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Chair

Mrs. Joy Smith

Standing Committee on Health

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● (1100)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): Could I ask all the members to take their seats. We have a lot of witnesses to listen to today for their very important testimony. We also have some business at 12:50 p.m., so we will be going until 12:50 p.m. and then we'll go in camera for committee business.

I would like to welcome the witnesses to the health committee this morning. We're very pleased that you could make it and very pleased that you're going to give us some of your insightful comments and expertise on this important topic.

Pursuant to Standing Order 108(2) and the motion adopted by the committee on March 13, 2008, section 25.9 of the Federal-Provincial Fiscal Arrangements Act, this is our third meeting on the statutory review of the 10-year plan to strengthen health care.

Before we begin, I want to mention that we have some committee business scheduled for the end of the meeting—a steering committee report and three budgets to pay witness expenses. It is very important that we get through this business following the presentations.

The organizations that will be taking part in the first panel are the Canadian Healthcare Association, the Wait Time Alliance, the Association of Canadian Academic Healthcare Organizations, the Canadian Generic Pharmaceutical Association, and Canada's Research-Based Pharmaceutical Companies (Rx & D).

We will begin with Ms. Pamela Fralick, president and CEO of the Canadian Healthcare Association.

Pamela, could you begin.

[*Translation*]

Ms. Pamela Fralick (President and Chief Executive Officer, Canadian Healthcare Association): Thank you, Madam Chair.

I am going to give my presentation in English rather than in French so that it is shorter. But I am always prepared to answer questions in French.

[*English*]

Thank you very much for this opportunity, and congratulations to the committee for doing this review. We view the accord as one of the very fundamental pieces of the health system right now. It's important that we maintain vigilance on it.

The Canadian Healthcare Association was very active during the 2004 proceedings. We contributed, we believe, to positive outcomes of the accord, including the predictable funding and direction for setting benchmarks. This 10-year plan that we're reviewing has been instrumental in putting Canada's health care system back on track. However, the system is not yet where we need it to be. As we review the accord, we'd like to emphasize that the delivery of services is not only about access and quantity but also about safety and quality. We have four items to bring to your attention in today's session.

The first is wait times. Our Wait Time Alliance colleagues are going to speak on this in much more detail. While we're prepared to respond to any questions, at this point we'll simply emphasize two points: first, the five priorities identified in the accord are a beginning, not an end; second, appropriateness and quality of care must also be a priority, even as we address access and quality.

The second issue is health human resources. The shortage of health human resources is not just a Canadian problem; it's international in scope. It remains serious, and it points to a crisis. The pan-Canadian framework on health human resources, developed under the auspices of the FPT advisory committee on health delivery and human resources, is a strong and necessary framework. We are, however, concerned that its implementation is not receiving the attention and support from all stakeholders that it must have to succeed. In particular, Canada requires multi-stakeholder coordination of our HHR activities that transcends geographic, professional, and political boundaries in order to address the critical issues related to health human resources.

The third issue is electronic health records. EHR is pivotal for moving forward on health renewal priorities. I'd like to quote the 2004 accord, which said that the accord is committed to:

> realize a vision of the Electronic Health Record through an ambitious plan and associated investment.

Canada Health Infoway investments now total $1.6 billion. However, the return on investment is estimated to have gross benefits exceeding investment dollars by an eight to one margin and to generate close to $40 billion in savings. CHA would like to reiterate its position that resources for an EHR must be allocated to allow for equitable coverage of all Canadians.

Our third point of emphasis is home care. The 2004 accord provided funding for post-acute and palliative home care. While that is a tremendously positive start, we think it is narrow and unrealistic as a view of home care in Canada. CHA continues to advocate for programs to provide both acute care replacement services and long-term home care. In the studies we reviewed, chronic home care was demonstrated to be significantly less costly than care in a long-term care facility. However, most home care is provided by informal, or unpaid, caregivers. One very impressive statistic tells us that 41% of Canadians who had to respond to home care needs within their family were forced to use personal savings just to survive. Canada's approach to home care must include continuing care as well as post-acute care.

Our fourth and final item for today is federal fiscal responsibility. Canadians legitimately expect to have access to comparable health services, regardless of the jurisdiction in which they reside, and the Canada Health Act commits to this. Since jurisdiction over health delivery is a provincial–territorial responsibility, some argue that the federal government should provide only the funding, without linking it to conditions or objectives. However, the federal government has a constitutional right, and some would say a duty, to use its spending power to achieve health objectives for the good of all Canadians. The people of this country rightfully expect pan-Canadian objectives to be developed and supported by all levels of government, and they are less concerned, frankly, about the ultimate source of the funding. Any move to minimize federal responsibility would have a negative impact on future pan-Canadian programs. These programs include a national pharmaceutical strategy, appropriate health human resources, and an EHR—all of which were identified in the accord. CHA would add home care to this list.

In conclusion, with respect to HHR, a strategy does exist. It needs our attention, all-stakeholder buy-in, prioritized funding, and most of all pan-Canadian coordination. With respect to the electronic health record, it is emerging in a fragmented manner that will not serve Canadians well.

● (1105)

To truly address patient safety and create efficiencies in the system, we must commit to a pan-Canadian HHR.

Home care—

The Chair: Thank you, Ms. Fralick.

We'll now go to Dr. Lorne Bellan and Dr. Jean-Luc Urbain, from the Wait Time Alliance.

Dr. Lorne Bellan (Co-Chair, Wait Time Alliance): Thank you very much.

Good morning, everyone.

I'm an ophthalmologist from Winnipeg, and Dr. Urbain is a nuclear medicine physician from London, Ontario. We are pleased to be here today on behalf of the members of the Wait Time Alliance.

Our presentation today will cover three areas: the WTA's overall assessment of the implementation of the 10-year plan to strengthen health care; key barriers to making further progress in reducing wait times in these five areas and beyond; and, finally, moving ahead, the next steps government should take to ensure Canadians have timely access to quality health care.

The most recent national grades for wait times are listed in table 1 of the WTA's 2008 report card and include: in joint replacement, a B for hips and a C for knees; in radiation oncology, an A; in cataract surgery, a B; and for bypass surgery, an A.

Overall, national grades are just part of the picture in terms of assessing wait times. Therefore, the WTA has provided performance trends in the five priority areas. In some instances, where wait times are not decreasing, resources are being increased that should either lead to future wait time reductions or handle surging demand to prevent further increases in wait times.

While progress is being made to reduce wait times in the five priority areas, more can and should be done. The 10-year plan makes a number of commitments regarding wait times, including the development of access indicators, benchmarks, multi-year targets, and reporting on progress. In these areas, commitments have only been partially met, at best.

While provincial and territorial governments did adopt benchmarks in December 2005, they did not include benchmarks for diagnostic imaging nor did they honour their commitment to cardiac care. The current benchmark for bypass surgery fails to recognize the continuum of care for cardiac patients. Because of this, wait times are not being meaningfully addressed in cardiac care.

The current benchmark of four weeks for radiation therapy from “ready for treatment” until the start of treatment differs significantly from the WTA recommendation of two weeks. The benchmark also does not reflect the research evidence that found wait times for beginning radiotherapy for treatment of all types of cancers should be as short as possible.

Also, some provinces have still not indicated goals for meeting their wait time benchmarks. While most provinces are making progress, it is not equal progress across the spectrum of care, and we are concerned that some provinces may not have the necessary funding, structures, and processes in place to ensure that the reductions can be maintained.

Moving to our second area, the WTA has identified three key barriers that continue to undermine the progress being made and our ability to accurately record that progress: one, clarifying and standardizing wait time definitions and criteria among provinces; two, improving the collection and dissemination of wait time information to the public; three, lack of progress in addressing health care workforce and infrastructure capacity issues.

Governments continue to use different starting points to measure when wait times actually start. There is also huge variation in the quality of reporting by governments on wait times, and governments have not adequately addressed the most significant barriers to timely access, that being the shortage of providers and system capacity.

Dr. Urbain.

● (1110)

Dr. Jean-Luc Urbain (Co-Chair, Wait Time Alliance): Thank you very much.

[*Translation*]

Being able to document progress in reducing wait times for access to health care in the five key areas listed in our brochure is encouraging. But it is not reasonably possible to limit access to health care to only five areas. Taking care of the medical needs of Canadians requires us also to deal with and evaluate access to other specialties such as emergency care, psychiatric care, plastic surgery, gastroenterology, pain management, gynecology and obstetrics.

The entire medical profession in Canada is well aware of the complexity of Canadian health care. We are all equally convinced that, in the 21 st century, Canadians deserve to have quick and easy access to the health care system. We also firmly believe that this goal is perfectly realistic.

[*English*]

The Chair: Thank you so much.

Next is the president and CEO of the Association of Canadian Academic Healthcare Organizations, Jean Bartkowiak.

[*Translation*]

Mr. Jean Bartkowiak (President and Chief Executive Officer, SCO Health Service, Association of Canadian Academic Healthcare Organizations): Thank you, Madam.

I am Jean Bartkowiak and I am President and Chief Executive Officer of the SCO Health Service here in Ottawa. I am joined by Dr. Arthur Slutsky, Vice President of Research at St. Michael's Hospital in Toronto.

[*English*]

We represent the Association of Canadian Academic Healthcare Organizations, which is the national voice of research hospitals, academic regional health authorities, and their research institutes in Canada.

You have received a copy of our written submission. For purposes of ACAHO's remarks, we shall speak to the three policy issues related to capacity-building and the 2004 health accord: health human resources; information and communications technology; and health research and innovation.

Wait times are the barometer by which Canadians perceive the performance of the health system. Their very existence is closely linked to a range of other policy issues. The health accord has contributed to a number of pockets of success where progress is being made when it comes to wait times and others where more work is required. This has been noted in the association's two reports on wait times, called *Wait Watchers* and *Wait Watchers II*, which identify a number of strategies to improve patient flow-through in the system.

