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Chair

Mrs. Joy Smith

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● (1530)

[*English*]

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

Before we start, I want to very quickly bring one thing to the committee. Last time we had an extra member from the NDP party who sat down and joined in the questioning. There are rules, and I only want to make you aware of the rules. After the committee meeting yesterday, a couple of people talked to me about the participation of other members in committee meetings. This is what everybody has to be aware of.

In addition to regular committee members, the Standing Orders also provide for associate members. Associate members are eligible to be named to subcommittees and may be designated to act as substitutes for regular members who are unable to attend committee meetings. Of course, that's when we sign the form and they sit in.

Any member of the House may attend committee meetings, question witnesses, and participate in the committee's public proceedings unless the House or the committee concerned orders otherwise, which means it's at the committee's discretion. In other words, someone may sit in, at the discretion of the committee, unless someone objects. In most committees, there is an objection if someone else sits in without permission from the committee itself. These members may move motions, vote, or be part of a quorum only when acting as an officially designated substitute for a permanent committee member.

I only want to make you aware of the rules. We'll be watching to make sure that everybody abides by the rules.

I would now like to welcome all the witnesses today who are coming to join us. We have witnesses from the Office of the Auditor General of Canada. Mr. Neil Maxwell is the assistant auditor general. I welcome you, Mr. Maxwell. It's great to have you here today. Glenn Wheeler, principal, thank you as well for being here. Louise Dubé, principal, I'm so glad you could join us.

From the Department of Health, we also have Karen Dodds, assistant deputy minister of the strategic policy branch. Welcome, Karen. Janice Dyer is the director general of applied research and analysis, strategic policy branch.

We also have the Department of Finance represented here today. Monika Bertrand is the chief, federal-provincial relations division, federal-provincial relations and social policy branch. It's a long title for one person.

I want to welcome you all. We look forward to your presentations today.

The Auditor General's office, the Department of Health, and the Department of Finance each have seven minutes to make a presentation. Following that, we will then go into the rounds of questioning.

Mr. Maxwell, would you be so kind as to begin. Thank you.

Mr. Neil Maxwell (Assistant Auditor General, Office of the Auditor General of Canada): Madam Chair, thank you for this opportunity to present the results of two chapters in our December 2008 report, a study on federal transfers to the provinces and territories and our audit of Health Canada's reporting on health indicators. With me today, as the chair has mentioned, is Glenn Wheeler, the principal responsible for those two chapters, and Louise Dubé, the principal responsible for our Health Canada audits.

Federal transfers to the provinces and territories make up a significant portion of the federal government's annual spending. They are a major source of funds for services provided to Canadians in areas such as health, post-secondary education, and social assistance. In the 2006-07 fiscal year, the most recent year for which complete information was available to us during the study examination period, these transfers amounted to about $50 billion or just under 23% of federal spending.

Our study looks at the three main types of transfer payments made by the federal government to the provinces and territories. We undertook this study to answer questions that parliamentarians have raised about federal transfers and our mandate to audit. Because this is a study and not an audit, it is descriptive and does not include recommendations.

In this work, we examined the three main mechanisms the federal government uses to transfer funds to the provinces and territories. The first and largest includes four major transfers managed by Finance Canada, including the Canada health and social transfer. The second mechanism involves the transfers of funds by individual federal departments to support specific programs areas. Finally, the third mechanism involves the federal government's transfers of funds to the provinces and territories using trusts managed by Finance Canada.

● (1535)

[*Translation*]

We found that the nature and extent of conditions attached to federal transfers to the provinces and territories varies significantly. While some transfers have specific conditions that recipients must meet, often including reporting to the federal government on the use of the transferred funds, others are unconditional. In all cases, the federal government is accountable for its decision to use transfers with or without conditions as the best policy choice available in the circumstances. However, as auditors, we recognize that decisions on whether, and to what extent, conditions are attached to transfers are policy decisions, often involving sensitive federal, provincial and territorial negotiations. In our work, we do not question policy decisions.

A significant change in transfer mechanisms used by the federal government was its introduction of trusts in 1999. Since then, 23 trusts have been established to transfer almost $27 billion to the provinces and territories. Transfers of this type are earmarked in public announcements by the federal government for specific purposes (for example, patient wait times guarantees), but there are no conditions that legally obligate provinces and territories to spend the funds for the announced purposes or to report subsequently on that spending to the federal government. As an alternative, federal officials told us that the government has opted in recent trusts to require provinces and territories to publicly announce how they intend to use the funds, on the assumption that their legislative assemblies and citizens will hold them to account for these commitments.

[*English*]

As mentioned, our December report also contains a chapter on our audit of Health Canada's reporting of health indicators.

The Government of Canada and provincial and territorial governments reached a series of agreements to strengthen and renew Canada's publicly funded health care system. The 2000 health communiqué, the 2003 first ministers accord on health care renewal, and the 2004 first ministers 10-year plan to strengthen health care called for governments to demonstrate accountability through comprehensive and regular reporting to Canadians.

One of the key commitments was for the federal, provincial, and territorial governments to report to the public on comparable health indicators. First ministers saw health care reporting as an important vehicle for enhancing transparency and accountability. All jurisdictions subsequently agreed on a comparable set of health indicators to report on. Public reporting by governments promotes accountability in a number of ways, for example, by allowing Canadians to see the extent to which governments are attaining their goals and objectives.

[*Translation*]

On behalf of the federal government, Health Canada has responded to commitments in the agreements on health indicator reporting by preparing Healthy Canadians: A Federal Report on Comparable Health Indicators. This report is published every two years, with additions in 2002, 2004, 2006 and one upcoming for 2008.

In our audit, we examined whether Health Canada's reporting on health indicators met the commitments made in the first ministers' health agreements. We also examined whether its reporting has improved over time.

We found that Health Canada met specific health indicator reporting obligations that were required by the agreements—including identifying common indicators for reporting with its provincial and territorial counterparts. The department has produced a health indicators report every two years.

Although Health Canada met the specific commitments to report on health indicators, The Healthy Canadians reports do not fulfill the broader intent of the agreements—that is to provide the information Canadians need on the progress of health care renewal. While the reports provide indicators, such as self-reported wait times for diagnostic services, they do not provide sufficient information to help readers interpret them. There is no discussion of what the indicators say about progress and health renewal. Without interpretation, their ability to inform Canadians is limited.

● (1540)

[*English*]

We reviewed each edition of *Healthy Canadians* to see if it had improved over time. We found the presentation of the information in all three editions was essentially the same, with some modest improvements, despite the fact that Health Canada had received feedback through consultations indicating that the information needs were not being fully met through the reports.

Madam Chair, Health Canada agreed with our recommendations and committed to a number of improvements for the 2008 edition, with the remaining action to follow, including a thorough review of its role and its approach to health indicator reporting in 2009. Health Canada needs to clarify its role relative to other health indicator reports produced by the Canadian Institute for Health Information, Statistics Canada, and the chief public health officer. Your committee may wish to ask Health Canada what improvements have been made in the 2008 edition and what plans are in place for subsequent improvement.

Madam Chair, that concludes my opening statement, and we would be very pleased to answer your committee's questions.

The Chair: Thank you very much, Mr. Maxwell. We look forward to inquiring about some things in a few moments.

We'll now hear from Karen Dodds, assistant deputy minister.

Dr. Karen Dodds (Assistant Deputy Minister, Strategic Policy Branch, Department of Health): Thank you. Madam Chair, members, I'm very pleased to have the opportunity to be here with you this afternoon.

[*Translation*]

I am here to talk about two important aspects of the Auditor General's report—federal funding and reporting, as related to health care.

The federal government has demonstrated its commitment to health care by increasing transfers to provinces and territories, including growing support for health.

[*English*]

I'd like to set the context for my remarks by noting that we've had a long and productive relationship with the Auditor General. We invited the Office of the Auditor General to audit the first release of *Healthy Canadians* in 2002, and then again in 2004 and in 2006. In 2008 the Office of the Auditor General decided a more overarching review of health information reporting would be useful. We're pleased that the Auditor General has undertaken this task and has provided to us the very useful feedback that they did in their report.

