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Mrs. Joy Smith

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● (1110)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): Good afternoon, ladies and gentlemen. I want to welcome you to the health committee today.

I have to especially welcome our guests this morning. I am very pleased that you could join us today and that we'll have an opportunity to listen to your very insightful comments.

We have, from the Department of Health, Dr. Karen Dodds. She is the assistant deputy minister of the health policy branch. We have Ian Potter, assistant deputy minister of the first nations and Inuit health branch. Welcome.

From the Public Health Agency of Canada, we have Jane Billings, senior assistant deputy minister of the planning and public health integration branch. We have Dr. Arlene King, director general of the centre for immunization and respiratory infectious diseases.

From the Department of Finance, we have Krista Campbell, who is the senior chief. She is from the director's office of the federal-provincial relations and social policy branch. That's a very large title. We have Yves Giroux, director of social policy with the federal-provincial relations and social policy branch as well. That's another long title, but a very important one. And we have Jonathan Roy, senior policy analyst, health, justice, and culture, social policy, with the federal-provincial relations and social policy branch.

Ladies and gentlemen, pursuant to Standing Order 108(2), the motion adopted by the committee on March 13, 2008, and section 25.9 of the Federal-Provincial Fiscal Arrangements Act, the committee today begins the first of four meetings on the statutory review of the progress in implementing the 10-year plan to strengthen health care.

We have with us the senior officials today, the Public Health Agency and the Department of Finance—those members I've just gone through.

Dr. Dodds, we will have your presentation now, for approximately 10 minutes, but seeing that you're speaking for everybody, we might push that forward a bit.

Dr. Dodds.

Dr. Karen Dodds (Assistant Deputy Minister, Health Policy Branch, Department of Health): Good morning, Madam Chair and members of the committee. Thank you for the opportunity to provide an overview of the progress on a wide spectrum of health care reform initiatives as set out in the 2004 health accord.

[*Translation*]

In my opening address today I would like to take about the nature and purpose of the accord and the progress made by Health Canada and the Public Health Agency of Canada on fulfilling the commitments made in the accord.

[*English*]

The 2004 health accord was a historic agreement by all federal, provincial, and territorial governments to renew their health care systems and to enhance accountability to their residents.

● (1115)

[*Translation*]

In the accord, the first ministers established a five-year plan to ensure that Canadians have access to the health care they need when they need it.

[*English*]

To achieve that goal, all governments committed to move forward on a comprehensive set of health care renewal initiatives. The accord initiatives were broad in scope, including, but not limited to, such things as reducing wait times, reforming primary care, developing electronic health records, expanding healthy living and public health initiatives, supporting health innovation and research, and improving aboriginal health.

To allow Canadians to see how governments were doing on meeting their commitments, the accord tasked the Health Council of Canada to report on the performance of the health care system and the progress of accord implementation.

[*Translation*]

Today I would like to talk about what Health Canada and the Public Health Agency of Canada have done to advance initiatives to reform health care.

[*English*]

I'd like to describe the funding commitments that have enabled provincial-territorial governments to move forward on health care renewal.

[*Translation*]

As a result of that funding, the public health care system in Canada is on the road to sustainability. Its level of funding is foreseeable and is growing.

[*English*]

To support the accord, the Government of Canada is flowing an additional $41.3 billion over 10 years to provinces and territories. This funding includes $35.3 billion in increases to the Canada health transfer, $5.5 billion in wait times reduction funding, and $500 million for medical equipment.

Funding to provinces and territories through the Canada health transfer alone will amount to over $22.6 billion cash in 2008-09, and with the annual 6% escalator, it will reach over $30 billion by 2013-14.

In addition to fiscal transfers to provinces and territories, the Government of Canada has demonstrated leadership through investments in patient wait time guarantees, electronic health records, public health and disease prevention, and support for the Health Council of Canada and the Canadian Institute for Health Information to ensure accountability to Canadians on health care.

I would like to begin the overview of specific initiatives with one of the key accord commitments: reducing wait times.

Recognizing that provinces and territories have primary responsibility for the delivery of health care services, the Government of Canada is providing them with $5.5 billion through the wait time reduction fund. This fund has allowed provinces and territories to augment their investments and diverse initiatives to reduce wait times.

[*Translation*]

In addition, the government has invested in developing strategies to manage and reduce wait times, as part of the National Wait Times Initiative.

[*English*]

This program has supported work by health care professionals and provincial governments to improve the management of wait times for hip and knee surgery. It has supported work to ensure diagnostic imaging is used appropriately, so that patients can have timely access to the care they need.

In a variety of ways, the program has assisted knowledge sharing and the adoption of best practices in addressing wait times.

[*Translation*]

Coming after these achievements, the government introduced the idea of patient wait times guarantees when it came to power two years ago. The goal was to give Canadians better assurance that they would receive the health care they need when they need it.

[*English*]

Today, all provinces and territories have committed to establish guarantees by 2010 and to conduct pilot projects to help pave the way.

In Budget 2007, the Government of Canada invested more than $1 billion in patient wait time guarantees, including $612 million for a patient wait times guarantee trust, which provinces and territories can use as they see fit in working towards their guarantees. The trust includes base funding of $112 million, from which each province received $10 million and each territory received $4 million. The remaining $500 million was allocated on an equal, per capita basis.

The budget also invested $400 million in funding to Canada Health Infoway to support the implementation of guarantees through the development of health information systems and electronic health records.

And the budget included a $30 million patient wait times guarantee pilot project fund. This fund is assisting provinces and territories in testing innovative approaches, including offering patients options for alternative care or recourse when guaranteed timeframes are exceeded.

The Government of Canada is also directly supporting four pilot projects to test guarantees. Two will test timeframes for diabetes and prenatal care in selected first nations communities. A third, managed by St. Elizabeth Health Care, will evaluate a patient wait times guarantee model for diabetic foot ulcer care in selected Manitoba first nations communities. And the fourth addresses surgical wait times for children, in collaboration with Canada's 16 pediatric health sciences centres.

The accord also committed governments to reform primary care and continue the development of electronic health records.

● (1120)

[*Translation*]

Investments by the Government of Canada in the Primary Health Care Transition Fund supported the far-reaching reform of the health care system, which in fact changed the organizational culture and deliver of primary health care. From 2000 to 2006, the government invested $800 million in that fund to help the provinces and territories and other stakeholders improve the way primary health care services are delivered throughout Canada.

[*English*]

These investments have increased the emphasis on health promotion, disease and injury prevention, and chronic disease management. They have expanded 24/7 access to health care services, created the tools needed for team-based care, and facilitated better coordination and integration of health care services through improved use of information technology.

There has also been accelerated development of electronic health records as a result of new Government of Canada investments in Canada Health Infoway. These investments now total $1.6 billion, including $400 million provided in Budget 2007. All provinces and territories are working with Canada Health Infoway to implement electronic health records and telehealth, which allow health care to be provided to Canadians more effectively and efficiently.

In the 2004 accord, all governments acknowledged that public health efforts on health promotion and disease and injury prevention are critical to achieving better health outcomes for Canadians and ensuring the long-term sustainability of the health care system.

[*Translation*]

The Government of Canada is placing greater stress on public health and disease prevention. It will invest $1 billion over five years in federal preparedness to deal with bird flu and flu pandemics. It will support the FPT National Immunization Strategy.

[*English*]

This strategy works to strengthen immunization infrastructure—such as support for FPT and expert committees, and data collection—and align publicly funded childhood immunization programs across jurisdictions, including pneumococcal, meningococcal, chicken pox, and whooping cough vaccines. Through a Budget 2007 investment of $300 million over three years, the Government of Canada has further advanced the strategy by promoting the launch of human papilloma virus vaccine programs to prevent cervical cancer.

The government also launched Canada's first national cancer control strategy, providing $260 million over five years to support the Canadian strategy for cancer control, in collaboration with the Canadian Partnership Against Cancer. In addition, the government has contributed $4.2 million in 2007-08 and $5.2 million per year thereafter to support the development of the Canadian heart health strategy and action plan.

In November 2008, an advisory committee will report back to the minister with recommendations and options for a comprehensive national strategy. In order to improve the quality of life for Canadians and their families dealing with mental illness, the government established the Mental Health Commission of Canada. Budget 2007 provided $55 million over five years for the commission, while Budget 2008 allocated $110 million for the commission's innovative demonstration projects.

