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Chair

Mrs. Joy Smith

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● (1105)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): Good morning. I want to welcome committee members.

I want to especially welcome the witnesses who have taken time to come to the committee today. We're so looking forward to hearing your presentations. We have a full complement of witnesses today, so we're going to have to stick very closely to the timelines.

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

We are very fortunate to have eight organizations with us today: the Canadian Health Professionals Secretariat; the Canadian Health Food Association; the Canadian Nurses Association; the National Aboriginal Health Organization; the Inuit Tapiriit Kanatami; the McGill Institute for the Study of Canada; the Canadian Health Coalition; and the Canadian Medical Association.

Because we have such a large complement of witnesses, we're going to have a maximum of five minutes for presentations per organization. Following that, we will go into the question period.

We will begin with Ms. Elizabeth Ballermann, co-chair of the Canadian Health Professionals Secretariat.

Mrs. Elisabeth Ballermann (Co-Chair, Canadian Health Professionals Secretariat): Thank you very much, Madam Chair.

It gives me great pleasure to be here on behalf of the Canadian Health Professionals Secretariat, or CHPS, as we call it, which is a national advocacy body that represents 70,000 unionized health professionals who deliver essential diagnostic, clinical rehabilitation, and preventive services. These highly trained professionals include medical laboratory technologists, physiotherapists, social workers, pharmacists, occupational therapists, dietitians, and psychologists, to name just a few of the non-physician and non-nursing health professions, and they work in every facet of health care.

The 10-year plan covers a lot of issues, all important to our members, but I'd like to focus on two main concerns: a failure to develop a strategic plan at the federal level to address the large and growing shortages of health professionals, and the failure to promote and ensure innovative solutions within the public system. I won't spend a lot of time on the latter.

On the shortages, as I said, our members are intimately involved in every step of care, from diagnosis to treatment to recovery, and a shortage of these professionals has serious consequences for timely, high-quality care. Most are aware of the shortage of doctors and nurses, but few know of the major, and in some cases growing, shortages among the many specialized disciplines we represent. Let me be clear. The shortage of these health professionals is not an impending problem; this crisis is here now.

In the interest of time, I'll focus on one specific discipline in our membership: medical laboratory technologists. It is estimated that 80% of diagnostic and treatment decisions are based on lab tests, and demand for many health services, including lab tests, exceeds existing capacity and is growing with the population and the ever-expanding types of testing.

Consider the following facts. The Canadian Society for Medical Laboratory Science estimates there are at least 1,000 vacant positions for laboratory technologists in Canada. At the same time, the CSMLS reports that 50% of the current workforce is eligible to retire by 2015. While there are aggressive recruiting strategies under way in some provinces, there just aren't enough academic seats, and, maybe even more problematic, there's a serious lack of clinical training positions.

There's a further complication. As a result of the major cuts of the 1990s, we're missing an entire generation from the industry, which has serious implications in terms of succession planning.

These are the facts. For some reason, governments have done little of significance to address these areas. It leaves people in some communities without access to critical services, and in some cases it places quality of care in jeopardy.

I strongly emphasize that the problem of shortages is deep and broad, affecting many different disciplines and not just our lab technologists.

There are five top areas where our governments must take action. The areas are:

- cuts by government in the mid-1990s, and I've discussed that already;

- lack of health human resource planning on a national level;

- interprovincial rivalries resulting in competition among provinces and across the world and luring of health professionals from one province to another, which is quite frankly poaching. These shortages require national solutions not isolated provincial initiatives.

- insufficient numbers of academic and clinical training positions in most provinces. Employment practices are contributing to the problem: part-time and casual workplaces and excessive overtime leading to burnout. Constant restructuring and reorganizing leads to instability, uncertainty, and poor morale. New equipment often sits idle because there aren't enough people to run it.

- lack of data, particularly among the varied professions in our membership, which is a major barrier to measuring and forecasting supply, mix, and distribution of professionals.

While the 10-year plan acknowledges the human resource crisis—I mentioned pharmacists and technologists—it did not establish a strategic plan or process to address the causes and remedy the problem. While we fully understand the difficult constitutional jurisdictional issues relating to health care, Canadians want and deserve a system that is second to none. It is imperative that all levels of government work to provide it.

On innovation in the public system, which has been covered a lot and will be covered again, I'm sure we all agree that the current system can't remain on autopilot, immune from change. Our position is that reform can and must be done through innovation within the public system, and unfortunately, the 10-year plan does not express this to our satisfaction.

We believe the federal government must do more to promote and ensure innovation within the public system for three reasons: it is the right thing to do, it's the smart thing to do, and innovation within the public system works.

We have listed a number of examples within our brief—

The Chair: Mrs. Ballermann, I'm sorry, I'm going to have to ask you to wrap up quickly because you're past time.

Mrs. Elisabeth Ballermann: Thank you very much.

● (1110)

In conclusion, I'll just restate the two main messages. Canada desperately needs an effective strategic plan at the federal level for a supply of health professionals, and our system requires reform.

The Chair: Thank you very much.

We'll now proceed to Ms. Anne Wilkie, vice-president of the Canadian Health Food Association.

Ms. Anne Wilkie (Vice-President, Head of Regulatory Affairs, Canadian Health Food Association): Good morning. Thank you for the opportunity to comment during the review of the 10-year plan to strengthen health care in Canada.

As mentioned, my name is Anne Wilkie and I'm the vice-president and head of regulatory affairs for the Canadian Health Food Association. The president and CEO, Ms. Penelope Merritt, apologizes for not being here today. The CHFA is hosting forums across the country for its members and the industry as a whole on legislation that was tabled earlier in April, and Ms. Merritt is hosting a session today in Montreal.

The Canadian Health Food Association is Canada's largest national trade association dedicated to the natural health and organic products industry. Our 1,300 members represent the entire supply chain and include growers, manufacturers, retailers, wholesalers, distributors, and importers involved in a variety of industry subsectors, such as vitamin and mineral supplements, herbal products, homeopathics, sports nutrition products, natural and organic foods, fibres, and health and beauty aids.

Our vision is for our industry to be the primary destination for all Canadians seeking optimal health and well-being. It is clearer now than ever before that more and more Canadians are discovering the positive health benefits that are associated with natural health products, and they are choosing these products to maintain and improve their health and well-being and that of their families. In fact, over 75% of Canadians have purchased natural health products. Our natural health products industry is currently valued at over $2.5 billion and it continues to grow.

The 1998 Standing Committee on Health's report, *Natural Health Products: A New Vision*, laid the groundwork for the creation of unique legislative and regulatory frameworks for natural health products, founded on the acknowledgement that natural health products were neither foods nor drugs.

The CHFA commends the government for their timely implementation of some of the 53 recommendations from the 1998 report. However, there is much more work to be done. In order to ensure that consumers have uninterrupted access to safe, effective, and innovative products at a reasonable cost, it is imperative that the government review the current regulatory environment for natural health products. We believe that for Canadians to continue to enjoy the access and choice of natural health products available today and to enable our industry to grow and to thrive, it is vital that the issues and concerns of the industry be addressed in a timely and appropriate manner that is reflective of the low-risk nature of these products.

Natural products play a key role in achieving optimal health and well-being. For increasing numbers of Canadians, there is a strong desire to have the ability to purchase a wide variety of natural health and organic products and to have the knowledge necessary to use them appropriately. To support Canadians in achieving optimal health and well-being, the federal government must provide a strong framework for Canada in health promotion and disease prevention. Research continues to demonstrate the health benefits associated with the use of natural health and organic products, and a compelling argument exists for the federal government to take a proactive leadership role in providing Canadians with the information they need to make informed choices.

We believe the Minister of Health should become the champion of the cause for wellness and work towards establishing Canada as a global leader in the evolution toward a more holistic and wellness-centred health care paradigm for the benefit of all Canadians.

The Canadian Health Food Association continues to push for a more proactive model of health care based on self-care, health maintenance, and health promotion.

We are therefore recommending to you the following:

- that the federal government become Canada's national leader in promoting a healthy lifestyle, increasing public awareness of the benefits of disease prevention, wellness, and self-care, including information on the benefits of natural and organic products;

- that the federal government encourage research that further defines the benefits of prevention, wellness, and self-care with respect to health optimization and risk reduction;

- that the federal government act as an international ambassador for a wellness centre model of health managment; and, lastly,

- that the federal government promote the benefits of organics as an option for Canadians seeking optimal health and well-being.

The Canadian Health Food Association is poised to work with the government as it strengthens its commitment to health promotion and disease prevention. Canadians expect this from their federal government. Let's be sure this opportunity is not lost. All Canadians will greatly benefit from this wellness approach.

Thank you for your time and attention, and I'd be pleased to answer any questions.

● (1115)

The Chair: Thank you so much.

We'll now go to Dr. Smadu.

Dr. Marlene Smadu (President, Canadian Nurses Association): Thank you, Madam Chair.

I'm Marlene Smadu. I'm the president of the Canadian Nurses Association. We represent over 133,000 registered nurses throughout the country.

Thank you for the opportunity to outline CNA's review of the progress of the 10-year plan to strengthen health care. I will make brief comments, with some recommendations around five of the areas. Further detail is provided in our brief.

First is a national pharmaceutical strategy. As part of the 10-year plan, first ministers agreed to the national pharmaceuticals strategy. In June of 2006, the national pharmaceuticals task force released its progress report to Canadians. CNA is concerned that many of the issues identified as priorities in the NPS are being addressed in isolation and that more focus needs to be put on a comprehensive strategy that addresses the issues, so we recommend sustained effort by the federal, provincial, and territorial governments to develop and implement a national strategy as outlined in the framework for a Canadian pharmaceutical strategy.

