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● (1535)

[*English*]

The Chair (Mr. Massimo Pacetti (Saint-Léonard—Saint-Michel, Lib.)): Good afternoon, everybody. Thank you for taking time out of your day and coming by to present your briefs.

Pursuant to Standing Order 83.1, we're here for the pre-budget consultations 2005.

The way we do this is I allow the groups a seven- to eight-minute opening intervention or statement to speak about their brief, or whatever they'd like to speak about for the consultations. If you can keep it to seven or eight minutes, I would like that, because I would otherwise have to interrupt you, and I don't want to do that. The members are going to want to ask questions after all of you are done.

I have a list of the groups here, but I also have a request that we have the Canadian Union of Public Employees go first.

Mr. Moist, you're first.

Mr. Paul Moist (National President, Canadian Union of Public Employees): Thank you, Mr. Chairman.

With me is Toby Sanger, an in-house economist with CUPE.

[*Translation*]

Thank you for the opportunity to present our priorities for the budget and our views on how we can improve the health of our economy.

We represent over 550,000 workers in virtually every community across Canada. Our members include a wide variety of workers who deliver public services on the front lines in virtually every community across Canada.

[*English*]

Mr. Chairman, we want to state that the standard of living in Canada as it relates to productivity is more than just money income. Health, social, and environmental aspects of well-being, the amount of non-work time we have, and the overall strength of our communities are very important to our membership and to Canadians, but these are not well reflected in gross domestic product or other income measures.

The basic concept of productivity is simple, but the factors affecting it are very complex. More than just human physical and entrepreneurial capital, capital must be high quality, appropriate, and effective.

● (1540)

[*Translation*]

High quality public services play an essential and direct role in increasing our quality of life in ways that are not directly reflected in productivity measures. High levels of social investment yield higher levels of productivity. France and Norway are more productive than the United States because of public investment, and their quality of life is higher.

[*English*]

We argue that quality public services increase productivity in a number of different ways. Investment in child care, education, health care, and infrastructure all demonstrate very direct rates of return on investment. Public services, we argue, increase our social cohesion and social capital, boosting both our productivity and our quality of life. Reducing poverty and inequality are key to increasing social cohesion as well as productivity.

Under the heading of “Restoring Balance” in our longer submission, which we've tabled with committee members, we argue that we need a common vision of social goals. Canadians will not share the goal of productivity unless they see its benefit. We argue in our larger submission that workers have not shared in the productivity gains they've largely created: real wages have declined as employers have kept wages down, while the cost of living has increased. Those who rely on social assistance or other income transfers have fared even worse.

So our major submission to you talks about the need to increase minimum wages and to provide funding for programs that reduce poverty and increase social inclusion. We argue that full employment —or having a good job—is the best social program there is.

Under the heading of “Enhancing Democratic Accountability and Governance”, we argue that the sponsorship scandal has damaged the federal government's credibility domestically and internationally. The scandal stemmed from a government program of outsourcing and privatization of a government function, a fact that has been ignored. We argue in our longer submission that outsourcing and privatization weaken accountability and governance.

At the program level, we argue in detail that defined transfers, with long-term and predictable funding, supported by a legislative accountability framework in a number of key areas, benefit Canada. These include: enforcement of the Canada Health Act; a national child care act with long-term funding commitments, and funds going only to public or not-for-profit providers; a post-secondary education act, which I'll mention in a moment; and a long-term plan to rebuild municipal infrastructure.

At the budget-making level, we argue for greater democracy and transparency. This process is important, but it's pretty limited. We argue against Bill C-67. We think it will diminish budgetary democracy at the federal level. We don't believe in enshrining a fixed ratio in terms of the allocation of the federal surplus.

In terms of macroeconomic policies, the easiest way to increase productivity, we argue, is to increase employment and reduce unemployment; the productivity of the unemployed is zero. Our country should pursue a full employment policy. The Bank of Canada's increases to rates—partly because of productivity—have slowed down, and in our view will increase, the cost of capital and have slowed down productivity growth even further.

In terms of tax policies, Mr. Chairman, the 2000 budget contained over $100 billion in tax cuts, ostensibly to increase investment and innovation. Since then, corporate profits and CEO compensation have soared, investment rates have dropped, and productivity has stagnated. We argue very strongly that you shouldn't take seriously any arguments that further broad-based cuts to corporate tax rates will necessarily spur investment.

We recommend that development assistance be increased and that we set budgetary principles that include having overseas development assistance pegged to 0.7% of our national income. We can't fathom having further corporate tax cuts while 6,000 children and adults die every day in Africa.

We make specific recommendations for accelerated federal spending on child care, which should rise to $10 billion by the year 2015, and for accountability measures in that act.

For post-secondary education, we call on you to increase federal transfers, with funding tied to reduction in tuition fees. You should establish a dedicated education transfer, upheld by legislation; prohibit funding to private, for-profit institutions and PPPs; and replace all individual financing programs with a national system of grants.

We talk at length in our long submission about Canadian companies investing too little in training, or less than half the OECD average.

● (1545)

We have specific recommendations on EI reform, which I won't mention right now.

In terms of the Canada Health Act, we need better reporting, monitoring, and enforcement, including the withholding of funding from provinces that violate the CHA principles, and we need the establishment of both a national pharmacare program and a national home care program, with funding tied to public delivery.

I'll finish on municipal infrastructure. The federal government was right to provide the GST rebate for municipalities...and the beginnings in the last budget of the new deals for cities and communities. But the amounts provided over the next two years are not sufficient. They could be accelerated from what the five-year plan was in the last budget, especially given recent increases and windfalls from federal fuel taxes. We need a long-term plan to rebuild municipal infrastructure and eliminate a $60-billion-plus deficit, with long-term commitments to allow municipalities to make cost-efficient investments.

We have appended for you this afternoon an emergency resolution on fuel price relief that is from our national convention in Winnipeg two weeks ago. We reject arguments about reducing federal taxes; rather we talk about you making a stronger commitment to municipalities for transportation and Kyoto-compliance objectives using the increased revenues you're deriving from fuel taxes.

There's much more in our submission, Mr. Chairman, but I'll stop for now and listen to my colleagues, and we will answer any questions afterwards.

The Chair: Thank you, Mr. Moist.

We'll start from the list I have here now.

From the Canadian Cancer Society, Ms. Kennelly.

Dr. Jo Kennelly (Director, Scientific Advancement and Public Policy, National Cancer Institute of Canada, Canadian Cancer Society): Thank you for the opportunity to provide a submission to the Standing Committee on Finance. I am here on behalf of Dr. Barbara Whylie, CEO of the Canadian Cancer Society.

Since we were here last year, approximately 69,000 Canadians have died of cancer. No one living in Canada has died of SARS this year and no one living in Canada has died of bird flu this year. As Dr. Terry Sullivan, the CEO of Cancer Care Ontario, stated last week, cancer is a sure and certain threat to the economic productivity of Canada.

We estimate that over the next 30 years, almost 6 million Canadians will be diagnosed with cancer; over 2.5 million Canadians will die as a result of this disease. Cancer will have a one-two punch on the economy: one, a loss in direct health care costs of over $176 billion; and two, cancer will reduce taxation revenues by over $248 billion, thus affecting the ability of all governments to pay for cancer services and other services.

Cancer will slash productivity to the tune of $540 billion in lost wages. Much of these productivity losses occur when someone with cancer suffers mild to severe disability; much of the productivity losses are needless. One of the key messages given by Dr. Whylie to the conference of federal-provincial-territorial health ministers during her presentation last weekend was that it is possible, using risk management tools, sharing evidence more evenly across Canada, and working in an inclusive manner with the provinces, to actively manage the known health and economic risks associated with the expected rise in new cancer cases as the baby boomers age.

Last week, the federal government announced a $59.5 million down payment toward a cancer strategy. It is not enough to meet the cancer challenges ahead. We are just four years away from the baby boomers hitting the health care system in significant numbers and with higher elevated risks of cancer.

Every year that we wait as a country to invest in an effective cancer strategy, we are less prepared for the tidal wave of cancer patients heading our way. The devastation to the lives of Canadians, our health care system, our businesses, and our economy that will result from this lack of emergency preparedness and management is completely unnecessary. We have the knowledge to make a difference. Management of the cancer challenge should not be left to a patchwork quilt of cancer control across the country that will leave our citizens, our workers, and parts of our economy vulnerable.

The $59.5 million for cancer announced last week was without expected results from this investment. A targeted, strategic, and results-oriented investment of this money is what Canadians deserve.

