Health Association.

Ms. Mills.

Dr. Christina Mills (President, Canadian Public Health Association): Good morning. I am pleased to be here today to speak to you on behalf of the Canadian Public Health Association.

● (0945)

[*English*]

Good morning.

I'll pass over the pats on the back about the agency and so forth that Dr. Schumacher has so ably passed on to you and go right into talking about our brief, which you have before you.

We focused on answering a couple of questions you asked us to address. Do we need changes in fiscal arrangements between the federal government and the provinces and territories, and how should any potential surpluses be allocated?

The Canadian Public Health Association, the CPHA, is a national, voluntary, not-for-profit organization guided by a voluntary board of directors. Our members span the country and the whole range of disciplines necessary to public health.

The simplest definition of public health is the improvement of the health of people through the organized efforts of society. There are five main functions: disease and injury prevention; health promotion; health protection; health assessment; and health surveillance. Public health is not only integral to our overall health system, it is its very foundation. An effective public health system is a prerequisite for the sustainability of our system.

In order to answer these questions, we've structured the brief around two themes, the need for strengthening the public health system and the need for strengthening the voluntary sector. You might ask why we are emphasizing the voluntary sector when we're talking about public health. Previously, I talked about the organized efforts of society. The voluntary sector is one of the three pillars of society, along with government and the private sector. In order to be able to hold up its third of the stool, it needs to have—as pointed out in the Canadian Council on Social Development report *Funding Matters*—stable, reasonably predictable, and adequate funding in order to carry out the many important functions that it serves for government and for the people.

I'll turn now to some of the specific recommendations that we outline for you in our brief.

Non-partisan, fact-based advocacy is an important function of the voluntary sector. Our recommendation to implement the policies reflected in the voluntary sector accord and the codes of good practice in funding and in policy development is directed to creating a regulatory framework particularly in tax laws that support the voluntary sector and encourage it in doing that advocacy. For example, the arbitrary limit on the percentage of voluntary organizations' funds that can be used for advocacy purposes works directly against the voluntary sector carrying out that function in the best way possible. In addition, the terms and conditions for grants and contributions work against us being able to really bring all the value-added that we have, as voluntary sector organizations, to work that we could be doing to assist the government in its efforts.

The second recommendation has to do with calling on provincial and territorial governments to allocate a portion of the increased resources coming from the federal government explicitly to the public health system. At present, although the public health system and prevention efforts are mentioned in the accord, there is no mechanism for ensuring that part of those increased funds goes toward actually shoring up the foundation of the health system. Canadians, the taxpayers of Canada, will need to be assured that part of this funding is going to the foundation and not just to the superstructure of the health system.

In the Naylor report, there was a call for $700 million per year for the public health agency and related public health functions, in addition to the $400 million currently undertaken or then undertaken by the public health branch of Health Canada. There's a significant gap between what was announced and what Naylor had requested. We're encouraged by the fact that this was described as an initial investment or a down payment, but now that we are aware that there's a surplus, we want to see that gap closed.

One specific item mentioned in our recommendations is the need for a national immunization program, including $100 million annually to the provinces and territories to initiate and sustain immunization programs and adequate support for the national immunization strategy. This commitment should be reviewed every three years, to keep pace with new recommendations for vaccine use. As you probably know, immunization is one of the most cost-effective, cost-beneficial interventions we have in modern health. This was recognized by the first ministers in approving the development of the national immunization strategy.

We need to have public health human resources addressed with the same attention and thoroughness as is presented in the overall health human resources strategy. We're recommending that the strategy to address health human resources incorporate a multi-disciplinary, sectoral study of Canada's public health workforce and a strategy for its renewal and sustainability.

I think we've already addressed the accountability recommendation, and it's complimentary to what the CMA has presented. We need to have reporting on the performance of the public health system, not just the health care system. The Health Council of Canada should include reporting on public health system performance and determinants of health as part of its brief.

Finally, in the area of international health, we need to move more quickly toward meeting our commitment of 0.7% of GNP to international development. The Canadian Council for International Co-operation has a very good plan to see us reach that by 2015, but the increments will have to be greater than they are now and are proposed to be in order to be able to do that. Specifically, though, we ought to be flowing some of these resources to Canadian executing agencies and not entirely through the world UN system.

● (0950)

The Chair: Okay, I have to cut you off. Groups have to keep their presentations to within five minutes. We're almost at nine minutes. It's because the members have to ask questions, and we have seven groups here. I'd like you guys to make your point, but please make it.

We'll go to the Canadian Health Coalition and Mr. McBane. Thank you.

Mr. Michael McBane (National Co-ordinator, Canadian Health Coalition): Thank you.

We welcome this opportunity to make some observations and some recommendations to the finance committee. As you know, the first ministers agreement has important federal funding commitments over the next ten years, including a cost escalator, which has been restored after it had been cut by the finance department.

Because it was signed, we think the agreement is a much better deal than those in 2000 and 2003, but it has the same weaknesses. As mentioned by the Canadian Medical Association, it has very poor accountability, reporting, and enforcement. Medicare is still on life support, not because of a lack of money but because of weak controls on where and how the money will be spent.

This agreement definitely falls short of the Prime Minister's election promise of a health care fix for a generation. It definitely also does not live up to his promise to stem the tide of privatization. It does not even mention, let alone address, the most serious threat to the integrity and sustainability of the public health care system as laid out by the Canada Health Act, and that is the tide of privatization and commercialization.

Accountability—not a decoy, but the real thing, the federal guardianship—is necessary to ensure that public funds are used to protect and strengthen medicare. Canadians, and especially their parliamentarians, especially this finance committee, need to follow the money, to insist on full public accounting of every tax dollar that goes into our health care system. I would assume all political parties around this table would accept the principle that federal tax dollars should be accounted for. We don't want our health dollars being used in a sponsorship-style method. Therefore, we need full accountability and reporting to Canadians.

I need to say that's not happening now, and I've attached appendix A to our brief. It is an excerpt from the Auditor General's report, saying that Parliament is kept in the dark on essential information. In particular, parliamentarians do not know if provinces are in compliance with the Canada Health Act. It is completely unacceptable for parliamentarians to be denied the essential information on provincial compliance. As you know, it is your statutory duty to make sure there's compliance before you transfer the dollars. It's extremely important. It's no accident that the two provinces in Canada most resistant to accountability, the Province of Alberta and the Province of Quebec, are the two provinces pushing for the privatization of the system.

I've also put a quote in from Marie-Claude Prémont, a lawyer in Montreal who has done an important study for the Romanow commission called “The Canada Health Actand the Future of Health Care Systems in Canada”. Her report points out that the Canada Health Act sets up the framework of a system to ensure equal access regardless of where you live and regardless of your income. As you know, that's diametrically opposed to a market-based health care system, such as we see emerging in Montreal, in Calgary, and in other well-to-do, rich centres. You'll notice you don't see this fragmentation of the system emerging in the Northwest Territories.

We equate this to basically a corporate virus infection of our public health care system. There are billions of dollars to be made in siphoning funds out of the health care system and into profits for investors. We have presented evidence—in fact, the whole Romanow report is solid evidence—that no facts have “ever shown, in fair and accurate comparisons, that for-profit makes for greater efficiency or better quality, and certainly have never shown that it serves the public interest any better. Never.” That's a quote from Dr. Arnold Relman in testimony before the Kirby committee.

So why is it that parliamentarians, including most first ministers, don't seem to show interest in the facts or in the values upon which medicare is built? If Canadians are gullible and think market-based solutions are going to solve health care problems, we will pay dearly for this mistake. Therefore, our recommendation to the finance committee today is that Parliament is expected to have enough information to know the extent to which the Canada Health Act is being respected. Canadians need to know where the money is going and how much money is being diverted into for-profit delivery. The annual report to Parliament consistently fails to identify or assess the significant privatization initiatives that threaten access on equal terms and conditions.

● (0955)

Therefore, we recommend that the Minister of Finance, working with the Minister of Health, fully enforce the accountability mechanism, as required by law, in the Canada Health Act, in particular the conditions on the transfer of federal funds to the provinces and territories for health care.

Second, we recommend that all provinces and territories must include in their data collection a breakdown by mode of delivery of health care services, for-profit and investor-owned versus public and not-for-profit.

Finally, in appendix B you'll see an excerpt of Alberta's submission to the Canada Health Act annual report. On the question of how much for-profit health care there is, we have a full page of responses of “not applicable”, “not applicable”, “not provided”, etc.

Parliament is being treated with contempt by the Government of Alberta, and I must say the Government of Quebec is even worse. Its report is one paragraph that says it doesn't recognize our law.

That's been challenged by Health Canada, but parliamentarians need to hold every province accountable to the federal accountability mechanism before any money is transferred.

Thank you very much.

[*Translation*]

The Chair: Next up is the Canadian Nurses Association. Ms. Tamlyn.

[*English*]

Dr. Deborah Tamlyn (President, Canadian Nurses Association): My name is Dr. Deborah Tamlyn, and I'm pleased to be here. I've been an RN for over 30 years. I have worked in Quebec, Ontario, Nova Scotia, and more recently in Alberta. I'm president of the Canadian Nurses Association.

We represent 11 provinces and territories. We have collaborative relationships with Quebec, but they are not members in our organization. We represent approximately 125,000 nurses across Canada.

I'm sure you've often heard the saying that nurses are the backbone of the system, and we all know that it's very important to have a healthy and flexible back. We also believe strongly in the importance of collaboration and of working within a team context. That's what we do on a day-to-day basis with our colleagues in the health system, in the public health system, and that's what we do at the policy level as well.

We have three essential messages that we would like to bring today, but they do echo and resonate what the previous articulate and more senior leaders in health care have presented today. I'm the new kid on the block, with less experience. Hopefully my ideas will be clear and you'll hear, in what I have to say, the substance that came from the previous presenters.

There are three areas I want to focus on. The first is the importance of having a national people plan for health care. Two, related to that people plan is the need for more investment to support education of individuals who want to make our health care system in Canada the very best it can be. Last but not least is to create some new and innovative opportunities to address upstream thinking and the determinants of health with a population that's very important to all of us, whether it be with our children or our grandchildren, and that is a focus on school health. Those three areas I just want to touch on and then we'll wrap up.

On the first area, the people plan, we've been working with what we call the "group of four", the Canadian medical, pharmacy, and health care associations. We all endorse and support the need for funding from the federal level to bring together the people within those fields and disciplines, and others, to look at planning for a pan-Canadian strategy. It's not only to look at what we need, at the supplies for the future, it's to look at how we can do things differently, how we can move out of some of the turf areas or silos we've been in. We think if the government were to invest in bringing us together, to work with us inside the tent rather than outside the tent, we could make some things happen that have been slow to arrive in the recent past.

The people plan is important, and it also would complement the work and evidence-based discussion that needs to occur to address wait times and other key areas, such as public health and safety.

Second to that people plan is investment in a strategy and framework related to it, the support for education. Other colleagues have mentioned this. We make some specific suggestions. Because the federal government is the fifth-largest employer in our end in the country, we think they should embark on a bursary program for supporting nurses who are going to be working in the federal system and who in return would commit to providing a return for service.

We also would like to see tuition support for those health professionals, in this case nurses, who need upgrading and skills training in the areas that have been targeted in the ten-year health plan.

We also support the SARS Naylor report, which says there needs to be support for those people who want to pursue training and education in public health.

In addition to that bursary support, we would like to see a change in the EI eligibility criteria so that those individuals who need upgrading, retooling, and so on would be eligible to tap into the funds available. We also support what the CMA was putting forth, that we extend the interest payment benefit for the Canada student loans to students in health programs.

In addition to that, one strategy that we think might help to serve rural and remote or underserviced areas of Canada would be to pay off a portion of the accumulated debt so that those individuals could move into those areas with less of a focus on that debt repayment.

We also believe there needs to be support for aboriginal individuals who want to pursue health careers. There needs to be support for the cost of study in those areas.

● (1000)

Last but not least, on the issue of supporting education we've submitted a proposal to HRDC and Citizenship Canada for the establishment of a web-based program that would link to the existing Coming to Canada initiative. It would provide prior assessment, language or cultural training, and information to those individuals in other countries who would like to come and be part of our health system in Canada. They wouldn't be so frustrated and angry when they arrived here, thinking they had an understanding of what it was going to take when in fact they came up very short in that understanding.

I've talked about a people plan and the need to support education. The last one I want to focus on is school health. We know the importance of the determinants of health. We know the issues we have around obesity, anorexia, the issue of drug use, the issue of depression, suicide, and so on. But we also know that when we invest in programs like school breakfasts, like on-site counsellors to help students who are at risk, we can make a difference. We need to do more in that area.

We are recommending that there be a joint initiative, that there be funds available federally to support provincial and territorial efforts to allow school boards and health districts or regions to name health coordinators for each of the school areas. The work would then focus on linking to what we want to achieve in the establishment of national and provincial health goals.

To wrap up...or maybe I'm done.

Am I done?

● (1005)

The Chair: Yes.

Dr. Deborah Tamlyn: Oh. I'm done.

Thank you.

The Chair: "In conclusion", "finally", and "to wrap up" are all the same thing.

The next group is the Canadian Paediatric Society. Mr. Walker, please.

Dr. Robin Walker (President, Canadian Paediatric Society): Hi. I'm Dr. Robin Walker, and I'm the president of the Canadian Paediatric Society. I want to thank you for inviting us to present to the Standing Committee on Finance. We do appreciate this opportunity to address you on some of the key child and youth health issues that the federal government has the opportunity to influence positively.

Time and time again, government reports prominently mention how children and youth are the future of Canada, yet few of the proposed programs designed to improve the health of Canadians specifically address their needs. Our society is dedicated to improving the health and well-being of children and youth, and has been over 80 years. We hope you will agree with us that the four issues and solutions we present to you today will actually help to ensure that children and youth are indeed our future.

Those issues include: the Public Health Agency of Canada, the national immunization strategy, national injury prevention, and school health. I will also add, in support of the Canadian Medical Association's position, that pediatrics faces the same human resource crisis that is faced in other areas of medicine, and that extends indeed to nursing and allied health in childhood and youth health.