[*Translation*]

The accord also committed the Government of Canada to continuing to invest in science, technology and research relating to health-specific innovation.

● (1125)

[*English*]

Over the last four years, the government has provided $440 million in new funding for health-specific innovation and $1.6 million in new funding for innovation with a health component. The importance of the Government of Canada's support for health innovation was confirmed by the science and technology strategy announced by Prime Minister Harper on May 17, 2007, which recognizes health and life sciences as a priority sector.

Aboriginal peoples continue to face health disparities compared to the rest of Canada. However, the Government of Canada is making progress on achieving better health outcomes for aboriginal people.

[*Translation*]

We are starting to see the results of the $700 million that the Government of Canada invested in Aboriginal health over five years as part of a commitment made at the special meeting of first ministers and Aboriginal leaders in 2004. This led to improvements in health promotion and disease prevention programs, Aboriginal health human resources and the adaptation and integration of federal and provincial health services for Aboriginal people.

[*English*]

In addition, the government continues to invest new resources in health services. Budget 2008 provides $147 million over two years to stabilize current health programs, make concrete improvements aimed at better health outcomes for first nations and Inuit, and support improvements in health care delivery through greater integration with provincial and territorial health systems.

The government is also building strong partnerships with first nations and provincial governments. The tripartite first nations health plan between the Government of Canada, the Province of British Columbia, and the British Columbia First Nations Leadership Council will help us improve service delivery and health service integration.

[*Translation*]

We will continue to work with our provincial and Aboriginal partners to improve the health of Aboriginal people and bridge the health outcomes gap.

[*English*]

In the accord, governments committed to keeping their residents informed of the progress made to improve their health care system.

[*Translation*]

The Government of Canada has always demonstrated leadership when it comes to public accountability in these issues.

[*English*]

As part of this commitment to enhanced accountability, the government issued reports based on comparable indicators and national data in 2002, 2004, and 2006. Another report is planned for later this year.

The government also fully funds the Health Council of Canada so it can report to Canadians on the progress of health care reforms. Since 2004, the Health Council has issued a number of public reports on the various elements of the accord.

Canadians are also benefiting from highly regarded data analysis from the Canadian Institute for Health Information, such as reporting on wait times and health expenditures. This further advances health care system transparency and accountability.

The government provided an additional $22 million per year in Budget 2007 for the Canadian Institute for Health Information. This brings Government of Canada funding to this organization to a total of $81 million annually.

Less than four years after signing the accord, much progress has been made on implementing accord initiatives.

[*Translation*]

The Government of Canada has provided the provinces and territories with sustainable funding to support their efforts to reform their health care systems.

[*English*]

The government has also demonstrated leadership in health care system renewal in other ways: by supporting provincial and territorial governments to introduce patient wait time guarantees, increasing investments in Canada Health Infoway to accelerate the development of electronic health records, and placing more emphasis on public health initiatives.

Strengthening health care requires leadership and partnership between patients, health care providers, and all levels of government. The government will continue to work diligently and closely with all its partners to maintain, improve, and protect the health of Canadians.

[*Translation*]

Health Canada and the Public Health Agency of Canada will be glad to provide support for the committee in reviewing the accord. We will give you all the assistance needed so that the review is a success.

[*English*]

This concludes my opening remarks. My colleagues and I from Health Canada, the Public Health Agency, and Finance Canada look forward to answering your questions.

Thank you.

● (1130)

The Chair: Thank you very much, Dr. Dodds.

We'll now go into our round of questioning, and it will be seven minutes per committee member.

We will start with Dr. Bennett.

Hon. Carolyn Bennett (St. Paul's, Lib.): Thanks very much.

Thank you all very much.

I got back from Washington yesterday, and I am very concerned that internationally Canada is falling way behind. Whether it's wait times or electronic health records or patient satisfaction, there is a concern that we have fallen dramatically behind in the last little while in the good intentions of 2004. Particularly on things like reducing wait times and improving access, where in the accord it says “reductions in wait times in priority areas such as”, and yet we seem to have stuck to the five original ones. We are being judged not only internationally, but by patients on how we're doing on all the other ones; whether it's for a shoulder injury, or for mental health visits, or finding a family doctor, this is a concern. So in terms of how we are reporting to patients on how we're doing on all these things, I think I'm quite concerned.

I'm also concerned in terms of the health human resources action plan including doctors, nurses, pharmacists, and technologists. I am not sure we're getting where we need to go. Particularly, I'd like to know what happened to the $100 million we gave to increase the number of aboriginal health resource professionals. We don't seem to be doing that, or for official languages, which I think is helpful to all. I guess you won't be surprised that I will ask, what ever happened to the goals and targets in public health? Have we set the targets we wanted from the health goals process that all the provinces and territories participated in? Do we have targets on any of the diseases or any of the social determinants of health?

I guess I'll leave it there, and my colleague will ask some of the other questions.

The strength of our health care system will only be the confidence Canadians have in it. I think we need to be able to show Canadians that they're doing as well here as they would anywhere. I guess that's why wait times become the talisman for this, the other point being that without an appropriate health human resources team in our country, poaching from province to province isn't going to work. That's why there was this accord, to make sure we had the right mix of health professionals for all of Canada.

Dr. Karen Dodds: I'll start, and I'll start by talking a little bit about patient wait times.

Yes, five areas were noted as key areas in the accord. I think people can tell that progress has been made in those five areas. The patient Wait Time Alliance came out with a report card today with some marks. Earlier this week the Taming of the Queue conference, which Health Canada supported, was hosted by the Canadian Medical Association.

Although there's been a focus on the five areas, I think that has helped raise the focus on wait times in general, and there has been work in other areas. Indeed, in my opening remarks I commented that what we've been doing federally includes some projects in areas other than the five specific areas for first nations health: prenatal care, diabetes care, and foot ulcers due to diabetes as well. I think the interest in wait times is spreading, and it's because of the attention the accord focused on them.

Hon. Carolyn Bennett: With due respect, in the allocation of OR time, if you get down to how this is working, the five are skewing for the patients who need other things. I think this is the way I certainly have it reported back. That was just a comment.

Please, I really want to know about the health human resources piece and how that is going, and also about choosing targets for the health goals for Canada.

● (1135)

Mr. Ian Potter (Assistant Deputy Minister, First Nations and Inuit Health Branch, Department of Health): Madam Chair, I can respond to Dr. Bennett's question with respect to the aboriginal health human resources initiative and the $100 million that was agreed to by Parliament for this initiative.

This initiative was intended to achieve four specific targets: doubling the number of first nations, Inuit, and Métis students receiving bursaries; doubling the number of health professionals over 10 years; increasing the number of certified health directors by one-third; and increasing by 50% the number of post-secondary institutions with aboriginal health student report programs.

The program has two more years to run. Up to the end of the last fiscal year, we'd spent approximately $36 million. We're in the middle of a review, Dr. Bennett, that will show us where we are. I can tell you that with respect to the bursaries and scholarships, we can actually show that there's been a sixfold increase in bursaries and scholarships since 2003-04. Anecdotally, there has been a significant increase in the number of medical schools and nursing schools that have particular programs to support aboriginal students.

With respect to health directors, we've had a successful meeting of the health directors who manage first nations clinics and medical services. They're organizing themselves. They're establishing professional practice standards, and I think we will see significant progress on that.

We should have a report at the end of this fiscal year, which will give you more specific details of what we've accomplished.

Thank you.

Dr. Karen Dodds: On the general issue of health human resources, it should be noted that according to data that's been released by the Canadian Institute for Health Information, progress has been made in increasing the supply of physicians and nurses since the 2004 accord. The number of practising physicians in Canada reached 62,307 in 2006, an increase of 4.9% since 2002, which is a rate of increase over the population growth, which is at just 4%.

The Chair: Thank you, Dr. Dodds.

I'm sorry, I'm going to have to stop now. The time is way over.

Monsieur Malo.

[*Translation*]

Mr. Luc Malo (Verchères—Les Patriotes, BQ): Thank you, Madam Chair.

Thank you for being here.