That said, there are other areas where direct net investments are needed. One critical area is the training, recruitment, and retention of health providers. The lack of available family physicians, specialists, nurses, or lab technicians has a direct impact on the availability of health services. Limited operating revenues for teaching hospitals or regional health authorities can also impact on the number of surgical suites, as can restricted capital budgets limit the number of diagnostic and therapeutic equipment in use.

If the prime objective of the health system is to ensure that Canadians have timely access to quality health care services, there are growing concerns that the current and future supply of health care professionals, be it physicians, nurses, pharmacists, physiotherapists, technicians, and others is not able, now or into the future, to meet the demand for health services.

While the 2004 health accord introduced a wait times reduction fund, the reality has been that moneys from this fund have already been transferred to the provinces and territories on an equal per capita basis for day-to-day operations of their health systems, based on specific provincial priorities, not necessarily aligned to a pan-Canadian perspective. Now is the time for renewed strategic investment in a shared national policy that will have a measurable and direct impact on wait times across the country.

More can and should be done to establish a pan-Canadian solution that focuses on graduating more health care professionals across the country. ACAHO is strongly supportive of the proposal by the Health Action Lobby to establish a five-year, $1 billion health human resources infrastructure fund. The essence of the fund is for the federal government to work with the provinces and territories to develop the necessary capacity to train the next generation of health care professionals. A copy of the proposal has been left with the clerk.

In addition to human resources, investments in information and communications technologies can have a more powerful and transformative impact on the overall organization, delivery structure, and performance of the health system. Not only can electronic health records improve the efficient exchange of patient information, minimize the duplication of diagnostic tests, and improve health outcomes and patient safety, they can also be a significant driver of how providers organize themselves and work together to provide care. ACAHO would encourage all levels of government to consider the additional investment that Canada Health Infoway requires and its significant payback to the system and to Canadians.

I will now ask my colleague, Dr. Slutsky, to make some closing comments on health innovation.

● (1115)

Dr. Arthur Slutsky (Vice-President of Research, St. Michael's Hospital, Association of Canadian Academic Healthcare Organizations): Thank you.

I'm the vice-president of research at St. Michael's Hospital in Toronto, home of the new Li Ka Shing Knowledge Institute.

The 2004 health accord recognized the value of health research and innovation in at least three ways: first, improving the health of Canadians; second, the impact of research on improving the cost-effectiveness of health care services; and third, producing world-class discoveries to leverage economic benefit as well as health gains, as recognized in the government's S and T strategy.

While significant investments in health research have been made by the federal government—for example, CIHR, Canada Research Chairs, and CFI—we must continue to sustain the momentum that has been created so that we can continue to participate in the benefits that come from future world-class research findings. We are on the threshold of a biotechnology revolution, and ACAHO is concerned that any retrenchment in funding would have serious consequences on our ability to attract and retain world-class researchers and to advance discovery and innovation.

Let's not go backwards. We do not want Canada to fall—

The Chair: Mr. Slutsky, I'm sorry to cut you off, but it's five minutes per organization.

Dr. Arthur Slutsky: I understand.

The Chair: We now have Mr. Keon. Mr. Keon is the president of the Canadian Generic Pharmaceutical Association.

Mr. Jim Keon (President, Canadian Generic Pharmaceutical Association): Thank you, Madam Chair.

[*Translation*]

The Canadian Generic Pharmaceutical Association is the national association that represents Canada's generic pharmaceutical industry.

Generic drugs are low-cost versions of brand-name drugs. They are produced by a number of manufacturers once the patents expire on the brand-name versions.

● (1120)

[*English*]

There are no differences in quality, purity, effectiveness, or safety between generic drugs and brand-name drugs. All drugs sold in Canada must be reviewed and approved by Health Canada. Each product, brand name or generic, must meet the strict regulations and standards established by the Food and Drugs Act.

Canadian generic pharmaceutical companies are proud of our contribution to affordable health care in Canada. In Canada the use of lower-cost generic prescription medicines saves governments, employers, and consumers almost $3 billion every year.

We're going to talk today about the national pharmaceuticals strategy. In September 2004, CGPA congratulated first ministers on their national pharmaceuticals strategy. We are, however, disappointed that this initiative does not appear to be moving forward, and we urge all governments, federal and provincial, to continue to take action on the NPS priorities.

I would like to highlight the current status of two NPS priorities this morning: generic drug pricing and faster access to non-patented medicines.

Regarding generic prices, many members of this committee may be familiar with the Competition Bureau's generic drug sector study, which was published in October 2007. In Canada, generic drugs fill fully 49% of all prescriptions, yet account for only 21% of the $19 billion Canadians spend annually on prescription medicines. Despite this, there has been some evidence that the retail prices paid for generic drugs in Canada are higher than the prices paid in other jurisdictions. This was of great concern to the generic pharmaceutical industry and other stakeholders, and the Competition Bureau report represents the first comprehensive analysis into the reasons why.

The study confirms that the generic pharmaceutical sector is highly competitive. When a product comes off patent, there are generally multiple generic entrants competing for a share of the market. In some cases, seven or more different companies will develop a generic version of a single product.

The problem is that while the industry itself is highly competitive, there are other elements of the provincial market frameworks for generic drugs that may prevent the full savings generated by this competition from reaching end payers.

I am pleased to advise this committee that some provinces have already reviewed and made enhancements to their market framework for generic drug products. CGPA was pleased to work with the provinces of Ontario and Quebec to achieve savings of 20% to 25% on the price of generic products and is actively working with other provinces to reduce their prescription drug costs.

With these changes, there is little doubt that retail prices for generic drugs in Canada will be in line with other jurisdictions in the OECD, and this will be reflected in future international surveys. Generic drugs save the health care system billions of dollars each year and are now a better value than ever.

The second element I want to talk about is faster access to non-patented medicines. With respect to this NPS priority, several provinces, including British Columbia, Saskatchewan, Ontario, Quebec, Newfoundland and Labrador, and Prince Edward Island have taken measures to speed up the listing of generic medicines on their drug benefit formularies to increase their savings. Other provinces, such as New Brunswick and Nova Scotia, already have efficient systems for listing generic medicines on their drug plan formularies.

In contrast, however, the federal government has not done its part to help achieve the first ministers' directive. In fact, new delays have been introduced in the three and a half years since this strategy was created, further slowing access to cost-saving generic medicines.

In October 2006 regulatory changes were made to the patented medicine notice of compliance regulations to limit the practice of evergreening of drug patents by brand-name companies. These tactics unfairly kept generic competition off the market and forced Canadians to pay monopoly prices much higher than they should have.

Unfortunately, the October 2006 changes also introduced a new data exclusivity regime, which gives brand-name drug companies an eight-year ban on generic competition. This is three years beyond our international trade obligations under NAFTA and TRIPS and puts our member companies at a disadvantage compared to their U. S. competitors, who are subject to just five years of data exclusivity. These extended monopolies also add more than $100 million to Canada's prescription drug bill each year.

There is yet another new development that is threatening timely access to generic medicines. The Government of Canada recently published proposed amendments to these same regulations that would overturn and override its Supreme Court of Canada ruling and reopen the evergreening loopholes that allow brand companies to abuse the patent system and unfairly delay generic competition.

The Chair: Thank you, Mr. Keon. There will be time for questions. My apologies, but you are over five minutes.

We'll now go to Mr. Russell Williams, the last of our first panel. Thank you.

● (1125)

[*Translation*]

Mr. Russell Williams (President, Canada's Research-Based Pharmaceutical Companies (Rx, & D)): Thank you very much.

I am proud to represent the companies who conduct research and make discoveries in order to save lives and improve our health system.

[*English*]

We are very proud that we are in the business of improving and saving lives. Our organization invests over a billion dollars in research and development and is the largest single source of health research in the business sector.

We are looking at an aging population when we look at our health care system, and we believe that optimal utilization of innovative medicines is part of the solution. New medicines and vaccines help reduce surgery, hospitalization, and wait times, and improve patient outcomes, which I think is our goal. Various diseases, such as leukemia, 30 years ago were almost fatal. Now 80% of children stricken by this form of cancer are alive five years later. Too many Canadians will die of cancer this year. I find that totally unacceptable when we have in our research 750 new medicines that we are studying to treat, cure, and prevent cancer. Chronic diseases like diabetes and infectious diseases require research to make discoveries.

We are looking at 338 medicines and vaccines in development. We've invested in this country in terms of research and vaccine both in Toronto and Quebec. Innovative medicines are 10% of the health care cost.

[*Translation*]

We represent only 10%, but when one dollar is invested in innovative medicines, the resulting saving is seven dollars.

[*English*]

One dollar invested means seven saved.

If you look at the Pitney Bowes study, they experimented and actually decided—against normal thinking about restricting and cost containment strategies—not to limit choice but to encourage more choice. Pharmacy costs went down 7%. The emergency department went down 26%, and overall diabetes decreased by 6%. That's phenomenal.

We have contributed to trying to share information through our program, “Knowledge is the best medicine”, in which 3.5 million Canadians have actually shared. Canadians must have access to the power and benefits of innovation in a timely way.

The issue of wait times is one that I believe very much we have to deal with. Despite Health Canada's efforts, their approval times are still long. Provincial governments range between 9% and 37%, in P. E.I. and Quebec, in terms of listing products. Innovative medicines, we very much believe, save money, reduce wait times, lower overall costs, and improve outcomes without compromising safety. We need the right medicine at the right time for the right patient.

My recommendation would be that we include access to innovative medicines as one of the targets for the 10-year plan, so it affects the other wait times.