On the Public Health Agency of Canada, the Canadian Paediatric Society believes that the improvement and protection of public health, including infectious and chronic disease prevention, clean water, and emergency preparedness, are top priorities for Canadians. Unfortunately, children and youth, because of their developing immune systems, are among those most negatively affected by an inadequate public health system.

We congratulate the government for establishing the Public Health Agency of Canada, naming Dr. David Butler-Jones the first Chief Public Health Officer, and understanding that a major and sustained investment is needed immediately to protect the health of people in this country. The CPS believes that to ensure the optimal establishment of the agency there is a need for $1.1 billion to be invested annually as core funding for the new agency. This funding needs to be reviewed every three years. This number is based on the Naylor report and the input of the Coalition for Public Health in the 21st Century.

As further pointed out by Dr. Naylor in his report, *Learning from SARS*, it is essential to have pediatric involvement in any response to a public health issue. We would like to see the creation of a centre for maternal, child, and youth health within the new agency, with dedicated funding, as we feel only this will ensure that the specific needs of our youngest citizens are met.

Further, we are pleased that the new agency is being established as a joint initiative between federal, provincial, and territorial governments, as well as non-government organizations. The agency needs to build on current successes and strengths, such as the existing Canadian pediatric surveillance program, rather than start from scratch. The CPSP, which is a joint program between the Public Health Agency and the Canadian Paediatric Society, has been very successful in collecting data on uncommon but highly important child and youth diseases and injuries.

The results generated by the program have been cited in important advances in public health, such as recommendations for universal varicella vaccines, the need for daily vitamin D supplementation to protect infants from rickets, and the recent Canadian ban on baby walkers. The contract for this program expires on March 31, 2005. We recommend that the Government of Canada demonstrate its commitment to children and youth by committing $400,000 annually to this program for at least the next five years.

On the national immunization strategy, I can be brief here because most of the main points have already been made by the Canadian Public Health Agency. This is one of the most effective public health advances of the last century. It is cost-effective and safe, and it has saved millions of lives and millions in health care resources.

While we can be proud of past successes, we cannot be proud of the patchwork of vaccine programs across Canada. All children need to have equal access to safe and proven vaccines, as recommended by the National Advisory Committee on Immunization. Therefore, we recommend that $10 million be invested annually to support immunization by providing for a coordinated national program. Such a strategy needs to be a joint initiative, not only of governments, but of non-governmental organizations such as the CPS, CMA, CPHA, and the CNA.

The $300 million that the Government of Canada identified in last year's federal budget for the purchase of childhood vaccines at the provincial level has been vital in ensuring that all children have equal access to all recommended vaccines. Almost all provinces have now used this money. We're urging those who have not to do so as soon as possible. We ask the federal government to make the funds for provincial childhood vaccine purchases permanent, once the current funding ends in 2006, and that it be reviewed annually to ensure it is still sufficient to ensure that all Canadians have equal access to recommended vaccines.

On national injury prevention, injuries are the leading cause of hospitalization of children over the age of one, yet they are largely preventable. They cost us $9 billion in 1995. We've all profited from advances in injury prevention, safer cars, seat belts, baby car seats, but much more needs to be done. Some examples are compulsory car booster seats for toddlers, bicycle helmet legislation in all provinces and territories, and better fall prevention programs for seniors

● (1010)

Canada needs a national injury prevention strategy, as pointed out by Dr. David Naylor. This needs to be part of a renewed commitment to public health and should include a coordinated system of education and communications programs, design and engineering strategies, and legislative initiatives; a national injury surveillance system; and research into the prevention of injuries and the cost-benefit of programs. We recommend that $10 million be allocated—similar to the national immunization strategy funding—in the coming fiscal year to the Public Health Agency of Canada to initiate the development of the program.

Finally, on school health, this is a tremendous opportunity. The educational system provides a unique opportunity to create comprehensive programs to deal with rising rates of obesity, poor nutrition, physical exercise, sexually transmitted infections, and mental health. We recommend that federal and provincial governments and NGOs look at this. It will pay huge dividends.

We recommend that $40 million, based on the recommendation of the consortium on school health, be dedicated to promote a pan-Canadian school health strategy and to encourage all levels of government to help improve the health of Canada's children and youth through the school system. We recommend NGO involvement in both the strategy and the programming, because of their credibility at the local level and the cost-effective methods of delivering programs to children.

We believe that children and youth are the future of this country. We believe these investments will make that future healthier and ensure that children and youth have the best opportunities possible. An investment today in health promotion and disease prevention will lead to a population less reliant on the health care system.

Thank you.

The Chair: Thank you.

[*Translation*]

Our next witness is Ms. Mary Lapaine from the Canadian Healthcare Association.

[*English*]

Mrs. Mary Lapaine (Board Chair, Canadian Healthcare Association): I'm Mary Lapaine, the board chair, and I'm going to start the presentation.

We'd like to remind you that the Canadian Healthcare Association is a federation of provincial and territorial hospital and health organizations across Canada. Our members cover the entire continuum of care, including hospitals, long-term care, home care, community health services, public health, and so on. Our board members, who are trustees and managers in the health system, bring to our table the realities of the front line.

CHA advocates for a responsive, sustainable, publicly funded health system and believes that such a system is achievable. Progress is being made. Health system renewal has been taking place across the country in various ways. There are continuous changes being made to enhance efficiency, effectiveness, integration, and quality. There's also a commitment to address the issues of wait times.

The CHA is concerned that while polls show that Canadians greatly value our publicly funded system, they do not have confidence in our system's ability to provide timely and quality care now and in the future. It is important to remind members of the finance committee why there is this lack of confidence in our health system.

This developed to a large extent in response to inadequate federal funding in the past; the stop-and-go approach to funding on the part of all governments in the nineties; inadequate investment in information technology and data management; and a lack of understanding of the labour-intensive nature of the health system or the complexity of the health sector.

Ms. Sharon Sholzberg-Gray (President and Chief Executive Officer, Canadian Healthcare Association): I'd like to continue and pay special attention to individuals who remain nominally committed to a publicly funded health system—maybe because it's politically popular—but believe or keep saying it's not sustainable. So I'd like to actually present a little bit of a good news story now. More of that story is in our brief, but I'd just like to refer to a few of the comments in the brief.

First of all, a new report on provincial-territorial health spending from the Canadian Institute for Health Information reveals projected provincial and territorial expenditures for this fiscal year of 2004-05 of about $84 billion, reflecting the lowest growth rate since 1997-98. That is 5.1% in nominal terms and only 2.9% in real terms. Actually, this might not be sufficient to deliver the services Canadians need, but it certainly demonstrates that health spending is not out of control. This is a message we keep hearing. Remember, there will be a 2.9% increase this year, and GDP growth is going to be at least 3%. Let's keep that in perspective.

Canada has been spending the same 9% to 10% of its GDP on health for the last 20 years, and this includes both public and private spending. In fact, it's private spending that went up more than public spending. Public spending is about 6.5% of our GDP—in fact, less than what the United States spends on its publicly funded health care as a percentage of its GDP. Administrative costs in Canada are approximately 13%, which compare favourably with other countries'; administrative costs in the U.S. are 30%. Administrative costs in Canada for hospitals are 8.4%, among the lowest amongst OECD countries.

Our publicly funded health system is respected internationally for ensuring healthy workers and affording businesses a distinct competitive advantage—and there's more, as I've said, in our brief.

We've long advocated for sufficient, ongoing, and predictable federal funding. We also believe that health funding commitments, in fact, all funding commitments for social programs and other needed programs, need to be part of a sound fiscal and budgetary plan, not based on surpluses that may or may not appear after the fiscal year has ended. We understand that tax rates need to be appropriate to stimulate economic growth and development and also to provide fairness to low-income Canadians, but we have noted in the past that there's a trade-off between tax cuts and government services. So we need a budgetary plan that includes, up front, planned expenditures for health and social programs, and then we can perhaps look at tax reductions and debt management. But it can't be accidental spending at the end of any fiscal year.

To this end, CHA urges this committee to support the investments totalling more than $41 billion over 10 years in the 2004 health accord. We'd like to say this will bring the federal share, I think, closer to the fair amount the federal government has not been contributing over the last number of years. If these investments are directed to ensure progress in the areas agreed to in the accord, we believe that with appropriate leadership and commitment to reform there's sufficient funding to achieve the health system outcomes the plan envisages—not everything, but the health system outcomes the plan envisages. We also would like to say that funding needs to be tied to the achievement of mutually agreed upon, pan-Canadian objectives. We will be examining the details of the legislation implemented in the accord to see whether it includes a reference to the objectives and outcomes that are linked to the new funding—that is, there has to be accountability written into the legislation.

We'd also like to refer to some unfinished business. We continue to advocate for a body of changes and principles that continue to be on our advocacy list: improved management reporting on health system expenditures and outcomes, based on mutually agreed upon evidence-based targets; investments in health research that are at least 1% of total health spending; the legislative framework that I referred to before; increased investments in an electronic health record; bringing a greater proportion of the health continuum, including home, community, and long-term care into the public envelope on a pan-Canadian basis, though not all necessarily with first-dollar coverage; recognizing the importance of all parts of the system, from acute hospital services to chronic care, to community services, to public health; primary health care reform; funding and managing enhanced drug coverage as part of an integrated system; a pan-Canadian health human resource strategy; an annual escalator for the CST, the Canada social transfer, noting the importance of the determinants to health; and more, as outlined in our brief.

● (1015)

Mrs. Mary Lapaine: CHA and its members acknowledge the substantial progress made across the country in the 2004 health accord, and we will work within the accord to achieve measurable progress for Canadians.

Thank you for hearing us. We will be happy to answer any questions.

The Chair: Thank you.

Members, we're going to go for six minutes in the first round because we're missing time.

Mr. Solberg, then Mr. Côté.

Mr. Monte Solberg (Medicine Hat, CPC): Thank you very much, Mr. Chairman. I'm going to split my time.

I really have one question. Probably others, more than one group, may want to answer this, but I'll direct it to Mr. Schumacher.

One of the key recommendations in your proposal was that there be accountability for these funds. Isn't the problem the fact that the provinces feel that if they agree to meet certain standards, at some point the federal government will simply withdraw funding, but they'll still be held to those standards? Is that one of the key problems, and what do we do about it?

Dr. Albert Schumacher: Well, I think we have evidence across Canada that the contrary is true. We've been able to compare immunization rates province to province, where there had been a variety of programs and a variety of funding. I think that has been a good thing. The federal government hasn't taken money away and it hasn't disciplined anyone. In fact, it has put more money into those programs. If we look at the new vaccines compared to the old vaccines, I think it has been very positive with how those things have been out there and reported.

● (1020)

Mr. Monte Solberg: But the federal government did withdraw funding when they made their big cuts in 1995.

Dr. Albert Schumacher: Right. I'm referring to the more recent times in the last several years. Yes, there has been a withdrawal of funding. I, and many other providers, am quite worried about that. In fact, until the first ministers' accord is ratified by Parliament and is no longer a piece of paper, I'm reluctant to renew the lease on my office. I'm still waiting for the action, but I think the intent is there.

To get back to your question, I believe Canadians are willing to wait and they're willing to queue, but they want to be sure they have a fair, reasonable, and safe waiting time to get the essential procedures they need, and those things should be equal whether you're in New Brunswick or in Saskatchewan. The only way of knowing that is to have things we measure and things we report that we can see. I think it will help restore some of the confidence in the system.

The directions and things that we've picked, as far as target areas, are not perfect. We've recruited the experts to help put together those safe and reasonable waiting times, the benchmarks, and the targets. Unfortunately, you're right, the premiers have been dragging on it. They've parked it now. They're going to think about it in the new year. Well, folks, we're going to get those benchmarks, targets, and everything ready so they can be discussed, hopefully, by you and by the people of Canada.

Ms. Sharon Sholzberg-Gray: Could I add to that, Mr. Chairman?

I think what the questioner is really referring to is the huge cuts in federal transfers to the provinces and territories that took place through the 1990s. They actually started in the early 1990s and then continued, I think, at a more rapid pace as we approached the 1995 budget. I think that is the story we would not like to repeat. There is no question that the federal government was not paying its fair share. It asked for certain principles to be achieved and then wasn't funding those principles. There is no question about that.

I think the real issue about a future legislative framework with accountability is that accountability is a two-way street. On the one hand, the federal government has to provide the appropriate amount of funding to the provinces and territories so that Canadians have access to comparable services wherever they live. I think it's a valid objective, but they have to fund it appropriately. On the other hand, of course, if the provinces agree to do it, they ought to do it, but they can't do it if they don't get enough funding. That's the issue.

By the way, that's what my members often say—my members being the hospitals, regional health authorities, and health agencies of this country. They can't deliver more services than can be provided by the money they're given.

I think there are multiple streams of accountability, but a legislative framework should make it clear that the federal government continues to provide these funds with a substantial escalator to achieve certain outcomes. It's going to measure whether these outcomes are achieved. If the federal government withdraws from the funding, it frankly doesn't have the moral authority to keep asserting those principles.

That was the problem in the 1990s. We advocated against it. We would not like to see that happen, but we're looking forward to the future and we think the future will be different.

Mr. Monte Solberg: Right, but the provinces are stuck. They don't have to withdraw all of the funding, but if they withdraw some of the funding, the provinces still need whatever is left. They're stuck. This is the concern, and I think it's a valid concern.

How do we overcome this? It's pretty clear that there should be accountability for federal funds, I agree with that, but how do we do it?

Dr. Deborah Tamlyn: I only want to add another piece.

I think you're talking about a fundamental breakdown in trust because of past actions. We're in a new era. We have new players. We have new ways of ensuring accountability, putting things into legislation, and so on. But if we can't get our act together in terms of relationships and working together—and that includes those of us in the professions as well as within government—if we can't do that, no matter how much money we sink into the system, we will fail the citizens of Canada.

It's why we're so passionate about the need to have some modicum of trust to move forward and at the same time build in those health council accountability measures, national objectives, and so on. We do really implore you to have that modicum of trust and move forward. We believe it can be done. Maybe we're naive—others who have lived through it are cynical—but I think we need to have some hope for the future.