Clearly the 10-year plan is an interference in matters that are under the jurisdiction of the provinces and Quebec. That is why Quebec is not a party to the agreement, under the Quebec clause, which was added to the action plan.

However, it is still worthwhile to take another general look at two objectives that are central to that plan. First, there are wait times to see doctors. I read in *La Presse* in 2007 that Canada ranked last among the seven countries surveyed in terms of how much time people had to wait to get an appointment with a doctor.

Since that study was published, on November 1, 2007, have things improved? If not, can you comment on the results of that study?

Second, better access to health care was one of the objectives. In a newspaper article published on January 9, 2008, I read that according to the 2007 National Physician Survey, 5 million Canadians had no family doctor.

Is that figure large or small? Is it better or worse than before? Can you comment generally on those figures, which were also published in the media?

Dr. Karen Dodds: First, I would like to point out that the 2004 accord specifically recognizes Quebec's desire to take responsibility for planning, organizing and managing health care services within Quebec.

● (1140)

[*English*]

With respect to wait times since November 2007, is there an improvement? No, I don't think we'd have any information on an improvement over the last five months. What we have is information on an improvement over the four years of the accord time.

In terms of access to health care services and health human resources, dollars were provided to provinces to do what they thought was best, in terms of the health human resources and to put them where they thought was best.

[*Translation*]

Mr. Luc Malo: In the introduction to your opening statement, you referred to certain actions taken by the federal government in relation to health care. I am thinking specifically of the Strategy for Cancer Control, the Mental Health Commission, the Heart Health Strategy and combating obesity.

In terms of those federal activities, is Quebec entitled to rely on what is called the Quebec clause, to withdraw with full compensation, and without any constraints or obligations dictated by the federal government?

Ms. Jane Billings (Senior Assistant Deputy Minister, Planning and Public Health Integration Branch, Public Health Agency of Canada): Those initiatives, such as the Strategy for Cancer Control, are intended for Canada as a whole. There is no specific amount allocated to each province. We are trying to change the living conditions of all Canadians.

Mr. Luc Malo: In your opinion, what was good about the 10-year plan to consolidate health care, Quebec having the power to withdraw unconditionally and with full compensation, could that also be applied to those strategies? Because, and this is quite plain, they relate directly to actions targeted to the particular audience, which everyone acknowledges as being under the jurisdiction of Quebec and the provinces.

Mme Jane Billings: The question you have asked suggests that there were amounts allocated to each province. That is not true in the case of these strategies. We do not allocate a precise amount to each province or to the provinces that choose not to participate in the initiatives.

Mr. Luc Malo: My question was more about the principle rather than the application or the mechanics. When a principle is agreed to, then the practice can be adjusted.

Can you comment on the principle, and not how these various strategies are applied?

Ms. Jane Billings: These strategies are developed based on information that is exchanged in order to improve practices everywhere in Canada. If we have to divide the strategy up, the results will not be as good. These strategies are not developed based on the principle you referred to.

Mr. Yves Giroux (Director, Social Policy, Federal-Provincial Relations and Social Policy Branch, Department of Finance): Mr. Malo, if I could ...

● (1145)

M. Luc Malo: Yes, go ahead.

Mr. Yves Giroux: In the case of the Mental Health Commission, these are research projects to determine the best approaches for dealing with mental health issues. This is something that Senator Kirby looked into. He identified major deficiencies in that regard. Under the new budget, the Mental Health Commission has received or will receive $110 million, subject to Bill C-50 receiving Royal Assent, to conduct research projects in five centres. Those funds are not intended for direct service delivery. Rather, they are meant for developing innovative mental health practices for clienteles defined as being at risk.

[*English*]

The Chair: Thank you, Mr. Giroux.

Ms. Wasylycia-Leis.

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

Thanks to all of you for your appearance today regarding what we as a committee consider to be perhaps the overriding issue of concern.

Let me start with wait times. As you've mentioned, Karen, the alliance came out with its report today. It is pretty scathing. It calls attention to the lack of significant change in the last year. We all know that the reduction or elimination of wait times was one of the five key promises of the present government in the 2006 election. We know that in Budget 2007 a serious commitment was enunciated to deal with wait times—in fact, you talked about a patient wait time guarantee. Today the alliance, which is made up of every professional medical organization in the country, has said that nothing has happened in a year.

In our access indicators, we see a change from an “incomplete” to a “C-plus”. This is a positive change, but it is still only slightly above average in benchmark targets, in wait time information. Overall, this is a pretty dismal record for a government that promised to eliminate wait times.

I'd like to know the nature of the problem What is being done to address this and to keep the promise?

Dr. Karen Dodds: Reducing wait times remains a priority for all governments. The new report card shows that in some areas Canadians are seeing improvements each year. The report also shows that the provinces and territories are meeting their commitment to provide Canadians with meaningful information on wait times. We want public reporting to continue to improve, and we are continuing to see improvements.

Focusing on wait times has some unanticipated positive impacts. Health care professionals who never talked to each other before are now doing so. You don't necessarily see these areas highlighted in the newspapers or in public reporting, but progress is certainly being made.

Ms. Judy Wasylycia-Leis: I appreciate that there have been slight—very slight—improvements in the grades given to wait times, but at this rate, Canadians aren't going to see much change while they're alive. My question is, is there a plan to make a real difference in this regard, something more than just another empty election promise? Is there anything in the works in your department to deal with this in a real way?

Dr. Karen Dodds: It's clear that we're all anxious to see further progress. The government is supporting further progress through dollars to the Canadian Institutes of Health Research, which is doing work on providing benchmarks and information.

Ms. Judy Wasylycia-Leis: I appreciate that. However, this issue has been before us for such a long time that Canadians are looking for more than a sharing of reports, more than just getting the problem on the radar screen. When Canadians are given an election promise to reduce or eliminate wait times, they expect that something might happen besides a sharing of information and better dialogue.

Let me leave it at that for now and go to another big area that my colleague, Carolyn Bennett, raised: human resources strategy. The five-year strategy is up now. We're waiting for the next five-year strategy. We're wondering what it is, when it will be kicked off, who will be in charge. What will be different in this five-year stretch that will actually produce results? After five years' effort on this front, we have the worst human resources problem in the history of health care in this country. We have a huge doctor shortage, a huge nurse shortage, a huge lab tech shortage. Yet there's been no concrete program, on the part of the federal government, to facilitate a process that will address this serious problem.

Is a new strategy in the works? Is a new five-year strategy being planned?

● (1150)

Dr. Karen Dodds: The $38 million per year that the government has invested is ongoing, so there will continue to be improvements and there will continue to be changes seen in the provision of health human resources.

On the access question, information from the Health Council indicates that 96% of Canadians do have access to primary health care.

Some of the information on wait times that was exchanged at the conference earlier this week indicated that provinces in a couple of areas have eliminated a backlog, so now they are turning their attention to other areas.

So you can see where we can expect to see some progress. I know all of us wish it was faster.

Ms. Judy Wasylycia-Leis: I probably don't have much time. Let me ask three or four questions.

The Chair: You only have one minute.

Ms. Judy Wasylycia-Leis: Is there a health human resource strategy being planned with goals and objectives for a five- or ten-year period?

Where is the national pharmaceutical strategy, which was part of the 10-year health plan? It is not mentioned in your report that I can tell. We have heard nothing. There have been no meetings. It looks like it is dead in the water, dying on the vine, gathering dust.

Where is the home care strategy that was part of the 10-year accord? First-dollar coverage for a number of services—I don't see that mentioned.

Where is the strategy for health care in the north?

Those are my four questions, as an initial go-round.

The Chair: Your time is almost up, Ms. Wasylycia-Leis.

Dr. Dodds, do the best you can with one or two of those.

Dr. Karen Dodds: Again, on health human resources, I'll reinforce that those dollars—$38 million per year—are ongoing and that we continue to work with our provincial partners on that.

On home care, the provinces are implementing their commitments on home care.

The Chair: Thank you.

We'll now go to Mr. Fletcher.

Mr. Steven Fletcher (Charleswood—St. James—Assiniboia, CPC): Thank you, Madam Chair. I would like to thank the witnesses for coming today.

I will make some comments and then I'll ask for comments from the panel. On human resources, one of the key areas where we could really benefit is through international medical graduates and our immigration policy.