Second is health human resources. We would like to commend the government on the development of a framework for pan-Canadian health human resource planning and the consultation that provided for stakeholder input. Unfortunately, progress on this action plan remains slow. We are concerned over the lack of pan-Canadian coordination. No provincial or territorial health system functions in isolation from others. Mobility of health professionals is one example of this issue.

All signs suggest that we are on the brink of a health human resource crisis. A key solution to the nursing crisis lies in more effective use of our existing resources. By including technology, changing work processes, and addressing those issues in the workplace that lead to absenteeism, greater efficiency of the health workforce can be achieved. Several organizations have made significant progress on this, yet there is no formal mechanism to share these learnings across Canada or our organizations. Therefore, CNA recommends that first ministers establish a formal mechanism to promote the sharing and adoption of the innovative yet practical solutions to the health workforce crisis.

Third is primary care reform. The 10-year plan identified the electronic health record as a priority for primary care reform. Despite the numerous documented benefits of an EHR, progress has been slow. CNA recommends that funding for the Canada Health Infoway be increased and accelerated in order to realize the first ministers' vision of the electronic health record.

Fourth is the area of health innovation. The 10-year plan recognized the importance of science, technology, and research to strengthening our health system, as well as our competitiveness and productivity. CNA feels there is significant room for improvement, in terms of investment in information and communications technology. In the area of ICT, health care lags 25 to 30 years behind the banking industry and other industries. To promote the purchase of ICT in the health sector, CNA recommends that governments establish a 100% rebate of the goods and services tax charged to ICT purchases in the health system.

In the area of research, nursing science has been shown to reduce mortality, improve quality, and contain costs, contributing to Canada's economic advantage. Through the $25 million Nursing Research Fund, we have built research capacity and a strong nursing science foundation over the last 10 years, but ongoing research investment is needed. CNA recommends the federal government support a new, 10-year, $79 million federal program submitted by the Canadian Consortium for Nursing Research and Innovation to meet these goals and enhance nursing's contribution to the health and life sciences.

Finally, there is accountability. Though transfers to the provinces increased dramatically as a result of the 10-year plan, they were not necessarily matched with accountability. Health Canada has reporting obligations to Parliament and must monitor and enforce the five criteria and the two conditions of the Canada Health Act. However, Health Canada continues to allow provinces and territories to refuse to provide information on the for-profit delivery of health care in their jurisdictions. CNA recommends that Health Canada make use of its discretionary powers to enforce the principles and conditions of the Canada Health Act with respect to its transfers and report back to Parliament.

In conclusion, while progress has been made on some elements of the 10-year plan, significant challenges and opportunities remain.

Thank you for the opportunity.

● (1120)

The Chair: Thank you so much for your presentation, Dr. Smadu.

We'll now go to Dr. Tremblay.

Mrs. Paulette Tremblay (Chief Executive Officer, National Aboriginal Health Organization): Good morning, Madam Chair and members of the committee. Thank you for the invitation to participate in this session.

I'm Paulette Tremblay. I'm the chief executive officer of the National Aboriginal Health Organization. NAHO is an aboriginal-designed and -controlled body committed to influencing and advancing the health and well-being of aboriginal peoples by carrying out knowledge-based strategies.

I'd like to start by saying that according to the 2006 census, there are 1.1 million first nations, Inuit, and Métis people in Canada, which accounts for 4% of the Canadian population. It's the fastest-growing segment of the population, at nearly six times faster than the 8% increase for the non-aboriginal population in Canada.

Some 54% of aboriginal people live in urban areas, and 48% of the aboriginal population consists of children and youth aged 24 and under, compared with 31% of the non-aboriginal population. The median age—which is really important, because this is the halfway point—shows 50% of the Inuit population as 22 years old and under, and it is 25 years old for first nations and 30 for Métis, compared with 40 years old for the non-aboriginal population.

I'm stating these stats to show that the greatest need for improved health care services exists for the aboriginal population in Canada.

In 2004, at the first ministers meeting, $100 million was committed over a five-year period towards the aboriginal health human resources initiative. The goals of the initiative were to increase the number of aboriginal people working in health careers, improve the retention of health care workers in aboriginal communities, and adapt current health care educational curricula to improve cultural competence in health care providers.

With respect to access to care and wait times, there's no longitudinal data to show whether overall access to primary care and wait times have improved. There is a trend towards more community-based health programming in first nations and Inuit communities, but these programs represent a different type of service and are not equivalent to primary acute care services.

With respect to more aboriginal health human resources, again at this time we do not have a mechanism to track it. However, what we did was make an internal analysis. The information is sorely lacking at this time with respect to numbers, but we went back to the old data from the 1996 and 2001 censuses to see, if we could begin with a preliminary perspective, a glimpse of what the numbers are for aboriginal peoples involved in health care.

With that analysis, between 1996 and 2001 the count of aboriginal people in health care positions grew by more than 5,000 placements. The largest increase in the number of aboriginal health care providers appears to be among the Métis. In Ontario, the number of on-reserve aboriginal health care providers has increased to 90% from 78%, and the number of aboriginal physicians, dentists, and veterinarians has nearly doubled from 145 to 280. The number of aboriginal optometrists, chiropractors, and other diagnosing professionals increased from 40 to 80. The number of aboriginal pharmacists, dieticians, and nutritionists has tripled from 60 to 200 on reserve and quadrupled from 40 to 160 off reserve. And the number of aboriginal registered nurses in Canada has increased to 915 jobs.

This is a beginning, a preliminary look or glimpse; nonetheless, these figures are an indication that the numbers are increasing. However, we look forward to working with Health Canada and our other partners on our next analysis, which will include the 2006 census data and which will give us more of a trend. But there is an obvious need for more information and more analysis.

Continuing on the subject of aboriginal health human resources, NAHO, with the support of its partners and guidance of the Canadian Institute for Health Information and Dr. Gail Tomblin Murphy, one of the foremost authorities on health human resource planning, has taken the lead on the creation of a minimum data set that will be used to support needs-based health human resource planning for first nations, Inuit, and Métis communities.

Progress on finalizing the minimum data set for the aboriginal health human resources initiative has been slow. There are complexities surrounding the development of indicators and measures that are relevant to first nations, Inuit, and Métis and access to high-quality, comprehensive, and comparable data, and there are issues surrounding privacy rights, both individual and collective. However, regardless of the complexities, all stakeholders have been working diligently to address and overcome the issues, and progress is being made.

● (1125)

Finally, I would like to touch on health administration in aboriginal communities.

The Chair: You're over time now, Dr. Tremblay.

There will be time for questions. Thank you so much for that.

We'll now go to Ms. Onalee Randell.

Ms. Onalee Randell (Director, Department of Health and Environment, Inuit Tapiriit Kanatami): Good morning. My name is Onalee Randell, and I'm the director of the department of health and environment at ITK, Inuit Tapiriit Kanatami. ITK is the national voice that represents the approximately 55,000 Inuit who live in four regions of Canada, in 53 communities.

We often hear about the concerns specific to Inuit, and we are pleased to be able to present on the 10-year plan and our assessment of it.

I want to first talk about areas where we've seen some specific improvements in the last five years. I think the plan has been instrumental in that. One of the areas is the recognition that jurisdictions, including the two territories and two provinces where Inuit reside, as well as the federal government, have committed and recognize the need to work together to address jurisdictional issues.

We need to continue to work together to ensure that Inuit, like all other Canadians, have access to the care they need when they need it. But we also need to make sure that these solutions are made in the north, with community involvement.

Inuit are much less likely to access health care than other Canadians. In 2001, 46% of Inuit children had access to a physician. The Canadian average is 86%. Many of the physician services and medical services are provided by fly-in doctors and fly-in dentists, and the only cases that are seen are emergency cases. If the doctor doesn't happen to be in the community, then individuals are sent out to receive medical care.

The priority area that I want to focus on today is health human resources, because this has been identified as an area where we can make the biggest impact in the shortest time. In developing a relevant health human resource solution for Inuit, we believe that people have to start thinking outside of the health care box and look at the social determinants.

I'm going to spend a few minutes talking about some of the recommendations we would make for an effective health human resource strategy.

First of all, cultural and linguistic competency is a priority area. That means that people providing health care in Inuit regions must be able to provide it in the language of choice, with familiarity of Inuit culture and values. Inuit and western health knowledge and values must be combined. We've seen success in these types of models in communities, such as the Nunavut midwifery programs, which allow Inuit in Nunavut to stay in their home regions to have their babies.

With respect to infrastructure, there's a tremendous gap in infrastructure in Inuit communities. In some cases, the reason that health care providers and professionals cannot be hired is because there are no houses or office space for them to work.

On community health care workers, the paradigm we are recommending in Inuit communities is to focus not only on health care professionals like doctors and nurses and physiotherapists, but on community wellness workers, at a community level, who can be trained in programs based in their communities.

We think there's a need for an urgent review of education systems, beginning with early childhood. *The Nunavut Project* report, by Thomas Berger, reported that 76% of Nunavut youth drop out of high school and do not graduate. There are limited education opportunities in Inuit communities. One of our priority areas would be to make sure we bring these education opportunities closer to home so that individuals do not have to go thousands of miles away from their home supports.

When we talk about student support and education opportunities, as Paulette was mentioning, the demographics of the Inuit population are significantly different from mainstream Canadians. We've identified that student support, helping students be successful, not only in high school but also in continuing education, is important.