Many countries have adopted such approaches and have seen remarkable results. In 1996, Ireland launched a national cancer strategy. A 15% reduction by 2001 in cancer death rates in the under 65 age group is one of the key successes of this plan. Other successes include improved return on investment for expenditure through better organization of cancer care. The U.K. cancer strategy was launched in 2000. It has seen a drop of 12.2% in cancer death rates in people under the age of 75 against the 1997 baseline. In Australia, the cancer strategy introduced in 1996 is one of seven national health priorities and disease-specific strategies developed in response to recognition of the growing economic impact of chronic diseases. New Zealand launched its cancer strategy in 2003, and France announced funding for its nationwide mobilization plan to combat cancer this year.

Targets have been set. While other countries have taken action and their citizens and economies are benefiting from evidence-based and strategic approaches to investment in cancer control, Canada has debated the utility of such plans.

● (1550)

The World Health Organization has promoted the benefit of funding disease-specific strategies such as cancer to combat diseases of significant economic burden since 1978. It is time to stop procrastinating and for the Government of Canada to make a meaningful investment in a comprehensive, inclusive, strategic, and results-oriented approach to cancer control.

Over 700 cancer experts, including provincial cancer agencies and the Public Health Agency of Canada, have developed a results-oriented cancer strategy, the Canadian strategy for cancer control, for Canada. The council of this strategy has employed sophisticated risk-management principles and expertise from the banking industry to establish cancer reduction targets for Canada and develop virtual networks of experts and knowledge transfer systems to move knowledge quickly and easily across Canada to enable the provinces and territories to better manage cancer locally. Where one lives in Canada should not be a determinant of quality of life or survival.

The expected preliminary 30-year targets set by the council, and verified through an analysis of international best practice, are a 45% reduction in new cancer cases on an annual basis by 2033 and a 51% reduction in cancer death numbers on an annual basis by 2033. These results are based on current knowledge and do not take into account new scientific developments.

The strategy is not a mechanism for imposing specific programs or services on any jurisdiction. A key principle of the strategy is that moving knowledge further faster saves lives.

Canada is not like other nations. It has a unique advantage from a risk-management perspective, in that it has 13 different provinces and territories providing health care. This provides us with the opportunity to share best practice and learn quickly from our mistakes. Fully funding and implementing the Canadian strategy for cancer control, as the House of Commons on June 7, 2005, urged the federal government to do, will bring Canada in line with international best practice, save lives, and reduce the known and manageable economic impact of cancer.

We are therefore asking the Standing Committee on Finance to make the following specific recommendation to the government. Given the impending cancer crisis in Canada and the resulting impact on the productivity of Canadians and Canada's economy, the Canadian Strategy for Cancer Control should be fully funded and immediately implemented by the federal government.

The cancer community is aligned behind the strategy and ready to go.

Thank you.

● (1555)

The Chair: Ms. Philp.

Dr. Karen Philp (National Director, Public Policy and Government Relations, Canadian Diabetes Association): Hi. Thank you for inviting our association to meet with you again today. Last year when we met we asked you for support for our request for a $50 million immediate and ongoing federal commitment to the Canadian diabetes strategy. Thanks to all of you, it was in last year's budget. I really want to say thanks on behalf of our volunteers.

This year, however, we're here to ask you to support the recommendations that will be made later today by the Chronic Disease Prevention Alliance of Canada, the Health Charities Coalition of Canada, and our partners, the Heart and Stroke Foundation and the Canadian Cancer Society. Our association is a proud member of these two coalitions and good partners with Heart and Stroke and the Canadian Cancer Society.

However, we do have a request for Canadians with diabetes. They have asked us to work with you to find a solution to this small problem. As we all know, a healthy workforce is one of Canada's most important economic assets, but if Canadians living with diabetes do not have the support they need to function effectively and efficiently in our economy, all Canadians in our economy pay the price.

The Chair: Ms. Philp, just slow down.

Dr. Karen Philp: Sorry. I did this last year too, didn't I?

The Chair: I'm not sure, but you're not the first one and you won't be the last one. The translators are the ones who have the problem.

Thank you.

Dr. Karen Philp: I actually provided you with a sheet of paper, and I'm going to cover some of the points there.

Diabetes costs the Canadian economy over $13.2 billion annually, and that includes the indirect costs of diabetes, such as work absences, disability leave, and workforce exit. Even mildly high or low blood glucose levels may impair cognitive functions and fine motor skills, hamper concentration, and cause grogginess. Diabetes is the sixth leading cause of death for Canadian men and the seventh leading cause of death for Canadian women. The result is over $1 billion in lost productivity due to premature mortality, and the cost of diabetes-related reduced productivity is high for all of us.

Statistics Canada states that Canadians with diabetes earn on average far less than other Canadians. Recently published U.S. research indicates that people with diabetes are 60% more likely to work while feeling unwell than those without diabetes and that there is a loss of productivity associated with that. So when Canadians call in sick and are unable to work, or are forced to drop out of the workforce because of serious health problems related to their diabetes, they do not generate economic output, pay taxes on earnings, or help raise our national economic standard of living.

But we know that Canadians with diabetes who are able to afford to manage their diabetes, according to the best available evidence, are able to work fully and contribute positively to their communities and workforce. Unfortunately, like cancer, it matters where you live in Canada if you have diabetes. The out-of-pocket cost for medications and supplies required to self-manage diabetes varies significantly across Canada. It can cost a Canadian with this disease up to $5,000 a year just for their medications and supplies. A lot of people don't know that people with diabetes all pay out of their own pockets for the diabetes medications and supplies. There are additional costs of up to $15,000 a year for insulin pumps, the additional cost of insurance, foot care, and just eating appropriate food.

In my brief you will see a table that shows what a working Canadian with type 1 diabetes, earning $15,000 a year, will need to pay, after all government subsidies, all co-pays, all programs, and all supports are included. This submission highlights what a Canadian earning $15,000 a year—that's $8.60 an hour—must pay out of their pocket to manage their diabetes. As you can see, the figures are pre-tax, and if you live in the Maritimes you're paying 21% to 25% of your pre-tax income just for medications and supplies. That's after the government has paid for everything they can. It's a lot better if you're actually in a non-insured health benefits program with the federal government, because of course you pay 0%. That's really excellent if you live in Nunavut and are covered by the federal program.

But particularly for Canadians who live in Atlantic Canada, their stories are quite heartbreaking. They phone us and tell us them. For example, we heard from Barb Marche and her son Liam from Red Brook, Newfoundland, that they pay about $450 a month out of their own pocket for Liam's insulin pump supplies. They also need to find another $6,000 every four years for a replacement insulin pump. They're struggling.

Florence Flynn of Cornwall, P.E.I., tells us she's less financially challenged right now because her husband's employer has a drug plan that covers most of the cost of her diabetes medications and supplies. At 63 years old her husband would like to retire from work, but they'd lose his drug coverage and would need to find more than $3,000 a year to pay for her diabetes medications and supplies.

Tammi Publicover, 30, from Halifax, Nova Scotia, told us that she ended up having to drop out of university for an entire year just to qualify for social assistance because she couldn't afford to pay for her diabetes medications and supplies while she was a student.

Robert Bacon from Terrebonne, Quebec, told us that although his private drug plan covers 80% of his costs, he still needs to pay $320 a month for his supplies.

Carissa Nikkel from Winnipeg, who was diagnosed with type 1 at the age of seven and is now 21, is trying to live on her own and is finding it extremely difficult to manage her diabetes medications and supplies, as well as all her housing and living expenses, on a $15,000-a-year job.

In the north, Sue Denison of Rankin Inlet, Nunavut, told us that while the government drug plan covers 80% to 100% of her costs, she finds living in the remotest part of Canada a challenge because she can't get access to healthy food at an affordable price or access to endocrinologists and other diabetes specialists.

So as you can see, in every province and territory across our country there are Canadians struggling to manage their diabetes to be productive citizens and contributors to their communities. As a result, we are asking the federal government to show leadership and invest in the upcoming budget to address some of the inequities in the current assistance for Canadians living with diabetes by recommending amendments so that the federal disability tax credit treats all Canadians living with insulin-dependent diabetes fairly. Why amend the disability task credit? Because it's the one mechanism that the federal government can use to directly help Canadians living with diabetes and their families and help them address the high personal cost of managing this disease.

● (1600)

The federal government last year, in response to the final report from the Technical Advisory Committee on Tax Measures for Persons with Disabilities, agreed to implement their recommendations that were designed to ensure a fairer treatment for Canadians who must take time out of their regular daily activities to undertake life-sustaining therapy.

Insulin is defined as a life-sustaining therapy because without it Canadians with diabetes die. Unfortunately, the amendments to the disability tax credit proposed in last year's budget do not reflect fully the technical advisory committee's recommendations. For example, in the final report, the technical advisory committee specifically recommends the inclusion of time required for essential preparation of, administration of, and recovery from life-sustaining therapy. For Canadians with diabetes prescribed insulin by their physician, the essential preparation activities are blood glucose testing and carbohydrate counting, and recovering from hypoglycemia is a regular occurrence for insulin-dependent Canadians.