Mr. Monte Solberg: Do I have more time?

● (1025)

The Chair: No, that's it. Thank you.

Monsieur Côté.

[*Translation*]

Mr. Guy Côté (Portneuf—Jacques-Cartier, BQ): Thank you for your presentations.

You will not be surprised to learn, nor would my Conservative colleagues, that I am uncomfortable talking about accountability when discussing Quebec's health care system. On top of accountability, there are of course conditions attached to the funding. I am not a health care expert, so my questions will be fairly general.

Each province has its own particular situation. Take Quebec, which has in the past, and still has, a human resources crisis, namely the shortage of nurses. However, as far as decentralized health care services and home care are concerned, we are perhaps ahead of other provinces. I'm referring to, amongst other things, local community health care centres, which do a lot of work in the area of prevention.

As regards national funding, beyond the issue of accountability, which can lead to many other problems which I will not discuss, the health care agreement, which some people said represented asymmetrical federalism, and others asymmetrical intervention, led to a certain backlash in the rest of Canada. Given the fact that each province is dealing with a different situation in the area of health care, that the provinces don't all have the same types of problems, would it not be better to massively transfer funding to Quebec and to the other provinces? Under such a scenario, provincial governments and the Government of Quebec would be accountable to their citizens, and if the citizens were not satisfied with the services provided by their province, they would act accordingly. Would this not be a solution both simple and truly reflective of the meaning of accountability to citizens?

Could I get an answer from the spokesperson for the nurses' organization?

[*English*]

Dr. Deborah Tamlyn: I have a problem. I didn't turn my translator on to the right button. Could you sum it up? Are you asking why not take a provincial approach and have the accountability at that level?

You do need that, no question about it. But what we're saying is that because nurses and doctors and other health providers move across the country and because people move across the country, having a national or a pan-Canadian approach will be something that provinces and territories can choose to endorse or not endorse in their own unique fashion. We think we need to bring the players around the table who understand health care and the issues and needs that citizens have and work from that in a complementary fashion.

We don't believe that only to leave it at a silo, a jurisdictional-territorial-provincial level will get the job done. Health is too much of an issue for citizens across the country. We believe quite strongly in that. While respecting the particular issues of aboriginal health, issues in Quebec, and issues in Alberta for that matter, we do need a national approach.

Ms. Sharon Sholzberg-Gray: If I can just add to that, in our full brief we actually addressed the need for some type of pan-Canadian comparability in the sense that most people would consider it inappropriate if people, for instance, had access to cardiac care in one province and not in another. The whole reason the federal government is transferring money, and frankly equalization funds too, is so that provinces have the fiscal capacity to deliver those services.

I don't think anyone is suggesting that the dollars be followed—not that kind of accountability. Frankly, accountability of the provincial governments to their respective publics is what's contemplated in any accountability framework.

On the other hand, if there isn't a legislative framework that puts these programs in place, at least in a way that makes it difficult for the federal government to remove itself from it, then the federal government can remove itself easily and that would be a danger to the provinces as well.

I think at one and the same time we need an accountability framework whereby everyone reports on a comparable basis to their respective population so we know we're getting something. No one wants to send blank cheques to anyone. That's not what accountability means today. At least we want to know what we're getting for it. At the same time there's a recognition that health is a provincial and territorial responsibility, and therefore there's flexibility in the way things are delivered and whatnot. But there's a certain group of services, frankly, that all Canadians think they ought to have access to, and it's not that difficult for provinces to agree to it. After all, they all say they agree with those same objectives anyway, so why is it so hard to say, I agree with those objectives and I'll make sure I'm accountable to my own population for achieving them?

● (1030)

The Chair: Mr. McBane.

[*Translation*]

Mr. Michael McBane: I would like to add something else. Quebeckers agree with the five principles contained in the Canada Health Act and they want the same services to be provided everywhere. But we need access to information so that it can be shared.

Now, as for the issue of annual reports,

[*English*]

there's a bit of a dodge on the issue of jurisdiction because the Government of Quebec is not reporting to the people of Quebec on all kinds of indicators that are required by federal law. In some ways, it's semantics whether the report goes with a blue cover to Quebec City and then federal officials can download it. That's fine with me. I don't have a problem. But they're not reporting to Quebec citizens on the indicators and on the criteria. That's been acknowledged by the Auditor General. It's been acknowledged by Health Canada. Let's face it, Quebec citizens are Canadian citizens who share the principles. They're taking the money, so let's have the accountability.

Dr. Albert Schumacher: If I can just give you one last point on that issue, if we look at human resources and at the aboriginals who are practising medicine and nursing in Canada, there are not enough. There are not enough in Quebec and there are not enough in the rest of Canada. We need a plan and a target and some benchmarks. We have less than a hundred aboriginal positions in the country. We need a thousand or two thousand. That has to be done collectively. There have to be targets and goals, and we need to share those.

The Chair: Thank you.

Mr. McKay.

Hon. John McKay (Scarborough—Guildwood, Lib.): Thank you, Mr. Chair.

Thanks to the witnesses.

You all seem to be singing from the same hymn book, and I want to carry on. Interestingly, the first two interventions were from the provinces that are least sympathetic to the position the panel has taken. I take a far more sympathetic position to your views that we should have accountability, and I too am looking forward to what the legislation will bring forward.

I want to direct my question to Mr. McBane, but advise others to jump in if they feel it's appropriate .

Your essential two points are that you want to fully enforce the Canada Health Act and get full data collection from all the provinces. They seem to be perfectly, fundamentally, sound points to me.

My question to you is, aside from cutting off—and I think last year 2003-04 under CHST we had a combination of $38.3 billion in tax transfers and cash transfers, and the projection next year for 2004-05 under the CHT and CST is $42.2 billion in points and cash—what's really changed? What more subtle mechanisms than cutting off the cheque would you propose using?

Mr. Michael McBane: Those are good questions. I think Canadians don't realize there are two enforcement regimes in the Canada Health Act. One of them is the one you're talking about—withholding money—but that applies to extra billing and user fees.

There's another enforcement regime that applies to the criteria of the Canada Health Act—the five principles—and whether provinces are in compliance with the whole legislative framework. That has never once been enforced. What the act calls for is if there's a concern, the minister sends a notice of concern and the province or territory then responds and explains what's going on.

There has never once been a federal Minister of Health, since the passage of the Canadian Health Act, who expressed a concern over any of the five criteria, whether it's portability or accessibility, etc. We've seen major changes in delivery, which we know is putting up financial barriers to access. We're seeing queue jumping, etc., with the emergence of private clinics, and there's never been an assessment of what impact that has on equal terms and conditions of access.

So we're not getting the information to know if provinces are in compliance with the basic legal framework. That's why, as you say, it's basic. We should have the data. Those questions are being asked by the Canada Health Act annual report. It's just that several of the provinces are not submitting any answers.

● (1035)

Hon. John McKay: Is the Canada Health Act, as it's presently drafted, of sufficient strength to require the information on which to make an assessment?

Mr. Michael McBane: I think you probably need to pass a regulation making it mandatory.

Hon. John McKay: So you think there's a bit of a gap there.

Mr. Michael McBane: Yes. In essence, the federal minister is leaving it up to the discretion of the provinces.

Hon. John McKay: Mr. Tholl.

Dr. William Tholl (Secretary General and CEO, Canadian Medical Association): I would like to comment particularly on the last part. In another life I had considerable experience with the Canada Health Act.

In fact, there's only one regulation that has been promulgated, and it is the information requirement, but it only pertains to user fees and extra billing. As Mr. McBane has pointed out, that was promulgated right after the Canada Health Act was passed in 1984. The reason for that was because the penalties there are non-discretionary and they're dollar for dollar.

If the federal government did want to ante it up, they could review and revise those regulations to include not just extra billing and user fees information. That's number one.

Number two, I'd like to comment on the question raised over here about what's in place now that wasn't in place before with respect to the flow of funds to the provinces, what's to mitigate against another 1995.

Nobody has mentioned here the Health Council of Canada, which now exists. Its role, in large measure, is to keep the accountabilities both coming and going. So we have that in place now, and prospectively, I would expect that Michael Decter and company would be commenting on whether provinces are keeping up their end and whether the federal government is keeping up its end from the financing point of view.

Hon. John McKay: But is he getting enough information to make that assessment?

Dr. William Tholl: Well, everybody is participating in the Health Council of Canada, again except Quebec, but even in the asymmetric add-on—

A voice: Alberta is not.

Dr. William Tholl: Alberta is not either.

But I guess where I was going with that is that even the addendum to the first ministers agreement indicated that Quebec would be participating in providing information to the Health Council of Canada.

Hon. John McKay: My second question will open up another can of worms. In another life I looked into privatization, public-private partnerships, and what struck me was the British model, where they were building four hospitals a year on public-private partnerships, and quite successfully.

It got to the point of political dialogue where they were about 10 or 15 years past us, and this was no big fuss. They didn't really care who owned the actual hospital. What they cared about was whether it was built efficiently, on time, and met the criteria. They almost had it down to a standardized contract, and it was really interesting to compare, whether they were on contract for the price quoted, and so on, versus public-only models.

So I'd be interested in your views on that part, not the provision of services but the provision of real estate or physical structures to the whole health care system.

Dr. Albert Schumacher: Historically, most of our institutions are private. They were built by religious orders, some of them a century ago, with heavy input from the community, heavy volunteer input as far as the funds that went in there were concerned, as well as the volunteer board trying to run them and keep them going. By bringing in medicare and nationalizing medicare, the federal government didn't automatically assume ownership for them. Those are still owned by those entities and by the communities, by and large.

So I think there is an important place for someone else. The religious orders have fallen out of building hospitals as a primary business, but there are other people who are interested, where that is some of their core business. Based upon that model and the fact that we didn't nationalize the hospitals and kill all the nuns and take it away from them, I think we've accepted that as part of the diversity of our health care system. It didn't matter whether it was with the Catholic Church or whether it was Mount Sinai or somebody else. I think that has a root in every Canadian community and that's something you need to promote.

So I think you have to look at Great Britain and other models like that. As long as the patient has the same access to quality, the same access to wait time, who cares who actually built the hospital or does the work of maintenance or what have you? You want to be sure the services that count are fully insured and that they have access to quality.

The Chair: Thank you.

Ms. Wasylycia-Leis.

● (1040)

Ms. Judy Wasylycia-Leis (Winnipeg North, NDP): Thank you, Mr. Chairperson.

On this whole debate of provincial responsibility and federal accountability, it seems to me the last thing Canadians want is a patchwork of systems across this country, and that the national medicare program has to be maintained at all costs.

It seems to me the accord helps in terms of putting our system on a more stable, predictable funding base. There was a significant injection of funds, but I don't know if we can say we're any closer to actually preserving medicare in terms of universal access, public accountability, non-profit administration, and so on, or that we can say with any certainty that the provisions under the health accord will be followed through in terms of their objective, that being the transformation of our health care model into something more holistic and cost-effective.

I want to focus on this issue of accountability. It seems to me we could have trust, as one important thing, but unless we have legislation for this accord, a firm commitment to enforce the Canada Health Act, and some tough measures to penalize provinces if they breach one of the five principles, all of this is lost.

Let me start with Mike and then continue with Sharon and anyone else who wants to answer on this one.

As my second question, just so you know I have one more issue, I really want to focus on the work done by CMA on the whole issue of investing our pension dollars in less than ethical areas where there is a detriment to our health care. It's the whole issue of the CPP investment policy.

Those are my two big issues.

Mike, do you want to start on the accountability one?

Mr. Michael McBane: I agree with you, Judy, that there has to be legislation requiring specific accountability measures, but I also think we have to reinvigorate and recommit to the current federal legal framework, which is the Canada Health Act.

It's disturbing to see first ministers spend so much time together and not talk about the Canada Health Act. I think some of them want it to die by neglect, and yet Canadians are very committed to the vision and the values and the system the Canada Health Act created and maintains.

As the Romanow report and its research have shown, the Canada Health Act is a very sophisticated legal framework that is the complete opposite of a market-based system—by design. That's how you get health care up in Iqaluit, in all the small towns of the Gaspé, and in Chibougamau, and in all parts of Prince Edward Island. It's not a market-based system: there's no money in it there. It's not because there are profitable services that doctors can make money from. That's not how you get access.

The legal framework is extremely important to equal access, which is what Canadians want. The lawyers and the health economists are clear that market-based provision matters a lot. The question is, why would it matter? Well, it matters a lot because of efficiencies, because of quality, and because of equal access and equal terms.

We have to stop fooling ourselves politically that we can change the legal framework and how the system is run and not impact on the five principles. That's completely dishonest. It's been named so by the research of the royal commission. Now we need our politicians to start defending the legal framework Canadians believe in. These are our values; they're enshrined in law. Now let's defend that law. When new pieces come up to expand the system, let's make sure they reflect the same mechanism of the Canada Health Act.

Ms. Sharon Sholzberg-Gray: You wanted me to respond on that issue as well. First of all, I agree that the Canada Health Act is an act that's always worth looking at and reminding ourselves about. In fact, I'm dismayed when I see journalists often say there's no conditionality attached to the funds, because the conditions of the Canada Health Act not only apply, by the way, to the Canada health transfer, but to the Canada social transfer as well—to both of them, even since the splitting of the two.

I'm a bit comforted by the fact that there's going to be an arbitration process to see about using the Canada Health Act in the future, but while the federal Minister of Health will have the right to make decisions on withholding funds for non-compliance, there will be a professional or expert advisory committee that will advise on whether or not there has been any contravention of the Canada Health Act. I think having a process everyone perceives to be fair is a step in the right direction.

I want to remind everybody that Canada Health Act services are only medically necessary hospital and physician services. I myself would not want to amend the Canada Health Act, because I guess I don't have confidence that, once opened, other things wouldn't find their way into it that maybe Canadians wouldn't want. But if we're looking at the provision of acute care replacement home care services, I think it would be quite easy to say that by regulation they could be part of the Canada Health Act, because they're really hospital services provided in hospitals without walls—or extra-murally, or whatnot.