But I must comment on the last presenter's comments. The new regulations do not in any way, shape, or form add any delay. The companies that the last presentation represented are, I believe, twisting the truth. There are regulations that protect intellectual property. They do not result in any increase of patents. They do allow for better research. It is fear mongering, and it does not deal with the essence of what we are trying to develop here—to have a research-based community that is strong and vibrant. He also neglected to mention that generics were forced by law to reduce their prices. They were considered the most overpriced, most expensive in the world. This is an area that we must deal with.

When you talk about generosity in this country, there is in fact a pricing regime in which governments are paying too much for generics, and yet the PMPRB shows in our pricing that it's 8% below international means.

[*Translation*]

We must find a solution together. We must tell the truth when we are discussing the matter.

[*English*]

There is no change in these amendments that would adversely affect any Supreme Court decision. In fact, what these amendments are trying to do is clarify the intent of Parliament back in 2006 to make sure on one hand that we have innovative medicines and on the other that we have protected an IP regime that is world class.

Furthermore, again, data protection, which the member just mentioned, is compared to that in Europe, which has 11 years of data protection. Canada rightfully moved for eight years, and they should be congratulated. Canada is currently moving on trying to correct a loophole that the generics are trying to profit on, which is not in the will of Parliament, and they are trying in fact to stop this loophole, this windfall that they have now found, and improve and protect what was decided upon in 2006. This should be encouraged and it should be protected.

Merci beaucoup.

The Chair: Thank you very much, Mr. Williams.

We'll now go to our questions. Usually we have a seven-minute round, but we're going to have a five-minute round to allow more questions, because of the two panels.

We'll begin with Mr. Thibault.

● (1130)

Hon. Robert Thibault (West Nova, Lib.): My point is very quick, so I'll ask for a short answer, if possible.

Madam Fralick, when I look at the scorecard from the Wait Time Alliance, the scores aren't great. They don't show a marked improvement over the previous year, but there are areas of improvement.

Are you an optimist or a pessimist, or a guarded optimist, when looking at the achievements of the 10-year plan with respect to wait times?

Ms. Pamela Fralick: I am an optimist by nature, and in this specific case, very much an optimist. And I thank you for the opportunity to remind the committee, and the others here, of the tremendous successes we have had.

My concern lies in any sense of complacency, that we have done enough. To me, this speaks to the most basic values of Canadians.

Hon. Robert Thibault: Thank you.

I will get back to that. We only have five minutes.

[*Translation*]

Dr. Urbain, when you were discussing wait times in your presentation, you mentioned that other surgical procedures or treatments run the risk of being adversely affected. Can we see that that trend yet?

Dr. Jean-Luc Urbain: It can be seen directly and indirectly. The associations I mentioned have said that they want to be part of the Wait Time Alliance because of the implications for their specialties. If you go to see a doctor, you do so as a person and not just as a heart, a brain, a liver or a spleen. I feel that we must tackle health care as a whole.

[*English*]

Hon. Robert Thibault: Thank you.

Perhaps I'll ask this of Dr. Bellan. You mentioned a lot of other areas, as have other people, in which we should be working more or making a greater effort. Do you think we need to add more money to that $42 billion in the 10-year program, or can adjustments be made within that $42 billion so that we reach that national objective?

Dr. Lorne Bellan: It's hard for me to answer that, because I don't know specifically how much each province has used of the money allocated to it. If they still have leftover capital, they may be able to allocate it to new areas.

I think even if new money were required, the experience that has been gained from the money that's been administered, or given out, so far is probably going to lead to less relative costs for any incremental increase in the future, compared with the first steps.

Hon. Robert Thibault: Mr. Bartkowiak, you spoke to that subject. It sounded like you were asking for more money.

[*Translation*]

Mr. Jean Bartkowiak: Yes, absolutely. Here is the problem that we face at the moment. Although we have the resources to provide the services, we are unfortunately facing a significant shortage of health professionals. We are trying to recruit them, but we do not have the nurses, the doctors and the other professionals needed to provide the services, not just right in the hospital, but also during recovery and at home. It is a serious problem.

Some teaching institutions are now increasing the number of professionals they are training, but it is not enough. I am sure that the other group will bring it up today. We have a significant human resources problem in the health care field. That is why we are proposing strategic investment designed to train health care professionals in Canada.

Hon. Robert Thibault: Thank you. I have to stop you because I have another question to ask the other witness about drugs and medications, before we move to the next panel.

[*English*]

Do I have 10 minutes left?

The Chair: You only have about a minute.

Hon. Robert Thibault: One minute, okay.

The question I have is on the national pharmaceutical strategy. I'd like to leave the other question about the generics, the innovators, and patents alone for now. I know it's being looked at by the industry committee.

But on the national pharmaceutical strategy, one of the perennial demands of the Canadian public has been for a national pharmacare program. We understand there are huge amounts of money needed to get there, but part of the strategy has some intermediate steps that we could look at. One is the drugs for rare disorders, and the other is the catastrophic cost of drugs, where you have people with diseases or ailments that require them to spend 30% or 40% of their revenues—

● (1135)

The Chair: Mr. Thibault, will you get to the question? You're out of time.

Hon. Robert Thibault: Yes.

Have you dealt with that as it was supposed to be dealt with?

Mr. Russell Williams: We are quite eager to work....

[*Translation*]

We want to work hand in hand with governments. As for catastrophic coverage, we find it unacceptable that access to medications is not the same from one region to another in this country. We are ready to establish a partnership with provincial governments. We must have a national approach while respecting the provinces in whose jurisdiction the matter lies.

[*English*]

The Chair: Thank you, Mr. Williams.

Madame Gagnon.

[*Translation*]

Ms. Christiane Gagnon (Québec, BQ): Thank you for being with us today.

I would like to talk about the question of First Nations' health. The federal government has a very specific clientele. The Wait Time Alliance and the Canadian Healthcare Association have looked into this. According to the Canadian Healthcare Association, it is impossible to know what advances have been made. It is not clear. We do not know if funds have been allocated. People bring up infant mortality and youth suicide, but we do not have a lot of data. In 2000, the Auditor General made very specific recommendations. All the shortcomings were highlighted. How can it be that, in 2006, no concrete results had yet been obtained?

Earlier, we were talking about the lack of human and financial resources. As we know, this is a federal responsibility. Do you not think that, if the federal government had good results with its own clients, it could show the way. Do you not think that the serious shortcomings identified by the Auditor General for the First Nations would give the provinces a clear idea of the situation? We ask them to give us their reports, their data. Getting a *C*in the 10-year plan is not very convincing.

I would like to know why we are not getting there. What resources do we not have? Have you looked into it? Has the Department of Health looked into the shortcomings in First Nations' health? I would like to put that question to the Wait Time Alliance and to the Canadian Healthcare Association.

[*English*]

The Chair: Perhaps we should get right to the answer, Madame Gagnon.

Who would like to answer that question?

Madame Fralick?

[*Translation*]

Ms. Christiane Gagnon: I asked the Alliance and the Canadian Healthcare Association.

[*English*]

The Chair: Dr. Bellan.

Dr. Lorne Bellan: I guess what I'll say is that your question highlights the general issue of lack of data collection. It's very hard for us to comment specifically about aboriginals or any other specific sector. It's hard for me to break it down into geriatrics versus youth. And it's partly because of the inadequate reporting of all aspects of health care that we have in the country. So I think one of the lessons we've learned from the initial efforts is that it's been tremendously useful to gather and report data, because then you can identify what the problems are and where you want to go next in the solution. But in the absence of any of that data being gathered, you're just making a guess.

I can't give you a more specific answer to your question about aboriginals because.... We get our data from the provincial governments or from the federal government, and there aren't even databases that we can turn to right now to answer your question. So the first step is to get those databases created.

The Chair: Go ahead, Madame.

[*Translation*]

Ms. Christiane Gagnon: I am also going to put the question to the Canadian Healthcare Association.

What recommendations would you like to make to Health Canada in terms of gathering data? What tools do you need to study the situation? That clientele is in federal jurisdiction. That could give a clearer idea of the steps needed that you cannot get at the moment.

[*English*]

Ms. Pamela Fralick: Thank you.

The members of the Canadian Healthcare Association have not discussed aboriginal issues specifically, but I would support the comments made by my colleague that without the data, we can't do anything, regardless of which population it is. So I would certainly support increasing our data.

If I could give one quick example, we know from the Canadian Institute for Health Information that they focus tremendous energy on gathering data on physicians and nurses. Only in the last couple of years have we turned our attention to other health professionals.

So we simply don't know. It is a most unfortunate situation.

If there could be more resources put into any one area around the HHR side of things, I would certainly highlight that as one of the top priorities: we need to understand the problem before we can evaluate and come up with solutions.

● (1140)

The Chair: Now we'll go to Madam Wasylycia-Leis, please.

Ms. Judy Wasylycia-Leis (Winnipeg North, NDP): Thank you, Madam Chairperson, and thanks to all of you.

Let me start with Russell Williams, on this issue of the gazetted changes with respect to notice of compliance.

Did you have any discussions with the government on these regulatory changes proposed in the *Gazette* on April 26?

Mr. Russell Williams: We had no consultations on these amendments.

Ms. Judy Wasylycia-Leis: You had no discussions at all with government prior to this being gazetted?

Mr. Russell Williams: That's what I just said.

Ms. Judy Wasylycia-Leis: Jim Keon, did you have any consultations with government?

Mr. Jim Keon: No. We've said many times we were very surprised and very disappointed at the short consultation period.

Ms. Judy Wasylycia-Leis: Mr. Williams just accused you of fear-mongering over this whole issue. It seems to me we are talking about serious issues—a national pharmaceutical strategy, national pharma-care—all of which are hampered by the lack of movement with respect to cheaper generic drugs getting onto the market.

Could you give us some sense of the impact of these regulatory changes that are being proposed?