However, the treatment of hypoglycemia in adults with diabetes is considered by the federal government as “recuperation time from therapy” and therefore not allowed for calculation as part of the eligibility criteria for the tax credit.

Secondly, the technical advisory committee recommended that the time spent on the activities directly related to determining the dose of life-sustaining medication, or insulin, is considered time spent administering that therapy, yet federal officials tell us that the time required for determining the medically appropriate dose of the insulin, specifically carbohydrate counting, is excluded and therefore not counted as time spent administering insulin therapy.

Unlike other therapies, insulin doses are constantly amended throughout the day, according to blood glucose levels, food intake, and activity levels. Without including all aspects of decision-making around the dose, an insulin-dependent Canadian with diabetes cannot determine, prepare, or administer the medically appropriate dosage of insulin. This medically necessary distinction makes carbohydrate counting for people with diabetes unique from the dietary considerations of most other diseases.

Carbohydrate counting is not a dietary requirement, restriction, or regime, as it is currently believed by federal government officials; it is a medical necessity. The best available evidence published in the Canadian Diabetes Association's *2003 Clinical Practice Guidelines for the Prevention and Management of Diabetes in Canada* recommends that individuals using insulin therapy should adjust their insulin based on the carbohydrate—starch and sugar—content of their meals. For people with diabetes using intensive insulin treatment regimes, education on matching insulin to carbohydrate content—for example, carbohydrate counting—is recommended—

● (1605)

The Chair: Ms. Philp, if you can just wrap it up, you're way over.

Dr. Karen Philp: Okay.

Finally, I want to note that there are significant challenges confronting physicians and endocrinologists in confirming their patients' eligibility for the disability tax credit. Already overburdened with medical activities, physicians are being asked by the Canada Revenue Agency to identify and certify the time a Canadian spends daily to manage his or her diabetes on a tax credit form. Physicians tell us that this meticulous exercise will be difficult to incorporate into their already overburdened work schedules, if not impossible to confirm.

What physicians clearly appreciate, however, is that intensive management of blood glucose levels is unequivocally related to the prevention of complications, and all of it takes time. Our concern is that well-meaning physicians will respond differently to the federal government's request. Some will sign the disability tax credit form T2201 and some won't—

The Chair: Sorry, but I have to interrupt, Ms. Philp. Thank you. You are way over.

From the Canadian Institutes of Health Research, Mr. Bernstein.

Go ahead.

Dr. Alan Bernstein (President, Canadian Institutes of Health Research): Thank you very much.

Thank you for the opportunity to present to you today.

I would like to leave you with two key messages. The first one is thank you. Thank you for the support that Parliament has given to us over the last five years, since we were created in 2000, on behalf of the 10,000 health researchers who are now funded by CIHR.

The second message is that the Government of Canada's investments in CIHR are leading directly to a more productive Canada through better health, a stronger and sustainable health care system, and a more prosperous and knowledge-based economy.

[*Translation*]

The Government of Canada's investments in CIHR are supporting a more productive Canada through better health, a stronger and sustainable health care system, and a more prosperous knowledge-based economy.

[*English*]

Since we were established in 2000, CIHR has transformed the way health research is conducted in Canada, and we have moved far beyond the traditional role of simply being a granting agency. We are working with over 120 partners in the public and private sectors, some of whom are here today from the health charities, who were instrumental six or seven years ago in making CIHR a reality. Today these partnerships represent an additional annual contribution of more than $90 million to CIHR-funded research that addresses such priority areas as wait times, cardiovascular disease, diabetes, arthritis, obesity, mental health, and cancer.

Through this collective effort, Canadian health researchers are advancing research knowledge that is improving the health and quality of life of Canadians, the real foundation of a productive society. CIHR-funded research daily receives prominent media coverage and is published in the world's most prestigious scientific journals. For example, CIHR-funded researcher, Dr. Steven Narod of the University of Toronto was acknowledged earlier this year as the world's most cited scientist in breast cancer research. Dr. Salim Yusuf of McMaster University, whom CIHR funds in partnership with the Heart and Stroke Foundation of Canada, had his landmark paper regarding risk factors for heart attacks named as a runner-up for scientific paper of the year by the prestigious British Medical Journal, *The Lancet*.

Moving forward, CIHR seeks to address key gaps in opportunities that were identified through broad national consultations with health researchers and other stakeholders. Areas that CIHR will focus on in the coming years include.... First, we will work to support a stronger health care system. Bold and far-sighted investments in health research today are essential to build an evidence-based, sustainable, and productive health care system for Canadians tomorrow. CIHR-funded research is playing a key role in the process of health care reform.

For example, in partnership with the provincial and territorial deputy ministers of health, CIHR recently funded research to assist them in meeting provincial commitments outlined in a ten-year plan to strengthen health care related to establishing evidence-based benchmarks for medically acceptable wait times. Eight teams that were funded last spring delivered their second report synthesizing the world's best research evidence related to a number of key priority areas, including hip replacements and sight restoration. Their work was the key factor that contributed to the success of the agreement reached just last weekend at the first ministers meeting on health.

To take the next step forward, clinical research is needed to bridge the growing translation gap between fundamental discovery and new and more effective approaches to prevention, diagnosis, and therapy. Currently, Canada lacks sufficient capacity to carry out the increasingly sophisticated and expensive clinical research of the 21st century. Our new clinical research initiative, a partnership with the Canada Foundation for Innovation, will transform Canada's capacity to carry out clinical research by establishing centres and national platforms for multidisciplinary teams. These centres and teams, which will be launched in partnership with CFI, the health charities, and the provinces, will bridge the gap between what we know in the lab and what we do in the clinic. They are designed to accelerate the translation of new science, new treatments, new diagnostics, and new companies.

Second, CIHR will work to improve productivity in the workplace. Canada's success in the race for global competitiveness depends on the health of our citizens and of our workforce. Mental disability now accounts for between 30% and 40% of disability claims in the workplace, translating to $33 billion annually in Canada. It is estimated that by 2020, depressive illnesses will become the leading cause of disease burden in the developed world. To address this issue, our Institute of Neurosciences, Mental Health and Addiction has created the mental health in the workplace initiative. New health research teams from across Canada are now working with workplace organizations to create the knowledge base and develop policy and interventions to improve quality of life in the workplace.

Our partners on this initiative include the Canadian Labour Congress, l'Institut de recherche Robert-Sauvé en santé et en sécurité du travail, and the Workplace Safety and Insurance Board of Ontario.

● (1610)

Third, CIHR will foster the next wave of biotech companies. Canada's biotech sector includes 470 companies of which over 80% are health related. It has revenues of $3.2 billion U.S., up 18% from 2002, and it employs roughly 12,000 highly skilled workers. Most of these companies have their roots in CIHR-funded research. Through our novel research and commercialization programs and our partnerships with public and private sector agencies, we are playing a catalytic role in commercializing university research.

Our commercialization policy explicitly recognizes the four elements that are key to our successful commercialization, a robust pipeline of outstanding research, talent, knowledgeable capital, and opportunities for the worlds of research, capital, and management to meaningfully interact.

Now we seek the opportunity to become a world leader in emerging technologies applied to health. The impact of nanoscience, nanoengineering technologies, is expected to be one of the most profound of all primary enabling technologies. That is why we have launched a major initiative in regenerative medicine and nanohealth. That initiative will contribute to an emerging national technology strategy, a top priority identified by Canada's national science adviser. Our partners in this initiative include the ALS Society of Canada, the Canadian Space Agency, the Heart and Stroke Foundation, the Juvenile Diabetes Research Foundation, the National Research Council, NSERC, and Neurosciences Canada.

Fourth, we will invest in people, the common theme that threads through the initiatives I've just described. People, bright young people, well trained and equipped with the research skills of the 21st century, are essential for our universities, teaching hospitals, to carry out research and to staff our new biotech companies and tech transfer offices.

Currently, we support more than 2,100 individual trainees, including undergraduate, masters and doctoral students and post-docs. This complements the 4,200 trainees who are supported on our research grants. Moreover, CIHR's highly innovative strategic training initiative and health research, a $120 million investment with our partners in the health charities, the provinces, and industry, has created 87 health research training centres supporting almost 600 graduate students and post-doctoral fellows.

We want to enhance those programs to develop new talent. That strategic training program grant should be augmented and increase the number and the stipends to attract highly qualified students into careers and health research, able to move into opportunities in industry, government, the health professions, commerce, and academia.

In conclusion, Mr. Chair, everything we know about knowledge-based economies, global competitiveness, productivity, and health tells us that investments in research, particularly health research, are among the wisest, efficient, and most prudent investments any society can make. Other countries are recognizing this. The United States, France, Germany, the U.K., Australia, South Korea, Japan, and now India and China are not standing still. Their investments in health research over the past five years and their planned investments over the next five years all equal or surpass Canada's.