[*Translation*]

To clarify, Healthy Canadians is a federal report to all Canadians, on comparable health indicators at a national level.

Each province and territory is committed, in the health accords, to releasing a separate indicator report covering their own jurisdiction, to their own citizens.

[*English*]

The Auditor General has indicated that Health Canada has met the specific health indicator reporting obligations of the accords. However, it noted there are ways that *Healthy Canadians* can be improved, and we've taken time to rethink some of those improvements for its next release. In *Healthy Canadians* 2008, to be released next month, we've taken the Auditor General's recommendations to heart and have made some significant improvements. We have expanded the report's scope by adding 19 new indicators drawn from a list of 70 comparable indicators approved by federal, provincial, and territorial health ministers. This brings the total number of indicators in *Healthy Canadians* to 37.

For example, on access we've added the proportion of the population that reports having a regular family doctor. We've added wait times for surgery and specialists.

● (1545)

[*Translation*]

On quality we have added, for example, mortality rate for stroke; mortality rate and readmission rate for acute myocardial infarction.

[*English*]

On health status and wellness, we've added, for example, life expectancy; infant mortality; low birth weight; and mortality and incidence rates for lung, prostate, breast, and colorectal cancer. We've also added more in-depth interpretation of the data by clearly relating it to accord commitments.

We will have a more proactive communications approach with a media release, posting on the Health Canada website, notification of health professionals, and highlighting of the report in announcements and speeches. For *Healthy Canadians* 2010 and beyond, we will be providing more data on first nations and Inuit health from the Aboriginal Peoples Survey. We're also working with other federal departments to determine how health data can be collected and reported for federal population groups, including the military and RCMP staff, veterans, refugees and some immigrants, and federal prisoners.

[*Translation*]

Our minister is very interested in the health status and well-being of Canadians. She is well aware of the indicators and statistics surrounding life expectancy, infant mortality and the prevalence of diabetes in the population. She is very supportive of improvements in reporting on health and the health care system.

[*English*]

So reporting to Canadians is, and will be, very important, and we'll do our utmost to go further in comparable indicator reporting.

We're here to answer any questions you may have. We look forward to profiting from the Auditor General's observations and the discussion this afternoon.

The Chair: Thank you very much, Karen, for those insightful comments.

We'll begin with our questions now. The first round is seven minutes each.

We'll start with Ms. Murray.

Ms. Joyce Murray (Vancouver Quadra, Lib.): Thank you.

I'm taken aback by the idea that the 2008 report is due in two days and we're spending two hours on the 2006 report. I hope I can make some questions and comments that will still be useful.

My background is having sat at a cabinet table for four years, wrestling with health spending that was ballooning out of control and gobbling up the budgets of other important ministries, like environment. At the same time, I have lots of constituents who are very concerned about health care and value for money and how we can avoid this continuing to balloon while maintaining a public health care system. I think indicators, measures, and goals and targets are critical to improving things. Just by measuring things, you improve them. There's research on continuous quality improvement.

A quick question I have is to the assistant deputy minister, Ms. Dodds. Given the purpose of the 2006 report—to provide information on comparable health indicators to help federal, provincial, and territorial jurisdictions and health care providers monitor trends and progress toward improving the health of Canadians—do you believe this report does that?

Dr. Karen Dodds: As we've noted, *Healthy Canadians* is one of the ways in which we fulfill our reporting obligations under the accords.

Ms. Joyce Murray: So that's a yes? You feel this actually helps with that goal?

Dr. Karen Dodds: There is an agreement in the accords that the comparable indicators would be common and agreed upon by federal, provincial, and territorial ministers of health. That 2006 report has 17; for 2008, we've more than doubled it, including another 19.

Ms. Joyce Murray: I appreciate that you've responded to the Auditor General's comments, which I thought were very tactful, considering the gap between how indicators could help us improve our health care delivery and what I thought this delivered in terms of usable information. The Auditor General's talk, in terms of delivery, page 8 or 9—no documentation to give you the guidance as to what to do, not clear what the report's trying to do, doesn't tell a performance story, has not improved over time. The recommendation is that Health Canada should review its role and approach to health indicator reporting. That's relatively pointed.

Do you believe, Ms. Dodds, that your 2008 report is a substantive change in approach, or is it an incremental improvement on what was in the 2006 report?

● (1550)

Dr. Karen Dodds: As the Auditor General noted in her report, and as we've discussed, we have not just the report *Healthy Canadians* in order to report on the health accord. The intent of *Healthy Canadians* has been, and has continued to be to this day, to report on the comparable indicators that were agreed upon by federal, provincial, and territorial ministers. We've added more and we've added interpretation this year. But beyond that, there are many other ways of reporting. The Auditor General noted, and we agreed, that it's difficult to pull everything together. We report every year to Parliament in our report on plans and priorities. We report in the departmental performance report and in our main estimates, etc., on different bits.

Ms. Joyce Murray: Yes, but I'm focusing on this one. But thank you for the context.

I have another question. What does it cost to produce this report, including all the staff time and salary and benefits that go into it?

Dr. Karen Dodds: I'm just checking with my colleague, who has more direct responsibility.

The Chair: Are you going to speak to that, Ms. Dodds, or would Ms. Dyer like to speak to it?

Ms. Dyer, do you want to comment on that, please?

Ms. Janice Dyer (Director General, Applied Research and Analysis Directorate, Strategic Policy Branch, Department of Health): In direct costs, we spend about $53,000 a year to produce the book. We have three people who work on it. The staff time for three people is roughly in the neighbourhood of $150,000 a year. That's about what we spend.

Ms. Joyce Murray: For two years?

Ms. Janice Dyer: We do it only every two years, so yes, we spend that amount of money divided by two. You're right.

Ms. Joyce Murray: As a public citizen reading this to figure out how we're doing and what we need to do, I would say it's not hugely helpful for actually providing health care the opportunity to monitor trends, etc. It's not helpful at all. I'm not trying to be critical here. You're attempting to do what a collection of provinces indicated would happen, but it just seems to be window dressing to me. I'm wondering if it is inherent in Health Canada's mandate and the politicization of potential outcomes that....

Maybe this is for Mr. Maxwell. Do you believe it's possible for Health Canada as an organization to meaningfully put forward indicators and trends that can inform the professional public and health care providers so we can improve how we deliver health care?

The Chair: Just to give you some time, Ms. Dodds, could you try to answer some of those inquiries?

Dr. Karen Dodds: Thanks very much.

Again, when you go beyond comparable indicators to trends and progress about health care, Health Canada provides up to $10 million every year to the Health Council of Canada. In the accord, the Health Council of Canada was mandated to do the overall reporting on trends and progress from the health accords. That's different and separate from simply the comparable indicator reporting.

We also provide $81 million every year to the Canadian Institute for Health Information. As well, we provide some funds to Statistics Canada. Those two organizations are very important in putting together the data which we then collect and put into *Healthy Canadians*.

What you see going into *Healthy Canadians* is just one small part focused on comparable indicators. In terms of the money, as my colleague said, it's three professionals versus several hundred at the Canadian Institute for Health Information and the large staff at Statistics Canada and their health program.

● (1555)

The Chair: Thank you, Ms. Dodds.

Monsieur Malo.

[*Translation*]

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

Good afternoon and welcome. Health Canada's clients include, of course, the aboriginal and Inuit population. The Auditor General's report was rather critical of the rather low number of indicators for studying or describing the state of health of aboriginal and Inuit communities, and it stated that more specific indicators have to be used for that population.

Given that Health Canada has acknowledged that its indicators are rather limited and are not able to follow changes in the state of health of aboriginal and Inuit populations, will the 2008 report indicate any improvements?

Dr. Karen Dodds: Thank you for the question.

[*English*]

Health Canada, as you've noted, does provide a range of health care programs and services to first nations and Inuit. We don't provide all health care services, and much of the difficulty in collecting data is the fact that we don't provide all services.