Mr. Jim Keon: The topic I focused on today was faster access to non-patented generic medicines, which was one of the objectives of the national pharmaceutical strategy of the 10-year health care plan. As I mentioned, the provinces have taken a number of measures to do that. Where the problem has come in is at the federal level.

I would say the generic industry in Canada is a real success story. We have jobs, exports. We do double the R and D of the brand-name companies, and we provide about half of all prescriptions in Canada.

We have a very long way to go, however, because in the United States generics are now filling 67% of all prescriptions. We're filling only 49% in Canada. Our industry, our sector, has a very long way to go to provide what it's doing.

The current changes are going to extend monopolies that run directly counter to the changes that were made in October 2006 and confirmed by the Supreme Court of Canada. We're, frankly, very surprised and disappointed. We think the government should probably pull those out and have a broader debate about pharmaceutical patent policies. That's what they want to do.

Mr. Russell Williams: May I respond?

Ms. Judy Wasylycia-Leis: I would just like to ask another question, and then I'll get Jim and you, Mr. Williams, to respond.

What impact will this have on a province like Manitoba, which recently put out a press release talking about the savings it might incur as a result of a number of drugs going off patent?

Mr. Jim Keon: The net effect is it delays the generic products from coming on the market, and the impact, of course, is that you have to pay the higher prices for much longer. On some of the large-selling drugs, you're looking at tens of millions of dollars in a Manitoba drug program, and they will not get the savings from the generics for possibly two or more years longer.

Regarding the ability to put unrelated patents on a list at Health Canada and keep generics off, the Supreme Court said you shouldn't be able to do that. We thought that was the law, and the provinces were basing their estimates on that. Now all of that is being changed.

The Chair: Our time is running out.

Mr. Williams, you wanted to make a comment. Go ahead.

Ms. Judy Wasylycia-Leis: In the context of that, if you could also address—

Mr. Russell Williams: The statements the generics have made are unfounded.

Ms. Judy Wasylycia-Leis: If you could also address the question, then—

Mr. Russell Williams: If I have time.

The Chair: Go ahead, Mr. Williams.

Mr. Russell Williams: Thank you very much, Madam Chair.

Ms. Judy Wasylycia-Leis: Excuse me, Madam Chair, it's my time. I didn't direct a question to him yet.

The Chair: We have only about 50 seconds, and you asked him to comment.

Ms. Judy Wasylycia-Leis: While he's commenting on that, if he could also comment on the feeling, the belief, the indications that although you may put one in ten dollars towards new research, most studies indicate that this is not in terms of new breakthrough drugs that will make a difference, but in evergreening, just redesigning drugs so that you can get more patent protection.

Mr. Russell Williams: Clearly, we believe in innovation and improving lives, and I think my figures clearly state that we actually are the ones saving lives. Generics are trying to copy our research, benefit from the fruits of our research.

The statements by the generics are completely unfounded. This will not extend patents. This is not based on a Supreme Court decision. If they had read the reassessment of the government, they'd see that all it is trying to do is clarify the intention to ensure that patents protected under regulations prior to 2006 continue to have that protection. It is straightforward in this.

The generics are actually trying to jump on a loophole and use a windfall interpretation that was never intended and is thwarting the will of parliamentarians. In fact, what they're trying to do is cut patents earlier.

I actually would like to challenge the generics and ask why it takes governments to force them to reduce their prices. We actually have stats that say if generics were more competitively priced—

● (1145)

Ms. Judy Wasylycia-Leis: I have the *Gazette* here, and the *Gazette* shows that we are in fact talking about the extension of brand-name patents.

The Chair: Thank you, Mr. Williams. Our time is up.

Mr. Tilson.

[*Translation*]

Ms. Christiane Gagnon: A point of order.

It upsets me to see the generic drug industry people here arguing a particular case with the brand-name industry. I do not feel that this is the appropriate place for that kind of thing. We have questions that we would like to ask the witnesses.

[*English*]

The Chair: This is not a point of order. We will now go to Mr. Tilson.

Mr. Tilson.

Mr. David Tilson (Dufferin—Caledon, CPC): Well, on the other hand, I like a good fight.

Some hon. members: Oh, oh!

Mr. David Tilson: The two of you are obviously saying opposite things, and I understand that.

Mr. Williams, have you had your say, or is there anything else you'd like to add to this debate? I'm going to give equal time to the other guy too.

Mr. Russell Williams: Well, if you want to go back and forth, but —

Mr. David Tilson: I don't know. We don't want to go on indefinitely, but I want to make sure you both have your say.

Mr. Russell Williams: Well, very clearly—and I actually do want to debate health care and do believe that—

Mr. David Tilson: Well, we don't have time for a debate. Please finish.

Mr. Russell Williams: I'm an ex-parliamentarian too, so I—

The Chair: Could I just point out today that we are on the 10-year plan?

Mr. Tilson, could you please go on to another question? Mr. Williams, I think, has finished.

Mr. David Tilson: No, this is my time; I want to ask this question.

Mr. Russell Williams: I very much believe that if we protect IP and at the same time ensure that we have proper pricing in this country and ensure good access to innovative medicines, we can in fact be an effective interlocutor, if I could say so, on the 10-year plan. I believe that access to innovative medicine saves lives and helps reduce hospitalization.

This other issue that has been brought to the table, which upsets some of the members, is an issue that has been debated in the industry committee. Unfortunately, the generics are misinterpreting the facts: it is not based on a Supreme Court decision. It does not extend patents; it does not increase prices. In fact, I would challenge the generics by saying it is their pricing regime that is thwarting innovation in this country.

Mr. David Tilson: Okay.

Mr. Keon.

Mr. Jim Keon: We presented our comments today in the context of the 10-year health care plan. The 10-year health care plan has a national pharmaceutical strategy, and an important element of that for the provinces is faster access to generics.

We're trying to save money. We've reached accords with a number of provinces to do just that. If they're delayed in getting access to our products, their costs are going to go up. I think that's an important aspect of the health care system.

Mr. David Tilson: Ms. Fralick, I think it was you who talked about the shortages of resources and the prioritizing of funding. We look at all this—the problems with health care—and no matter which country or province you're in, it's called "lack of money". I'd like you to elaborate on your comment about the prioritization of funding.

Ms. Pamela Fralick: Thank you.

We can always use more money, but I think there are other things that can be done within the system to promote efficiencies, and specifically around health human resources. Yes, if we had all the money in the world, we would take it and use it, but there are things we can do.

We can get the data. If you don't measure it, you can't manage it. We need to focus on healthy health care work places, so that we can attract people and keep them in the workplace. We need to really focus on interprofessional education and practice, maximizing current scopes and using health professionals as they should be used, within their full scope of practice, and on some advanced practice roles that are emerging as a result of good innovation.

Primary health care was a fantastic investment of funds from the federal government, $780 million, which created numerous models of how to deliver health care differently. These are all things—again, we don't have time, I know, to go on, but we could—that will promote efficiencies within the system. This is why I said earlier that I'm an optimist. I think there are things we can do.

That being said, the HHR issue is heading to a crisis.

● (1150)

Mr. David Tilson: Concerning the issue of wait times, Mr. Bellan, how does one prioritize the different categories of wait times? You've given gradings; how do you pick which is more important?

Dr. Lorne Bellan: It's a very difficult thing to do. I think you start off by looking at where the problem areas are. The initial five that were selected were picked because it was generally perceived from a political standpoint—basically, I think, from the feedback that you as parliamentarians received—that this was where the pressure was.

We're recommending, if you've looked at our report, another group of six that we've championed and have said are the next areas. The reason we selected those six was that we approached all of the national specialty societies at the meeting we have in conjunction with the Canadian Medical Association and said, "We want to expand our organization. Who here feels that they have critical problems with wait times that need to be addressed and for which you can come up with a benchmark to solve it?"

These were the groups that came forward and said, "These are the problems we have and we think we should go for it."

The Chair: Thank you, Dr. Bellan.

I want to thank the panel. This brings to a close our presentation by our first panel, and I thank you for coming today. I realize we have tight times, but anyone who wants to carry on a conversation can do it outside those doors.

I would ask that the next panel come forward and we'll start our next round right away.

Mr. Russell Williams: Madam Chair, actually, I would like to respond—really quite quickly—that we have been constantly in conversation with the industry department. We are constantly.... I wanted to clarify that.

The Chair: I'm sorry, Mr. Williams, we have a pause. Sorry about that.

Ms. Judy Wasylycia-Leis: On a point of order, Madam Chair.

The Chair: We're coming to the next panel, Ms. Wasylycia-Leis. We're in a pause. There's no committee.

● _____ (Pause) _____ ●

The Chair: I would ask that everybody please take their seat. I would like to get on with our next panel.

You're welcome to sit in on the rest of the meeting or carry on your conversations outside, but our committee members are ready to go to our next panel right now.

Ladies and gentlemen, the organizations that will be taking part in the second panel are: the Canadian Labour Congress; the Canadian Union of Public Employees; the Canadian Federation of Nurses Unions; the Canadian Pharmacists Association; and the Canadian Society for Medical Laboratory Science.

We will begin with Barbara Byers of the Canadian Labour Congress. There are five minutes, as we did before.

● (1155)

Ms. Barbara Byers (Executive Vice-President, Canadian Labour Congress): Thank you very much.

I'll try to stay within the five minutes. I know you'll keep me to that, but don't start the clock yet.

It's started. Okay.

On behalf of the three million members of the Canadian Labour Congress and their families, I want to thank the committee members for this opportunity to appear today.