I would like to take a moment to thank the Liberals for their support of our immigration policy. I hope the Liberals will continue to support our immigration policy to allow IMGs to come in and contribute to our country in a timely manner.

Some hon. members: [*Inaudible—Editor*]

Mr. Steven Fletcher: Madam Chair, members are heckling. I wish they would listen to these very important comments.

In regard to the Wait Time Alliance, I have the report here. I am afraid my friend from the NDP mischaracterized the report.

We have to remember that we came from 10 years of darkness and from the abyss in health care, and the patient wait time report card on the progress—

Some hon. members: [*Inaudible—Editor*]

Mr. Wajid Khan (Mississauga—Streetsville, CPC): A point of order. I want to listen to what the gentleman is saying. There seems to be a lot of noise here.

The Chair: I call this to order, and I would ask all members to please stick to the topic at hand. Thank you.

Carry on, please, Mr. Fletcher.

Mr. Steven Fletcher: I am talking about the Wait Time Alliance. The member from the NDP raised it and mischaracterized the wait times.

Let me quote from their press release. It said:

> Significant changes from last year's WTA Report Card on progress toward implementing the 2004 10-Year Plan to Strengthen Health Care are:
>
> - Access indicators: the grade changed from an "incomplete" in 2007 to a C+ in 2008.
>
> - Benchmark targets: the grade increased from a D in 2007 to a C+ in 2008.
>
> - Wait time information: the grade increased from a C in 2007 to a C+ in 2008.

The trend is moving forward. We're moving up. I am sure we are going to see even more progress. But the key is that there's progress. From nothing we have something, and we have a future.

So I have three questions for the panel. One is, I would like you to talk a little bit more about the Wait Time Alliance, and I would also like you to talk a little bit about the funding, the $612 million, for wait times. And there was base funding, and I wonder, how many provinces and territories have received base funding.

● (1155)

[*Translation*]

[*English*]

I also want to follow up with our friend from Quebec.

[*Translation*]

What was the consequence of the agreement made with Quebec?

[*English*]

The Chair: Dr. Dodds.

Dr. Karen Dodds: One of your first questions was about work on health human resources and the internationally educated health professionals initiative. That initiative is under way. It has been established to accelerate and expand the assessment and integration of internationally educated health professionals into the health care system. The government has committed $18 million per year for five years to that initiative.

You were also asking for some further information on the Wait Time Alliance report card.

Mr. Steven Fletcher: And how does the funding work?

Dr. Karen Dodds: On the specific areas of wait times, for hip replacements it's a B; for knee replacements it's a C; for cancer care it's an A; for sight restoration it's a B; and for cardiac care it's an A. So some of those results are definitely on the plus side.

Mr. Steven Fletcher: The report card does show significant improvements in the areas of sight restoration and join replacement.

I realize I'm coming to the end of my time, but I'd like to take a moment on behalf of the government to thank the people of Health Canada and the Public Health Agency, and all the medical practitioners on the front line, who have allowed us to really make such stark improvements in the health care system in such a short period of time. I hope for and look forward to the continued support of the official opposition in our government as we move forward.

The Chair: Dr. Dodds, there's still a minute and a half if you have any further comments you would like to bring forward.

[*Translation*]

Dr. Karen Dodds: Mr. Fletcher asked a question about the funds allocated to the provinces and territories. Each province received $10 million and each territory received $4 million.

[*English*]

The Chair: Mr. Fletcher, you have one more minute.

Mr. Steven Fletcher: Of the $612 million for patient wait times, maybe you could elaborate on how the provinces are spending that. There was an accusation that the money is being syphoned off for other things. But between fixing the fiscal imbalance and the health accord, is it not true that the provinces have received a significant amount of money to enable them to fulfill their responsibilities under the Constitution?

Ms. Krista Campbell (Senior Chief, Federal-Provincial Relations Division, Federal-Provincial Relations and Social Policy Branch, Director's Office, Department of Finance): In response to questions about the patient wait times guarantee, all of the funding has been provided to provinces and territories—the $612 million through the trust fund. In order to be eligible to receive funding, all provinces and territories had to make commitments on how they intended to use that funding. They are held to account by their auditors general and their health departments. They make announcements through their budgets and are ultimately held accountable for how they spend that funding by their citizens and their electorate.

The Chair: Thank you very much.

We'll now go to the second round, which is a five-minute round, beginning with Mr. Temelkovski.

● (1200)

Mr. Lui Temelkovski (Oak Ridges—Markham, Lib.): Thank you very much, Madam Chair, and welcome back.

Thank you to the presenters.

I would also like to thank the department for all the hard work. We're not as evil as the government makes the opposition out to be.

Of the overall budget of $42 billion that was to be spent on health care, how much was dedicated to the pharmaceutical strategy?

Ms. Krista Campbell: The government made a number of commitments under the new funding. There was an existing health transfer. An additional $41.3 billion was added, which included some short-term commitments for health care and pharmaceuticals. There was an increase in the base of the Canada health transfer of $500 million specifically for home care and pharmaceuticals. But the Canada health transfer, as a large unit, goes to the provinces and territories, and they report overall on how they use those funds. They're not expected to indicate that $12 from their total transfer went to *x*. It goes into their overall health budget, and then they allocate it according to their respective priorities.

Mr. Lui Temelkovski: So there's nothing specific that says to the provinces that they have to develop a pharmaceutical strategy with this much money as allocated to that specific issue. Right?

Ms. Krista Campbell: They have the commitments in the health accord, and they were given additional funding, but how they link the commitments and how they apportion the overall Canada health transfer is up to them to determine, according to their priorities, and then report to their public.

Mr. Lui Temelkovski: I understand a committee has been struck with regard to the national pharmaceutical strategy. Am I right?

Dr. Karen Dodds: There has been federal-provincial-territorial work specifically on the national pharmaceutical strategy. One of the ways in which the federal government supports it—and this committee has looked at the common drug review process—is to provide funding directly to the Canadian agency for assessment of health care technologies, which includes drugs and aspects of the common drug review.

Mr. Lui Temelkovski: Do they meet on a regular basis?

Dr. Karen Dodds: No.

Mr. Lui Temelkovski: Does this committee meet on a regular basis to—

An hon. member: There's not even a federal co-chair. Canada meets on a regular basis.

Dr. Karen Dodds: The FPT committee on the national pharmaceutical strategy issued a report in 2006.

Mr. Lui Temelkovski: So they have not met since 2006 to set their priorities and their goals and objectives?

Dr. Karen Dodds: I don't know whether the committee has met. We can give you information on meetings if you'd like. We continue to work with the provinces on forward-looking aspects of the national pharmaceutical strategy.

Mr. Lui Temelkovski: Maybe you can also provide us with the name of the co-chair of that committee as well, please.

Continuing on that, could you tell us what has been done to establish a common national drug formulary for participating jurisdictions?

Dr. Karen Dodds: As I noted, that would be the work that's done now under CADTH on the common drug review. It still remains that each province decides whether or not to take the recommendations from the common drug review.

Mr. Lui Temelkovski: Okay. Is there any development on the breakthrough drugs? It says here to accelerate access to breakthrough drugs—that was part of the program. Are you aware of any accelerated plans taking place to make these drugs available to Canadians?

Dr. Karen Dodds: I'm sorry, that's really more of a regulatory question, and I don't have the answers here. We'll get you an answer.

The Chair: Could you direct that answer to the clerk's office, and she can distribute it to all the members? Thank you, Dr. Dodds.

Mr. Lui Temelkovski: How about the purchasing strategies? It was mentioned in the accord that there will be purchasing strategies put together to assess best prices available to Canadians for their drugs. Has that review gone on, or where is it in the program? Has it been initialized? Is it in the middle? Is it near its final stages? We're also speaking on this in terms of vaccines as well.

● (1205)

The Chair: Dr. Dodds, could you give an answer to that for Mr. Temelkovski?

Dr. Karen Dodds: With respect to pricing and purchasing strategies, work has focused on non-regulated business management approaches such as price negotiations, and some provinces are exploring opportunities for multilateral buying groups. Also, the federal Competition Bureau undertook a study to examine the potential causes for the relatively high prices of generic drugs and how to make the markets work better.

The Chair: Thank you, Dr. Dodds.

Mr. Tilson.