To summarize our recommendations, we believe that in order for any health care reform to be successful, we must ensure that there is community involvement in community health and that the community that uses the health services should be involved in the design, delivery, and maintenance of the system, not simply as the recipient of the end product.

As well, we have to be willing to look at alternative models of health care delivery in developing the solutions. We've spent a significant amount of time researching models in other countries, such as Alaska, that have had great success in addressing remote and rural health care delivery. We need partnerships to be formalized and recognized if we are going to continue to move forward to the benefit of Inuit in Canada.

● (1130)

Thanks for the opportunity to speak to you today.

The Chair: Thank you.

We now go to Dr. Maioni.

Dr. Antonia Maioni (Director, McGill Institute for the Study of Canada): Merci.

I am a visiting scholar at the McGill Institute for Health and Social Policy and a political scientist at McGill University.

[*Translation*]

Ladies and gentlemen, thank you for inviting me to speak about health care, which is an important issue for me, since I have focused most of my research on it, as a political scientist, but also because of its important place in Canadian political life and the life of all Canadians.

I would like to focus on three points that I welcome you to explore further during the question period: first of all, my general impression of this 10-year agreement, with respect to the broader public debate on health care reform; then, the positive aspects of this 10-year plan; and, finally, the issues to be resolved.

On September 15, 2004, I was in Ottawa with many of you, attending the First Ministers Conference which, very late in the night, resulted in an agreement setting out the parameters of the 10-year Plan to Strengthen Health Care. What struck me, as both a political scientist and observer at the conference, was the lack of trust, among provincial and territorial representatives, of their federal counterparts—and vice versa—but, at the same time, the realization by First Ministers of the political significance of this issue. In other words, one had the impression that the political leaders had finally understood that, in spite of the constraints and problems associated with this in economic, legal and logistical terms, this was an issue of fundamental relevance to all Canadians.

● (1135)

[*English*]

The reason why the 10-year plan of 2004 is so important is that it came on the heels of a remarkable trend in Canadian attitudes about health care, from exceptionally positive majorities supporting public health insurance and the health care system in the early 1990s to a rising trend of uneasiness and insecurity about the system's sustainability.

Was there a crisis? Well, there had certainly been a squeeze on public finances that had exposed some of the weaker elements of the organization and financing of health care systems. But my colleagues and I, among them Stuart Soroka, who wrote a report on public opinion for the Health Council of Canada, have qualified this crisis as more of a crisis in confidence, one born of a growing disillusionment with political leaders in terms of their capacity and willingness to address the problems that seem to wrack the health care system.

This was something that persisted despite the myriad number of provincial health care reports and even the Commission on the Future of Health Care in Canada's report of 2002. The paradox is that most Canadians are satisfied with the care they receive but are uneasy about the future. They are also concerned about specific issues, namely, emergency room overcrowding, waits to see specialists, and wait lists for specific services.

This brings me to my second point. What has the 10-year plan done to alleviate some of these concerns? The positive aspect is that it was signed, which I guess is proof of some goodwill in some corner of this place we call Ottawa. For observers of health policy, though, the good news is that the 10-year plan was based on strengthening health care through a series of concrete measures that were accompanied by the much-needed security of multi-year funding.

I am not one of those who thinks it's only about the money, but certainly a reinvestment in health on the part of the federal government could be seen as a positive development for provinces trying to put their own financial houses in order.

The measures that were raised in this 10-year plan are not minor affairs. As the other witnesses have said, they spoke to needs as varied as human resources, home care, and public health, as well as the needs of specific populations and the more general commitment to accountability and transparency.

The emphasis on wait times was a clear message to Canadians that their personal concerns were being heard and addressed, and in the years since there has been a noticeable commitment on the part of most provinces to primary health care reform and to better management of wait times in specific areas, which can be seen, at least in part, as facilitated by the commitment of the 10-year plan in this regard.

[*Translation*]

Thirdly, and to conclude, the plan was also problematical in a number of areas. It is important to recognize that we are talking about areas that are fairly complex and quite difficult to reform and reconcile. However, the First Ministers' Plan had the benefit of at least recognizing that they are all interrelated, when it comes to health care, and that you cannot address one part of the problem without confronting the realities of another. From a political standpoint as well, I believe that recognition of the asymmetry of the arrangements made with Quebec was also appropriate. For the first time in a long time, Quebec was included in the wording of the agreement, rather than in parentheses or in a footnote, as some of my colleagues would say.

However, these same advantages may have undermined the scope and success of the plan. First of all, the political focus on waiting times seemed to strengthen the perception that waiting time is equivalent to access to health care—a perception that continued to be prevalent when the Supreme Court handed down its ruling in the Chaoulli case. And yet, it is clear that waiting times for a particular service are only a symptom of the problem—organizational or financial—and not necessarily the real problem.

[*English*]

The Chair: Thank you, Dr. Maioni. I'm afraid you're over time. Do you have much left?

Dr. Antonia Maioni: Thank you.

The Chair: Okay, thank you.

Mr. Michael McBane, welcome. I noticed that you just walked in, and just on time. May we have your presentation, please?

Mr. Michael McBane (National Coordinator, Canadian Health Coalition): Sure. I apologize for being late.

On behalf of the Canadian Health Coalition, I'd like to thank the committee for the opportunity to appear. I must say, however, that I'm very disappointed in the limited amount of time, and obviously the limited number of Canadians who have the opportunity to appear at this extremely important exercise in accountability.

The Canadian Health Coalition is a public advocacy organization that was formed in 1979 at a conference called SOS Medicare that was attended by Tommy Douglas, Emmett Hall, and Monique Bégin. So all three federal political parties at one time believed in medicare. We have since had a second SOS Medicare conference, in Regina, last May. We had the pleasure of having Monique Bégin back again and a number of other notable Canadians and international experts.

Obviously there's been progress made in health care since the 2004 accord, but we have a long way to go. And we need the federal government back at the table. The federal government has an important and irreplaceable role to play in ensuring comparable access to a continuum of quality, appropriate care for all Canadians.

The first point I want to raise is a question. Why is the accountability gap in health care growing? We have a lot more money on the table—$41 billion plus a 6% escalator—and there's less accountability for the money. That's a huge problem. Medicare belongs to Canadians. Canadians pay for it. Canadians are the shareholders. Federal guardianship is necessary to ensure that public funds are used appropriately.

I should also point out that the Auditor General of Canada, in a number of reports, has said that the Minister of Health is unable to assure Parliament that provinces are in compliance with the Canada Health Act. If you can't ensure compliance, you should not be passing on the money. Parliament should be performing its duty to hold the minister to account so that we know if provinces are in compliance with the Canada Health Act.

The annual report on the Canada Health Act is a disgrace. It's a series of blank pages, and I would urge this committee to exercise its duty to hold the minister to account and to stop keeping Parliament in the dark about where our money is going, particularly with the growth of privatization.

I just want to quote from an access to information document from Health Canada that says that while the CHA issue per se doesn't address private delivery, there are serious implications that affect the health care system, such as charging for insured services and allowing queue-jumping. It also says that the government is free to say that there's no evidence to suggest that private delivery is more cost-effective, of higher quality, or more efficient than public delivery. The silence from the Minister of Health on these questions is deafening. The Deputy Minister of Health understands these questions, but they stop at the minister's desk.

I just want to jump quickly, then, to the other question I ask, which is why the federal government is standing by as medicare is being sabotaged as we speak in the province of Quebec, in the province of British Columbia, and soon in the province of Alberta.

Very briefly, there are two competing and conflicting visions of the future of medicare. According to Roy Romanow, one view, high on rhetoric, low on evidence, and masquerading as something new, is based on the premise that health care is a commodity, that what medicare needs is more market-based solutions. This view is advocated across the country by Claude Castonguay in Quebec, Don Mazankowski in Alberta, Michael Kirby, Preston Manning, and, to my left, Dr. Brian Day. There's a lot of money to be made in breaking medicare, and this is the reason owners of private, for-profit surgical and diagnostic clinics are promoting privatization.

The other vision is rooted in our narrative as a nation. Backed by evidence and ethics, it strongly believes that health care is a public good. It believes that democratically elected governments, upholding the rule of law, not corporate bottom lines, should define common needs, regardless of where you live. You should have access, even if you don't live in Vancouver or Toronto or Montreal.

Weak accountability mechanisms facilitate privatization, and it's no accident that the provinces that are resisting accountability—the Province of Quebec, the Province of Alberta, and the Province of British Columbia—are the provinces leading the way in opening the delivery of insured services to unaccountable commercial interests.

● (1140)

Fourth, why is progress in implementing the 2004 accord being impeded? Canadians need better access to a broad range of services, including pharmacare, home care, and home supports. We need to continue building a quality-based system that takes prevention and appropriateness of treatment seriously.

A reasonable citizen would conclude, after what you were told by the Health Council of Canada a few days back, that Canada's new government is actually impeding progress in implementing the 2004 health accord. Nowhere is this more obvious than in the dismantling of the federal-provincial-territorial working group on accountability. That's more than symbolic.

The other area where it's obvious that the federal government has withdrawn as an active player is in the implementation of the national pharmaceutical strategy. In fact, we're going backwards. The federal government has announced new regulations that will impede access to affordable medicine. That is a violation.

Just to conclude—

● (1145)

The Chair: Thank you, Mr. McBane. You're slightly over. Can you conclude very quickly? We have other people who want to speak.

Mr. Michael McBane: Sure. I will wrap up with two sentences.

Medicare needs public guardians, not private traders. Canadians expect the federal government to be the guardian of medicare and to enforce the Canada Health Act to ensure national standards. They expect the law to be implemented in all provinces, including Quebec.

Thank you.