In 2004, when the first ministers committed to the 10-year plan to strengthen health care, they recognized the importance of ensuring that Canadians have access to the care they need when they need it. The commitment was made that governments across the country would improve access to care and reduce wait times. They said it was imperative to increase the supply of health care workers and that strategic investments had to be made in community-based services, including home care, a pharmaceutical strategy, and health promotion. They affirmed the principles of the Canada Health Act. They said that timely access to health care should be based on need, not ability to pay, and that all levels of government would work together to meet the needs of Canadians.

Over the past few years, we have seen these commitments cast in terms of the interests of the private health industry. The opponents of medicare are on a major offensive against public health insurance and delivery, and governments are too readily entertaining the argument that privatization equals sustainability. Already, some governments are introducing competitive markets for health care, which is, by definition, damaging to primary care reform and to the seamless delivery of health care between the acute, intermediate, and long-term dimensions of the system.

If the provinces and territories follow Quebec's example, we will have private insurance, two-tier care, and doctors working in both the public and private systems.

Increasingly, governments allow private clinics to take the easiest and most easily billed surgeries from hospitals, so those clinics are operating, for all intents and purposes, as for-profit hospitals.

We object to the way in which employers encourage private clinics to grow by compelling injured workers to receive their surgeries in for-profit clinics. We want to say most emphatically that in no way is this a best practice to be advanced as a broader wait time strategy for medicare.

Due to an exclusion from the Canada Health Act, the federal government is also playing a role in permitting our public workers' compensation systems to be used to create markets for the private delivery of acute care and rehabilitation.

Provincial governments are choosing public-private partnerships for hospitals despite clear evidence that this is the most costly alternative. This course of action is advanced by the federal government, which established a massive new program to promote public-private partnerships.

The privatization of health care services has already resulted in the loss of jobs, inadequate wages and benefits, and reduced community control of our public health care system. Women health care workers, aboriginal women, and immigrant women especially feel the brunt of this degradation of work. Medicare is under threat from privatization, and the attacks are becoming increasingly targeted.

We indeed need sustained action on a national health human resources strategy to address critical shortages of all health care sector workers. As well as focusing on resources for training, we need governments to review what is happening to the quality of health care work. If the quality of work continues to decline, workers will not enter or stay in the health care field.

The government must not meet our health human resources needs by relying on a strategy that encourages internationally trained health care workers to come to Canada only to endure low pay, poor working conditions, and less than full citizenship rights. Immigrant workers deserve to be respected. The federal government must work with provinces to ensure that credential recognition is dealt with in a way that respects the internationally trained workers and contributes to strengthened public health care access across the country. We have to look at the role of Canada as a poaching nation, given that there is no investment in developing countries in their health care systems and health care education.

Furthermore, we would ask members of this committee to call on the government for real action on a national pharmacare plan. The CLC urges members to reflect on the spiralling costs of pharmaceuticals and the pressure this is placing on our health care system. We need a universal, publicly funded, and publicly administered insurance plan to cover prescription drugs. We're not looking only at catastrophic coverage, because that's not able to control the rising costs of pharmaceuticals, which are undermining public health care.

● (1200)

Since the 10-year plan was announced, the CLC continues to hear from our affiliates that medicare is still Canada's most important social program.

The Chair: Thank you, Ms. Byers. You're over the five minutes, but you've made some very good points.

Ms. Barbara Byers: We'll send you our document—

The Chair: We also have time for questions.

Mr. Moist.

Mr. Paul Moist (National President, Canadian Union of Public Employees): Thank you, Madam Chair and members of the committee.

CUPE is privileged to represent over 500,000 Canadians, 170,000 of whom work in all aspects of health care.

Our overarching comment today is under the umbrella of accountability. The 10-year plan, and indeed all medicare dollars, should be spent and accounted for in accordance with the Canada Health Act. Every year the annual report on the Canada Health Act falls short. Provinces don't report. There's page after page of non-accountability. For the Health Council of Canada, created to ensure accountability in the 10-year plan, with two provinces refusing to participate, we're not sure how the accounting or the accountability can hold true.

What's the evidence of our concerns on accountability?

One, since the 10-year plan was signed, the number of private, for-profit clinics delivering medically necessary services has doubled.

Two, in terms of illegal fees, some provinces—notably British Columbia and Quebec—are allowing private clinics to charge privately for diagnostic and surgical services, which are clearly necessary hospital services within the definition of your Canada Health Act.

Three, queue jumping. Some doctors get around the ban on user fees and extra billing by charging patients for uninsured services, which leads to queue jumping and potential conflicts of interest.

Four, commercialization is linked to the wait times guarantee debate. The 10-year plan approach to wait times in the federal government's model of care guarantees has hastened commercialization of medicare. Almost two years ago, the federal wait times adviser, Dr. Postl, issued his report. In our view, it has been all but ignored on the issue of wait times.

Five, public-private partnerships. There are 38 P3 hospitals under way in four Canadian provinces. Through this government's initiative, PPP Canada Inc., the federal government is actually pushing the P3 model in all sectors, including health care. We believe that P3 hospitals deserve immediate investigation and action by this health committee, the Auditor General, and the current Parliament.

Our recommendations, to close, are to enforce the Canada Health Act, a requirement of Parliament; establish a national long-term care program; implement a wait time strategy that guarantees public sector improvements, or, in short, follow Dr. Postl's advice; establish a national pharmacare program; create a national infrastructure fund to build and redevelop hospitals and long-term care facilities; follow through on the commitments made in the Kelowna accord and the "Blueprint on Aboriginal Health"; establish a national strategy to combat health-care-acquired infections; and finally, develop and implement a pan-Canadian human resources strategy to achieve better working conditions, training, upgrading programs, and wage parity to improve retention and recruitment across health care, which is another recommendation of Dr. Postl.

Thank you, Madam Chair.

The Chair: Thank you very much, Mr. Moist.

Next is Linda Silas, who is the president of the Canadian Federation of Nurses Unions.

Ms. Linda Silas (President, Canadian Federation of Nurses Unions): *Bonjour.*

The Canadian Federation of Nurses Unions represents 138,000 nurses in nine provinces, plus 20,000 associate members who are part of the Canadian Nursing Students' Association. Our members work in hospitals, in long-term care facilities, in communities, and in our homes.

We thank the Standing Committee on Health for the opportunity to share our views. We will bring 10 renewed calls for action. These are nothing new; they are renewed calls for action, and we believe they are essential to fulfill the next step for the vision set by the first ministers in 2003 and 2004. We're focusing on health human resources and accountability.

Regarding health resources, the first ministers said that "access to timely care across Canada is our biggest concern and a national priority". They also linked it to health human resources. The concern resonates all the louder in light of the Canadian Medical Association's estimate of 4 million to 5 million Canadians not having a family physician or access to primary health care. The nursing sector does not fare any better. It is estimated today that we are short over 20,000 nurses if we only take into account the overtime and the vacancy rates.

Canada is home to over 250,000 nurses, of which over 80% are unionized, but working conditions are far from satisfactory. For example, just overtime and illness in Ontario are estimated to cost $1 billion. For every nurse under 35, there are two nurses over 50. We know we're an aging workforce, if not the oldest workforce. To keep up with this demand, we need to graduate about 12,000 nurses per year, and we only graduate about 8,400 now.

Here are our suggestions.

We believe the government needs to coordinate health human resources at a national level. For example, Saskatchewan, P.E.I., and Newfoundland and Labrador lose 30% of their new graduates to other provinces. The first recommendation is, of course, a pan-Canadian health human resource strategy.

The second recommendation is that we believe research in nursing needs to continue. We had $25 million over 10 years, and it is finishing this year. We're asking to renew this funding.

On the third recommendation, we all know we have to work together to implement healthy workplace initiatives to retain and recruit all staff.

Fourth, through the 10-year plan to strengthen health care, the federal government committed to reducing the financial burden on students in specific health education programs. We urge the federal government to honour this commitment as soon as possible.

The fifth recommendation is to have explicit targets for enrolments, funding and other support, new faculty, and appropriate technology.

In the home care sector, nurses echo the plea of VON Canada to call the federal government to create and support an expert advisory panel on family caregiving.

Accountability, as this government has emphasized, is vital to all areas of government, and health care is no exception. The Canadian Federation of Nurses Union, partnered with CUPE, launched the campaign called "Your Medicare Rights". We are talking to the public about extra billing, user fees, commingling, queue jumping, etc., but what we really need is the federal government to act on this.

Our seventh recommendation talks about the Health Council of Canada having the authority to ask the provinces and territories to report on matters concerning the Canada Health Act. Health Canada should make use of their powers to enforce the principles and conditions under the CHA.

We've also asked the Auditor General to perform an audit on federal moneys transferred to the provinces in health care delivery.

Regarding pharmacare, we know the cost of prescription drugs rose 77% between 1996 and 2006. We spend more on drugs in this country than we spend on doctors. We know that New Zealand achieved a 50% saving using its coordinated bargaining methods for bulk buying. Nurses recommend that the federal government develop a national pharmaceutical program. We had progress in 2004, but since the national pharmaceuticals strategy, not much has happened.

Lastly, we have the structure in place, so let's use it. Each province and territory should prepare a yearly report to the Advisory Committee on Health Delivery and Human Resources on the 10-year plan, taking into account its objective and proposed funding. The advisory committee can in turn report to the federal health minister as well as to key health stakeholders.

Health care is the business of taking care of people, and we need people to do it.

Thank you.

● (1205)

The Chair: Thank you so much, Ms. Silas.

We'll now go to Mr. Jeff Poston.

Dr. Jeff Poston (Executive Director, Canadian Pharmacists Association): Thank you very much, Madam Chair.

The Canadian Pharmacists Association very much welcomes this opportunity to present to you today during your review of the 10-year plan to strengthen health care.