● (1045)

The Chair: Thank you.

I want to give Mr. Tholl a chance to reply—in ten seconds, please.

Dr. William Tholl: Ten seconds, Mr. Chair.

First, there is political accountability through the Health Council of Canada.

Second, the Canada Health Act does provide for penalties called “gravity of default” penalties. There have in fact been letters of concern sent. As an example, when Minister Rock was the Minister of Health, he wrote to Alberta about the clinics. The trigger has never been pulled to impose gravity-of-default penalties, but those penalties do exist in the Canada Health Act.

Third, in terms of accountability, particularly for the access fund, we would like to see, just to repeat, the $4.5 billion. That part of the first ministers accord that is to buy change and put some wheels under the accessibility promises needs to be subject to contribution agreements, just as the primary care transition funds were.

Those need not be the same contribution agreements across all provinces. They can be tailored to each province according to their particular status. But we're recommending very clearly that the $4.5 billion be subject to contribution agreements, unlike the other amounts of money that will be added to the Canada health transfer base.

The Chair: Thank you.

I have four speakers left and I have less than 10 minutes.

Ms. Judy Wasylycia-Leis: Mr. Chair, with the committee's indulgence, I wonder if Dr. Schumacher could give a brief statement on why it's so important to look at the question of how we invest pension dollars.

The Chair: Let me suggest you discuss it with him after the meeting. I have only ten minutes and four speakers. Perhaps I can ask the witnesses to stay an extra five minutes and I'll give four minutes each.

I have Mr. Pallister, Mr. Bell, Mr. Loubier, and Madame Minna.

Mr. Pallister, you have four minutes. Thank you.

Mr. Brian Pallister (Portage—Lisgar, CPC): Thank you, Mr. Chairman.

I want to thank all of you for your presentations and for being here today.

You have alluded to some threats to this system in your presentations. I would submit that perhaps it's at least as much a threat to the system that we have provincial governments who proceed with private clinics. That may be a threat to the system, and according to Mr. McKay it is. Certainly it is to his government at election time. It's frequently suggested that these provinces are threats to the health care system. I think at least as much of a threat might be the lack of leadership on the part of the federal government, which seems to allude to these threats at election time but doesn't do anything about them between elections.

I would submit also that another threat we face in any monopoly delivery system is we want to make sure we don't become like a monopoly. That is to say, if we are more concerned with the people who deliver the services and the benefits to them than we are with the people who receive the services, and we appear to be that way, then frankly we shouldn't be surprised that Canadians wouldn't support us in trying to preserve that system. The higher priority has to be the recipient of the service rather than the deliverer of same.

That being said, there are many examples that come to my attention from constituents who need the services of the system. Those should be our top priority. I certainly hear it from the nurses all the time; that's their top priority. Yet people within the system and people who use the system are telling me they are encountering certain situations.

For example, a lady wrote me recently. She is undergoing treatment at St. Boniface hospital in Winnipeg. She is nauseous; she vomits. They have to call two people to clean up: one for the bowl and one for the floor. There are seven different janitorial job descriptions in that hospital.

Nurses and LPNs are telling me they are not allowed to practice according to their own training. Registered and baccalaureate nurses are not allowed to practice the skills they have developed in their training. We're not getting the human resource maximum we need out of this system.

Don't confuse this Manitoban with an advocate for private health care. My big concern is that we make sure the system works. If it works effectively, then people will support it. From that lament, I'll segue into some specific issues you've raised.

First, rural doctor shortages concern me very much, as they do all of us. You mentioned the bursary program in your presentation, Doctor.

Other countries use income-contingent loan repayment plans for their student loans, which assist the situation you describe where people have graduated but are going on to further training. They don't have to start repaying; they repay automatically through their income tax form. I think you're familiar with the system. If they make money, they pay back.

Is that a system your association has looked at, and what is your view on it?

● (1050)

Dr. Albert Schumacher: The problem is the continued accumulation of debt, not just the fact that you have to repay. Many of our post-graduate programs are getting increasingly complex as care goes up. Although it takes a minimum of nine years after high school to become a family doctor in Canada, to become a specialist you're often talking 11 or 12 years. It's not a lot different in nursing or other fields, where master's degrees are becoming more common now and you need a lot of post-graduate help in different areas.

You need to defer payment, but you also need to do something about that ongoing interest accumulation. I mean, thank God interest rates right now are at a sub-5% level in many cases.

Our concern is that it influences what people will do with their careers. It's no secret that the Canadian Armed Forces has to pay a signing bonus of $225,000 to a family doctor coming into the army in order to keep the numbers up. You're seeing many communities around the country now competing for physicians, paying large amounts of money or other things in order to get them there. Rural communities are disadvantaged because they don't have the money to pay, and their students often come from families that make less income, who need from day one in medical school that guarantee; they need to be able to see to the end that they won't have a larger debt than most houses in their community are worth. Because that will be a disincentive.

The Chair: Mr. Bell.

Mr. Don Bell (North Vancouver, Lib.): Thank you.

I find that very interesting, and I'm glad to hear the presentations. There seem to be some common themes running through from all of you, and I identify or appreciate that.

I heard about the threats, by the way, and just as a sidebar, maybe one of the real threats to the system is political partisanship and not focusing on the issues.

But to move to one issue, the question that was raised by I think Dr. Schumacher regarding the GST—the second of the three points you addressed on health. This has been raised. We had Minister Goodale before us two days ago or...I've lost...it's sort of all a blur right now. But the point was raised with respect to it being extended to municipalities. And there's the rest of the MUSH group—the universities, the schools, and the health systems—that I believe should get the benefit from that GST exemption.

The issue I wanted to ask Deborah, from the Canadian Nurses Association, about follows through on Mr. Pallister's question on the provision of medical practitioners in rural or less popular areas, and the incentives. I was interested in the discussion that just occurred.

Are there papers or things you could direct me to that have addressed this issue? The kinds of incentives you talked about would also apply, I presume, to immigrant workers who come here from... I'm thinking of nurses from the Philippines.

I'm from British Columbia, so I'm well aware of the issues of getting credentials for foreign workers who come in, who have skills that may need either some fine-tuning to meet Canadian standards or who simply need a quicker way for them to be legitimized, if their skills are equivalent—whether they're doctors or nurses.

What kinds of practical incentives work to get them to go into these areas that are less popular initially?

Dr. Deborah Tamlyn: There are specific papers and information that we will gladly send to your office, and I'm sure CMA would have that as well.

I think you raised a very important point, and that is, as we have a lower supply of health professionals, those areas that tend to put in the incentives, that have quality workplaces, and that are preferred areas to live and work in will have the advantage over other areas. So how can we level the playing field and make sure that rural and remote areas...also that new Canadians, people who are immigrating to Canada, can be assisted?

This has been a priority agenda item for us and for the physicians.

I just wanted to piggyback on a comment that was made by an earlier speaker, and that is the issue of whether we are self-serving as health professionals, whether this really is all about our concern about our numbers, our remuneration, and this kind of thing. I think that view could be taken; it's a highly cynical view.

I think what we're concerned about and what we want to focus on is how we can allow licensed practical nurses, nurses' aids, nurse practitioners...how physicians and specialists can work in different ways.

I just wanted to clarify that this isn't just about preserving the status quo, or that we don't have evidence and new age thinking to bring to bear. We want to apply that to take new approaches for aboriginal health, rural and remote areas, and the growing number of new Canadians we'll be dealing with.

● (1055)

The Chair: Thank you.

Monsieur Loubier.

[*Translation*]

Mr. Yvan Loubier (Saint-Hyacinthe—Bagot, BQ): Thank you, Mr. Chairman. I apologize for arriving late.

I've been hearing the same speech for a while now, but every time I am just as astounded when I hear it. You're asking for coercive and punitive measures, when we should be targeting the federal government's share of health care costs. When the program was started it was in line with the Canada Health Act, and the federal contribution towards health care costs was 50 per cent. But now, it has dropped to about 18 per cent, and under last September's agreement, that share is supposed to rise to 23 per cent.

In the private sector, if a party has a minority stake of 25 per cent in a business, this party would normally not control the business. Today, you're asking that the major contributor, that is the provinces, which fund up to 75 per cent of health care costs, be made a trustee of the federal government with regard to the management of hospitals. May I remind you that until now, the federal government has not demonstrated that it is exceptionally competent in the management of two types of hospitals, namely hospitals for native people and those for veterans, since they are national catastrophes.

It's all very well and good for politicians to shoulder their share of responsibility, which is what we do. However, threats have also been made by professional orders, something which is not often discussed. I'm referring to the orders of physicians, nurses and other specialized professionals working in a hospital setting. Dr. Schumacher, you mentioned a little earlier that it takes 10 years to plan for and train new workers. But the fact that you impose quotas on the number of students is also problematic. In my region as elsewhere, there is a shortage of physicians. You can even read signs along highways which say: “We have been trying to attract three physicians in the last five years”, and yet those positions are still not filled. This is another type of threat.

What do you think of, on the one hand, the coercive and punitive control of the federal government, which only contributes 25 per cent, as Judy explained earlier, and, on the other hand, your role as representatives of the professional orders?

[*English*]

Dr. Albert Schumacher: Thank you.

You've put forward a very important target. Until we started doing measurements, we didn't understand that 25% of patients in Quebec don't have access to a family doctor. That's probably almost the worst place in the country, at least among the provinces—it may be worse in the territories. On the other hand, Nova Scotia, perhaps, is doing the best. There's only 5% of people who report that they don't have a family doctor, the national average being about 12% to 15%.

Is that a bigger priority in Quebec and something that one should do even more to address? Absolutely. Can you tackle everything in the world? No. But it would be something in Quebec that certainly no one would object to coming up number one as something we should do to address. There's a variety of strategies where one could do that.

There needs to be the investment to make sure we're training enough physicians and we have enough resident training spots. That was alluded to in the last question. There are many immigrant physicians who come here, international medical graduates, who we need to have spots for to train and license here. In this last year, of the 850 qualified doctors who could go into a residency spot, we had only 85 spots, so only one in 10 who were qualified could get a spot for a year or more. That's something we need to be addressing.

Should these be in rural areas? Absolutely. Does it need to be funded? Yes. Can the federal government actually intervene and do something about this? Absolutely. The federal government has a direct role in this kind of work. After all, they were the ones that built four medical schools back in the late sixties: Sherbrooke, Memorial, Calgary, and McMaster.

So I believe there's a federal role here to help exactly those kinds of areas and those kinds of communities to attract, retain, and educate physicians.

● (1100)

[*Translation*]

The Chair: Thank you, Mr. Loubier.

Ms. Minna.

[*English*]

Go ahead.

Hon. Maria Minna (Beaches—East York, Lib.): Thank you, Mr. Chairman.

I wanted to start with Mr. McBane.

You were talking about violations in health care in various aspects. Has there been any monitoring? Has your organization or anyone done a bit of monitoring to see how predominant it is, how prolific the violations are, and in what areas they are occurring the most? Is there a sense? I hear about them a great deal. I hear them anecdotally; I've read some reports.

I'd really like to get a better handle on this. And maybe Health Canada should be able to tell us; maybe we should have asked for that report. I just wondered if you knew.

Mr. Michael McBane: We certainly don't have the resources to do systematic monitoring. I would argue that Health Canada does. There are a lot more people working there than we have at the Canadian Health Coalition, and they have the legal responsibility to monitor. However, I don't think we're looking at hundreds and thousands of problems. We're looking at a couple of major strategic assaults on the system that are deliberately designed.

The privatizers speak of taking a bite size that we can bite, but because of the political support for the system, you have to be careful how you privatize it. The strategic targets they're looking at are public-private hospitals. They're looking at elective surgeries. They're basically cherry-picking the profitable surgeries of some of the specialists, but not everywhere.

Calgary is the headquarters, and the Charest government sent emissaries to Calgary to find out how to privatize. You're seeing examples in Montreal emerge. It's the rich centres of urban Canada in Calgary, Vancouver, and Montreal. We've had problems in Toronto. We've worked hard with the new government in Ontario to reverse and stop this trend. They ran on that ticket and promised they would stop the trend. They've taken some steps in that direction.

I don't think it's a hopeless cause. I don't think it's inevitable. It's isolated, extremely dangerous, and it has to be addressed, but it's basically setting up private parallel services. Sometimes the same doctor is running a private operation centre in the morning and a private clinic in the afternoon. It's the same position. We wouldn't let anyone else operate that way in society. It's a fundamental conflict of interest.

Hon. Maria Minna: I agree. I've seen that happen in other countries. If it's allowed to grow, it becomes a two-tier system over time.

The other comment or question I have has to do with the new health council. I had a great deal of hope in terms of accountability, monitoring, finding out what was working and what was not, which provinces were doing best in shared best practices, monitoring human resources, and all those kinds of things.

I knew that Quebec was not reporting, although I think they started under the last accord, but I'm not sure they're agreeing to do that. I didn't realize Alberta was not reporting. That means it weakens the ability of the council to actually do its job. How can we change that? Have you any suggestions on how that can be changed?

Ms. Sharon Sholzberg-Gray: First, I'd like to note that it's not the council that's going to be collecting the data. It seems to me that it's the Canadian Institute for Health Information that will be collecting the data and passing it on to the council. The council will comment on what needs to be done on the basis of that data.

Quebec has actually joined the Canadian Institute for Health Information, and all of the provinces are submitting data to CIHI. That's the good news.

● (1105)

Hon. Maria Minna: Does that include Alberta?

Ms. Sharon Sholzberg-Gray: That includes Alberta.

The data is being collected. The fact is, though, that some provinces don't have representation on the council. That doesn't mean the council isn't going to be able to give advice and comments on the whole country, because it's going to have the data. In a sense, there is a way.

The real issue is on what's going to be in its first report, expected in January 2005. I expect the reports will be more vigorous as time passes, so we could look to them.

The Chair: Time is up. We have run way over.

I want to thank everybody for being here. If any of you want to have a discussion, that's fine, but we have to get the next group in.