The Chair: Thank you, Mr. McBane.

There will be time for questions, so if someone asks you one, you'll be able to expand on your thoughts.

We'll now go to Dr. Day.

Dr. Brian Day (President, Canadian Medical Association): Thank you.

Thank you for having me here today. The CMA appreciates the opportunity to present to the Standing Committee on Health, and I thank you for placing me to the left of Michael McBane.

To quote from the accord in 2004:

> First ministers remain committed to achieving results, recognizing that making health care sustainable and able to adapt to the ever-changing needs of Canadians will take time, sustained commitment, and adequate resources.

Based on the last three years, all too few of the accord's commitments have been kept.

Going back 74 years, in 1934, some 12 years before Sir William Beveridge's plan for a national health service in Britain, the Canadian Medical Association produced guidelines for a Canadian national health program funded and administered by the state. The Beveridge NHS plan was a partial template for Canadian medicare.

The NHS has recently undergone renewal and has evolved for the better. Patients have reaped rewards as wait lists have been effectively eliminated in just four years. Universal health care and excellent access can co-exist. We in Canada still cling to a system modelled on the old NHS. Our system needs to be more efficient, effective, and responsible. My presentation will focus on wait times and access, the shortage of doctors, and patient focus, care, and funding.

I'd like to emphasize that progress on wait times has been limited and is not consistent across the country. Provider and capacity shortages continue to be major barriers to access. Medically harmful wait times are not necessary. Wait times lead to human suffering and also carry severe economic costs. Just this year, we released a report showing that the economic cost, in 2007 alone, of patients waiting longer than medically recommended was $14.8 billion. That stunning total was for just four procedures identified as priorities in the 10-year plan. Imagine the cost if all the thousands of procedures were included.

A million Canadians continue to suffer on wait lists because of deficiencies in our system, and this is unacceptable. We need to break the back of wait times for the sake of our patients and for the economic health of Canada. This will require leadership, a revolutionary change in focus, and sustainable investments.

While the first ministers acknowledged the need to increase the supply of health professionals, not enough has been done. Canada is 26,000 doctors short of the average in developed countries and ranks 24th in doctors per population. The poll released by the Canadian Medical Association today found that Canada's doctor shortage ranked second to the economy in importance, and 91% of Canadians say the doctor shortage will influence their vote in an election. Political parties that ignore this issue in the next election could pay a price at the polls. We must increase the numbers, and we must be self-sufficient in the supply of health professionals.

In the 10-year, $40 billion plan to strengthen health care, the needs for improved efficiency, productivity, and performance were not adequately addressed. We must invest in health information technology; we currently spend only one-third of the OECD average in our hospitals. Many countries have systems that provide universal care, have no wait lists, and cost the same or less to run compared to ours.

Wait lists can and must be eliminated. We have to make the system work for patients, not the other way around. We must reposition patients at the centre of our health system and have the funds follow the patient—patient-focused funding.

The system of block funding for our health institutions must be changed. Block funding blocks access. As patients become a value to an institution rather than a cost, productivity and efficiency will improve and wait lists will fall. Canada remains the last country in the developed world to almost exclusively fund hospitals with block funding. In England, patient-focused funding helped eliminate wait lists in less than four years.

Why do we continue to keep patients on wait lists when research shows it's cheaper to eliminate the wait lists? Our system is encompassed in a vicious circle whereby rationing of services leads to limited access, reductions in the workforce, limited investment in technology, long wait lists that negatively impact the economy, resulting in funding pressures that force rationing, so completing the circle. Patient-focused funding can break that circle.

● (1150)

The 2004 first ministers accord was supposed to lead to a fix for a generation. It must not take a generation to fix.

Thank you.

The Chair: Thank you, Dr. Day.

Just before we go to questions, I want to say that we will be adjourning the witnesses at ten to one, because we do have ten minutes' worth of committee business that we need to do as a committee.

Having said that, we'll go into the seven-minute round at this time, starting with Mr. Temelkovski.

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

And thank you to all the witnesses.

Dr. Day, you mentioned that you're glad to be sitting to the left of Mr. McBane, but some of us on this side see you as being a little bit to the right of the Conservatives as well. It's all a matter of perception, I think.

You mentioned, Dr. Day, that there is a shortage of 26,000 doctors at this time, and I'd like to speak in regard to the human resources area of the plan. I'm assuming there are shortages of nurses as well, and radiologists, and so on. Right?

How many doctors do we graduate per year in Canada? Maybe we can get into the nuts and bolts of this.

Dr. Brian Day: There has been some progress with qualifying doctors. We're now up to close to 2,700. But to give you the numbers, in Canada we have seven medical school spots for every 100,000 citizens. Britain, for example, has 13, so we're way, way off from being self-sufficient in the supply of doctors.

Mr. Lui Temelkovski: What would it take to move that up?

Dr. Brian Day: We need to expand medical schools. There has been some progress in the last few years across the country, but it's not enough. We would like to see us get closer to the British statistic of 13 medical school spots per 100,000 citizens.

Mr. Lui Temelkovski: You're saying there are 13 schools per 100,000?

Dr. Brian Day: No, we have seven spots in medical school for every 100,000 citizens.

Mr. Lui Temelkovski: And they have 13?

Dr. Brian Day: They have 13.

Mr. Lui Temelkovski: That is roughly double. Would that be part of the investment we would have to make?

Dr. Brian Day: Yes, and the point I've been trying to make in my presentation is that we are spending a lot of money to keep people waiting in Canada. It costs more to have wait lists than not to have wait lists. Research shows that.

These people on wait lists are deteriorating while they wait. They end up being lost to the economy if they're not working. Their medical costs rise as they deteriorate medically. And we know, as doctors, that if we keep someone waiting for a year, it ends up costing more. They're going to the doctor for prescriptions during that time; they're on pain killers, and they're sometimes getting addicted; and they medically deteriorate while they wait. So it's actually cheaper to eliminate wait lists.

Mr. Lui Temelkovski: Was there a genuine concern or request to increase the number of physicians in Canada?

Mr. William Tholl (Secretary General and Chief Executive Officer, Canadian Medical Association): Perhaps I can answer that question.

We bottomed out at an intake of about 1,500 new graduates a year in the mid-1990s, and we're now up to about 2,700 enrollees in medical school today. So there has been a genuine concerted effort to increase physician supply.

We estimate that in order to get to a steady state, because it's going to take some time for those new medical students to graduate from the system, we probably would need about another 300, getting to about 3,000 doctors per year entering medical school, in order to get to a steady state.

● (1155)

Mr. Lui Temelkovski: It was mentioned by Professor Maioni, I believe, that there was some mistrust between the provincial, territorial, and federal governments when they were sitting around the table to set up this 10-year plan.

Does that mistrust still exist?

Dr. Antonia Maioni: I think it exists so long as there's a tension in terms of the roles of the spheres of government about who in fact makes decisions in health care. I think that's one of the questions that has not been resolved. It's not been resolved who should make decisions that would perhaps alleviate some of the problems that Dr. Day and other witnesses have made. It's not clear the federal government can do all that much about the number of graduates of medical schools, for example, when medical schools are under post-secondary education, which is a provincial responsibility.

So the big political questions about who decides have not been resolved. When you tackle that question of who makes the decisions, you're getting at the question about who gets.... If you decide, you decide who gets what, who gets what when, who gets how much, and who gets what kind and whether services can be provided privately, publicly, and how much money should be involved. But the big question is who should decide, and I think that fundamental tension is still there.

Not to belittle *le pas en avant* that the 2004 plan did make, it did break a logjam that was, in effect, paralyzing political debate about health care. So we've moved a step closer, but I don't think we've actually resolved that fundamental issue yet.

Mr. Lui Temelkovski: Dr. Day.

Dr. Brian Day: There are right now, as we speak, 1,500 young Canadians born here, educated here, with undergraduate degrees here who are going to medical school in foreign countries because they can't get a place in Canada. The federal government could have a role in helping repatriate them, because we know from statistics that these students tend not to come back, and we're losing young talent. That's one of the deficiencies that's happening as a result of our inability to create spaces in Canada. But certainly in the short term we should be trying to encourage those 1,500 young Canadians to come back to Canada and practice.

Mr. Lui Temelkovski: My understanding is that doctors are coming back in larger numbers then previously. They were leaving more so before and now they're returning.

Dr. Brian Day: The doctors, yes, but these students—we know from statistics and surveys among them—do not tend to come back. These are young students who are going to medical school in foreign countries right now.

Mr. Lui Temelkovski: Professor, my only—

Dr. Antonia Maioni: Well, they're often not able to come back. It depends on the country where they're studying. In some cases, their degree is not recognized by medical boards, so it's not just the government's fault. There's some kind of corporate professional accountability at play here as well. Those degrees actually have to be recognized, and they're not always recognized, so of those 1,500, some can't come back.

Another point—just to point out what Dr. Day was saying—is that it's not just the absolute number of physicians—

The Chair: Dr. Maioni, just very briefly, if you could. We are way over.

Dr. Antonia Maioni: It's simply the distribution of physicians as well. For example, at McGill, my university, the big problem is having residency in primary care filled. It's not about the specialists. They've got a lot of residents willing to do that; it's the primary care doctor that is the real rare specimen these days.

The Chair: Thank you, Dr. Maioni.

Madame Gagnon.

[*Translation*]

Ms. Christiane Gagnon (Québec, BQ): Thank you.

You are frustrated at not having more time, but we would also be frustrated were we unable to ask as many questions as we would like.