I firmly believe that the initiatives I've highlighted today, examples of our bold vision and ambitious plans for the next five years, will lead to a more productive Canada, a healthier Canada, a more efficient health care system and a stronger economy.

CIHR's success to date could not have happened without the sustained support of the Government of Canada. Now I ask you to build on that foundation. We urgently require a multi-year commitment to increase our base budget from its current level of approximately $700 million to $1 billion over the next three years. This is an ambitious target but an essential one if CIHR is to deliver on its parliamentary mandate.

Thank you.

● (1615)

The Chair: Thank you.

From the Chronic Disease Prevention Alliance of Canada, Ms. Harvey.

Ms. Jean Harvey (Interim Executive Director, Chronic Disease Prevention Alliance of Canada): Good afternoon, committee members and Chair. I'd like to introduce myself. I'm Jean Harvey, the interim executive director for CDPAC, Chronic Disease Prevention Alliance of Canada. I'd also like to introduce Karen Cohen, a member of our steering committee for CDPAC. She's the associate executive director of the Canadian Psychological Association.

You have a little brochure in your package, but CDPAC is a network of 54 voluntary public and private sector organizations, a very active provincial-territorial alliance, with over 1,000 active CDPAC members. They're all across the country and they're networking together around a mission. The mission is to foster a country-wide movement toward an integrated population health approach. We're looking at the prevention of chronic diseases through collaborative leadership, advocacy, and capacity building.

When we look at what's happening with chronic disease and its impact on productivity in Canada, there are reasons to be optimistic and there are also reasons to be alarmed.

Starting with the positive, we are optimistic because we do see the increasing recognition of the growing burden of chronic diseases, as well as the progress to date in mobilizing efforts to advance healthy living in Canada. This was evidenced only this past week. The federal government announced the allocation of the $300 million toward the integrated strategy for healthy living and chronic disease within the Public Health Agency of Canada. Certainly, CDPAC commends the federal government very much for its leadership in this area. It's an important step forward, and we look forward to working with the government on the development and implementation of this strategy.

Another progress is the growing number in the range of sectors, the organizations and the individuals who are coming together to collectively problem-solve around the growing rates of obesity, physical inactivity, and other risk factors. It's also encouraging, on the chronic disease side, to see some of the wins in the battleground. For example, in tobacco we know that a combination of information and support, policy, regulation, and the concerted efforts by many has led to a reduction in smoking rates. So there is success.

We also know more today than ever before on how we can prevent chronic disease by reducing key risk factors. That's the good news. It shows that we're on the right track. In fact, an encouraging stat is that 80% of premature heart disease, stroke, and type 2 diabetes and 40% of cancer in Canada could be prevented if we had healthy diets, regular physical activity, and avoided tobacco products. That was the positive side. However, there is cause for alarm and a need for a sense of urgency about where we go from here.

Chronic disease costs Canada an estimated $93 billion annually. This figure includes an estimated $54 billion in lost productivity due to short-term and long-term disability and premature death. We know that our population is aging and we have a high prevalence of overweight, obesity, and physical inactivity, so we can expect this number to actually go up. The World Health Organization has predicted that chronic disease in Canada will increase by 15% and will kill over 2 million Canadians over the next 10 years.

We do know what the risk factors are, as I've mentioned, but unfortunately, those risk factors are pretty widespread in our community. In fact, 60% of adult Canadians are overweight or obese, 80% of Canadians are physically inactive and don't get health benefits from physical activity, and while there have been successes in tobacco—which we know about—we still need to remember that 20% of Canadians are defined as current smokers today.

Clearly, we need to do more, both to improve the lives of Canadians and to reduce the drain of chronic disease on our country's health care system and in turn on the productivity. We therefore urge the government to expand its commitment to chronic disease and healthy living in three key ways.

First, we urge the federal government to commit more funds and to build on the $300 million investment in healthy living and chronic disease prevention as soon as possible. There are three sub-bullets under that point. One is that we're looking for new additional funding to look at increasing the effectiveness of the integrated chronic disease and healthy living strategy. That's really being done. It needs to be done through integrated approaches and addressing key risk factors.

We also believe that additional funding is needed to address chronic diseases that weren't covered in the original amount.

● (1620)

Chronic diseases such as mental disorders and chronic respiratory disease, and additional risk factors like psychosocial factors, which we all know affect our health, need to be looked at and funded.

We also believe that $15 million should be allocated to allow the ongoing inclusion of a physical measure component within the Canada health measures survey. We need these numbers so that we can enhance health surveillance and evaluate the chronic disease prevention initiatives that are going on in the country.

Secondly, we recommend that the federal government call on the provincial-territorial governments to earmark for public health activities a portion of the increased health care resources provided through the 10-year action plan on health, with a specific portion of that being allocated to health promotion and chronic disease prevention. We believe chronic disease needs to be supported by a strong public health system across the country.

Thirdly, we recommend that the government provide substantial, dedicated funding for community-level infrastructure that supports healthy living. With that we're talking about recreation facilities, green spaces, cultural and educational activities—and you'll find that this is also recommended in the Heart and Stroke Foundation's brief.

The other piece around this same recommendation is that we believe 7% of the transportation infrastructure funding should be allocated to infrastructure that promotes active transportation. Active transportation is walking and cycling, for example. You'll also find that recommendation supported in the Go for Green submission, which is coming later this week, and again, by the Heart and Stroke Foundation of Canada.

We know that infrastructure that supports healthy living and active transportation encourages greater physical activity, and we know this contributes to other important health determinants—greater social support, community involvement, early childhood development, and better air quality.

In addition to these specific recommendations, CDPAC supports the recommendation of the Canadian Coalition for Public Health in the 21st Century and the Canadian Public Health Association towards the full funding of the Public Health Agency of Canada—you heard their briefs earlier—and supports enhanced funding for health research, as you've just heard outlined in the CIHR brief, which is also supported by the Heart and Stroke Foundation, the Health Charities Coalition of Canada, and Research Canada.

In conclusion, we urge the federal government to include effective chronic disease prevention and healthy living as an essential component of the federal government's vision for enhanced productivity in Canada. We ask that the government do this by enhancing its commitment to the integrated chronic disease prevention and healthy living strategy, encouraging more investment in public health and chronic disease prevention across the country, and investing in community infrastructure that supports Canadians in making healthy living a reality. If we do all those, we really do expect the return on the investments to be substantial.

Thank you very much.

● (1625)

The Chair: Thank you, Ms. Harvey.

I have just a quick question on the third recommendation. It's the first time I've heard this—allocating 7% of the transportation infrastructure funding to active transportation infrastructure. How do you know that's not happening right now? Are there any statistics?

Ms. Jean Harvey: Right now it really varies across the country. It's about 5% right now. The reason it's 7% is that about 7% of Canadians walk or cycle to get to work or to school. In terms of a fair share of funding, that's why the number 7% was brought out.

The Chair: Where did the 5% come from? Municipalities or...?

Ms. Jean Harvey: Yes, I think it was a number that Go for Green had put together. They've done surveys across the country. But it really varies across the country. Quebec is higher, and other provinces are much lower.

The Chair: Thank you.

From the Health Charities Coalition of Canada, Mr. Hoult.

Mr. Peter Hoult (Member, Steering Committee, Health Charities Coalition of Canada): Good afternoon. Thank you for the opportunity to appear before you on behalf of the Health Charities Coalition of Canada. My name is Peter Hoult, and I'm a volunteer and a member of the HCCC steering committee. I'm also a volunteer with the Kidney Foundation of Canada, a member organization of the HCCC.

I know you are all aware that health charities play a number of key roles in the health system, including research, public education, and direct delivery of services. The HCCC represents national health charities by providing a strong, unified voice on issues of shared concern to our members. Our members, which include 16 of the largest and strongest organizations in Canada, bring together a wealth of knowledge, expertise, experience, and resources. The national health charities that belong to the HCCC are committed to improving and strengthening the health of Canadians, a goal we share with the Government of Canada.

Across the country, health charities comprise thousands of staff and millions of volunteers who serve Canadians in their communities year around. Volunteers formally contribute about 93 million hours per year. Informal volunteer time—that of families and friends and neighbours helping one another—is estimated to be a total of 2.3 billion hours. Voluntary organizations represent an important human resource in the Canadian health system.

The voluntary health sector is also a major stakeholder in the field of health research. Our members alone fund approximately $150 million each year to support research and developments in health. This is a significant amount of money, all of which is raised through donations from individuals, corporations, and foundations. Because of the close and important ties between national health charities and Canadians, the HCCC provides an important channel for policy and decision-makers to learn of the views and concerns of the people of Canada.