We do continue to support the collection of data. We have supported the First Nations Regional Longitudinal Health Survey, which is administered by the Assembly of First Nations. Results from the first cycle of that survey were released in November 2005, and we've committed $12.5 million to support infrastructure, data collection, and dissemination for the next survey, with results expected in 2010. So the frequency with which we get data on the first nations and Inuit people doesn't match our two-year cycle for *Healthy Canadians*.

We've also contributed $5 million, in collaboration with other departments for a total of $40 million, to fund Statistics Canada's 2006 on- and off-reserve Aboriginal Peoples Survey. That's an omnibus survey that collects information from first nations, Inuit, and Métis on health and social determinants of health indicators. That information was released in December 2008, and we look forward to further studies on that information.

We're an active participant on the federal-provincial-territorial task force on aboriginal health data and indicators, which is overseeing provincial- and territorial-led pilot projects aimed at improving existing aboriginal health data sources.

[*Translation*]

Mr. Luc Malo: From what I understand the next report will not include any clear improvements with respect to the Auditor General's assessments or observations.

Dr. Karen Dodds: We have added 19 comparable indicators for the Canadian population but not for first nations and Inuit populations. At this point in time we do not have the data to allow us to do that.

Mr. Luc Malo: Mr. Maxwell, do you have anything to add with respect to that specific area?

Mr. Neil Maxwell: Thank you, Madam Chair.

As we noted in our audit, the department is obviously facing several challenges. This is very difficult work to undertake.

[*English*]

That is true, and this perhaps gets to the earlier question as well.

There are many challenges. It seemed to us that probably the most important thing for Health Canada to do, both in terms of first nations information and indicators more generally, was a really good job of mapping out all these different forms of reporting, which are done both inside Health Canada and outside, and then try to have a good plan for filling the gaps.

The gaps are as much about aboriginal health as they are about all the other parts of the national picture and the other parts of the federal population. If you look at the veterans, members of the Canadian Forces, and Correctional Service of Canada inmates, there's a number of populations there too where there's very little information.

● (1600)

[*Translation*]

Mr. Luc Malo: As you know, the Government of Quebec has always said that it will cooperate with the federal government with respect to information related to indicators, however it does not feel obliged to do so because it is accountable to its own population.

In paragraph 1.19 of Chapter 1, you state the following:

> More recent large transfers reflect a shift away from government-to-government reporting and toward government-to- citizen reporting. Under this model, the federal government reports to Parliament on how much it transferred to provincial and territorial governments and why. Recipient governments are then expected to report to their legislative assemblies, their citizens, and their stakeholders on how they use public funds, including federal transfers. Provincial and territorial compliance with these reporting expectations may be subject to audit by their respective auditors.

Mr. Maxwell, is that not what is happening with the federal government's attempt to use comparable indicators, whereas the provinces are more inclined to do what you are suggesting in paragraph 1.19 of your audit?

Mr. Neil Maxwell: Madam Chair, our mandate is restricted to the federal level, therefore we did not look at what the provincial governments are doing in that area.

[*English*]

I would add that really in these two different studies we were talking, in the first chapter, of course, about arrangements much broader than health alone. So when we were talking about the nature of accountability, it was not just about health but more broadly.

[*Translation*]

Mr. Luc Malo: You would agree that generally this is a practice... You said yourself that this involves the more recent larger transfers. One could therefore assume that this is becoming the preferred model. Did I understand correctly?

Mr. Neil Maxwell: Yes. According to the officials we discussed this with,

[*English*]

very much, this model is something that dates back to the 1990s. The Social Union Framework Agreement included many of these principles, that it was no longer accountability of governments to governments as much as, increasingly, accountability of governments to their citizens. So it is a principle that you see increasingly being relied upon. And in our study we talked about one very obvious example of that, which is the trusts.

[*Translation*]

The trusts are truly based on that principle.

Mr. Luc Malo: Thank you.

Thank you, Madam Chair.

[*English*]

The Chair: Thank you very much.

It's now the NDP's turn. There has been a request for Ms. Carol Hughes to speak, and before you came in today.... The rules are that she may speak providing the form is done and the member leaves so she can ask the questions. So you should not be in the room if Ms. Hughes is going to be asking the questions. And just to let you know, no one can come in and ask questions without asking the will of the committee, first of all.

So Ms. Wasylycia-Leis, if it's Ms. Hughes, would you please allow her to speak and you can take this time to....

Ms. Judy Wasylycia-Leis (Winnipeg North, NDP): Exit? I'd be glad to turn over things to Carol. I've brought the forms for her.

The Chair: Thank you.

All right, the forms are signed now. Ms. Hughes, as soon as Ms. Wasylycia-Leis leaves, you may start.

Ms. Judy Wasylycia-Leis: Are the rules absolutely that they can't have another member in the room?

The Chair: They are, Ms. Wasylycia-Leis. They are. Trust me.

An hon. member: That's a strange rule.

● (1605)

Ms. Judy Wasylycia-Leis: Yes, it is. That's a very strange rule.

The Chair: You can discuss it with the clerk later. Let's go on.

Ms. Hughes, go ahead.

Hon. Carolyn Bennett (St. Paul's, Lib.): She doesn't have to leave the room.

The Clerk of the Committee (Mr. Georges Etoka): No, she doesn't have to.

The Chair: Well, then you have to step back.

Ms. Judy Wasylycia-Leis: I didn't think I had to leave the room.

An hon. member: I don't think you have to leave the table, either.

The Chair: Well, you've signed the paper.

Last time, to be quite honest, this came up because there was no paper signed. And I let it go because I thought we could just discuss this today. So any time another member wants to speak we have to be clear that the paper has to be signed. That was brought up to me after the committee.

Ms. Hughes, go ahead.

Hon. Carolyn Bennett: Madam Chair, perhaps you would seek unanimous consent that we would allow the member of Parliament to sit at the table, seeing that there are enough chairs.

The Chair: Of course. Yes, go ahead.

Ms. Hughes, go ahead.

Hon. Carolyn Bennett: So please do come back to the table.

The Chair: Let me clarify, Ms. Wasylycia-Leis. Last time the rules were not observed, and what happened was that you were both at the table, asking questions. Members came to me afterwards, so we clarified the rules. The rules are that the paper has to be signed, which it has been done. So I understand, yes, they can stay at the table, then.

Mrs. Carol Hughes (Algoma—Manitoulin—Kapuskasing, NDP): Thank you. I'm glad we got that cleared up.

The Chair: I am too. It caused quite a bit of trouble last time. Thank you.

Mrs. Carol Hughes: We are in the midst of an economic crisis, and it has become even more critical than ever that we fully grasp our government spending in order to make important choices to support Canadians through these tough economic times. Health is a major spending item and obviously an area to examine. The Health Council of Canada has just launched an initiative to promote a critical value-for-money assessment of health financing in Canada. It's released a document to stimulate debate and launch a new website as well.

So one of my questions is this. Does the Auditor General have any comment on how this important value-for-money discussion might be inhibited by the state of health transfers, as described in your report?

Mr. Neil Maxwell: Thank you, Madam Chair.

We've had a chance to skim that report. I believe it was just released yesterday. I have a sense of the Health Council, and of course, we follow its work quite closely in terms of our audit work.

The reason we did this audit goes back to those three health accords. As I said in my opening statement, it's really about the importance of accountability. As we looked at the *Healthy Canadians* report, what we'd often ask ourselves was, is this a good report card? Does this give you a good sense of what's being accomplished by those many tens of billions of dollars that we've invested in health care in 2000, 2003 and 2004?

As we said in the audit, we found the report—and certainly the 2006 one, which we audited—quite deficient. We really questioned the value of putting it forward, but I would then certainly say that accomplishing this or getting a good report card on health outcomes is clearly something that's important for accountability.

Mrs. Carol Hughes: Just as a follow-up question for the Department of Health, has Health Canada not conducted such assessments to make sound decisions on federal health spending?

I have another one as well. How can it make decisions if it doesn't ensure it has the information?