Mr. David Tilson (Dufferin—Caledon, CPC): I understand the accord talked about primary health care. I think you mentioned some of that in your remarks.

There were governments committed to ensuring that they meet the objective of 50% of Canadians having 24/7 access to multidisciplinary teams by 2011. There were a number of other commitments made. Can you give us any details of the progress from the time the accord was made up until now with respect to those commitments?

Dr. Karen Dodds: All provinces and territories have implemented initiatives to meet those commitments. Indeed, in all jurisdictions, multidisciplinary teams have been set up. Almost all jurisdictions have set up 24/7 health information lines that are staffed by nurses and other health professionals who offer health advice.

Most jurisdictions are also continuing to implement primary health care renewal measures. In some cases, provinces are better coordinating various types of care services while others are improving chronic disease management.

All provinces and territories have accelerated the development and implementation of electronic health records and telehealth, in large part by working on projects with Canada Health Infoway, which has been funded with $1.6 billion in federal investments. Infoway and the provinces and territories have made significant advancements on this front—for example, 54% of diagnostic imaging exams are now filmless, and 67% of Canadians are now uniquely identified in client registries.

The Health Council confirmed in its February 2007 report that seven provinces and territories are on track to achieve the goal of 50% of residents having access to an electronic health record by or before 2010, although all provinces and territories are still working toward the 50% goal.

Mr. David Tilson: I'd like to add to the exchange between Ms. Wasylycia-Leis and Mr. Fletcher on this report. Obviously the report does indicate there is an improvement. Moneys come from the federal government. In Ontario, moneys also come from a health premium. I'm from Ontario. It got people all excited when they put forward that health premium.

My question is whether the provinces are pulling their weight. I mean, we're giving the money. We, the federal government, don't deliver health care. Whether it's wait times or whatever, are the provinces doing what they said they would do under this accord?

Ms. Krista Campbell: The provinces and territories have primary responsibility for the design and delivery of their health care systems. They are responsible for the choices with respect to the priorities they make and how they deliver services to their population.

Canada is a considerably decentralized federation, where provinces are able to levy taxes and, for the most part, decide the activities to tax within their jurisdiction. Determining whether or not provinces are pulling their weight and providing services the way people want to see them is a question for each of the populations in those provinces to challenge their governments on.

The federal government does have a role in terms of the Canada Health Act, a certain amount of national standards, encouraging mobility across the provinces, and ensuring that programs like equalization help provinces provide comparable services at reasonably comparable levels of taxation, but beyond that it really is up to the individual provinces to determine and to answer to their electorates as to whether they are doing enough.

They have made commitments. We are seeing progress. The funding is flowing the way it was intended to flow. Beyond that, as I stated, I think it is up to the provinces to determine.

● (1210)

Mr. David Tilson: You gave a good answer. That's normally an answer we give.

I have a question from this book you gave us. Tab 3 talks about wait times. Can you help me read these charts? It's full of dots, and I don't know what it means. Can you read them? I can't.

Dr. Karen Dodds: That would have been provided by the committee, not by us.

Mr. David Tilson: By the committee.

The Chair: Okay. Thank you very much.

We will now go to Monsieur Ménard.

[*Translation*]

Mr. Serge Ménard (Marc-Aurèle-Fortin, BQ): Thank you, Madam Chair.

Thank you for coming here.

I am probably going to continue talking about something we talked about a lot this morning, but about which there is really very little I could tell a constituent who asked me about wait times. The work that has been done is unquestionably considerable and respectable. It shows that we are living in a wealthy country, we have to acknowledge that, and that health care is a matter of concern. As well, like other wealthy countries, particularly the European countries, and not entirely like our neighbours to the south, we are concerned that all Canadians be equal when it comes to illness and that they be able to benefit from scientific developments. So this can be a very positive thing. Generally speaking, the public recognizes that we have a good health care system, that when we enter the health care system we are well cared for, with empathy and with all the technical and scientific quality that can be provided today.

The objective of everyone being equal when it comes to illness means that many people have to deal with lengthy delays. This is the main subject about which we hear criticism from the public. The government was aware of this. All the politicians were aware of it, when they wrote the 10-year plan. If I remember correctly, they allocated $5 billion dollars to this in the plan. My constituents would like to know whether this is producing results.

I have been listening to you since this morning and I don't really know what to tell them to persuade them. I can tell them that we have gone from C to B, to C- or D, and so on. People don't understand things that way. What people do understand, and I realize it can be difficult to find, is what the newspapers often give us. For this surgery, there are so many weeks of wait time. For that disease, there are so many weeks or months of wait time. This morning we learned that it took five years to get a sleep apnea diagnosis.

Could you tell me, framing it in that kind of way, where there has been progress? What progress? What was the wait time when the program started? What is it now? What is the wait time objective? I think it would be a good idea to have an average, if you can give one, but I imagine it depends on the topic. Could you help me here? Could you explain, as you did to the person who spoke before me, what I can look at on the table? How can I simplify it so I can respond to my constituents' main concern?

Dr. Karen Dodds: I can give you a few specific or concrete examples, and I will start with Quebec.

● (1215)

[*English*]

Long waits for cataract surgery and hip and knee surgeries have declined very sharply. In Ontario, between November 2004 and April 2007, wait times for hip replacements dropped by 27%, or 94 days, while waits for knee replacements fell 30%, or 133 days. Wait times for cataract surgery decreased 41%, or 128 days.

In Nova Scotia, women aged 50 to 69 are getting mammograms at nearly double the rate they did at the start of the decade.

In Alberta, 90% of patients were receiving cardiac bypass surgery within 11 weeks in November 2007, down from 17 weeks a year earlier.

So those are a few specific examples that I think citizens would relate to.

[*Translation*]

Mr. Serge Ménard: If I tell them what you have just told me, they will probably ask me whether those are not the best results. How do we judge it overall? What is the answer? The people who spoke before me told you that the tables you give us in the reports incomprehensible. Could you tell us what to read in the report and perhaps give us an explanation ...

[*English*]

The Chair: Your time is up.

Dr. Dodds, perhaps you could just answer that question for Monsieur Ménard.

Dr. Karen Dodds: If you want specific information across Canada, the Health Council of Canada has an annual report and the Canadian Institute for Health Information has a 2007 report on wait times.

The Chair: Thank you, Dr. Dodds.

Mrs. Davidson.

Mrs. Patricia Davidson (Sarnia—Lambton, CPC): Thank you, Madam Chair.

Thanks very much to our presenters and panel here this morning and this afternoon for helping us try to understand and evaluate this accord. It's certainly an important issue.

Although we're only into the fourth year of this accord, there are a lot of questions that not only this committee but the public, the people, are asking.

I have three or four questions. Maybe I'll just put them out and give you an opportunity to respond.

One of the things I want to ask about is in regard to wait times in the targeted areas. We've seen that there are improvements in the targeted areas, but is that having any negative impact on untargeted areas? I think that's been rather inferred here this morning. I'm not sure anybody has addressed it, so I'd like to hear that.

Also, another issue that Dr. Bennett brought up was in regard to the data collection. She rightly referred to the fact that she could be considered in that physician count, when in fact there may be physicians included who are not practising physicians. Is this different from the way the data was collected before, or are we comparing apples to apples or apples to oranges when we talk about the increase, the growth in the numbers? I need that clarified.

One other thing was the provincial obligations. I understand that, in many respects, health care delivery is the responsibility of the province. The federal government transfers the funds and the provinces spend them. Are some provinces doing things differently? Have some provinces met their obligations more closely in human resource areas as opposed to wait time guarantees, or is it standard across the country?

My final comment is that since this is a ten-year plan and we are in our fourth year of it.... When I look at the indicators in this report card—and I'm seeing it for the first time, just fifteen minutes ago—I see that access indicators have gone from inconclusive to C plus; establishing the wait time benchmarks has not moved, but establishing the timetable to achieve those benchmarks has gone from a D to a C plus; and collecting and disseminating wait time information has gone from a C to a C plus.

I think there has been a considerable amount of movement in four years of a ten-year plan, but maybe my expectations aren't as high as those of some others. How do you feel about it? Did you have higher expectations than this? Do you think there's movement there too? Those are my questions.