The government has demonstrated a commendable commitment to the health of Canadians, as demonstrated in the recent commitment of $300 million to the integrated strategy on healthy living and chronic disease, the creation of the Public Health Agency of Canada, and the continued investment and support of the Canadian Institutes of Health Research and research chairs. We commend the government for these investments. However, today we have tabled a brief with a number of recommendations that we believe can help the health and productivity of Canadians. I would like to touch upon a few of the more significant ones.

First, we believe that the Income Tax Act needs to be amended to better reflect the extraordinary costs incurred by many Canadians. To do this, we believe the federal government should broaden the definition of disability to provide tax relief to Canadians who have increased costs due to acute, chronic illness and/or disabilities. We believe this is necessary because individuals with disabilities who are impaired by either a lengthy illness or chronic disease incur extraordinary costs both in managing the disease or disability and in day-to-day life. Inclusion of mental and physical infirmity, instead of the more restrictive disability tax credit definition, would make it more relevant to many more people. And the current definition of severe and prolonged impairment in physical and mental functions excludes many people with chronic illness.

Second, we recommend that the taxation system should better recognize the involuntary nature of health- and disability-related costs. The Income Tax Act does not meet all the needs of people who incur these costs. Since the act focuses more on disability, those suffering from chronic or acute illnesses are potentially excluded, even though their needs are as great as those of the disabled.

It is also the view of our members and their constituents that a taxpayer should be able to pay his or her spouse, common-law partner, or some other party who is not necessarily in the business of supplying attendant care. The attendant care deduction in section 64 provides that expenses paid to an attendant to enable an individual to work or to attend certain educational institutions is deductible within certain limits, but this does not entitle the taxpayer to pay his or her spouse or common-law partner to carry out these activities. We believe the taxpayer should be able to pay his or her spouse or common-law partner, and we believe that section 67 of the act would limit this amount to a reasonable amount if that was a specific concern. The inclusion of this would support the economic independence of the disabled community and strengthen the economy and productivity of Canadians.

Finally, in addressing tax policy, HCCC recommends and strongly believes there should be more fairness in the administration of the disability tax credit. We believe the same fairness provisions that are provided for matters related to interest and penalties, for example, should be accorded to filers of the T2201. Where there is a negative T2201 or an incomplete T2201, the taxpayer should be able to apply for a fairness review to the advisory committee. The advisory committee would have the expertise to evaluate whether or not fairness should be accorded. As in the case of the rest of the fairness legislation, it would also provide for a judicial review of fairness through the court system.

● (1630)

The HCCC also believes the federal government should continue to provide national leadership in health research for the common good and the public good. The government should build on its investment through the CIHR, the pre-eminent vehicle for health research in our country. Our members actively support the recommendation of Dr. Bernstein asking the government to commit to a planned increase in the CIHR budget to $1 billion over the next three years. At the same time, however, the federal government should also include national health charities in the federal funding program for indirect costs of research. Until this change is made, national health charities have agreed not to fund the indirect costs of research.

The term "indirect costs" refers to the administration costs that underpin an institution's research activities—for example, heating, lighting, ethics review boards, facilities for animals, and so forth. The services that give rise to indirect costs are not due to a single research project. The government and national health charities fund a major portion of health research in Canada. Until March 2001, research grants from the federal government and charities funded only the direct research costs.

However, increases in federal government funding for direct research also increased the operating expenses and indirect costs for universities and research hospitals. This is because these institutions need to use more staff, equipment, and infrastructure in order to take full advantage of the highest levels of direct research funds available while maintaining their teaching and community service mandates.

As a result, the Association of Universities and Colleges of Canada urged the federal government to fund indirect costs of research. Specifically, the AUCC asked the government to fund indirect costs at a rate of 40% because evidence showed that indirect costs are indeed this high. Although the AUCC requested a blanket rate of 40%, these costs do vary by type of research. For example, the indirect costs of social sciences research may only be 15% to 20%, while the indirect costs of medical research can be as high as 50%.

In March 2001, the federal government approved $200 million in one-time funding to cover the indirect costs of federally sponsored research. These funds were distributed to universities and teaching hospitals based on a formula that took into account the amount of direct research funding received solely from the three federal granting councils: the Natural Science and Engineering Research Council, the Social Sciences and Health Research Council, and the CIHR.

In the 2003 budget, the federal government announced that the program for indirect costs would be made permanent with $225 million funding in 2003-04. In 2004-05, this was increased to $245 million and has been further increased to $260 million in 2005-06. Meanwhile, health charities, for the most part, continue to fund direct research costs only and remain excluded from this program.

The Health Charities Coalition initially lobbied for the coverage of all research costs and supported the establishment of the indirect cost program largely because it was clear the amount would come from a separate funding source and not directly from research funding. However, soon after the indirect cost program was established, it became clear that the funding of indirect costs associated with government grants for research was having a negative impact on charities such that universities indicated they would ask charities to reimburse them for indirect costs, and some universities began to discourage researchers from accepting charity-funded grants if they also received a funding offer from the CIHR.

The federal government's recent policy changes provide incentives for research institutions, including universities and teaching hospitals, to favour research funds from the three federal granting councils over funds from health charities. This is compounded by the fact that the allocation formula for research chairs under the Canada research chairs program also excludes health charities. The result is that health charity grants are viewed as having less value. This puts pressure on researchers funded by charities to seek funding elsewhere and puts pressure on the health charities to fund indirect costs.

The work that national health charities do for the health of Canadians is critical. In order to continue to respond to needs of our stakeholders and meet new challenges and opportunities, national voluntary organizations require strong support from the government. Sustainable federal funding is critical for such areas as the developing and delivering of services and programs, health promotion, and prevention.

A commitment such as this would support a program of predictable increases in federal government investments in research that will send a strong signal to both researchers and other research funders. It will allow for strategic planning in advance that supports systemic research campaigns. It will also ensure that our talented scientists, researchers, and doctors know that they can pursue their important work here. Research is sometimes referred to as the ultimate patient service.

● (1635)

To close, the government has an opportunity to take a strengthened leadership role in the areas of tax policy and the indirect costs of research. It can successfully do so in partnership with national health charities and the voluntary sector as a whole. We can be involved in a real and tangible way in strategic health planning and redesigning health care delivery. Together, we can improve the health of all people of Canada and improve overall Canadian productivity.

Thank you.

The Chair: Thank you, Mr. Hoult.

From the Heart and Stroke Foundation of Canada, we have Mr. Myers.

Mr. Cleve Myers (Chair, Heart and Stroke Foundation of Canada): Thank you, Chair, and good afternoon, members. My name is Cleve Myers, and I'm the volunteer chair of the Heart and Stroke Foundation of Canada. I'm accompanied today by Ms. Sally Brown, who is our CEO.

I want to thank you for the opportunity to go last this afternoon, because I'm sure there's a better opportunity that you'll remember what it is that we're saying. In truth, though, I think you'll find some common themes across the presentations this afternoon.

The mission of the Heart and Stroke Foundation of Canada is to improve the health of Canadians by preventing and reducing disability and death from heart disease and stroke, through research, through health promotion, and through advocacy.

We want to first of all commend the federal government for its leadership in health and health promotion over the past year, including the $300 million investment in the integrated strategy for healthy living and chronic disease. We look forward to working with the government on development and rollout of this strategy, including a cardiovascular strategy.

Our brief today focuses on the importance of addressing obesity as a means of alleviating the increasing burden of chronic diseases, such as heart disease and stroke. By reducing obesity and reducing the burden of heart disease and stroke, we can help to ensure a healthier population and workforce, which in turn makes for a more productive national economy and also reduces pressure on health care funding and wait times.

Mr. Chair, cardiovascular disease inflicts a terrible toll upon Canadians. It's the leading cause of death in Canada, accounting for 75,000 deaths annually, or 33% of all deaths. Cardiovascular disease also represents the leading cause of hospitalization in the country. It is the single leading cause of drug prescriptions. It's a costly disease responsible for about $18.5 billion annually in direct and indirect costs. This burden is exacerbated by obesity, which is a significant risk factor for heart disease and stroke, and also for cancer and diabetes, as you've heard. Approximately 60% of Canadians are either overweight or obese.

The foundation is active in the area of obesity control. Among other things, we have recently co-hosted a national think tank, in conjunction with CIHR, the Canadian Institute for Health Information, and the Public Health Agency of Canada, addressing obesity in Canada. Participants included policy, scientific, urban planning, and other experts.

We run Canada's most credible food information program, the Health Check program that currently includes over 500 products in your grocery stores. You can identify it as the little red check mark on foods in the grocery store. We fund innovative obesity-related research initiatives to help build capacity in this field in Canada.