Dr. Karen Dodds: We collect information, as I said, from a wide variety of sources. We fund the Canadian Institute for Health Information, at $81 million per year. CIHI, as it's otherwise known, works with the provinces as well and has developed a very credible, solid reputation as a collector and publisher of health information. We fund Statistics Canada as well, and other surveys, which I mentioned when Mr. Malo asked his question about first nations. So we certainly put an investment into the information that we believe we need to make good decisions.

Mrs. Carol Hughes: Health Canada has come before this committee for years acknowledging the vacuum of knowledge about where federal health transfers are used but pleading that it can't hold other jurisdictions responsible. What is disturbing about the lack of monitoring and surveillance is not whether or not the recipients are accountable per se, but that Health Canada doesn't appear to think it's worth its while to find out as much as possible about how federal transfer money is being spent. So when you consider that about $24-plus billion dollars are in play, ignorance is not bliss.

Now, why doesn't Health Canada follow its transfers to see if they're being used effectively, whatever the accountability is?

● (1610)

Dr. Karen Dodds: We take measures that we have the authority to take. As your colleague Mr. Malo noted, and as the Auditor General noted in chapter 1, all jurisdictions have their own responsibility, their own accountability. That's one of the issues with the *Healthy Canadians* report. In 2002 and 2004. All provinces did report on comparable indicators in their own jurisdictions, but they have ceased to do that.

We're not responsible for the transfers. I don't know whether my colleague from Finance has any further comment on those, but we do follow up all of the information that we can with respect to health and health care.

Mrs. Carol Hughes: Did you want to add anything?

Ms. Monika Bertrand (Chief, Federal-Provincial Relations Division, Federal-Provincial Relations and Social Policy Branch, Department of Finance): What I would add is that under the Canada health transfer in 2009, we are providing about $24 billion in cash support to provinces and territories. The transfer stands from the 2004 accord, as you're probably aware, and it provides growing, predictable support to the provinces and territories in support of their health care needs. The health transfer is legislated until 2013-14, so it will grow to about $30 billion. As I said, it is very much based on a political agreement that was struck in 2004.

Some of the measures of the CHT are for specific purposes. In the 2004 health accord, you will see there was funding for medical equipment. But it is all part of the CHT now, and we do not follow the specific purposes that were set out in the 2004 accord. Instead, it's up to the provinces and territories to use the funding according to their priorities and to be accountable to their residents for how they spend this $24 billion-plus each year.

Mrs. Carol Hughes: I'm wondering if the Auditor General has any comments with respect to that, because obviously there seem to be some inefficiencies; it's not working the way it should. There are still some concerns with regard to how these transfer payments are not being monitored properly.

Mr. Neil Maxwell: Madam Chair, the study about how the transfers work is largely in the first chapter. What we said is that when there are conditions it's the responsibility of the federal government to ensure those conditions are being met and, if they're not being met, that they're taking action. This is a principle the government officials talked to us a lot about. You apply that principle to this particular case of the CHT, and I think that then becomes the basis upon which Health Canada, in its responsibilities, does the monitoring of the CHT. To the extent to which there are conditions—and they are conditions under the Canada Health Act, obviously—that then become the responsibility of Health Canada.

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

We'll now go to Dr. Carrie.

Mr. Colin Carrie (Oshawa, CPC): Thank you very much, Madam Chair.

I want to thank the witnesses for being here today. When I knew that both of you were coming I was kind of excited, because one of the criticisms I always get as a politician is that people say the right hand doesn't know what the left hand is doing, and it seems that today we have a great opportunity because we have both hands right here in front of us at committee.

I wanted to ask a particular question, and it's directed to Mr. Maxwell.

You mentioned that the 2006 report was quite deficient, and here we have Health Canada in front of us and they've responded with the 2008 report. I thought Madam Dodds did a great presentation here. She's indicated that in *Healthy Canadians* 2008 they're going to be adding 19 new indicators.

What do you think of that? We have you here in the room now and I think it's a unique situation. Health Canada is saying what they have in this report coming up, but they also outline in 2010 what they would like to do: provide more data for first nations and Inuit health from Aboriginal Peoples Surveys, work with other federal departments, etc. In the spirit of efficiency and accountability, do you have some suggestions or comments for Health Canada proactively? What do you think?

● (1615)

Mr. Neil Maxwell: Yes, thank you, Chair.

There are several things. One is that, like any good auditor, we would reserve judgment until we can see it—we're from Missouri. Nonetheless, I think that in listening to what Health Canada has said it has done as part of 2008, there's certainly much more change there than we saw in any of the previous editions, and their conclusion was that each of the previous three editions was largely just a repetition of the one that preceded it, with relatively little creativity, relatively little sense of trying to continuously improve. On the face of it, what they have set out to do in 2008 is a step in the right direction.

In response to our recommendations, Health Canada made very clear, as does your question, that this is just an interim step, that there are a number of recommendations we made that they have not attempted to deal with in 2008 and that remain for future years.

Certainly, to your question and to some of the previous questions, I think one of the big unknowns in here is the extent to which the federal government, through its leadership, can bring the provinces back to the table. As Ms. Dodds said, when this all began after the 2000 and 2003 accords, the provinces were on board. Slowly over time the provinces chose to no longer publish comparable indicator reports in the form that was called for under the three accords, leaving just the federal government in that game. Certainly part of the original and continuing logic, the raison d'être of all this, is that Canadians would have the basis to look not just at what the federal government has to say but also at what the provinces have to say. That's the notion of comparable. In the title, "comparable" has a very important meaning, the ability to compare.

Mr. Colin Carrie: That's what I like to see. I see the two of you here in the room. I was wondering, do you have dialogue in between the reports, or would that defeat the purpose? Is that not exactly mandated? I would like to see, from an efficiency standpoint, if they're on the right track, which they appear to be. They've listened to you, they've made some changes, they've put some projections there. I think it would be a really good idea if there were that dialogue. Is that something you can do or is that something you do regularly?

Mr. Neil Maxwell: Madam Chair, absolutely. We have had discussions through the years. We've been involved in this production for some years, in each of the editions, in different ways. We have those ongoing dialogues. As auditors, when we do that we're very careful to maintain our independence, for the simple and very important reason that if we were so involved with working with Health Canada or any other departments that we were no longer objective, then we really couldn't do our audit job later on. However, within the confines of that, there's quite a bit we can and do do, absolutely.

Mr. Colin Carrie: Very good. Thank you.

To Health Canada, I was wondering if we could get a comment on the evaluation and the approach you're taking. Have you held public consultations on the issues of improving recording on health indicators? What were the outcomes of those consultations? Would you be able to elaborate on those today?

Dr. Karen Dodds: Thank you very much.

We have, in the past, had some consultations and we have responded to them. They go back a way. As we've indicated in our response to the Auditor General's recommendations, we plan on doing that again in this calendar year. It is not a large population in Canada that has had a real interest in health indicators. The value for money report by the Health Council may raise that, because indeed the chief purpose of that report is to prompt Canadians to ask questions about health care. There's no new information in the report. It's a report designed to have people ask questions. However, we've used people in the interim always—colleagues across Health Canada and the Public Health Agency—to provide input to us in terms of what indicators make sense and what data we do have.

Mr. Colin Carrie: Are there web-based consultations where average Canadians can put their comments in? Mr. Maxwell brought up a comment with the provinces. Is there that ongoing dialogue with the provinces to see how we can better work together?

Dr. Karen Dodds: There are many ways in which we work with the provinces. If you'd like to pursue that, I would. However, in terms of reporting and accountability, as Mr. Malo has said for Quebec, most of the provinces are in the same mindset that they will report to their residents on their progress. They do it in a variety of ways too.

We continue to work together on a number of elements, absolutely, under the health accord. We do have plans to have *Healthy Canadians* 2008 on our website. You can comment on anything on our website from the website.

● (1620)

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

Now we're going to be going to our second round. It is five minutes, and we'll start with Ms. Duncan.

Ms. Kirsty Duncan (Etobicoke North, Lib.): Thank you, Madam Chair, and thank you to all of you for coming.