While medication use is an integral component of Canadian health care, adverse drug events and medication misuse remain a serious issue. In a recent Canadian study, 24% of patients were admitted to a hospital's internal medicine service for drug-related causes, and over 70% of these admissions were deemed preventable. Similarly, another recent study in Vancouver found that one out of every nine emergency department visits was due to a drug-related cause, and over two-thirds of these were preventable. It's against this background and concerns about appropriate use and access to care that we want to base some of our remarks to you today.

Since the announcement of the 10-year plan in 2004, some progress has been made; however, there are many challenges that remain unmet. I'm going to focus on four areas.

First is the national pharmaceutical strategy. Progress has been slow to date. There's been a relative lack of progress in overall strategy. The process has not been very transparent, consultation with stakeholders took place relatively late in the day, and we still don't know what's happening in many of the key areas, if indeed any progress has been made on issues such as expensive drugs for rare diseases or the development of a common national formulary. We're concerned that many of the issues identified as priorities in the NPS are being addressed in isolation, and we see the need for more focus on a comprehensive strategy to address the issues.

Appropriate use of pharmaceuticals needs to be a key focus of the national pharmaceutical strategy. In September 2006, over 20 months ago, the progress report on the national pharmaceutical strategy identified further work to be done. We've seen little activity, and the process seems stalled.

There have been a few initiatives in the NPS that have resulted in meaningful benefits for Canadians: some provinces have announced catastrophic drug coverage programs; the recently announced Bill C-51 should modernize the drug approval process; the Patented Medicine Prices Review Board has been analyzing non-patented drug prices; and some provinces have announced new regulations and policies concerning pharmaceuticals. There needs to be a sustained effort by federal, provincial, and territorial governments to continue to develop and implement a truly national pharmaceutical strategy.

With respect to health human resources, the 10-year plan recognized the need to increase the supply of health care professionals in Canada, including doctors, nurses, and pharmacists. There has been progress in health human resources planning. Health Canada has invested in interprofessional education and collaboration, support for integration of internationally educated health care professionals, and generation of data for the seven priority health care providers identified in the 10-year plan.

The approval of an FPT framework for pan-Canadian planning and progress in provincial plans to manage health human resources have been positive developments; however, there is much more that remains to be done. Areas of focus need to include planning based on population needs; addressing shortages, particularly of doctors, nurses, and pharmacists, and of other health care professionals; and healthy workplace issues. We also still need better data collection.

Thirdly, I want to comment on primary health care reform. This is critical to the sustainability of the health care system as we move forward. Much more work is needed to address issues of timely access to care, interprofessional collaboration, and optimizing the scopes of practice of health care professionals. As medication experts and the most accessible health care providers, pharmacists need to be further integrated into primary health care and primary health care teams.

Finally, I want to comment on electronic health records. EHR and telehealth are key technologies to enable health system renewal. Adoption of computer technology and electronic health records by clinicians remains a challenge. Progress has been slow. Most provinces are developing a drug information system that will include a complete drug profile and enable e-prescribing applications. We believe the electronic health record will enable primary health care reform and allow health care practitioners to better care for their patients.

Better information will lead to better health care decisions, and DIS applications will lead to enhanced drug safety. To this end, funding for Canada Health Infoway needs to be increased in order to realize the vision of the electronic health record.

● (1210)

In conclusion, while progress has been made on some elements of the 10-year plan, significant challenges and opportunities remain. More funding and more work will be required to address the issues that were identified by the first ministers four years ago.

Thank you very much.

The Chair: Thank you, Mr. Poston.

Mr. Kurt Davis.

Mr. Kurt Davis (Executive Director, Canadian Society for Medical Laboratory Science): Thank you, Madam Chairman.

I'd like to share with you some concerns today in a key area of health human resources in the area of clinical education.

The medical laboratory has been referred to as the diagnostic engine of the health care system. With over 85% of physician decisions being based on medical lab results, you can be pretty well assured that you need to have a good motor in this engine. I think you would all agree that we need to keep this as a priority, and I hate to inform you, but the “service engine” light has been on for some time.

Canada is facing a nation-wide shortage of medical laboratory technologists. We predict that by 2015, half of Canada's MLTs will be eligible to retire. Since 1998, we've been alerting decision-makers that the number of seats in MLT education programs is not sufficient to produce enough new graduates to replace those who will leave the workforce. Currently there are 27 education programs across Canada, with an estimated 762 students enrolled in those programs.

Provincial governments across Canada have responded to our promptings about the shortages by opening new programs and expanding existing programs. This is a positive development; however, we're still short 120 seats of the recommendations contained in our 2002 HR report.

But there's a bigger problem.

Funding for new and expanding programs has been provided for the classroom portion only of those institutions. Unfortunately, little thought has been given to support for clinical training.

As with most health professions, clinical training is a vital component of medical laboratory science education. Completion of a clinical placement is a mandatory component of a Canadian accredited training program.

In 2002, our organization started to hear anecdotal reports that clinical sites, the vast majority of which are in hospitals, were finding it increasingly difficult to devote resources to educating students. Technologists on the bench simply didn't have the time to educate students, because of staffing shortages. Their first priorities —which they should have been—were patient results.

Our 2004 research study, *Clinical Placements for Canadian Medical Laboratory Technologists: Costs, Benefits, and Alternatives*, revealed several issues that compromise the ability to deliver the clinical component of MLT programs in the future. Significant issues identified in the study included inadequate funding for clinical education, student training resources seriously impacted by clinical staffing shortages, and a lack of research on best practices in clinical education.

Some people have suggested that clinical simulation would be cheaper, faster, and would relieve the burden on clinical sites. We wanted to put those assumptions to the test, and earlier this year we published the results of a study that found that simulation-based training to be resource intensive in terms of both personnel and equipment. Programs adopting simulation required the very expensive high-tech laboratory equipment that is used in today's hospitals, with very high start-up costs and operational costs—clearly a wasteful duplication of resources. Two colleges that participated in our study indicated that they had already been forced to terminate their simulation programs because of the lack of ongoing government funding.

Our study also revealed that there is a lack of research evidence to support the use of simulation in medical lab technology programs.

And we're not alone. Other health professions are facing similar problems. The pan-Canadian health human resources plan explicitly recognizes the importance of clinical education and sets a specific goal of increasing access to clinical training and clinical education.

Herein lies the rub. UBC's Dr. John Gilbert notes that the responsibility for funding of clinical education at the provincial level lies "in the purgatory of clinical education", somewhere between the ministries of health and education. Specific funding for clinical education is pretty well non-existent. How can we increase access to clinical training if no one is willing to claim responsibility for providing the necessary resources to support it?

So where are we today? We're in a situation where clinical sites, primary hospital labs, are refusing to accept students because of staffing shortages. It has become a vicious cycle. They can't take students because they're too busy due to staffing shortages, and they're short of staff because there aren't enough new graduates.

We need to break this cycle now. CSMLS is recommending that provincial and federal governments target funds to support on-site clinical education for medical laboratory technologists. Across Canada, we need funding for 140 dedicated clinical preceptors in our labs who can devote the necessary time and attention to support students.

We further recommend that funding also be made available to conduct additional research into the value and effectiveness of clinical simulation. A reinvestment today may help ease the future impact of a shortage of medical laboratory professionals.

● (1215)

The Chair: Thank you so much, Mr. Davis.

We'll now go into our five-minute first round of the second panel presentation, and we'll start with Mr. Temelkovski.

Mr. Lui Temelkovski (Oak Ridges—Markham, Lib.): Thank you, Madam Chair.

Thank you to all the presenters.

The 10-year plan committed government to increase the number of health professionals, including targets for training, retention, and recruitment, and making their plans public—it asked that everybody make their plans public. Also, the federal government agreed to expand assessment of internationally trained graduates, make efforts in aboriginal communities, reduce the financial burden on students, and so on.

Mr. Davis, you mentioned that there's a shortage of laboratory staff. Have your membership numbers increased in the last three or four years, or have they remained relatively similar?

● (1220)

Mr. Kurt Davis: In our organization, the membership numbers have been holding steady because of the reality that the retirees have not been leaving as fast as was originally anticipated, so the number of new graduates coming into the system is basically keeping pace. I think the mutual fund meltdown of 2001 is keeping professionals in the workforce more than they originally planned.

But I know that right now we actually have a problem, this week, in that we have too many job ads coming in. Our staff can't keep up with the postings on our website.

Mr. Lui Temelkovski: What is the situation with the pharmacists, Mr. Poston?

Dr. Jeff Poston: One of the positive things that came out of the plan was funding for the Canadian Institute of Health Information. Pharmacists are one of the health care professions for which CIHI is building a better database, so that we can get a better understanding of numbers.

We still see shortages, though; we still have shortages in practice. I think the one concern is that we're far from being self-sufficient as a country. We're heavily dependent on internationally trained pharmacists.

Mr. Lui Temelkovski: So we're still short.

Dr. Jeff Poston: We're still short, and I think what's happening—the other concern—is that we're becoming increasingly dependent on foreign-trained pharmacists.

Mr. Lui Temelkovski: And what is the case for the nursing association, Madam Silas?

Ms. Linda Silas: The shortage is in a crisis situation. In 2005-06, a report was given on the HHR pan-Canadian strategy. But we have to realize that CIHI counts a nurse like me and a doctor like Dr. Bennett, and we haven't touched a patient in a while. That doesn't help in the numbers.

Just in the city of Winnipeg, there are today 870 vacancies in nursing positions. In Edmonton and Calgary, it's 2,000 vacancies. We spend 18 million hours of overtime per year. That's equal to 10,000 full-time jobs in nursing. So there is a crisis.

Mr. Lui Temelkovski: So from the three organizations, what I hear is that there's a crisis in terms of numbers of professionals who are needed. Yet we have a report that says everything is rosy.