Again, if there are any items you'd like to add, you can always submit something to the clerk, but if you are going to submit something, we'd appreciate it in a brief format.

Again, thank you all for being here.

The meeting is suspended.

● (1106)

(Pause)

● (1107)

● (1115)

[*Translation*]

The Chair: We will resume the meeting.

I would like to thank all the witnesses for having taken the time to appear before the committee.

Since there are seven groups before us, each group will have five minutes to speak. I will let you know 30 seconds before your time is up.

We will begin by hearing from the Canadian Dental Association.

[*English*]

Mr. Dean, the floor is yours.

Dr. Alfred Dean (President, Canadian Dental Association): Thank you, Mr. Chairman, and good morning, members of the committee.

I want to thank you for inviting me to present the financial priorities of Canadian dentists. My name is Alfred Dean and I am president of the Canadian Dental Association. I live and practise dentistry in Cape Breton in Nova Scotia.

Joining me today is Andrew Jones, the director of corporate and government relations at the CDA here in Ottawa.

The room is full and you clearly have a lot on your plate, so I'll just take a few minutes of your time today to speak to some important dental issues.

Just in our lifetimes we have made significant improvements in our oral health. Folks my age can expect to keep their teeth well into old age; compare this to our parents, who were lucky to have any natural teeth at all. The generation to follow us will do even better; many of them will never have a cavity. This optimistic view was reinforced earlier this year when some basic oral health questions were included for the first time in Statistics Canada's community health survey. The questions were limited and relied on self-diagnosis, but they did give us a glimpse into our nation's oral health status. In this survey, 83% of Canadians reported having good to excellent oral health. That's the good news.

I hate to be the one to bring you a tough message, but here it is: dentistry does not get very much attention from government. I know it's a shocker, but there you have it, and it's hard to understand why. Dentistry accounts for about 7% of total health spending in Canada, amounting to some $9 billion. It is second only to cardiovascular disease, in terms of overall ranking. Of the $9 billion, only a small portion, less than 6%, is publicly funded.

I'm going to go out on a limb and guess that the reason dentistry is overlooked is that we fall outside of our national medicare system. I'm not suggesting that it should be otherwise. Medicare is already stretched thin by its current commitments. However, we do need to put our heads together to find ways to reach out to those with unmet dental needs. There are still too many Canadians for whom a visit to the dentist is a rare event. In the community health survey I referred to a moment ago, 14.5% of Canadians reported only poor to fair oral health.

That may not sound like a big number, but consider the impact on the whole health system. Serious oral diseases can be associated with chronic pain, and oral cancer is among the most fatal of all cancers. Researchers are also starting to understand that oral health is linked to overall health. If your mouth is sick, the rest of your body is affected—and the effects may be quite major. Periodontal diseases seem to be a complicating factor in heart disease, pre-term and low-birth-weight babies, and pneumonia. There is a definite connection with diabetes, where the disease cycle of each negatively impacts the other.

These are big health care concerns, both in terms of their impact on quality of life and their costs to the health care system. As always, the costs of neglect far outweigh the costs of prevention. If it turns out that dentists can help to avert or reduce the severity of some of these diseases, we can achieve important savings, not just to the health care system but also to the economy as a whole. Think of the lost work days, the hospital emergency visits for abscessed teeth, and the kids who have trouble concentrating in school because of cavities and pain—and all of these for an entirely preventable disease.

So what can we do about it? At the community level, most dentists are providing care on an individual basis where they see the need. In my community in Nova Scotia this is certainly the case. At the organizational level, dental associations, more than ever before, are examining the issues around access to care, including barriers, models of delivery, and best practice solutions. But we cannot do it alone.

● (1120)

We need a better focus on oral health issues within government. In our brief we recommend the immediate placement of a chief dental officer. This position will be crucial to centralizing efforts at the community, provincial, and territorial levels. This officer can be someone who can be a go-to for the profession and can coordinate best practices in oral health promotion across the country.

We also make a number of recommendations about what to do and what not to do in terms of developing new funding mechanisms for dentistry. Patients must be free to choose their dentist, the leader of their oral health team. The dentist-patient relationship must be fostered and be free from third-party intervention in treatment planning. There should be recognition that dentistry is best delivered in an inclusive setting by a coordinated team of providers. Economies of scope and scale are lost if patients must seek individual oral services from disconnected providers in separate facilities.

Although there is a lot more I would like to say, I will end here. I know that our full brief will be considered as you prepare your report and recommendations to Finance Minister Goodale. It contains additional detailed information on many subjects, including the funding crisis in dental education; the need for more oral health research; the oral health of first nations and Inuit; the strengths of tax incentives for dental plans; disparities in retirement savings; and the need for parental leave provisions for dentists and other self-employed professionals.

The Chair: Thank you.

[*Translation*]

We will now hear from Ms. Ziebarth from the Canadian Dental Hygienists Association.

[*English*]

Mrs. Susan Ziebarth (Executive Director, Canadian Dental Hygienists Association): Thank you for the opportunity to contribute this brief to the discussion of health financing.

I am Susan Ziebarth, executive director of the Canadian Dental Hygienists Association. I'd like to introduce my colleague Judy Lux, who is involved with health policy at CDHA.

Oral health services are the missing link in the health system. The Canadian health system is well equipped to provide services for many diseases; however, as the Minister of State for Public Health, Carolyn Bennett, points out, we have a health care system where the mouth is not considered part of the body.

Recent research showing a link between periodontal disease and systemic disease provides an impetus for reconnecting the mouth and the body. Research on the oral systemic disease link provides a persuasive argument for transforming the notion of oral health as a separate entity from general health. Dental hygiene treatment of periodontal disease reduces the need for insulin in diabetes, the risk of respiratory disease in high-risk individuals, the number of spontaneous pre-term births, and the risk of loss of life and disability due to cardiovascular disease.

The cost savings would be significant. A U.S. study indicates that the reduction in premature, low birth-weight babies due to dental hygiene treatment would prevent 45,000 pre-term births each year. This would save $1 billion in intensive care costs alone.

Two oral disease prevention initiatives, water fluoridation and fissure sealants, are particularly cost-effective prevention methods. Yet fewer than half of Canadians have access to water fluoridation, and fissure-sealant programs are greatly underutilized in public health programs.

Oral health promotion and disease prevention programs should not be a luxury but a way to improve overall health and reduce long-term health care costs. CDHA recommends that the federal government call on the provincial and territorial governments to earmark a portion of the increased resources provided in the first ministers 2004 ten-year plan for public health, including the following activities: oral health promotion and disease prevention programs; and water fluoridation and fissure sealant programs.

With respect to access to care, among OECD nations, Canada has the second lowest per capita public oral health expenditures. How does this directly impact Canadians? A considerable segment of the population, including low-income Canadians, seniors, and aboriginal peoples, has limited access to oral health care services.

The result is significant disparity in oral health status. Dental decay rates for children from low socio-economic status families are twice as high as their more affluent peers and two to five times higher for aboriginal children than for non-aboriginal children. In addition, the root caries rate is three times greater for seniors than for those under age 45. This negatively impacts on growth, development, and quality of life of Canadians.

Aboriginal peoples' oral health is a stain on Canada's reputation. The non-insured health benefits program for first nations and Inuit peoples reaches only 38% of the eligible population, and oral health providers are not located in all areas where aboriginal peoples live.

CDHA recommends creation of categorical federal public oral health programs for all low-income Canadians and increased financial support for the NIHB program of the First Nations and Inuit Health Branch of Health Canada in order to undertake a wellness model that gives priority to promotion and prevention strategies, makes better use of mobile dental hygienists to serve remote areas, and permits and facilitates a more independent role for dental hygienists.

CDHA applauds the government in establishing the new Public Health Agency of Canada and appointing the Chief Public Health Officer. This agency must have a strong leadership role in the following areas: creation of a chief oral health officer position located within the Public Health Agency; overseeing the implementation of the Canadian oral health strategy developed by the federal-provincial-territorial dental directors; ensuring that oral health issues are included in all chronic disease prevention initiatives; overseeing the collection of world health surveillance information that would provide information for a national report on Canada's oral health status; and increasing support for front-line local oral health programs, which have been eroded over the last several years. Meeting these goals requires strong, stable funding for federal public health functions.

● (1125)

CDHA recommends the federal government increase to $1 billion per year its core funding for federal public health functions, including a portion earmarked specifically for the operation of the Public Health Agency of Canada and front-line oral health programs and services.

Human resources planning and research are both critical in ensuring that the Canadian public receives quality oral health services. CDHA recommends the federal government allocate sufficient funds through Human Resources and Skills Development Canada and Health Canada to collect accurate data on oral health human resources and conduct a multidisciplinary sector study of Canada's public health workforce. CIHR's institute for population and public health ensure that oral disease prevention and health promotion are integral aspects of the research they are undertaking, including research on the efficacy of oral health promotion and disease prevention.

The Public Health Agency of Canada has a mechanism for systematic review of the evidence for effectiveness of public oral health interventions. Now is the time for leadership, and we're looking to you for your strong support.

Thank you.

The Chair: Thank you. That's pretty good—15 seconds over. I'm not talking about the presentation; I'm just a time person. I'll let the other members decide whether the presentation was good.

Next is the Sport Matters Group, Mr. Lachance.

● (1130)

[*Translation*]

Mr. Victor Lachance (Senior Leader, Sport Matters Group): Thank you, Mr. Chairman. I would like to thank committee members for giving us the opportunity to speak before the committee today.

My name is Victor Lachance and I represent the group called "Le sport est important". With me is Mr. Page, who is the Director General of Diving Canada.

[*English*]

We're pleased to report to the committee that in the past two years there has been some good progress on sport policy, and there's been some progress on fiscal policy as it affects sport. Today, compared to two years ago, I think there's much more recognition of sport's contribution to health objectives and healthy communities. I think that's good. There's much more recognition of the sheer size and scope of the sport and recreation sector, with over 34,000 organizations across Canada, according to the last report from Statistics Canada.

There's recognition of the need for more physical activity everywhere you look and anywhere you look. I think we're getting that message, especially for young people. More recently, alarm has been raised over the poor state of high-performance sport, especially as we prepare to host the 2010 Olympics. So I guess those things are fairly good.

Two years ago we brought before this committee the need to better align fiscal policies with federal sport policies, in particular the Canadian sport policy, which was adopted in 2001 by all 14 levels of government—federal, provincial, and territorial. It was a landmark piece of work that was supported by the entire sport sector. At that time we proposed that Sport Canada's budget should be increased from $75 million to at least $180 million to fully implement that policy, with $100 million a year for the pan-Canadian physical activity strategy developed by the Coalition for Active Living. Where are we now?

Sport Canada's budget today stands at about $120 million. Some would argue that about $30 million of that is pretty soft, because it was only announced this year for one year, but it still stands at $120 million. So we're about halfway there to the $180 million. Unfortunately, there hasn't been the same kind of progress made for physical activity, even though the need is as great as ever, and even though federal, provincial, and territorial ministers have agreed collectively to increase physical activity in each province by 10% by 2010. So there's been good policy work, but fiscal policy still has a little way to go.

We welcomed in the throne speech the goal of enhancing sport activities at both the community and competitive levels, as well as the more recent statements by the Prime Minister calling for a new plan for sport in Canada that addresses this country's commitment to a healthy, thriving, and productive sport system.

In our view, we do have a Canadian sport policy. I think this would go a long way toward addressing the throne speech and the Prime Minister's call for a plan. There's a new memorandum to cabinet that's being prepared right now by Sport Canada as we speak to address the implementation of the Canadian sport policy in the throne speech—the minister's call. What is needed now for this committee's consideration, in order to implement these worthy goals, is more money and new instruments that are harmonious with the current federal, provincial, and territorial nature of sport activity in Canada.

For more specific recommendations I will call on Tim.

Mr. Timothy Page (Executive Director, Diving Canada, Sport Matters Group): Thank you, Mr. Chairman.

We have four specific recommendations to bring to your committee's attention this morning. The first deals with a new approach to the management and delivery of sport and physical activity that will help to provide leadership of the system, more timely decision-making, and a better integration of policy, program, and funding decisions. In particular, we suggest to you the creation of a single federal government department, with a full cabinet minister for sport and physical activity.

Over the last five years there have been four separate individuals responsible for sport in Canada. We think with a move to a single department with a full cabinet minister there will be much greater integration and therefore much greater synergies within the community and within government relating to sport and physical activity. A move of this nature would be entirely consistent with how the vast majority of provincial governments are organizing themselves with respect to sport and physical activity. We suggest in the same breath the creation of an arm's-length agency to help in implementing the Canadian sport policy.

Our next recommendations touch on investment for sport. We're looking for predictable, stable, long-term funding to the physical activity and sports sectors, in an amount equivalent to 1% of the federal government's current health care budget. There would be a minimum of $180 million a year for sport—as my colleague Victor has suggested, up from the $120 million currently invested—and a minimum of $100 million for the physical activity community.

Third, we're suggesting a strategy for private sector and general public support through a non-profit, non-governmental foundation to encourage innovative public-private partnerships. We'd invite the committee to look again at the Mills committee's recommendations on tax measures.

Fourth, we're encouraging the federal government to take an active role in the long-term investment for community facilities and infrastructure.

On that point we'll stop our presentation and look forward to the question and answer period afterwards.

Thank you.

● (1135)

The Chair: Thank you.

The next group I have here is the Canadian National Institute for the Blind.

Ms. Moore.

Ms. Cathy Moore (National Director, Consumer and Government Relations, Canadian National Institute for the Blind): Thank you, Mr. Chairman.

[*Translation*]

I cannot give my presentation in French today, but I promise you this: next year, it will be entirely in French.

[*English*]

The Canadian National Institute for the Blind would like to make three recommendations to this committee. Two involve a nationwide equitable library system for persons who cannot access regular print. The third recommendation is to ask for the newly formed Public Health Agency of Canada to take a leadership role in adding vision loss services to the health care system.