A number of witnesses have told us that the 10-year Plan was not really a success. Ms. Ballermann, representing the Canadian Health of Professionals Secretariat—, you say that enforcement of the 10-year Plan is not a success. It has not yielded the desired results with respect to health human resources. Having made that observation with respect to human resources and other aspects of the plan—as a number of you have done—how do you think we should go about developing a long-term plan, for example, in order to have more students studying medicine or various health care technologies? That is where there is a problem. There are waiting lists. We are told that the problem is not necessarily related to money but, rather, to resources.

What long-term advice would you give the government—be it the federal government or another level of government, since we really do not know who has the ultimate authority—as a means of guiding provincial actions in this area?

● (1200)

[*English*]

Mrs. Elisabeth Ballermann: Thank you.

Absolutely, we do require significantly increased seats in post-secondary education, not just for physicians and nurses, but for the panoply of health providers. There are examples, for example, in my home province of Alberta, where the government identified a certain shortage of nurses when the vacancies for health science professionals, the people whom we represent, exceeded those in nursing. But the Alberta government said they were creating 200 more nursing seats in post-secondary education and 40 for the allied health professions. The focus needs to include all the health care providers, and we need the data from across the country to address that. Data among some of the disciplines we represent—some of which have small handfuls because they're so specialized, some of which have only several thousand—are lacking simply because of the size of these groups. But their presence or absence is key to providing all of the services that are in the health care system—the diagnostic testing, the therapeutic testing. So clearly we need to increase the seats.

When we have the seats, we need to ensure that they're effectively utilized, insofar as we have to make sure we select the students in such a way that we don't lose them from the limited seats. There is a problem with attrition in some training programs, so if you start with 20 students and only 10 graduate, you've lost that opportunity for 10 people. So the selection of students, the seats themselves—all of these need to be addressed.

[*Translation*]

Ms. Christiane Gagnon: There is no doubt that the zero deficit objective was what resulted in this situation. However, the Canada Health and Social Transfer was not paid over a number of years, when the Liberals were in office. We are behind by some 15 or 20 years in terms of everything that could have been done to meet today's needs.

An alliance was established to monitor waiting times in various provinces. Some provinces are doing better than others in that respect. Perhaps they are better equipped or are devoting more money to it. I am thinking of Saskatchewan and Manitoba. There is also Quebec, which is going it alone and asking not to be a part of any national strategy.

I don't know which of you is in the best position to answer my question. What do you think of the support being given the provinces? Do they have more human resources? Are the provinces investing more money than the federal government? And what conclusions can be drawn from the comments made by the Wait Time Alliance?

[*English*]

Dr. Brian Day: Well, there are two things. First, there's a lack of comparability of data across the country. Different provinces are measuring things differently. You'll find, for instance, in certain provinces you are not put on a wait list. Even after you've seen a specialist and you've been told you need surgery, there are another two or three steps before you're actually put on the wait list.

Second, in our opinion, there are major concerns with the fact that governments are tending to target the four or five specific areas. As practising doctors and surgeons, for instance, we see resources being narrowed. We call it the balloon effect, where you take resources—whether they be nurses, doctors, or money—from one area of necessary care and put them into another. That's the problem with starting off with only five targeted areas; there is that balloon effect.

● (1205)

[*Translation*]

Mr. William Tholl: I have a number of comments to make.

[*English*]

In my opinion, as I look at the provinces that have performed well and those that haven't, it has to do with leadership and it has to do with assignment of responsibility. In Ontario you have Dr. Alan Hudson as the wait time czar. In Manitoba it's Dr. Brian Postl, the wait time czar. You have specifically tasked people to bring down and keep down wait times. I think that's the major distinction between those provinces that have been more successful or less successful in terms of the WTA scorecard.

[*Translation*]

Ms. Christiane Gagnon: The Health Council of Canada's data with respect to reports on Aboriginal health were not available. It is not clear what progress has been made; we don't even know whether funding has yet been allocated. In answer to questions with respect to monitoring, have you made the same observations, or is it because they are not providing better support with a view to meeting Aboriginal needs? In fact, we wanted to invite representatives of various organizations so they could tell us what their needs are.

[*English*]

The Chair: Madame Gagnon, we're just over time.

[*Translation*]

Ms. Christiane Gagnon: My colleague will pursue that in another round.

[*English*]

The Chair: Madame Tremblay, would you like to address that question quickly?

Mrs. Paulette Tremblay: To the question in relation to data not available, we are missing data. There are gaps. We are not able to track because we have no mechanism yet to look at the real numbers of aboriginal health human resources. Using the statistics from Stats Canada isn't good enough; they're not fully accurate at times. It's some sort of measure, but we need more. We need to go to the community level to see what is actually happening, what is needed, and we're beginning that with the needs assessment and situational analysis for first nations health managers. We have a contract with Health Canada under which we've begun project work. We're doing a needs assessment. But we're just beginning; we're only starting.

The Chair: Thank you, Dr. Tremblay.

Madam Wasylycia-Leis.

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

And thanks to all of you.

You should know that this is the last chance we get to hear from the public about the 10-year accord. Time is limited.

Mike, you made a good point. It has not necessarily been by the wishes of the committee, but I think, really, by design of the government, because we got a letter right from the very start from the Minister of Health suggesting that a focused, time-limited review by the committee would be in order. The suggestion was that very little progress has been made; therefore, there wouldn't be much point, even though we're almost halfway through the 10-year period.

I simply need to know from all of you—and I'll ask this in three different areas—what recommendations you would have for us as we prepare our report. It is a critical juncture. We're talking about the overall state of our health care system. I want to break it into three areas.

One, with respect, Mike, to the Canada Health Act, you were the only one who mentioned the lack of accountability and the failure of this government to live up to the standards in the Canada Health Act, which is part of the accord. People seem to forget. Written right in the accord is an agreement on the part of all governments to the existing system, and they pledge to renew the system, not dismantle the system.

We couldn't get the minister for this committee to deal with the CHA, we couldn't get the motion passed here at committee, so what do we do now to get some accountability from this government with respect to the Canada Health Act?

That's the first question. Then I want to go on to health human resources and then aboriginal health.

Mr. Michael McBane: Maybe to respond quickly from the perspective of the Canadian Health Coalition, there is an essential statutory duty on the part of the federal government, and if the current government doesn't believe in that, then maybe they're in the wrong job.

We have an election coming, and if they think health care is exclusively provincial and that Canadians don't want national standards, that Quebeckers don't want health care when they move to British Columbia, and vice versa, then that should part of the election debate.

I think we are at an impasse. We don't have real accountability. This committee has been shot down, in terms of examining the accountability standard in the Canada Health Act annual report, which is totally inadequate, according to the Auditor General.

I think most Canadians want to know where their money is going, so I think we have to keep at it and demand higher standards of accountability.

● (1210)

Ms. Judy Wasylycia-Leis: Thank you.

The minister was before committee, and it was interesting that he didn't mention the words “Canada Health Act”, “medicare”, “universal health care”, or “national health care” once. So I do question where he's coming from, what the government agenda is. But you're right, maybe all we can do is hold them to account in an election.

I know there are other hands, but let me raise another question and then have you jump in. That is the question of health human resources, which I think, by everyone who has appeared before the committee, is probably the number one issue facing the health care system.

When the deputy ADM appeared before the committee at the start of these sessions, there was not a word from her, Karen Dodds on the health human resource strategy. When the minister was asked, he basically tried to suggest, “Oh, we're doing a bit in terms of foreign graduates, and really it's a provincial responsibility.”

I guess I would like to hear from Elisabeth, from Marlene and from Antonia, and of course Dr. Day, on what we put in this paper, this response to the 10-year accord, that will drive this agenda and move it forward. This spring we're at the end of the five-year health human resource strategy. The government has no commitment to put a new strategy in place. What are we going to do?

Let's start with Elisabeth, and then Marlene.

Mrs. Elisabeth Ballermann: Thank you very much.

It's a difficult problem. The constitutional squabbling between the federal and provincial governments has been going on for generations. It seems to me we need to ensure that we have a plan and data to determine how many health professionals we will need and where we will need them. We need to have some level of encouragement to prevent the situation where Newfoundland educates a school of respiratory therapists and they all move to Alberta because that's where the money is. We need to do something to equalize the level of health human resources in this province, so it's not just a matter of wherever the money is best and that's where they're going to go.

I acknowledge that this is an incredibly difficult problem in a free country where people are free to move from point A to point B, but we have to figure out how to create incentives to ensure that all regions of this province have enough, and also that we create enough health professionals for our own uses. It is unconscionable that we would be going to other countries to take their highly qualified professionals when they desperately need them themselves.

Ms. Judy Wasylycia-Leis: Antonia, Marlene, and Dr. Day, I agree there are problems in terms of jurisdiction, but wouldn't it help to at least have the federal government enunciate the problem and say we have a serious crisis that we have to get on top of?

Marlene, and then Antonia.

Dr. Marlene Smadu: Thank you for the opportunity.

Before I address the health human resources, I do want to let you know that we did talk about accountability for the Canada Health Act in our brief as well.

Ms. Judy Wasylycia-Leis: Sorry, yes, you did.

Dr. Marlene Smadu: That's a very important issue for us as the Canadian Nurses Association.

The Chair: I want you to keep in mind that there are two questions directed to two people and we only have a minute left.

Dr. Marlene Smadu: Okay. I'll be very pointed.

The federal government is a huge employer of health human resources. There's a role they have to play in that regard. We have a pan-Canadian health human resources plan and it needs to be implemented. It deals with many of the things that Elisabeth talked about. On self-sufficiency, we need to ensure we are creating enough health providers for ourselves. We live in a global environment where the health human resources are a big challenge.