I don't get it. I don't get it because for me it's very simple: if you don't increase the number of pharmacists, if you don't increase the number of nurses, if you don't increase the number of technologists, how are these wait times being improved? Who's improving them? Do we have better machines? Are they working 36 hours a day? Where is the misunderstanding, or is there information that's not coming through properly?

Dr. Jeff Poston: I think the report on wait times identified better utilization of existing staff as one of the key things—actually taking a very critical look at how existing staff is being used. There has been some research work around that, and certainly some of the improvements around administration of waiting lists and those types of things have been critical. So I think there have been some administrative changes made, in utilization of staff and administration, that have improved wait times.

But you're correct. The underlying problem is simply going to get worse, as we all I think have aging workforces. As I say, from our perspective we're becoming heavily dependent on foreign-trained pharmacists. The situation is going to get worse unless we have some significant new investment.

Mr. Lui Temelkovski: Mr. Moist, could we hear from your union?

The Chair: I'm sorry, Mr. Temelkovski, we're out of time now.

I'm going to have to go to Monsieur Malo.

Mr. Lui Temelkovski: I'm sure he will continue.

[*Translation*]

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

I am going to continue along the same lines as Mr. Temelkovski and talk about human resources. You all deal with human resources. As I understand it, every sector has a shortage of human resources.

In the Strategic Health Human Resources Action Plan that is part of the 10-year plan to strengthen health care, there is an important commitment to, and I quote:

> targeted efforts in support of Aboriginal communities and Official Languages Minority Communities to increase the supply of health care professionals for these communities;

So, efforts must be much more targeted. In fact, we spoke earlier about First Nations communities and the lack of data. Do you know if the objective has been achieved in First Nations communities? As a professional association and perhaps as a trade union, are you part of the effort to achieve that very specific objective?

● (1225)

[*English*]

Mr. Paul Moist: I would say baby steps have been taken. Our biggest success story is with the Government of Saskatchewan and the health authorities in Saskatchewan. We've taken aboriginal employment for support workers in an acute care setting from 1.8% of the employees to 11%. One hundred percent of the employees have received aboriginal cultural training to prepare Saskatchewan health care workers, but that's the exception, not the norm.

We have had sitting on the federal minister's desk, for about a year apparently, an approved partnership agreement for CUPE to take similar initiatives to workplaces across Canada to employ aboriginals, but we haven't been able to get it signed off on. I would say we have taken some very good baby steps, but there is still much to do yet.

[*Translation*]

Ms. Linda Silas: The only provinces where real progress is being made are Saskatchewan and Manitoba, where funding really is made available for First Nations people to study to become nursing assistants or nurse practitioners. Funds and programs are in place. There is similar funding for doctors, but I do not have all the details.

As Paul said, there have already been committees in the past on health resources in First Nations communities, but everything has been put on hold.

Mr. Luc Malo: Why?

Ms. Linda Silas: We do not know. Among the witnesses here, I notice that there is not one representative of a First Nations organization. It is difficult to prepare a presentation for the committee. This is 2008; we have to come up with research, not fancy words. Communities and associations, like nurses, for example, do not have the research resources to be able to prepare very quickly. It is a big problem. It is a big problem also in the light of the $115 million they have received.

Mr. Luc Malo: So you are telling me that the committee will never hear a First Nations group because it is incapable of preparing for its appearance here.

Ms. Linda Silas: I cannot say that. I can say that it is difficult enough for a large organization like ours to prepare a presentation in the time we had. It is even more difficult for a small organization.

My recommendation to the committee would be to conduct a study exclusively on the situation of First Nations and to give the witnesses much more time to prepare to appear before the committee. I am not aboriginal and I cannot speak for them. But it is a problem.

[*English*]

Ms. Barbara Byers: Can I just add something there?

Over a long number of years, the Canadian Labour Congress has proposed a system of training insurance under EI. We were trying to get some pilots going across the country to address specifically the question of aboriginal workers who may be in the health system, who may be in support work, and who want to train for some other types of jobs, and also the question of new Canadians, immigrants, and so on.

That's something we will continue to push—that currently employed workers should have access to their EI system in order to increase their skills so that they can move into other jobs within the health care system as well.

But one of the things we have to also recognize—and Romanow recognized it in his report—is that Canada has a responsibility not to poach from other countries in terms of immigration.

The Chair: Thank you, Ms. Byers.

Ms. Wasylycia-Leis.

Ms. Judy Wasylycia-Leis: I want to pick up on that point. It seems to me that the only pan-Canadian strategy this government has for dealing with the human resource shortfalls in the health care field is to bring in, open up, or change priorities with respect to immigration, making it possible to bring people in with foreign temporary work permits and scrapping any good programs that were working, such as the one in Saskatchewan to train aboriginal folks in the health care field, to increase education places, to recognize foreign credentials. All of the things that would deal with the shortage are not on the books, but this immigration proposal is.

Is that your stance? And what's the problem with it?

Barb? Linda?

● (1230)

The Chair: Ms. Byers and Mr. Davis have indicated.... We'll hear Ms. Byers first and then Mr. Davis.

Ms. Judy Wasylycia-Leis: And also Linda Silas.

Ms. Barbara Byers: The temporary foreign worker program is not working, for those workers who are being brought in. It is not immigration; it's exploitation. It's not working for the system either.

As well, we have a number of workers who have immigrated to Canada who cannot get access to the kinds of training they need. The temporary foreign worker program is not a good program in any occupation that workers have been brought in for.

Mr. Kurt Davis: There's a key issue in the clinical education for foreign workers as well in our profession, because many of them have taken advantage of bridging programs that are provided to integrate them into the Canadian workplace. You're robbing Peter to pay Paul for a bridging program that's taking seats away, usually, from a local clinical program of an academic training program in a local college. Bridging programs and integrating international students into the system in Canada are a lose-lose situation in our profession.

Ms. Judy Wasylycia-Leis: I guess one of the best examples today —

The Chair: I think Ms. Silas wanted to answer.

Ms. Judy Wasylycia-Leis: Let me just reference the question for Linda Silas in terms of the fact that as we're sitting here today, Saskatchewan nurses are at the bargaining table. The pilot project for aboriginal health care workers seems to be on the shelf or dead, yet Saskatchewan has just recruited 297 nurses from the Philippines. It seems to me this is typical of what's happening across the country, and there's no Canadian strategy to deal with it.

Ms. Linda Silas: Immigration, all the panels have said, is not the solution. We should be an open country. We're a great country, but we have to be responsible. We're a very rich country, and we should be sustainable in our health human resources and our education programs. What message we are giving to our children is one of my issues, as a mother.

In regard to Saskatchewan and Manitoba, we have to realize that we still have under Indian Affairs a department called Aboriginal Workforce Participation Initiatives, and that's what Paul was talking about. It's again at a standstill, but it's looking at collective agreements and how you bring aboriginal people into your collective agreements, because the word “union” doesn't even exist in aboriginal language, for example. The grievance procedure is very different.

Those were very positive initiatives that are on the same hold. We're hoping they will all come back. Again, we're a rich country, and we should educate our own and welcome others.

Ms. Judy Wasylycia-Leis: Thank you.

Maybe I have time to ask Paul a couple of questions on the Canada Health Act and the whole move towards privatization and the use of PPPs and so on.

Didn't you take the government to court over dereliction of duty concerning the Canada Health Act? Where do we stand now, in terms of enforcement, and how can we make a difference?

Mr. Paul Moist: Through the chair, we did take the previous government to court over the annual report, which has pages and pages left blank from many provinces. Some provinces, such as Manitoba and Saskatchewan, comply. The Federal Court ruled that we certainly had a point and that it was up to parliamentarians to enforce this, as the givers of the cheques, if you will.

So there's no accountability there.

As I said, there are two provinces not participating in the Health Council of Canada. I don't know how they can be accountable. I hear often that we shouldn't intrude on the provinces. Well, I think the citizens in those provinces expect your cheque to have accountability attached to it.

The ultimate intrusion, on the other hand—PPP Canada Inc.—for any project over $50 million.... You couldn't build an acute care hospital in a large Canadian city for under $150 million. Any project with more than $50 million, this government is saying, you must consider a private hospital, a P3 hospital.

So we intrude in provincial jurisdiction there, but we don't enforce millions of dollars going out in medicare transfers, and we accept many blank pages. CUPE doesn't accept that.

The Chair: Thank you, Mr. Moist.

Mr. Brown.

Mr. Patrick Brown (Barrie, CPC): Thank you.

It would be appropriate today to direct my questions to the Canadian Federation of Nurses Unions. I know this is National Nursing Week. I spent Monday morning in my riding going to work with a few nurses and seeing what a splendid job they do in the health care facilities there.

When we look at the 10-year health accord, we see that there are certainly some success stories we can be proud of. I asked my local hospital what the patient wait times partnership has meant to them, and they mentioned to me 606 additional cancer, cataract, and joint replacement surgeries and 1,880 more MRI hours.

There have been some positive steps forward. When you delve deeper, there are some things we can learn from this, and I want to get your comments on them. When I look for things we can improve in the future, I notice the human resources issue is a huge one. In my riding, there are 30,000 individuals who don't have a family doctor, and the shortage of nurses is related to the shortage of doctors. I see this at the Royal Victoria Hospital.

There is a geographical disparity in health care services in this country. The level of service is not as high in rural Canada, in small towns. There are not as many medical professionals practising there. I'm not sure this health accord recognizes the challenges we have in this geographical disparity.

One thing we can look to improve upon is how we match our national expectations on a provincial level. I wonder whether we have all the levers required to ensure that our health care dollars are being spent on the priorities that you all have spoken about. I was intrigued, Ms. Silas, when you spoke of an audit of provincial funds coming from the federal government.

Could you expand upon that? Why do you believe it is needed, and what expectations would you have if there were to be more tools for an audit of these federal funds? What are your expectations for those federal funds, within the provincial administration?