Recommendations 1 and 2 go together. Recommendation 1 is a request that the Government of Canada take a leadership role in developing a nationwide equitable system of library delivery, in cooperation with provinces and municipalities obviously, since the library system, like many things in Canada, is spread out provincially and federally. How do we do that? It's very possible now, with the newly formed Library and Archives Canada, to use that as a federal vehicle to shepherd the production of alternate format library material. Why is that needed? It's needed because only 3% of library material is available to persons with print disability, by which I mean library material that is in either audio, e-text, or Braille format.

There are, in fact, three million Canadians in Canada who cannot access regular print. This includes persons with learning disabilities, persons with dexterity issues, etc., along with people who are blind or visually impaired. Those three million Canadians are clearly not being served. The CNIB is serving the blind and visually impaired population, which is a small percentage of that three million, but even so and 85 years later, we are still, as I say, at 3% of print that's available. To give you a visual image of that, just think about the Ottawa phone book and consider one page as being available to the print-disabled while the rest of the book is available to everyone else. It's clearly not a system that is equitable or reflective of Canadian values.

Our third recommendation is to add or begin to consider vision loss services, which right now are mainly located—and this is outside the province of Quebec—within the purview of the CNIB, which is a private, not-for-profit charity. We receive about 27% of our total budget from governments, both provincial and federal. The rest is raised literally through bingos, lotteries, and other fundraising activities. However, we are serving about 100,000 people a year. The 2000 census indicated that there are at least 600,000 people in Canada right now with severe vision loss, so we're seeing about one-sixth of that population now and we are at pretty well full capacity.

We know three things about vision loss in Canada. One, it's common. One in nine people over the age of 65 can expect to experience severe vision loss in their lifetime. We know a lot of vision loss is preventable, and this is again a message that needs to get out to the Canadian public. For people who smoke, quitting smoking at any time in your life will reduce your chances of age-related vision loss by 30%. Healthy vegetables and healthy eating will too.

So it's common, it is preventable, but there is also chronic vision loss at the end of the day. It is not preventable, not remediable by the medical system, but it can be remediated or ameliorated by rehabilitation. Rehabilitation in this context means to restore to health or well-being. It is possible, through training, through psycho-social supports, to enable someone with chronic vision loss to remain in or resume a productive role in society, remain a taxpayer, remain in the community. With visual rehabilitation it's possible to delay the institutionalization of seniors. It's possible to prevent falls and hip fractures, again with appropriate vision rehabilitation. Why would we do this? Because it will save us money.

You have sat through this morning listening to many requests in the health care system. Although it's not a popular notion, we all know the health care system as it exists is not necessarily sustainable for the next twenty or thirty years. So where do we need to go? We need to go into the prevention area in a much stronger way, and the newly formed Public Health Agency of Canada is certainly the agency, the federal vehicle, to lead that—as I believe it is tending to do—along with its other roles.

I would like to conclude by saying that we ask for support of the Library and Archives Canada as the federal vehicle to develop a nationwide equitable library service for print-disabled Canadians, and we would ask the support of the Public Health Agency of Canada to bring vision loss services into the health care system and out of the social service area where they now rest.

Thank you.

● (1140)

The Chair: Thank you.

The next group I have is the Canadian AIDS Society, Mr. Lapierre.

[*Translation*]

Mr. Paul Lapierre (Executive Director, Canadian AIDS Society): Good morning. My name is Paul Lapierre and I am the Executive Director of the Canadian AIDS Society. With me is Mr. Mark Creighan, a lobbyist and communications expert.

[*English*]

The Canadian AIDS Society will be recommending seven items to the Standing Committee on Finance.

First of all, I would like to give details about the Canadian AIDS Society. We are a coalition of 120 member organizations located across the country. The work we're trying to accomplish is assisting people living with HIV and AIDS, while also moving forward to ensure there are good prevention initiatives in place to prevent HIV and AIDS.

As we all know, there are over 56,000 Canadians living with HIV and AIDS. HIV/AIDS is still fatal and is still preventable. There is no cure in place. There is treatment available, but access to treatment is an issue, due in large part to various jurisdictions, various formulas, and the costs involved. These are issues that I'll be addressing in one of my recommendations.

When it comes to HIV and AIDS and prevention, we know we're looking at attitude and behaviours. One key recommendation we are making today is that funding allocated under the new Public Health Agency be targeted to prevention. We need to look at determinants of health, we need to do some health promotion, and we need to address the behaviour of many Canadians who don't know they are engaging in activities that put them at risk of getting infected by HIV and AIDS.

In the Romanow report, which was published a couple of years ago, there was one key recommendation that a new catastrophic drug program be implemented. When it comes to HIV and AIDS, it's very common for one individual to spend over $1,500 a month on treatment alone. That does not include complementary therapy and it does not include the cost of family doctor visits, specialists, hospital stays, and so on.

We are urging the government to create a catastrophic drug plan, because that will also ease the access you are facing, depending on your status in Canada. As we all know, if you are a member of the aboriginal community, you are accessing different formulas than those people who are residents in Ontario or Quebec or Newfoundland. There are discrepancies in this country when it comes to access to treatment, so we are hoping the creation of that catastrophic drug program will address those barriers and ensure that people have access to HIV medication across the country, regardless of their province of residence, regardless of their status.

There's a second recommendation we would like to move forward. Last May, then Health Minister Pettigrew made an announcement that the federal government will double its funding for the Canadian strategy on HIV and AIDS over the next five years. It was a good step in the right direction. Nevertheless, the Standing Committee on Health recommended a year ago that over $100 million be allocated for the Canadian strategy on HIV and AIDS. Also, an expert committee recommended $106 million a year on HIV and AIDS. We are therefore urging the government to revisit this and respect the standing committee's decision, but also to look forward to investing $106 million a year, as recommended by the experts in this country. As part of that recommendation, the government is pushing an increase over five years. Both committees have recommended that the increase take effect immediately.

As we speak, by the end of the day, ten new Canadians will be infected. Those infections could have been prevented, so we need to invest in prevention.

Furthermore, many Canadians access the disability tax credit program that eases their burden and lets them remain active citizens. Unfortunately, the current disability tax credit program does not include people living with HIV and AIDS. We are recommending that the disability tax program be expanded to include people living with HIV and AIDS.

As we know, many Canadians are co-infected with both HIV and hep-C, or HCV, so another recommendation we'd like to put forward is that we'd like the government to renew the hep-C strategy for a five-year commitment.

My last recommendation is critical to the fourth pillar of Canadian society. As recommended or as recognized by the voluntary sector accord, we need a strong financial commitment to the voluntary sector. Many organizations dealing with housing issues, poverty issues, health promotion, education, and so on, are organizations that are not receiving any type of funding.

We are urging the government to implement the voluntary sector accord and to implement and come up with financial resources to ensure that not-for-profit organizations are viable, stable, ongoing, creative, and can actually make an impact for people at risk, people living in poverty, people living with HIV and AIDS, and so on.

On that note, knowing that my five minutes is coming to an end, I would like to make an end. Merci.

● (1145)

The Chair: They did come to an end.

[*Translation*]

We will now hear from Mr. Kyle from the Canadian Cancer Society.

[*English*]

Just one second, sorry, before I forget, because then I'm not going to get back to it.

[*Translation*]

Mr. Lapierre, do you have a brief for us?

Mr. Paul Lapierre: Because of technical difficulties, we were not able to print out our brief this morning, but we will get it to you later on today.

The Chair: Fine. Please do so as soon as possible.

[*English*]

Mr. Kyle, go ahead.

Mr. Kenneth Kyle (Director, Public Issues, Canadian Cancer Society): Thank you, Mr. Chair, committee members.

I think Monsieur Dupuis has circulated our brief. It's the one with all the coloured charts and so forth.

I'd like you for a moment to think of all the people living in Manitoba, Saskatchewan, and Alberta—all the children, teenagers, and adults—and think of how many people they are. The same number of people who currently reside in those three provinces will get cancer in Canada over the next 30 years, or the people of British Columbia and Saskatchewan, or half the people of Ontario.

We're here today to inform you that Canada lags behind other nations in reducing cancer incidence in four main cancer types and we lag in developing a national cancer control system.

You've heard today about the need for various strategies, the strategy for this and that. We have something very exciting to present to you today. We have actually developed a strategy, and you'll find the details in our brief. Dr. Kennelly, who is with me, will be able to answer any technical questions. Dr. Kennelly is becoming a national treasure. She formerly was policy adviser to three prime ministers in New Zealand and is here in Canada now to help us with this strategy.

We do now have a strategy and we have a strategy that respects provincial jurisdiction. We have developed a strategy for the country called the Canadian strategy for cancer control, based on best practice from overseas in cancer control and from key learnings from the banking industry in managing the economic risks of cancer.

Our model matches the sophistication, success, and ongoing achievements of the Canadian medical community. The Canadian strategy for cancer control will surpass international best practice examples and place Canada at the forefront of cancer control worldwide. It will leapfrog Canada to the front of the pack in preventing and managing cancer.

If funded, the Canadian strategy for cancer control will crystallize in the saving over the next 20 years of—this is really incredible—116,000 lives. We will save $23 billion in wage productivity, $10 billion in government revenues, and $2.7 billion in health care costs.

A key feature of our strategy is that at the heart of the strategy is making evidence about the progression of cancer available for use by the provinces, by the provincial governments. Experience from Europe shows respect for the autonomy of other jurisdictions in health delivery will bring the greatest benefits to Canada.

Here's the economic problem. We have increasing numbers of people with cancer as the baby boomers move into the higher cancer-at-risk age profiles. We all know what has been the story of baby boomers as they've moved through the population. There are increasing demands for health services that have resulted from increases in health care costs and inflation.

Over the next 30 years, 2.3 million Canadian workers will get cancer and 858,000 will die of cancer. Economic productivity of cancer risk is $545 billion. Direct health care costs of cancer risk are $175 billion. Canada is expected to lose over $250 billion in tax revenues—$154 billion in federal tax revenues and $96.6 billion in provincial tax revenues. Of this $250 billion, $228 billion will be associated with morbidity costs, which are productivity losses prior to death.

The really big message from these numbers is that when Parliament is looking at cancer and the impact on the economy—and we know we are addressing the finance committee here today, not the health committee—the focus should be on prevention and in managing cancer incidence and prevalence and not death.

Economic impact associated with death from cancer is a marginal cost relative to the loss of productivity through losses in tax revenue and workforce participation that occurs as cancer morbidity creates a drag on all the economies in Canada.

The other really big message to take away from these numbers is that the governments of Canada need to start a process of preventing and preparing for and managing the increasing economic costs associated with cancer.

● (1150)

The benefits of the Canadian strategy for cancer control are many.

The Canadian strategy and its risk management platform is poised to bring Canada to the front of the pack around the world in comparison to what other countries are doing. Canada will build on existing global cancer control leadership that includes national coalitions of cancer registries for ongoing surveillance; excellence in basic research, including molecular biology and so forth; centres of excellence in areas such as clinical trials and behavioural and psycho-social sciences; tobacco control, including warning labels, tax research, ETS protection; and committed and well-integrated non-governmental organizations.

In conclusion, I'd like to mention something about tobacco tax. Higher tobacco taxes are an important means of not only reducing smoking, especially among price-sensitive teenagers, but also raising revenue for government. Past increases in tobacco taxes have advanced both these objectives. The sudden onset of price discounting by tobacco manufacturers in the last two years has resulted in a tax decrease of about $10 per carton for roughly 35% of the market. There is a pressing need for a tobacco tax increase to respond to this price discounting.

In conclusion, in thinking about the budget surplus—one of the questions you directed to us—we need to think about investing in information platforms and strategies such as the Canadian strategy for cancer control, which we have developed, and that will enable governments across Canada to understand and manage economic risks associated with the projected increase in cancer. The other thing that could be done with the surplus is to reinstate funding to Canada's tobacco control program.

Mr. Chair and members of the committee, these buildings on Parliament Hill are Canada's most important health...and health care institution. More affliction and distress can be prevented by decisions this committee tables than by incisions at the operating table.

Thank you.

● (1155)

The Chair: Thank you.

The next group I have is the Canadian Coalition on Public Health in the 21st Century.

Ms. Wilson or Ms. Law.

Ms. Maureen Law (Consultant to the World Bank, Canadian Coalition on Public Health in the 21st Century): Thank you, Mr. Chairman.

Elinor Wilson and myself are the co-chairs of the Canadian Coalition for Public Health in the 21st Century. The coalition is a partnership of some 37 national non-government professional health and research organizations and coalitions, which are committed to making Canadians the healthiest people in the world by advocating for an effective, integrated public health system

The coalition came into existence in May 2003. Since then we've been delighted by the creation of the new Public Health Agency of Canada and the appointment of a Chief Public Health Officer. Along with the Minister of State for Public Health, this is finally giving public health a visible face.

The federal government also committed $225 million per year to national public health functions, in addition to the existing $400 million core Health Canada funding. These are very good first steps, but a gap remains between the Naylor committee's recommendations for an additional $700 million annually and the current commitments.

We know that health services are largely a matter of provincial jurisdiction, but the health of Canadians and a public health approach to maintaining it are matters of national and pan-Canadian importance, and, for that matter, of international importance as well.

You have our brief. I'm not going to go into that, but I want to make a few brief comments on our recommendations.

The first recommendation is that the federal government should call on the provincial and territorial governments to earmark a portion of the increased resources provided in the ten-year plan for public health activities. We were very pleased to see the reference to public health in the accord, but there was no line item for public health in the attached budget, despite the fact that it's clear we need a strong pan-Canadian public health system to prevent illness and promote health.

The second of our recommendations is that the federal government should increase to $1 billion per year its core funding for federal public health functions. Naylor called for an additional $700 million per year for agency and related functions. Adding the $400 million for current activities of the population and public health branch, we come to $1.1 billion. Since the government is now reporting a substantial surplus, we think the time has come to meet the requirements identified by Naylor. By the way, this recommendation asks for $1 billion, not $1.1 billion, because we asked for the additional $100 million for immunization in a separate recommendation. The new funds identified in the last budget were described as a down payment, and we're here to remind you that the full amount is coming due.