Dr. Antonia Maioni: It's not just about health; it's about education, it's about labour, and it's about other social services. We can't just think about health in a silo any more. This has to be an interdisciplinary effort, on the one hand.

Secondly, I don't see a lot of movement on that collaboration between disciplines and this particular issue of health human resources. We don't want health human resources to become the crisis *du jour*, as wait times were back then. We figured out it wasn't really about wait times; it was about doctors actually performing the services. We have to worry about having the crisis *du jour* attitude.

The next thing is about dispute resolution. There's a part about dispute resolution. I don't know if Michael alludes to this in his context, but I don't know what's going on there. Do we have any better way of resolving disputes than before? That too is at the heart of the problem between federal and provincial governments.

The Chair: Thank you, Dr. Maioni.

We'll now go to Mr. Brown.

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

My questions are for Mr. Day. I have three areas I want to delve into with you.

As we look at the health accord, obviously the rationale behind having hearings like this is to be able to improve whatever the next step is. I have three areas of concern I want to get your perspective on.

One is the different levels of service we have in Canada in terms of rural and urban delivery of health services. If you look at areas like physician shortages, obviously they're much more acute in a rural area than they are in an urban setting. The tendency is that hospitals face greater crunches in small towns on a range of levels.

Capacity is another issue I have a concern with. I'm not convinced the health accord gives enough attention to the capacity issues hospitals are facing. I look at my own hospital, the Royal Victoria Hospital. They tell me that consistently they're at 96% or 98% capacity, and there isn't a lack of beds. What leadership can we provide to have a vision and a plan to make sure there is an adequate infrastructure in the country so that our hospitals aren't always running at capacity?

A third area, an area that I think everyone is concerned about and has touched upon, is the recruitment and retention of health professionals. I sit on my own physician recruitment task force in Barrie, and I know many communities have these task forces, which are sort of competing with each other to recruit health professionals. It's certainly an effective solution to tread water right now, but it is in no manner a long-term solution.

I know you talked about the fact that we've gone from 1,500 to 2,700 graduates a year from medical schools. What is the long-term level we need? I understand that we'll be approaching 3,000, but what is the number that actually would serve Canada well? Is it 4,000? Is it 5,000? It would be interesting to know exactly where Canada needs to be.

I heard mention of the 1,500 doctors trained overseas and the need to bring them back. That's an area of concern too. Are there things we can do to expedite that process? You never want to have someone delivering pizzas or driving a taxi when he can be helping Canadians. But at the same time, are there any concerns that people who have not been accepted at Canadian medical schools but who might have got in abroad are up to our standards?

I realize we have equivalency exams. Are there things we can do to make sure those equivalency exams are as seamless as possible? I understand the cost for equivalency exams is $1,000 or $2,000, and many new Canadians don't have the funds to pay for those exams.

We set up a scholarship fund in my riding of Barrie to pay for those exams for foreign-trained doctors because they don't have the capacity to pay for books. What could we do nationally to help foreign-trained doctors integrate into the system faster?

● (1215)

Dr. Brian Day: With respect to rural and urban, we have a strategy on that. In British Columbia, for example, and elsewhere, it's been shown that if you have students from rural areas going to medical school, they're more likely to practise in a rural setting. In fact, the data on that in British Columbia is very positive. Those from the rural centres tend to want to go back. Of course, the crisis in medical manpower is at its greatest in rural Canada.

In terms of capacity, the theme I talked about in my remarks was about empowering the patient, not focusing on the system, which is what some people here want to do. Put the patient at the centre and not the system at the centre, and have everyone revolve around the patient. One of those means is to attach the funding to patients so that when patients go to an institution they are a value, not a cost.

We are the last OECD country that block-funds our hospitals. When you say there's no capacity.... There is no incentive in our system for a hospital to be efficient, to be effective in admitting and discharging a patient. We've seen a situation in Britain, which had a national health service and has universal health care, where in three and a half years wait lists have gone down and capacity has increased, because there's more.... For example, if I have an operation that takes one and a half hours and it's 3:30 in the afternoon, they won't let me do that operation because I might go overtime. That's because the patient is using up the hospital's money. So it's inefficient, and it's not putting the patient at the centre of the system.

On recruitment, 1,500 medical students are going to foreign medical schools, and many of them are very, very bright. In fact, there are over 200 Canadians in Australia and over 300 in Ireland. At one of the Australian universities, four of the top five students in the graduating class were Canadians. So they're not B students.

I think, again, we have a problem with recruitment and retention. Yet we have a situation in which 50% of newly trained orthopedic surgeons—some of the biggest wait lists in the country are for orthopedic surgery—leave within five years of graduation because we can't give them operating room time.

So the word that defines our approach to our health system is rationing. We're rationing access. The way we can break that is by attaching the funding to the patient, and then the vicious circle will be broken.

● (1220)

Mr. Patrick Brown: Is there any comment?

Ms. Anne Wilkie: Just very briefly, yes.

I wanted to comment that I'd like to see everybody kind of step back. We're all dealing with this issue of a shortage of resources and wait list times. We're coming from a different perspective. We'd like to see the resources focused more on health promotion and disease prevention.

There are excellent stats out there, health economic data, that show the health care cost savings that arise from the use of supplements. If you feed pregnant women multivitamins with folic acid, you reduce significantly the risk of neural tube defects. If you have supplements routinely used by elderly populations—calcium and vitamin D, for example—there are huge reductions in hip fractures. If you give lycopene to increase eyesight, there are benefits. There are decreased visits to doctors. There's decreased interdependency. There are huge savings that can be realized from the use of supplements and from giving the power back to consumers before they become patients.

The Chair: Thank you, Ms. Wilkie.

Now we'll go to the second round, and that will be five minutes for the questions and the answers.

We'll start with Ms. Kadis.

Mrs. Susan Kadis (Thornhill, Lib.): Thank you, Madam Chair, and welcome to all our witnesses.

I know we have very little time. There seems to have been a theme that's cropped up at all our meetings, and that is that there seems to be a lack of federal leadership by our current government on a variety of these important goals and objectives in the 10-year plan. One, in particular, is the national pharmaceutical strategy.

Ms. Smadu, we can't seem to get information on this. What's happening? We don't know if there's a co-chair of the intergovernmental body. What do you think is hindering this process? This appears to be typical of why we're not achieving a lot of these goals quickly enough.

So I'd like to ask you that and give everyone an opportunity, briefly, to put forth recommendations for our committee's report on the plan to strengthen health care.

Dr. Marlene Smadu: Thank you.

The national pharmaceutical strategy is very important to the Canadian Nurses Association and to nurses in the country. I can't answer your question about what stage it's at. We know that the report came out in June 2006, but I'm not sure what the next stage is, though perhaps Lisa can add something. We have not been informed, so we're very anxious to know.

Mrs. Susan Kadis: I would just ask you specifically, is there a federal partner? Do you have a federal presence in this particular case of the national pharmaceutical strategy, for example?

Dr. Marlene Smadu: Do we as an organization, do you mean?

Mrs. Susan Kadis: Yes. What's happening with that? We can't seem to get that information.

Dr. Marlene Smadu: No.

Mrs. Susan Kadis: Is there a co-chair, and if so, who?

Mr. McBane?

Mr. Michael McBane: From talking with them, provincial ministers of health seem extremely frustrated that they have a colleague in the federal government who doesn't even want to meet them. They don't even have regular meetings any more, and it's because the federal government will not come to the table with financial resources. They want to cut and run from health care.

We know the commitment has serious financial implications and that we won't expand pharmaceutical coverage without a federal financial contribution. That's why the process has stopped, because it's not a priority of the current government.

The perversion of all of this is that meanwhile the federal government is increasing the drug bill and refusing to share in the cost of paying those bills with the provinces with a federal-provincial agreement on pharmacare.

It's the worst of both worlds: they've violated the agreement to expand access to affordable medicine, and yet they're not prepared to share the costs of the rising drug bills. That's unacceptable. It's poisoning federal-provincial relations in every other health file as well.

● (1225)

Mrs. Susan Kadis: You're saying, essentially, that the government is implying that they support the accord, but in fact are not doing so, in many instances.

Mr. Michael McBane: That's right.

Mrs. Susan Kadis: Do you have some general recommendations for the committee on what you believe would help to strengthen health care for Canadians, for our committee report?

Dr. Marlene Smadu: In our brief we talk about the importance of properly investing in technology in the health care system. We represent over 134,000 registered nurses in Canada, and if you go into the health care institutions, you'll know that we are far behind banking, retail, or even pizza delivery companies in terms of their ability to use technology appropriately to facilitate their work.

When we speak of the shortage of our numbers, we're talking about being short 113,000 registered nurses by 2016. The number is so large that people can't even get their heads around it. We've really focused our attention on saying that we have to do our work differently, that we have to design our work differently, that we have to ensure we're using the full health care team to their fullest scope of practice and that we're working in a collaborative fashion with the patient at the centre.

But those things take tools. I know there was a question asked earlier about what kinds of tools. I just came back from the World Health Assembly in Geneva, and there probably weren't ten people in the room, representing 194 countries, who didn't have Palm Pilots or BlackBerrys or cellphones. You will not find those being used by nurses; they are not available to nurses in the health care system.

For a very easily available technology and a relatively small investment, we could make people's work more manageable. They would be able to work to their full scope of practice, using their nursing knowledge.

Mrs. Susan Kadis: And it would also cut down on adverse drug reactions—

Dr. Marlene Smadu: Absolutely.

Mrs. Susan Kadis: —which is something this committee has been examining in another study as well.

Dr. Marlene Smadu: Yes.