We believe that in order to reduce obesity, we must aggressively tackle the problem on a number of fronts. First, the federal government should utilize tax incentives and explore the use of tax disincentives to promote healthy diets and physical activity. In particular, tax incentives should be used to encourage physical activity and healthy dietary habits. We have strong evidence to indicate that tax incentives do work. There are many healthy foods that are currently taxed in restaurants. The GST should be removed from these foods. As well, the federal government should consider removing the GST from non-elite sports equipment, such as bicycles, and consider giving tax breaks to individuals for the purchase of public transit passes.

Canadians are supportive of these measures. For example, a recent Environics poll of more than 2,000 Canadians conducted this autumn found that 80% of Canadians agreed that sales tax should be removed from exercise equipment such as bikes; 60% of Canadians believe the government should provide tax credits or breaks for the purchase of gym memberships; and about 85% of Canadians were supportive of removing the sales tax from healthy food.

While we know tax disincentives are not popular, we do believe they warrant serious consideration, especially when used in conjunction with tax incentives. We must remember that taxation has been extremely effective in the case of tobacco. There are a number of examples of jurisdictions in the states currently applying some type of tax to unhealthy food products or junk food. The GST could be applied to unhealthy foods that are currently untaxed in retail stores, such as unhealthy cereals, shortenings, etc. This type of tax is an excellent means of raising revenue for healthy living and health promotion programs.

More research is needed in this area to examine the precise health impacts of taxation. In a recent Environics poll conducted this autumn, more than half of Canadians agreed that additional sales taxes should be applied to unhealthy foods or junk foods in order to reduce obesity.

The combination of tax incentives and disincentives is a good means of encouraging the food industry to reformulate their products in favour of healthier ingredients. Moreover, if combined properly, the impact on government treasuries could be revenue neutral.

● (1640)

Second, we recommend that the federal government allocate at least 7% of transportation-related infrastructure funds toward the development of community infrastructure that would promote the use of active modes of transportation, as Ms. Harvey set out earlier.

We also recommend a $10-million-a-year investment in social infrastructure projects. Why? Because there's sufficient evidence to indicate that the built environment negatively impacts our ability to be physically active and maintain a healthy weight. The type of transportation we use is a key element in this. Building on the federal government's commitment to a new deal for communities, serious consideration should be given to using existing infrastructure funds to fund social infrastructure and active transportation projects that can facilitate active living. This would include parks, recreation facilities, walking trails, sidewalks, and biking trails.

Finally, with a view to establishing a more complete evidence base in the area of healthy living and obesity, we do need a vibrant health research enterprise in Canada that has the capacity to support both investigative or initiated research, as well as strategic research in the areas such as obesity.

Other organizations that have appeared before your committee have recommended that the federal government announce its intention to increase CIHR's annual operating budget to around the billion dollar level within three years. We strongly agree with this and believe this figure is a conservative estimate of CIHR's requirements, so we would endorse what Mr. Bernstein has said this afternoon.

Members will notice that in our brief we also raise concerns about how the federal government's program for the indirect costs of research negatively impacts health charity funded research, as has been set out by the previous speaker, Mr. Hoult. This is a serious issue, as health charities spend approximately $150 million annually on health research, yet this research funded by donor dollars is not covered by the federal program. We strongly believe this unintended consequence of the federal government's indirect costs of research program must be corrected, as it weakens our national research enterprise by disadvantaging health charity research.

In conclusion, by acting and taking a leadership role in three areas —namely, utilizing tax incentives and exploring disincentives, by providing infrastructure funds that can promote active living, and by strengthening our national health research enterprise—the federal government could, in cooperation with the voluntary sector, make real progress toward reducing obesity. Through the reduction of obesity, we can help to ensure a healthier population and workforce, which in turn is conducive to a more productive national economy.

In light of the budget surpluses we have been enjoying in this country, we need to have the foresight and the courage to invest in the obesity reduction measures we've highlighted today. This is money well spent.

The Heart and Stroke Foundation of Canada works closely with all of our partners in chronic disease, and we're proud to endorse the pre-budget briefs submitted by the following coalitions, of which we are members: Research Canada; the Chronic Disease Prevention Alliance of Canada; the Canadian Coalition for Public Health in the 21st Century; and the Health Charities Coalition of Canada.

Thank you very much.

The Chair: I had a tough time with this group. I think most of the groups went over their nine minutes, so that's not going to leave much time for the members. I'm just going to go with one round of five minutes.

I have Mr. Solberg, Monsieur Bouchard, Madame Boivin, and Ms. Wasylycia-Leis.

And I would just remind the witnesses that it's five minutes for questions and answers. If you can keep your answers to a brief intervention, I think the members would appreciate it.

Mr. Solberg.

● (1645)

Mr. Monte Solberg (Medicine Hat, CPC): Thank you very much, Mr. Chairman.

I really regret that we have such a short period of time. We've had some excellent presentations and some really interesting ideas.

I want to start by asking a question of the people from the Canadian Cancer Society. Today in the House, my colleague Steven Fletcher asked a question about a national cancer strategy. As you know, on June 7, a motion was passed in the House—it was his motion, actually—calling on the government to support a national cancer strategy.

When he asked a question today about that, he was told that the government has already put a billion dollars into this. What do you say to that? I'm sure that's probably not an adequate response, from your perspective.

Dr. Jo Kennelly: We recognize that the minister has, in the last week, been promoting the notion of a billion dollars spent on cancer. I guess we have three points on that.

One of them is that the government hasn't actually told us about the results of that billion dollars spent, so we have no information on what that billion dollars has actually given us in outcomes. We know from international experience, which I alluded to in my submission, that other countries have spent a lot less than a billion dollars of new money and have had significant reductions in cancer death rates.

The second point we would like to make is that our experience of that billion dollar spend over the last few years is that it has been ad hoc, uncoordinated, and time-specific. I'll just give the committee a couple of examples of that.

The tobacco expenditure is an area where there's a big announcement one day, a flurry of activity, and then a slow erosion of money over the next few years. The tobacco mass media campaign has been gutted because of collateral damage as a result of the sponsorship scandal.

Another example of this ad hoc, time-limited lack of strategic investment has been in the Canadian prostate cancer research initiative. Money was put into this initiative and not renewed, and that created problems in terms of capacity for Canadian scientists.

The final point I'd like to make, to bring it back to the strategy that has been developed by over 700 cancer experts, is that this strategy is strategic, it's evidence-based, it's coordinated, and it's designed especially to track expenditure against outcomes.

Mr. Monte Solberg: Time is so short. Mr. Myers spoke about a series of different tax incentives to encourage healthy living and disease prevention. In fact, my colleague Ms. Ambrose has pointed out that our youth caucus is actually working with the diabetes association on some great preventive health care ideas.

I wonder whether other witnesses would care to comment on the utility of using the tax system to encourage this. It affects, basically, all the health care sectors. I'm not sure how CUPE ended up on this panel, but others may wish to comment on this and tell us whether or not they've considered it and whether it's part of their own proposals and ideas to help deal with diseases you're all trying to fight.

Ms. Jean Harvey: I'll start. Certainly, CDPAC has looked at some of those tax policies Heart and Stroke was talking about. We've done a lot of collaboration together, Heart and Stroke and CDPAC, with cancer and diabetes. We concur that we've been looking at those and looking at the evidence to see what works. So we concur with the comments.

Mr. Monte Solberg: Here's one final question for Mr. Hoult. I noticed in your proposal that you didn't actually have, anywhere that I could see, a recommendation that the government extend the capital gains exemption on gifts of listed securities to 100%, which would obviously help charities.

This is a proposal that has been pushed quite heavily by a number of people, but in particular by Don Johnson, who comes to this committee every year. I was quite surprised that it's not in your proposal. I'm wondering why.

● (1650)

Mr. Peter Hoult: The Health Charities Coalition of Canada represents health charities. We are working on various positions that we are trying to put forward to the government and other stakeholders and partners where we can find common interest among the health charities.

I think you're right that we're all probably interested in this; it's just that we haven't gotten around to looking at that particular area as far as the activities of the committee right now are concerned.

Mr. Monte Solberg: So you support it as far as you understand it?

Mr. Peter Hoult: I'm sure all health charities generally would be supportive. I can't imagine they wouldn't be supportive of income tax measures that made giving to charities more effective.

The Chair: Thank you, Mr. Solberg.

Mr. Bouchard.

[*Translation*]

Mr. Robert Bouchard (Chicoutimi—Le Fjord, BQ): Thank you Mr. Chairman.

I would also like to thank our witnesses for their excellent presentations.

My question is for the representative of the Canadian Cancer Society. I was quite surprised to see the figures that you brought forward. Of course, there is cause for concern when we hear that over the next 30 years, 6 million people could develop cancer, and 2 million will die from it. Moreover, in the future, cancer will have a considerable effect on productivity. This is indeed disturbing. It is a disease that is of concern to us, a disease that we must take seriously. There is no question that funding is warranted.

Should Canada base its leading strategy on prevention and cancer screening? That is the question that comes to mind. Should we concentrate on cancer prevention and screening?