Our third recommendation is that the federal government should allocate sufficient funds for the conduct of a multidisciplinary sectoral study of Canada's public health workforce and the development of a strategy for its renewal. We have noted that over the past decade or so public health human resources have been severely diminished by cuts and reorganizations. We need to fast track this work in this area so that our much needed prevention and health promotion activities can finally be fully implemented.

Our fourth recommendation is that the federal government should make a long-term funding commitment to national immunization, including $100 million annually to the provinces and territories to initiate and sustain immunization programs and $10 million annually to support a national immunization strategy. This commitment should be reviewed every three years.

Communicable diseases are not respectful of constitutional jurisdiction. We need ongoing, pan-Canadian funding of immunization, including vaccines.

Recommendation five is that Health Canada update the "Economic Burden of Illness in Canada" report every three years and formally incorporate this concept into its sustainable development strategy with respect to the balancing of surveillance prevention programming and research. Obviously, we need good data to help in refocusing planning and spending in the health sector.

Finally, our recommendation six is that the federal government should direct the Health Council of Canada to include the performance of the public health system, as well as the health care system, in its reporting to Canadians. This implies that we need to develop measurable goals and surveillance systems that will facilitate good reporting on the determinants of health. This would serve to increase our understanding of what works and maybe what doesn't work to improve the health of Canadians, and this is the goal of not only of this coalition, but no doubt it is one that is shared by this committee and by all Canadians.

Thank you, Mr. Chairman.

● (1200)

The Chair: Thank you.

We'll start with the members.

Mr. Pallister.

Mr. Brian Pallister: Thank you all very much for your presentations and the materials you've brought us today.

Dr. Kennelly, I'm sure that in the next few months you're going to long for Auckland, but welcome to Canada.

As we all know, tobacco is the leading killer of Canadians. I think we're talking of close to 50,000 a year. The government has decided to make cuts to the tobacco control program at the same time as they're subsidizing tobacco farms to the tune of over $70 million. We'll let that sit.

There has also been the cessation of the anti-smoking advertising program as a result of the sponsorship scandal, something I think we should take steps to restore as soon as possible.

You've talked about the need for us to study best provincial practices, and I'd like you to expand on that, if you would.

Dr. Jo Kennelly (Director, Scientific Advancement and Public Policy, Canadian Cancer Society): The basis of the strategy is a risk management model. What we've done is we've based it on the banking industry, in terms of how they manage risk across a whole range of different portfolios. It's also based on my experience in New Zealand, where we did a risk management model for treasury on the aging of the population.

When we looked at Canada, we found there were different health care systems operating in a sense in the provinces and that cancer within those systems in terms of.... The differences are minor, but they're still there, and we found there are different philosophies that operate between Alberta and other provinces, and cancer as its sits as a public policy issue within those provinces is also different. So rather than taking that problem head on and saying we need to roll out a strategy on top of the provinces', we looked at various jurisdictions around the world, and we particularly looked at Europe and the EU model, where there are member states.

At the centre of the cancer control strategy in the EU it's evidence-based. What happens is the power of the strategy is evidence, so as evidence becomes available as you observe cancer, as you observe how it progresses through an economy, as you observe what techniques work with certain cancers, like prostate cancer, breast cancer, lung cancer, and you observe them at a very low level, then you can provide that information up through a strategy to be made available in Europe for the member states and in Canada for the provinces.

What we're suggesting here is that there are in Canada some provinces that are doing much better than others, and even if you can bring the provinces that are doing less well in terms of prevention and treating cancer up to the base level within Canada, there's about $20 billion worth of savings over the next thirty years just based on getting best practice across Canada.

If you take account that Canada is actually lagging behind other nations in terms of addressing the top four cancers, and if you then import into this model best practice from overseas, from Finland, from Australia, from New Zealand, from the U.K., in a whole range of different areas across your model, it's not $20 billion you're talking about, it's $20 billion to $100 billion.

So our model is that in the first instance you have to be able to observe the problem, and at the moment our surveillance system catches incidence at a very general level, but it doesn't tell us how to manage.... For instance, what prevention strategy is best for prostrate versus breast, versus lung? And the prevention strategy at the disease-specific level is going to actually bring the greatest gains and economic gains in the future, because science is heading in the direction of developing viruses and other sorts of techniques to attack cancer at a site-specific level. So public policy measures have to move to understand site-specific cancers and where to target our money across the cancer spectrum, across all 200. That's what we're saying.

Mr. Brian Pallister: Thank you very much.

Do I have some time?

The Chair: Yes, you have two minutes.

Mr. Brian Pallister: Dr. Dean, I caught a bit of your presentation, and we all recognize the limits of time, but I'm very interested and very concerned about what I consider to be a serious problem with regard to aboriginal children's dental circumstances. I understand from some of my dentist friends that the non-insured health benefit program is not, shall we say, working effectively.

How would you—I hate using a pun here—put some teeth into the program? In your report, sir, you speak of fundamental changes that should be made. Can you elaborate on what those fundamental changes should be?

● (1205)

Dr. Alfred Dean: Yes. I think to turn a pun, government could help this program and bite into this by simply removing the bureaucracy and the heavy administrative burden. What we'd like to see is the NIHB program move toward the industry standard in terms of what dentists deal with every day in their practice lives, with insurance carriers, with all patients, including yourself. Unfortunately, that's not what the NIHB program is.

In our opinion, it's advertised as a needs-based program, but really it's a cost containment program, and too much money is being spent on administration and administrative burden in order to try to save money. That excess money being spent on bureaucracy is not being put into care.

Mr. Brian Pallister: The money that's being spent on containing costs is actually one of the costs you'd like to see eliminated. Is that correct?

Dr. Alfred Dean: Of course.

Mr. Brian Pallister: Do I have a minute?

The Chair: You have 40 seconds. Go ahead.

Mr. Brian Pallister: I only want to make a remark to the Sport Matters Group.

Thank you for your presentation. Never have I been more aware of the need for physical activity than over the last several weeks in these hearings. I would like to see us actually purchase stationary bikes and bring them in here for the presenters and for you folks back there. The linkages are so obvious between physical activity and personal well-being, with a sense of well-being and reduced incidences of disease, illness, and so on.

Thank you to all of you for the work you do, and thank you to your members and the volunteers in your organizations. I think we sometimes fail to recognize the volunteer pillar and the work that's done in sport, for example. I've had joyous rewards come to me as an athlete for years and years in my life, from volunteers that too often I think we take for granted.

Your mission is one that I certainly subscribe to. I think there's incredible value to be derived from the work of volunteers, but it has never been more important in our society to not take that work for granted. With the incidences of childhood obesity, we could do away with Nintendo. We could solve some of the problems, but we can't. We have to address the challenges we face in a responsive way.

One of the challenges we face comes to me frequently from my friends who are volunteers in the sports world. It's the challenge of not only keeping people from getting overweight, but also keeping bureaucracies from getting overweight. How do you address that challenge within your organization?

I know I'm giving you a large topic to address, but in terms of administrative efficiency within your own sports organizations, is that something you're tackling? How do you go about it?

Mr. Timothy Page: First, thank you for your encouraging opening comment. We too believe that the sport and physical activity sector is a strong contributor to the government's overall objective as it relates to health care.

Overhead is an issue that affects everybody. We take a dollar and we typically stretch it to the equivalent of $10, given the strength of our volunteer commitment. Our overheads are painfully low to complete the work we have.

As the sport community, our concern is to ensure that we have strong coaching, athletes who are enjoying the opportunities to properly train, and facilities that enable folks from all walks of life and all parts of Canada to be able to enjoy the benefits that come from physical activity. As a sport community, our priority is on investing in those who make a difference and investing at the administrative level to make sure we're effectively managing those funds and nothing more.

● (1210)

The Chair: Thank you, Mr. Page.

Mr. Bell.

Mr. Don Bell: Thank you.

First of all, I would say that my coming to Ottawa has improved my physical activity. I now walk 11 blocks back and forth every day. I used to walk 50 feet back and forth to my car in north Vancouver every day. Now it's sometimes a little colder than I would like.

I have a couple of questions. One is for Susan or Judy from the Canadian Dental Hygienists Association. The comment was that less than 50% of Canadians have access to water fluoridation. Is that a drop, or is it still not as high as it could be? What's the reason? Most of your urban areas are fluoridated, are they not?

Mrs. Judy Lux (Communications Specialist, Health Policy, Canadian Dental Hygienists Association): Yes, most of the urban areas are. The rural areas aren't, and the majority of the north is not fluoridated.

Mr. Don Bell: Is that because of low population, the cost to the system, or education?

Mrs. Judy Lux: We're claiming it is cost-effective, so cost is certainly a factor for organizations and communities that want to implement it. In the long term, they'll see that it will be beneficial to the community.

Mr. Don Bell: What is needed to try to help that?

Mrs. Judy Lux: Well, I think we need leadership by the federal government. Although it's a regional issue, we need leadership by the federal government to let communities know about the research. There are new studies in this regard that could be distributed to the regional government.

Mr. Don Bell: Okay.

To Mr. Lachance or Timothy, regarding your Sport Matters presentation, you indicated on page 2 of your brief that there are three options the federal government could take to provide leadership of the system, more timely decision-making, and better integration of policy. You indicated the creation of a single government department, and you indicated that's one of your four recommendations, the creation of a full cabinet ministry.

Now, you did say in your report that there were three options—to create a single government department, to have an arm's-length agency, or to have a combination of the two. Do I understand, therefore, from your verbal comments as you led in, that you believe the single government department is the way to go?

Mr. Victor Lachance: The short answer is whatever works. Really what we're looking for is an integration of existing policies and program decisions, not at the federal level alone, because sport has a multi-jurisdictional nature. Funding decisions are excruciatingly slow. Sport organizations, including diving, in any one fiscal year may get a funding decision as late as November, to spend the money in a fiscal year. That kind of slow decision-making is of no use to anyone.

Government departments, understandably, are set up to deal with broad policy issues and provide ministerial advice and so on, which they do well. They deal with international relations, and carry out research and so on. They are not set up, understandably, to capitalize on strategic opportunities that will come up that sport organizations can identify. In the case of a national sport organization, it could be as simple as hiring a coach. Let's say there's an opportunity to hire an internationally accomplished coach, discussions are under way, and we're looking for a little bit of support from the federal government. Eight months later, a positive word may come through, but that coach is long gone.

On the allocation of funds for sport participation, it has become difficult to do that through Sport Canada. Even though some resources were identified in the 2002 budget for that purpose, it is being done in a somewhat ponderous, difficult way through federal-provincial processes. Some of these are sound in terms of strategies, but I think those strategies would actually work better if within the sport sector people worked more closely. We believe that would occur through greater specific attention within the government—that is, an integration of sport and physical activity, as is largely done in the provinces and other countries—or combined with an agency whose job is to implement the Canadian sport policy, to be measured for results on that basis.

Mr. Don Bell: Thank you.

To Paul Lapierre of the Canadian AIDS Society, you mentioned that some of your goals—I've shortened them down here—involve health education and this catastrophic drug plan. Has there been a lessening of awareness or of emphasis on education? It was very intense for a period. Do you find it's still there and being focused on as much as is necessary?

● (1215)

Mr. Paul Lapierre: With the arrival of treatment in 1997, there was a sense that treatment was there and therefore a cure was there. There's a sense of apathy now. People feel that popping pills every day isn't the end of the world. As well, we don't see as many people dying, so the face of AIDS has shifted over the years.

One of the greatest challenges is stigma and discrimination. We're talking about people with addiction, people living in poverty. For many Canadians, HIV/AIDS is a problem in Africa, not necessarily our own country. We're facing the need to increase awareness and implement curriculum educational programs. There are so many conflicting issues out there that people tend to forget it's happening in our own country.

Mr. Don Bell: Okay.

Finally, to Mr. Kyle or Dr. Kennelly of the Canadian Cancer Society, there were some recent announcements with respect to a cervical cancer breakthrough. I'm just wondering about genome mapping, about the idea of having some kind of a concentration of research facilities. The Canadian Cancer Society and the B.C. cancer agency have talked about trying to pull those into one unit. There is a unique opportunity there, and I don't know if you're aware of that initiative or whether you support it. What do you think of it?

Dr. Jo Kennelly: That initiative sits alongside this, and the new science that comes onboard will feed into this platform at the centre to observe cancer. Without this observation platform, that science gets lost, and it becomes public policy by press release.

What we're trying to do here is create a platform that allows that new science to feed into it and then allows us to see from different perspectives. Treasury Board will have a completely different perspective on what that science means for them in terms of dollars from that of the Canadian Cancer Society, which will be looking at it in terms of quality of life, increased life, and all those sorts of things. You need a central point to be able to even have the discussion with the treasury, and for trade-offs about what we're doing here to be clear.

That sort of information will feed directly into this, but what we don't have in Canada at the moment is the ability to pull it all together.

In the same way, if you go 10 years back in the United States, there was all this research going on in genomics in different labs across the United States. What happened was that supercomputing and the ability to write fancy algorithms came along, and the creation of a platform. They pulled together all the information from databases and created a map of the human genome, which is really just a collection of research.

What we're suggesting here is that what we need in Canada is something similar to mapping the human genome for cancer—and for other diseases as well: this is a benefit not just for cancer; the benefits are for a whole range of diseases. Once you can pull that research together, then you can look at questions such as: What does cancer look like? Where do we push the button? Do we push it here? How can one province learn from another?

We don't have that platform at the moment.

The Chair: Thank you.

Ms. Wasylycia-Leis.

Ms. Judy Wasylycia-Leis: Thank you. I have a bunch of different questions.

I want to start with recommendations on the non-monetary front and first ask the Cancer Society the question I wanted to ask Dr. Schumacher earlier. That is the question about the CPP investment board investing in tobacco companies. It would seem to me if we're serious about trying to do whatever we can on all fronts to crack down on addiction to tobacco, perhaps we as a committee should be giving some directions to the government to change the CPP investment board criteria to prevent our public pension dollars being invested in tobacco companies, thus siding with the tobacco industry to block more effective labelling to warn people about the dangers of smoking.

Do you have any opinion?

Mr. Kenneth Kyle: Thank you, Ms. Wasylycia-Leis.