● (1220)

Dr. Karen Dodds: I'll start. I'll take them in the order in which you put them.

Dr. Bennett suggested that the attention on wait times in specific areas could be having a negative impact on other areas. Indeed, information from the Canadian Institute for Health Information indicates that is not happening, that the attention on wait times in certain areas is not then extending wait times in other areas. So the information is that this is not happening.

With respect to data collection, what we did have and what we do have, I think this is one of the big advantages of starting to focus attention on a certain area. It's clear, for example, that before you had a commitment to address wait times, probably most provinces couldn't even tell you what the wait time was. There are still discussions about what the definition of a wait time in a certain area is.

So in all of the areas of health, the data are improving. The discussion and the work on just starting to measure things is improving our data and our understanding. I think that's an enormous benefit, and that is certainly going to benefit areas beyond the targets. Again, you see some of that reflected in the Wait Time Alliance report card, and if you talk to organizations such as the Canadian Institute for Health Information, they'll tell you the same thing, that the quality of data and the reproducibility of data province to province is improving with time.

In terms of provincial obligations, a number of members have noted that the provinces themselves are responsible for how they organize and deliver services. So we do see different undertakings in different provinces. A lot of that can even simply reflect demographics. The Atlantic provinces, with the more senior population, an older population, will do things differently from Alberta and British Columbia, which might have a younger population. Again, I would refer you to the Health Council for their reports by province on what's going on.

The Chair: Thank you very much, Dr. Dodds.

Ms. Wasylycia-Leis, please.

Ms. Judy Wasylycia-Leis: Thanks, Madam Chairperson.

Let's go back to health human resource strategies for a moment. I know you've said that there is money that will continue, but I didn't get any answer about a plan. I think we really need to know where the focal point in the federal government is with respect to this dire situation—a serious shortage on many, many fronts. Just today the Canadian Society for Medical Laboratory Science held a press conference and talked about the critical shortage there and the fact that half of our technologists are eligible to retire in eight years, yet there's no plan to recruit and augment and ensure an adequate supply of technologists, who are vital for the whole system.

For my first question, one of the concerns of this organization is that a focus on clinical education was part of this 10-year accord and part of the health human resource strategy. According to this organization, there's a significant shortage of clinical instructors. Once someone in this field has completed the initial training and goes into the clinical world, we just don't have the capacity to provide them with on-the-job training and education. That's something that's been raised for many years as part of the health human resource strategy.

Where is that issue of clinical instruction in the health human resource strategy specifically, and where is the plan for dealing with shortages in all health care professional fields for the next five years?

Dr. Karen Dodds: The action plan builds on the pan-Canadian health human resource strategy, which was established in 2003. One of the most successful aspects of that strategy has been ongoing collaboration that occurs through an FPT process and includes stakeholder engagement. Collaborative efforts are being used to share and centralize data, identify barriers, and share best practices among participants. Obviously, the planning is to work to help ensure an adequate supply and an appropriate mix of health care professionals. It builds on work, on health labour relations and information on health sector labour relations collected in the health cross-jurisdictional labour relations database, and on work on interdisciplinary or interprofessional education and investments in post-secondary education. This includes federal funding through the interprofessional education for collaborative patient-centred practice initiative. This is to ensure that nurses can work with doctors, physiotherapists can work with nurses, that all of the different health care professionals can work well together.

● (1225)

Ms. Judy Wasylycia-Leis: The problem, in the case of technologists, is having adequate instruction capacity to equip them to take on this profession on a certified basis.

What has been done on what has already been identified as a problem? Is the federal government putting some resources into provincial systems to augment clinical education instruction? Is the government putting in place a fund to help ensure that there are more training places for nurses? Is there a fund in place to augment the number of spaces available for doctors?

This is not a foreign idea. This is something the Canadian government has done in the past. It has played an active role in terms of actually augmenting training capacity and education opportunities to ensure that we won't have a serious shortfall, which we are facing. It's imminent.

We need a sense of urgency from the federal government. There has to be some focal point, a locus of activity, a strategy, money, an idea—anything—that you could convey to us today.

Ms. Krista Campbell: There is, and the funding that's provided to provinces and territories though the Canada health transfer is available for health human resources to address the various pressures they're facing.

Ms. Judy Wasylycia-Leis: Is there money beyond that for this particular issue?

The Chair: I'm sorry, Ms. Wasylycia-Leis, your time is up.

Can you just quickly finish in the next few seconds?

Ms. Krista Campbell: In addition to the Canada health transfer, there was the $5.5 billion provided to provinces and territories for wait times reductions in the 2004 plan. The initial upfront payment of $4.25 billion, made through a trust fund, was to jump-start some of the wait times issues. The $250 million transfer that will be ongoing as of 2009-10 specifically targets health human resources strategies. It is to help ensure that the progress made on wait times, and continuing and ongoing progress on wait times, has dedicated funding for health human resources.

The Chair: Thank you, Ms. Campbell, for your very insightful and concise comments.

We'll go to Mr. Khan.

Mr. Wajid Khan: Thank you, Madam Chair, and thank you for being here today. This is my first day on this committee and I've learned a lot.

Given the comments Ms. Wasylycia-Leis made about health care workers, I hope we can count on their support for Bill C-50, an immigration bill. That is one way of bringing in technicians and nurses.

An hon. member: [*Inaudible—Editor*]

Mr. Wajid Khan: Yes, that's why I'm asking for your support.

How is the Government of Canada helping Canadian innovation to be brought to market?

Second, some comments were made about the general transfer of funds to provinces and territories. Specifically, what funds are being transferred, and how, to the Province of Ontario?

Dr. Karen Dodds: I'll start with your question about health innovation and research.

The Government of Canada has provided, since 2004, $440 million in new funding for health-specific innovation and $1.6 billion in new funding for innovation with a health component.

They have focused on four pillars of research innovation. They cover direct costs of research, mainly through the Canadian Institutes of Health Research. Through Budgets 2006, 2007, and 2008, the annual base budget for the Canadian Institutes of Health Research has increased by 17.5%. It's now at $820.1 million. It includes indirect costs for research through the support of post-secondary institutions across the country. There's funding that goes directly to people—to students and researchers who excel. It also goes to infrastructure, chiefly through the Canadian Foundation for Innovation, which has invested $3.75 billion in infrastructure projects across the country in the last decade.

On the specific provinces, my colleague will....

● (1230)

Ms. Krista Campbell: With respect to funding for Ontario, Ontario receives about $4.1 billion this year through the Canada health transfer. They receive funding under the recently launched HPV immunization trust. The patient wait times guarantee trust, launched in Budget 2007, as well as ongoing funding through the 2004 wait times reduction trust, establishes part of the accord.

We can leave the exact figures for those, but they're also available on the Department of Finance's website.

Mr. Wajid Khan: Thank you very much.

Do I have more time?

The Chair: You have two more minutes.

Mr. Wajid Khan: I've got lots of time. That's good.

If we look at this Wait Time Alliance report card—do you have that in front of you?—on page 1, if you go to Ontario, it shows A for hip, A for knee, A for cancer, and A across. Could you tell me if this is the actual grade or if this is the difference between where it was and where it is today? How would you read that chart for Ontario?

A's all across—that's perfect, top of the class.

Dr. Karen Dodds: The A's indicate that 80% to 100% of the population is getting treatment within the benchmark.

Mr. Wajid Khan: That's a pretty good score, wouldn't you say?

Do you believe that the wait time targets that are set for 2010 and 2011 are attainable, keeping in mind the current progress?

Dr. Karen Dodds: Again, each province has set a specific priority area, and we do believe they will meet their commitments by 2010. For example, in Ontario, the priority area is cataract surgery, and the timeframe is 26 weeks. Quebec has four priority areas. For cancer, radiation therapy, eight weeks is the timeframe. For joint replacement and cataract surgery, it hasn't yet specified a timeframe. So again, the priority area and the timeframe are known.

Ms. Krista Campbell: I apologize. If I could just correct the record for the committee—too many very small numbers on my tables. Ontario's Canada health transfer is $8.6 billion.

Mr. Wajid Khan: Thank you very much for the correction.

The Chair: Thank you very much, Ms. Campbell, for your correction and for your insightful comments.

We'll now go to Mr. Dhaliwal, who will be sharing his time with Ms. Bennett. You only have five minutes.