I think we admire the goal of *Healthy Canadians*—anything to increase transparency and accountability. We're all interested in improving the health of Canadians. But I do have some concerns.

First of all, I guess it is national data. I wonder why the data are not disaggregated, because health conditions vary so much from one part of the country to another. I'm wondering what the data are comparable to. If we really wanted to do this, I think we would have a table of the health indicators and then by region and perhaps by vulnerable population.

These are some of the questions. I'm wondering when the 2008 report is due. I understand that a committee has been struck but that they're going to report after the 2008 report. I could be wrong on that. Is there a template for doing this? Is there a province or someone we can point to and say they're doing this well, and can we emulate that?

Dr. Karen Dodds: Those are good questions. Why aren't the data disaggregated? As I just said, it's clear in the accord that it's an agreement between first ministers. Each province will report to its residents, so it's not up to the federal government to report to Quebeckers or Ontarians on the situation in their specific provinces.

The other question you asked, by population, again, the only—

Ms. Kirsty Duncan: Could I interrupt? I'm sorry.

It's impossible with national data to then set goals to make real change. Is there a way we can look at this differently?

Dr. Karen Dodds: The reason for comparable indicators is so that you can, if all of the provinces report, have consistency in what they're reporting. The Auditor General has noted this in the past. One of the challenges is to become consistent in health reporting in each jurisdiction. That's been one of the benefits of having the federal government put a highlight or a spotlight on certain issues.

One of them, for example, is wait times. When we started work on wait times, you couldn't even find information about wait times. As your colleague said, how do you determine progress in something that you don't measure? Seeing that wait times was a priority in the accords, we started measuring it. You quickly find out that not just province by province are there differences, but region by region, and hospital by hospital, and specialty by specialty there are differences. This is an area in which all jurisdictions have worked very closely to try to improve the consistency of health data so we can do what you're interested in doing, and we're making great progress.

Ms. Kirsty Duncan: The regional comparisons are so important.

The other thing I wanted to bring up—and I know I've thrown a lot of questions out there—is that when you actually look through so many of the indicators, they're voluntary reporting.

Dr. Karen Dodds: One of the institutions that does do regional reports at times is the Canadian Institute for Health Information.

● (1625)

The Chair: You have about 30 seconds. Did you have something?

Ms. Kirsty Duncan: Are you able to address even the idea of a table? If we're going to be truly transparent, that seems to me a very good way of becoming transparent.

Dr. Karen Dodds: What kind of table?

Ms. Kirsty Duncan: Indicators down the one side, regions across. I know that brings you back to the issue of regional disparity.

Dr. Karen Dodds: And regional reporting as well.

The Chair: Thank you so much.

We'll now go to Ms. Davidson.

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

Thank you very much to the presenters for being here today. Certainly this is an issue of great importance to all of us and of great interest to us.

One thing I would like to return to and perhaps get some comments on from both Mr. Maxwell and Ms. Dodds is the transfers and the accountability and whether or not people have to be accountable for how they spend those transfers. This is the one thing I get the most comments on from residents, the fact that the federal government transfers all of these millions of dollars to the provinces but there is no accountability or no way to hold the provinces accountable for how they spend that money.

It may be determined that this money, when it leaves the federal coffers, is thought to be for a specific purpose, but it may not end up being used totally for that. I think this causes a great deal of concern to Canadians: the fact that we have a federal government, regardless of who that government may be, that is interested in health care and is contributing, and we've made the commitment that we're increasing the health transfers by 6%.... How can we assure people that those health transfers are going to go where they need to be going and that they're going to go where the federal government intends them to go? Is there a mechanism? It's my understanding that there is not a mechanism right now to do that, but is there something we can do once the accords are renewed, or once there is something else negotiated? Is there something we can put in those agreements that would allow for this?

Maybe, Mr. Maxwell, you could respond from your point of view, and Ms. Dodds or Ms. Bertrand, you could respond from yours.

Ms. Monika Bertrand: Let me start with a general comment on transfers. At the Department of Finance we are responsible for four major transfers. Two of those are unconditional transfers—and they're in support of health, of course, depending on provincial and territorial priorities. There's equalization, which is an unconditional transfer that exists to ensure that provinces can offer comparable levels of services at comparable levels of taxation. Territorial formula financing is a similar transfer that takes into consideration the needs and the costs of the north. These two transfers are unconditional, and provinces use them wherever their most pressing needs are.

Two other transfers, health and social transfers, are conditional transfers. The health transfer provides support to health care systems in provinces and territories, and there is a condition attached to them. It is the Government of Canada's main support for the Canada Health Act, so the condition is related to the five principles in the Canada Health Act and to extra billing and user fees. The social transfer is also a conditional transfer, and the condition attached to it is that there cannot be any minimum residency requirements. Those are the two conditions that guide these two large transfers to provinces and territories.

In terms of accountability, Canada is one of the most decentralized federations in the world. Provinces are free to set their own tax rates and to decide what they're going to tax. With that revenue, the provinces are free to set their own priorities as to what their key policies are and what policy priorities they wish to fund with these revenues. Similarly, with the transfers—the $52 billion that we provide to the provinces and territories—they are fairly free to use these large amounts to meet their own needs and priorities, and they're not obliged to report back to the federal government. In a mature federation, they are obliged or encouraged to report back to their own residents, but not to the federal government. This is how the transfers have evolved over time.

If you go back to when we were looking for national standards, our transfers were cost-sharing transfers, and there was a specific goal and purpose defining why these were cost-sharing transfers and why we expected provinces to report back to the federal government. Starting in 1977, we have pretty much moved away from that principle and towards the principle of public accountability.

This is just how the transfers have evolved and how the federation has evolved.

● (1630)

The Chair: Thank you very much, Ms. Bertrand.

Did you want to make another comment, Ms. Dodds? Did you want to add to that?

Dr. Karen Dodds: I would, if you don't mind.

The Chair: Sure. Go ahead.

Dr. Karen Dodds: Concerning the provinces' ability to set their priorities, no matter which area of the health accords you look at, the provinces have set different priorities. If you look at wait times, the provinces have chosen very different wait times and guarantees to emphasize. One of the issues is that provinces, depending on their population and the situation, are focused on improving something first that might be different from what another province chose.

A table of indicators might be helpful, but if you looked it would be very difficult to say that province X is making the most progress, because they're all picking different things upon which to put the emphasis, and their own citizens are the ones to hold them accountable.

The Chair: Thank you,Ms. Dodds.

Monsieur Dufour.

[*Translation*]

Mr. Nicolas Dufour (Repentigny, BQ): Thank you very much.

Thank you for coming today.

In her November 2006 report, the Auditor General concluded that: "Health Canada does not know whether regulatory responsibilities are fully met", with respect to the product safety, drug products and medical devices programs.

According to the report, failure to carry out these responsibilities could have consequences for the health and safety of Canadians, such as exposure to hazardous non-conforming products and to ineffective and dangerous therapeutic products.

Health Canada should undertake a review and establish program baselines in order to meet their regulatory responsibilities. What is the status of that review?

[*English*]

Dr. Karen Dodds: I'm not certain which Auditor General report you're referring to. I know there was one that looked at two of our regulatory programs, and indeed the department did report on progress with respect to those regulatory programs on a regular basis. As this committee was looking at this most recent report, I don't have all of the latest information available, but I know we were providing regular updates with respect to that older chapter from the OAG.

[*Translation*]

Mr. Nicolas Dufour: Fine.

Ms. Louise Dubé (Principal, Office of the Auditor General of Canada): Given that I was responsible for that report, allow me to expand on that information. Health Canada actually provides progress reports and one of these should be ready soon.

Mr. Nicolas Dufour: My second question is about anti-smoking programs. The minister recently told us that one of her priorities was tobacco control, mainly with respect to first nations. We know that the percentage of smokers is very high amongst aboriginals: 56%. In 2004 it was 71% for the Inuit. Yet, the government cut $10 million from anti-smoking programs that focused mainly on pregnant women and young Inuit.