There's lots of research to show that when you have electronic health records, appropriate access to information, and appropriate technology, you will make work better, you will increase the quality, increase the patient safety, and ensure better patient outcomes.

Mrs. Susan Kadis: Thank you.

Ms. Maioni.

Dr. Antonia Maioni: If you are going to start investing in electronic health records, then the federal government had better step up to the table to cut some cheques, because that is the most expensive investment you can make in a health care system.

It is also probably in the long term the most effective way of using your money in long-term investment. But until we get electronic health records or some kind of sense to the mess we have, we're not going to be able to confront the realities and the real challenges of the future.

The Chair: Thank you, Dr. Maioni.

Now we'll go to Mr. Tilson.

Mr. David Tilson (Dufferin—Caledon, CPC): Thank you.

Some of the witnesses have suggested that some of the provinces haven't been pulling their weight. One witness—I can't remember which one—said the federal health minister hadn't pursued that.

I would like some of you to talk more specifically about that. If my assumption is correct, then what evidence is there that some provinces aren't pulling their weight, and which ones are they?

Anyone?

Mr. William Tholl: I guess what was being referred to is the most recent Wait Time Alliance report, where it basically said that there was progress across the board, but differentially from one province to another. All you need to do is look at that—I could give it to you. It basically gives a score.

Mr. David Tilson: I have that.

It's simply that one of the witnesses had said that some provinces were not pulling their weight. It was one of you two; I can't remember which one. Everybody is denying it. All right.

I'll move on to another area, Madam Chair, and that is the issue of home care. The 10-year plan committed governments to provide first dollar coverage for certain home care services: one, short-term acute home care; two, short-term community mental health care; and three, end-of-life home care.

Can any of the witnesses comment on whether various governments, the federal, provincial or territorial, have reported progress in providing the home care services?

I'm not doing very well here.

Mr. Michael McBane: I would comment that the accord's agreement on home care is extremely narrow and very inadequate to the home care needs of Canadians. That's contributing to serious problems with access to hospital services. If you can't give people access to home services, they're going to land in the hospitals.

The accord is very, very weak on home care. We need national home care standards, to raise them up, and you don't get national standards from provinces.

● (1230)

Mr. David Tilson: You're saying the provincial governments haven't provided any progress. Is that what you're saying?

Mr. Michael McBane: No, they've met the limited goal of the two-week post-acute care, but we've narrowed the goals so much. We're not talking about comprehensive home and community supports in the accord; it's only a two-week period. We've met that. But now we need to get on with the full continuum of home care.

Mr. David Tilson: Does anyone else have a comment?

Yes.

Mrs. Elisabeth Ballermann: I think it would be fair to say that to have a specific report from province to province to province is probably not possible. The reality is we still see situations where patients cannot be discharged home because there aren't people to provide the home care. It brings us back to the fundamental question of the human resources in the system.

I think we can all agree that prevention, of course, and social determinants...absolutely, we need to address those. But if there aren't the people, the occupational therapists, the physical therapists, the nurses, and the personal care attendants to provide the care in people's homes, it bottlenecks the whole system. Everything from getting people into emergency, through the wards, through the surgeries and home...if those people aren't getting the services at home, we'll not be able to solve the broader questions.

Mr. David Tilson: I'm looking at your paper. Unfortunately, time ran out on a couple of items on pages 5 and 6 of your report, Ms. Ballermann, and that has to do with specifically the third item, "Innovation within the public system works". You give out quite a number of examples of how wait times can be reduced. Can you add to that, because you really did get cut off and didn't have a chance to speak to that?

Mrs. Elisabeth Ballermann: Yes, unfortunately, time being what it is.

There are some tremendous examples. I'll give you one.

The Pan-Am Clinic in Winnipeg used to be a private system where orthopedic surgeries, shoulder and knee arthroscopies, etc., used to be done on a private basis. In other words, the government would fund for it, but there would be profit taken out of that system. The Government of Manitoba has taken that back into the public system.

It is now spending less per procedure than it did when it was a private, for-profit perspective, and the throughputs are amazing. All of the money they are saving on procedures, rather than going into the pockets of the investors.... And Dr. Wayne Hildahl, who is the executive director of that and used to be the owner, has publicly said the difference is he's not putting the profits in his pocket any more. "We're reinvesting that money in services and are able to increase the number of procedures we're doing." That's only one example.

There are a number of others that are there as well, whether they're in Alberta or in other provinces.

The Chair: Thank you, Ms. Ballermann.

We'll now go to Monsieur Malo.

[*Translation*]

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

At the various meetings we have had with respect to the 10-year Plan, there has been a lot of discussion of waiting times. Today is no exception in that regard. Dr. Day and a number of witnesses referred to this. It has become popular to assume that the current state of the health care system is directly linked to waiting times.

Ms. Maioni, you seem to be saying that we need to change that paradigm. Could you delve into this a little further and explain to us why we may want to set that aside and focus on something else?

Dr. Antonia Maioni: I would not say that it should be set aside, but it does need to be put in context. It is important to understand the reality of health care services. Waiting times for specific types of care depend to a certain extent on the kind of service that is required, the waiting time and the patient's general health status. It is important to know why the service is required in order to understand why those delays occur. It is a little like what happened on the *Titanic*. We know that there were a number of minor problems on the *Titanic*, but we cannot say that the ship was not sturdy. Certain things should have been included during construction.

Dr. Day focuses on the number of physicians, which may resolve the problem with waiting times but, as I see it, that is too broad a way of addressing the problem. Waiting times are really a symptom of something else. Why is a particular hospital unable to resolve a situation appropriately? Operating rooms may not be available. But why?

Reference was made to a report in *La Presse* the other day. It said that one of the reasons why there are not as many day surgeries in such and such a hospital is that there is not enough available equipment. Those problems can be resolved without our seeking to recruit hundreds of thousands of additional physicians. There are other things that can be done within the system.

● (1235)

Mr. Luc Malo: To come back to what Ms. Tremblay said earlier in terms of assessing whether health care agreements have been complied with as far as the Aboriginal people are concerned, you seemed to be saying that you were about to assess all of that.

Can you tell me how you intend to accomplish that? Do you have all the tools you require to carry out such an assessment? What money will you use to pay for it? And, will it be sufficient? Will the Aboriginal population be involved? It's a well known fact that, when Statistics Canada carries out surveys or prepares an analysis involving these populations, there is some reluctance to respond. How can you be sure that monitoring of the agreements—in order to ensure that commitments are met—will be carried out appropriately?

[*English*]

Mrs. Paulette Tremblay: I know from the research we do with the communities that there's a real movement toward community-based approaches whereby communities are involved. We engage the communities in anything we do. It's time-consuming and messy. It takes time to engage people and build capacity as you go, but we are moving in that direction. It's the right way to go.

I think you have to engage populations. Just as Dr. Day was talking about patient-centred treatment, I think it's aboriginal-centred, community-based treatment and involvement. We know that works. Yes, we need more tools. They will engage in assessment if we engage them from a community-based approach that's holistic. Yes, we need money to do it.

[*Translation*]

Mr. Luc Malo: Why did it take four years to realize that we were not equipped to carry out this kind of analysis?

[*English*]

Mrs. Paulette Tremblay: Why did we take four years? We've always needed the tools. We're building capacity in the communities around research, and it's been missing. There's been a gap and now we're beginning to build it. Our organization has been in existence for only eight years, and we're now in the process of getting out there and gathering information. So it's just becoming available now, and there's a lot more to do.

[*Translation*]

Mr. Luc Malo: Has the $200 million for the Aboriginal Health Transition Fund been allocated? In 2007, the Health Council of Canada's report did not mention it. Now we are in May, 2008; do you know whether that money is available?

[*English*]

Mrs. Paulette Tremblay: I can't answer that question.

The Chair: Thank you, Dr. Tremblay. We'll try to get that answer for Monsieur Malo.

We'll now go to Ms. Davidson.

Mrs. Patricia Davidson (Sarnia—Lambton, CPC): Thank you, Madam Chair, and thanks to each of our presenters for being here with us this morning.

It has certainly been an interesting discussion that we've been having to this point. I would just like to bring it back to the focus on the 10-year health care study and try to get an answer, from whoever wishes to give one, about where we can go forward.

I think we've all realized that we have issues that need to be dealt with. We know we're looking at the health human resources issue; we know we're looking at wait time issues; we know we are looking at a lot of other issues, such as jurisdictional issues.

I also know, through another body I belong to.... I have met at different times with the CMA. I have met with the emergency room doctors. I have met with family physicians. I also work with our doctor recruitment group in my own municipality, as does my colleague.

But there are so many issues that have come up that I don't know the direction we need to be taking. We have licensing issues. We've talked about foreign-trained doctors, and in speaking with the other medical groups at different times, I have heard different statements made. The point has been made that we have enough money in the health care system and that it just needs to be expended differently. Statements have been made that our hospitals have enough capacity and they just need to be operating differently. Maybe that speaks to this patient-focused care that Dr. Day was talking about.

But there are so many issues on which we just seem to keep going in circles. Although this is a 10-year federal health accord, we have two provinces who are not part of it. What kind of a challenge does that pose?

Could anybody give me a simple answer on how we should move forward, and how do we coordinate the different jurisdictional issues? Is that where we start?

This is open to anybody.

● (1240)

Dr. Brian Day: Okay, I'll start.

I think we have to ask ourselves why we have one of the most expensive health systems in the world and we're not performing. We had a Pollara poll done in December 2007 in which 68% of the Canadian public felt that the health system needed a complete overhaul or rebuild. You may not believe Canada's World Health Organization ranking of 30th, or the OECD ranking of 18 out of 20, or the recent European consumer ranking that put us at 23 alongside 29 European countries and last in terms of value for money.