[*English*]

Dr. Jo Kennelly: Thank you for that question.

In answer to your question, I can say prevention is a leading priority area for the Canadian strategy for cancer control, but it is there in conjunction with other areas in terms of managing the known cancer risks and known cancer cases that are heading our way. So whilst our largest action group is focusing on prevention, also a lot of money will be going towards managing the known cancer cases. A dollar of money spent on prevention today takes at least a decade to have significant effects, and in that decade, over the next 10 years, we have to manage those people who are going to suffer from cancer. It's a “both and” approach.

[*Translation*]

Mr. Robert Bouchard: Thank you.

My second question is to the representative the Canadian Institutes of Health Research.

You say that a number of institutions invest in health research in Canada. You also say that the institutions currently require $700 million and you recommend an increase to $1 billion for the next three years. That is a lot of money, and those are heavy increases. I am not sure if that would include new research programs.

In past years, were any successful programs eliminated, do some of them no longer exist? I would like to hear what you have to say on that.

[*English*]

Dr. Alan Bernstein: Thank you very much for that question. I have a two-part answer.

First, in terms of programs that don't exist, I'll just tell the committee that every single application that comes to us is reviewed by peers for its merit and likely impact on science and on health. As to the success rate, your chances of getting a grant from us are of the order of 25% to 30%, depending on the competition; it varies a little bit from year to year.

Unfortunately, a lot of programs that should be continued are in fact terminated because we just don't have enough money to fund even all the excellent programs, never mind just the very good programs. We are constantly reviewing grants for the excellence of the program as judged by other scientific peers.

The second part of my answer would be that the increase in our budget I'm asking for, to $1 billion, does reflect a number of things, not the least of which are the new initiatives I talked about on clinical research, for example, on nano-health and nano-medicine and on global health.

The other issue, which I didn't refer to, is that every university and teaching hospital in this country is expanding its capacity for doing health research because they understand the very exciting revolution we are in right now, in health research very specifically. This is a very, very exciting time.

I think all of us are reading the papers these days about the new drugs, for example, that are coming on the market for treating cancer; I'm going back to the cancer issue. That is coming out of research. Just for us to be able to keep up with the demand of very good scientists and academics who are being recruited in universities and hospitals right across Canada is necessitating an increase in our budget. This is a very exciting time.

● (1655)

The Chair: Thank you, Mr. Bernstein.

Madame Boivin, and then Ms. Wasylycia-Leis.

[*Translation*]

Ms. Françoise Boivin (Gatineau, Lib.): Thank you, Mr. Chairman.

Welcome, everyone, and thank you for your presentations.

I would like to start by explaining why you have my full support. I come from the Outaouais region; I am the member for Gatineau, which is just across the river. In my region, the obesity rate — and some might say that I am part of that group — the smoking, and cancer rates, etc., are extremely high. So these are certainly great concerns. Your intervention is therefore quite timely.

I am happy to see that Mr. Moist is here. I don't want him to be bored, so I will ask him a few questions.

Mr. Bernstein, in your presentation, you mentioned something that I feel is extremely important because we are right in the thick of our pre-budget analyses. You spoke about productivity, and all of the organizations that you represent are working towards ensuring that our people, our resources and we ourselves remain healthy. Without health, as you know, not much can be accomplished. You spoke of a scourge which is ever increasing, namely, mental illness. You said, Mr. Bernstein, that by 2020, depression will become the main cause of death in the industrialized world.

I have a question for Mr. Moist, the president of CUPE. Is this something that you are seeing in the workplace? Is your union working on this? Are there any strategies? What can be done to improve these situations? For all of the health organizations that would like to send a message to the federal government, what do you think of a program like ParticipACTION, which was abolished? Should it be reinstated, so that we can get people moving again?

I can't remember which one of you deals with diabetes, but it is a terrible situation. I have parents coming to my office with three and four year old children who have to have daily injections. Something must be done to eradicate this problem which, to my way of thinking, is a much more frightening epidemic than the one that is currently making the headlines.

What kind of program could the federal government devise to improve public health? Has the union detected this type of problem and do you know what causes it? What can be done?

[*English*]

Mr. Paul Moist: Thank you for the question.

Mr. Bernstein and I were just talking before we started today. He mentioned the Canadian Labour Congress as a partner; in the initiatives he outlined were members of the congress. As with most unions, our long-term disability plans and our workers' compensation experience for stress-related or psychosomatic-related workplace stress show by far the greatest increases in the last number of years, and they're putting the cost of some of our long-term disability plans over the moon.

We very much want to work with organizations like Mr. Bernstein's and others here. We represent a lot of workers who work in mental health and in some of the organizations around the table here, but the workplace is not a static place; it's a very dynamic place. Illness related to work is a huge productivity question for Canadian business and for all employers. This area, where it's not a broken arm or a broken back but it's stress-related, is by far the greatest growing area of workplace concern. It has to do with health and wellness and it has to do with workloads in the workplace.

I'll finish by saying I'm a public sector worker. We've just hit 3 million workers in Canada who are employed by the public sector as defined by Statistics Canada, including the federal government. Those employment levels haven't been hit since 1994 because there was a lot of downsizing; there was a lot of restraint. That plays itself out in the workplace in a number of ways, and one of the ways is in the stats cited by Mr. Bernstein.

● (1700)

Ms. Françoise Boivin: But does the union recognize that fact, and is it maybe trying to act on it?

Mr. Paul Moist: Our best labour relationships across Canada—and I'll just speak for CUPE—are ones where we're proactive. Once a worker is out of the workplace for two years, the chances of integration, no matter what his or her physical or mental state, are diminished extensively. In our best labour relationships, reintegrating people into the workforce, perhaps not in their full job but in some other job, has a cost benefit for the employer and for our LTD plans and certainly a benefit for the employee.

That exists in some workplaces; that doesn't exist in others. We actually need the support of agencies sitting around the table here to educate, I dare say, both unions and employers on the merits of early intervention.

Ms. Françoise Boivin: Thank you.

The Chair: Merci, Madame Boivin.

Could I ask the witnesses to hang on for five or ten minutes? Is that okay?

Ms. Wasylycia-Leis.

Ms. Judy Wasylycia-Leis (Winnipeg North, NDP): Thank you, Mr. Chairperson, and thank you to everyone again for great presentations.

This whole debate and discussion on productivity in the context of the next budget has really come down to a debate, a dialogue, around the issues of investing in health and child care, as we've seen today from most presenters, and a small vocal minority who believe the only way to deal with productivity in this country is really to lower corporate taxes again. It comes up time and time again as a solution. Yesterday was a good example, the whole panel—bankers, mining corporation heads, and the Taxpayers Federation. The only solution is to give a break to the corporations and everything will be fine.

If you listen to the news, you'd be worried, too, based on the Liberals' determination to put back the corporate tax cuts that were taken out by the NDP's better balanced budget, or to give some broad-based tax cut and not yet again deal with the investment agenda.

My question is to Paul Moist. Can you give us any indication, based on your research and your analysis, of how a tax cut for corporations is actually going to help productivity in this country? Can you give us some enlightenment on this debate?

Mr. Paul Moist: I'll quote two sources—one, Stats Canada, and the other, the TD Bank—to completely rebut what you heard here yesterday.

Stats Canada tells us:

> Much of the slowdown in labour productivity relative to multifactor productivity is attributable to the deterioration in capital intensity, or capital services per hour worked.

What that means is that, in Canada, between 2000 and 2004, capital intensity fell because of low rates of investment in capital, on the heels of the largest tax cuts in Canadian history, the 2000 budget.

My friends at the TD Bank and I don't often quote one another in submissions, in terms of the most productive nations on the planet appearing to be heavily regulated western European nations.

On this notion that government is too big and needs to be downsized, we're at historically low levels of investment in government services relative to the size of the economy: 12% federal program spending, 12% of GDP, the lowest level since the Second World War. So that's not an argument to expand government spending for the sake of it, but relative to the size and the wealth of the overall economy, government spending is not a problem.

There is no correlation between investment in workers or investment in retooling and tax cuts. The opposite happened with the 2000 tax cuts.

● (1705)

Ms. Judy Wasylycia-Leis: Thanks. While you addressed my question, you also took on that Conservative myth that we're at an all-time high in terms of spending. In fact, we're actually at a lower level of spending on a per capita basis than historically has been the case.

While we're on the issue of debunking myths, perhaps you could help us with another one, Paul, and that is one that has been perpetrated and perpetuated by the Conservatives, but also yesterday by the Taxpayers Federation. CUPE is very active in the area of child care and knows the importance of a national child care program. Can you tell folks here why it doesn't make sense to scrap a national day care program where you invest in non-profit quality centres and instead give vouchers to parents so that they can go out and buy the day care they need, which supposedly is going to give choice to parents and make their lives easier so that they can be more productive members of society?