Given that this was one of the minister's priorities, has Health Canada issued a directive to cancel those $10 million cuts, or demonstrated a will to establish an equivalent anti-smoking program?

● (1635)

[*English*]

Dr. Karen Dodds: I know when the minister was with the committee on the supplementary estimates there was some discussion, and as I recall, there were no reductions to any of the programs that were specific to first nations and Inuit people with respect to tobacco or any of their addiction strategies.

[*Translation*]

Mr. Nicolas Dufour: Thank you very much.

[*English*]

The Chair: Do you have a question, Monsieur Dufour?

Then we will go to Mr. Brown.

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

I appreciate the comments so far.

There are a few indicators that I was curious about in terms of why we don't monitor them or whether there's been any effort to monitor them. One of them is capacity issues. Is there ever information that is shared, or has Health Canada looked into studying the capacity challenges that hospitals have? I know that in Simcoe Muskoka the number one challenge the hospitals have is capacity. RVH, for example, is at 98% capacity, and that's their biggest request right now with the provincial government.

Could there be some federal surveillance of that significant challenge to the health system?

Dr. Karen Dodds: Thanks for the question.

We have regular meetings with our provincial and territorial colleagues and we work at the federal level on those issues that the provinces agree warrant a national and a federal presence. One of the issues that have been undertaken in collaboration with provincial and territorial colleagues is health human resources, which obviously has a direct impact on capacity in hospitals. The federal government has provided significant funding over the last number of years to support a pan-Canadian strategy on health human resources.

Mr. Patrick Brown: I am interested in health human resources, but in terms of capacity, I'm thinking about the lack of beds available. For example, if we look at wait times, is the fact taken into account that frequently patients are sent away from the hospital because there is no capacity to handle any other patients? I know on numerous occasions patients at RVH in Barrie are sent to a different hospital; they're told they're no longer able to go there.

Is that added into the indicators on the time periods involved, when people are not able to be served at their local hospital?

Dr. Karen Dodds: Certainly we collect, as others do, information about wait times. Part of the focus on wait times has helped to elaborate these different sorts of process parts in the different steps between somebody thinking they have a serious problem that needs to be addressed by a specialist, seeing their family physician, being referred, going to emergency, and all of those different things.

What we do from the federal level is align what we're doing with federal roles and responsibilities. So to support provinces in their responsibility, because it's a provincial responsibility to deliver health care and hospital services, we have worked with them very much on health human resources, which should help issues such as wait times.

This most recent budget announced another $500 million for Canada Health Infoway to support a number of things, including the goal of having 50% of Canadians with an electronic health record by the end of 2010, I believe it is, which really should also help the issue with wait times across the system.

Mr. Patrick Brown: By 2010, did you say? Is that the date?

Dr. Karen Dodds: I'm pretty sure that's the goal.

Mr. Patrick Brown: On that note in terms of electronic health records, I'm also very curious about that. Are there any monitoring abilities for how that's trickling down? Does the federal government have any means by which we can track where we are in that process?

● (1640)

Dr. Karen Dodds: Again, those moneys go to Canada Health Infoway, which is an independent organization funded by the federal government.

Mr. Patrick Brown: Does Health Canada get a report from Canada Health Infoway?

Dr. Karen Dodds: We do. Their goal is to have 50% of Canadians with an electronic health record by 2010. I believe it's 100% by 2016.

The budget this year also included funds to work on electronic medical records, which are specific, then, to physicians' offices instead of being patient specific and doctor specific.

Mr. Patrick Brown: If I recall, in 2006 there was $400 million for electronic health records as well, wasn't there, in the budget?

Dr. Karen Dodds: The total investment is now $2.1 billion, I believe, to Canada Health Infoway.

Mr. Patrick Brown: So if 2010 is a year away with a goal of 50%, do we have any idea of where we are, being so close to 2010?

Dr. Karen Dodds: Yes. Canada Health Infoway publishes annual reports and periodic reports. They believe they're on target for meeting those targets of 50% coverage by 2010.

Mr. Patrick Brown: The reason I ask is that the CEO at the hospital in Barrie told me they've never seen a nickel from the provincial government or Canada Health Infoway for electronic health records. I asked them if there were any electronic records, and they said there's no immediate timeline where they'd be looking at that. I obviously find that disconcerting when I see all this money allocated.

The Chair: Mr. Maxwell, I think you also want to comment on some of these things.

Mr. Neil Maxwell: Yes. Thank you, Madam Chair. This is such a great opportunity that I can't let it pass by.

As we speak, we're in the midst of doing an audit on electronic health records for this fall. It's an interesting one too, because we're working in collaboration jointly with six of the provincial auditors general who are looking at how electronic health records are being rolled out in their respective provinces. Stay tuned.

Mr. Patrick Brown: Is Ontario one of them?

Mr. Neil Maxwell: Yes, Ontario is one of the provincial auditors general working with us.

The Chair: We'll now go to Dr. Bennett.

Hon. Carolyn Bennett: There's a little frustration in that if it's measured, it gets noticed. If it gets noticed, it gets done. It's a frustration that we all feel. There's a cottage industry of people looking at data and indicators and steering away from ranking. The whole objective of Canadians being able to understand whether we're winning or losing, with all this money that's going into it, is really not happening.

From the Public Health Agency, the chief public health officers report annually to the CIHI, the Health Council of Canada, and the OECD. The OECD data seem to be better than what we get from any Canadian government department. I'm not sure where the OECD gets theirs from.

But it's frustrating that the goal of being able to tell a Canadian who lives in B.C. whether or not he or she is really doing better on cancer outcomes than somebody who lives somewhere else seems to be not possible. As our colleagues have said, it needs to be put into a grid somewhere to let people figure out that certain provinces are doing better at some things and other provinces are doing better at other things. In the way they have actually reported, interesting provinces, such as Saskatchewan, have said these are the things they're doing really well, these are the things that they've improved on, and these are things where they still need work.

Can we not find a way to get everybody together around a table to say this is the way we would like everybody to report and step up to the table? I would like to know whether or not it's been tried. Have all these groups ever sat in a room together and had a little chat about indicators or data? Whether it's hepatitis C in prisons, or aboriginals on and off reserves, or any of these things, we really need to know if we're winning or losing in terms of our policies. How do Canadians find out how we're doing on post-traumatic stress for the military?

In order for us to fight for more funds for these things, we really need to know that we're funding what works and we've stopped funding what doesn't work. The most exciting thing in the report is to see that tobacco has gone down. We spent $100 million on that. When I was elected, the rate was 31%. It is now 19%. That's a success. Those are the kinds of things that Canadians would hope we're doing.

But maybe I should ask this of the Auditor General's office. You could study anything that you wanted to and you chose to study this. But you chose to do a study instead of an audit, and there are no recommendations. As a group, what are we supposed to do with all this? There are five or more different groups doing the same thing, and not one report speaks to Canadians about what we're doing or how we're doing across the country.

● (1645)

Mr. Neil Maxwell: Madam Chair, to clarify, we're really talking about two different chapters that we are presenting here. One is a study, which is the description of how the federal transfers work in general. The second part, which is very much an audit, is the piece where we have the comments about the health indicator reports.

That's what I took the question to be.

Hon. Carolyn Bennett: It was mainly a rant.

Mr. Neil Maxwell: I got that part of it too.

The Chair: We only have one more minute.

Mr. Neil Maxwell: Thank you, Madam Chair. I'll be brief.

There are really two levels, I would say, where activity has to go on. First of all, Health Canada really needs to get together with all of the other players here. You mentioned the CIHI, the PHAC, and Statistics Canada. When you look at what's been published, there's clearly an opportunity to make some low-hanging fruit, as I would characterize it. There are clearly a lot of things they could be doing, the least of which is simply interpreting the data that they already have.

In the report, there are many examples both provincially and within the federal family, including the chief public health officer's own report, where very insightful interpretation is provided, sometimes with quite limited data. A lot more could be done. But in the longer term are the opportunities that come from improving the indicator set and the data sources. Again, we were quite disappointed to see that four editions into this—eight years—things have been relatively stable, with very little improvement. Again, we're encouraged to see some of the steps that are being taken.