Mr. Sukh Dhaliwal (Newton—North Delta, Lib.): You could give four and a half minutes to me and thirty seconds to her.

The Chair: I would be very careful to keep to that time.

Mr. Sukh Dhaliwal: Thank you, Madam Chair.

Welcome to the talented members of the panel here. I'm not going to go into politics. I'm going to be very direct. Otherwise I can talk for hours, as Mr. Fletcher said earlier.

Last time the Minister of Health was here, he did not have answers to these questions that I'm going to ask you. How many millions of people in Canada do not have a doctor, a family doctor, available to them? Can you give me the numbers, please?

Dr. Karen Dodds: The data would indicate 4% of Canadians.

Mr. Sukh Dhaliwal: I'm looking for how many millions. Can you tell me in terms of numbers, so people can easily understand?

Dr. Karen Dodds: Our colleague at Finance has done the math and says it's 1.3 million.

Mr. Sukh Dhaliwal: It's 1.3 million people without a doctor. Can you tell me how many foreign graduates in Canada are not practising medicine?

Dr. Karen Dodds: We wouldn't have that number. I don't think we'd have a way of getting that number.

Mr. Sukh Dhaliwal: Are you aware that part of this wait time guarantee is the shortage of medical professionals?

● (1235)

Dr. Karen Dodds: I'm not sure I exactly understand the question.

Mr. Sukh Dhaliwal: When we say that wait times are getting longer and longer, part of the problem is that we are short of medical professionals.

Dr. Karen Dodds: Well, the discussion we've had this morning and the information that a variety of parties have tabled indicate that wait times are getting shorter and shorter.

Mr. Sukh Dhaliwal: I'm not asking you that.

This is why I wanted to be sure. Part of the problem is a shortage of medical professionals. Answer yes or no, please.

Dr. Karen Dodds: I think the attention given to health human resources, the fact that the federal government provides $38 million ongoing to the provinces for health human resources, indicates that, yes, we understand there are pressures, and the provinces do what they feel is best in terms of health human resources.

Mr. Sukh Dhaliwal: That's good.

I'm going to go back to this. This government tried to create an agency. It made a promise in the last election campaign, but it has broken that promise. Instead it created—

An hon. member: I thought you didn't want to get into politics.

Mr. Sukh Dhaliwal: It's not politics. I'm coming back to my question.

Instead it created an agency. I've travelled to many countries—Europe, Eastern Europe, South Asia—and I see the medical professionals there are qualified either equally to the Canadian standards or better. I see a lot of people from Canada going to those countries to get that medical—

The Chair: Mr. Dhaliwal, three minutes is up. You're going to share your time with Dr. Bennett.

Mr. Sukh Dhaliwal: I said four and a half.

Over 6,000 Canadian-born students are studying medicine, and instead of coming back to this country they go to the U.S., because the United States has its act together. Here the federal government is not getting its act together to create residency spots for those Canadian-born students who have a medical education across this globe. What is this government doing to solve that problem?

Dr. Karen Dodds: I would like to raise two points.

The first is there is an initiative and funds for bringing back to Canada and recognizing the internationally educated health care professionals. The latest statistics I'm aware of are that recently more Canadian-born physicians have returned to Canada than have left Canada for the United States.

Mr. Sukh Dhaliwal: That's not true.

Mr. Yves Giroux: If I may add to that, the recognition of foreign credentials is the jurisdiction of provinces and territories. What the federal government can do in that respect is somewhat limited. However, we have set up an office for the recognition of foreign credentials to help people be referred to the appropriate authorities in the provinces and territories.

Hon. Carolyn Bennett: I have found this pretty disappointing in terms of what the department has presented. Because all the funding arrangements, as it says in the accord, require that jurisdictions comply with the reporting provisions, I would like to move that the officials prepare a formal report addressing the progress on each of the ten aspects of the 2004 health accord and provide it to the clerk by May 1, 2008, so we would be able to read it before we deal with this on May 6. That would include a breakdown of the wait times funding, the $5.5 billion, breakdowns on the progress on wait times in each province and territories in all five priority areas in the 2004 —

The Chair: Dr. Bennett, if you would bear with me, Mr. Fletcher has a point of order.

Go ahead, Mr. Fletcher.

Mr. Steven Fletcher: Thank you, Madam Chair.

I think we need to focus on the witnesses. I don't believe a motion is appropriate at this time. We have just begun our hearings. If we can continue with the questioning, I have some questions. I think we should just move forward in the format we've agreed to.

● (1240)

The Chair: Thank you, Mr. Fletcher.

One moment, Dr. Bennett.

That motion is in order. It is something you can do at this point. However, we do have witnesses today. The fact of the matter is we are here to listen to those witnesses. This is not an appropriate time for debate, but perhaps we could have that debate at another meeting.

Dr. Bennett.

Hon. Carolyn Bennett: No, let's just vote on it right now and then we will know that the officials will prepare....

An hon. member: Question.

Some hon. members: [*Inaudible—Editor*]

The Chair: Order, please.

We can vote on it right now. It is within the parameters of the committee.

Mr. Fletcher.

Mr. Steven Fletcher: Madam Chair, this is very unusual. I have been on this committee now for almost four years. I don't recall any occasion where a motion was brought forward in the middle of a presentation of witnesses. Moreover, I think the motion is premature in that we haven't even finished hearing from the witnesses.

The Chair: One moment, please.

We will hear from Dr. Dodds, first of all, but the fact of the matter is the question can be put. It is something that can happen.

Dr. Dodds, did you have a question?

Dr. Karen Dodds: The Health Council of Canada is to report on progress on matters under the accord. Their last report was November 2007. Their next report is expected in three weeks. We would be very happy to provide the committee with the past report and the new one when it's published.

The Chair: Thank you.

Will this resolve the matter? You have the answer.

Hon. Carolyn Bennett: No.

The Chair: The report will be out in three weeks.

Hon. Carolyn Bennett: That would not be acceptable. The Health Council of Canada is allowed to report only on the jurisdictions participating in the council. I think those binders the department has there show that they have done an analysis of progress on the accord. I would like them to table their analysis of progress on the accord, with both finance and health considerations.

The Chair: Mr. Khan.

Mr. Wajid Khan: Dr. Bennett's intent is welcome, and I guess she has the right to put the motion. No problem there. But as the parliamentary secretary stated, the witnesses are here and we ought to listen to them rather than going into a debate on this issue.

The Chair: Mr. Khan, Dr. Bennett is within her right to put the question forward. I will say as chair of this committee that we have important witnesses here that we should be listening to. To my way of thinking, going into a debate between committee members right now is not a respectful thing to do.

I will put the question forward.

An hon. member: [*Inaudible—Editor*]

The Chair: I have just clarified with the clerk and we cannot table the motion, Mr. Tilson. We can vote on the question right now.

All in favour?

(Motion agreed to)

The Chair: I have to express my apologies to the witnesses. You know what it is like in the political world. We are very interested in what you have to say to the committee today, and we would certainly like to continue.

Mr. Fletcher.

Mr. Steven Fletcher: Thank you, Madam Chair.

I think the fact that the report is going to come down in three weeks should have alleviated the concerns of the member from St. Paul's.

Mr. Dhaliwal, who is visiting, may not appreciate that residency spots and medical graduates fall within provincial jurisdiction. What doesn't fall within provincial jurisdiction is people from abroad trying to get into the country. Our immigration bill is designed to ensure that people with skills in the medical area—doctors, nurses, and others—will be able to get into the country and not have to deal with the 800,000-person waiting list that we inherited as a government.

I wonder if you could explain the IMG program and what the government is doing to encourage people with the proper qualifications to come to Canada. A lot of the provinces have received a tremendous amount of money through transfer payments to help create residency spots. I know that's the case in Manitoba, and I believe it's happening in other places. As a matter of fact, Manitoba just announced $5 million today.

I have another question dealing with the Health Council of Canada.

● (1245)

[*Translation*]

How much money does the federal government allocate to the Health Council of Canada? Is it enough?

[*English*]

I wonder if you could also expand a little bit more on what Health Council reports and other reports the health committee could expect shortly that we would find helpful.

Thank you, Madam Chair.

Dr. Karen Dodds: Thank you.