Mr. Paul Moist: Well, it won't be CUPE research, and I don't have it in front of me, but OECD research talks about that being one of the most inefficient uses of money, that type of transfer to the individual.

Canadian families are starving for early childhood development spaces, child care spaces that are affordable and that are available. It's the availability.

Tonight I will celebrate child care workers day with the minister responsible for the government. We're working very hard with the government to make this a pan-Canadian system. Regarding those individual transfers to families, it's not inappropriate to use the tax system to deal with individuals, but in the area of early childhood development and child care, no, there is no empirical evidence to support the notions that you say some of your parliamentarian colleagues are putting forward. They don't accord with any research in the OECD nations.

The Chair: Thank you, Ms. Wasylycia-Leis.

I have two more to go. Ms. Ambrose and Ms. Minna, if you could split the time, it will be for three minutes each.

Ms. Ambrose.

Ms. Rona Ambrose (Edmonton—Spruce Grove, CPC): Thank you, Mr. Chair.

I have a broader question on preventative health for the panel.

My colleague and I were sitting here discussing it, and we kind of drew a little chart.

I wanted to ask you about the competing interests between funding for acute treatment and funding for research and prevention, because both are obviously very expensive and both are very necessary in the health system. It's almost as though we're at a crux now, where we see all these successes in innovation and research obviously leading to more treatment. In the long term, we're hopefully looking at more investment in preventative health, but all of you who are dealing with the preventative health issue are directly competing with funding that's going into front-line treatment.

Could you elaborate a little to the committee on the challenge of that? How do you see the finance committee making recommendations on the allocation of funding for preventative health specifically?

Ms. Brown, or whoever would like to start.

Dr. Jo Kennelly: It's not an either/or answer, and it depends on the tools you use to get the answer. Through applying the risk-management tools from the banking industry, we've learned that you can maximize spending on prevention and maximize spending on dealing with the problem at hand.

Good health care policy is made up of two things: it's the science and it's the evidence. As Dr. Bernstein talked about today, we are investing a lot in science and evidence. We're getting a lot of science and good results out of that money, but we also need to invest in managing the results of that science so that it then transfers to policy-makers to make budgetary decisions.

Ms. Rona Ambrose: Do you see the investment in research driving the policy forward?

Dr. Jo Kennelly: I think there's an intermediary step. You need a system to manage the avalanche of new data, particularly in the cancer area. Over the next 10 years, we're expecting an avalanche of new data and new results from Canada's investment in genomic-based research.

As we've designed in the Canadian strategy for cancer control, you need a management system to take that information and make it available to politicians and policy-makers to make those trade-offs between one item versus another, in terms of economics but also in terms of the health and quality of life of Canadians.

● (1710)

Ms. Rona Ambrose: Is the CIHR, the Canadian Institutes for Health Research, a body that could function in such a way as you're describing? Does it do that? I'm not sure.

Dr. Jo Kennelly: They're doing some work in that area.

Dr. Alan Bernstein: If I could jump in here, I'd go back to your first question, and then I'll come back to that very quickly.

I agree with my colleague. I don't see it as an either/or answer. If you look at the dollar amounts, the amount of money we spend on research in this country relative to the total cost of health care is much less than 1%. That's number one.

Number two, within our 13 institutes, we fund a lot of research and we fund a lot of research on prevention. If you're going to do prevention, as I think you were getting at, you need evidence-based decision-making.

The single main priority for our Institute of Nutrition, Metabolism and Diabetes is on obesity, particularly childhood obesity, which is something that has been discussed here. In fact, in one of the newspapers today, there was a debate between our scientific director for that institute and another scientific colleague on how significant family genetics are in contributing to obesity or whether it is simply a lifestyle decision. We need the evidence. Of course, that's where we come in.

To go to your last question, our mandate from Parliament is to do research and to translate it. We are indeed setting up mechanisms that are intermediaries, as Ms. Kennelly was talking about, for exactly that kind of knowledge translation.

Ms. Rona Ambrose: Thank you.

The Chair: Thank you, Ms. Ambrose.

Ms. Minna.

Hon. Maria Minna (Beaches—East York, Lib.): Thank you, Mr. Chair. To follow up on what was just said, I want to say I agree 100% with what Mr. Bernstein said, that it's not one or the other. In fact, I would think we need to continue to fund the health care system and the reform of the health care system—there's no question—to make sure it's public and strong.

But we also have to increase the research. I think the investments we've made over the last 10 years—it needs to be said that prior to that there was hardly anything going on in that field—in the creation of the CIHR and a whole lot of other research bodies...now we're beginning to see the actual benefit.

I was quite interested to hear your comment about the wait times, and about your contribution to the wait time issue, because we've been talking a great deal about wait times in an abstract sense—although the people who are waiting certainly are suffering and feeling it very personally. But up until now, we haven't seen something that was so high profile—and your organization was actually able to impact that. I've always supported it, but that just reinforces that position. So I have no problem whatsoever recommending an increase in funding for research, because without it, I don't think we have a future. It's a bit like driving without your lights on, which wouldn't be very smart for any country to do.

Having said that, I don't have a whole lot of questions, except that I agree with a lot of what's going on, and I'm glad to hear that.

I have a couple of questions. Actually, I agree with pretty much with what's been presented here today. I have difficulty, but really it's a question, except for a couple of things, of clarifying here and there.

Mr. Moist, I wanted to ask you a question with respect to the millennium scholarship—because I have said before, and I've had this discussion with other presenters with respect to the RESP benefiting only certain Canadians and not all, depending on whether or not you're able to put money away, and so on. So you would replace all of that...and I don't have a problem with that. Have you any idea what that would cost, the kind of...? Have you done any modelling on that to help guide us a bit?

Mr. Toby Sanger (Senior Economist, National Services Department, Canadian Union of Public Employees): There has been some work done, particularly by the Canadian Federation of Students. It depends how much would be included in assisting needs-based grants. But to replace the millennium scholarship fund and the different tax-supported board of education programs, that amounts to quite a bit of money provided through the tax system.

Hon. Maria Minna: Okay.

Mr. Paul Moist: I would also say, going back to the creation of the CHST and the one major change made since then, that in the original CHST created after the 1995 budget, most of the space got occupied by health care funding, and the luck of the draw of us not having a recession and not having to deal with that.... Post-secondary was also part of the original envelope of the CHST, and it took a back seat. For a country as advanced as Canada to have an RESP system available to only wealthier Canadians to save money...fully 50% of Canadians have nothing in RRSPs or RESPs because they can't afford to.

The millennium scholarship program—it's hard to argue against money, but the form it takes.... We say scrap all of that and create a single envelope of grants to students. The budget presented here last year created a minor concession to the debt load held by students: that they would pay interest only after a six- or a nine-month period. Well, that still establishes as a matter of fact that many young people are going to enter the workforce with debt loads you and I didn't have after we were able to go to school. So put it under one roof.

● (1715)

Hon. Maria Minna: I have one last, very quick question. I have to be fast here; we don't have much time. But one last question I wanted to ask has to do with the EI system providing training benefits to both employed and unemployed. In fact, I made this recommendation together with two of my colleagues back in 1994, when we did the social security review, that it should probably be expanded to do exactly this, and we haven't done it. But I wanted to ask you—a lot of businesses in this country do train, but a large number of businesses don't do any training at all—should we be providing incentives for them to train? Or should we be charging a tax for those that don't train, because if we're providing training for them, maybe they should pay for it in one way or another?

Mr. Paul Moist: I certainly wouldn't be reducing corporate tax levels until we saw some evidence of increased training levels across the board, number one.

Number two, in terms of EI, the mantra around here is often reduce the contribution rates. We have two problems with that: one, fewer than 50% of the unemployed qualify for EI any longer; and two, we absolutely don't want our contributions, as workers or businesses, to go to general revenues of the government, whatever political stripe they are. It's unbelievable to me.

We met with the Prime Minister last year, with labour leadership. It's unbelievable to me that you've made an amendment, which we supported, that gives workers time off work when they're giving birth to children or raising children and EI pays for that. It was never our desire for EI to pay for that, but that's where it is. Then, if they're unlucky enough to get back on the job and get laid off, the time they were off for child-rearing purposes can't be counted and they're not entitled to EI. That consequence was never intended by EI.

We make five recommendations in this submission to you on EI. We could meet for hours on the subject of EI.

The Chair: Thank you, Ms. Minna.

Unfortunately, we're running out of time. I had a few questions as well, with the same sentiments as the rest of my colleagues. We're just running out of time. I have to apologize, but this is just the structure. We don't have enough time. We never have enough time, it seems, and this is a perfect opportunity where we had the same type of panel and we could probably have asked the same types of questions, but we still ran out of time.

Again, thank you for your time. It's well appreciated.

The meeting is adjourned.

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