The Chair: I'm sorry, we have to go to Ms. Hughes now.

Dr. Karen Dodds: Madam Chair, if I might just add, in regard to the Organisation for Economic Co-operation and Development, OECD, it's actually Health Canada that supplies them with their data. So the OECD data are indeed passed to them from us.

The Health Council, which got the mandate in the health accords for reporting, has certainly produced annual reports addressing the accord commitments, health outcome reports. If you go to their web page, their list of reporting is quite extensive. It is there and it's available.

The Chair: Thank you.

Ms. Hughes, you're next. You have five minutes.

Mrs. Carol Hughes: I want to thank you again for all your input. It's certainly greatly appreciated, and the work that you do.

We find quite serious the problems identified in chapter 8 concerning the quality of Health Canada reporting. One other glaring illustration is the department's annual reporting on the Canada Health Act. It shows that the problem is systemic in the culture of the department, if not the government, not limited to the *Healthy Canadians* report, and that it really must be dealt with.

The latest Canada Health Act report was basically slipped into the parliamentary record again with the Clerk of the House on February 12. There were no bells, no whistles, not even an announcement. It's very much like last year, when it was tabled while the House wasn't sitting.

We find that the quality of the report is very inadequate. Just as in the *Healthy Canadians* report cited in chapter 8 in front of us, there is no contextualization, no explanation of what the data signifies for a public health system, and once again there are huge gaps in information.

This is a report to the Canadian public on its number one social program. We really rely on this. It is a report to Parliament in order that we as members of Parliament are able to assess the state of the public health of Canada and that we be able to make some changes or suggestions or at least try to improve it.

In preparing for today's meeting, I reviewed past Auditor General reports and referred specifically to the 2002 report, chapter 3, Health Canada, federal support for health care delivery, and its earlier chapter 29 in the 1999 report. The conclusions can still be applied directly today, more than six years later.

So to the Auditor General, basically are you satisfied that your conclusions and recommendations are not treated seriously by Health Canada?

● (1650)

Mr. Neil Maxwell: Thank you, Madam Chair.

Just by way of a little bit of information, we do monitor on an annual basis how well departments are doing on our recommendations. I'll turn to Health Canada specifically in a moment, but in general what we find—it's one of our performance indicators and we publish it in our own departmental performance report—is that, by and large, departments do listen to what we have to say. Our statistics have consistently shown the majority of our recommendations and such get acted on. That's the general case.

More specifically in this case, we have not recently returned to looking at the state of the monitoring of the Canada Health Act, which we looked at in 1999 and again in 2002, as the member has mentioned. So without further study, I wouldn't want to opine the extent to which we're satisfied with the action taken.

Dr. Karen Dodds: I think within Health Canada, as in all federal departments, we also keep track of our action and follow-up in terms of Auditor General reports. Part of each Auditor General report is obviously a response from the department on the action we plan. The Auditor General comes back and checks, but we check regularly as well on making progress.

I know that just within the last week in Health Canada we've done a status report on any outstanding recommendations. Certainly from what I saw, there's nothing going back to 1999 or 2002 that hasn't been fully met in terms of an Auditor General report, but we'll take it back and look at as well.

Mrs. Carol Hughes: Your feedback says that will change with regard to how *Healthy Canadians* will move forward. We'll have to wait, I guess, until we see the Canada Health Act report as to how that actually comes about and whether they're going to coincide or whether it's going to be a totally different report.

I have one more question, if I have enough time.

The Chair: You have 30 seconds.

Mrs. Carol Hughes: Okay, I think I'll just leave it at that. Thanks.

The Chair: Thank you so much.

We'll now go to Ms. McLeod.

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): Thank you, Madam Chair.

First of all, I would like to briefly talk about indicators. The collection of indicators is an ongoing science, and we have increasingly sophisticated opportunities. I think we are making great strides as a government. We've talked about the OECD reports and how they feed through. We truly are doing much better now than we were a number of years ago in looking at these questions.

Perhaps I can also state that to think that anyone who has ever worked at the provincial level is not incredibly accountable to the public for those health care dollars.... You're under an incredible pressure, as I'm sure Madam Murray could attest, of accountability for those dollars. Having said that, it is a responsibility of the provinces, and they are often under a lot of heat for it. The ability to look across Canada is, of course, very important.

I have a few questions, and the first would be this. I appreciate the look at indicators and how you're going to monitor indicators. Where are you going, over time, with that particular piece? You mentioned that there will be some consultation, but is there talk about a framework of regular dialogue to look at the ever-changing opportunities for gathering data on indicators?

Dr. Karen Dodds: One of the great benefits of having the Auditor General come in, even though you're feeling that the Auditor General is always criticizing your program, is that it has people interested in the work you do. For the first time, you get a lot of feedback on the work you do. I have with me colleagues who are involved. I think it is wonderful to hear that there's interest in improving it. We'll take all of these comments into consideration.

As I said, we have indicated that we'll do consultations in this calendar year. We'll certainly feed into them what we've heard from around the table. We heard and paid attention, obviously, to the Auditor General's recommendations. In looking at what we've done with *Healthy Canadians* 2008, which comes out next month, our determination is that we've met five of the seven recommendations. But there are clearly some dealing with the broader interpretation of helping Canadians that we'll still work to improve upon, for sure.

● (1655)

Mrs. Cathy McLeod: I believe we're going to have more opportunities for more sophisticated information as our electronic health and medical records are implemented.

My other question—I have two more, if I have time—is this. There must be real challenges around the aboriginal population, when you have very different groups responsible for the delivery of health care services. Is there anything you can do by way of reporting on some of these populations?

The Chair: Ms. Dodds, do you want to answer that question?

Dr. Karen Dodds: Thank you.

As I said, one of the issues is that when we get the information from the provinces, there's no differentiation with respect to ethnicity. We get a big pool and we can't pull it out. Not all reserves participate in surveys. We have continued to support specific surveys looking at first nations, Inuit, and aboriginals. I've mentioned them before. There's a regional longitudinal health survey, which we've helped support by funding of $12 million. There's another one that we've worked on, the Aboriginal Peoples Survey. With time, with improved relations between government officials and first nations and Inuit health people, and a collaborative approach to indicating what data you want and why.... For Inuit and aboriginal people, their data is their data, so you have to approach surveys and research with them in a specific way. Increasingly, we're able to do that and get better data.

Mrs. Cathy McLeod: And I would—

The Chair: You have 30 seconds, Ms. McLeod.

Mrs. Cathy McLeod: Okay, I'll leave it. Thank you.

The Chair: Are you finished? Okay.

Let's go to Mr. Uppal.

Mr. Tim Uppal (Edmonton—Sherwood Park, CPC): Thank you very much, Madam Chair.

And thank you all for coming and taking the time.

I'm actually going to split my time with Mr. Carrie.

My question may be a simple one, but I think it's important because the report is important and we're into having several of them. I think Canadians in general should know more about the report and should be able to make their own assessments and understand more about it. What are you doing to make the report more available to Canadians or just to make Canadians more aware of the report itself?

Dr. Karen Dodds: In response to one of the Auditor General's recommendations, we are making sure there's going to be a media release this year. The report itself will be available on the website. We'll have some printed copies, but most people now are using the Internet and the web as a way of accessing information. So the report will be available on the website.

We will notify interested parties, because from previous reports we've had connection with some people. All of them will be informed that the report is out, as will other stakeholders we have on our lists. We also intend to make reference to the report in different announcements and speeches that the department's responsible for to try to raise awareness of the report.

Mr. Tim Uppal: I know you touched a bit on this previously, but just what are you doing to improve the report itself from one report to the next? On this report coming up, how would Canadians know it's been improved?

Dr. Karen Dodds: Actually, in the report itself I don't know if we note the improvements. We have more than doubled the number of indicators. We had 17; we've added another 19. In each section there's clearly an interpretation as to how this relates to an accord commitment and a narrative that's in plain language to help Canadians understand the purpose of the indicator.