The internationally educated health professionals initiative has been established to accelerate and expand the assessment and integration of internationally educated health professionals into the health care system. The federal government has committed $75 million over five years to this initiative. We work with the provinces, whose responsibility it is to integrate them into the health human resource population within the province. They also have the $18 million per year on the health human resource strategy itself that they can use for that impact.

In terms of the Health Council, they can draw up to $10 million per year. I believe in the last year they drew under $7 million, so it's clear that their funding is adequate for what they want to do. They can continue to increase their draw to a maximum of $10 million per year.

Health Canada does not have a mandate to collect information from the provinces. It was the Health Council of Canada that was given the mandate, with the health accord, to do the reporting at the provincial and territorial levels. As I said, their next report is expected out in about three weeks' time.

Mr. Steven Fletcher: Do I have any time left?

The Chair: You do, Mr. Fletcher. You have two minutes.

Mr. Steven Fletcher: The Canadian strategy for cancer control is something the Conservative Party championed when we were in opposition and the government at the time refused to implement. Now that it's fully funded and moving forward, I wonder if the witnesses can comment on the strategy and the progress there. Of course, cancer is a huge issue. There probably isn't a single Canadian alive who hasn't been touched by cancer in some way.

I'd also like to give an opportunity to the witnesses. They have witnessed an exchange, a debate. I think there were some facts that were not correct or that were missing. I'd like to give the witnesses an opportunity to address any errors or omissions found in the presentation of the other parties.

Ms. Jane Billings: With respect to what the federal government is doing with cancer, certainly preventing and managing cancer is complex. It requires the collaborative efforts of the entire cancer community across the country.

The Government of Canada has a long history of working with a broad range of partners in cancer control. Some specific examples of federal efforts to fight cancer include $300 million over three years for provinces and territories to support the launch of a national human papillomavirus vaccine program to protect women against cancer of the cervix, and the $124.8 million investment in cancer research by the Canadian Institutes of Health Research in 2006 and 2007, with a total of almost $650 million invested in CIHR cancer research since 2000.

In addition, Budget 2006 committed $260 million over five years to the implementation of a disease-specific strategy known as the Canadian strategy for cancer control, which will be implemented by the Canadian Partnership Against Cancer.

Further, our healthy living and chronic disease initiative supports an integrated approach to chronic diseases by addressing common risk factors for cancer, such as unhealthy eating, unhealthy weight, and physical inactivity.

● (1250)

The Chair: Thank you, Dr. Billings.

Could we now go to Monsieur Malo.

[*Translation*]

Mr. Luc Malo: Thank you, Madam Chair.

I could go back to the plans and strategies that we consider, and the Government of Quebec considers, to be interferences in matters under the jurisdiction of Quebec and the provinces, but I would rather directly address an aspect of health care that the federal government is specifically responsible for. I am referring to the entire question of Aboriginal health care.

At page 79 of tab 5 of the report, I read what the governments promised:

> Develop Aboriginal health reporting framework. ... What we know/don't know ... Unclear if funds have been released. ... Aboriginal health reporting framework will be completed by 2007, with reporting to begin in 2010-2011. ... Status is unclear. ... Aboriginal health blueprint released in November 2005 with an additional $1.3 billion for health initiatives. ... Status is unclear. ... Targets to reduce infant mortality, youth suicide, childhood obesity and diabetes by 20% in 5 years and by 50% in 10 years. ... Status is unclear. Many jurisdictions have programs to address health disparities faced by Aboriginal peoples, but these programs are not coordinated through a national strategy.

When I read all that, I get the impression that they are trying to solve problems that are connected with things under the jurisdiction of Quebec and the provinces rather than clearly and directly tackling the question of what the government should be doing, which is looking after the populations for which it is responsible when it comes to health care, that is, Aboriginal people.

Can you explain why we don't know anything and why nothing of what was promised is clear?

[*English*]

The Chair: Who would like to take that question?

Mr. Potter.

Mr. Ian Potter: Madam Chair, I can respond to that question, and thank you very much for it.

I am not certain of the member's concern with respect to the lack of reporting. We have been reporting, on an annual basis, our activities, and we could provide further information to the chair for your perusal.

With respect to the commitments for aboriginal health, it is not an exclusively federal-provincial area. It's an area of mixed responsibility, and therefore much of the work we have done is in clear partnership with provinces, territories, and aboriginal people.

The government has increased its expenditures on the first nations and Inuit health branch from 2004-05, the year of the accord—when it was $1.677 million—$100 million, to the budget tabled estimates for this fiscal year 2008-09, of $2.37 million. That is a 54% increase in the budget, an average increase of 9%.

In the accord there was a provision that the federal government commit $700 million over the next five years for a number of initiatives: an aboriginal health transition fund; an aboriginal health human resources initiative, which I spoke of earlier; and programs with respect to suicide prevention, diabetes, maternal child health, and early childhood development.

Those programs, I'm pleased to say, are operating well. As I said, they require partnerships and collaboration with the aboriginal organizations and provinces. The aboriginal health transition fund has agreements with all provinces on partnerships for improving and adapting the programs of the federal and provincial governments to better serve aboriginal populations.

And we were pleased to be able to sign an agreement with the Government of British Columbia for a new tripartite plan, which will bring a new type of benefit to the health services for aboriginal people, collaborating with and making more efficient and effective the programs that are run by the three different groups at the moment.

Thank you.

● (1255)

The Chair: Thank you, Mr. Potter.

Your time is up Monsieur Malo.

Mr. Tilson.

Mr. David Tilson: Most of you have assisted two administrations—the Liberal administration and now the Conservative administration. I wonder if you can tell us about the areas with respect to the accord and the progress thereof that you're proud of.

The Chair: Who would like to respond to Mr. Tilson?

Ms. Arlene King (Director General, Centre for Immunization and Respiratory Infectious Diseases, Public Health Agency of Canada): Thank you very much, Mr. Tilson, for your question.

I think there are two key areas where there has been significant progress made. One is in the area of preparedness for infectious disease emergencies, specifically a pandemic preparedness. There was a million dollars invested in 2006, and considerable progress has been made not only with the development of our Canadian pandemic plan, but also as components of that progress on a pandemic vaccine strategy, which will enable all Canadians to have access to a pandemic vaccine as quickly as possible in the event of a pandemic.

In May 2006 there was a federal-provincial—territorial health ministerial agreement to achieve a stockpile for early treatment with anti-viral drugs in the event of a pandemic—a 55-million-dose target—and we have achieved 53 million doses within that stockpile. We are only two million doses short because we have not yet determined what pediatric formulation of drug would be optimal for that stockpile.

Additionally, I think the area of health human resource capacity has also been addressed through pandemic funding, particularly in public health. I want to talk about the fact that we do have 23 federal health workers supporting surveillance and outbreak investigation in provinces and territories right now, and through the pandemic funding that was allocated in 2006, we will be achieving approximately 53 full-time equivalents in provinces and territories to support public health capacity development, which I think is really very important.

I also would like to talk a bit more about our international contributions as well as pandemic planning. We all know that pandemics are in fact by definition a global event. We've contributed $106 million to international pandemic preparedness, and we certainly have been recognized by the WHO as a global leader in pandemic planning. I think it's something we all need to be very proud of.

On another note, I'd like to talk about immunization because we know that immunization is among the most cost-effective and effective strategies for improving health in the population.

The Chair: Dr. King, I just have to tell you that we are about to adjourn, so perhaps you want to say a couple of words about that, and then we will have to stop.

● (1300)

Ms. Arlene King: Two key investments in immunization were made. One was in Budget 2004, and that covered four vaccines. I'm pleased to say that all jurisdictions have implemented programs for all four programs, and we look forward to data coming as a result of the impact of those four programs. It's a critical initiative.

The other is the HPV immunization fund, which has been really important and was lauded by the Society of Obstetricians and Gynaecologists of Canada as being an important initiative. To date so far, we have four provinces that have implemented programs and five other provinces and territories that have announced their intent to implement programs this year. So I think this is very important for women's health.

Thank you.

The Chair: I want to say a special thank you to the witnesses. As Mr. Khan said, we learn so many new things every day being on this committee, and you've really added a lot to that bank of knowledge. I want to especially thank you.

The meeting is adjourned.

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