We certainly support this initiative and we congratulate the Canadian Medical Association, which has been spearheading it. Part of the comprehensive approach to reducing the tobacco epidemic is the concept, which I'm sure many are familiar with, of de-normalization. It points out that the tobacco industry is not a normal industry. De-normalization shows that it's a rogue industry.

We certainly support this initiative, and I think we have some information on our website.

● (1220)

Ms. Judy Wasylycia-Leis: Thanks for that.

I want to go into questions of teeth and dental issues.

We in the NDP have often pushed the idea of including dental care under medicare, but it's been a hard one to advance. We're still trying to get some of the original promises around pharmacare and home care addressed, never mind denticare.

What advice would you have for us to make some inroads in ensuring coverage of dental care under a universally accessible program?

Dr. Alfred Dean: The first thing I would say is I think it's fair to say the envelope for health care in this country is not big enough to include dentistry, so we certainly don't advocate for it.

I would tell you that about 70% of Canadians have access to oral health care either through their employers or through some other health benefit program. On top of that, some provinces have children's programs, which over time have been eroded a little bit, so there are many children in this country, and particularly children of lower socio-economic status, who are not getting the care they deserve.

What do you do about it? You have to understand that dentistry is regulated provincially in this country, but we've always advocated for a social safety net for those people in our country who fall through the cracks. There are many of them. As many as 25% or 30% of Canadians fall through the cracks and have no access. Many of them never see a dentist, or very rarely. As I said in my brief here this morning, an unhealthy mouth affects the rest of your body and it affects the economy.

What I'm advocating is that the federal government, perhaps through our suggestion of a dental health officer—who could be the coordinator or go-to person in this country to help coordinate possible provincial programs—encourage, through the social health transfer to the provinces, improved oral health care in this country.

Ms. Judy Wasylycia-Leis: Fair enough. Whether we go by the route of universal coverage or of a safety net approach, it is still going to cost a considerable amount of money.

My question is to whoever wants to answer it. Although the federal government may be awash in surplus dollars, all of the requests we've had over the last few days will certainly surpass any capacity, and it really does come down to hard choices. What we're grappling with as a committee is the right balance between spending on programs, investing in Canadians, tax cuts, and repayment of the debt. I'm wondering if anybody wants to indicate what advice they might have for us on that front.

Mrs. Susan Ziebarth: One of the common themes you're hearing from just about everyone here at the table is that of prevention, the focus on prevention of disease. I think we'd all agree it is a huge area of investment.

Ms. Judy Wasylycia-Leis: Would you agree with foregoing tax cuts in order to ensure we had the dollars for prevention, health promotion, and public health?

Mrs. Susan Ziebarth: That remains to be seen.

Ms. Judy Wasylycia-Leis: Anybody?

Mr. Victor Lachance: I think that's the sort of thing Romanow said in his report when it came to things like physical activity: a 10% increase in physical activity will give you a better return than trying to achieve it through tax cuts.

There are real-life situations that Canadians face. To recertify, a pee-wee coach has to pay $1,000 out of his or her own pocket. Certainly a tax measure that would be a non-refundable tax credit for that kind of expenditure would be an economic incentive for people to become coaches in their communities and help build community and help develop kids.

There are different ways of investing, but I would agree with the notion that prevention pays dividends in ways that are a more constructive use of public funds, and we would support that decision.

● (1225)

Ms. Judy Wasylycia-Leis: Perhaps Mark or Paul—and Cathy, I see—would like to....

Mr. Paul Lapierre: I think, as mentioned in the throne speech, prevention is the best cure. That's one thing said. But also, there's a lot of duplication when it comes to heath care. Let's talk about the drug review process. There was an intent to have a common drug review process in this country, but what was created was an added layer of bureaucracy.

If we're looking, moving forward, at a common, national pharmacare program, we need the buy-in of all partners. I think we'd also increase purchasing power with one agency instead of going through 12 different formularies to negotiate prices with drug companies.

There's a way to be creative, but we need to act in a win-win fashion and be part of the solution, not be perceived as part of the problem.

Ms. Judy Wasylycia-Leis: Cathy?

Ms. Cathy Moore: I don't want to oversimplify a very complicated issue, but I would suggest that one way of saving money and increasing the tax base is to move people who are currently tax users into tax-paying mode. That's a simple way of saying that marginalized groups don't want to be marginalized, don't have to be marginalized, and can certainly become taxpayers with appropriate programming and intervention. So you could increase your tax base considerably by applying some of these suggestions around prevention, and also by moving people into a taxpaying capacity.

Ms. Judy Wasylycia-Leis: Thank you very much.

The Chair: Thank you.

Mr. Loubier, and then Mr. McKay.

Could I just ask the witnesses to stay about an extra 10 minutes? Thank you.

Mr. Loubier.

[*Translation*]

Mr. Yvan Loubier: Thank you, Mr. Chairman.

I would like to begin by thanking all of you for your presentations, which were very interesting and enlightening.

I would also like to reassure Ms. Ziebarth that in our capacity as the privileged representatives of millions of Canadian citizens who have the opportunity to speak on their behalf within the House of Commons, members of Parliament are more aware than anyone else of the fact that our mouth is part of our body. We are extremely sensitive to that fact.

Mr. Lapierre, my colleague Réal Ménard reminds us on a near-weekly basis of the problems experienced by people living with HIV/AIDS. Your request for $100 million per year has been forwarded to the Bloc québécois caucus. We strongly support your request and will try to include it in the report and recommendations of this committee.

Ms. Moore, I will not forget your promise to give your presentation in French next year. As for me, I promise to ask all my questions of you in English at that time. Now we are even. You do not know what I am capable of, Mr. Chairman.

I have a question for you, Ms. Moore, but I would like to first congratulate your organization, the CNIB. When I was younger, I worked with a close friend who had received help from your organization. Without the CNIB, I do not think that this person could have done as well as she did.

My question deals with visually impaired students. If a young person decides to go to college or university today, will there be more services at the disposal of this person today than in the 1980s? What services are available today? If only 3% of library resources in Canada are accessible to the visually impaired, you would think that resources are just as scarce for someone wishing to study in a very specialized area.

[*English*]

Ms. Cathy Moore: Yes, the resources are scarce; however, if you add in educational resources, we can bring the 3% up to 5% of materials that are available in alternate format—a stunning increase.

It is somewhat easier now for students to go through and acquire the materials they require because the production is more streamlined, with the production of digital books, the invention of scanners, etc. So in some ways it is easier for a student, and there is also a larger acceptance that students with disabilities are expected to go on to post-secondary education. It is not quite the unusual event it used to be. But it is still very difficult to receive materials in a timely fashion. Over and over again, people receive their textbooks in alternate format in November after the mid-term exam, for example. We're getting there, but we're not there yet.

● (1230)

[*Translation*]

Mr. Yvan Loubier: Ms. Moore, do you think that people are well enough aware of the obstacles facing blind people? I am thinking about a small incident that turned into a major misunderstanding recently. A blind student tried to go and study English as a second language with his guide dog, and they wanted the guide dog to learn English as well! Do you think an example like that shows a lack of awareness?

Are we making progress, or are you under the impression there is still a lot of work to do?

Ms. Cathy Moore: With your permission, I will turn the question around. It is not a question of obstacles, but a question of capabilities. Blind people have the capability to do anything, but people do not know that. And that is the problem.

[*English*]

When someone sees someone who is blind, they see only the obstacles. They do not see the possibility, the capability, the problem solving that is there. If someone arrives at your doorstep looking for a job, looking to go to school, or that sort of thing, they have overcome an enormous number of things already. You want to hire that person. You want to have that person in your school. Those people are the doers, the achievers, the ones who don't take no for an answer. So it's best to look at the capacity of these groups, rather than the obstacles they may be facing.

[*Translation*]

Mr. Yvan Loubier: Mr. Lachance, I finally have an opportunity to ask you a question.

The Quebec government, through its Minister of Health, Mr. Couillard, announced a health policy change a few days ago. From now on, part of the focus will be on prevention and promoting sport. Are you aware of this policy and what do you think about it? Is it part of your philosophy, that you outlined so brilliantly earlier?

Mr. Victor Lachance: Yes, it is absolutely part of our philosophy. We must admit that the Quebec government, at least since I have been involved in sport, has always been a leader in recognizing the role of physical activity, the outdoors, and sports and integrating these aspects into health promotion. So in principle, Quebec is a model.

I would recommend that you examine what is being done in the Province of Nova Scotia. It has recently linked health promotion to sports and leisure, because it recognizes the need to integrate its policies instead of separating them. So the province does not have to choose between the performance of its athletes and increasing the participation of young people, for example. So we know that the Quebec government has made a bit more of an effort than other provinces to implement Canada's policy on sport.

The Chair: Thank you. May I ask you a short question?

Are you suggesting that sport should be part of the Department of Health rather than the Department of Canadian Heritage at the federal level?

Mr. Victor Lachance: I would start by saying that it could be one or the other. From a more practical perspective, I must say that Health Canada has not presently set aside any money for physical fitness. There's not even a budget for that at Health Canada. It is the ministers responsible for sport who have committed to increasing the participation of young people. It is the ministers responsible for sport who have set the objective of increasing physical fitness in each province. It is also the ministers responsible for sport who have attempted to get a bit of funding to invest in physical fitness.

For us, there must be one department looking after the matter, as well as an agency or a non-governmental mechanism to work with the government.

● (1235)

Mr. Yvan Loubier: It would be revolutionary to have a Minister of Health and Sport. That would throw everyone a real curve ball.

The Chair: Thank you.

Mr. McKay.

[*English*]

Hon. John McKay: Thank you, Mr. Chair.

I'm in the unfortunate position of being the only thing between you and lunch. I was wondering actually, when they said that someone was getting English as a second language training for a blind person, whether they were teaching the dog to bark in English. My first thought on that wasn't quite the right thought, I suppose.

First, I have a question for the sports people. I guess the nub of my question is that they are battling a cultural deficit here as much as anything else. I have a daughter who's a high-performance swimmer and competes internationally. She goes to Europe and to the United States to compete, and frankly, her training facilities are dumps. Her coaches are underpaid. They're using techniques that the Europeans, the Australians, and the U.S. passed on years ago.

I run—all those cursed stairs down by the Rideau, all 146 of them—and I wonder at times whether sports is just the poor cousin of culture; that in this country we just are not, aside from hockey, a sports-oriented culture. I'm just wondering, in a general sort of way, whether you feel like you're pushing an egg uphill with your nose.

Mr. Victor Lachance: I have to agree that sport doesn't get the attention it should. Sport and recreation organizations make up 21% of the entire voluntary sector. That's larger than anything else: two million volunteers—larger than anything else; 5.3 million volunteer positions—larger than anything else. That sector, however, only accounts for 5.3% of revenues within the voluntary sector, so there's a big disparity there.

Why is that the case? I think it's because sport does so much. Sport develops people and builds communities. It is where people come together in their communities to volunteer, first learn about volunteerism, and then learn how to do things together—like the elementary school of democracy. It does contribute to health. It does all of this, but no one's looking at the whole picture and saying, here's where we should invest.

In the case of high-performance athletes, there's no question that Australia spends 50% more for a country that has half the population. Germany invests $300 million a year in high performance. Our whole Sport Canada budget is only $120 million. France puts in $135 million a year on sport organizations; we put in $30 million. The U.K. contributes $750 million. There must be something these countries know that we can learn from. As you say, we also know that our athletes live roughly below the poverty line. No one would know this better than, let's say, a sport administrator.

Mr. Timothy Page: Your daughter's swimming coach would benefit greatly from knowing one year to the next whether or not he or she could rely on a reasonable salary. One of our recommendations to this committee is for much more predictable, long-term, stable funding. If we don't know before September or October of any given year what moneys will be available to invest in our infrastructure, it's tough for the coaching community and for the athletes to know where they're headed.

With 2010 literally around the corner, and the House of Commons members standing on their feet, as they did a couple of weeks ago, in recognition of our Olympians and para-Olympians, it's clear that the public's expectations are for Canada to do well in Whistler/Vancouver in 2010. Greater investments need to be made today in order for that to happen.

Hon. John McKay: It seems to me that we like to take the glory but we don't necessarily like to pay the bills. There's a disconnect. You made your point very well.

I'm going to switch to the Cancer Society folks for the last minute here on the modelling issue. As I listened to your presentation, for the longest time I was a little puzzled what you were actually talking about. When you used the genome analogy, that started to make some sense.

Is the nub of the issue that you're pulling in research from all over the country and in effect collating that research and elevating the knowledge base of the practitioners?

● (1240)

Dr. Jo Kennelly: That's the alternate. It's elevating the knowledge of practitioners, but also of policy-makers. It's knowing where the levers are in Alberta, Quebec, and the Atlantic provinces in what works best for them, how their cancer profile looks, how their economies are at risk, how that varies, and how you can share the best learning across not only the policy environments but the clinicians and best practice.

Hon. John McKay: Why doesn't that happen now?

Dr. Jo Kennelly: It happens in a sense. It happens in terms of surveillance and CAPCA, which is a provincial agency of cancer agencies. But there isn't this observation platform at the centre of it. There isn't the sophistication that we are proposing—a risk management approach that compares one with the other.

At the moment, the level of understanding of cancer is still in general terms. The science has taken off, and it's site-specific stuff. The understanding and observation haven't caught up with the science. In Canada, a study was done in 2001 that showed Canadian science research on cancer was number one in the world, in terms of the impact on people living in Canada, and number one in terms of tracking through into clinical. But that research is not being spread out of its local jurisdiction into other areas.

Hon. John McKay: Thank you.

The Chair: I want to thank the witnesses, the groups, for appearing. It's very well appreciated. I think Brian said it best. I'm sure there are people behind your organizations who have helped prepare for the presentations, so thank you very much.

As I said to the other panel, if there's anything the groups want to add or submit to us, you can still do so. I'm warning you ahead of time, the less we get, the better it is, so it's best to be straight to the point. If you have anything costed, it's obviously going to help as well.

Thank you again, and have a good day.

The meeting is adjourned.

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