We decided we wouldn't do the consultations before finalizing the 2008 report because then we wouldn't get the 2008 report out until too long in 2009. It was a hard decision to make. So the consultations that we do this year will feed into our work on the 2010 report.

● (1700)

Mr. Tim Uppal: Okay, thank you.

Mr. Colin Carrie: Thank you, Madam Chair.

I think a lot of Canadians don't understand sometimes the difficult place that the Government of Canada is. It's kind of a juggling act, because the provinces take such a large role in health care delivery. But many people don't understand that the federal government is responsible for the first nations and the Inuit. So Health Canada does that. But then there's the military and National Defence, the veterans and Veterans Affairs, the RCMP, Public Safety, refugees and Citizenship and Immigration, inmates...we're looking at Correctional Service Canada.

Would you be able to explain to us how you work with the different departments that are responsible for these different populations and how you can use that to improve future *Healthy Canadians* reports?

Dr. Karen Dodds: It should be noted that the federal government doesn't provide all care to any specific population. We provide different care to different populations. So for first nations and Inuit people, it can be different if they're on-reserve or off-reserve. We are typically providing primary care, but if specialist services are needed, the story is that you are often flying people down to specialty hospitals that are obviously part of the provincial system. The same thing happens with all of the populations that the federal government has responsibility for. It's not the full bit of services, it's just a part.

That gives us a real challenge with respect to data, but we work with our colleagues in what's called the federal health partnership. So it's an organized forum of all of the departments that have any kind of responsibility for health, and it is very informative. We have worked on shared drug purchases. We've worked on electronic health records together, on health human resources. We need to hire doctors and nurses ourselves. It's just as much a challenge for the federal government as it is for the provinces and the territories to hire doctors and nurses. So we collaborate in that organization.

It's very helpful because such a variety of perspectives come to the table then. Correctional Service has a very different kind of model and set of priorities as compared to us, who are dealing with first nations and Inuit people. So you get a large amount of information gathered and sharing of best ideas.

The Chair: Thank you, Dr. Carrie. Our time is just up now. Thank you.

We have completed our two rounds of seven minutes and five minutes. Mr. Maxwell wanted to have some ending comments today to the committee, but first I want to ask the committee this. We do have about half an hour and I have some announcements to make, so it is the will of the committee whether or not someone else has questions they want to ask.

You do? Okay, we'll go to your question and answer, and then perhaps what we'll do is have Mr. Maxwell wrap up.

Ms. Murray.

Ms. Joyce Murray: Thank you.

Continuing the line of discussion about how we can be more effective with our health spending and get better outcomes so that we don't end up with the entire provincial budgets devoted to health twenty years from now, I'm interested in your comments about the use of trusts for federal funding. What I understand from your report is that there is perhaps even less accountability for how that money is spent than in regular transfers. Would that be correct?

Mr. Neil Maxwell: Thank you, Madam Chair.

I think it's difficult to say if it's more or less. It's different. The accountability is very much different, and as we describe in the study, the mechanism is essentially a trust. It's essentially an unconditional one in that there are some administrative things the provinces need to do, but once the money leaves the federal coffers, it essentially goes without any conditions. As has been described here—and I think the official from Finance Canada described this as well quite well—the federal government is relying very much on this notion that the provinces, having received that money and having made some public declarations, have in recent years.... One thing that Finance Canada has insisted on is that the provinces explain what they're going to use the money for. So it's all built on the principle, on the hope that there will be enough of a dynamic within each of the respective provinces that accountability will follow.

So I think that's the nature of the accountability that so much of this is structured on.

● (1705)

Ms. Joyce Murray: I appreciate that elaboration. I understood that from your remarks.

I'm curious that you've decided to make this a study and not an audit. Had it been an audit, what would your recommendations have been? Are you able to provide them? It sounds like you have some ideas.

Mr. Neil Maxwell: Well, it was a study for the very reason that essentially we asked ourselves a question: what kind of value-added could the legislative auditor add to our clients around this table and throughout Parliament? And our conclusion was that there was a lot of confusion about these transfers. Are they conditional? Are they not conditional? So really our decision to do a descriptive piece was largely because we thought the most important thing was that parliamentarians need to be much better informed about the implications on accountability of these different decisions.

Ms. Joyce Murray: So do you think there shouldn't be trusts as a vehicle for transferring funds for no purposes?

Mr. Neil Maxwell: On that question, the reason we didn't do an audit is that essentially all the judgmental elements here are judgments about policy, and so much of that is the result of all the federal-provincial negotiations that have been described here.

Ms. Joyce Murray: I have a last quick question, and maybe Finance would have a better ability to weigh in on this. Is there a way of distributing funds through trusts? I understand why governments do that towards the end of the year, for good public policy reasons. But is there a way to distribute a trust, have it have the integrity of the financial vehicle that it is, which is essentially independent of the donor, and still have accountability so that we can know that it is contributing or how it is contributing to the goals that the government has?

Ms. Monika Bertrand: The conditionalities surrounding trust funds are in terms of eligibility. So I think it was mentioned that there are operating principles, and operating principles outline the rationale for providing the funding and they give some broad examples of how the funding should be used. What Finance has asked provinces to do with recent trust funds is to make public announcements to their residents to make sure they understand what the operating principles are and to give some examples of how they intend to use these funds.

So those are eligibility conditions. Once they meet those, the funding flows to the trustee and provinces can then draw this funding and use it according to their own needs. Now, what we do in those operating principles—and this is really all we can do—is encourage provinces and territories to report back to their residents.

Ms. Joyce Murray: Can you force them to?

Ms. Monika Bertrand: No.

The Chair: Thank you, Ms. Murray.

Ms. Dodds.

Dr. Karen Dodds: Thank you.

I'd like to make some comments about health spending writ large, because we certainly do track health spending and track the drivers of health spending and that kind of information.

A study done internally looking at every year going back to 1970 has shown that the increase in health funding has not had a negative impact on other programs at the federal or provincial levels. When you look at our expenditure, GDP versus health expenditure, we're right in the middle of the pack with respect to other OECD numbers. When you look at GDP growth versus expenditure growth and compare us to other OECD countries, we're the lowest. So to put things in context internationally, we're all seeing increased health costs, clearly improvements are being made, clearly we are increasing our usage of the system, and yet our health spending is, over GDP, the lowest of the OECD countries.

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

Mr. Maxwell, would you now like to give some closing comments?

Mr. Neil Maxwell: Yes, thank you, Chair. Thank you very much for this opportunity to come here and talk about our work. This is what we live for, and this is why we do all this work.

The other thought I had to leave with your committee is in terms of what next steps might be. As I mentioned before, as the auditors we monitor annually what kind of action is done by departments, satisfactory or unsatisfactory. We will do that for the health indicators.

I might suggest that the interest that's been shown today might well lead your committee to revisit this question. It seems to me that in the coming year there will be two very important events. One will be when the 2008 *Healthy Canadians* is available, when people are no longer talking about it in theory but have something concrete to look at. Your committee might wish to revisit this topic then. I think the other very important thing in the next year—and we haven't talked much about this—is the response by Health Canada, but they intend to do quite a thorough evaluation by August 2009.

Again, I thank you for the interest.

● (1710)

The Chair: Mr. Maxwell, Ms. Dodds, and of course Ms. Dyer, Ms. Bertrand, everybody who's here, Ms. Dubé, Mr. Wheeler—I don't want to leave anyone out—I have to say that all of you have been contributors to this conversation today and to these questions. We really appreciate your coming. I know each one of us has gained a lot of insight from some of your questions and answers today to some of the questions we had. We really felt this was a real treat for our committee.

So thank you so much for doing that. And I would bid you goodbye. I'm sorry, we have to go right into another part of our committee, but certainly we will contact you again and speak with you on some of these issues. Thank you.

Committee, while our guests are departing, we'll talk about our future business. I think we need to go in camera for this. So we'll suspend for just a couple of minutes to allow our guests to depart as we go in camera.

[*Proceedings continue in camera*]

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