● (1235)

Ms. Linda Silas: With respect to the audit request, the last audit was done in 2002, if my memory serves me right, and a lot of federal dollars are going to the provinces and territories on health care. You have to realize that Health Canada is the sixth-largest health care employer in the country, so we need to know where our dollars are going.

You're right that there has been progress made in wait time management, but a lot of it has been in managing the wait list itself. We still have physicians and specialists who keep their wait time lists on post-it notes. We need a lot more computerization, etc. We have in Canada, through Health Canada, an advisory committee on health development and health human resources. It is a pan-Canadian committee. They need to go further than the bureaucrats. They need to involve the stakeholders. They need to involve the people around this table so that they know what's going on. I have to give credit to HRSDC. They've gone into rural communities. We have a project in Regina, which is not rural. We have another project in Cape Breton, though, for the skills upgrading of nurses, and we have a big one in front of Health Canada to do more of that.

You and Monsieur Malo are saying that there's good news, but it's not transferring to the regions. It's stuck at the bureaucratic level, and we need to implement the stakeholders throughout. We have to make sure that what the minister hears is what the CEO of a hospital and the nurse on the floor hears. Everything has to connect, and to do it we have to work together.

Mr. Patrick Brown: I heard from my local nurses union that with all these goals being set for health care, people have to reallocate dollars. CEOs of hospitals are doing this. You talk about the shortage of nurses. All these nurses who are eager to work are being given part-time positions rather than full-time ones. With respect to human resources, how would it alleviate the situation if we put more funds into full-time than part-time? In some cases, when you add up the overtime, we're paying more for part-time.

Ms. Linda Silas: It's the supply and demand magical question. Everyone has their role. Hospitals are now paying $3,000, $5,000 to nursing students to guarantee them there. Why wouldn't the federal government have a program? You've just established a federal program for police officers. We need to establish one for health care workers. CMA proposed a $1 billion education plan for health care professionals about five years ago. It's still not being acted upon.

That $3,000 that your hospital gives could go into health human resources.

● (1240)

The Chair: Thank you so much, Ms. Silas.

Ms. Kadis.

Mrs. Susan Kadis (Thornhill, Lib.): Thank you, Madam Chair, and thank you to our guests today.

We've heard through today's hearings, as well as previously in other sessions, regarding the need for more financial resources. Are there other impediments to achieving improvements in the 10-year health care plan to improve the health and safety of Canadians? Is it financial? Is there enough commitment from the federal government currently to achieve these goals? We have continuously heard of the need for a pan-Canadian strategy. We have also heard the concern that it's not there to the extent that it was originally, and that it has been weakened. There was $42 billion. There was great promise.

I would be very interested to know what you feel will get us there and what your recommendations would be to this committee.

Ms. Barbara Byers: If I can begin, one of the things we would recommend to the committee is that if you want to look at the question of controlling costs and providing needed services to people, you really have to get into the national pharmaceutical strategy. That has to be there.

Earlier I believe Mr. Brown raised the question about the levers to control costs and dealing with that. Well, the federal government has those levers. They can deal with the question of patent protection and the long, long years of patent protection. They can deal with the question Ms. Silas raised about New Zealand's bulk buying and bringing down costs. That's one of the issues.

If the strategy is to continue to throw money into the private sector, they will bleed the system dry and no one will be able to afford it.

Dr. Jeff Poston: I think we have to continue to focus on ways of reforming the system and better ways of using the money that's currently invested.

We have to look very critically at scopes of practice of health care professionals. We have been very interested in the experiment in Alberta to look at better utilization of pharmacists, where pharmacists have been given prescriptive authority under some well-defined conditions.

I think we heard from earlier presenters today looking at the need to actually invest in home care and long-term care. If we can keep people out of hospitals for longer, and if we can treat people with minor ailments using pharmacists or nurse practitioners, we don't have to always rely on the physicians.

The whole issue of health care reform is something I think we need to continue to work on.

I have one caution. I've heard twice this morning about New Zealand and bulk purchasing of drugs. That has been fairly disastrous in New Zealand. It has led to significant drug shortages, because with bulk purchasing you create a monopoly supplier. If the monopoly supplier has problems with raw materials or manufacturing, you lose that supplier in the market and suddenly you have no drugs. So I think there needs to be some caution about some of the solutions.

Thank you.

Ms. Linda Silas: As I said in our last recommendation, we have to consult a lot more than we're doing. This is the first report on the 10-year plan. We need one every year. And it has to start at the level of the bureaucrats, to the advisory committees, and come back to you with all the stakeholders.

I know you have a lot on your plate, but if it's not done on a yearly basis for the next six years, until we're done, we will analyze the 10-year plan as a failure, and we will all be responsible for it.

Mrs. Susan Kadis: Thank you.

The Chair: You have another minute.

Hon. Carolyn Bennett (St. Paul's, Lib.): We would love it if you would give an overview of what would make your heart go pitter-patter if it was in our report.

Ms. Barbara Byers: You can start with implementing 99% of what was in the Romanow commission. You could bring in a lot of those things: MRIs, the other—

Hon. Carolyn Bennett: Just a second. This is a review of the 10-year plan.

Ms. Barbara Byers: Yes.

Hon. Carolyn Bennett: So in terms of how we think we're doing on the 10-year plan, what do you think our report should focus on in the areas you think are weak or the areas we should be focused on?

Mr. Paul Moist: CUPE would argue that you should enforce the accountability question under the Canada Health Act and under the agency or councils set up under the 10-year program.

Number two, we think the Auditor General and Parliament itself need to look into the push by the current government toward, “If you want money for infrastructure renewal, including health care facilities, you must consider privatization options”. That is anti-Canadian, in our view.

● (1245)

The Chair: Thank you, Mr. Moist.

We'll now go to Mrs. Davidson.

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

I'd like to bring us back to where Dr. Bennett was going.

This is a review of the 10-year accord, so when we look at this review, we need to look at what's in this accord, not what you'd like to see in it, because we're reviewing what is in there. I'm sure all of us, whether we're presenting or whether we're sitting here, would like to see some different things. That opportunity will come, but it's just not here right now.

I'll start with Ms. Silas.

Do you see initiatives or innovations that may not be there yet but that hold promise for further progress in improving things and improving the health care work environment that is here, things that we can make recommendations on? I think we've heard a lot in the last few years about the work environment.

Could you start? And then perhaps maybe you'd like to speak to it too.

Ms. Linda Silas: There are a lot of initiatives out there on a healthy workplace. People—employers and unions—are realizing that we have to create a healthy workplace to retain our staff. That's happening. We need more target funding towards that. We need a better evaluation. The partners are working on it, but at a micro-level. It needs to be expanded.

To come back to the 10-year plan, we need to read the 10-year plan again. It starts with accountability. It talks about the national pharmaceutical strategy as the first step. We're talking about a national pharmacare program. We're talking about HHR. The plan is specific. The federal government should be helping our students. Nothing has been done.

On home care, it's very specific. There has been silence on that since then.

And for aboriginal health, there is specific target funding.

Let's go and read the plan again, and we will be successful in 10 years.

Mr. Kurt Davis: The quality work-life initiative, I think, is a key issue, because we have a lot of debris lying around from the 1990s, when we went through the years of health reform. In our profession, they reduced the workforce by 27%, basically overnight, and that has not come back since that time. So the people are working under pressures and stresses that most of you cannot imagine. The current proceedings going on in Newfoundland are just a little evidence of the issues that can happen when medical laboratory testing goes wrong.

We need to stand by the health human resources plan. The ACHDHR strategy is great, but we need to be assured that the provinces follow suit. The wealthiest jurisdiction in this country is not playing in the game. They're doing whatever they want, and they're relying on poaching from the rest of Canada. The reality is there is a global shortage of health professionals; it's not a "made in Canada" thing. If you think we're in trouble, you should look south of our border. There's a sucking sound that scares me.

Mrs. Patricia Davidson: Can I just ask another question to you?

Does the fact that there are two provinces that don't belong to this accord or don't participate in this accord present other problems or other challenges?

Mr. Kurt Davis: I think it's a key factor, because there is, for better or worse, provincial pilfering going on already. Most of our health professions do have national mobility, with their certifications and their registrations, so, as was commented on earlier, full graduating classes have left one province to go work in another. How can a province plan its health human resources if all of its grads disappear? It's just not feasible.

Dr. Jeff Poston: I would add that I think that's a symptom of the overall underinvestment that's taking place in this country, in terms of educating and training health care professionals. Because you have such an endemic shortage across the board, you have this sort of movement that creates major problems in one province. It's just an overall symptom of the fact that we need a lot more investment to ensure that we're going to be self-sufficient with respect to health human resources as we move forward. That's clearly a priority.

I would add that we have to make some real progress on a national pharmaceutical strategy, and we mustn't lose sight of the need for primary health care reform. We hear a lot about funding hospitals and, if you like, funding the status quo, but I think if we're going to move forward and have our system sustainable, we have to take a close look at health care reform.

● (1250)

The Chair: Mr. Moist.

Mr. Paul Moist: Just on wait times, I have a couple of sentences.

I read your transcripts from April 17. You had Department of Health and Public Health Agency of Canada officials, with pages and pages and pages of testimony on wait times and not a syllable about a person you appointed as part of the 2004 health care accord, Dr. Postl. His 40-page report was issued by the government on June 30, 2006, on the eve of a long weekend. Part of your committee's report ought to be, at a minimum, an audit of Dr. Postl's recommendations regarding wait times.

The Chair: All right. Thank you, Mr. Moist.

I want to thank all the witnesses for coming today. Your comments were very useful and very insightful.

The committee will now be going in camera, so I will ask that you exit the committee room quite quickly so we can go into our committee business. I'll give you one minute.

[*Proceedings continue in camera*]

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