Canadians are spending a lot of money to get inadequate service, and I think unless we look at the system—which we're not doing—and unless we look at things like the way we fund the system.... The biggest single cost is hospital care, and it is not being done efficiently. It is 30% of the total budget. If we could save a lot of money in that area, we can look after rural and aboriginal health.

The other thing—which no one has really brought up in any detail—is the public-private thing. It doesn't matter whether I would philosophically support the private sector, because Canada does not have any private hospital infrastructure, so we have to solve it within public hospitals, and it can be solved by making them more efficient.

I think our study earlier this year showed that for just four areas in the accord, it costs $15 billion to keep people on wait lists. There is now a study out on the Stats Canada website showing that the costs of mental health to the economy in one year are $51 billion. This is money going down the drain. We're wasting a lot of money in Canada, and we need to fix that.

The Chair: If I could just clarify something, all provinces and territories have signed the accord. Two provinces are not in the Health Council.

Mrs. Patricia Davidson: Okay, thank you.

Mr. Michael McBane: I think it's important for the federal government to provide leadership, but not in educating doctors. There are some areas that are obviously under provincial management, but at the federal government level we require some oversight and guardianship, some leadership to encourage innovations in the public system to solve problems, and some funding. Those are the areas that we see lacking right now—that kind of commitment to grow the system, to build the system, to expand it. Public insurance works, but we need more of it to cover prescription drugs and home care services. That won't happen without the federal government contributing to cost sharing.

I would like to see the committee get specific in its recommendations, for example, that the federal government share 25% of the costs of pharmaceuticals as a major step forward, as foreseen in the health accord. What's been lacking is the financial commitment to come to the table to build the expansion of a public system. I think everyone here knows, as Elisabeth said, that there are public solutions to questions, and they've been documented by the Health Council of Canada. The question is why everyone else isn't pursuing those successful models. That's where we need the guardian to push and to make sure we get value for our money.

The Chair: Thank you, Mr. McBane.

We'll now go to Ms. Wasylycia-Leis.

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

You've raised some very important issues here today. I think they will be helpful in our report.

One of them, as Antonia, Michael, and others have raised, is the issue of funding. For such a long period of time, every time we talked about a greater financial role by the federal government, we were dismissed as tax-and-spend individuals, when all the system really needed was innovation and reform, but that didn't mean more money. It seems to me that we have a situation in which federal transfers to the provinces still haven't got us up to a 25% partnership. As long as that's the case, it's pretty hard to advance a reform agenda.

Nowhere I think is that more apparent than when it comes to aboriginal, first nations, and Inuit peoples. I know that along with this main accord there was a separate accord signed on September 13, 2004. It committed to substantially increase the resources from the federal government to Inuit and first nations communities. I haven't been able to find out where that money is, other than in the last budget. The only significant health care announcement—and it's not even significant—was $147 million over two years for something about integration between health systems.

I need to know what is really happening and what we should be recommending, since we are talking about one of the most neglected areas, and seeing the most in terms of costs to the system, whether it's for mental health issues, suicide, addictions, you name it.

Why don't you start?

● (1245)

Ms. Onalee Randell: Thank you.

A lot of the money from 2004 is flowing, but one of the challenges is that just as it's starting to flow, it is almost done, because the last year is 2009-10. For example, for the aboriginal health transition fund, which was $200,000—and I'll tell you about the Inuit share of it—the first part of that money, a significant portion of it, flowed March 12. We have less than three years to spend five years' worth of funding. There's been some effect, but people are already starting to worry about what they're going to do with it in the future.

As far as the number of resources dedicated to mental health goes—$65 million over five years for suicide prevention for first nations and Inuit—that doesn't address anywhere near the need for suicide prevention, mental health counselling, and mental health supports.

The jurisdictional issues that people have been talking about between provinces and the federal government tend to be escalated in the Inuit communities. That's why in my presentation I talked about one of the benefits we have being improved relationships, but there's still a long way to go.

Someone asked previously what we can do and what kind of recommendations we should focus on. Other people around the table have mentioned that health promotion and disease prevention are of the utmost importance. If 85% of a population is hungry and malnourished or has nutritional deficits, then it's very difficult for them to be healthy. For Inuit populations specifically, they are the only group we can find for which life expectancy is decreasing. Canadian life expectancy is increasing, but the Inuit population across Canada has the same life expectancy Canadians had in 1940.

We need urgent and emergent recognition of this issue. It's difficult for people to contribute to health human resources if they're not healthy enough to make it through school or to be contributing as they could be.

Ms. Judy Wasylycia-Leis: Thank you very much. I'm glad you're both here to raise these issues with us.

I wanted to touch on one more issue if I have time. That is the role of the federal government, generally, on health care.

Marlene, you touched on it with respect to both accountability and the national pharmaceutical strategy. When I tried to suggest to the minister the other day that he really ought to follow through on a long-awaited promise for national home care, he basically said to me that I was raising issues that were provincial and I should go back to provincial politics.

Are we past the point of ever being able to hope for expanding medicare into areas of pharmaceuticals and home care and prevention, so that we can actually do the next step in medicare that we all dreamed of and still do?

Dr. Marlene Smadu: My own personal belief, and I guess it's my professional belief, is that we have to have a pan-Canadian federal approach in health care. I live and work in Saskatchewan. Anybody from there has that in their blood. They know that the medicare that we experienced was only phase 1, and that if we don't deal with prevention, promotion, and the holistic approach to health, we're never going to be able to deal with the challenges that our impoverished population, our aboriginal, first nations, and Inuit population experience.

● (1250)

The Chair: Thank you, Dr. Smadu.

Mr. Vellacott.

Mr. Maurice Vellacott (Saskatoon—Wanuskewin, CPC): Thank you.

I'm not exactly sure who would be the best to answer this question; I know there are a few who might want to jump in on it. It's on the issue of midwives. There has been the suggestion by numbers of people that more of an endorsement and support and encouragement for midwives would be a great help in terms of reducing costs.

I know there are turf protection issues involved there as well. I'm well aware that professional bodies have their own vested interests, if you will, sometimes. But I would appreciate a response on that, maybe from the Canadian Nurses Association, and possibly from Dr. Day or Dr. Tholl. I know Saskatchewan is moving that way. There have been other provinces ahead of us. I see it as a good thing. Birth is a natural, normal kind of thing; it's not a disease. For most normal deliveries it can be a good thing and reduce costs significantly.

I would appreciate your comments with respect to that.

Dr. Marlene Smadu: Yes, the Canadian Nurses Association is very supportive of midwives. As part of the International Council of Nurses, many of our colleagues in other countries represent nurses and midwives, and Canada is certainly far behind in terms of the proportion of midwives. Many of the jurisdictions are moving for the legislation and the supports, the education programs, to be able to support midwifery.

I would go back to the comment I made earlier, that in a time of limited health human resources we have to make sure we're utilizing all of our health providers and health professionals appropriately, that we're incorporating them as part of a team that provides the best service to the patients, and midwives have a long history of being able to provide excellent service to women and families.

Dr. Brian Day: I could comment. I'm in favour of midwives because I was delivered by a midwife.

But I think it has to be within the context of the skill set. Back when I was a young doctor in Manchester, England, I did 45 home deliveries with midwives. But there was a whole structure built to support that. We had what we called a flying squad. You'd have a surgeon who could do a caesarean section with an anesthesiologist and backup nurses and equipment in any home within two or three minutes. So midwives within a hospital setting, I think, will be a help, but not a major solution.

The other thing is that a lot of young doctors now are female. In fact, the majority of medical students, up to 70% in many medical schools, are female. My wife is a physician. That's a favourite part of their profession, and they like doing deliveries and looking after the mother and the baby.

So I think it's part of a solution, and I think we're supportive of collaboration with midwives, but it's not going to solve the major issues facing Canadian health care right now.

The Chair: Thank you so much. I want to thank particularly all the witnesses today for coming and giving your very insightful comments. We had a very large panel today, and you were very direct, very focused, and very helpful.

We do have some committee business, so if I could ask you just to leave the room as quickly as possible, with our thanks, we'll go straight into committee business, because I know members have to get on to their other duties.

So thank you. I'll give you a minute to just do that.

● _____ (Pause) _____

●

● (1255)

The Chair: Okay. I just very briefly want to give you some information for Thursday, just to remind you that there will be a three-hour meeting, from 10 a.m. to 1 p.m. So come prepared for a long meeting. Nine witnesses are confirmed, three of whom will appear by video conference. The minister is scheduled to appear from 11:50 to 1 p.m., and he will speak for 25 minutes, from 11:50 to 12:15, followed by questions until 1 p.m. The minister will have a PowerPoint presentation and a one-and-a-half-minute video.

I just wanted to make you were aware that this coming Thursday will be a longer meeting for everybody, and there of course will be food here and a chance for you to have some lunch along the way as well.

I want to thank you so very much. I must say I want to especially thank this committee for keeping within the timelines. I like to be very fair. I know one or two people feel they should get ten minutes while everybody else gets three or five, but unfortunately I try to keep it very fair for everybody, and I thank you for your consideration.

Mr. Temelkovski.

Mr. Lui Temelkovski: I have two issues. Was there a time change in the minister's appearance, because I believe he was scheduled to be here for a longer period? That's number one, and number two is to ask if we have made provisions for lunch.

The Chair: Yes, we have provisions for lunch, as I just said, and no, the time is the same.

The meeting is adjourned.

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